STATE OF CALIFORNIA — STATE AND CONSUMER SERVICES AGENCY PETE WILSON, Governor

Department of Consumer Affairs

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

RECEIVED
SACRAMENTO
MEDICAL BOARD
OF CALIFORNIA

98 APR -9 PM 2:41

DIVISION OF LICENSING

PM 1:21

APPLICATION FOR PHYSICIAN AND SURGEON'S EXAMINATION OR LICENSURE

026912 305 5/13/98

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

MBC USE ONLY

1. Name: Last: Dutton First: Caryn Middle: Ruth 024933 508 Jul 98

2. Other names you have used (include maiden name):

3. Social Security Number◆ [redacted]

4. Address: Number and Street/Rural Route (include apartment number, if any): 143 Pasa Robles Ave

5. Sex: ☒ Female ☐ Male

City: Los Altos State: CA Zip Code: 94022 Country: USA

6. Telephone Number: Home: ( ) Work: [redacted]

7. Date of Birth: Mo/Day/Yr [redacted] Place of Birth: [redacted]

8. California Driver's License Number, if applicable: NUMBER [redacted] EXPIRATION [redacted]

9. Are you a U.S. citizen? ☑ Yes ☐ No
If you are an international medical school graduate, you must provide an original full and unrestricted license to practice medicine in another state or country, OR official documentation of U.S. citizenship, OR an official Declaration of Intent to become a U.S. citizen.

10. Have you ever filed an application for physician and surgeon examination or licensure in California? ☐ Yes ☑ No
IF YES, PLEASE GIVE DATE PREVIOUS APPLICATION WAS SUBMITTED AND ATTACH ANY APPLICATION MATERIALS YOU MAY HAVE RETAINED. _____

11A. List the names and addresses of all colleges or universities attended where pre-professional, postsecondary instruction was received. Please submit official transcripts with the school seal affixed for each school attended.

Name	Address	Dates of Attendance
Amherst College	Amherst, MA 01002	9/88 - 5/92
University of Massachusetts	Amherst, MA	6/90 - 7/90

11B. Check whether the following premedical courses were successfully completed and show where completed:

Course	Yes	No	Name of College or University
Chemistry	✓		Amherst College
Physics	✓		"
Biology or Zoology	✓		"

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

School Name	Address	Place of Instruction	Dates of Attendance	Degree Awarded
University of Connecticut	Farmington CT		8/92 - 5/96	M.D.

DOCTOR OF MEDICINE DEGREE, as referenced above: (Note: A U.S. graduate may, in lieu of the original, submit an official certified photocopy that has the school seal affixed and the signature of the registrar certifying authenticity.)

Name of Medical School: University of Connecticut School of Medicine
Address of Medical School: Farmington CT 06030
Exact Date of Issuance: May 23, 1996

◆ MANDATORY DISCLOSURE OF SOCIAL SECURITY NUMBERS
Disclosure of your social security number (or federal employer identification number [FEIN], if you are a partnership) is mandatory. Section 30 of the Business and Professions Code and Public Law 94-455 (42 USCA 405(c)(2)(C)) authorize collection of your social security number. Your social security number or FEIN will be used exclusively for tax enforcement purposes, for purposes of compliance with any judgment or order for family support in accordance with Section 11350.6 of the Welfare and Institutions Code, or for verification of licensure or examination status by a licensing or examination entity which utilizes a national examination and where licensure is reciprocal with the requesting state. If you fail to disclose your social security number or your FEIN, your application for initial licensure will not be processed AND you will be reported to the Franchise Tax Board, which may assess a $100 penalty against you.

CT002
School Code

L1A

07A-100 (Rev. 2/97)

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

IF YES, LIST NAME, LOCATION, DATE AND RESULT OF EXAMINATION. SUBMIT AN ORIGINAL OFFICIAL EXAMINATION HISTORY REPORT FROM EACH EXAMINATION AGENCY. APPLICANTS WHO HOLD CERTIFICATION THROUGH THE EDUCATIONAL COMMISSION FOR FOREIGN MEDICAL GRADUATES (ECFMG) WILL NEED TO SUBMIT AN ORIGINAL VALID ECFMG CERTIFICATE PRIOR TO WRITTEN EXAMINATION AND LICENSURE.

Examination	Location	Date	Result
USMLE Step 1	Farmington, CT	June '94	[redacted]
USMLE Step 2	Farmington, CT	August '95	[redacted]
USMLE Step 3	San Mateo, CA	May '97	[redacted]

Written Examination

14. Have you ever been licensed to practice medicine in any state or country? ☐ Yes ☒ No

IF YES, LIST STATE OR COUNTRY, LICENSE NUMBER, DATE ISSUED AND DATES OF PRACTICE IN EACH ISSUING AGENCY'S JURISDICTION. SUBMIT A LETTER OF GOOD STANDING FROM EACH STATE IN WHICH YOU ARE OR HAVE BEEN LICENSED. PLEASE INCLUDE TEMPORARY, TRAINING, OR PROVISIONAL LICENSES.

State or Country	License Number	Date of Issuance	Dates of Practice in that Jurisdiction

License Data

LGS

15A. 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

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

Facility Name	Address	Type of Service	Dates of Attendance
Kaiser Permanente Medical Center	900 Kiely Blvd Santa Clara CA	Ob/Gyn	6/96 to present
			dlf

Postgraduate Training

QUESTIONS 15B through 21: For any positive response to the following questions, please provide ALL official documentation regarding the matter in addition to written explanations. If applicable, an applicant should also provide official hearing/court documents and original letters of explanation from appropriate medical school or training program directors. APPLICANTS ARE ALSO REQUIRED TO REPORT ANY MATTER THAT IS PENDING OR IN WHICH CHARGES HAVE BEEN DROPPED OR EXPUNGED.

15B. Have you ever withdrawn from, or been suspended, dismissed or expelled from a medical school or postgraduate training program? [redacted] Yes [redacted] No

16. Have you ever been charged with, or been found to have committed, unprofessional conduct, professional incompetence, gross negligence or repeated negligent acts or malpractice by any medical licensing board, other agency, or hospital or has any disciplinary action ever been filed or taken regarding any healing arts license which you now hold or have ever held, or is any such action pending? Include any disciplinary actions by the U.S. Military, U.S. Public Health Serviceor other U.S. federal governmental entity. IF YES, GIVE DETAILS BELOW. [redacted] Yes [redacted] No

License Data

State	Date	Charge	Disposition

MBC USE ONLY

17. Has a claim or action for damages ever been filed against you in the course of the practice of medicine or any other healing art which resulted in a malpractice settlement, judgement or arbitration award of over $30,000.00? ☐ Yes ☐ No

IF YES, GIVE DETAILS BELOW.

Name of Claimant	Location of Court	Brief Description of the Facts

18. Have you ever been denied a license, permission to practice medicine or any other healing art, or denied permission to take an examination in any state, country, or U.S. federal jurisdiction, or is any such action pending? ☐ Yes ☐ No

IF YES, GIVE DETAILS BELOW.

State or Country	Date of Denial	Reason for Denial

19. Have you ever voluntarily surrendered a license to practice in the healing arts in this or any other state, or voluntarily surrendered your narcotic (controlled substance) permit (state or federal) to any licensing board or any other agency, or is any such action pending? ☐ Yes ☐ No

20. Have you ever had staff privileges in a hospital denied, suspended, limited, revoked or not renewed for medical disciplinary cause, or resigned from a medical staff in lieu of disciplinary or administrative action, or is any such action pending? ☐ Yes ☐ No

21. Do you have any condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety, including but not limited to, any of the following? ☐ Yes ☐ No

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

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

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

QUESTION 22: For any positive response to the following question, please provide ALL official documentation regarding the matter in addition to written explanations. If applicable, an applicant should also provide official hearing/court documents and original letters of explanation from appropriate medical school or training program directors.

22. Have you ever been convicted of or pled nolo contendere to any violation (including misdemeanors and felonies) of any federal, state or local law of any state, the United States, or a foreign country or any violation relating to the possession, use, illegal sale, transportation, manufacture, distribution or dispensing of controlled substances, or is any such action pending? *(Exclude violations of traffic laws, including speeding, which resulted in fines of $300.00 or less.)* If YES, give details below. ☐ Yes ☐ No

YOU ARE REQUIRED TO LIST ANY CONVICTION THAT HAS BEEN SET ASIDE AND DISMISSED OR EXPUNGED. IN ADDITION TO CERTIFIED COURT DOCUMENTS, A SEPARATE LETTER EXPLAINING THE DETAILS OF THE OFFENSE IS REQUIRED.

Violation and Location	Date	Penalty or Disposition

TOP OF PHOTO

BOTTOM OF PHOTO

PHOTO DECLARATION

I hereby declare under penalty of perjury under the laws of the State of California, that the photo of myself attached hereto, was taken on or about [redacted], 19[redacted]

my age then being [redacted] years;

my color of hair [redacted];

my color of eyes [redacted];

my height [redacted] ft. [redacted] in.;

my weight [redacted] lbs.;

and identifying marks are _____

Signature of Applicant: Caryn R. Dutton

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 PROGRAM MANAGER OF THE LICENSING PROGRAM IS THE CUSTODIAN OF RECORDS.

NOTARY:

STATE OF California)

COUNTY OF Santa Clara)

Caryn Ruth Dutton being duly sworn, says She is the person referred to in the foregoing
PRINT FULL NAME OF APPLICANT

application for a physician and surgeon's certificate in the state of California and that She has carefully read and thoroughly understands all the requirements therein, and that the statements made herein and all attachments are true and correct under penalty of perjury under the laws of the State of California. She requests that the Licensing Program of the Medical Board of California initiate a review of the records to determine his/her eligibility for examination, postgraduate training or licensure in California. In making this request, She authorizes the release of any information or records held by any individual or agency, relative to his/her training and qualifications as a physician and surgeon, upon request by the Medical Board for use in evaluating his/her application.

Caryn Ruth Dutton
SIGNATURE OF APPLICANT (WRITE FULL NAME NOT INITIALS)

Signed and sworn to before me this 31st day of March, 1998.

CAROL S. ADAMS
COMM. # 1051117
Notary Public — California
SANTA CLARA COUNTY
My Comm. Expires MAR 3, 1999

NOTARY SEAL

Carol S. Adams
SIGNATURE OF NOTARY PUBLIC

900 Kiely Blvd. Santa Clara, CA. 95051
ADDRESS

My commission expires 3-3-99

L1D

07A-100 (Rev. 2/97)

STATE OF CALIFORNIA — STATE AND CONSUMER SERVICES AGENCY PETE WILSON, Governor

RECEIVED SACRAMENTO MEDICAL BOARD OF CALIFORNIA QUALITY ASSURANCE Consumer Affairs 98 FEB 19 AM 11:14 DIVISION OF LICENSING

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

RECEIVED SACRAMENTO MEDICAL BOARD OF CALIFORNIA 98 FEB 18 AM 9:40

CERTIFICATE OF MEDICAL EDUCATION

MEDICAL SCHOOL: DO NOT COMPLETE IF PHOTOGRAPH OF APPLICANT/STUDENT IS NOT ATTACHED BELOW.

This certifies that Caryn Ruth Dutton (FULL NAME OF APPLICANT) of West Hartford, CT (ADDRESS WHEN ENROLLED) enrolled in University of Connecticut (NAME OF MEDICAL SCHOOL) Farmington, CT (LOCATION)

on the ____ day of August (MONTH) 1992 and was granted the following credits on enrollment:

Premedical Education: *Two years of preprofessional postsecondary education, including the subjects of physics, chemistry, and biology (Business and Professions Code Section 2088).*

~~N/A~~ Amherst College (EDUCATIONAL INSTITUTION) 9/88 - 6/92 (DATES)

Advanced Credits: *Credits previously obtained at an approved medical, dental, or osteopathic school.*◆

N/A (MEDICAL SCHOOL) ____ (TOTAL CREDITS) ____ (DATES)

The undersigned further certifies that the records of this institution show that S he attended in this institution four (SPECIFY NUMBER) years of resident instruction of 126 (NUMBER OF WEEKS) weeks each, completing at least 4,000 hours, of which at least 80 percent actual attendance is required, in the subjects set forth hereunder (Business and Professions Code Section 2089), and that:

☒ S he was granted the degree Bachelor/Doctor of Medicine by OR ☐ he withdrew from the above mentioned medical school on the 23rd day of May (MONTH), 19 96.

Anatomy
Otolaryngology
Obstetrics and Gynecology
Radiology, including Radiation Safety
Tropical Medicine
Physiology
Biochemistry
Pathology, Bacteriology and Immunology
Ophthalmology
Dermatology
Embryology
Histology
Human Sexuality as defined in Section 2090
Medicine
Surgery, including Orthopedic Surgery
Urology
Psychiatry
Neurology
Alcoholism and Chemical Dependency
Preventive medicine, including Nutrition
Physical Medicine
Therapeutics
Neuroanatomy
Child Abuse Detection and Treatment
Geriatric Medicine
Pediatrics
Pharmacology
Anesthesia
Family Medicine◆◆
Spousal or Partner Abuse Detection & Treatment◆◆◆

[redacted]

◆ Each school where professional medical instruction was received MUST complete one of these forms. If more than one school was attended, photocopies of this blank form may be made and used. Note that photograph and all entries to the form must be **original**.

◆◆ ONLY applicable to medical students who graduate from medical school on or after May 1, 1998

◆◆◆ ONLY applicable to medical students who enrolled in medical school on or after September 1, 1994.

TRANSCRIPTS FOR ALL ADVANCED CREDITS AND MEDICAL SCHOOL CREDITS MUST BE SUPPLIED WITH THIS CERTIFICATE

Medical School Seal MUST be Imprinted Partially on the Photograph.

Signed and the school seal affixed this 9 day of Feb, 1998.

BY Deborah Litt
PRESIDENT, SECRETARY, DEAN

L2

State of California Department of Consumer Affairs

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

CERTIFICATION STATEMENT

This is to certify that Caryn Ruth Dutton
(Name of Physician)

is in an approved ACGME/CCME postgraduate training position that commenced on June 23, 1996 and is expected to be completed on June (Month) 22 (Day) 2000 (Year) in Obstetrics and Gynecology (Type of Training)

at Kaiser Permanente Medical Center
(Name and Address of Facility)
900 Kiely Blvd, Santa Clara, CA

AFFIX OFFICIAL HOSPITAL SEAL OR NOTARY SEAL IN THE BOX AT THE LEFT.

"I hereby declare under penalty of perjury under the laws of the State of California that the above statements are true and correct and the facility is approved by the ACGME or the CCME to offer the type and level of training completed by the applicant and that the applicant is being trained in an approved ACGME or CCME program position."

David K. Levin, M.D.
(Type or print name of Director of Medical Education)

David K Levin MD
(Signature of Director of Medical Education)

02/02/98
(Date)

(408) 236-4921
(Telephone Number)

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

07A-107-LA (2/97)

L4 *(formerly Form L9)*

State of California Department of Consumer Affairs

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

CERTIFICATE OF COMPLETION OF ACGME/CCME POSTGRADUATE TRAINING

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

PART 1: To be completed by the applicant/trainee.

Last Name of Trainee	First Name	Middle Initial
Dutton	Caryn	R

Current Address:	Social Security Number:
143 Pasa Robles Ave	[redacted]

City	State	Zip Code	Telephone Number:
Los Altos	CA	94022	[redacted]

PART 2: To be completed by the facility. Completion of this form will certify that the individual named in PART 1 above and whose photograph is attached to this form, formally completed an accredited postgraduate training program at this facility. The following information is provided to certify "satisfactory" completion. PLEASE SEE THE REVERSE FOR A DEFINITION OF "SATISFACTORY."

Name of Facility	Address of Facility
Kaiser Permanente Medical Center	900 Kiely Blvd., Santa Clara, CA 95051

Name of Program Director:	Telephone Number:
David K. Levin, M.D.	(408)236-4921

Signature of Program Director	Date Signed:
[signature]	02/02/98

List Categorical Specialty Area of Training Completed by Trainee:	Date Training Commenced:	Date Training Completed:
OB/Gyn	06/23/96	06/22/97

If the training was rotating or transitional, list the specific rotations and the number of weeks spent in each (SEE THE REVERSE FOR INFORMATION ON SATISFYING THE GENERAL MEDICINE TRAINING REQUIREMENT):

PART 3: To be completed by the Director of Medical Education and affixed with the official facility seal.

Name of the Director of Medical Education:	Facility Name:
David K. Levin, M.D.	Kaiser Permanente Medical Center

Facility Address:			
900 Kiely Blvd.			
City	**State**	**Zip Code**	**Telephone Number:**
Santa Clara	CA	95051	408)236-4921

[redacted]

PART 4: Signature of Director of Medical Education certifying satisfactory completion of training.

ATTENTION PROGRAM DIRECTOR!
IF TRAINEE IS IN HIS/HER FIRST YEAR OF POSTGRADUATE TRAINING, DO NOT SIGN OR DATE THE STATEMENT BELOW UNTIL AFTER THE COMPLETION OF THE TRAINEE'S LAST DAY OF TRAINING.

I hereby declare under penalty of perjury under the laws of the State of California that the above statements are true and correct and that the training program is approved by the ACGME or the CCME to offer the type and level of training completed by the applicant and that the applicant was trained in an approved ACGME or CCME program position.

Signature of Director of Medical Education:	Date Signed:
[signature]	02/02/98

OFFICIAL HOSPITAL SEAL OR NOTARY SEAL, DATE AND SIGNATURE MUST BE AFFIXED TO CERTIFY TRAINING.

L3A