MEDICAL BOARD OF CALIFORNIA
LICENSE LOOKUP SYSTEM

License Information:

The following information is maintained by the Medical Board of California. For more information, click on the blue tabs above.

License:	**G 41844** Licensee may be a U.S. or Canadian medical school graduate whose pathway to licensure was based on the NBME examination.
License Type:	Physician and Surgeon
Name:	AQUADON E UMOREN, M.D.
Address of Record:	**PO BOX 1444** **CORONA, CA 92878**
Address of Record County:	RIVERSIDE
License Status:	**License Renewed & Current** Licensee meets requirements for the practice of medicine in California.
Public Record Action(s):	No Public Record Actions available
Original Issue Date:	July 23, 2003
Expiration Date:	February 28, 2013
School Name:	UNIVERSITY OF ILLINOIS COLLEGE OF MEDICINE
Year Graduated:	1978

Survey Information:

The following information is **self-reported by the licensee and has not been verified by the Board.**

Activities In Medicine:	PATIENT CARE - 1 TO 9 HOURS
Primary Practice Location Zip Code:	92562
Board Certification(s):	OBSTETRICS & GYNECOLOGY Visit ABMS to verify
Primary Practice Area(s):	OBSTETRICS & GYNECOLOGY
Secondary Practice Area(s):	No secondary practice areas identified
Post Graduate Training Years:	4 YEARS
Ethnic Background:	Declined to Disclose
Foreign Language(s):	Declined to Disclose
Gender:	Declined to Disclose

Public Record Action(s):

Please select the Public Record Documents tab to view the public document database. If information is posted in the Administrative Disciplinary Actions, Court Order, Administrative Citation Issued, or License Issued with Public Letter of Reprimand categories below, documents may be available for review. To find out what information is and is not available, please click here.

Administrative Disciplinary Actions:

The Medical Board's public disclosure screens are updated periodically as new information becomes available. Please contact the Central File Room at (916) 263-2525 or at 2005 Evergreen Street, Suite 1200, Sacramento, CA 95815, to obtain a copy of public documents at a minimal charge.

No Administrative Disciplinary Actions found.

Court Order:

This information would be provided if a physician's practice has been temporarily restricted or suspended pursuant to a court order. Please contact the Central File Room at (916) 263-2525 or at 2005 Evergreen Street, Suite 1200, Sacramento, CA 95815, to obtain a copy of the public documents.

No Court Orders found.

Administrative Action Taken by Other State or Federal Government:

This information is provided by another state/federal government agency. The Medical Board of California may take administrative action based on the action imposed by another state/federal government agency. For more information or verification, contact the agency listed below that imposed the action.

No Administrative Actions Taken by Other State or Federal Government found.

Felony Conviction:

The information provided only includes felony convictions that are known to the Board. All felony convictions known to the Board are reviewed and administrative action is taken only if it is determined that a violation of the Medical Practice Act occurred. For more information regarding felony convictions, contact the court of jurisdiction listed below.

No Felony Convictions found.

Misdemeanor Conviction:

California Business and Professions Code section 2027 (A)(7) states effective 1/1/07, any misdemeanor conviction that results in a disciplinary action or an accusation that is not subsequently withdrawn or dismissed shall be posted on the Internet. To see if a conviction has been expunged or dismissed, please contact the court below.

No Misdemeanor Convictions found.

Administrative Citation Issued:

A citation and/or fine has been issued for a minor violation of the law. This is not considered disciplinary action under California law but is an administrative action. Payment of the fine amount represents satisfactory resolution of this matter.

No Administrative Citations found.

License Issued with Public Letter of Reprimand:

The Medical Board of California has concurrently issued the applicant a medical license and a Public Letter of Reprimand for a minor violation that does not require probationary status or warrant denial. The issuance of a Public Letter of Reprimand is not considered disciplinary action and is not reported to the National Practitioner Databank or the Federation of State Medical Boards.

No License Issued with Public Letter of Reprimand found.

Hospital Disciplinary Action:

The action taken by this healthcare facility against this physician's staff privileges to provide health care services at this facility was for a medical disciplinary cause or reason. The Medical Board is authorized by law to disclose only revocations and terminations of staff privileges. The Medical Board is prohibited from releasing a copy of the actual report or any other information.

No Hospital Disciplinary Actions found.

Malpractice Judgment:

A malpractice judgment is a payment for damages and does not necessarily reflect that the physician's medical competence is below the standard of care. The Medical Board reviews all such reported judgments and action is taken only if it is determined that a violation of the Medical Practice Act occurred. The Medical Board is prohibited by law from releasing a copy of the judgment report or any other information concerning the judgment. For more information contact the court of jurisdiction listed below.

No Malpractice Judgments found.

Arbitration Award:

An arbitration award is a payment for damages and does not necessarily reflect that the physician's medical competence is below the standard of care. The Medical Board reviews all such reported arbitration awards and action is taken only if it is determined that a violation of the Medical Practice Act occurred. The Medical Board is prohibited by law from releasing a copy of the arbitration award report or any other information concerning the award.

No Arbitration Awards found.

Malpractice Settlements:

A settlement entered into by the licensee is a resolution of a claim for damages for death or personal injury caused by the licensee's negligence, error, or omission in practice, or by his or her rendering of unauthorized professional services. The Medical Board is required by law to disclose certain information related to the existence of multiple settlements made on or after January 1, 2003 in an amount of $30,000 or more.

No Malpractice Settlements found.

Note: "No information available from this agency" may not indicate none exists; but indicates no information has been reported to the Medical Board of California and/or that the Board is unable to post the information on the Web site by law.

Public Record Documents:

All imaged documents provided by the Medical Board are being made available to provide immediate access for the convenience of interested persons. While the Medical Board believes the information to be reliable, human or mechanical error remains a possibility, as does delay in the posting or updating of information. Therefore, the Medical Board makes no guarantee as to the accuracy, completeness, timeliness, currency, or correct sequencing of the information. The Medical Board shall not be responsible for any errors or omissions, or for the use or results obtained from the use of this information. The types of documents which are available include, but are not limited to, accusations, decisions, suspension/restriction orders, public letters of reprimand and citations.

No documents found.

Please note that documents with an effective date prior to calendar year 2000 may not be available via the Web. To obtain a copy of the documents not posted on this site, please contact the Central File Room at (916) 263-2525 or click here for information on ordering public documents.

STATE OF CALIFORNIA — STATE AND CONSUMER SERVICES AGENCY

GRAY DAVIS, Governor

State of California Department of Consumer Affairs

MEDICAL BOARD OF CALIFORNIA

1426 Howe Avenue, Suite 54, Sacramento, CA 95825-3236
TEL: (916) 263-2499/FAX: (916) 263-2487 Internet: www.medbd.ca.gov

RECEIVED SACRAMENTO MEDICAL BOARD OF CALIFORNIA 03 APR 25 PM 12:18

525-4-2503

APPLICATION FOR PHYSICIAN'S AND SURGEON'S LICENSE

009918

Please READ all instructions prior to completing this application. ALL questions on this application must be answered, and all supporting documents must be submitted as per instructions. Please type or print neatly. When space provided is insufficient, attach additional sheets of paper. All attachments are considered part of the application.

FALSIFICATION OR MISREPRESENTATION OF ANY ITEM OR RESPONSE ON THIS APPLICATION OR ANY ATTACHMENT HERETO IS A SUFFICIENT BASIS FOR DENYING OR REVOKING A LICENSE.

MBC USE ONLY — Personal Data

1. NAME: Last: UMOREN First: AQUADON Middle: EMMANUEL

2. Other names you have used (include maiden name): NONE

3. U.S. Social Security Number*: [redacted]

4A. (PUBLIC ADDRESS; will be released by the Board to the public): Number and Street/P.O. Box/Rural Route/Apartment Number, if any. [redacted]

City [redacted] State [redacted] Zip Code [redacted] Country

4B. (CONFIDENTIAL ADDRESS): Number and Street/Rural Route/Apartment Number, if any. [Applicants must provide a confidential street address if a P. O. Box is used as the Public Address in #4A above.] [redacted]

City [redacted] State [redacted] Zip Code [redacted] Country

5. Telephone Number:
Home: [redacted]
Work: [redacted]

6. California Driver's License Number (optional): NUMBER EXPIRATION

7. Date of Birth (Month/Day/Year) and Place of Birth: [redacted] [redacted]

8. Sex: ☒ Male ☐ Female

9. Are you a U.S. citizen? ☒ Yes ☐ No

10. Have you ever filed an application for Physician's and Surgeon's examination or licensure in California? ☒ Yes ☐ No

IF YES, PLEASE GIVE DATE PREVIOUS APPLICATION WAS SUBMITTED. 1980

11. List the names and locations of all colleges or universities attended where pre-professional, postsecondary instruction was received. Please submit official transcripts with the school seal affixed for each school attended. Transcripts will not be returned.

MBC USE ONLY — Pre-Medical Education

Name	City, State, Country	Dates of Attendance
LOYOLA UNIVERSITY OF CHICAGO	CHICAGO . ILL. U.S.A.	1969 — 1973

12. List the names and locations of all schools where professional medical instruction was received, and, where applicable, the degree awarded.
PLEASE SUBMIT: 1) an original Certificate of Medical Education (Form L2) and official transcripts with the signature of the dean or registrar and the school seal affixed from each school attended; and,
2) an original medical diploma and a 8 1/2" x 11" photocopy (original diploma will be returned).

MBC USE ONLY — Medical Education — L2 Trans

School Name	City, State, Country	Dates of Attendance	Degree Awarded
UNIVERSITY OF ILLINOIS SCHOOL OF MEDICINE	CHICAGO . ILL . U.S.A.	1974 — 1978	M.D.

DOCTOR OF MEDICINE DEGREE, as referenced above.

Name of Medical School	Address of Medical School	Exact Date of Issuance
UNIVERSITY OF ILLINOIS SCHOOL OF MEDICINE	P.O. BOX 5220 CHICAGO ILLINOIS 60680	SEPT 1974 - DEC 1978

* MANDATORY DISCLOSURE OF U.S. SOCIAL SECURITY NUMBERS

Disclosure of your U.S. social security number is mandatory. Section 30 of the Business and Professions Code and Public Law 94-455 (42 USCA 405(c)(2)(C)) authorize collection of your social security number. Your social security number will be used exclusively for tax enforcement purposes, for purposes of compliance with any judgment or order for family support in accordance with Section 17520 of the Family Code, or for verification of licensure or examination status by a licensing or examination entity which utilizes a national examination and where licensure is reciprocal with the requesting state. If you fail to disclose your social security number your application for initial licensure will not be processed AND you will be reported to the Franchise Tax Board, which may assess a $100 penalty against you.

MBC USE ONLY
1001
School Code

L1A

07A-100 (Rev. 3/01)

MBC USE ONLY

13. Have you taken any of the following written examinations:- National Boards, other state boards, USMLE, SPEX, FLEX, ECFMG or LMCC? ☒ Yes ☐ No

Written Examination

IF YES, LIST NAME, LOCATION, DATE AND RESULT OF EACH EXAMINATION; FAILURES MUST ALSO BE DISCLOSED. EACH EXAMINATION AGENCY MUST SUBMIT AN ORIGINAL OFFICIAL EXAMINATION HISTORY REPORT DIRECTLY TO THE MEDICAL BOARD OF CALIFORNIA. THESE REPORTS WILL NOT BE RETURNED.

Examination	Date	Result (Pass/Fail)
NATIONAL BOARDS PARTS I, II, III	1975, 1978, 1980	[redacted]

☑ ☐ ☐

14. Have you ever been licensed to practice medicine in any state, territory, province, country, or U.S. federal jurisdiction? ☒ Yes ☐ No

License Data

IF YES, LIST THE JURISDICTION, LICENSE NUMBER, DATE ISSUED AND DATES OF PRACTICE IN THAT JURISDICTION. PLEASE INCLUDE PERMANENT, TEMPORARY, TRAINING, PROVISIONAL, LIMITED LICENSE, OR PERMIT. AN ORIGINAL OFFICIAL LETTER OF GOOD STANDING (LGS), OR COMPARABLE LICENSE HISTORY CERTIFICATION, IS REQUIRED FOR EACH PERMANENT, TEMPORARY, TRAINING, PROVISIONAL, LIMITED LICENSE, OR PERMIT OBTAINED IN ANY U.S. STATE, U.S. OR CANADIAN TERRITORY, CANADIAN PROVINCE, OR U.S. FEDERAL JURISDICTION. EACH LGS, OR COMPARABLE CERTIFICATION, SHOULD BE MAILED BY THE ISSUING AUTHORITY DIRECTLY TO THE MEDICAL BOARD OF CALIFORNIA.

LGS

Jurisdiction	License Number	Date of Issuance	Dates of Practice in that Jurisdiction
ALABAMA	17872	02/14/94	STILL PRESENTLY LICENSED
MISSISSIPPI	14368	06/95	STILL PRESENTLY LICENSED

☐ ☒ ☑ ☐

15. Do you hold any other professional license in any state, territory, province, country, or U.S. federal jurisdiction? ☐ Yes ☒ No

IF YES: PROFESSION: _____, LICENSE NO.: _____, JURISDICTION: _____.

Other Professional Licenses

HAS THIS LICENSE EVER BEEN REVOKED, OR SUBJECT TO DISCIPLINE? IF YES, PLEASE PROVIDE ALL OFFICIAL DOCUMENTATION REGARDING THE MATTER IN ADDITION TO A WRITTEN EXPLANATION. YOU ARE ALSO REQUIRED TO REPORT ANY MATTER THAT IS PENDING OR IN WHICH CHARGES HAVE BEEN DROPPED OR EXPUNGED.

☒ Yes ☒ No

☑

16A. Are you currently, or have you ever been, a participant in a postgraduate training program in a facility in the U.S. or Canada? (You must include every residency, internship, and fellowship, whether or not completed.) ☒ Yes ☐ No

Postgraduate Training

IF YES, LIST NAMES AND ADDRESSES OF ALL FACILITIES. SUBMIT AN ORIGINAL CERTIFICATE OF COMPLETION OF ACGME/RCPSC POSTGRADUATE TRAINING (FORM L3A) FROM EACH FACILITY. (DO NOT COMPLETE FORM L3As TO DOCUMENT TRAINING RECEIVED IN RESEARCH FELLOWSHIP PROGRAMS.) ALL TRAINING MUST BE LISTED, REGARDLESS OF WHETHER IT WAS SATISFACTORILY COMPLETED OR WILL BE USED TO MEET LICENSING REQUIREMENTS.

Facility Name	Address	Categorial Specialty Area	Dates of Attendance
MARTIN LUTHER KING JR/ CHARLES DREW HOSPITAL	12021 S. WILMINGTON AVE, LA. CA 90059	INTERNSHIP/GMS	JAN 1979 - DEC 1979
MARTIN LUTHER KING JR CHARLES DREW HOSPITAL	12021 S. WILMINGTON AVE, LA CA 90059	RESIDENCY	JAN 1980 - JUN 1983

☑ ☐ ☐ ☐

QUESTIONS 16B through 23:
If you answer YES to any of the following questions, please provide ALL official documentation regarding the matter in addition to your written personal explanations. An applicant must provide official hearing/court documents and original letters of explanation from medical schools or training program directors. If these documents are not provided with the application, they will be requested before review of the application can proceed. APPLICANTS ARE REQUIRED TO REPORT ANY MATTER THAT IS PENDING OR IN WHICH CHARGES HAVE BEEN DROPPED OR EXPUNGED.

16B. Have you ever withdrawn from, or been suspended, dismissed or expelled from a medical school or postgraduate training program OR have you ever taken a leave of absence from such a school or program?

IF YOU ANSWERED YES, BOTH APPLICANT AND SCHOOL/PROGRAM MUST PROVIDE DETAILS ON A SEPARATE ATTACHMENT.

☒ Yes ☒ No

☑

NAME OF APPLICANT: AQUADON E. UMOREN M.D.

DATE OF BIRTH: [redacted]

L1B

MBC USE ONLY

License Data

For all of the below, also include any disciplinary actions by the U.S. Military, U.S. Public Health Service, or other U.S. federal governmental entity.

17A. Have you ever been charged with, or been found to have committed, unprofessional conduct, professional incompetence, gross negligence, or repeated negligent acts or malpractice by any medical licensing board, other agency, or hospital?

17B. Has any disciplinary action ever been filed or taken, including but not limited to, informal or confidential discipline, consent orders, or letters of warning, regarding any healing arts license which you now hold or have ever held?

17C. Is any such action as described above pending?

17(A) X Yes X No

17(B) X Yes X No

17(C) X Yes X No

IF YOU ANSWERED YES TO 17A, 17B OR 17C, PROVIDE DETAILS ON A SEPARATE ATTACHMENT.

18. Has a claim or action for damages ever been filed against you in the course of the practice of medicine or any other healing art which resulted in a malpractice settlement, judgement, or arbitration award of over $30,000.00?

X Yes X No

IF YOU ANSWERED YES, PROVIDE DETAILS ON A SEPARATE ATTACHMENT.

OK

19. Have you ever been denied a license, permission to practice medicine or any other healing art, or denied permission to take an examination in any state, territory, country, or U.S. federal jurisdiction, or is any such action pending?

X Yes X No

IF YOU ANSWERED YES, PROVIDE DETAILS ON A SEPARATE ATTACHMENT.

20. Have you ever voluntarily surrendered a license to practice medicine or any other healing arts in this or any other state, or voluntarily surrendered your narcotic (controlled substance) permit (state or federal) to any licensing board or any other agency, or is any such action pending?

X Yes X No

IF YOU ANSWERED YES, PROVIDE DETAILS ON A SEPARATE ATTACHMENT.

21. Have you ever had staff privileges in a hospital denied, suspended, limited, revoked, or not renewed for medical disciplinary cause, or resigned from a medical staff in lieu of disciplinary or administrative action, or is any such action pending?

X Yes X No

YOU MUST DISCLOSE ANY INFORMAL OR CONFIDENTIAL DISCIPLINARY ACTION.

22. Do you have any condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety, including but not limited to, any of the following?

X Yes X No

IF YES, PLEASE CHECK THE APPROPRIATE BOX(ES) BELOW:

- ☐ A condition which required admission to an inpatient psychiatric treatment facility.
- ☐ Alcohol or chemical substance dependency or addiction.
- ☐ Emotional, mental or behavioral disorder.
- ☐ Other (explain): _____

FOR ANY OF THE BOXES CHECKED ABOVE, PLEASE SUBMIT COMPLETE OFFICIAL INPATIENT AND OUTPATIENT TREATMENT RECORDS, EVIDENCE OF ONGOING REHABILITATION TREATMENT, AND A PERSONAL WRITTEN EXPLANATION.

FOR ALL OF THE BELOW, YOU ARE REQUIRED TO LIST ANY CONVICTION THAT HAS BEEN SET ASIDE AND DISMISSED OR EXPUNGED, OR WHERE A STAY OF EXECUTION HAS BEEN ISSUED.

23A. Have you ever been convicted of, or pled nolo contendere to, ANY violation (include every misdemeanor or felony) of any local, state, or federal law of any state, territory, country, or U.S. federal jurisdiction?

23B. Is any criminal action related to the above pending?

23 (A) X Yes X No

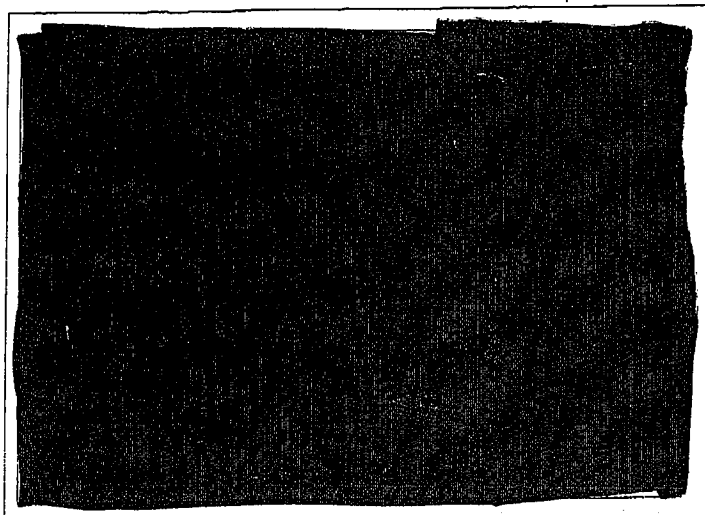
23 (B) X Yes X No

IF YOU ANSWERED YES TO 23A OR 23B, PROVIDE DETAILS ON A SEPARATE ATTACHMENT.

NAME OF APPLICANT: AQUADON E. LIMOREN MD

DATE OF BIRTH: [redacted]

L1C



Notice: All items in this application are mandatory; none are voluntary. Failure to provide any of the requested information will delay the processing of your application. The information provided will be used to determine your qualifications for licensure per Section 2080 of the California Business and Professions Code, which authorizes the collection of this information. The information on your application may be transferred to other medical licensing authorities, the Federation of State Medical Boards, or other governmental or law enforcement agencies. You have the right to review your application subject to the provisions of the Information Practices Act. The Chief of the Licensing Program is the custodian of records.

Applicant Declaration/Signature *and* NOTARY

STATE OF Tx

COUNTY OF Harris

The applicant, AQUADON E. UMOREN M.D., [redacted], being first duly sworn
(PLEASE PRINT FULL NAME) (DATE OF BIRTH)

upon his/her oath deposes and says: that I am the person herein named subscribing to this application; that I have read the complete application, know the full content thereof, and declare under penalty of perjury, that all of the information contained herein and evidence or other credentials submitted herewith are true and correct; that I am the lawful holder of the degree of Doctor of Medicine as prescribed by this application, that the same was procured in the regular course of instruction and examination, and that it, together with all the credentials submitted, were procured without fraud or misrepresentation or any mistake of which I am aware and that I am the lawful holder thereof. Further, I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past, present, and future), business and professional associates (past, present, and future), and all government agencies (local, state, federal, or foreign) to release to the Medical Board of California or its successors any information, files or records, including medical records, educational records, and records of psychiatric treatment and treatment for drug and/or alcohol abuse or dependency, requested by that Board in connection with this application; or any further or future investigation by that Board necessary to determine my medical competence, professional conduct, or physical or mental ability to safely engage in the practice of medicine. I further authorize the Medical Board of California or its successors to release to the organizations, individuals, or groups listed above any information which is material to this application or any subsequent licensure. **I UNDERSTAND THAT FALSIFICATION OR MISREPRESENTATION OF ANY ITEM OR RESPONSE ON THIS APPLICATION OR ANY ATTACHMENT HERETO IS A SUFFICIENT BASIS FOR DENYING OR REVOKING A LICENSE.**

SIGNATURE OF APPLICANT: A E Umoren
(PLEASE SIGN FULL NAME, NOT INITIALS)

Signed and sworn to before me this 01 day of April 2003
MONTH YEAR

RUBEN REYES
Notary Public, State of Texas
My Commission Expires
MARCH 26, 2005

NOTARY SEAL

Ruben Reyes
SIGNATURE OF NOTARY PUBLIC

14104 NW FRWY Hou, Tx 77040
ADDRESS

My commission expires _____

L1D

STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY — EDMUND G. BROWN JR., Governor

DEPARTMENT OF Consumer Affairs

BOARD OF MEDICAL QUALITY ASSURANCE
1430 HOWE AVENUE, SACRAMENTO, CALIFORNIA 95825
Applications and Examinations
920-6411

PLEASE FORWARD TO YOUR MEDICAL SCHOOL

CERTIFICATE OF EDUCATION

This Certifies That Aqua Don Umoren
(Full name of applicant)

enrolled in University of Illinois Medical Center., Chicago
(Name of medical school (college))

on the 23rd day of September (Month) 19 74 (Year).

☒ as a Freshman.

☐ with advanced standing based on _____ (Please specify).

The undersigned further certifies that official transcripts on file show that prior to completing the study of medicine the applicant herein referred to completed at least a two-year resident course of college grade including:

☐ PHYSICS ☐ CHEMISTRY ☐ BIOLOGY (or) ZOOLOGY (Check course(s) completed)

at _____ (Please indicate school), and that he attended while at this

medical school (college) Four (4) (Specify number) courses of lectures of Thirty-Six (36) (Specify number of weeks) weeks each,

completing _____ (Total hours) hours in the subjects below listed, and that he/she:

☒ was granted the degree { Bachelor / Doctor } of Medicine

☐ left the above mentioned medical school (college) for the following reasons(s):

_____

_____

on the 2nd day of December (Month) 19 78 (Year).

Please indicate which of the following courses of study were successfully undertaken by the applicant:

Anatomy	Dermatology	Preventive medicine, including nutrition	Otolaryngology
Embryology	Physical medicine	Radiology, including radiation safety	Obstetrics and gynecology
Histology	Therapeutics	Medicine	Human sexuality as defined in Section 2192.3
Neuroanatomy	Tropical medicine	Pediatrics	Child abuse detection and treatment
Physiology	Surgery, including orthopedic surgery	Psychiatry	
Biochemistry	Urology	Neurology	
Pathology, bacteriology and immunology	Ophthalmology	Anesthesia	
	Pharmacology		

(Please see attached Transcript.)

Signed and the College seal affixed this 18th day of April (Month) 19 80 (Year).

[Affix Seal Here]

By _____ (President, Secretary, Dean)

Gerald L. Schmidt Ed.D.
Associate Director of Records.

MEDICAL BOARD OF CALIFORNIA LICENSE RENEWAL APPLICATION
PHYSICIAN AND SURGEON

SSN= [redacted]

ART 3

State of California Department of Consumer Affairs

YES, I WISH TO CONTRIBUTE $25 FOR THE FAMILY PHYSICIAN TRAINING PROGRAM

YES I WISH TO CONTRIBUTE $50 FOR THE S.M. THOMPSON LOAN REPAYMENT PROGRAM

ENSE NO. 141844

EXPIRES 02/28/07

	AMOUNT DUE NOW	DELINQ FEE IF POSTMARKED AFTER 03/30/07
	$805.00	$885.50
VOLUNTARY FEE =	$	$
TOTAL ENCLOSED =	$	$

TIVE AQUADON E. UMOREN
CROWN MEDICAL GROUP INC.
36450 INLAND VALLEY DR #201
WILDOMAR CA 92595

D. Continuing Medical Education (CME) Certification Statement: I CERTIFY UNDER PENALTY OF PERJURY UNDER THE LAWS OF CALIFORNIA TO THE FOLLOWING STATEMENT : CERTIFY THAT I DO MEET EACH OF THE CONTINUING MEDICAL EDUCATION REQUIREMENTS LISTED ON THE BACK OF THIS FORM OR THAT I MEET THE CONDITIONS WHICH WOULD EXEMPT ME FROM ALL OR PART OF THE REQUIREMENTS OR I HOLD A PERMANENT CME WAIVER.

SIGNATURE REQUIRED HERE: _____ DATE: _____

E. FOR ADDRESS CHANGE ONLY
IF YOUR ADDRESS SHOWN IS INCORRECT, CORRECT IT BELOW.

STREET 25470 MEDICAL CENTER DR #205

CITY MURRIETA STATE CA ZIP 92562

PHONE NUMBER ( )

G. FINANCIAL INTEREST STATEMENT:
I CERTIFY UNDER PENALTY OF PERJURY THAT I HAVE DISCLOSED ON THIS RENEWAL APPLICATION FORM (SEE REVERSE FOR SPACE) THE NAMES OF THOSE HEALTH-RELATED FACILITIES IN WHICH I OR MY FAMILY HAVE A FINANCIAL INTEREST OR I CERTIFY UNDER PENALTY OF PERJURY I HAVE NO FINANCIAL INTEREST TO DISCLOSE.

Signature required here

11/12 Hold

002181 72 63010700006 000418442 022309
BANK OF AMERICA 148 CA ST TREAS-DEPT OF CONSUMER AFFAIRS

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
PO BOX 942520
SACRAMENTO CA 94258-0520

G. Financial Interest Statement

Please print or type the name(s) and address(es) of each health-related facility in which you or your immediate famil have a financial interest. If more space is needed, please attach additional listings. If you have no interests to declare, please write "none" in the area below and sign your name o the front of this document at G.

Health-Related Facility Name	Address

SMBCLS 02/28/05

RETURN THE ENTIRE FORM TO THE RETURN ADDRESS ON THE BACK. MAKE A PHOTOCOPY FOR YOUR RECORDS.

PART 2

Since you last renewed your license, have you had any license disciplined by a government agency or other disciplinary body; or, have you been convicted of any crime in any state, the U S A and its territories, military court or a foreign country? PLEASE READ INSTRUCTIONS BEFORE ANSWERING I. ☐ YES J. ☒ NO

License Renewal Applicatic
Physician and Surgeon

F. ☐ YES, I WISH TO CONTRIBUTE $25 FOR THE FAMILY PHYSICIAN TRAINING PROGRAM

H. ☐ YES, I WISH TO CONTRIBUTE $50 FOR THE S.M. THOMPSON LOAN REPAYMENT PROGRAM

D. **Continuing Medical Education (CME) Certification Statement:** I CERTIFY UNDER PENALTY OF PERJURY UNDER THE LAWS OF CALIFORNIA TO THE FOLLOWING STATEMENT: I CERTIFY THAT I DO MEET EACH OF THE CONTINUING MEDICAL EDUCATION REQUIREMENTS LISTED ON THE BACK OF THIS FORM OR THAT I MEET THE CONDITIONS WHICH WOULD EXEMPT ME FROM ALL OR PART OF THE REQUIREMENTS OR I HOLD A PERMANENT CME WAIVER.

SIGNATURE REQUIRED HERE: A E Umoren DATE: 02/12/0

LICENSE NO.	EXPIRES	AMOUNT DUE NOW	DELINQ FEE IF POSTMARKED AFTER 03/30/09
G 41844	02/28/09	$805.00	$885.50
	VOLUNTARY FEE =	$	$
	TOTAL ENCLOSED =	$ 805.00	$

ACTIVE AQUADON E. UMOREN
25470 MEDICAL CENTER #205
MURRIETA CA 92562

E. **FOR ADDRESS CHANGE ONLY**
IF YOUR ADDRESS SHOWN IS INCORRECT, CORRECT IT BELOW.

STREET P. O. Box 1444
CITY CORONA STATE CA ZIP 92878
PHONE NUMBER (205) 365-1356

G. **FINANCIAL INTEREST STATEMENT**
I CERTIFY UNDER PENALTY OF PERJURY THAT I HAVE DISCLOSED ON THIS RENEWAL APPLICATION FORM (SEE REVERSE FOR SPACE) THE NAMES OF THOSE HEALTH-RELATED FACILITIES IN WHICH I OR MY FAMILY HAVE A FINANCIAL INTEREST OR I CERTIFY UNDER PENALTY OF PERJURY I HAVE NO FINANCIAL INTEREST TO DISCLOSE.

A E Umoren
Signature required here

OVER

630107000007000060004184420102280900080500000088550

002622 182 63010700006 000418442 012111
BANK OF AMERICA 148 CA ST TREAS-DEPT OF CONSUMER AFFAIRS

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
PO BOX 942520
SACRAMENTO CA 94258-0520

G. Financial Interest Statement

Please print or type the name(s) and address(es) of each health-related facility in which you or your immediate family have a financial interest. If more space is needed, please attach additional listings. If you have no interests to declare, please write "none" in the area below and sign your name on the front of this document at G.

Health-Related Facility Name	Address
24 786.00	

SMBCLS 03/28/09

License Renewal Applicatio
Physician and Surgeon

PART 1 — Since you last renewed your license, have you had any license disciplined by a government agency or other disciplinary body; or, have you been convicted of any crime in any state, the U S A and its territories, military court or a foreign country? PLEASE READ INSTRUCTIONS BEFORE ANSWERING I. ☐ YES J. ☒ NO

D. **Continuing Medical Education (CME) Certification Statement:** I CERTIFY UNDER PENALTY OF PERJURY UNDER THE LAWS OF CALIFORNIA TO THE FOLLOWING STATEMENT: I CERTIFY THAT I DO MEET EACH OF THE CONTINUING MEDICAL EDUCATION REQUIREMENTS LISTED ON THE BACK OF THIS FORM OR THAT I MEET THE CONDITIONS WHICH WOULD EXEMPT ME FROM ALL OR PART OF THE REQUIREMENTS OR I HOLD A PERMANENT CME WAIVER.
SIGNATURE REQUIRED HERE: A.E. Umoren DATE: 01/15/11

F. ☐ YES, I WISH TO CONTRIBUTE $25 FOR THE FAMILY PHYSICIAN TRAINING PROGRAM

LICENSE NO.	EXPIRES	AMOUNT DUE NOW	DELINQ FEE IF POSTMARKED AFTER 03/30/11
G 41844	02/28/11	$786.00	$864.00
	VOLUNTARY FEE =	$	$
	TOTAL ENCLOSED =	$ 786.00	$

ACTIVE AQUADON E. UMOREN
PO BOX 1444
CORONA CA 92878

E. FOR ADDRESS CHANGE ONLY
IF YOUR ADDRESS SHOWN IS INCORRECT, CORRECT IT BELOW.

STREET _____

CITY _____ STATE _____ ZIP _____

PHONE NUMBER ( )

G. FINANCIAL INTEREST STATEMENT
I CERTIFY UNDER PENALTY OF PERJURY THAT I HAVE DISCLOSED ON THIS RENEWAL APPLICATION FORM (SEE REVERSE FOR SPACE) THE NAMES OF THOSE HEALTH-RELATED FACILITIES IN WHICH I OR MY FAMILY HAVE A FINANCIAL INTEREST OR I CERTIFY UNDER PENALTY OF PERJURY I HAVE NO FINANCIAL INTEREST TO DISCLOSE.

Signature required here

OVER

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