

### License Information:

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

License:	A 92178  Licensee may be a U.S. or Canadian medical school graduate whose pathway to licensure was based on the FLEX (Federation Licensing Exam), USMLE (United States Medical Licensing Exam) or LMCC (Licentiate of Medical Council of Canada) written examination and has been licensed less than four years in another state OR may be an International medical school graduate whose pathway to licensure was based on the above exams or approved combinations of the NBME (National Board Medical Exam), FLEX or USMLE.
License Type:	Physician and Surgeon
Name:	ROY SILVER, M.D.
Address of Record:	SUITE 444E 8631 W 3RD STREET LOS ANGELES, CA 90048
Address of Record County:	LOS ANGELES
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 15, 2005
Expiration Date:	July 31, 2013
School Name:	ST. GEORGE'S UNIVERSITY SCHOOL OF MEDICINE
Year Graduated:	2000

### **Survey Information:**

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

Activities In Medicine:	PATIENT CARE - 40+ HOURS	
Primary Practice Location Zip Code:	90048	
Board Certification(s):	No board certifications identified	
Primary Practice Area(s):	OBSTETRICS & GYNECOLOGY	
Secondary Practice Area(s):	No secondary practice areas identified	
Post Graduate Training Years:	4 YEARS	
Ethnic Background:	CAUCASIAN/WHITE/EUROPEAN/MIDDLE EASTERN	
Foreign Language(s):	HEBRÉW	
Gender:	Male	

### 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 <a href="https://licensess.org/licensess/citation">https://licensess/citation</a> is not available, please click <a href="https://licensess/citation.org/licensess/citation">https://licensess/citation.org/licensess/citation.or

### 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.

### Disclaimer

All information provided by the Medical Board of California on this Web page, and on its other Web pages and Internet sites, is made available to provide immediate access for the convenience of interested persons. While the 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 Board makes no guarantee as to the accuracy, completeness, timeliness, currency, or correct sequencing of the information. Neither the Board, nor any of the sources of the information, shall be responsible for any errors or omissions, or for the use or results obtained from the use of this information. Other specific cautionary notices may be included on other Web pages maintained by the Board. All access to and use of this Web page and any other Web page or Internet site of the Board is governed by the Disclaimers and Conditions for Access and Use as set forth at California Department of Consumer Affairs' Disclaimer Information and Use Information.

84029 GRAY DAVIS, GOVERNOR



### EDICAL 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



APPLICATION FOR PHYSICIAN'S AND SURGEON'S LICENSE

001433

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 PROGRAM

FALSIF	FICATION OR MISREPRESENTATION ATTACHMENT HERETO IS A SUFF	N OF ANY ITEM OR RI CIENT BASIS FOR DE	ESPONSE ON THIS AF NYING OR REVOKING	PLICATION OF A LICENSE.	RANY .	MBC USE '
1. NAME: Last		First		Middle	<del></del>	Personal
SILVE	$\mathcal R$	ROY	•		1	Data
2. Other names you have used			3. U.S. Social Se	curity Number	•	
44 (PUBLIC ADDRESS: will be	released by the Board to the public	); Number and Street/	P.O. Box/Rural Route/	Apartment Nui	noer, ir any.	
The personal states						
City	State		ip Code	Country		
				115.	4	
4B. (CONFIDENTIAL ADDRESS	): Number and Street/Rural Route/ address if a P: O. Box is used as	Apartment Number, if the Public Address in	any. [Applicants must #4A above.]	provide a con	fidential street	
	<b>发生,不是这个一个,不是一个一个一个一个一个一个一个一个一个一个一个一个一个一个一个一个一个一个一个</b>		<del></del>		·	
City	State	2	ip Code	Country USA	•	
				-		
5. Telephone Number: Home ( Work:		6. California Driver's L NUMBER	icense Number (optional E	): EXPIRATION	• •	
7. Date of Birth (Month/Day/Yea	ar) and Place of Birth:					
			·	,		_
8. Sex: 🖾 Male	☐ Female	9. Are you a U.S. cit	izen?	Yes	□ No	
IF YES, PLEASE GIVE DATE PREVIOUS APP	LICATION WAS SUBMITTED.  US of <u>all</u> colleges or universities atterpts with the school seal affixed for each	nded where pre-profes	sional, postsecondar		No No as received.	P Me
			·-		<u> </u>	Edul
Name	City, State, C		<del></del>	ates of Attendance		
BRANDETS UNIV	WACTHAM, MA U.	5 A	08/9/	-05/99	<u>/</u>	-i 👹 i
PLEASESUBMIT: 1) an original and the	of <u>all</u> schools where professional medicinal Certificate of Medical Education (Form school seal affixed from <u>each</u> school attenual medical diploma and a 6 1/2" x 11" pt	L2) and official transcripts ded; and,	s with the signature of the o			Medical Education
School Name	. City, State, Count	у	Dates of Attend	lance	Degree Awarded	
STI bearves Univ	Grenula, wes	t Indles	08/96-06	100	MD	
7				,	· .	
DOCTOR OF MEDICINE DEGREE, a	s referenced above:					
Name of Medical School	Address of Medical Sch	ool		Exact Date of	of Issuance	
ST. George's VAIV	Gretlada, h	est Indies	•	06/1	6/00	
<ul> <li>MANDATORY DISCLOSURE OF U.S. S Disclosure of your U.S. social security number collection of your social security number. Y or order for family support in accordance wi which utilizes a national examination and whi</li> </ul>	,	Professions Code and Public L for tax enforcement purposes f ation of licensure or examination of If you fail to disclose your so	for purposes of compliance with on status by a licensing or exam cial security number your applic	(C)) authorize any judgment nination entity alion for initial	MBC USE ONLY chool Code	1A

M	80	U!	SE

***	1110	77
xami		L.
~ # ! ! ! !	7	~
1		
2		7

I. Have you ever been licensed to practice medicine in any state, territo		
I. Have you ever been licensed to practice medicine in any state, territo		
l. Have you ever been licensed to practice medicine in any state, territo		
. Have you ever been licensed to practice medicine in any state, territo		
	ory, province, country, or U.S. federa	al jurisdiction?
		☐ Yes Ø No
(ES, LIST THE JURISDICTION, LICENSE NUMBER, DATE ISSUED AND DATES OF PRACTICE IN T ITED LICENSE, OR PERMIT. AN ORIGINAL OFFICIAL LETTER OF GOOD STANDING (LGS), OR IPORARY, TRAINING, PROVISIONAL, LIMITED LICENSE, OR PERMIT OBTAINED IN ANY U.S. ST N. EACH LGS, OR COMPARABLE CERTIFICATION, SHOULD BE MAILED BY THE ISSUING AUTH	COMPARABLE LICENSE HISTORY CERTIFICATION ATE, U.S. OR CANADIAN TERRITORY, CANADIAN	N, IS REQUIRED FOR <u>EACH</u> PERMANENT,  I PROVINCE, OR U.S. FEDERAL JURISDIC-
Jurisdiction Ucense Number	Date of Issuance Date	s of Practice in that Jurisdiction
S: PROFESSION:, LICENSENO.:,  THIS LICENSE EVER BEEN REVOKED, OR SUBJECT TO DISCIPLINE? IF YES, PLEASE PROVID  ANATION. YOU ARE ALSO REQUIRED TO REPORT ANY MATTER THAT IS PENDING OR IN WH	JURISDICTION:  DE ALL OFFICIAL DOCUMENTATION REGARDING  ICH CHARGES HAVE BEEN <u>DROPPED</u> OR <u>EXPUN</u>	IGED.
		LJ Yes K∏ No i
. Are you currently, or have you ever been, a participant in a postgrad a must include every residency, internship, and fellowship, whether of the followship in the fellowship in the fellowshi	r not completed.)	☑ Yes ☐ No
	Catagorial Sansialty Assa	Dates of Attendance
Facility Name Address	Categorial Specialty Area	
York Univ-Dountown Hap.	OB/bus	
Facility Name Address  York Valv - Downtown Hap.  Ursity Medical Center: 2040 w. Charleston Wood St.  Listy Medical Center: Las veras NV 89102	OB/bus	11/00 - 07/01 07/01- Present

directors. If these documents are not provided with the application, they will be requested <u>before review</u> of the application can proceed. APPLICANTS ARE REQUIRED TO REPORT ANY MATTER THAT IS <u>PENDING</u> OR IN WHICH CHARGES HAVE BEEN <u>DROPPED OR EXPUNGED</u>.

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.



NAME OF APPLICANT:



DATE OF



MBC	USE
ON	1 V

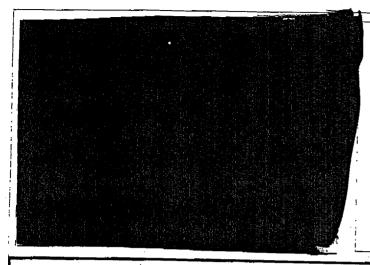
Examination  Date  Feault (Pass/Fail)  Have you ever been licensed to practice medicins in any state, territory, province, country, or U.S. federal jurisdiction?  WEB, LIST THE JURGBOLTOM, LICENSE MUMBER, DATE SELEC AND DATES OF PRACTICE IN THAT JURISDICTION. PLEASE INCLIDE PERMANENT, TEMPORY, TOWNSON, TEMPORY, TRANSON, PROJECTION, LICENSE MUMBER, DATE SELEC OR PRIMIT OD TANSON IN ANY U.S. STATE, U.S. OR CANDAM TERRORY, CANDAM PROVISIONAL, INVESTIGATION, SHOULD BE MADE TO TRANSON ANY U.S. STATE, U.S. OR CANDAM TERRORY, CANDAM PROMISED, ASSESSON, MICHAEL STATE, U.S. OR CANDAM TERRORY, CANDAM PROMISED, ASSESSON, JURISDICTION, SHOULD BE MADE TO TRANSON ANY U.S. STATE, U.S. OR CANDAM TERRORY, CANDAM PROMISED, ASSESSON, JURISDICTION, SHOULD BE MADE TO THE RESULANDENT TOWN RECOMMENDED OF AUXILIARY ASSESSON, JURISDICTION, SHOULD BE MADE TO THE RESULANDENT TOWN RECOMMENDED OF AUXILIARY ASSESSORY.  JURISDICTION TO THE MEDICAL DATE OF AUXILIARY ASSESSORY.  JURISDICTION TO THE MEDICAL DATE OF AUXILIARY ASSESSORY.  JURISDICTION TO THE SELECTION OF AUXILIARY ASSESSORY.  JURISDICTION	Examination    Date   Result (Pass/Fill)	. Have you taken any of the following written examinat				☑ Yes	□ No
Examination  Date  Result (Pass/Fa)  Lineary you ever been licensed to practice medicine in any state, territory, province, country, or U.S. federal jurisdiction?  In Have you ever been licensed to practice medicine in any state, territory, province, country, or U.S. federal jurisdiction?  In Have you ever been licensed to practice medicine in any state, territory, province, country, or U.S. federal jurisdiction?  In Have you ever been licensed to practice medicine in any state, territory, province, country, or U.S. federal jurisdiction?  In Have you ever been licensed to practice medicine in any state, territory, province, country, or U.S. federal jurisdiction?  In Have you ever been licensed to practice medicine in any state, territory, province, country, or U.S. federal jurisdiction on U.S. federal jurisdiction  In Have you ever been licensed to practice medicine in any state, territory, province, country, or U.S. federal jurisdiction?  In Have you ever been licensed to practice medicine in any state, territory, province, country, or U.S. federal jurisdiction?  In Have you ever been licensed to practice medicine in any state, territory, province, country, or U.S. federal jurisdiction?  In Have you ever been licensed in any state, territory, province, country, or U.S. federal jurisdiction?  In Have you country province, country, or U.S. federal jurisdiction?  In Have you country province, country, or U.S. federal jurisdiction?  In Have you country province, country, or U.S. federal jurisdiction?  In Have you were been, as subsect to use province, country, or U.S. federal jurisdiction?  In Have you were been licensed in any state, territory, province, country, or U.S. federal jurisdiction?  In Have you are A.SO recursed to the province you were been, as participant in a postgraduate training program in a facility in the U.S. or Canada?  In Have you currently, or have you ever been, as participant in a postgraduate training program in a facility in the U.S. or Canada?  In You were younted to the yount younted y	Examination  Date  Result (Pass/Fall)  Like you ever been licensed to practice medicine in any state, territory, province, country, or U.S. federal jurisdiction?  It have you ever been licensed to practice medicine in any state, territory, province, country, or U.S. federal jurisdiction?  If yes  No  Yes, List The JURGES, OR FERMIT. AN ORGANA, ORFICAL LETTER OF GOOD STANGING (Log), OR COMPARABLE LICENSE INCLUDE PERMANENT, TEMPORAMY, TRAINING, PROVISIONAL,  JURISDICTORS, OR FERMIT. AN ORGANA, ORFICAL LETTER OF GOOD STANGING (Log), OR COMPARABLE LICENSE INCLUDE PERMANENT, TEMPORAMY, TRAINING, PROVISIONAL,  JURISDICTORS, OR COMPARABLE CERTECATION, SHOULD BE MAKED BY THE BESING AUTHORITY ORBICALY TO THE MEDICAL BOARD OF CAURDINA.  JURISDICTORS  Date of Issuance	YES, LIST NAME. LOCATION. DATE AND RESULT OF EACH EXAMINATION, F	AILURES MUST ALSO BE DISC	CLOSED, EACH EXAMINATIO	ON AGENCY MUST S	UBMIT AN ORIGINAL C	FFIÇIAL
4. Have you ever been floensed to practice medicine in any state, territory, province, country, or U.S. federal jurisdiction?    Yes	A, Have you ever been licensed to practice medicine in any state, territory, province, country, or U.S. federal jurisdiction?    Yes	CAMINATION HISTORY REPORT DIRECTLY TO THE MEDICAL BOARD OF CAL	IFORNIA. THESE REPORTS V	MLL NOT BE RETURNED.			1.
Yes	4. Have you ever been licensed to practice medicine in any state, territory, province, country, or U.S. recert jurisdiction   Yes  No  New Yes, List the Jurisdiction, Ucense number, Date issued AND DATES OF PRACTICE IN THAT JURISDICTION, PLEASE INCLUDE PREMAMENT, TEMPORARY, TRAINIG, PROVIDIONAL, MITTED LIDENS, OR PREMIT. AN ORIGINAL OPPORAL LETTER OF GOOD STANDING (LOS), OR COMPARABLE UCENSE INSTORY CERTIFICATION, IS REQUIRED FOR EAST PREMAMENT, TEMPORARY, TRAINING, PROVIDIONAL, MITTED LIDENS, OR REPORT AND REQUIRED TO LIBERT OF THE ISSUED COMPARABLE CONTROL PROVIDED, CANDAIN TERRITORY, CANDAINA PROVINCE, OR U.S. PEDITAL JURISDICTION.  JURISDICTION   Date of Issuance   Dates of Practice in that Jurisdiction   Ucense Number   Date of Issuance   Dates of Practice in that Jurisdiction    LOD you hold any other professional license in any state, territory, province, country, or U.S. federal jurisdiction?   Yes  S No  No  No  No  No  No  No  No  No	Examination		Date		Result (Pass/	Fail)
Yes	4. Have you ever been licensed to practice medicine in any state, territory, province, country, or U.S. recert jurisdiction   Yes  No  New Yes, List the Jurisdiction, Ucense number, Date issued AND DATES OF PRACTICE IN THAT JURISDICTION, PLEASE INCLUDE PREMAMENT, TEMPORARY, TRAINIG, PROVIDIONAL, MITTED LIDENS, OR PREMIT. AN ORIGINAL OPPORAL LETTER OF GOOD STANDING (LOS), OR COMPARABLE UCENSE INSTORY CERTIFICATION, IS REQUIRED FOR EAST PREMAMENT, TEMPORARY, TRAINING, PROVIDIONAL, MITTED LIDENS, OR REPORT AND REQUIRED TO LIBERT OF THE ISSUED COMPARABLE CONTROL PROVIDED, CANDAIN TERRITORY, CANDAINA PROVINCE, OR U.S. PEDITAL JURISDICTION.  JURISDICTION   Date of Issuance   Dates of Practice in that Jurisdiction   Ucense Number   Date of Issuance   Dates of Practice in that Jurisdiction    LOD you hold any other professional license in any state, territory, province, country, or U.S. federal jurisdiction?   Yes  S No  No  No  No  No  No  No  No  No		1	<u> </u>	į	. <u> </u>	
TYES, LIST THE JURISDICTION, LICENSER NUMBER, DATE ISSUED AND DATES OF PRACTICE IN THAT JURISDICTION. PLEASE INCLUDE PERMANENT, TRANSPORTANT, TRANSPORTANT, TRANSPORTANT, TRANSPORTANCE, PROVISIONAL, MITTED LICENSE, OR PERMIT. AN DRIGHMA, DEPICIAL LETTER OF GOOD STANDING (LGS), OR COMPARABLE LICENSER INSTRUMENT, CANADIAN PROVINCE, OR U.S., PEDRAL JURISDICTION, SERVICIANS, PROVINCED, OR U.S., PEDRAL JURISDICTION, SERVICIANS, SERV	14. Have you ever been ilicensed to practice medicine in any state, territory, province, country, or U.S. receral jurisdiction?    Yes   No				•		4
PYES, LIST THE JURSDICTION, LICENSE NUMBER, DATE ISSUED AND DATES OF PRACTICE IN THAT JURISDICTION. PLEASE INCLIDE PERMANENT, TEMPORARY, TRAINING, PROVISIONAL, INTER LICENSE, OR PERMAN, TRAINING, PROVISIONAL, MICRO LICENSE, OR PERMANENT, AND CRIBENCE, AND CRIBENCE, PROVIDED AND AND VIS. STATE, LOCATION, PROVINCE, OR U.S. FECERAL, JURISDICTION, S. RECURRED FOR PERMANENT, TEMPORARY, TRAINING, PROVISIONAL, MURTED LICENSE, OR PERMANENT, THE PROVINCE, OR U.S. FECERAL, JURISDICTION, S. RECURRED FOR PERMANENT, THE PROVINCE, OR U.S. OR CAMPAN PROVINCE, OR U.S. FECERAL, JURISDICTION, SHOULD BE MAKED BY THE SISLING AUTHORITY DIRECTLY TO THE MEDICAL BOARD OF CAUPONIA.  JURISDICTION:	14. Have you ever been licensed to practice medicine in any state, territory, province, country, or U.S. receral jurisdiction?    Yes   No						
TYES, LIST THE JURISDICTION, LICENSE NUMBER, DATE ISSUED AND DATES OF PRACTICE IN THAT JURISDICTION. PLEASE INCLUDE PERMANENT, TEMPORARY TRANSPORT PROVIDED AND TRANSPORT PROVIDED TO BE ADDITION OF PRACTICE IN THAT JURISDICTION. PLEASE INCLUDE PERMANENT, TEMPORARY, TRANSPORT, PROVIDED FOR BEAUTHERY OF GOOD STANDING (LOS), OR COMPARABLE LICENSE INSTRUMENT, PROVIDED FOR BEAUTHERY DATES OF GOOD STANDING (LOS), OR COMPARABLE LICENSE IN REQUIRED FOR BEAUTHERY DATES.  JURISDICTION. EACH LOS, COMPARABLE CERTIFICATION, IS NOLD BE MAKED BY THE BISSING AUTHORY DIRECTLY TO THE MEDICAL BOARD OF CAULDINAN.  JURISDICTION:  LICENSE NUMBER OF PRACTICE IN THAT JURISDICTION:  LICENSE NUMBER OF PRACTICE IN THAT JURISDICTION:  LICENSE NUMBER OF PRACTICE IN THAT JURISDICTION:  LICENSE PROPERSION:	4. Have you ever been licensed to practice medicine in any state, territory, province, country, or U.S. receral jurisdiction				· · · · · ·	· · · · · · · · · · · · · · · · · · ·	
Yes	Ves. LIST THE JURBOCTION, LICENSE NUMBER, DATE ISSUED AND DATES OF PRACTICE IN THAT JURBOICTION, PLEASE INCLIDE PERMANENT, TRANKING, PROVISIONAL, MITTED LICENSE, OR PERMAT. AN ORIGINAL, DIFFICIAL LETTER OF GOOD STANDING (LOS), OR COMPANABLE LICENSE HISTORY CERTIFICATION, IS REQUIRED FOR BEAD PERMANENT, TRANKING, PROVISIONAL, JURISDICTION, PLEASE INCLIDE PERMANENT, TRANKING, PROVISIONAL, JURISDICTION, PROVIDED LICENSE, OR PERMAT. AN ORIGINAL, DIFFICULTY DIFFERENCES, TRANKING, PROVISIONAL, JURISDICTION, PROVIDED LICENSE, OR PERMAT. AN ORIGINAL CHARGES THAT ESSENDIAL SUPPORT AND ALL OFFICIAL DOCUMENTATION REGISTED. DO 19 JURISDICTION.  JURISDICTION.  LICENSE NO.  JURISDICTION.  AND THIS LICENSE EVER BEEN REVONED, OR SUBJECT TO DISCIPLINE? IF YES, PLEASE PROVIDE ALL OFFICIAL DOCUMENTATION REGISTED IN THE MATTER IN ADDITION TO A WARTTEN PROPERTY OF A PERMANENT. YOU ARE ALSO REQUIRED TO REPORT ANY MATTER THAT IS PENDING OR IN WINCH CHARGES HAVE SEEN DROPPED OR EXPUNSED.  YES. AT YOU CURRENTLY, OF 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  NO YES, UST NAMES AND ADDRESSES OF ALL FACULTIES. SUBMIT AN ORIGINAL CERTIFICATE OF COMPLETION OF ACOME/ROPS POSTGRADUATE TRAINING (FORM LSA) FROM EACH CULTY. (CO NOT COMPLETE FORM LSAS TO OCCUMENT TO RAIN BE SUBSTON RESERVED PROGRAMS.) ALL TRAINING MAST BE LISTED, REGARDLESS OF WHETHER IT AS SURFACE OF COMPLETE ON A COMPLETE FORM LSAS TO OCCUMENT TO RAIN BE SUBSTON RESERVED FOR PROGRAMS.) ALL TRAINING MAST BE LISTED, REGARDLESS OF WHETHER IT AS SURFACE OF COMPLETE ON THE SURFACE AND ADDRESSES OF ALL FACULTIES. SUBMIT AN ORIGINAL CERTIFICATE OF COMPLETION OF ACOME/ROPSC POSTGRADUATE TRAINING (FORM LSA) FROM EACH CULTY. (CO NOT COMPLETE FORM LSAS TO OCCUMENT TO RAIN BE SUBSTON RESERVED. PROGRAMS.) ALL TRAINING MAST BE LISTED, REGARDLESS OF WHETHER IT AS SURFACE OF THE PROGRAMS.) ALL TRAINING MISTER LISTED, PROGRAMS. IN JURIS	4. Have you ever been licensed to practice medicine in	any state, territory, pr	ovince, country, or U	J.S. federal jur	sdiction?	İ,
MITED LICENSE, OR PERMIT. AN ORIGINAL CHITCH OF GOOD STANDING (LOS), OR COMPARABLE LICENSE PRICTORY, INSTRUMENCE, OR U.S. FERRAL JARSDICON, EACH LOS, OR COMPARABLE CERTIFICATION, SHOULD BE MAKED BY THE ISSUING AUTHORITY DIRECTLY TO THE MEDICAL BOARD OF CAUPONNA.  Jurisdiction  License Number  Date of Issuance  Dates of Practice in that Jurisdiction  License Number  Date of Issuance  Dates of Practice in that Jurisdiction  License Number  Date of Issuance  Dates of Practice in that Jurisdiction  Ves OF No  Yes: PROFESSION:  JURISDICTION:  JU	MITED LEGENSE, OR PERMIT. AN ORIGINAL OPPICAL LETTER OF GOOD STANDING (LGS), OR COMPARABLE LIGENSE HISTORY CARRIPTICATION, IS RECOURDED ON EACH PERMINANCE.  JURISDICION, EACH LGS, OR COMPARABLE CERTIFICATION, SHOULD BE MALED BY THE ISSUING AUTHORITY DIRECTLY TO THE MEDICAL BOARD OF CAUPONIA.  JURISDICION  LICENSE Number  Date of Issuance  Dates of Practice in that Jurisdiction  License Number  Date of Issuance  Dates of Practice in that Jurisdiction  LICENSE NO.  JURISDICTION:  JURISDICTION:  JURISDICTION:  JURISDICTION:  JURISDICTION:  JURISDICTION:  AND THE LICENSE EVER BEEN REVOKED, OR SUBJECT TO DISCPLINE? IF YES, PLASE PROVIDE ALL OFFICIAL DOCUMENTATION REGARDING THE MATTER IN ADDITION TO A WRITTEN REPAIRS FOR THE AUTOR OF THE AUTOR PROVIDED OF IN WHICH CHARGES HAVE BEEN DROPPED OR EXPURSED.  AND THE LICENSE EVER BEEN REVOKED, OR SUBJECT TO DISCPLINE? IF YES, PLASE PROVIDE ALL OFFICIAL DOCUMENTATION REGARDING THE MATTER IN ADDITION TO A WRITTEN REPAIRS PROVIDE ALL OFFICIAL DOCUMENTATION REGARDING THE MATTER IN ADDITION TO A WRITTEN REPAIRS FOR THE AUTOR OF THE AUTOR PROVIDED OF				· · · · · · · · · · · · · · · · · · · ·	_	20 No
Do you hold any other professional license in any state, territory, province, country, or U.S. federal jurisdiction?  Yes No  Yes: PROFESSION:	Do you hold any other professional license in any state, territory, province, country, or U.S. federal jurisdiction? Yes S No  Yes: PROFESSION:	MITED LICENSE, OR PERMIT. AN ORIGINAL OFFICIAL <b>LETTER OF GOOD S</b> EMPORARY, TRAINING, PROVISIONAL, LIMITED LICENSE, OR PERMIT OBTA	<b>ITANDING (LGS),</b> OR COMPA NINED IN ANY U.S. STATE, U.	RABLE LICENSE HISTORY O S. OR CANADIAN TERRITOR	CERTIFICATION, IS F RY, CANADIAN PRO	EQUIRED FOR <u>EACH</u> INCE, OR U.S. FEDE	PERMANENT,
YES: PROFESSION:	VES: PROFESSION:	Jurisdiction License Number	Date	of Issuance	Dates of F	Practice in that Juris	diction
LICENSE PROFESSION:  JURISDICTION:  JURISDICTON:  JURISDICTION:  J	AS THIS LICENSE EVER BEEN REVOKED, OR SUBJECT TO DISCIPLINE? IF YES, PLEASE PROVIDE ALL OFFICIAL DOCUMENTATION REGARDING THE MATTER IN ADDITION TO A WRITTEN XPLANATION. YOU ARE ALSO REQUIRED TO REPORT ANY MATTER THAT IS <u>PENDING</u> OR IN WHICH CHARGES HAVE BEEN <u>DROPPED</u> OR <u>EXPUNDED</u> .  SA, 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  No  Yes, LIST NAMES AND ADDRESSES OF ALL FACILITIES. SUBMIT AN ORIGINAL CERTIFICATE OF COMPLETION OF ACCIME/RCPSC POSTGRADUATE TRAINING (FORM L3A) FROM EACH ACCIUTY. (DO NOT COMPLETE FORM L3AS TO DOCUMENT TRAINING RECEIVED IN RESEARCH FELLOWSHIP PROGRAMS.) ALL TRAINING MUST BE LISTED, REGARDLESS OF WHETHER IT AS SATISFACTORITY COMPLETED OR WILL BE USED TO MEET LICENSING REQUIREMENTS.  Facility Name Address Categorial Specialty Area Dates of Atlendance  Land Virial Pown from Hard.  Address Categorial Specialty Area Dates of Atlendance  Of by 11/22 - 07/01  Address Categorial Specialty Area Dates of Atlendance  Of by 11/22 - 07/01  ADDRESS TO ANY SYLVE STORM STATES OF A	1		. :		<del> </del>	
AS THIS LICENSE EVER BEEN REVOKED, OR SUBJECT TO DISCIPLINE? IF YES, PLEASE PROVIDE ALL OFFICIAL DOCUMENTATION REGARDING THE MATTER IN ADDITION TO A WRITTEN REPAIR AND ADDITION TO A WRITTEN REPAIR AND ADDITION TO A WRITTEN REPAIR AND ADDRESSES OF REPAIR AND ADDRESSES OF ALL FACILITIES. SUBMIT AN ORIGINAL CERTIFICATE OF COMPLETION OF ACGME/RCPSC POSTGRADUATE TRAINING (FORM L.3A) FROM EACH ACLITY. (SO NOT COMPLETE FORM L.3AS TO DOCUMENT TRAINING RECEIVED IN RESEARCH FELLOWSHIP PROGRAMS.) ALL TRAINING MUST BE LISTED, REGARDLESS OF MHETHER IT AS SATISFACTORILY COMPLETE FORM L.3AS TO DOCUMENT TRAINING RECEIVED IN RESEARCH FELLOWSHIP PROGRAMS.) ALL TRAINING MUST BE LISTED, REGARDLESS OF WHETHER IT AS SATISFACTORILY COMPLETE DOR WILL BE USED TO MEET LICENSING RECOUREMENTS.  Facility Name  Address  Categorial Specially Area  Dates of Attendance  Oa/byn  11/30 - 07/01  AND LICENSTONS 16B through 23: YOU ANSWER YES TO any of the following questions, please provide ALL official documentation regarding the matter in addition to your written propagation of the following provide official hearing/court documents and original letters of explanation from medical schools or training information in medical schools or training incotors. If these documents are not provided with the application, they will be requested before review of the application can proceed. APPLICAN EQUIRED TO REPORT ANY MATTER THAT IS PENDING ON IN WHICH CHARGES HAVE BEEN DROPPED ON EXPUNCED.	AS THIS LICENSE EVER BEEN REVOKED, OR SUBJECT TO DISCIPLINE? IF YES, PLEASE PROVIDE ALL OFFICIAL DOCUMENTATION REGARDING THE MATTER IN ADDITION TO A WRITTEN XPLANATION. YOU ARE ALSO REQUIRED TO REPORT ANY MATTER THAT IS <u>PENDING</u> OR IN WHICH CHARGES HAVE BEEN <u>PROPPED</u> OR <u>EXPUNDED</u> .  YES NO  SA. 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  NO  Yes, UST NAMES AND ADDRESSES OF ALL FACILITIES. SUBMIT AN ORIGINAL CERTIFICATE OF COMPLETION OF ACCIME/REPSC POSTGRADUATE TRAINING (Form LSA) FROM EACH ACLUTY. (OO NOT COMPLETE FORM LSAS TO DOCUMENT TRAINING RECEIVED IN RESEARCH FELLOWSHIP PROGRAMS.) ALL TRAINING MUST BE LISTED, REGARDLESS OF WHETHER IT AS SATISFACTORILY COMPLETED OR WILL BE USED TO MEET LICENSING REQUIREMENTS.  Facility Name Address Categorial Specialty Area Dates of Atlendance  YOU ANK VAIN - DOUNT WILL BE USED TO MEET LICENSING REQUIREMENTS.  FACILITY - DOUNT WILL BE USED TO MEET LICENSING REQUIREMENTS.  YOU ANSWER YES TO any of the following questions, please provide ALL official documentation regarding the matter in addition to your written p xplanations. An applicant must provide official hearing/court documents and original letters of explanation from medical schools or training processor. See The Proposed APPLICAN EQUIRED TO REPORT ANY MATTER THAT IS PENDING OR IN WHICH CHARGES HAVE BEEN DROPPED OR EXPUNGED.						i
AS THIS LICENSE EVER BEEN REVOKED, OR SUBJECT TO DISCIPLINE? IF YES, PLEASE PROVIDE ALL OFFICIAL DOCUMENTATION REGARDING THE MATTER IN ADDITION TO A WRITTEN REPLANATION. YOU ARE ALSO REQUIRED TO REPORT ANY MATTER THAT IS PENDING OR IN WHICH CHARGES HAVE BEEN DROPPED OR EXPUNDED.  AS THIS LICENSE EVER BEEN REVOKED, OR SUBJECT TO DISCIPLINE? IF YES, PLEASE PROVIDE ALL OFFICIAL DOCUMENTATION REGARDING THE MATTER IN ADDITION TO A WRITTEN REPLANATION. YOU ARE ALSO REQUIRED TO REPORT ANY MATTER THAT IS PENDING OR IN WHICH CHARGES HAVE BEEN DROPPED OR EXPUNDED.  YES NO  8A. 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  8A. Are you currently, or have you ever been, a participant in a postgraduate training program in a facility in the U.S. or Canada?  Yes NO  8A. Are you currently, or have you ever been, a participant in a postgraduate training program in a facility in the U.S. or Canada?  Yes NO  NO  8A. Are you currently, or have you ever been, a participant in a postgraduate training program in a facility in the U.S. or Canada?  Yes NO  Yes, UST NAMES AND ADDRESSES OF ALL FACILITIES. SUBMIT AN ORIGINAL CERTIFICATE OF COMPLETE POSTGRADUATE TRAINING (Form L3A) FROM EACH CILITY. (SO NOT COMPLETE FORM L3AS TO DOCUMENT TRAINING RECEIVED IN RESEARCH FELLOWSHIP PROGRAMS.) ALL TRAINING MUST BE LISTED, REGARDLESS OF WHETHER IT AS STATE ACTIONS THE PROGRAMS.) ALL TRAINING MUST BE LISTED, REGARDLESS OF WHETHER IT AS STATE ACTIONS THE PROGRAMS. ALL TRAINING MUST BE LISTED, REGARDLESS OF WHETHER IT AS STATE ACTIONS THE PROGRAMS.) ALL TRAINING MUST BE LISTED, REGARDLESS OF WHETHER IT AS STATE ACTIONS THE PROGRAMS.) ALL TRAINING MUST BE LISTED, REGARDLESS OF WHETHER IT AS STATE ACTIONS THE PROGRAMS.) ALL TRAINING MUST BE LISTED, REGARDLESS OF WHETHER IT AS STATE ACTIONS THE PROGRAMS.) ALL TRAINING MUST BE LISTED, NO PROGRAMS.) ALL TRAINING MUST BE LISTED	AS THIS LICENSE EVER BEEN REVOKED, OR SUBJECT TO DISCIPLINE? IF YES, PLEASE PROVIDE ALL OFFICIAL DOCUMENTATION REGARDING THE MATTER IN ADDITION TO A WRITTEN RELAVANTION. YOU ARE ALSO REQUIRED TO REPORT ANY MATTER THAT IS <u>PENDING</u> OR IN WHICH CHARGES HAVE BEEN <u>PROPPED</u> OR <u>EXPUNDED</u> .  AS THIS LICENSE EVER BEEN REVOKED, OR SUBJECT TO DISCIPLINE? IF YES, PLEASE PROVIDE ALL OFFICIAL DOCUMENTATION REGARDING THE MATTER IN ADDITION TO A WRITTEN REPUBLING. YOU ARE ALSO REQUIRED TO REPORT ANY MATTER THAT IS <u>PENDING</u> OR IN WHICH CHARGES HAVE BEEN <u>PROPPED</u> OR <u>EXPUNDED</u> .  YES, LIST NAMES AND ADDRESSES OF ALL FACILITIES. SUBMIT AN ORIGINAL CERTIFICATE OF COMPLETION OF ACCIME/REPSC POSTGRADUATE TRAINING (Form LSA) FROM EACH CILITY. (DO NOT COMPLETE FORM LSAS TO DOCUMENT TRAINING RECEIVED IN RESEARCH FELLOWSHIP PROGRAMS.) ALL TRAINING MUST BE LISTED, REGARDLESS OF WHETHER IT AS SATISFACTORILY COMPLETED OR WILL BE USED TO MEET LICENSING REQUIREMENTS.  Facility Name  Address  Categorial Specially Area  Dates of Atlendance  LIM VANK VIN' - DOUT AWA HAP  AND LAST VINES VI			<u> </u>			· 4
AS THIS LICENSE EVER BEEN REVOKED, OR SUBJECT TO DISCIPLINE? IF YES, PLEASE PROVIDE ALL OFFICIAL DOCUMENTATION REGARDING THE MATTER IN ADDITION TO A WRITTEN REPLANATION. YOU ARE ALSO REQUIRED TO REPORT ANY MATTER THAT IS PENDING OR IN WHICH CHARGES HAVE BEEN DROPPED OR EXPUNDED.  AS THIS LICENSE EVER BEEN REVOKED, OR SUBJECT TO DISCIPLINE? IF YES, PLEASE PROVIDE ALL OFFICIAL DOCUMENTATION REGARDING THE MATTER IN ADDITION TO A WRITTEN REPLANATION. YOU ARE ALSO REQUIRED TO REPORT ANY MATTER THAT IS PENDING OR IN WHICH CHARGES HAVE BEEN DROPPED OR EXPUNDED.  YES NO  BA. Are you currently, or have you ever been, a participant in a postgraduate training program in a facility in the U.S. or Canada?  YES NO  BA. Are you currently, or have you ever been, a participant in a postgraduate training program in a facility in the U.S. or Canada?  YES NO  BA. Are you currently, or have you ever been, a participant in a postgraduate training program in a facility in the U.S. or Canada?  YES NO  YES, LIST NAMES AND ADDRESSES OF ALL FACILITIES. SUBMIT AN ORIGINAL CERTIFICATE OF COMPLETION OF ACQUE/ROPS C POSTGRADUATE TRAINING (FORM L3A) FROM EACH CICLITY. (DO NOT COMPLETE FORM L3AS TO DOCUMENT TRAINING RECEIVED IN RESEARCH FELLOWSHIP PROGRAMS.) ALL TRAINING MUST BE LISTED, REGARDLESS OF WHETHER IT AS STATEFACTORILLY COMPLETE DOR WILL BE USED TO MEET LICENSING RECOURSEMENTS.  FACILITY ON THE PROGRAMS OF THE METHOD OF ACCUMENTATION OF ACQUE/ROPS C POSTGRADUATE TRAINING MUST BE LISTED, REGARDLESS OF WHETHER IT AS STATEFACTORILLY ON THE PROGRAMS.  AS SATISFACTORILLY COMPLETED OR WILL BE USED TO MEET LICENSING RECOURSEMENTS.  FACILITY OF A PROGRAMS OF THE METHOD OF ACCUMENTATION OF ACQUE/ROPS C POSTGRADUATE TRAINING (FORM LICENSES OF WHETHER IT AS STATEFACTORILLY OF ACQUERNMENT OF THE METHOD OF ACCUMENT OF THE METHOD OF ACCUMENT OF THE METHOD OF ACCUMENT OF THE METHOD O	AS THIS LICENSE EVER BEEN REVOKED, OR SUBJECT TO DISCIPLINE? IF YES, PLEASE PROVIDE ALL OFFICIAL DOCUMENTATION REGARDING THE MATTER IN ADDITION TO A WRITTEN REPLANATION. YOU ARE ALSO REQUIRED TO REPORT ANY MATTER THAT IS <u>PENDING</u> OR IN WHICH CHARGES HAVE BEEN <u>PROPPED</u> OR <u>EXPUNGED</u> .  AS THIS LICENSE EVER BEEN REVOKED, OR SUBJECT TO DISCIPLINE? IF YES, PLEASE PROVIDE ALL OFFICIAL DOCUMENTATION REGARDING THE MATTER IN ADDITION TO A WRITTEN REPLANATION. YOU ARE ALSO REQUIRED TO REPORT ANY MATTER THAT IS <u>PENDING</u> OR IN WHICH CHARGES HAVE BEEN <u>PROPPED</u> OR <u>EXPUNGED</u> .  YES, LIST NAMES AND ADDRESSES OF ALL FACILITIES. SUBMIT AN ORIGINAL CERTIFICATE OF COMPLETION OF ACCIMENTATION OF ACCIDENT OF A			i			
YES: PROFESSION:	VES: PROFESSION:			•			
A. Are you currently, or have you ever been, a participant in a postgraduate training program in a facility in the U.S. or Canada?  Yes Mo Yes, LIST NAMES AND ADDRESSES OF ALL FACILITIES. SUBMIT AN ORIGINAL CERTIFICATE OF COMPLETION OF ACGME/RCPSC POSTGRADUATE TRAINING (FORM L3A) FROM EACH CILITY. (DO NOT COMPLETE FORM L3AS TO DOCUMENT TRAINING RECEIVED IN RESEARCH FELLOWSHIP PROGRAMS.) ALL TRAINING MUST BE LISTED, REGARDLESS OF WHETHER IT IS SATISFACTORILLY COMPLETED OR WILL BE USED TO MEET LICENSING REQUIREMENTS.  Facility Name Address Categorial Specialty Area Dates of Attendance  W. Vark Vin'r - Davintawa Hap.  All 11 20 - 07/01  AND CAST OF STATE	A. Are you currently, or have you ever been, a participant in a postgraduate training program in a facility in the U.S. or Canada?  Yes	•					_
Yes, LIST NAMES AND ADDRESSES OF ALL FACILITIES. SUBMIT AN ORIGINAL CERTIFICATE OF COMPLETION OF ACGME/RCPSC POSTGRADUATE TRAINING (FORM L3A) FROM EACH ACLITY. (DO NOT COMPLETE FORM L3AS TO DOCUMENT TRAINING RECEIVED IN RESEARCH FELLOWSHIP PROGRAMS.) ALL TRAINING MUST BE LISTED, REGARDLESS OF WHETHER IT AS SATISFACTORILY COMPLETED OR WILL BE USED TO MEET LICENSHIP REQUIREMENTS.  Facility Name  Address  Categorial Specialty Area  Dates of Attendance  LIM YORK Viniv - Dount own Itage.  AND YOR WILL STORM STE 200  OS/BYN  OT/01 - Present  UESTIONS 16B through 23:  you answer YES to any of the following questions, please provide ALL official documentation regarding the matter in addition to your written prolanations. An applicant must provide official hearing/court documents and original letters of explanation from medical schools or training prectors. If these documents are not provided with the application, they will be requested before review of the application can proceed. APPLICAN EQUIRED TO REPORT ANY MATTER THAT IS PENDING OR IN WHICH CHARGES HAVE BEEN DROPPED OR EXPUNGED.	Yes, LIST NAMES AND ADDRESSES OF ALL FACILITIES. SUBMIT AN ORIGINAL CERTIFICATE OF COMPLETION OF ACGME/RCPSC POSTGRADUATE TRAINING (FORM L3A) FROM EACH ACLITY. (DO NOT COMPLETE FORM L3AS TO DOCUMENT TRAINING RECEIVED IN RESEARCH FELLOWSHIP PROGRAMS.) ALL TRAINING MUST BE LISTED, REGARDLESS OF WHETHER IT AS SATISFACTORILLY COMPLETED OR WILL BE USED TO MEET LICENSING REQUIREMENTS.  Facility Name Address Categorial Specialty Area Dates of Attendance  LIM YORK VIN'T - Downtown trap.  AINVIR'S TY MENUAL (Lister: Las vigas IV 39/02 05/bys 07/01 Present  UNESTIONS 16B through 23:  you answer YES to any of the following questions, please provide ALL official documentation regarding the matter in addition to your written perplanations. An applicant must provide official hearing/court documents and original letters of explanation from medical schools or training procedure. If these documents are not provided with the application, they will be requested before review of the application can proceed. APPLICAN EQUIRED TO REPORT ANY MATTER THAT IS PENDING OR IN WHICH CHARGES HAVE BEEN DROPPED OR EXPUNGED.				• .	LJ TES	
Yes, LIST NAMES AND ADDRESSES OF ALL FACILITIES. SUBMIT AN ORIGINAL CERTIFICATE OF COMPLETION OF ACGME/RCPSC POSTGRADUATE TRAINING (FORM L3A) FROM EACH ACILITY. (DO NOT COMPLETE FORM L3AS TO DOCUMENT TRAINING RECEIVED IN RESEARCH FELLOWSHIP PROGRAMS.) ALL TRAINING MUST BE LISTED, REGARDLESS OF WHETHER IT AS SATISFACTORILY COMPLETED OR WILL BE USED TO MEET LICENSING REQUIREMENTS.  Facility Name  Address  Categorial Specialty Area  Dates of Attendance  LIM YORK YOU'V - DOWNTOWN HOP.  ADVIS WILLIAM STREET  AND STREET  AND STREET  DATES OF ALL FACILITIES. SUBMIT AN ORIGINAL CERTIFICATE OF COMPLETION OF ACGME/RCPSC POSTGRADUATE TRAINING (FORM L3A) FROM EACH  CATEGORY AND ACCOUNTS TO A STREET OF COMPLETION OF ACGME/RCPSC POSTGRADUATE TRAINING (FORM L3A) FROM EACH  AS SATISFACTORILY COMPLETE FORM L3AS TO DOCUMENTS.  Facility Name  Address  Categorial Specialty Area  Dates of Attendance  11   20 - 0 +   0    OB   Byn  O +   0    OF   0    O	Yes, LIST NAMES AND ADDRESSES OF ALL FACILITIES. SUBMIT AN ORIGINAL CERTIFICATE OF COMPLETION OF ACGME/RCPSC POSTGRADUATE TRAINING (FORM L3A) FROM EACH ACLIUTY. (DO NOT COMPLETE FORM L3AS TO DOCUMENT TRAINING RECEIVED IN RESEARCH FELLOWSHIP PROGRAMS.) ALL TRAINING MUST BE LISTED, REGARDLESS OF WHETHER IT AS SATISFACTORILY COMPLETED OR WILL BE USED TO MEET LICENSING REQUIREMENTS.  Facility Name  Address  Categorial Specialty Area  Dates of Attendance  LIM YORK VINEY - Dount away Hopp.  AND WILL AND SHE 200  OB/BYN  11/30 - 07/01  AND SHE WILL AND SHE 200  OB/BYN  OT/01 - Present  UESTIONS 16B through 23:  you answer YES to any of the following questions, please provide ALL official documentation regarding the matter in addition to your written perplanations. An applicant must provide official hearing/court documents and original letters of explanation from medical schools or training prectors. If these documents are not provided with the application, they will be requested before review of the application can proceed. APPLICAN EQUIRED TO REPORT ANY MATTER THAT IS PENDING OR IN WHICH CHARGES HAVE BEEN DROPPED OR EXPUNGED.	6 <u>A</u> . Are you currently, or have you ever been, a participa	ant in a postgraduate	training program in	a facility in the	U.S. or Canada	?
YES, LIST NAMES AND ADDRESSES OF ALL FACILITIES. SUBMIT AN ORIGINAL CERTIFICATE OF COMPLETION OF ACGME/RCPSC POSTGRADUATE TRAINING (FORM L3A) FROM EACH ACILITY. (DO NOT COMPLETE FORM L3AS TO DOCUMENT TRAINING RECEIVED IN RESEARCH FELLOWSHIP PROGRAMS.) ALL TRAINING MUST BE LISTED, REGARDLESS OF WHETHER IT AS SATISFACTORILY COMPLETED OR WILL BE USED TO MEET LICENSING REQUIREMENTS.  Facility Name Address Categorial Specialty Area Dates of Attendance  LIM YORK Vin's Downtown Hap.  AND LISTED AND STREET AN	Yes, UST NAMES AND ADDRESSES OF ALL FACILITIES. SUBMIT AN ORIGINAL CERTIFICATE OF COMPLETION OF ACGME/RCPSC POSTGRADUATE TRAINING (FORM L3A) FROM EACH ACCILITY. (DO NOT COMPLETE FORM L3AS TO DOCUMENT TRAINING RECEIVED IN RESEARCH FELLOWSHIP PROGRAMS.) ALL TRAINING MUST BE LISTED, REGARDLESS OF WHETHER IT AS SATISFACTORILY COMPLETED OR WILL BE USED TO MEET LICENSING REQUIREMENTS.  Facility Name  Address  Categorial Specialty Area  Dates of Attendance  11/20 - 07/01  AND LISTED WILL CHART.  AND WILL STORY WILL STO	ou must include every residency, internship, and fellov	vship, whether or not	completed.)		. 157 ∨oo	
Address Categorial Specially Area Dates of Attendance  The North Valv - Davintava Hap.  Address Categorial Specially Area Dates of Attendance  Address Categorial Special Area Dates of Attendance  Address Categorial Special Area Dates of Attendance  Address Categorial Area Dates of Attendance  Address Categorial Area Dates of Attendance  Ad	Address Categorial Specialty Area Dates of Attendance  Lin York Valv - Downtown Hap.  Address Categorial Specialty Area Dates of Attendance  Lin York Valv - Downtown Hap.  All Training Must be Listed, Regardless of Whether in Address Categorial Specialty Area Dates of Attendance  Lin York Valv - Downtown Hap.  All Job - 0 +   0    All Ursity Middle Control of the following questions, please provide ALL official documentation regarding the matter in addition to your written perplanations. An applicant must provide official hearing/court documents and original letters of explanation from medical schools or training princetors. If these documents are not provided with the application, they will be requested before review of the application can proceed. APPLICAN EQUIRED TO REPORT ANY MATTER THAT IS PENDING OR IN WHICH CHARGES HAVE BEEN DROPPED OR EXPLINING PROTECTOR. If these vous ever withdrawn from, or been suspended, dismissed or expelled from a medical school or postgraduate training program OR.						LJ 140
UESTIONS 16B through 23: you answer YES to any of the following questions, please provide ALL official documentation regarding the matter in addition to your written programmers are not provided with the application, they will be requested before review of the application can proceed. APPLICAN EQUIRED TO REPORT ANY MATTER THAT IS PENDING OR IN WHICH CHARGES HAVE BEEN DROPPED OR EXPUNGED.	UESTIONS 16B through 23: you answer YES to any of the following questions, please provide ALL official documentation regarding the matter in addition to your written purplanations. An applicant must provide official hearing/court documents and original letters of explanation from medical schools or training prectors. If these documents are not provided with the application, they will be requested before review of the application can proceed. APPLICAN EQUIRED TO REPORT ANY MATTER THAT IS PENDING OR IN WHICH CHARGES HAVE BEEN DROPPED OR EXPUNGED.  B. Have you ever withdrawn from, or been suspended, dismissed or expelled from a medical school or postgraduate training program OR.	CILITY. (DO NOT COMPLETE FORM L3As TO DOCUMENT TRAINING REC	EIVED IN RESEARCH FELLO	LETION OF ACGME/RCPSC NSHIP PROGRAMS.) ALL T	POSTGRADUATE 1	RAINING (FORM L3 LISTED, REGARDLES	A) FROM EACH S OF WHETHER IT
UESTIONS 16B through 23: you answer YES to any of the following questions, please provide ALL official documentation regarding the matter in addition to your written propagations. An applicant must provide official hearing/court documents and original letters of explanation from medical schools or training prectors. If these documents are not provided with the application, they will be requested before review of the application can proceed. APPLICAN EQUIRED TO REPORT ANY MATTER THAT IS PENDING OR IN WHICH CHARGES HAVE BEEN DROPPED OR EXPUNGED.	UESTIONS 16B through 23: you answer YES to any of the following questions, please provide ALL official documentation regarding the matter in addition to your written preparations. An applicant must provide official hearing/court documents and original letters of explanation from medical schools or training prectors. If these documents are not provided with the application, they will be requested before review of the application can proceed. APPLICAN EQUIRED TO REPORT ANY MATTER THAT IS PENDING OR IN WHICH CHARGES HAVE BEEN DROPPED OR EXPUNGED.  B. Have you ever withdrawn from, or been suspended, dismissed or expelled from a medical school or postgraduate training program OR.	Facility Name A	ddress	Categorial Spe	cialty Area	Dates of Atte	endance
UESTIONS 16B through 23: you answer YES to any of the following questions, please provide ALL official documentation regarding the matter in addition to your written proposed in the provide official hearing/court documents and original letters of explanation from medical schools or training prectors. If these documents are not provided with the application, they will be requested before review of the application can proceed. APPLICAN EQUIRED TO REPORT ANY MATTER THAT IS PENDING OR IN WHICH CHARGES HAVE BEEN DROPPED OR EXPUNGED.	UESTIONS 16B through 23: you answer YES to any of the following questions, please provide ALL official documentation regarding the matter in addition to your written p replanations. An applicant must provide official hearing/court documents and original letters of explanation from medical schools or training p rectors. If these documents are not provided with the application, they will be requested before review of the application can proceed. APPLICAN EQUIRED TO REPORT ANY MATTER THAT IS PENDING OR IN WHICH CHARGES HAVE BEEN DROPPED OR EXPUNGED.			03/64	<u> </u>	11/00 - 0	7/01
NUESTIONS 16B through 23:  you answer YES to any of the following questions, please provide <u>ALL official documentation</u> regarding the matter in addition to your written purposed to any of the following questions, please provide <u>ALL official documents and original letters of explanation from medical schools or training purposed. APPLICAN in the specific provided with the application, they will be requested before review of the application can proceed. APPLICAN EQUIRED TO REPORT ANY MATTER THAT IS <u>PENDING</u> OR IN WHICH CHARGES HAVE BEEN <u>DROPPED OR EXPUNGED</u>.</u>	RUESTIONS 16B through 23:  you answer YES to any of the following questions, please provide ALL official documentation regarding the matter in addition to your written parallel solutions. An applicant must provide official hearing/court documents and original letters of explanation from medical schools or training parectors. If these documents are not provided with the application, they will be requested before review of the application can proceed. APPLICAN EQUIRED TO REPORT ANY MATTER THAT IS PENDING OR IN WHICH CHARGES HAVE BEEN DROPPED OR EXPUNGED.  3B. Have you ever withdrawn from, or been suspended, dismissed or expelled from a medical school or postgraduate training program OR.	niversity Reducal Center Law 1000	ston Over ste 20	05/bun		07/01- Pr	esent
you answer YES to any of the following questions, please provide <u>ALL official documentation</u> regarding the matter in addition to your written properties. An applicant must provide official hearing/court documents and original letters of explanation from medical schools or training preceded. APPLICAN rectors. If these documents are not provided with the application, they will be requested before review of the application can proceed. APPLICAN EQUIRED TO REPORT ANY MATTER THAT IS <u>PENDING</u> OR IN WHICH CHARGES HAVE BEEN <u>DROPPED OR EXPUNGED.</u>	you answer YES to any of the following questions, please provide <u>ALL official documentation</u> regarding the matter in addition to your written perplanations. An applicant must provide official hearing/court documents and original letters of explanation from medical schools or training percetors. If these documents are not provided with the application, they will be requested <u>before review of the application can proceed. APPLICAN EQUIRED TO REPORT ANY MATTER THAT IS <u>PENDING</u> OR IN WHICH CHARGES HAVE BEEN <u>DROPPED OR EXPUNGED.</u>  33. Have you ever withdrawn from, or been suspended, dismissed or expelled from a medical school or postgraduate training program OR.</u>	- vegas	V/~~	1-7	<del>- :</del>		
you answer YES to any of the following questions, please provide <u>ALL official documentation</u> regarding the matter in addition to your written properties. An applicant must provide official hearing/court documents and original letters of explanation from medical schools or training preceded. APPLICAN rectors. If these documents are not provided with the application, they will be requested before review of the application can proceed. APPLICAN EQUIRED TO REPORT ANY MATTER THAT IS <u>PENDING</u> OR IN WHICH CHARGES HAVE BEEN <u>DROPPED OR EXPUNGED.</u>	you answer YES to any of the following questions, please provide <u>ALL official documentation</u> regarding the matter in addition to your written perplanations. An applicant must provide official hearing/court documents and original letters of explanation from medical schools or training percents. If these documents are not provided with the application, they will be requested <u>before review of the application can proceed. APPLICAN EQUIRED TO REPORT ANY MATTER THAT IS <u>PENDING</u> OR IN WHICH CHARGES HAVE BEEN <u>DROPPED OR EXPUNGED.</u>  B. Have you ever withdrawn from, or been suspended, dismissed or expelled from a medical school or postgraduate training program OR.</u>		_				
you answer YES to any of the following questions, please provide <u>ALL official documentation</u> regarding the matter in addition to your written properties. An applicant must provide official hearing/court documents and original letters of explanation from medical schools or training preceded. APPLICAN rectors. If these documents are not provided with the application, they will be requested before review of the application can proceed. APPLICAN EQUIRED TO REPORT ANY MATTER THAT IS <u>PENDING</u> OR IN WHICH CHARGES HAVE BEEN <u>DROPPED OR EXPUNGED.</u>	you answer YES to any of the following questions, please provide <u>ALL official documentation</u> regarding the matter in addition to your written perplanations. An applicant must provide official hearing/court documents and original letters of explanation from medical schools or training percents. If these documents are not provided with the application, they will be requested <u>before review of the application can proceed. APPLICAN EQUIRED TO REPORT ANY MATTER THAT IS <u>PENDING</u> OR IN WHICH CHARGES HAVE BEEN <u>DROPPED OR EXPUNGED.</u>  B. Have you ever withdrawn from, or been suspended, dismissed or expelled from a medical school or postgraduate training program OR.</u>						• 1
EQUIRED TO REPORT ANY MATTER THAT IS <u>PENDING</u> OR IN WHICH CHARGES HAVE BEEN <u>DROPPED OR EXPUNGED</u> .	EQUIRED TO REPORT ANY MATTER THAT IS PENDING OR IN WHICH CHARGES HAVE BEEN DROPPED OR EXPUNGED.  B. Have you ever withdrawn from, or been suspended, dismissed or expelled from a medical school or postgraduate training groups OR	you answer YES to any of the following questions, plea planations. An applicant must provide official hearing rectors. If these documents are not provided with the ap	court documents an plication, they will be	d original letters of e requested before rev	xplanation from	m medical scho ication can proc	ols or training
3B. Have you ever withdrawn from, or been suspended, dismissed prayabilise from a modified school account of the suspended dismissed prayabilise from a modified school account of the suspended dismissed prayabilised from a modified school account of the suspended dismissed prayabilised from a modified school account of the suspended dismissed prayabilised from a modified school account of the suspended dismissed prayabilised from a modified school account of the suspended dismissed prayabilised from a modified school account of the suspended dismissed prayabilised from a modified school account of the suspended dismissed prayabilised from a modified school account of the suspended dismissed prayabilised from a modified school account of the suspended dismissed prayabilised from a modified school account of the suspended dismissed prayabilised from a modified school account of the suspended dismissed prayabilised from the suspended dismissed from the suspended dismiss	B. Have you ever withdrawn from, or been suspended, dismissed or expelled from a medical school or postgraduate training program OR	EQUIRED TO REPORT ANY MATTER THAT IS <u>PENDING</u>	OR IN WHICH CHAR	GES HAVE BEEN <u>DR</u>	OPPED OR EX	PUNGED.	
	Designation of the control of the co						

NAME OF APPLICANT:

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

DATE OF

•	2000 to 2000 PAD JUNE 2 2000				
For all of the	thirw, also include any disciplinary actions by th	e U.S. Military, U.S. Public H	ealth Service, or other U.S	5. federal governm	MBC ON Lice therital Da
17A, Have y	ou ever been charged with, or been found to have co or repeated negligent acts or malpractice by any me			•	1
178. Has an	ny disciplinary action ever been filed or taken, includ ming, regarding any healing arts license which you	41. (	•	ine, consent orde	rs, or
	such action as described above pending?		17(A)	Yes No	
IF YOU ANS	WERED YES TO 17A, 17B OR 17C, PROVIDE DETAILS O	NC	17(B)	Yes No	
	E ATTACHMENT.		17(C)	Yes No	
resulted in a	im or action for damages ever been filed against you malpractice settlement, judgement, or arbitration av	u in the course of the practic vard of over \$30,000.00?	e of medicine or any othe	r healing art whic	h
IF YOU ANS	WERED YES, PROVIDE DETAILS ON A SEPARATE ATTACHMI	ENT,		Yes No	
19. Have you to take an exa	ever been denied a license, permission to practice r imination in any state, territory, country, or U.S. fed	medicine or any other healin	g art, or denied permissio	on ·	
ł	vered yes, provide details on a separate attachme		en sedon pending y	Yes No	
20. Have you e surrendered y pending?	ever voluntarily surrendered a license to practice m our narcotic (controlled substance) permit (state of	edicine or any other healing rederal) to any licensing bo	garts in this or any other and or any other agency,	state, or voluntari	ily tion
	ered yes, provide details on a separate attachmei			Yes No	
21. Have you e resigned from	ver had staff privileges in a hospital denied, suspen a medical staff in lieu of disciplinary or administrati	ided, limited, revoked, or notive action, or is any such	renewed for medical disc	ciplinary cause, or	
	LOSE ANY INFORMAL OR CONFIDENTIAL DISCIPLINARY ACTION.	any addit act	eon beuding?	Yes No	
22. Do you have skill and safety	e any condition which in any way impairs or limits y , including but not limited to, any of the following?	our ability to practice medic	ine with reasonable		
	, PLEASE CHECK THE APPROPRIATE BOX(ES) BELOW:			res No	
	A condition which required admission to an inpa Alcohol or chemical substance dependency or a Emotional, mental or behavioral disorder. Other (explain):	atient psychiatric treatment ddiction.	t facility.		
OR ANY OF THE E	BOXES CHECKED ABOVE, PLEASE SUBMIT COMPLETE <u>OFFICI</u> REATMENT, AND A PERSONAL WRITTEN EXPLANATION.	IAL INPATIENT AND OUTPATIENT	TREATMENT RECORDS, EVIDE	NCE OF ONGOING	
OR ALL OF THE B	ELOW, YOU ARE REQUIRED TO LIST ANY CONVICTION THAT EEN ISSUED.	HAS BEEN SET ASIDE AND DISA	MSSED OR EXPUNGED, OR W	HERE A STAY OF	
3 <u>A</u> . Have you e r federal law of	ver been convicted of, or pled noto contendere to, any state, territory, country, or U.S. federal jurisdict	ANY violation (include every tion?	misdemeanor or felony)	of any local, state	
	inal action related to the above pending?		23 (A) 🧱 Ye	s No	
IF YOU ANSWERS	ED YES TO 23A OR 23B, PROVIDE DETAILS ON A CHMENT.		23 (B) Ye	s No	
AME OF APPLIC	CANT:		DATE OF BIRTH:		
	Roy SILVER				



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.

	Declaration/Signature and NOTARY
STATE OF NOVADA	
COUNTY OF CLARK	
The applicant, ROY SILVER (PLEASE PRINT FULL NAM)	(DAYE OF BIRTH), being first duly sworn
contained herein and evidence or other credentials subthe degree of Doctor of Medicine as prescribed by this a instruction and examination, and that it, together with all resentation or any mistake of which I am aware and tha hospitals, institutions or organizations, my references, present and professional associates (past, present, and future), release to the Medical Board of California or its success educational records, and records of psychiatric treatment requested by that Board in connection with this application determine my medical competence, professional conduction medicine. I further authorize the Medical Board of California or groups listed above any information which is material.	son herein named subscribing to this application; that I have read and declare under penalty of perjury, that all of the information imitted herewith are true and correct; that I am the lawful holder of application, that the same was procured in the regular course of it the credentials submitted, were procured without fraud or misrepart I am the lawful holder thereof. Further, I hereby authorize all personal physicians, employers (past, present, and future), business and all government agencies (local, state, federal, or foreign) to sors any information, files or records, including medical records, int and treatment for drug and/or alcohol abuse or dependency, ion; or any further or future investigation by that Board necessary to ct, or physical or mental ability to safely engage in the practice of fornia or its successors to release to the organizations, individuals, to this application or any subsequent licensure. I UNDERSTAND OF ANY ITEM OR RESPONSE ON THIS APPLICATION OR ANY
SIGNATURE OF APPLICANT:	7
(PLEA:	SE SIGN FULL NAME, NOT INITIALS)
Signed and sworn to before me this day of	HAGNET ZOCK
CAROL A. ALLEN Notory Public State of Novoubs No. 02-75388-1 My apprt. exp. June 3, 2005	SIGNATURE OF NOTARY PUBLIC  ADDRESS  SIGNATURE OF NOTARY PUBLIC  SIGNATURE OF NOTARY PUBLIC  ADDRESS  SIGNATURE OF NOTARY PUBLIC  SIGNATURE OF NOTARY PUBLIC  ADDRESS  SIGNATURE OF NOTARY PUBLIC  ADDRESS  SIGNATURE OF NOTARY PUBLIC  SIGNATURE OF NOTARY PUBLIC  ADDRESS  SIGNATURE OF NOTARY PUBLIC  SIGNAT
7A-100(Rev. 3/01)	My commission expires (277)



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



# CERTIFICATE OF MEDICAL EDUCATION

MEDICAL SCHO	OOL: PLEASE COMPLETE TH	HIS FORM IN THE ENGLISH LANGUAGE.	
This certifies that Roy Ful	SILVER		
5 62 24 5	l de la	U.S SOCIAL SECURITY NO DATE OF BIRTH-MM/DE	D/YYYY
enrolled in 51 George 5 U	1 / JUSITY School of Wed _	Grenada, West Indies	
on the 16 day of	ille onto	LOCATION	
19 august	MONTH DEAR I	was granted the following credits on enrollment:	
Advanced Credits: Credits pre	1996 40		
Autorice Greats. Creats pre	viously obtained at an approved medical, o	dental, or osteopathic school.*	
MEDICAL SC	HOO! 1		
	***	TOTAL CREDITS DATES	
The undersigned further certifies that the years of resident instruction of		he applicant attended in this institution NUMBER OF VEA g at least 4,000 hours, of which at least 80 percent actual	RS
attendance is required, in the subjects sa	OF WEEKS	or least 4,000 flours, of which at least 80 percent actual	1
	a forth hereunder (Business and Profe	essions Code Section 2089), and that the applicant:	
	ne degree Bachelor/Doctor of Medicine		/
	. <b>1</b> 21	e by OR	
the above mentioned medical	school on the de	ay of we soo	
Anatomy		MONTH YEAR	
Otolaryngology "	Embryology Histology	Physical Medicine	
Obstetrics and Gynecology	Human Sexuality as defined in Section	Therapeutics	
Radiology, including Radiation Safety Tropical Medicine	MICHIE		
Physiology	Surgery, including Orthopedic Surgery Urology	Geriatric Medicine	
Biochemistry	Psychiatry	Pediatrics	
Pathology, Bacteriology and Immunology  Ophthalmology	Neurology	Pharmacology	
Dermatology	Alcoholism and Chemical Dependency	Anesthesia	
- Simulation of the state of th	Preventive medicine, including Nutrition	Family Medicine***	
Fach school whom		Pain Management and End-of-Life Care****	
attended, photocopies of this blook	cal instruction was received MUST co	emplete one of these forms. If more than one school was	
attended, photocopies of this blank  * ONLY applicable to medical students	who opposed in the second used.	was whole than one school was	,
<ul> <li>ONLY applicable to medical students</li> <li>ONLY applicable to medical students</li> </ul>	who enrolled in medical school on or a	after September 1, 1994	
** ONLY applicable to medical students  *** Only applicable to medical students w	the enrolled in the state of	or after May 1, 1998	
J. J	no enfolied in medical school on or af	fter June 1, 2000.	
MEDICAL SCHOOL SEAL MUST DE ATTENTIO	N MEDICAL SCHOOL: The person who	h	
or adopt	on.	his form MAY NOT be related to the applicant by blood, marriage	
Only the	President Dean or Popleton		
evidence	of that delegation must be attached to this fo	m. If that signature authority is being delegated to another person, orm (may be a photocopy). Such delegation must be on official s.	
івпетнеа	d and must be dated within the first 12 months	s.	
		te //	
Signed	of dethe school seal attiked this	Devoi Juint 2004	- H
	William / / Mearlhan	MONTH YEAR	
	VUUUUUUUUUV	Margaret A. Lambert	96.60E
BY		Dean of Enrollment Planning	
	PRESIDENT, DEAN, O	RREGISTRAL INIVERSITY Registrar	4
A-100-L2 (Rev. 3/01)	.   \	THINGISHY DEUISHAL	



MEDICAL BOARD OF CALIFORNIA

1426 Howe Avenue, Suite 54, Sacramento, CA 95825-3236

(915) 263-2499/FAX (916) 263-2487 Internet: www.medbd.ca.gov

CERTIFICATE OF COMPLETION OF ACGME/RCPSC POSTGRADUATE TRAINING

To be completed by the facility for every medical school graduate completing postgraduate training in the United States of Canada.

كالمستجمعين المستمر والمستجمع والمستجمع				
Only the Program Director on I the Director of it	RE OF MEDICAL EDUCATION: THE PERSON WHO SIGNS Nedlact Education may sign this lam, If that signature Nich delegation must be on official interhead and mu	tarranoush in Seesid generations to coupling to	PPLICANT BY BLOOD, MARRIAGE, SEXADOPTION, swidence of Roll delegation must be	
PART 1. To be completed by the 44	PLICANT			
LAST NAME of Applicant	First Name	A STATE OF THE STA	Middle Initial	oll
47/AVER				
		T-l-share History		
U.S. Social Security Number	Date of Birth; MW/DD/YYYY	Telephone Number.		
Paragraphic Epicturian in the contribution of the contribution	ar a turka. Tenang katikan ang kanalang da an	Home:	Work: ( de Barrier de la	
				_
Ourrent Address:	The state of the s		•	
	<b>建立於海岸區區在北京學科學科科學科科</b>		· · · · · · · · · · · · · · · · · · ·	
	219	Zip.Code		
PART 2: To be completed by the DE	SOCRAM DIRECTOR	A PARTON STATE OF THE PARTON O	关系的数据,通过 <b>的</b> 数据数据,还是这个大概是对为	te de
	the not sign and date this form hefore it	in last stay of any postgraduate	training year which will be used by t	he î
applicant to quality to licensure C	ompletion of this form will certify that the	individual named in PART 1 of	overcompleted a period of accredite	8
posigraduate training at this facility	If a period of training WAS NOT comple	sted in a satisfactory manner, pl	lease provide a separate detailed	
narrative explanation. The following	g information is provided to certify "satis	tactory" completion. PLEASE S	LE THE REVERSE FOR A DEFINITION	M
OF "SATISFAC ORY	通常的 医甲基甲基甲基甲基甲基甲基甲基甲基甲基甲基甲基甲基甲基甲基甲基甲基甲基甲基甲基		压力。中国《西亚亚斯斯图》。第15年,在第5	
Name of Facility:	1	Address of Facility:		
NYU DOU	untown Hospite	ョーフクルバル	an St. NYNY 160	38
Name of Program Litractor:		1000111	Telephone Number:	
Frank A	Danning, MD	m mal 2	0/21312-5840	
Signature of Program Director	3/1/1/19			
Contract of the Contract of th		U)	Date Signed:	
List Calegorical Spindlally Fee of Tigining Co			1 100 01/05	
List Categorical Specialty Fresh of Training Co		raining Commenced:	Date Training Completed:	
GOSTETTICS Y	CYMP COLUSY III	16100	16130101	
If the training was rimating ( a transitional, list i	the specific rotations and the number of weeks spec	nt in each (SEE THE REVERSE FOR I	NFORMATION ON SATISFYING THE	
GENERAL MEDICINE TRUINING REQUIRE	MENT):			
	÷	•		
				.
PART 3 To be competed by the DI	RECTOR OF MEDICAL EDUCATION and a	Hired with tholologist facility's		dista
Name of the Director of Medical Education:		and the state of t		
		Name of Facility:		.
000	Irren Lichtmi	$0 + \sqrt{y} u \psi c$	watown Tospit	97
Address of Fedility:				
1100011	iAm Street			
City	State	Zip Code	Telephone Number:	~~
New York	$\mathcal{N}\mathcal{V}$	10138	12/2/3/2-5790	~ I
PARTA SIGNALUS OF DIRECTOR OF	MEDICAL EDUCATION contilying satisfac			
	MICOURT EDUCATION COMPINED SAISTAC	lety completion of faining		
Attention: Director of Madical Education	Do not eign and date this form before the last day	of any postgraduate training year which	will be used by the prolicent to quality for	
mosnowit. This fertil they be signed by the c	surrent Director of Madical Education; if does not ne	ed to be signed by the person who was	the Director of Medical Education at the time	01
the training listed above.				" I
Notice to Applicant: M1 ils form is used to	verify posigraduate training beyond that which is re-	outred for licensure, this form can be at	noed by the Director of Madient Education and	. 1
and a configure of district the rest of the standard of the	irazning, filowever, il voli are heersad amar ma data	i i libbit Which Impinists usua econoloisid Al	ID if the form was signed before the final day	. ·
me training year, is new it im must be comple	eted and submitted to the Medical Board of Californ	<sup>†</sup> स.		
	0.57011			_
	OFFICIAL HOSE MILST RE AFEI	PITAL SEAL, OR NOTARY SEAL, DAT XED IN THE BOX TO THE LEFT TO (	E AND SIGNATURE	1
	1		· · · · · · · · · · · · · · · · · · ·	J
	i hereby declare under panalty of perf	ury under the laws of the State of	California that the above statements ar	ne 1
	I time and correct and that the trailing	l Diodram is aboroved by the ACC	MF of the BCDSC to alter the America	1
ត្តៃទីហីនិ ១៩៦៣ខ្មែច	rever or transmit combiners by tue	applicant and that the applicant was RCPSC program position.	ras trained in an approved ACGME or	ĺ
OFFITAL OR NOTARY		wer are brodism position.		
Ē	Signature of Director of Medical Education	3lion-	Date Signed:	
ō				T.
-	•			

07A-100-L3 (Rev. 501)





# MEDICAL BOARD OF CALIFORNIA

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





# CERTIFICATE OF COMPLETION OF ACGME/RCPSC POSTGRADUATE TRAINING

To be completed by the facility for every medical school graduate completing postgraduate training in the United States

ATTENTION PROGRAM DIRECTORS AND DIRECTORS OF MODIFY the Program Director and the Director of Medical attached to this form (may be a photocopy). Such deleted	MEDICAL EDUCATION: THE PERSON WHO SIGHS I Education may sign this form. If that signature egation must be an afficial intellight of any second	HIS FORM MAY NOT BE RELATED TO buthority is being designed to ano	THE APPLICANT BY BLOOD	MARRIAGE, OR ADOPTION.
PART 1: To be completed by the APPLICA	100	24-1004 William the last 12 months	k Dela Servica de Mala	Production in the Control of the Control
LAST NAME of Applicant	First Name			
SILVER	BOY			Middle Initial
U.S. Social Security Number:	Date of Birth: MWDD/YYYY	Telephone Number:		
				nietiek Gerick IV en daar van de
Current Address:		Home:	Work:	1846年中央党制的
A CONTRACTOR OF THE SECONDARY				
City	State	Zip Code		·
DART 2 T				
PART 2: To be completed by the PROGRA ATTENTION PROGRAM DIRECTOR! Do no applicant to qualify for licensure. Complete	化邻性异性 医阿拉克氏试验检尿管 化二氯甲基酚 化氯磺磺基磺磺磺磺磺磺磺磺基磺磺磺磺基		ANGLEMBER	<b>经产品的</b> 所求的数
DUSTUIRUITATE TRAINING At this tacilies, i.e.,			- ALUQVIE COMPINIATORIO	DOMAN OF THE PARTY
postgraduate training at this facility. If a penarrative explanation. The following inform OF "SATISFACTORY."	ariod of training <u>WAS NOT</u> complete nation is provided to certify "satisfac	d in a satisfactory manner	, please provide a se	parate detailed
Name of Facility:		TEAS	E SEE THE REVERS	FOR A DEFINITION
IMIN OF HENADA SON	the son -	Address of Facility:		<b>新原用。如果,是自己的學問題以</b>
Name of Program Director.	HOSE OF MEDICINE	2040 W. CF	HARLESTAN B	LVD STEZO
SUSTIPH H. KOTAS,	SR. M.D.		Telephone Number.	/
Signature of Program Director:			(702) 671. Date Signed:	2300
List Categories Specialty Area of Training Completed	IN MI			/
(1)B/(SX)	Date Train	ning Commenced:	Date Training Compl	eted:
If the training was rotating or transitional, list the specific GENERAL MEDICINE TRAINING REQUIREMENT):	c rotations and the number of weaks and the	11/2001	10/31/0	<u> </u>
GENERAL MEDICINE TRAINING REQUIREMENT):	of weeks spent in	HE REVERSE FOR	R INFORMATION ON SAT	ISFYING THE
PART 3: To be completed by the DIRECTOR	OF MEDICAL TO THE REST OF THE PERSON OF THE			
PART 3: To be completed by the DIRECTOR lame of the Director of Medical Education:	OF MEDICAL EDUCATION and affix	ed with the official facility	seal.	
STANLEY M. KI	PC 87	Name of Facility:		
ddress of Facility	·	UNIV. N	EV. 507	7
2040 W CHAR	LESTON BLVD		* 12 a	
" LAS VEGAS	State NV	Zip Code	Telephone Number:	
ART 4: Shinanne wenger tarras		89102	- (702) 671 6	401
ART'4: Signature or Director of Medica	CEDUCATION certifying satisfaction	y completion of training.		
Attention: Director of Medical Education! Do not sig licensure. This form may be signed by the current Direct the training listed above.	in and date this form before the last day of an	ly postgraduate training year which	th will be used by the envi	
licensure. This form may be signed by the current Directive training listed above.	ctor of medical Education; it does not need to	be signed by the person who wa	s the Director of Medical t	cant to qualify for Education at the time of
Votice to Applicant: If this town is				
he Program Director before the final day of training. Ho he training year, a new form must be completed and su	wever, if you are licensed after the date upor	o for licensure, this form can be a n which training was completed A	igned by the Director of M	edical Education and
	or the Medical Board of California.		was signed	berore the final day of
	OFFICIAL HOSPITAL	SEAL OR NOTARY SEAL, DA	TE AND SIGNATURE	
CAROL A ALLEN The	THE PART INCLU	IN THE BOX TO THE LEFT TO	CERTIFY TRAINING.	
No. 02-7570 Noved	reby declare under penalty of penjury to e and correct and that the training prog level of training completed by the appli	Inder the laws of the State of	f California that the ab	ove statements are
My appr. exp. June 3, 200	level of training completed by the appli	cant and that the applicant w	PME or the RCPSC to ras trained in an appro-	offer the type and
and A Nola		nor oo program position.	та т	ACGME OF
	ature of Director of Medical Education:		Date Signed:	Service Landaum
8/13/04	Stanly mich	us.	distail	
-100-L3 (Rev. 3/01)	NI WING I TO		10/10/	



### MEDICAL BOARD OF CALIFORNIA

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



# **ELIGIBILITY FOR REDUCED INITIAL LICENSE FEE**

(If you are enrolled in an ACGME/RCPSC postgraduate training program at the time of licensure, you are entitled to a reduced initial license fee. This form is used to certify current participation in a training program.)

This is to certify that Roy SILVER	
(Name of Applicant)	(U.S. Social Security Number) (RCPSC postgraduate training position that
(bate-0/3)rth 4MM/DD/11-11)	Nor do posigraduate training position triat
commenced on November 1 70	and is expected to be completed on
October 31 LOOY in JOBS tetric.  Month Day Year	(Type of Training)
at University Medicale Center	Dept of OB/Gyn
2040 W. Charleston, Ste 200	
Lus Vegas NV 89102	
Cus - 2705 100 87102	
ATTENTION DIRECTOR OF MENON EDUCATION	
ATTENTION DIRECTORS OF MEDICAL EDUCATION: THE PERSON WHO SIGNS THIS FORM MAI MARRIAGE, OR ADOPTION.	'NOT BE RELATED TO THE APPLICANT BY BLOOD,
Only the Director of Medical Education may sign this form. If that signature authority is be delegation must be attached to this form (may be a photocopy). Such delegation must last 12 months.	eing delegated to another person, evidence of that be on official letterhead and must be dated within the
I hereby declare under penalty of perjury under the law above statements are true and correct and the facility RCPSC to offer the type and level of training comple applicant is being trained in an approved ACGME	is approved by the ACGME or the ted by the applicant and that the
(Type or print name of Director of Medical Education)	
(Signature of Director of Medical Education)	
8/13/04	17-671-7300
(Date) (Telepho	ne Number)
CAROL A. ALLEN	OFFICIAL HOSPITAL SEAL, OR
No. 02-75388-1	IOTARY SEAL (WITH DATE AND
	OTARY'S SIGNATURE) MUST BE FIXED IN THE BOX AT THE LEFT.
(Mot A HUEL 8/13/04	TOTAL THE LEFT.
L	

NOTE: Do not use this form in lieu of Form L3A, "Certificate of Completion of ACGME/RCPSC Postgraduate Training."

07A-107-L4 (3/01)

Name of Applicant (type or print FULL name):



# MEDICAL BOARD OF CALIFORNIA

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



# OFFICIAL BREAKDOWN OF UNDERGRADUATE CLINICAL CLERKSHIPS

(The completion of this form is required only of international medical school graduates.

Please complete this form in the English language.)

U.S. Social Security Number:

KOY SZEVE	FR	Date of Birth	-MM/DD/YYYY;	
Only undergraduate clinical clerks PATIENTS IN A CLINICAL SETT criteria should NOT be	hips in which the applicant participated in DIRI ING should be reported on this form. Any clini reported on this form as they will NOT satisfy	ECT, HANDS-O cal clerkships c California's clini	N DIAGNOSIS OR TREA ompleted that do not mee cal training requirements.	TMENT OF the above
	UNDERGRADUATE CLINICAL C ng completed prior to issuance of your ing in date/chronological order, commi			nd on the
CLINICAL SUBJECT AREA	FACILITY NAME AND ADDRES	t	DATES OFATTENDANCE FROM - TO (Month/Day/Year)	WEEKS OR WEEKLY HOURS OF CREDIT
medicine 5	Loyal Harpshire Cty Hon buncheser, Harpshire,	Puk 1	0/26/98	4 .
wedure of	monday unveisity for	actiful 1	23 198	12
Sugery	Thorton Nexth Surry	uk at o	2/15/99	12
Cordinarcula Diseases	Adre day as above	or of	10/99	2
08/6zn	Som as above	of ex	124/99	6
Asy Cheety	Brinet General Hosp	top or	105799	6
ATTENTION DEANS OR REGISTRARS: THE PERSO.  Only the Dean or Registrar may sign this form. this form (may be a photocopy). Such delega	N WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE A If that signature authority is being delegated to another ation must be on official letterhead and must be dated	APPLICANT BY BLOC	DD. MARRIAGE, OR ADOPTION. of that delegation must be att	ached to
MEDICAL SCHOOL SEAL	Margaret A Dean of Enroll	A. Lambert ment Planni	าต	
decla that I	FULL NAME of Delitive Reigns re under penalty of perjury, that I am/was the I have carefully read this porth and that the states.	_		bove and
respe	/ Whatapand Offmalman	87	16/09	el À.
A-100-L5A (Rev. 3/01)	Signature of Dean or Registrar	The state of the s	Date	

OFFICIA REAKDOWN OF UNDERGRADUATE CLINICAL CLERKSHIPS

(Continued from the front of this form. If additional space is needed, you may photocopy this side of the form; however, original signatures and seals (below) will be required on all photocopies submitted.)

Name of Applicant (type or	print FULL name):	. Social Security Number:	
Roy Si	Date	of Birth-MM/DD/YYYY:	
	UNDERGRADUATE CLINICAL CLE	RKSHIPS	
CLINICAL SUBJECT AREA	FACILITY NAME AND ADDRESS	DATES OF ATTENDANCE FROM – TO (Month/Day/Year)	WEEKS OR WEEKLY HOU OF CREDIT
Jedistrics	meni Cheldin Hospets Meni El		6
fediatrics orthopedies	Union of Souther cot	02-4/08/99	6
FAmily PRACTICE	Altowhead Regimel w Sh Blindding, CA	ed de 12/29	41
Juldine	Streto ca	01/17/20 13/10/00	8
OB/Gyr	Brooklyn Horpital V	L 03/13/00	4.
OB Om	hor Salari college Hos	fite 04/10/00	4
Dedictrice	meni Chelden's Hospit	06/02/00	40
objayo	hong Island Callege ? brooklyn ny D	1. 06/05/00 06/16/00	2_0
	U		
-TIY IIIO DOON Of Recistral than the the time.	I WHO SIGNS THIS FORM <u>MAY NOT</u> BE RELATED TO THE APPLIC If that signature authority is being delegated to another per must be on official lefterhead and must be dated, within the		had to this
MEDICAL SCHOOL SEAL	Margaret A. Lar Dean of Enrollment	nbert Planning	AND TO MIS
declare	FULL NAME of Dean of Registration	TYPE OR PRINT)	
that I have respect.	The salement	is made herein are strictly true in every	e and
00-LSB (Rev. 3/01)	Signature of Dean or Registrar	<i>8/16/0 ♀</i> Date	5B



7A-100-1.6 (Rev. 3.01)

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

# CERTIFICATE OF CLINICAL TRAINING

The completion of this form is required only of international medical school graduates, BUT may be omitted if all clinical training was done in the primary teaching hospital of the medical school and such hospital is located in the same country as the medical school AND the medical school completes and certifies the "Official Breakdown of Undergraduate Clinical Clerkships form, Form L5A/B.] Please complete this form in the English language.

Complete ONE certificate for EACH clerkship, signed by the facility program director or instructor.

Only undergraduate clinical clerkships in which the applicant participated in DIRECT. HANDS-ON DIAGNOSIS OR TREATMENT OF PATIENTS IN A CLINICAL SETTING should be reported on this form. Any clinical clerkships completed that do not meet the above criteria should NOT be reported on this form as they will NOT satisfy California's clinical training requirements. This is to certify that

THE WORLD STREET HERE WE	STUDEN	T'S NAME		
DATE OF BIRTH-MMIDDOMY	a student of St.	George's r	Iniversity Scl	US SUCIAL SECURIT NO
completed a clerkship offered I			MEDICAL SCHOOL	nool of Medicine
Completed a clerkship offered I	Dy Long Island (	ollege Hos	spital	
	220 1	NA	ME AND ADDRESS OF FACILITY	
. /	339 Hicks Str	<u>eet, Brook</u>	_	.201
from 4		_		
MONTH DAY	YEAR thro	ugh	9	in the clinical area
of		MONTA.	DAY	YEAR THE SIMILE OF THE SERVICE OF TH
Ci	INICAL AREA	(	(Ob)	•
This facility S is affiliated with	a U.S. or International school			
	with a U.S. or International school	This facil	ity of does have an ACG	ME-accredited residency program
Name of U.S. or International m	rint a U.S. or international school ledical school if affiliation	la l	in the areas of: Me	edicine/Pediatrics
			does not have an A	CGME-accredited residency
SUNY DOWNSTATE MEI	ICAL CENTER @ BF	OOKLYN	program.	· ·
Market and the second s				
ATTENTION FACILITY PROGRAM DIRECTOR ADOPTION.	S OR INSTRUCTORS: THE PERSON W	O SIGNS THE FORM		
ADDITION.		O SIGNS THIS FORM E	MAY NOT BE RELATED TO THE	APPLICANT BY BLOOD, MARRIAGE, OR
Only the Facility Program Director or Instru be attached to this form (may be a photo	copy). Such delegation must be a	n official letterhead a	ng delegated to another pe	rson, evidence of that delegation must
· Av			The most be added within the	lost 12 months.
1 DEC	langh	SWear or off-	464	
or instructor for	the student named above du ted this form and that the stat	ing the clerkship	that I am/was the the in	dividual facility program director
and complet	led this form and that the state	ements made hen	morcaleo ano mar i nav Bin are shicky teraja a	e carefully read
		D	A s	rery respect
i S	Janel U.	<u>Kicciar</u>	( ME)	
Official Hospital	TYPE OR PRINT NAME OF FACILITY PRO	GRAM DIRECTOR OR INSTRU	CTOR	
ंह	339 Hicks Stre	et		
sp.i.				<i></i>
	Brooklyn,		N V	1
Seal	17701 781-	136	STATE	71201 zip coos
	TELEPHONE NUMBER	206	/// <i>//</i> //	•
		•	SIGNATURE OF FACILITY PE	OGRAM DIRECTOR OR INSTRUCTOR
OTE: IN ABSENCE OF AN OFFICIAL RESENCE OF A NOTARY PUBLIC WI	HOSPITAL SEAL THE FACULE	7/ 2000	——————————————————————————————————————	
RESENCE OF A NOTARY PUBLIC WI	HO AFFIXES HIS/HER OFFICIA	T PROGRAM DIRE	CTOR OF INSTRUCTOR	MUST SIGN THIS FORM IN THE
igned and sworn to before me ti	w.t.	THO INNI SEAL.	•	: · · · · · · · · · · · · · · · · · · ·
Same and sworm to perote the fi	11S da	By of		
			HTHOM	YEAR
	I_ <del></del>		•	· - ·
	NOTAR NOTAR	PUBLIC		
•	18			• • • • • • • • • • • • • • • • • • •
	ADORES			
	<sup>™</sup> My Co	mmission Expires		
<del></del>	_		<del></del>	- Para (1997年 - 1997年 - 1997



### MEDICAL BOARD OF CALIFORNIA LICENSING PROGRAM

1426 Howe Avenue Sacramento, CA 95825-3236 (916) 263-2499



# CERTIFICATE OF CLINICAL TRAINING

(The completion of this form is required only of international medical school graduates.)

NOTE: THIS FORM MAY BE OMITTED IF ALL CLINICAL TRAINING WAS DONE IN THE PRIMARY TEACHING HOSPITAL OF THE MEDICAL SCHOOL AND SUCH HOSPITAL IS LOCATED IN THE SAME COUNTRY AS THE MEDICAL SCHOOL AND THE MEDICAL SCHOOL COMPLETES AND CENTIFIES THE OFFICIAL BREAKDOWN OF UNDERGRADUATE CLINICAL CLERKSHIPS FORMS, FORMS LSA/B.

Complete ONE certificate for EACH clerkship, signed by the instructor or facility program director.

This is to certify that	Roy Sil	ver		-	, a student
•		3	TUDENT'S NAME		
of St George's U	niversity School	of Medicine		·	, completed a
		MEDICAL SCHOOL			
clerkship offered by _	Royal Hampshire	County Hospi	tal, Romsey Road	<u>, Winchester. Ha</u>	mpshire.
	⇔S022 5DG.		ADDRESS OF FACILITY	ON!	
from 26 October		19 98 through	20 November	, 19 98	in the clinical area
D/	TE	, , , <u> </u>	DATE	<del></del>	
of Med	icine				
U	CLINICAL AREA				
Mr Michael Bu	ckingham		haina dulu suuren esv	she is/was the indiv	idual instructor or
	<u> </u>			nd thathe has careft	
program directi	or for the student name	bot the eletements	eventsinp indicated at	ly true in every respect	<i>}</i>
CON	npietea unis rorm ano.t	nat ine statements	wada valan sia sürcü	iy uuc ui evety tespeci	
	_				
This families 50	- FEI-4-1-25-110	Intro-Victoria de India	T_ :		
This facility Dis	affiliated with a U.S. or	(ntemational school	•	ve an ACGME-accredited res	idency program
☐ is n	<del></del>	#Eliata di	in the areas		
Name of U.S. Of links	mational medical school, if a	птатец.		thave an ACGME-accredited	residency
, <b>l</b>			program.		
	Mr	Michael Bucki	ngham		
STGRADUATE MEDIC	AL CENTRE	T NAME OF INSTRUCTOR OF PACE	TVFROGRAMOWACTOR		
POSTGRADUATE MEDIC ROYAL HAMPSHIRE COL	NTY HOSPITAL ROX	al Hampshire	County Hospital		•
WINCHESTER	\ <del>\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\</del>	MBERANDSTREEY			
HANTS SO22 5DG	ROTE ROTE		chestan Hamnshi	re. <u>SO22 5DG. UK</u>	
FAX: 01962 824422 FAX: 01962 825168	E   ROII	isey moad, will			
774, 01902 020100	0104	060000	M	Bu Ku Khan	
	TELEPHONE	2 863535		URE OF HISTRUCTORFACILITY PROGRAM	
	I (GLEP PROPERTY	NAME R	digitation		
<del></del>					
NOTE: IN ABSENCE OF	AN OFFICIAL HOSPITAL S	EAL, THE INSTRUCTO	R OR PROGRAM DIRECTO	OR MUST SIGN THIS FORM	IN THE PRESENCE
OF A NOTARY PUBLIC W	MO AFFIXES HIS/HER OF	FICIAL NOTARY SEAL			•
Signed and aware to	before me this	31st	day of	August	, <b>19</b> 99
Signed and sworm to	DOIGHT-ITIC UIIS				
r		7			,
<b>i</b> 1		Z NOTARYPU	BI IC		
l <del>i</del>					
1! -		3			
		ADDRESS			<u> </u>
		<u> </u>	<del>-/</del> .		
li /	·	My Corre	mission Expires		
		My Com	<i></i>		<b>16</b>



### ICAL BOARD OF CALIFORNIA LICENSING PROGRAM

1426 Howe Avenue Sacramento, CA 95825-3236 (916) 263-2499



# CERTIFICATE OF CLINICAL TRAINING

(The completion of this form is required only of International medical school graduates.)

NOTE: This form may be omitted if all clinical training was done in the primary teaching hospital of the medical school and such hospital is located in the same country as the medical school and the medical school completes and certifies the Official Breakdown of Undergraduate Clinical Clerkships forms, Forms L5A/B.

Complete ONE certificate for EACH clerkship, signed by the instructor or facility program director.

This is to certify that Roy Silver a student a student
St Cooper's University School of Medicine completed a
clerkship offered by Mayday University Hospital, Mayday Road, Thornton Heath, Surrey.
CR7 7YE. UK
from 23 November 1998 through 12 February 1999 in the clinical area
of Medicine
Dr Rupert Courtenay-Evans <u>being duly sworn</u> , says <u>he is/was the individual instructor or program director for the student named above during the clerkship indicated and that he has carefully read and completed this form and that the statements made herein are strictly true in every respect.</u>
This facility is affiliated with a U.S. or International school  I is not  Name of U.S. or International medical school, if affiliated:  This facility ideas have an ACGME-accredited residency program  in the areas of:  I does not have an ACGME-accredited residency program.
CROYDON CHEST CUM Rupert Courtenay-Evans  Mayday University Hospitaly University Hospital
Mayday Road Mayday Road, Thornton Heath, Surrey OR7 7YE. UK  Thornton Heath CR 77 TE COOE  Thornton Heath STATE  Thornton Heath STAT
TELEPHONEMARER SIGNATURE OF INSTRUCTOR POLITY PROGRAM DIRECTOR
NOTE: IN ABSENCE OF AN OFFICIAL HOSPITAL SEAL, THE INSTRUCTOR OR PROGRAM DIRECTOR MUST SIGN THIS FORM IN THE PRESENCE OF A NOTARY PUBLIC WHO AFFIXES HIS/HER OFFICIAL NOTARY SEAL.  Signed and sworm to before me this 14th day of August , 19 99.
NOTARY PUBLIC
ADDRESS
My Commission Expires



# MEDICAL BOARD OF CALIFORNIA LICENSING PROGRAM

1426 Howe Avenue Sacramento, CA 95825-3236 (916) 263-2499



## CERTIFICATE OF CLINICAL TRAINING

(The completion of this form is required only of International medical school graduates.)

NOTE: THIS FORM MAY BE OMITTED IF ALL CLIBICAL TRAINING WAS DONE IN THE PRIMARY TEACHING HOSPITAL OF THE MEDICAL SCHOOL AND SUCH HOSPITAL IS LOCATED IN THE SAME COUNTRY AS THE MEDICAL SCHOOL AND THE MEDICAL SCHOOL COMPLETES AND CERTIFIES THE OFFICIAL BREAKDOWN OF UNDERGRADUATE CLINICAL CLERKSHIPS FORMS, FORMS L5A/B.

Complete ONE certificate for EACH clerkship, signed by the instructor or facility program director.

This is to cortify that Roy Silver	, a student
This is to certify triat	UDENT'S NAME
of St George's University School of Medicine	, completed a
clerkship offered by Mayday University Hospital, Ma	ayday Road, Thornton Heath, Surrey.
NAME AND A	ADDRESS OF FACILITY
CR7 7YE. UK	
from 15 February , 19 99 through	7 May , 1999 in the clinical area
of Surgery	DATE
CLINICAL AREA	•
Dr Rupert Courtenay-Evans	hain duk numan anya ha inkuna tha individual instructor or
- program director for the student named above during the	being duly sworn, sayshe is/was the individual instructor or clerkship indicated and thathe has carefully read and
completed this form and that the statements	made herein are strictly true in every respect.
Samuel and the	
This facility Dis affiliated with a U.S. or International school	This facility I does have an ACGME-accredited residency program
☐ is <u>not</u> Name of U.S. or international medical school, if affiliated:	in the areas of:
	program.
The state of the s	
CROYDON CHEST CLINICipert Courter	nay-Evans
May any Injures by Hospital	
Mayday University Hospital University	y Hospital
Mayday Road ADDRESS: MANDER AND TREET	~
Mayday Road ADDRESS: MANDER AND TREET	rnton Heath, Surrey CR7 7YE. UK
Mayday Road Mayday Road, Tho:  Thornton Heat CRY /YE  0181 401 3137	rnton Heath, Surrex CR7 7YE. UK
Mayday Road ADDRESS: MANDER AND TREET	rnton Heath, Surrex, CR7 7YE. UK
Mayday Road Mayday Road, Tho: Thornton Heather CRY /YE NOTE: IN ABSENCE OF AN OFFICIAL HOSPITAL SEAL, THE INSTRUCTOR	rnton Heath, Surrey CR7 7YE. UK  SIGNATURE OF REPROCONTACULTY PROGRAM DIPECTOR
Mayday Road Mayday Road, Thornton Heating CRY / E Mayday Road, Thornto	SICHATURE STREET OF PROGRAM DIRECTOR MUST SIGN THIS FORM IN THE PRESENCE
Mayday Road Mayday Road, Tho: Thornton Heather CRY /YE NOTE: IN ABSENCE OF AN OFFICIAL HOSPITAL SEAL, THE INSTRUCTOR	SICHATURE STREET OF PROGRAM DIRECTOR MUST SIGN THIS FORM IN THE PRESENCE
Mayday Road, Tho: Thornton Heating CRY / E Mayday Road, Tho: Thornton Heating CRY / E Mayday Road, Tho: Thornton Heating CRY / E Mayday Road, Tho: Mayday Ro	SIGNATURE OF PROGRAM DIRECTOR MUST SIGN THIS FORM IN THE PRESENCE  day of
Mayday Road, Tho: Thornton Heating CRY / E Mayday Road, Tho: Thornton Heating CRY / E Mayday Road, Tho: Thornton Heating CRY / E Mayday Road, Tho: Mayday Ro	SIGNATURE OF PROGRAM DIRECTOR MUST SIGN THIS FORM IN THE PRESENCE  day of
Mayday Road Mayday Road, Tho: Thornton Heather CRY /YE Mayday Road, Tho: Mayday Road	SIGNATURE OF PROGRAM DIRECTOR MUST SIGN THIS FORM IN THE PRESENCE  day of
Mayday Road, Tho: Thornton Heating CRY / E Mayday Road, Tho: Ma	SICHATURE OF ME RUCYOF ACUTY PROGRAM DIFECTOR  R OR PROGRAM DIRECTOR MUST SIGN THIS FORM IN THE PRESENCE  day of August 19 99  Dission Expires



# MEDICAL BOARD OF CALIFORNIA LICENSING PROGRAM

1426 Howe Avenue Sacramento, CA 95825-3236 (916) 263-2499



### CERTIFICATE OF CLINICAL TRAINING

(The completion of this form is required only of International medical school graduates.)

NOTE: This form may be quitted if all clinical training was done in the primary teaching hospital of the medical school and such hospital is located in the same country as the medical school and the medical school completes and certifies the Official Breakdown of Undergraduate Clinical Clerkships forms, Forms LSA/B.

Complete ONE certificate for EACH clerkship, signed by the instructor or facility program director.

This is to certify that	Roy Silver			, a student
. •	wangitu Cabaal -		TUDENT'S NAME	
of St George's Uni	versity School of	Medicine		completed a
clerkship offered byMa	ayday University Ho	spital, Ma	ayday Road, Thornton Heath, Surrey	7.
	CR7 7YE. UK	NAME AND	ADDRESS OF FACILITY	
from 10 May	, 19 <sup>9</sup>	through	21 May 19 99 in	the clinical area
Candialogy			DATE	•
of Cardiology	CLINICAL AREA			
	- Application on Artical			•
Dr Rupert Courte			being duly swom, sayshe is/was the individual	ual instructor or
program director compi	for the student named abo leted this form and that th	ove during the e statements	clerkship indicated and thathe has carefully made herein are strictly true in every respect.	∕read and
This facility D is D is not Name of U.S. or Interna	affiliated with a U.S. or Internal tional medical school, if affiliated.	•	This facility does have an ACGME-accredited resident in the areas of: does not have an ACGME-accredited reprogram.	·
	Dr. Bupe	rt Courte	nav-Evans	· · · · · · · · · · · · · · · · · · ·
I CROYDON	CHEST CLEUR	INSTRUCTOR OR FACIL	LITY PROGRAM DIRECTOR	
1 Mayday Uni	iversity Hospital	Universit	y Hospital	· · · · · · · · · · · · · · · · · · ·
Mayday Roc	ADDRESS MANGER AND Mayday		rnton Heath, Surrey. CX7 7YE. UK	
Thornton He	athe CR7 7YE	h1 2127	STATE	IP CODE
L Inomion re	THE CITY TOTAL	10T 2T21	SIGNATURE OF INSTRUCTORFACILITY PROGRAM DR	ECTOR
NOTE: IN ARSENCE OF AN	OFFICIAL HOSPITAL SEAL TI	HE INSTRUCTO	R OR PROGRAM DIRECTOR MUST SIGN THIS FORM IN	THE PRESENCE
OF A NOTARY PUBLIC WHO	AFFIXES HISHER OFFICIAL	NOTARY SEAL.		
Signed and sworn to be	fore me this14t	h	day of August	, <b>19</b> _ <u>99</u> .
r		<b>י</b>	<b>.</b>	
<b>!</b> !		Z NOTARY PUB	SUC	
		ADDRESS		<del>/</del>
		1 0	vission Funion	Q 1. (A) A (A)
			nission Expires	
A7 A. 100.3 4 (Par) 7/07)	<del></del>			

Sloke of Colfornia Department of Allairs

# EDICAL BOARD OF CALIFORNIA LICENSING PROGRAM

1426 Howe Avenue Sacramento, CA 95825-3236 (916) 263-2499



### CERTIFICATE OF CLINICAL TRAINING

(The completion of this form is required only of International medical school graduates.)

NOTE: THIS FORM MAY BE OMITTED IF ALL CLINICAL TRAINING WAS DONE IN THE PRIMARY TEACHING HOSPITAL OF THE MEDICAL SCHOOL AND SUCH HOSPITAL IS LOCATED IN THE SAME COUNTRY AS THE MEDICAL SCHOOL AND THE MEDICAL SCHOOL COMPLETES AND CERTIFIES THE OFFICIAL BREAKDOWN OF UNDERGRADUATE CLINICAL CLERKSHIPS FORMS, FORMS LSA/B.

Complete ONE certificate for EACH clerkship, signed by the instructor or facility program director.

This is to continue that Roy Silver	a student
This is to certify that	STUDENT'S NAME
of St George's University School of Medic	ine, completed a
clerkship offered by Mayday University Hospita	
CIERKSNIP OTIETED BY THAT GLOSS TO THE STATE OF THE STATE	ME AND ADDRESS OF FACILITY
CR7 7YE. UK	
from 24 May , 19 <sup>99</sup> thr	rough 2 July 19 99 in the clinical area
DATE	DATE
of Obstetrics & Gynaecology	•
Dr Rupert Courtenay-Evans	being duly sworn, sayshe is/was the individual instructor or
program director for the student named above duri	ng the clerkship indicated and thathe has carefully read and nents made herein are strictly true in every respect.
completed this form and that the statem	iens made nerent are sureny add in ordry rosposa.
This facility D is affiliated with a U.S. or International scho	Time received in the second se
Name of U.S. or International medical school, if affiliated:	in the areas of:  does not have an ACGME-accredited residency
	program.
	urtenay-Evans
Mayday University Hoden Unive	
ADDRESS HAMBER AND TREET	There was been constructed by
	Thornton Heath, Surrey. CRY 7YE. UK
Thornton Heath CR7 77 to 101 31	37  SIGNATURE OF INSTRUCTOR FACULTY PROGRAM I PRECTOR
THE PERSON NAMED IN COLUMN 1	SIGNATURE OF RETRUCTORY ALSO IN PROGRESSION LINES. TOP
NOTE: IN ABSENCE OF AN OFFICIAL HOSPITAL SEAL, THE INSTR	RUCTOR OR PROGRAM DIRECTOR MUST SIGN THIS FORM IN THE PRESENCE
OF A NOTARY PUBLIC WHO AFFIXES HIS/HER OFFICIAL NOTARY	SEAL.
Signed and swom to before me this14th	day of, 19, 19
Z NOT	TARY PUBLIC TARY PUBLIC
I I I I I I I I I I I I I I I I I I I	PRESS
	Commission Expires
07 A . 100_1 6/9 = , 7/971	· ·



# MEDICAL BOARD OF CALIFORNIA LICENSING PROGRAM

1426 Howe Avenue Sacramento, CA 95825-3236 (916) 263-2499



### CERTIFICATE OF CLINICAL TRAINING

(The completion of this form is required only of international medical school graduates.)

TE: This form may be omitted if all clinical training was done in the primary teaching hospital of the medical school and such hospital is located in the same jutry as the medical school and the medical school completes and certifies the Official Breakdown of Undergraduate Clinical Clerkships forms, Forms L5A/

Complete ONE certificate for EACH clerkship, signed by the instructor or facility program director.

The state of the s	
This is to certify that Roy SILVER STUDENT'S NAME	, a student
of Si bearge's University School of Addictive	, completed a
clerkship offered by Bariet General Hospital  NAME AND ADDRESS OF FACILITY  Barnet  CA	
NAME AND ADDRESS OF FACILITY	VS 3DJ
Condon Vit. Barnet Ex	
rom, 19through	, 19 in the clinical area
of Psychratry 9	
CLINICAL AREA	•
Dr. C. Rafina being duly sworn, says	he is/was the individual instructor or
program director for the student named above during the clerkship indicated and completed this form and that the statements made herein are strictly	
This facility is affiliated with a U.S. or International school This facility in does have	e an ACGME-accredited residency program
LJ is not in the area	as of:
program.	have an ACGME-accredited residency
On I PATWA	
OR. L. RATNA TYPE OR PRINT NAME OF INSTRUCTOR OR FACILITY PROGRAM DIRECTOR	
CONSULTANT PSYCHIATRISTANCE GENERAL HOSP BARNET GENERAL HOSPITAL MARSTREET	1TAL
WELLHOUSE LANES LONDOW, U.K. BAR	NET ENS 3DET
BARNET, HERTS. ENS 3D. 1 9. 16 /16/7	TE CODE
TELEPHONE NUMBER SIGNATURE	OF INSTRUCTOR FIGURE PROGRAM DIRECTOR
IOTE: IN ABSENCE OF AN OFFICIAL HOSPITAL SEAL, THE INSTRUCTOR OR PROGRAM DIRECTOR	R MUST SIGN THIS FORM IN THE PRESENCE
F A NOTARY PUBLIC WHO AFFIXES HIS/HER OFFICIAL NOTARY SEAL.	
Signed and sworn to before me this day of	, 19
NOTARY PUBLIC  O  ADDRESS	
' <u>e</u>	
My Commission Expires	
\-10016 (Rev 3/99)	



### EDICAL BOARD OF CALIFORNIA LICENSING PROGRAM 1426 Howe Avenue Sacramento, CA 95825-3236 (916) 263-2499



## CERTIFICATE OF CLINICAL TRAINING

(The completion of this form is required only of international medical school graduates.)

NOTE: This form may be omitted if all cunical training was done in the primary teaching hospital of the medical school and such hospital is located in the same country as the medical school and the medical school completes and certifies the Official Breakdown of Undergraduate Clinical Clerkships forms, Forms L5A/B.

Complete ONE certificate for EACH clerkship, signed by the instructor or facility program director.

12m 5745	*
This is to certify that	STUDENT'S NAME , a student
of <u>ST GEORGE'S WALVERSITY SG</u>	HOGE OF MEDICINE , completed a
clerkship offered by	CHILDREN'S HOSPITAL
	MIAMI FLURIDA 33155
from Aug 16th, 2000 through	h Sept 24th 2000 in the clinical area
OF PEDIATRICS CUNICAL AREA	·
program director for the student named above during th	_being duly swom, sayshe is was the individual instructor or se clerkship indicated and that _ he has carefully read and s made herein are strictly true in every respect.
This facility is affiliated with a U.S. or International school is not  Name of U.S. or International medical school, if affiliated:	This facility does have an ACGME-accredited residency program in the areas of: does not have an ACGME-accredited residency program.
TYPE OR PRINT NAME OF INSTRUCTOR OR FACE    STATE   STATE     OS   ADDRESS: MUMBER AND STREET     OS   CITY     OS	STATE  STATE  STATE  STATE  STATE  SIGNATURE OF INSTRUCTOR FACILITY PROGRAM DIRECTOR
OF A NOTARY PUBLIC WHO AFFIXES HIS/HER OFFICIAL NOTARY SEAL  Signe rand sworm to before me, this  NOTARY PUBLIC WHO AFFIXES HIS/HER OFFICIAL NOTARY SEAL  NOTARY PUBLIC WHO AFFIXES HIS/HER OFFICIAL	my Det May was



### MEDICAL BOARD OF CALIFORNIA LICENSING PROGRAM

1426 Howe Avenue Sacramento, CA 95825-3236 (916) 263-2499



# CERTIFICATE OF CLINICAL TRAINING

(The completion of this form is required only of international medical school graduates.)

NOTE: This form may be omitted if all clinical training was done in the primary teaching hospital of the medical school and such hospital is located in the same country as the medical school and the medical school completes and certifies the Official Breakdown of Undergraduate Clinical Clerkships forms, Forms L5A/B.

Complete ONE certificate for EACH clerkship, signed by the instructor or facility program director.

ABOVE CRITERIA SHOULD NOT BE REPORTED ON THIS FORM AS THEY WILL NOT SATISFY CALIFORNIA'S CLINICAL TRAINING REQUIREMENTS.
This is to certify that <u>Roy STLVER</u> , a student
This is to certify that Roy SILVER student's NAME  of ST. George's UNIVERSITY School of Medicine completed a  MEDICAL SCHOOL  Clerkship offered by Los Angele's County -USC Medical Center  NAME AND ADDRESS OF FACILITY
clerkship offered by Los Angeles County -USC Medical Center
MAIND ADDRESS OF FACILITY SEC.
from Nov. 8 , 19 99 through Dec 19 , 19 99 in the clinical area
of Onthopical Surgery Clinical AREA
program director for the student named above during the clerkship indicated and that _he has carefully read and
completed this form and that the statements made herein are strictly true in every respect.
This facility is affiliated with a U.S. or International school This facility I does have an ACCME according to the condition of the condition
This facility does have an ACGME-accredited residency program in the areas of: (NOTHOPAEDIC)
does <u>not</u> have an ACGME-accredited residency program.
TYPE OR PRINT NAME OF INSTRUCTOR OR FACILITY PROGRAM DIRECTOR
BIO San Habro St. #322
CS ANGE CS CA 90033
TELEPHONE NUMBER  SIGNATURE OF INSTRUCTOR/FACILITY PROGRAM DIRECTOR
NOTE: IN ABSENCE OF AN OFFICIAL HOSPITAL SEAL, THE INSTRUCTOR OR PROGRAM DIRECTOR MUST SIGN THIS FORM IN THE PRESENCE OF A NOTARY PUBLIC WHO AFFIXES HIS/HER OFFICIAL NOTARY SEAL.
Signed and sworn to before me this day of, 19
NOTARY PUBLIC
Tary
My Commission Expires
07A-100-L6 (Rev. 3/99)



### MÉDICAL BOARD OF CALIFORNIA LICENSING PROGRAM 1426 HOURS AVENUE

1426 Howe Avenue Sacramento, CA 95825-3236 (916) 263-2499



# CERTIFICATE OF CLINICAL TRAINING

(The completion of this form is required only of international medical achool graduates.)

NOTE: This form may be omitted if all climical training was done in the primary teaching hospital of the medical school and such hospital is located in the same country as the medical school <u>and</u> the medical school completes and certifies the Oppicial Breakdown of Undergraduate Clinical Clerkships forms L5A/B.

Complete ONE certificate for EACH clerkship, signed by the instructor or facility program director,

	STATE OF THE PROPERTY OF
This is to certify that Roy Silver	a student
of St. George's University School of M	TUDENT'S NAME
MEDICAL SCHOOL	
clerkship offered by Arrowhead Regional Medical Ce	
400 North Pepper Avenue, Colton, CA 9232	ADDRESS OF FACILITY
December 20 99	Japuary 14 00
from December 20 19 99 through	19 in the clinical area
of Family Medicine	
CLINICAL AREA	•
Andre V. Blaylock, M.D.	being duly swom, sayshe is/was the individual instructor or
Production of the statement named above allows the	Clarkship indicated and that he has a to .
completed this form and that the statements	made herein are strictly true in every respect
This facility is affiliated with a U.S. or international school	This facility I does have an ACGME-accredited residency program
Name of U.S. ar international medical school, if affiliated:	intheareasof: Family Medicine
UC Irvine	☐ does <u>not</u> have an ACGME-accredited residency program.
Arrowhead Regional 1	Medical Center
TYPEORPRINT NAME OF INSTRUCTOR DIR FACILITY  400 North Pepper Ave	
G APPREAN NUMBER AND STREET	
TYPE OR PRINT HAME OF INSTRUCTOR OR FACILITY  400 North Pepper Ave Apprecia Number And STREET  Colton. CA 92324  CITY	4-11-1-1
<u>(909) 580–6268</u>	Mine V. Bleson
TELEPHONE NEWSCH	SECULTURE OF INSTRUCTOR MACEUTY PROCRAMO INCOME.
NOTE: IN ABSENCE OF AN OFFICIAL HOSPITAL SEAL, THE INSTRUCTOR OF A NOTARY PUBLIC WHO AFFIXES HIS/HER OFFICIAL NOTARY SEAL	OR PROGRAM DIRECTOR MUST SIGN THIS FORM IN THE PRESENCE
Signed and sworn to before me this Q C +2	day of anuary 1951
	20. C.Co. k
SALLY CLARK  SALLY CLARK  Comm. # 1150861	N. Pepper Avenue
NOTARY PUBLIC CALIFORNIA UI	ton, GA 92324 1819
an Sernardino County	ssion Expires 8102001
07A-100-L6 (Rev. 2/97)	R
THE THE OWNER, LAND	





### MEDICAL BOARD OF CALIFORNIA LICENSING PROGRAM

1426 Howe Avenue Sacramento, CA 95825-3236 (916) 263-2499



# CERTIFICATE OF CLINICAL TRAINING

(The completion of this form is required only of international medical school graduates.)

NOTE: This form may be omitted if all clinical training was done in the primary teaching hospital of the medical school and such hospital is located in the same country as the medical school and the medical school completes and certifies the Official Breakdown of Undergraduate Clinical Clerkships forms, Forms L5A/B.

Complete ONE certificate for EACH clerkship, signed by the instructor or facility program director.

This is to certify that	Roy Silver	, a student
		UDENT'S NAME
of St. George's	University School of Medicin	ie, completed a
	MEDICAL SCHOOL	C.V.
clerkship offered by	San Joaquin General Hospital	Yana Yana Yana Yana Yana Yana Yana Yana
		DDRESS OF FACILITY
	500 W. Hospital Road Fr	ench Camp, Ca 95231
. Tanun 15	7	V 1 40
from January 17	, 2000 through	March 10 XXX2000 in the clinical area
	cine Sub-Internship	DAIE
of <u>Medi</u>	CLINICAL AREA	·
	CLINICAL AREA	
	•	
	b	peing duly sworn, says_he is/was the individual instructor or
		clerkship indicated and thathe has carefully read and
compl	eted this form and that the statements m	nade herein are strictly true in every respect.
·		
This facility 🛭 is	affiliated with a U.S. or International school	This facility
· ☑ is <u>not</u>	• 1	in the areas of: IM, FP, Surgery
Name of U.S. or Internal	tional medical school, if affiliated:	does not have an ACGME-accredited residency
1		program.
1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	James K. Saffier, N	
	TYPEORPRINT NAME OF INSTRUCTOR OR FACILITY  San Joaquin General  ADDRESS: Number AND STREET  500 W. Hospital Roa	
불성하다 그 그 등록	San Joaquin General	l Hospital
그 그 일 하는 그는 그를 하는 것이 없다.	ADDRESS: NUMBER AND STREET	
	500 W. Hospital Roa	
	<u> </u>	ZIP CODÉ
ب نے ب بے تاریخ	(209) 468-6624	SIGNATURE OF INSTITUTION FACILITY PROGRAM DIRECTOR
	TELEPHONERUMBER.	SISSEMPLE OF INSTRUCTION PACIFITY PROGRAMMINECTOR
NOTE: IN ADDENICE OF AN		
OF A NOTARY PURILC WHO	OFFICIAL HOSPITAL SEAL, THE INSTRUCTOR ( AFFIXES HIS/HER OFFICIAL NOTARY SEAL.	OR PROGRAM DIRECTOR MUST SIGN THIS FORM IN THE PRESENCE
OF ANOTARY FOREIGNAMO	AFFIXES HIS/HER OFFICIAL NOTART SEAL.	
Signed and sworn to be	fore me this	day of
li		
	NOTARY PUBLIC	
<u>" " " " " " " " " " " " " " " " " " " </u>	ita <sub>n</sub>	
	NOTARY PUBLIC	
1		ssion Expires_
07A-100-I 6/Rev 2/97)		





### MEDICAL BOARD OF CALIFORNIA LICENSING PROGRAM 1426 Howe Avenue



Sacramento, CA 95825-3236 (916) 263-2499

# CERTIFICATE OF CLINICAL TRAINING

(The completion of this form is required only of international medical school graduates.)

NOTE: THIS FORM MAY BE OMITTED IF ALL CLINICAL TRAINING WAS DONE IN THE PRIMARY TEACHING HOSPITAL OF THE MEDICAL SCHOOL AND SUCH HOSPITAL IS LOCATED IN THE SAME COUNTRY AS THE MEDICAL SCHOOL AND THE MEDICAL SCHOOL COMPLETES AND CERTIFIES THE OFFICIAL BREAKDOWN OF UNDERGRADUATE CLINICAL CLERKSHIPS FORMS, FORMS L5A.

Complete ONE certificate for EACH clerkship, signed by the instructor or facility program director.

This is to certify that Roy Silver  of St. George's Univ. School  clerkship offered by The Grooklyn Hos	TUDENT'S NAME  1. OF Medicine, completed a
121 Dehalb Avenue Constant	
from March 13, 7000 through	April 7 , 19 in the clinical area
of Syn. Oncology Clinical AREA	·
completed this form and that the statements	being duly sworn, says <u>k</u> he is/was the individual instructor or eclerkship indicated and that <u>k</u> he has carefully read and made herein are strictly true in every respect.
This facility is affiliated with a U.S. or International school is not Name of U.S. or International medical school, if affiliated:	This facility does have an ACGME-accredited residency program in the areas of:  does not have an ACGME-accredited residency program.
r Unicent Tr	ricom MD
TYPE OR PRINT NAME OF INSTRUCTOR OR FACIL	TY PROGRAM DIRECTOR
ADDRESS: NUMBER AND STREET  OF OVERLAND  ADDRESS: NUMBER AND STREET	IOSII
CITY CITY TELEPHONE NUMBER	STATE ZIP CODE
NOTE: IN ABSENCE OF AN OFFICIAL HOSPITAL SEAL, THE INSTRUCTOR A NOTARY PUBLIC WHO AFFIXES HIS/HER OFFICIAL NOTARY SEAL.	OR PROGRAM DIRECTOR MUST SIGN THIS FORM IN THE PRESENCE
Signed and sworn to before me this	day of 19
NOTARY PUBL	c , 19
NOTARY PUBLICATION ADDRESS  ADDRESS  AUX Connection	
L	ssion Expires
07A-(00-L6 (Rev. 2/97)	

State of Consumer Consumer Affairs

## MEDICAL BOARD OF CALIFORNIA LICENSING PROGRAM 1426 Howe Avenue Sacramento, CA 95825-3236 (916) 263-2499



# CERTIFICATE OF CLINICAL TRAINING

(The completion of this form is required only of international medical school graduates.)

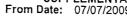
OTE: This form may be omitted if all clinical training was done in the primary teaching hospital of the medical school and such hospital is located in the same country is the medical school and the medical school completes and certifies the Official Breakdown of Undergraduate Clinical Clerkships forms, Forms L5A/B.

Complete ONE certificate for EACH clerkship, signed by the instructor or facility program director.

to to be analise that:	Ray 5	FLVER STUDENT'S NAME		, a studer
		STUDENT'S NAME	4	_, completed a
	ST. GEORGE'S UNIVER	SSITY SCHOOL OF M	EDICINE	
erkship offered by		MIAMI CHILDREN	I'S HOSPITAL	
•		NAME AND ADDRESS OF	ACILITY	
	3100 SW 62ND AV			
om May S	20.0	O through	DATE 252	, 2 <u>006</u> in the clinical are
·	PEDIATRICS			
•	CLINICAL AREA			
MAKINI	DANON M.I	) being du	ly swom, sayshe	is/was the individual instructor of
1	- All a student demand about	ve during the clerkship	n indicated and that	_he has carefully read and
comple	eted this form and that the	statements made he	rein are strictly true	n every respect.
•				
This facility  is	affiliated with a U.S. or Internati	onal school This fa	cility 🛘 does have an AC	GME-accredited residency program
☐ is not	•		in the areas of:	
Name of U.S. or Internat	ional medical school, if affiliated:	·	does <u>not</u> have at program.	ACGME-accredited residency
			program	
	K/n.D.	CO DANON,	mh.	·
	TYPEORPHINT NAMED	FINSTRUCTOR OR PACILITY PROGRAM	OIRECTOR	
	TYPEOR PRINT NAME OF BAND ADDRESS: MAJMBER AND CITY OF	SW WZNE	1 ane	
•	ADDRESS: NUMBER AND	STREET	•	33/55
,		- 6010	577.4	ZIP COOE
	305-66	2-8367	SICHATI RECEISE	THUCTOR/FACILITY PROGRAMOIRECTOR
			the state of the s	
 	TO EMOR NUMBER			
NOTE IN ADSSUCE AND ADDRESS OF THE PARTY OF	POSEICIAI HOSPITAI SFAL T	HE INSTRUCTOR OR PRO	OGRAM DIRECTOR MUS	ST SIGN THIS FORM IN THE PRESEN
NOTE: IN ABSENCE OF A	POFFICIAL HOSPITAL SEAL, TO PETICIAL	HE INSTRUCTOR OR PRO NOTARY SEAL.		ST SIGN THIS FORM IN THE PRESEN
NOTE: IN ABSENCE OF A NOTARY PURE WHO	OF THE NAME OF THE OFFICER	HE INSTRUCTOR OR PRI		ST SIGN THIS FORM IN THE PRESENT
NOTE: IN ABSENCE OF A	OF THE NAME OF THE OFFICER	HE INSTRUCTOR OR PRI NOTARY SEAL.		
NOTE: IN ABSENCE OF A NOTARY PURE WHO	OF THE NAME OF THE OFFICER	3/sf		
NOTE: IN ABSENCE OF A NOTARY PURE WHO	efore me this	THE INSTRUCTOR OR PROMOTE TO THE INSTRUCTOR OF THE INSTRUCTOR OR PROMOTE TO THE INSTRUCTOR OR INSTRUCT		

### STATE DEPARTMENT OF CONSUMER AFFAIRS INTERNET CASHIERING SYSTEM MEDICAL BOARD OF CALIFORNIA SUPPLEMENTAL INFORMATION REPORT

From Date: 07/07/2009





Person Id: Question

1284654

Name:

Silver, Roy

Answer

To Date: 07/07/2009

I Have Completed Cme And Can Document Not Less Than 50 Hours Of Approved Cme For The Two-Year Period Immediately Preceding The Expiration Date Of My License. Or I Meet The Conditions Which Would Exempt Me From All Or Part Of The Requirements.

I Have Completed 12 Hours Of Pain Management And End-Of-Life Care.

I Am Exempt From The Completion Of 12 Hours Of Pain Management And End-Of-Life Care Continuing Education Requirement Because I Am A Radiologist Or Pathologist.

Only For General Internists And Family Physicians Who Have 25% Of Their Patient Population Aged 65 Years Or Older: I Have Completed At Least 20% Of The Required Cme In Geriatric Medicine Or The Care Of Older Patients. Click No If Not Applicable.

Enter Name/Address Of Facility Where You Or Your Immediate Family Hold Financial Interest. Type "None", If None Held.

I Certify Under Penalty Of Perjury Under The Laws Of The State Of California That The Information Contained In This Application Is True And Correct.

I Have Read My Profile On The Medical Board Web Site At Www.Mbc.Ca.Gov And Acknowledge The Information Contained Therein As Current And Accurate.

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?

Total Questions Asked For Person:

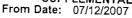


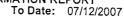
8





### STATE DEPARTMENT OF CONSUMER AFFAIRS INTERNET CASHIERING SYSTEM MEDICAL BOARD OF CALIFORNIA SUPPLEMENTAL INFORMATION REPORT







Person Id: Question

1284654

Name:

Silver, Roy

Answer

I Have Completed Cme And Can Document An Average Of 25 Hours Of Approved Cme Each Calendar Year Resulting In A Minimum Of 100 Hours Over The Last 4 Years.

I Have Completed 12 Hours Of Pain Management And End-Of-Life Care (Must Be Completed By December 31, 2006).

I Am Exempt From The Completion Of 12 Hours Of Pain Management And End-Of-Life Care Continuing Education Requirement Because I Am A Radiologist Or Pathologist.

I Have Read My Profile On The Medical Board Web Site At Www.Medbd.Ca.Gov And Acknowledge The Information Contained Therein As Current And Accurate.

Enter Name/Address Of Facility Where You Or Your Immediate Family Hold Financial Interest. Type "None", If None Held.

I Certify Under Penalty Of Perjury Under The Laws Of The State Of California That The Information Contained In This Application Is True And Correct.

Only For General Internists And Family Physicians Who Have 25% Of Their Patient Population Aged 65 Years Or Older: I Have Completed At Least 20% Of The Required Cme In Geriatric Medicine Or The Care Of Older Patients. Click No If Not Applicable.

Total Questions Asked For Person:



7

