QUAL

STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY

RECEIVED BY EXAMINERS '94 JAN -2 PM 3:27

PETE WILSON, Governor

'94 JUN -2 PM 2:07

Department of Consumer Affairs

MEDICAL BOARD OF CALIFORNIA

1426 HOWE AVENUE, SUITE 54, SACRAMENTO, CA 95825-3236
(916) 920-6411

APPLICATION FOR PHYSICIAN AND SURGEON'S EXAMINATION OR LICENSURE

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 per instructions. **Please type or print neatly. When space provided is insufficient, attach additional sheets of paper.**

MBC USE ONLY

01403.00 4/3/94 6/13/94

1. Name: Last AUERBACH First SAMUEL Middle LOUIS

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

3. Social Security Number — See disclosure statement on L1C

4. Address: Number and Street/Rural Route (include apartment number, if any) 7725 SHORE ROAD

City BROOKLYN State NEW YORK ZIP Code 11209 Country USA

C01032 600.00 8/2/94

5. Telephone Number: Home Work

6. Date of Birth: Mo/Day/Yr

Place of Birth:

7. Sex: ☐ Female ☒ Male

8. Are you a U.S. citizen? ☒ Yes ☐ No

If you are a Foreign Medical Graduate, you must provide an original Certificate of Naturalization, Declaration of Intent to become a U.S. citizen, or a full unrestricted license to practice medicine in a state or country.

9. Have you ever filed an application for examination or licensure in California? ☒ Yes ☐ No

If YES, give date previous application was submitted: 1982

10. List name and address of all colleges or universities attended where pre-professional, postsecondary instruction was received. Please submit an official sealed transcript for each school attended.

Name	Address	Period of Attendance From (Mo/Yr)	Period of Attendance To (Mo/Yr)
NYU		9-72	6-76

NON-MEDICAL EDUCATION ☐ ☐ ☐

10.a Check whether the following premedical courses were successfully completed and show where completed:

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

11. List name and address of all schools where professional medical instruction was received. Submit an original Certificate of Medical Education (Form L2) and official sealed transcripts from each school attended.

Name	Address	Place Where Instruction Received	Period of Attendance From (Mo/Yr)	Period of Attendance To (Mo/Yr)
Universidad del Noreste	Best mailing address is P.O.B. 1856 McAllen, Texas 78501	Tampico Tamps Mexico and Suite 16, 158 S East Cano Hidalgo TX 78557	8-76	6-80

MEDICAL EDUCATION CHE TRANS ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ MEX 35 School Code

12. Doctor of Medicine Degree granted by: (submit original medical diploma and a photocopy; Note, a U.S. graduate may, in lieu of the original, submit an official certified photocopy that has the school seal affixed on the signature of the registrar certifying authenticity.)

Name of Medical School	Address of Medical School	Exact Date of Issuance
Universidad del Noreste	Apartado Postal 467 Tampico Tamps MEXICO	June 6, 1980

NOTE: APPLICANT MUST PROVIDE NAME, ADDRESS AND DATE OF ISSUANCE OF DEGREE.

07A-100 (REV. 7/91)

L1A

MSC USE ONLY

13. Have you taken any of the following written examinations: National Boards, other State Boards, FLEX, ECFMG Certification?

If YES, list name, location, date and result of examination. Submit certification of scores from each examination agency. Applicants who hold ECFMG certification will need to submit an original valid ECFMG certificate for examination and licensure. ☒ Yes ☐ No

Name	Location	Date	Result
ECFMG	Buffalo, NY	3-83	
FLEX	Buffalo, NY	12-90	
FLEX	Bklyn NY	12-92	

14. Have you satisfactorily completed at least one year of qualifying postgraduate training in U.S. or Canadian facilities? ☒ Yes ☐ No

(Note: Do not complete Form 13 (s) to document training received in research or clinical fellowship programs)

If YES, list name and address of all facilities. Submit an original Certificate of Completion of ACGME Postgraduate Training (Form 13) from each facility.

Name	Address	Type of Service	Period of Attendance	
			From (Mo/Yr)	To (Mo/Yr)
	See attached sheet			

QUESTIONS 14A–23 For any positive response to these questions, applicant should provide, in addition to written explanations, any documentation regarding the matter.

14A. Have you ever withdrawn from, or been suspended, dismissed or expelled from, a medical school or postgraduate training program? Yes ☐ No

15. Have you 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 issuing agency's jurisdiction for each. Submit a Letter of Good Standing from each state in which you are licensed or have been licensed. Please include temporary, limited, or provisional licenses.

State or Country	License Number	Date of Issuance	Dates of Practice in Issuing Agency's Jurisdiction	
			From (Mo/Yr)	To (Mo/Yr)
New York	191774	3-23-93		

16. Has any disciplinary action ever been filed or taken regarding any healing arts license which you now hold or have ever held? Include any disciplinary actions by the U.S. Military, U.S. Public Health Service or other U.S. federal governmental entity.

If yes, give details below. Yes No

State	Date	Charge	Disposition

L1B

FILL

MBC USE ONLY

17. Have you ever been denied a license, permission to practice medicine or any other healing arts, or permission to take an examination in any state, country, or U.S. federal jurisdiction? Yes No

If yes, give details below.

State or Country	Date of Denial	Reason for Denial

18. Have you been charged with unprofessional conduct or any other unlawful activity by any healing arts licensing authority or by the U.S. military and are awaiting final disposition by that body? You must also list any pending actions or accusations. Yes No

19. Have you ever voluntarily surrendered a license to practice in the healing arts in another state? Yes No

20. Have you ever had staff privileges in a hospital denied, suspended or revoked, or resigned from a medical staff in lieu of disciplinary action? Yes No

21. Are you now, or were you in the past, addicted to or treated for addiction to controlled substances, such as narcotics or alcohol? Yes No

22. Have you ever been convicted of, or pled nolo contendere to a violation of any federal, state or local law relating to the manufacture, distribution or dispensing of controlled substances? Yes No

If yes, give details below.

Violation and Location	Date	Penalty or Disposition

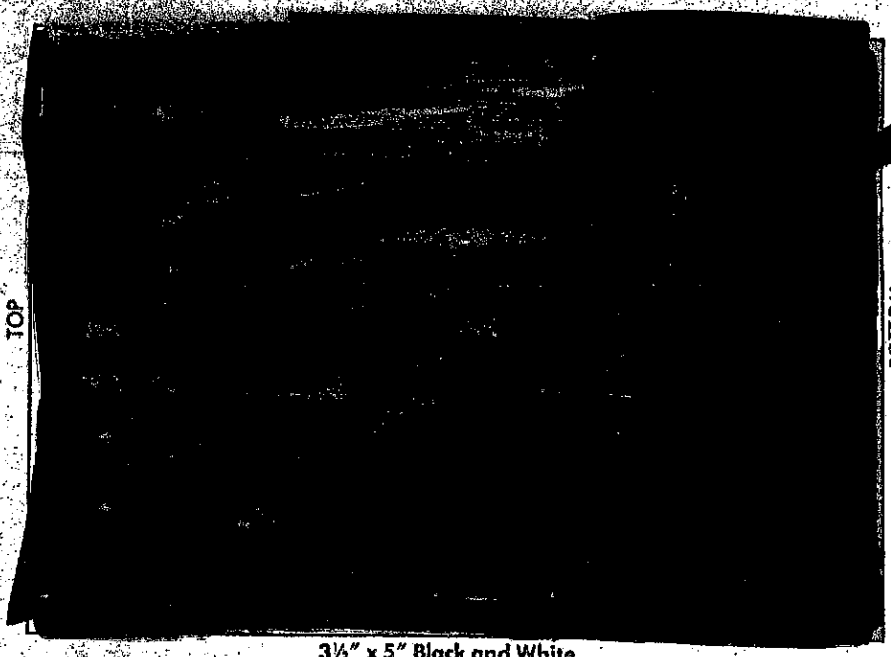
23. Have you ever been convicted of, or pled nolo contendere to any offense, misdemeanor or felony of any state, the United States, or a foreign country? (except violations of traffic laws resulting in fines of $75.00 or less.) Yes No

YOU ARE REQUIRED TO LIST ANY CONVICTION THAT HAS BEEN SET ASIDE AND DISMISSED UNDER SECTION 1203.4 OF THE PENAL CODE OR UNDER ANY OTHER PROVISION OF LAW. A SEPARATE LETTER EXPLAINING THE DETAILS OF THE OFFENSE IS ALSO REQUIRED, IN addition TO CERTIFIED COURT DOCUMENTS.

If yes, give details below.

Violation and Location	Date	Penalty or Disposition

"Disclosure of your social security number is mandatory. Section 30 of the Business and Professions Code and Pub. L. 94-455 (42 U.S.C.A. 405 (c) (2) (C)) authorizes collection of your social security number. Your social security number will be used exclusively for tax enforcement purposes. If you fail to disclose your social security number, you will be reported to the Franchise Tax Board, which may assess a $100 penalty against you."



3½" x 5" Black and White

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 _____, 19 ____

my age then being _____ years;

color of hair _____;

color of eyes _____;

height ____ ft. ____ in.;

weight _____ lbs.;

identifying marks _____

NOTE: All items in this application are mandatory; none are voluntary. Failure to provide any of the requested information will result in the application being rejected as incomplete. The information provided will be used to determine qualification for licensure, per Section 2080 of the Business and Professions Code which authorizes the collection of this information. Information regarding the issuance or denial of a license by the Board may be transmitted to any other medical licensing authority or the Federation of State Medical Boards. Applicants have the right to review their application subject to the provisions of the Information Practices Act. The Program Manager of the Division of Licensing is the custodian of records.

NOTARIZATION PORTION

STATE OF New York)
COUNTY OF Erie)

Samuel Louis Auerbach, being duly sworn, says he is the person referred to in
PRINT FULL NAME OF APPLICANT
the foregoing application for a physician and surgeon's certificate in California and that he 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.

He requests that the Division of Licensing, Medical Board of California, initiate a review of the records to determine their eligibility for examination, postgraduate training or licensure in California. In making this request, he authorizes the release of any information or records held by any individual or agency, relative to their training and qualifications as a physician and surgeon, upon request by the Board for use in evaluating their file.

Samuel Louis Auerbach
Signature of applicant: (Write FULL name, not initials)

Signed and sworn to before me this 1st day of June, 19 94.

Signature of Notary Public Julie A. Wrazien

(NOTARY SEAL)

JULIE A. WRAZIEN
NOTARY PUBLIC, STATE OF NEW YORK
QUALIFIED IN erie COUNTY
My Commission Expires 3/19, 1996

Address 228 Lorraine Dr. Buffalo, NY 14223

My commission expires 3/19/96

07A-100 (REV. 7/91)

L1D

STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY

PETE WILSON, Governor

Consumer Affairs

MEDICAL BOARD OF CALIFORNIA

1426 HOWE AVENUE, SUITE 54, SACRAMENTO, CALIFORNIA 95825-3236
(916) 920-6411

RECEIVED
SACRAMENTO
MEDICAL BOARD
OF CALIFORNIA
94 JUN 30 AM 11:06

CERTIFICATE OF MEDICAL EDUCATION

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

This certifies that SAMUEL LOUIS AUERBACH MD
(FULL NAME OF APPLICANT)

of Calle 16 #405 Col. Monte Verde, Cd. Madero, Tamps Mexico (ADDRESS WHEN ENROLLED) enrolled in Universidad del Noreste School of Medicine (NAME OF MEDICAL SCHOOL)

Prolongacion Avenida Hidalgo - Tampico Tamps Mexico (LOCATION) on the 16 day of August (MONTH) 19 76 (YEAR)

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).

— — —
EDUCATIONAL INSTITUTION — DATES

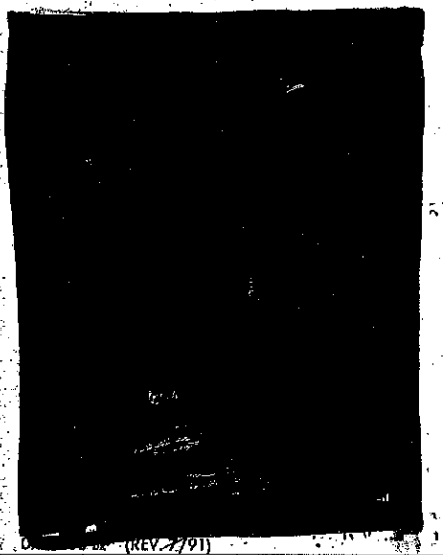
Advanced Credits. Credits previously obtained at an approved medical school.*

— — —
MEDICAL SCHOOL — TOTAL CREDITS — DATES

The undersigned further certifies that the records of this institution show that he attended in this institution 4 (SPECIFY NUMBER) years of resident instruction of 44 (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

OR
☒ he was granted the degree Bachelor/Doctor of Medicine by DIPLOMA DE MEDICO-CIRUJANO
☐ he withdrew from
the above-mentioned medical school on the 6th day of June (MONTH) 80 19—.

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 2099~~
Medicine
Surgery, ~~including Orthopedic Surgery~~
Urology
Psychiatry
Neurology
Preventive medicine, including Nutrition
~~Physical Medicine~~
~~Therapeutics~~
Neuroanatomy
~~Child Abuse Detection and Treatment~~
~~Geriatric Medicine~~
Pediatrics
Pharmacology
Anesthesia



Signed and the college seal affixed this 14 day of JUNIO, 19 94.

BY LIC. MARIO A. LIZARRAGA BOLIO/DIRECTOR GENERAL DE SERVICIOS ESCOLARES.
(PRESIDENT, SECRETARY, DEAN)

06-14-94

Medical School Seal MUST Be Imprinted Partially on the Photograph.

TRANSCRIPTS OF PREMEDICAL EDUCATION, ADVANCED CREDITS, AND MEDICAL SCHOOL CREDITS MUST BE SUPPLIED WITH THIS CERTIFICATE

* 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

(REV. 7/91)

L2

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

Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
1426 HOWE AVENUE
SACRAMENTO, CALIFORNIA 95825-3236

RECEIVED
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BOARD OF MEDICAL QUALITY ASSURANCE
94 JUL 25 PM 12:37

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SACRAMENTO
MEDICAL BOARD OF CALIFORNIA
94 JUL 25 AM 8:58

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. Do not complete if photograph of applicant is not attached on the reverse side. Also, please print or type information on the form.

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

Last Name Of Trainee: AUERBACH | First Name: SAMUEL | Middle Initial: L

Current Address: 7725 SHORE RD | Phone Number: (

City: Brooklyn | State: NY | Zip Code: 11209

PART 2: *To be completed by 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. See reverse side of Form for definition of "satisfactory".

Name of Facility: Millard Fillmore Hospital

Address of Facility: 3 Gates Circle, Buffalo NY 14-209

Name of Program Director: Dr Izzo, | Phone Number: (716) 8879663

Signature of Program Director: [signature] | Date Signed: 7-21-94

List Categorical Specialty Area of Training Completed by Trainee: INTERNAL MEDICINE PGY-1 | Date Training Commenced: 7-1-84 | Date Training Completed: 6-30-85

If the training was rotating or transitional, list in the space provided below, the specific rotations and the number of weeks spent in each

Note: To qualify for licensure in California, applicants who are graduates of a foreign medical school must complete at least four months of postgraduate training in general medicine as part of the one-year requirement. Applicants who are graduates of a U.S. or Canadian medical school, who have not completed the one-year of postgraduate training required for licensure by July 1, 1990, must also complete four months of training in general medicine as part of the one year required for licensure. The general medicine requirement may be satisfied by actual clinical practice where the applicant has direct patient care responsibilities in any particular specialty or sub-specialty area for at least four months. If the general medicine requirement is satisfied by training in a specialty area other than family practice, internal medicine, surgery, pediatrics or obstetrics and gynecology, the Program Director must submit a description of the type of training in sufficient detail to allow the Division of Licensing to make a determination regarding its acceptability.

(OVER)

L3A

07A-100 (3/Rev. 2/92)

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

Name of Director of Medical Education: M. Luther Musselman, M.D. **Phone Number:** (716) 8874663

Facility Name: Millard Fillmore Hospital **Date Form Completed:** 7/21/94

Facility Address: 3 Gates Circle

City: Buffalo **State:** NY **Zip Code:** 14209

The individual signing this form is formally certifying and documenting, under penalty of perjury, that the physician received instruction appropriate for the particular postgraduate level and that they satisfactorily completed the training program in accordance with the accepted standards and the criteria defined as equating to "satisfactory" performance as described below. In cases where the Director of Medical Education is certifying the completion of the minimum one-year of training required for licensure, he or she will personally be attesting to the fact that the physician/trainee has acquired the skill and qualifications necessary to safely assume the unrestricted practice of medicine in this state.

Definition of "Satisfactory": The physician performed at an adequate level based on evidence of satisfactory progressive scholarship and professional growth including demonstrated ability to assume graded and increasing responsibility for patient care

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.

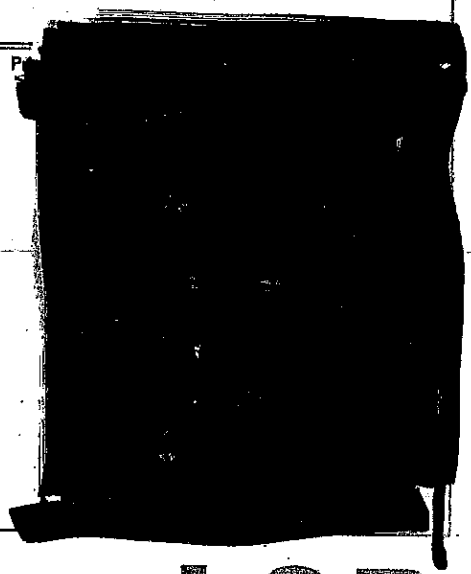
Signature of Director of Medical Education: [signature]

M. Luther Musselman, M.D.

Date Signed: 7/21/94

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

[illegible] D. COMO
Notary Public, [illegible] New [illegible]
[illegible] 1996



L3B

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

Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
1426 HOWE AVENUE
SACRAMENTO, CALIFORNIA 95825-3236

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. Do not complete if photograph of applicant is not attached on the reverse side. Also, please print or type information on the form.

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

Last Name Of Trainee: AUERBACH | First Name: SAMUEL | Middle Initial: L

Current Address: 7725 SHORE RD | Phone Number: [redacted]

City: Brooklyn | State: NY | Zip Code: 11209

PART 2: *To be completed by 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. See reverse side of Form for definition of "satisfactory".

Name of Facility: DEPARTMENT OF VETERANS AFFAIRS MEDICAL CENTER

Address of Facility: 130 West Kingsbridge Road, Bronx, NY 10468

Name of Program Director: ROBERT L. JONES, M.D., Chief of Staff | Phone Number: 718-584-9000x6524

Signature of Program Director: Robert L Jones, M.D., FACOS | Date Signed: 7-5-94

List Categorical Specialty Area of Training Completed by Trainee: Internal Medicine | Date Training Commenced: 7/1/85 | Date Training Completed: 6/30/86

If the training was rotating or transitional, list in the space provided below, the specific rotations and the number of weeks spent in each:

Note: To qualify for licensure in California, applicants who are graduates of a foreign medical school must complete at least four months of postgraduate training in general medicine as part of the one-year requirement. Applicants who are graduates of a U.S. or Canadian medical school, who have not completed the one-year of postgraduate training required for licensure by July 1, 1990, must also complete four-months of training in general medicine as part of the one year required for licensure. The general medicine requirement may be satisfied by actual clinical practice where the applicant has direct patient care responsibilities in any particular specialty or sub-specialty area for at least four months. If the general medicine requirement is satisfied by training in a specialty area other than family practice, internal medicine, surgery, pediatrics or obstetrics and gynecology, the Program Director must submit a description of the type of training in sufficient detail to allow the Division of Licensing to make a determination regarding its acceptability.

(OVER)

L3A

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

Name of Director of Medical Education: A.J. RONAN

Phone Number: (718) 584-9000 x6905

Facility Name: VAMEDICAL CENTER

Date Form Completed: 6/27/94

Facility Address: 130 West Kingsbridge Road, Bronx, NY 10468

City: Bronx **State:** NY **Zip Code:** 10468

The individual signing this form is formally certifying and documenting, under penalty of perjury, that the physician received instruction appropriate for the particular postgraduate level and that they satisfactorily completed the training program in accordance with the accepted standards and the criteria defined as equating to "satisfactory" performance as described below. In cases where the Director of Medical Education is certifying the completion of the minimum one-year of training required for licensure, he or she will personally be attesting to the fact that the physician/trainee has acquired the skill and qualifications necessary to safely assume the unrestricted practice of medicine in this state.

Definition of "Satisfactory": The physician performed at an adequate level based on evidence of satisfactory progressive scholarship and professional growth including demonstrated ability to assume graded and increasing responsibility for patient care.

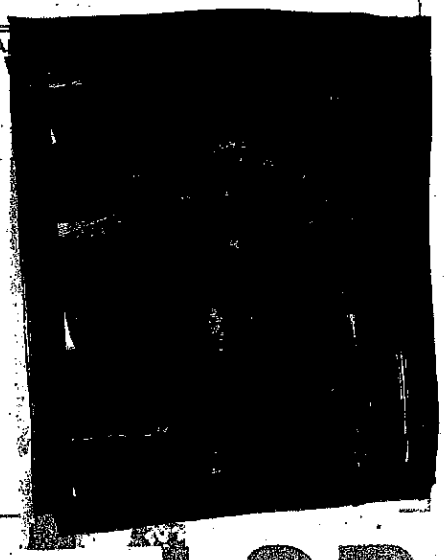
I hereby declare under penalty of perjury under the laws of the State of California that the above statements are true and correct and that the training program is approved by the ACGME or the CCME to offer the type and level of training completed by the applicant and that the applicant was trained in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

Signature of Director of Medical Education: Edward J. Ronan

Date Signed: 6/30/94

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

PA



L3B

STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY

MEDICAL BOARD OF CALIFORNIA
1426 HOWE AVENUE
SACRAMENTO, CALIFORNIA 95825-3236

Consumer Affairs

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. Do not complete if photograph of applicant is not attached on the reverse side. Also, please print or type information on the form.

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

Last Name Of Trainee: AUERBACH | First Name: SAMUEL | Middle Initial: L.

Current Address: 7725 SHORE RD. | Phone Number: [redacted]

City: Brooklyn | State: NY | Zip Code: 11209

PART 2: *To be completed by 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. See reverse side of form for definition of "satisfactory".

Name of Facility: Wilson Memorial Regional Medical Center/Div. of United Health Services Hosp.

Address of Facility: 33-57 Harrison Street, Johnson City, New York 13790

Name of Program Director: Roy D.F. Gill, M.D. | Phone Number: (607) 763-6396

Signature of Program Director: [signature] | Date Signed: 6/7/94

List Categorical Specialty Area of Training Completed by Trainee: Internal Medicine | Date Training Commenced: 7/1/86 | Date Training Completed: 6/30/87

If the training was rotating or transitional, list in the space provided below, the specific rotations and the number of weeks spent in each:

Note: To qualify for licensure in California, applicants who are graduates of a foreign medical school must complete at least four months of postgraduate training in general medicine as part of the one-year requirement. Applicants who are graduates of a U.S. or Canadian medical school, who have not completed the one-year of postgraduate training required for licensure by July 1, 1990, must also complete four-months of training in general medicine as part of the one year required for licensure. The general medicine requirement may be satisfied by actual clinical practice where the applicant has direct patient care responsibilities in any particular specialty or sub-specialty area for at least four months. If the general medicine requirement is satisfied by training in a specialty area other than family practice, internal medicine, surgery, pediatrics or obstetrics and gynecology, the Program Director must submit a description of the type of training in sufficient detail to allow the Division of Licensing to make a determination regarding its acceptability.

(OVER)

L3A

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

Name of Director of Medical Education: Richard Wu, M.D.

Phone Number: (607) 763-6393

Facility Name: Wilson Mem. Regional Medical Cent./Div. of UHSH

Date Form Completed: 6/7/94

Facility Address: 33-57 Harrison Street,

City: Johnson City State: New York Zip Code: 13790

The individual signing this form is formally certifying and documenting, under penalty of perjury, that the physician received instruction appropriate for the particular postgraduate level and that they satisfactorily completed the training program in accordance with the accepted standards and the criteria defined as equating to "satisfactory" performance as described below. In cases where the Director of Medical Education is certifying the completion of the minimum one-year of training required for licensure, he or she will personally be attesting to the fact that the physician/trainee has acquired the skill and qualifications necessary to safely assume the unrestricted practice of medicine in this state.

Definition of "Satisfactory": The physician performed at an adequate level based on evidence of satisfactory progressive scholarship and professional growth including demonstrated ability to assume graded and increasing responsibility for patient care.

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.

Richard Hk Wu MD

Signature of Director of Medical Education: RICHARD HK. WU MD

Date Signed: 6/7/94

L3B

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

Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
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1426 HOWE AVENUE
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RECEIVED
94 JUN 24 AM 9:57
DIVISION OF LICENSING

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SACRAMENTO
MEDICAL BOARD
OF CALIFORNIA
94 JUN 23 PM 3:58

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. Do not complete if photograph of applicant is not attached on the reverse side. Also, please print or type information on the form.

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

Last Name Of Trainee: AUERBACH | First Name: SAMUEL | Middle Initial: L

Current Address: 7725 SHORE RD | Phone Number: [redacted]

City: Brooklyn | State: NY | Zip Code: 11209

PART 2: *To be completed by 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. See reverse side of Form for definition of "satisfactory".

Name of Facility: Albany Medical Center Hospital

Address of Facility: 47 New Scotland Ave. (A74)

Name of Program Director: Daniel C. Kredentser, M.D. | Phone Number: (518) 262-5587

Signature of Program Director: [signature] | Date Signed: 6/7/94

List Categorical Specialty Area of Training Completed by Trainee: Ob/Gyn Resident | Date Training Commenced: 7/1/87 | Date Training Completed: 6/30/88

If the training was rotating or transitional, list in the space provided below, the specific rotations and the number of weeks spent in each.

1. St. Peter's Hospital - 4 months total Ob/Gyn (86Y 1 year)
   - AMC OB - 2 months
   - Medicine - 2 months
   - AMC Gyn - 2 months
   - AMC VS/OB - 2 months

Note: To qualify for licensure in California, applicants who are graduates of a foreign medical school must complete at least four months of postgraduate training in general medicine as part of the one-year requirement. Applicants who are graduates of a U.S. or Canadian medical school, who have not completed the one-year of postgraduate training required for licensure by July 1, 1990, must also complete four-months of training in general medicine as part of the one year required for licensure. The general medicine requirement may be satisfied by actual clinical practice where the applicant has direct patient care responsibilities in any particular specialty or sub-specialty area for at least four months. If the general medicine requirement is satisfied by training in a specialty area other than family practice, internal medicine, surgery, pediatrics or obstetrics and gynecology, the Program Director must submit a description of the type of training in sufficient detail to allow the Division of Licensing to make a determination regarding its acceptability.

(OVER)

L3A

07A-100-L3 (Rev. 2/92)

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

Name of Director of Medical Education: M. Luther Musselman, M.D. **Phone Number:** 716 8874663

Facility Name: Millard Fillmore Hospital **Date Form Completed:** 7/21/94

Facility Address: 3 Gates Circle

City: Buffalo **State:** NY **Zip Code:** 14209

The individual signing this form is formally certifying and documenting, under penalty of perjury, that the physician received instruction appropriate for the particular postgraduate level and that they satisfactorily completed the training program in accordance with the accepted standards and the criteria defined as equating to "satisfactory" performance as described below. In cases where the Director of Medical Education is certifying the completion of the minimum one-year of training required for licensure, he or she will personally be attesting to the fact that the physician/trainee has acquired the skill and qualifications necessary to safely assume the unrestricted practice of medicine in this state.

Definition of "Satisfactory": The physician performed at an adequate level based on evidence of satisfactory progressive scholarship and professional growth including demonstrated ability to assume graded and increasing responsibility for patient care

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.

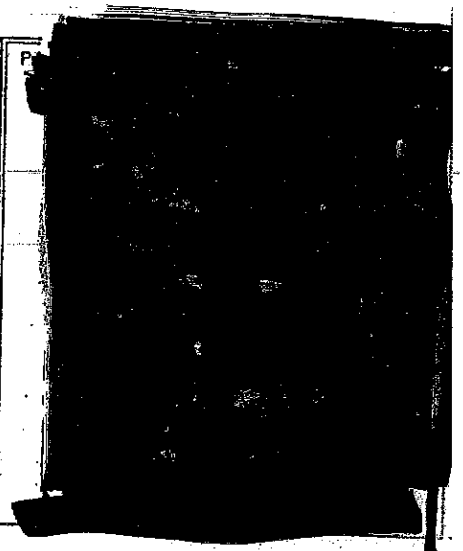
Signature of Director of Medical Education: [signature]

M. Luther Musselman, M.D.

Date Signed: 7/21/94

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

[illegible] Notary Public, [illegible] New [illegible]
[illegible] 1996



L3B

RECEIVED
SACRAMENTO
94 JUL 12 PM 2:33
DIVISION OF LICENSING

STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY

PETE WILSON, Governor

Consumer Affairs

QUALITY ASSURANCE

MEDICAL BOARD OF CALIFORNIA
1426 HOWE AVENUE
SACRAMENTO, CALIFORNIA 95825-3236

RECEIVED
SACRAMENTO
MEDICAL BOARD
OF CALIFORNIA
94 JUL 11 AM 10:45

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. Do not complete if photograph of applicant is not attached on the reverse side. Also, please print or type information on the form.

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

Last Name Of Trainee: AUERBACH | First Name: SAMUEL | Middle Initial: L

Current Address: 7725 SHORE RD | Phone Number: [redacted]

City: Brooklyn | State: NY | Zip Code: 11209

PART 2: *To be completed by 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. See reverse side of Form for definition of "satisfactory".

Name of Facility: DEPARTMENT OF VETERANS AFFAIRS MEDICAL CENTER

Address of Facility: 130 West Kingsbridge Road, Bronx, NY 10468

Name of Program Director: ROBERT L. JONES, M.D., Chief of Staff | Phone Number: 718)584-9000x6524

Signature of Program Director: [signature] | Date Signed: 7-5-94

List Categorical Specialty Area of Training Completed by Trainee: Internal Medicine | Date Training Commenced: 7/1/85 | Date Training Completed: 6/30/86

If the training was rotating or transitional, list in the space provided below, the specific rotations and the number of weeks spent in each:

Note: To qualify for licensure in California, applicants who are graduates of a foreign medical school must complete at least four months of postgraduate training in general medicine as part of the one-year requirement. Applicants who are graduates of a U.S. or Canadian medical school, who have not completed the one-year of postgraduate training required for licensure by July 1, 1990, must also complete four months of training in general medicine as part of the one year required for licensure. The general medicine requirement may be satisfied by actual clinical practice where the applicant has direct patient care responsibilities in any particular specialty or sub-specialty area for at least four months. If the general medicine requirement is satisfied by training in a specialty area other than family practice, internal medicine, surgery, pediatrics or obstetrics and gynecology, the Program Director must submit a description of the type of training in sufficient detail to allow the Division of Licensing to make a determination regarding its acceptability.

(OVER)

L3A

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

Name of Director of Medical Education: A.J. RONAN

Phone Number: (718) 584-9000 x6906

Facility Name: VAMEDICAL CENTER

Date Form Completed: 6/27/94

Facility Address: 130 West Kingsbridge Road, Bronx, NY 10468

City: Bronx State: NY Zip Code: 10468

The individual signing this form is formally certifying and documenting, under penalty of perjury, that the physician received instruction appropriate for the particular postgraduate level and that they satisfactorily completed the training program in accordance with the accepted standards and the criteria defined as equating to "satisfactory" performance as described below. In cases where the Director of Medical Education is certifying the completion of the minimum one-year of training required for licensure, he or she will personally be attesting to the fact that the physician/trainee has acquired the skill and qualifications necessary to safely assume the unrestricted practice of medicine in this state.

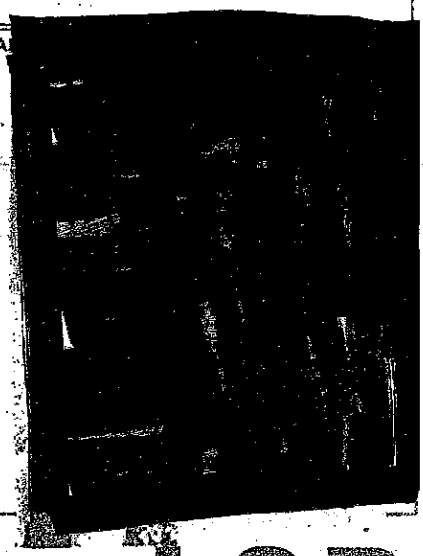
Definition of "Satisfactory": The physician performed at an adequate level based on evidence of satisfactory progressive scholarship and professional growth including demonstrated ability to assume graded and increasing responsibility for patient care.

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: Edward J. Ronan

Date Signed: 6/30/94

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



L3B

STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY

RECEIVED SACRAMENTO BOARD OF MEDICAL

PETE WILSON, Governor

Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
1426 HOWE AVENUE
SACRAMENTO, CALIFORNIA 95825-3236

DIVISION OF LICENSING

RECEIVED SACRAMENTO MEDICAL BOARD OF CALIFORNIA

94 JUN 13 AM 7:56

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. Do not complete if photograph of applicant is not attached on the reverse side. Also, please print or type information on the form.

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

Last Name Of Trainee: AUERBACH | First Name: SAMUEL | Middle Initial: L.

Current Address: 7725 SHORE RD. | Phone Number: [redacted]

City: Brooklyn | State: NY | Zip Code: 11209

PART 2: *To be completed by 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. See reverse side of form for definition of "satisfactory".

Name of Facility: Wilson Memorial Regional Medical Center/Div. of United Health Services Hosp.

Address of Facility: 33-57 Harrison Street, Johnson City, New York 13790

Name of Program Director: Roy D.F. Gill, M.D. | Phone Number: (607) 763-6396

Signature of Program Director: [signature] | Date Signed: 6/7/94

List Categorical Specialty Area of Training Completed by Trainee: Internal Medicine | Date Training Commenced: 7/1/86 | Date Training Completed: 6/30/87

If the training was rotating or transitional, list in the space provided below, the specific rotations and the number of weeks spent in each:

Note: To qualify for licensure in California, applicants who are graduates of a foreign medical school must complete at least four months of postgraduate training in general medicine as part of the one-year requirement. Applicants who are graduates of a U.S. or Canadian medical school, who have not completed the one-year of postgraduate training required for licensure by July 1, 1990, must also complete four-months of training in general medicine as part of the one year required for licensure. The general medicine requirement may be satisfied by actual clinical practice where the applicant has direct patient care responsibilities in any particular specialty or sub-specialty area for at least four months. If the general medicine requirement is satisfied by training in a specialty area other than family practice, internal medicine, surgery, pediatrics or obstetrics and gynecology, the Program Director must submit a description of the type of training in sufficient detail to allow the Division of Licensing to make a determination regarding its acceptability.

(OVER)

L3A

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

Name of Director of Medical Education: Richard Wu, M.D. Phone Number: (607) 763-6393

Facility Name: Wilson Mem. Regional Medical Cent./Div. of URSH Date Form Completed: 6/7/94

Facility Address: 33-57 Harrison Street,

City: Johnson City State: New York Zip Code: 13790

The individual signing this form is formally certifying and documenting, under penalty of perjury, that the physician received instruction appropriate for the particular postgraduate level and that they satisfactorily completed the training program in accordance with the accepted standards and the criteria defined as equating to "satisfactory" performance as described below. In cases where the Director of Medical Education is certifying the completion of the minimum one-year of training required for licensure, he or she will personally be attesting to the fact that the physician/trainee has acquired the skill and qualifications necessary to safely assume the unrestricted practice of medicine in this state.

Definition of "Satisfactory": The physician performed at an adequate level based on evidence of satisfactory progressive scholarship and professional growth including demonstrated ability to assume graded and increasing responsibility for patient care.

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.

Richard Hk Wu MD

Signature of Director of Medical Education: RICHARD HK. WU MD

Date Signed: 6/7/94

PA

L3B

07A-100 L3 (Rev. 2/92)

STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY

Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
1426 HOWE AVENUE
SACRAMENTO, CALIFORNIA 95825-3236

RECEIVED
94 JUN 24 AM 9:57
DIVISION OF LICENSING

PETE WILSON, Governor

RECEIVED
SACRAMENTO
MEDICAL BOARD
OF CALIFORNIA
94 JUN 23 PM 3:58

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. Do not complete if photograph of applicant is not attached on the reverse side. Also, please print or type information on the form.

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

Last Name Of Trainee: AUERBACH | First Name: SAMUEL | Middle Initial: L

Current Address: 7725 SHORE RD | Phone Number: [redacted]

City: Brooklyn | State: NY | Zip Code: 11209

PART 2: *To be completed by 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. See reverse side of Form for definition of "satisfactory".

Name of Facility: Albany Medical Center Hospital

Address of Facility: 47 New Scotland Ave. (A74)

Name of Program Director: Daniel C. Kredentser, M.D. | Phone Number: (518) 262-5587

Signature of Program Director: D C Kredentser | Date Signed: 6/7/94

List Categorical Specialty Area of Training Completed by Trainee: Ob/Gyn Resident | Date Training Commenced: 7/1/87 | Date Training Completed: 6/30/88

If the training was rotating or transitional, list in the space provided below, the specific rotations and the number of weeks spent in each.

1 @ St. Peter's Hospital - 4 months total Ob/Gyn (86-1 year)

- AMC OB - 2 months
- Medicine - 2 months
- AMC Gyn - 2 months
- AMC VS/OB - 2 months

Note: To qualify for licensure in California, applicants who are graduates of a foreign medical school must complete at least four months of postgraduate training in general medicine as part of the one-year requirement. Applicants who are graduates of a U.S. or Canadian medical school, who have not completed the one-year of postgraduate training required for licensure by July 1, 1990, must also complete four-months of training in general medicine as part of the one year required for licensure. The general medicine requirement may be satisfied by actual clinical practice where the applicant has direct patient care responsibilities in any particular specialty or sub-specialty area for at least four months. If the general medicine requirement is satisfied by training in a specialty area other than family practice, internal medicine, surgery, pediatrics or obstetrics and gynecology, the Program Director must submit a description of the type of training in sufficient detail to allow the Division of Licensing to make a determination regarding its acceptability.

(OVER)

L3A

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

Name of Director of Medical Education: Catherine Ekstrand **Phone Number:** (518) 262-3593

Facility Name: Albany Medical Center **Date Form Completed:** June 15, 1994

Facility Address: 43 New Scotland Avenue

City: Albany **State:** New York **Zip Code:** 12208

The individual signing this form is formally certifying and documenting, under penalty of perjury, that the physician received instruction appropriate for the particular postgraduate level and that they satisfactorily completed the training program in accordance with the accepted standards and the criteria defined as equating to "satisfactory" performance as described below. In cases where the Director of Medical Education is certifying the completion of the minimum one-year of training required for licensure, he or she will personally be attesting to the fact that the physician/trainee has acquired the skill and qualifications necessary to safely assume the unrestricted practice of medicine in this state.

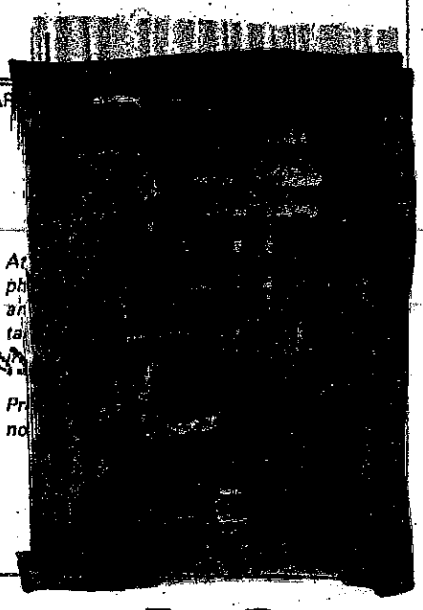
Definition of "Satisfactory": The physician performed at an adequate level based on evidence of satisfactory progressive scholarship and professional growth including demonstrated ability to assume graded and increasing responsibility for patient care.

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: Catherine Ekstrand

Date Signed: June 15, 1994

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



L3B

STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY

PETE WILSON, Governor

Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
1426 HOWE AVENUE
SACRAMENTO, CALIFORNIA 95825-3236

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SACRAMENTO
MEDICAL BOARD
OF CALIFORNIA
'94 JUN 14 PM 4:04

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. Do not complete if photograph of applicant is not attached on the reverse side. Also, please print or type information on the form.

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

Last Name Of Trainee: AUERBACH | First Name: SAMUEL | Middle Initial: L

Current Address: 1725 SHORE RD | Phone Number: [redacted]

City: Brooklyn | State: NY | Zip Code: 11209

PART 2: *To be completed by 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. See reverse side of Form for definition of "satisfactory".

Name of Facility: Lutheran Medical Center

Address of Facility: 150 55th Street, Brooklyn, New York, 11220

Name of Program Director: Donald M. Zarou, M.D. | Phone Number: (718) 630-7350

Signature of Program Director: Donald M. Zarou, M.D. | Date Signed: 6/6/94

List Categorical Specialty Area of Training Completed by Trainee: Ob/Gyn | Date Training Commenced: 8/24/88 | Date Training Completed: 6/30/89

If the training was rotating or transitional, list in the space provided below, the specific rotations and the number of weeks spent in each:

Note: To qualify for licensure in California, applicants who are graduates of a foreign medical school must complete at least four months of postgraduate training in general medicine as part of the one-year requirement. Applicants who are graduates of a U.S. or Canadian medical school, who have not completed the one-year of postgraduate training required for licensure by July 1, 1990, must also complete four-months of training in general medicine as part of the one year required for licensure. The general medicine requirement may be satisfied by actual clinical practice where the applicant has direct patient care responsibilities in any particular specialty or sub-specialty area for at least four months. If the general medicine requirement is satisfied by training in a specialty area other than family practice, internal medicine, surgery, pediatrics or obstetrics and gynecology, the Program Director must submit a description of the type of training in sufficient detail to allow the Division of Licensing to make a determination regarding its acceptability.

(OVER)

L3A

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

Name of Director of Medical Education: Vincent J. Vigorita, M.D. **Phone Number:** (718) 630-7380

Facility Name: Lutheran Medical Center **Date Form Completed:**

Facility Address: 150 55th Street, Brooklyn, New York, 11220

City: Brooklyn **State:** New York **Zip Code:** 11220

The individual signing this form is formally certifying and documenting, under penalty of perjury, that the physician received instruction appropriate for the particular postgraduate level and that they satisfactorily completed the training program in accordance with the accepted standards and the criteria defined as equating to "satisfactory" performance as described below. In cases where the Director of Medical Education is certifying the completion of the minimum one-year of training required for licensure, he or she will personally be attesting to the fact that the physician/trainee has acquired the skill and qualifications necessary to safely assume the unrestricted practice of medicine in this state.

Definition of "Satisfactory": The physician performed at an adequate level based on evidence of satisfactory progressive scholarship and professional growth including demonstrated ability to assume graded and increasing responsibility for patient care.

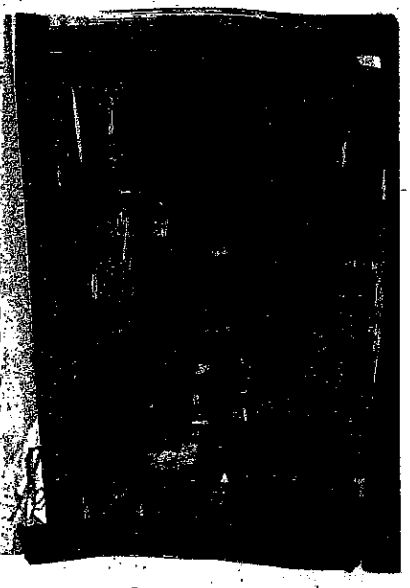
I hereby declare under penalty of perjury under the laws of the State of California that the above statements are true and correct and that the training program is approved by the ACGME or the CCME to offer the type and level of training completed by the applicant and that the applicant was trained in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

Signature of Director of Medical Education: [signature]

Date Signed: 6/6/94

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

PAR



L3B

07A-100-L3 (Rev. 2/92)

STATE OF CALIFORNIA--STATE AND CONSUMER SERVICES AGENCY

GEORGE DEUKMEJIAN, Governor

Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
1426 HOWE AVENUE
SACRAMENTO, CALIFORNIA 95825-3236

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. Do not complete if photograph of applicant is not attached on the reverse side. Also, please print or type information on the form.

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

Last Name Of Trainee: AUERBACH | First Name: SAMUEL | Middle Initial: L

Current Address: 7725 SHORE RD | Phone Number: [redacted]

City: Brooklyn | State: NY | Zip Code: 11209

PART 2: *To be completed by 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. See reverse side of Form for definition of "satisfactory".

Name of Facility: Millard Fillmore Hospital

Address of Facility: 3 Gates Circle Buffalo NY 14209

Name of Program Director: Dr S. Hole | Phone Number: (716) 887 4663

Signature of Program Director: [signature] | Date Signed: 7/21/94

List Categorical Specialty Area of Training Completed by Trainee: Advanced Pelvic Surgery | Date Training Commenced: 7-1-93 | Date Training Completed: 6-30-94

If the training was rotating or transitional, list in the space provided below, the specific rotations and the number of weeks spent in each.

Note: To qualify for licensure in California, applicants who are graduates of a foreign medical school must complete at least four months of postgraduate training in general medicine as part of the one-year requirement. Applicants who are graduates of a U.S. or Canadian medical school, who have not completed the one-year of postgraduate training required for licensure by July 1, 1990, must also complete four-months of training in general medicine as part of the one year required for licensure. The general medicine requirement may be satisfied by actual clinical practice where the applicant has direct patient care responsibilities in any particular specialty or sub-specialty area for at least four months. If the general medicine requirement is satisfied by training in a specialty area other than family practice, internal medicine, surgery, pediatrics or obstetrics and gynecology, the Program Director must submit a description of the type of training in sufficient detail to allow the Division of Licensing to make a determination regarding its acceptability.

(OVER)

L3A

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

Name of Director of Medical Education: Martin Luther Musselman, M.D.

Phone Number: 716 887-4663

Facility Name: Millard Fillmore Hospital

Date Form Completed: 7/22/94

Facility Address: 3 Gates Circle

City: Buffalo State: NY Zip Code: 14209

The individual signing this form is formally certifying and documenting, under penalty of perjury, that the physician received instruction appropriate for the particular postgraduate level and that they satisfactorily completed the training program in accordance with the accepted standards and the criteria defined as equating to "satisfactory" performance as described below. In cases where the Director of Medical Education is certifying the completion of the minimum one-year of training required for licensure, he or she will personally be attesting to the fact that the physician/trainee has acquired the skill and qualifications necessary to safely assume the unrestricted practice of medicine in this state.

Definition of "Satisfactory": The physician performed at an adequate level based on evidence of satisfactory progressive scholarship and professional growth including demonstrated ability to assume graded and increasing responsibility for patient care.

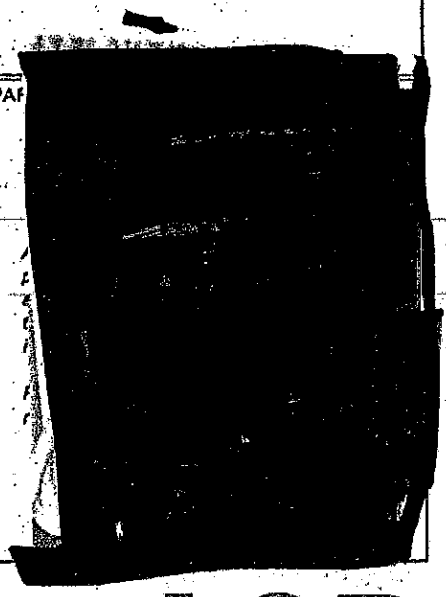
I hereby declare under penalty of perjury under the laws of the State of California that the above statements are true and correct and that the training program is approved by the ACGME or the CCME to offer the type and level of training completed by the applicant and that the applicant was trained in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

Signature of Director of Medical Education: M. Musselman

Date Signed: 7/22/94

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

PAF



L3B

STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY

PETE WILSON, Governor

Consumer Affairs

DIVISION OF LICENSING

MEDICAL BOARD OF CALIFORNIA
1426 HOWE AVENUE
SACRAMENTO, CALIFORNIA 95825-3236

DIVISION OF LICENSING

ASAP

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. Do not complete if photograph of applicant is not attached on the reverse side. Also, please print or type information on the form.

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

Last Name Of Trainee: AUERBACH | First Name: SAMUEL | Middle Initial: L

Current Address: 7725 SHORE PD | Phone Number: [redacted]

City: Brooklyn | State: NY | Zip Code: 11209

PART 2: *To be completed by 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. See reverse side of Form for definition of "satisfactory".

Name of Facility: UNIVERSITY OF SOUTH ALABAMA MEDICAL CENTER

Address of Facility: 2451 FILLINGIM ST, MOBILE, AL, 36617

Name of Program Director: IAN H THORNEYCROFT PHD MD | Phone Number: (205) 470-5815

Signature of Program Director: [signature] | Date Signed: 6/20/94

List Categorical Specialty Area of Training Completed by Trainee: OBSTETRICS AND GYNECOLOGY * | Date Training Commenced: | Date Training Completed: 9-30-91 JAY

If the training was rotating or transitional, list in the space provided below, the specific rotations and the number of weeks spent in each.

* THE FIRST PART OF RESIDENCY WAS STARTED IN ANOTHER PROGRAM.

Note: To qualify for licensure in California, applicants who are graduates of a foreign medical school must complete at least four months of postgraduate training in general medicine as part of the one-year requirement. Applicants who are graduates of a U.S. or Canadian medical school, who have not completed the one-year of postgraduate training required for licensure by July 1, 1990, must also complete four-months of training in general medicine as part of the one year required for licensure. The general medicine requirement may be satisfied by actual clinical practice where the applicant has direct patient care responsibilities in any particular specialty or sub-specialty area for at least four months. If the general medicine requirement is satisfied by training in a specialty area other than family practice, internal medicine, surgery, pediatrics or obstetrics and gynecology, the Program Director must submit a description of the type of training in sufficient detail to allow the Division of Licensing to make a determination regarding its acceptability.

7-8

L3A

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

Name of Director of Medical Education: IAN H. THORNEYCROFT, PhD, MD

Phone Number: (205) 470 5815

Facility Name: University of South Alabama Medical Center

Date Form Completed: 6-20-94

Facility Address: 2451 Fillingim St Mobile, AL 36617

City: State: Zip Code:

The individual signing this form is formally certifying and documenting, under penalty of perjury, that the physician received instruction appropriate for the particular postgraduate level and that they satisfactorily completed the training program in accordance with the accepted standards and the criteria defined as equating to "satisfactory" performance as described below. In cases where the Director of Medical Education is certifying the completion of the minimum one-year of training required for licensure, he or she will personally be attesting to the fact that the physician/trainee has acquired the skill and qualifications necessary to safely assume the unrestricted practice of medicine in this state.

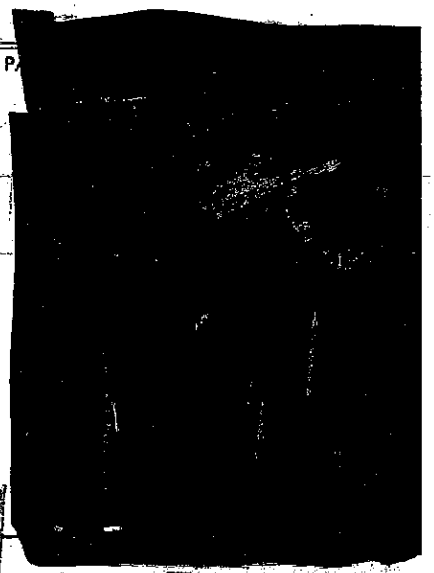
Definition of "Satisfactory": The physician performed at an adequate level based on evidence of satisfactory progressive scholarship and professional growth including demonstrated ability to assume graded and increasing responsibility for patient care.

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: 6/22/94

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



Dr. Ian H. Thorneycroft appeared before me this 22 day of June, 19 94.

DAWN F. OVERSTREET, NOTARY PUBLIC

MY COMMISSION EXPIRES 9/25/95

L3B

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

State of California, Department of Consumer Affairs

MEDICAL BOARD OF CALIFORNIA

1426 HOWE AVENUE, SUITE 54, SACRAMENTO, CALIFORNIA 95825-3236
(916) 920-6411

REPORT OF JUNIOR YEAR CLINICAL ROTATIONS

ONLY ROTATIONS IN WHICH THE APPLICANT PARTICIPATED IN DIRECT, HANDS-ON DIAGNOSIS OR TREATMENT OF PATIENTS, IN A CLINICAL SETTING MAY BE REPORTED ON THIS FORM. IF ROTATIONS WERE COMPLETED DURING THE JUNIOR OR SENIOR YEAR OF MEDICAL SCHOOL BUT DO NOT SATISFY THIS REQUIREMENT, THEY SHOULD **NOT** BE REPORTED ON THIS FORM BECAUSE THEY DO NOT SATISFY CLINICAL TRAINING REQUIREMENTS.

	Clinical Area	Type*	Facility Name and Address	Dates of Attendance From—To	Weeks of Credit	Instructor or Supervisor	Program Director
1.	OTOLARYNGOLOGY	R	MANHATTAN EYE, EAR & THROAT HOSPITAL 210 E. 64th Street; NY, NY	7-3-78 to 7-31-78	4		
2.	GENERAL SURGERY	R	BROOKDALE HOSPITAL MEDICAL CENTER ~~LINDEN BLVD. AT BROOKDALE PLAZA~~ BROOKLYN, NEW YORK	8-1-78 to 9-30-78	9		
3.	CARDIOLOGY	R	LUTHERAN MEDICAL CENTER 150 55th Street; BROOKLYN, NY	10-2-78 to 10-31-78	4		
4.	PULMONARY MEDICINE	R	BROOKDALE HOSPITAL MEDICAL CENTER LINDEN BLVD. AT BROOKDALE HOSPITAL BROOKLYN, NY	11-1-78 to 11-27-78	4		
5.	OPHTHALMOLOGY	R	BROOKDALE HOSPITAL MEDICAL CENTER LINDEN BLVD. AT BROOKDALE HOSPITAL ~~BROOKLYN, NY~~	12-1-78 to 12-31-78	4		
6.	INTERNAL MEDICINE	R	CONEY ISLAND HOSPITAL 2601 OCEAN PARKWAY; BROOKLYN, NY	2-1-79 to 6-22-79	20		
7.							

*Enter "E" for elective or "R" for required. Eighteen (18) weeks maximum allowable elective rotations.

NOTE—APPLICANT WILL SIGN THIS STATEMENT IN PRESENCE OF NOTARY PUBLIC.

"I hereby declare under penalty of perjury under the laws of the State of California that the foregoing information contained in this document and any attachments are true and correct." AUERBACH (ADLER) SAMUEL LOUIS — Samuel Louis Auerbach (Adler)
PRINT, LAST NAME. FIRST NAME. MIDDLE NAME. SIGNATURE OF APPLICANT (WRITE FULL NAME)

Signed and sworn to before me this 2 day of June 1994

Signature of Notary Public [signature]

KATHLEEN A. GUENTHER
Notary Public, State of New York
Qualified in Erie County
My Commission Expires August 31, 19

Address 3 Bates Circle Buffalo, NY 14209 — My commission expires 8/31/

L5A

LIC. MARIO A. LIZARRAGA BOLIO/DIRECTOR GENERAL DE SERV. ESC. being duly sworn, says: he is/was the dean or registrar for the student named above and that he has carefully read this form and that the statements made herein are strictly true in every respect.

Signature of Dean or Registrar (Write FULL Name)

05-14-94

MEDICAL SCHOOL — DIRECCION GENERAL DE SERVICIOS ESCOLARES

07A-100/25A (REV. 7/91)

STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY

PETE WILSON, Governor

State of California Department of Consumer Affairs

MEDICAL BOARD OF CALIFORNIA

1426 HOWE AVENUE, SUITE 54, SACRAMENTO, CALIFORNIA 95825-3236
(916) 920-6411

REPORT OF SENIOR YEAR CLINICAL ROTATIONS

ONLY ROTATIONS IN WHICH THE APPLICANT PARTICIPATED IN DIRECT, HANDS-ON DIAGNOSIS OR TREATMENT OF PATIENTS, IN A CLINICAL SETTING MAY BE REPORTED ON THIS FORM. IF ROTATIONS WERE COMPLETED DURING THE JUNIOR OR SENIOR YEAR OF MEDICAL SCHOOL BUT DO NOT SATISFY THIS REQUIREMENT, THEY SHOULD **NOT** BE REPORTED ON THIS FORM BECAUSE THEY DO NOT SATISFY CLINICAL TRAINING REQUIREMENTS.

	Clinical Area	Type*	Facility Name and Address	Dates of Attendance From—To	Weeks of Credit	Instructor or Supervisor	Program Director
1.	OBSTETRICS & GYNECOLOGY	R	NASSAU HOSPITAL - WINTHROP UNIV. HOSPITAL 259 1st Street; MINEOLA, NY	7-2-79 to 8-31-79	8		
2.	PEDIATRICS	R	ST. VINCENT'S HOSPITAL MEDICAL CENTER OF RICHMOND; 355 BARD AVE., SI, NY	9-3-79 to 10-19-79	6		
3.	OBSTETRICS & GYNECOLOGY	E	LONG ISLAND COLLEGE HOSPITAL 340 HENRY STREET, BROOKLYN, NY	10-22-79 to 12-7-79	7		
4.	INTERNAL MEDICINE	E	CONEY ISLAND HOSPITAL 2601 OCEAN PARKWAY, BROOKLYN, NY	2-1-80 to 2-29-80	4		
5.	GENERAL SURGERY	E	BROOKDALE HOSPITAL MEDICAL CENTER LINDEN BLVD. AT BROOKDALE PLAZA BROOKLYN, NY	3-2-80 to 3-31-80	4		
6.	UROLOGY	R	ST. VINCENT'S HOSPITAL MEDICAL CENTER OF RICHMOND, 355 BARD AVE., SI, NY	4-1-80 to 5-30-80	8		
7.							

*Enter "E" for elective or "R" for required. Eighteen (18) weeks maximum allowable elective rotations.

NOTE—APPLICANT WILL SIGN THIS STATEMENT IN PRESENCE OF NOTARY PUBLIC.

"I hereby declare under penalty of perjury under the laws of the State of California that the foregoing information contained in this document and any attachments are true and correct." AUERBACH (ADLER) SAMUEL LOUIS [signature]

PRINT: LAST NAME, FIRST NAME, MIDDLE NAME — SIGNATURE OF APPLICANT (WRITE FULL NAME)

Signed and sworn to before me this 7th day of June 1994

Signature of Notary Public [signature]

Address 3 [illegible] Circle, Buffalo, NY 14209 My commission expires 8/31/94

NOTARY SEAL: KATHLEEN A. GUENTHER 4675182 Notary Public, State of New York Qualified in Erie County My Commission Expires August 31, 1994

MEDICAL SCHOOL SEAL

LIC. MARIO A. LIZARRAGA ROLIO/DIRECTOR GENERAL DE SERV.ESC. being duly sworn, says: he is/was the dean or registrar for the student named above and that he has carefully read this form and that the statements made herein are strictly true in every respect.

Signature of Dean or Registrar (Write FULL Name)

06-14-94

07A-100-L5B (REV. 7/91)

L5B

STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY

PETE WILSON, Governor

State of California Department of Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
1426 HOWE AVENUE, SUITE 54, SACRAMENTO, CALIFORNIA 95825-3236

RECEIVED
SACRAMENTO
MEDICAL BOARD
OF CALIFORNIA
94 JUN 29 AM 8:53

QUALITY ASSURANCE
94 JUN 30 AM
DIVISION OF LICENSING

CERTIFICATE OF CLINICAL TRAINING

Complete one certificate for each clerkship, signed by the instructor or facility program director.

ONLY ROTATIONS IN WHICH THE APPLICANT PARTICIPATED IN DIRECT, HANDS-ON DIAGNOSIS OR TREATMENT OF PATIENTS, IN A CLINICAL SETTING MAY BE REPORTED ON THIS FORM. IF ROTATIONS WERE COMPLETED DURING THE JUNIOR OR SENIOR YEAR OF MEDICAL SCHOOL BUT DO NOT SATISFY THIS REQUIREMENT, THEY SHOULD NOT BE REPORTED ON THIS FORM BECAUSE THEY DO NOT SATISFY CLINICAL TRAINING REQUIREMENTS.

This is to certify that SAMUEL AUERBACH (STUDENT'S NAME), a student of Universidad del Noreste. (MEDICAL SCHOOL), participated in a clerkship offered by St. Vincent's Med. Ctr. of Richmond 355 Bard Ave., SI, NY 10310 (NAME AND ADDRESS OF FACILITY)

from April 1, (DATE) 19 80 thru May 30, (DATE) 19 80 in the clinical area of SURGERY/Urology (CLINICAL AREA). That the above named student successfully completed this clerkship on May 30, (DATE) 19 80.

DENNIS A. BLOOMFIELD, MD being duly sworn, says he ~~he~~/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.

This facility ☒ is ☐ is not affiliated with a U.S. or foreign medical school.

Name of U.S. or foreign medical school if affiliated: NEW YORK MEDKAL COLLEGE

This facility ☒ does have an ACGME-accredited residency program in the areas of: INTERNAL MEDICINE

☐ does not have an ACGME-accredited residency program.

[OFFICIAL HOSPITAL SEAL]

FRANCIS CORGAN, MD
TYPE OR PRINT, NAME OF INSTRUCTOR OR FACILITY PROGRAM DIRECTOR

355 BARD AVE., STATEN ISLAND, NY 10310
Address, Number and Street

City State ZIP Code

PHONE NUMBER 718-876-2429

SIGNATURE OF INSTRUCTOR/FACILITY PROGRAM DIRECTOR

D.A. BLOOMFIELD, M.D.

NOTE: IN ABSENCE OF OFFICIAL HOSPITAL SEAL, THE INSTRUCTOR OR PROGRAM DIRECTOR MUST SIGN THE FORM IN THE PRESENCE OF A NOTARY PUBLIC WHO AFFIXES HIS OFFICIAL NOTARY SEAL.

Signed and sworn to before me this _____ day of _____, 19____

[NOTARY SEAL]

NOTARY PUBLIC

ADDRESS

My commission expires _____

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 Junior and Senior Year Clinical Rotations forms.

LE

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

Consumer Affairs

RECEIVED SACRAMENTO BOARD OF MEDICAL QUALITY ASSURANCE
94 JUN 20 AM 11:09

MEDICAL BOARD OF CALIFORNIA

1426 HOWE AVENUE, SUITE 54, SACRAMENTO, CALIFORNIA 95825-3236
(916) 920-6411

RECEIVED SACRAMENTO MEDICAL BOARD OF CALIFORNIA
94 JUN 17 PM 2:11

DIVISION OF LICENSING

CERTIFICATE OF CLINICAL TRAINING

Complete one for each clerkship, signed by the instructor or facility program director.

ONLY ROTATIONS IN WHICH THE APPLICANT PARTICIPATED IN DIRECT, HANDS-ON DIAGNOSIS OR TREATMENT OF PATIENTS, IN A CLINICAL SETTING MAY BE REPORTED ON THIS FORM. IF ROTATIONS WERE COMPLETED DURING THE JUNIOR OR SENIOR YEAR OF MEDICAL SCHOOL BUT DO NOT SATISFY THIS REQUIREMENT, THEY SHOULD NOT BE REPORTED ON THIS FORM BECAUSE THEY DO NOT SATISFY CLINICAL TRAINING REQUIREMENTS.

This is to certify that SAMUEL AUERBACH (STUDENT'S NAME), a student of UNIVERSIDAD DEL Noreste (MEDICAL SCHOOL), participated in a clerkship offered by Brookdale Hosp. Med. Ctr.; Linden Blvd. at Brookdale Plaza Bklyn, N.Y. 11212-3198 (NAME AND ADDRESS OF FACILITY) from March 1, 1980 (DATE) thru march 31, 1980 (DATE) in the clinical area of General Surgery (CLINICAL AREA). That the above named student successfully completed this clerkship on March 31, 1980 (DATE).

_____ being duly sworn, says 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.

This facility ☐ is ☐ is not affiliated with a U.S. or foreign medical school.

Name of U.S. or foreign medical school if affiliated: _____

This facility ☒ does have an ACGME-accredited residency program in the areas of: Surgery

☐ does not have an ACGME-accredited residency program.

OFFICIAL HOSPITAL SEAL

Alvin I. Kahn, MD., F.A.C.P.
TYPE OR PRINT, NAME OF INSTRUCTOR OR FACILITY PROGRAM DIRECTOR

The Brookdale HOspital Medical Center
Address Number and Street

Linden Blvd., Brooklyn, New York 11212
City State ZIP Code

PHONE NUMBER (718) 240-5721

Alvin I. Kahn M.D.
SIGNATURE OF INSTRUCTOR/FACILITY PROGRAM DIRECTOR

NOTE: IN ABSENCE OF OFFICIAL HOSPITAL SEAL, THE INSTRUCTOR OR PROGRAM DIRECTOR MUST SIGN THE FORM IN THE PRESENCE OF A NOTARY PUBLIC WHO AFFIXES HIS OFFICIAL NOTARY SEAL.

Signed and sworn to before me this _____ day of _____, 19____

NOTARY SEAL

_____
NOTARY PUBLIC

_____
ADDRESS

My commission expires _____

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 Junior and Senior Year Clinical Rotations forms.

07A-100-16 (REV. 7/91)

L6

STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY

PETE WILSON, Governor

Consumer Affairs

MEDICAL BOARD OF CALIFORNIA

1426 HOWE AVENUE, SUITE 54, SACRAMENTO, CALIFORNIA 95825-3236
(916) 920-6411

RECEIVED
SACRAMENTO
BOARD OF MEDICAL
QUALITY ASSURANCE

94 JUN 30 AM 9:19

RECEIVED
SACRAMENTO
MEDICAL BOARD
OF CALIFORNIA

94 JUN 28 PM 2:54

DIVISION OF LICENSING

CERTIFICATE OF CLINICAL TRAINING

Complete one certificate for each clerkship, signed by the instructor or facility program director.

ONLY ROTATIONS IN WHICH THE APPLICANT PARTICIPATED IN DIRECT, HANDS-ON DIAGNOSIS OR TREATMENT OF PATIENTS, IN A CLINICAL SETTING MAY BE REPORTED ON THIS FORM. IF ROTATIONS WERE COMPLETED DURING THE JUNIOR OR SENIOR YEAR OF MEDICAL SCHOOL BUT DO NOT SATISFY THIS REQUIREMENT, THEY SHOULD NOT BE REPORTED ON THIS FORM BECAUSE THEY DO NOT SATISFY CLINICAL TRAINING REQUIREMENTS.

This is to certify that SAMUEL AUERBACH (STUDENT'S NAME), a student of Universidad del Noreste (MEDICAL SCHOOL), participated in a clerkship offered by Long Island College Hospital; 340 Henry St.; Bklyn, NY 11201 (NAME AND ADDRESS OF FACILITY)

from October 22 (DATE) 19 79 thru December 7 (DATE) 19 79 in the clinical area of Obstetrics & Gynecology (CLINICAL AREA). That the above named student successfully completed this clerkship on December 7 (DATE) 19 79

SHERWOOD H. PUTTERMAN M.D. being duly sworn, says 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.

This facility ☒ is ☐ is not affiliated with a U.S. or foreign medical school.

Name of U.S. or foreign medical school if affiliated: State U. of N.Y. Health Science Center

This facility ☒ does have an ACGME-accredited residency program in the areas of: OBS/GYN
☐ does not have an ACGME-accredited residency program.

OFFICIAL HOSPITAL SEAL

SHERWOOD H. PUTTERMAN, M.D.
TYPE OR PRINT, NAME OF INSTRUCTOR OR FACILITY PROGRAM DIRECTOR

The Long Island College Hospital
Address, Number and Street

340 Henry St. Brklyn NY 11201
City State ZIP Code

PHONE NUMBER (718) 780 1245

SIGNATURE OF INSTRUCTOR/FACILITY PROGRAM DIRECTOR

NOTE: IN ABSENCE OF OFFICIAL HOSPITAL SEAL, THE INSTRUCTOR OR PROGRAM DIRECTOR MUST SIGN THE FORM IN THE PRESENCE OF A NOTARY PUBLIC WHO AFFIXES HIS OFFICIAL NOTARY SEAL.

Signed and sworn to before me this _____ day of _____, 19_____

NOTARY SEAL

NOTARY PUBLIC

ADDRESS

My commission expires _____

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 Junior and Senior Year Clinical Rotations forms.

07A-100-16 (REV. 7/91)

L6

STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY

PETE WILSON, Governor

Consumer Affairs

MEDICAL BOARD OF CALIFORNIA

1426 HOWE AVENUE, SUITE 54, SACRAMENTO, CALIFORNIA 95825-3236
(916) 920-6411

RECEIVED
SACRAMENTO
MEDICAL BOARD
OF CALIFORNIA
94 JUN 20 PM 3:54

CERTIFICATE OF CLINICAL TRAINING

Complete one certificate for each clerkship, signed by the instructor or facility program director.

ONLY ROTATIONS IN WHICH THE APPLICANT PARTICIPATED IN DIRECT, HANDS-ON DIAGNOSIS OR TREATMENT OF PATIENTS, IN A CLINICAL SETTING MAY BE REPORTED ON THIS FORM. IF ROTATIONS WERE COMPLETED DURING THE JUNIOR OR SENIOR YEAR OF MEDICAL SCHOOL BUT DO NOT SATISFY THIS REQUIREMENT, THEY SHOULD **NOT** BE REPORTED ON THIS FORM BECAUSE THEY DO NOT SATISFY CLINICAL TRAINING REQUIREMENTS.

This is to certify that SAMUEL AUERBACH (STUDENT'S NAME), a student of Universidad del Noreste (MEDICAL SCHOOL), participated in a clerkship offered by St. Vincent's Med. Ctr. of Richmond 355 Bard Ave., SI, NY 10310 (NAME AND ADDRESS OF FACILITY)

from September 7, (DATE) 19 79 thru October 19, (DATE) 19 79 in the clinical area of Pediatrics (CLINICAL AREA). That the above named student successfully completed this clerkship on October 19, (DATE) 19 79.

ALBINA A. CLAPS, M.D. being duly sworn, says She is/~~was~~ the individual instructor or program director for the student named above during the clerkship indicated and that She has carefully read and completed this form and that the statements made herein are strictly true in every respect.

This facility ☒ is ☐ is not affiliated with a U.S. or foreign medical school.

Name of U.S. or foreign medical school if affiliated: New York Univ. School of Medicine

This facility ☒ does have an ACGME-accredited residency program in the areas of: _____
☐ does not have an ACGME-accredited residency program.

OFFICIAL HOSPITAL SEAL

ALBINA A. CLAPS, M.D.
TYPE OR PRINT NAME OF INSTRUCTOR OR FACILITY PROGRAM DIRECTOR

355 BARD AVENUE
Address: Number and Street

STATEN ISLAND (City) NEW YORK (State) 10310 (ZIP Code)

PHONE NUMBER (718)876-4638 * Albina A. Claps MD
SIGNATURE OF INSTRUCTOR/FACILITY PROGRAM DIRECTOR

NOTE: IN ABSENCE OF OFFICIAL HOSPITAL SEAL, THE INSTRUCTOR OR PROGRAM DIRECTOR MUST SIGN THE FORM IN THE PRESENCE OF A NOTARY PUBLIC WHO AFFIXES HIS OFFICIAL NOTARY SEAL.

Signed and sworn to before me this 15 day of June, 19 94

NOTARY SEAL

Rose D. Macaluso
NOTARY PUBLIC

ROSE D. MACALUSO
Commissioner of Deeds
City of New York No. 5-680
Certificate filed in Richmond
Commission Expires Jan. 1, 19 95

ADDRESS

My commission expires _____

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 Junior and Senior Year Clinical Rotations forms.

07A-100-L6 (REV. 7/91)

L6

STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY

PETE WILSON, Gov

Consumer Affairs

RECEIVED SACRAMENTO BOARD OF MEDICAL QUALITY ASSURANCE

MEDICAL BOARD OF CALIFORNIA
1426 HOWE AVENUE, SUITE 54, SACRAMENTO, CALIFORNIA 95825-3236
(916) 920-6411

RECEIVED SACRAMENTO MEDICAL BOARD OF CALIFORNIA

94 JUN 30 AM 8:52

94 JUN 29 AM 8:52

DIVISION OF LICENSING

CERTIFICATE OF CLINICAL TRAINING

Complete this certificate for each clerkship, signed by the instructor or facility program director.

ONLY ROTATIONS IN WHICH THE APPLICANT PARTICIPATED IN DIRECT, HANDS-ON DIAGNOSIS OR TREATMENT OF PATIENTS, IN A CLINICAL SETTING MAY BE REPORTED ON THIS FORM. IF ROTATIONS WERE COMPLETED DURING THE JUNIOR OR SENIOR YEAR OF MEDICAL SCHOOL BUT DO NOT SATISFY THIS REQUIREMENT, THEY SHOULD NOT BE REPORTED ON THIS FORM BECAUSE THEY DO NOT SATISFY CLINICAL TRAINING REQUIREMENTS.

This is to certify that SAMUEL AUERBACH (STUDENT'S NAME), a student of Universidad del Noreste (MEDICAL SCHOOL), participated in a clerkship offered by Nassau Hospital - Winthrop University Hospital
259 First Street; Mineola, NY 11501 (NAME AND ADDRESS OF FACILITY)

from 7-2, (DATE) 19 79 thru 8-31, (DATE) 19 79 in the clinical area of Ob/Gyn (CLINICAL AREA). That the above named student successfully completed this clerkship on 8-31 (DATE) 19 79.

Victor Alinovi, M.D. being duly sworn, says 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.

This facility ☒ is ☐ is not affiliated with a U.S. or foreign medical school.

Name of U.S. or foreign medical school if affiliated: _____

This facility ☒ does have an ACGME-accredited residency program in the areas of: OB/Gyn

☐ does not have an ACGME-accredited residency program.

OFFICIAL HOSPITAL SEAL

Dev Maulik, M.D.-Chairman
TYPE OR PRINT NAME OF INSTRUCTOR OR FACILITY PROGRAM DIRECTOR

259 First Street
Address, Number and Street

Mineola, Ny 11501
City State ZIP Code

PHONE NUMBER (516)663-2465

SIGNATURE OF INSTRUCTOR/FACILITY PROGRAM DIRECTOR

NOTE: IN ABSENCE OF OFFICIAL HOSPITAL SEAL, THE INSTRUCTOR OR PROGRAM DIRECTOR MUST SIGN THE FORM IN THE PRESENCE OF A NOTARY PUBLIC WHO AFFIXES HIS OFFICIAL NOTARY SEAL.

Signed and sworn to before me this _____ day of _____, 19____

NOTARY SEAL

NOTARY PUBLIC

ADDRESS

My commission expires _____

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 Junior and Senior Year Clinical Rotations forms.

07A-100-L6 (REV. 7/91)

STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY

PETE WILSON, Governor

Consumer Affairs

RECEIVED
SACRAMENTO
BOARD OF MEDICAL
QUALITY ASSURANCE
94 JUN 30 AM 9:16

MEDICAL BOARD OF CALIFORNIA

1426 HOWE AVENUE, SUITE 54, SACRAMENTO, CALIFORNIA 95825-3236
(916) 920-6411

RECEIVED
SACRAMENTO
MEDICAL BOARD
OF CALIFORNIA
94 JUN 28 PM 3:47

CERTIFICATE OF CLINICAL TRAINING

DIVISION OF LICENSING

Complete one certificate for each clerkship, signed by the instructor or facility program director.

ONLY ROTATIONS IN WHICH THE APPLICANT PARTICIPATED IN DIRECT, HANDS-ON DIAGNOSIS OR TREATMENT OF PATIENTS, IN A CLINICAL SETTING MAY BE REPORTED ON THIS FORM. IF ROTATIONS WERE COMPLETED DURING THE JUNIOR OR SENIOR YEAR OF MEDICAL SCHOOL BUT DO NOT SATISFY THIS REQUIREMENT, THEY SHOULD NOT BE REPORTED ON THIS FORM BECAUSE THEY DO NOT SATISFY CLINICAL TRAINING REQUIREMENTS.

This is to certify that SAMUEL AUERBACH (STUDENT'S NAME), a student of Universidad del Noreste (MEDICAL SCHOOL), participated in a clerkship offered by Brookdale Hospital Medical Center, Linden Blvd. at Brookdale Plaza, Brooklyn, NY 11212 (NAME AND ADDRESS OF FACILITY)

from 12-1 (DATE) 1978 thru 12-29 (DATE) 19 78 in the clinical area of OPHTHALMOLOGY (CLINICAL AREA). That the above named student successfully completed this clerkship on 12-29, (DATE) 19 78.

_____ being duly sworn, says 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.

This facility ☐ is ☑ is not affiliated with a U.S. or foreign medical school.

Name of U.S. or foreign medical school if affiliated: _____

This facility ☑ does have an ACGME-accredited residency program in the areas of: OPHTHALMOLOGY
☐ does not have an ACGME-accredited residency program.

Alvin I. Kahn, MD. F.A.C.P.
TYPE OR PRINT, NAME OF INSTRUCTOR OR FACILITY PROGRAM DIRECTOR

The Brookdale Hospital Medical Center
Address: Number and Street

Linden Blvd., Brooklyn, NY. 11212
City State ZIP Code

PHONE NUMBER (718) 240-5721

Alvin I. Kahn MD
SIGNATURE OF INSTRUCTOR/FACILITY PROGRAM DIRECTOR

OFFICIAL HOSPITAL SEAL

NOTE: IN ABSENCE OF OFFICIAL HOSPITAL SEAL, THE INSTRUCTOR OR PROGRAM DIRECTOR MUST SIGN THE FORM IN THE PRESENCE OF A NOTARY PUBLIC WHO AFFIXES HIS OFFICIAL NOTARY SEAL.

Signed and sworn to before me this _____ day of _____, 19____

NOTARY SEAL

_____
NOTARY PUBLIC

_____
ADDRESS

My commission expires _____

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 Junior and Senior Year Clinical Rotations forms.

07A-100-L6 (REV. 7/91)

L6

STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY

PETE WILSON, Governor

Consumer Affairs

MEDICAL BOARD OF CALIFORNIA

1426 Howe Avenue, Suite 54, Sacramento, California 95825-3236
(916) 920-6411

RECEIVED
SACRAMENTO
MEDICAL BOARD
OF CALIFORNIA
94 JUN 17 PM 2:11

94 JUN 20 AM 8:39
DIVISION OF LICENSING

CERTIFICATE OF CLINICAL TRAINING

Complete one certificate for each clerkship served by the instructor or facility program director.

ONLY ROTATIONS IN WHICH THE APPLICANT PARTICIPATED IN DIRECT, HANDS-ON DIAGNOSIS OR TREATMENT OF PATIENTS, IN A CLINICAL SETTING MAY BE REPORTED ON THIS FORM. IF ROTATIONS WERE COMPLETED DURING THE JUNIOR OR SENIOR YEAR OF MEDICAL SCHOOL BUT DO NOT SATISFY THIS REQUIREMENT, THEY SHOULD NOT BE REPORTED ON THIS FORM BECAUSE THEY DO NOT SATISFY CLINICAL TRAINING REQUIREMENTS.

This is to certify that SAMUEL AUERBACH (STUDENT'S NAME), a student of Universidad del Noreste (MEDICAL SCHOOL), participated in a clerkship offered by Brookdale Hospital Medical Center, Linden Blvd. at Brookdale Plaza; Brooklyn, N.Y. (NAME AND ADDRESS OF FACILITY)

from 11-1, (DATE) 19 78 thru 11-30, (DATE) 19 78 in the clinical area of PULMONARY MEDICINE (CLINICAL AREA). That the above named student successfully completed this clerkship on 11-30, (DATE) 19 78.

Elliot Bondi. being duly sworn, says 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.

This facility ☑ is ☐ is not affiliated with a U.S. or foreign medical school.

Name of U.S. or foreign medical school if affiliated: _____

This facility ☒ does have an ACGME-accredited residency program in the areas of: Pulmonary Medicine

☐ does not have an ACGME-accredited residency program.

OFFICIAL HOSPITAL SEAL

ELLIOTT BONDI
TYPE OR PRINT NAME OF INSTRUCTOR OR FACILITY PROGRAM DIRECTOR

BROOKDALE HOSPITAL
Address: Number and Street

BROOKLYN, NY 11212
City State ZIP Code

PHONE NUMBER 718 240 5236

SIGNATURE OF INSTRUCTOR/FACILITY PROGRAM DIRECTOR

NOTE: IN ABSENCE OF OFFICIAL HOSPITAL SEAL, THE INSTRUCTOR OR PROGRAM DIRECTOR MUST SIGN THE FORM IN THE PRESENCE OF A NOTARY PUBLIC WHO AFFIXES HIS OFFICIAL NOTARY SEAL.

Signed and sworn to before me this _____ day of _____, 19____

NOTARY SEAL

NOTARY PUBLIC

ADDRESS

My commission expires _____

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 Junior and Senior Year Clinical Rotations forms.

07A-100-16 (REV. 7/91)

LE

STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY

PETE WILSON, Go

Consumer Affairs

SACRAMENTO MEDICAL BOARD OF CALIFORNIA
BOARD OF MEDICAL QUALITY ASSURANCE
1426 HOWE AVENUE, SUITE 54, SACRAMENTO, CALIFORNIA 95825-3236
(916) 920-6411

RECEIVED
SACRAMENTO
MEDICAL BOARD
OF CALIFORNIA
94 JUN 24 PM 12:48

94 JUN 27 AM 9:55

DIVISION OF LICENSING

CERTIFICATE OF CLINICAL TRAINING

Complete one certificate for each clerkship, signed by the instructor or facility program director.

ONLY ROTATIONS IN WHICH THE APPLICANT PARTICIPATED IN DIRECT, HANDS-ON DIAGNOSIS OR TREATMENT OF PATIENTS, IN A CLINICAL SETTING MAY BE REPORTED ON THIS FORM. IF ROTATIONS WERE COMPLETED DURING THE JUNIOR OR SENIOR YEAR OF MEDICAL SCHOOL BUT DO NOT SATISFY THIS REQUIREMENT, THEY SHOULD NOT BE REPORTED ON THIS FORM BECAUSE THEY DO NOT SATISFY CLINICAL TRAINING REQUIREMENTS.

This is to certify that SAMUEL AUERBACH (STUDENT'S NAME), a student of Universidad del Noreste (MEDICAL SCHOOL), participated in a clerkship offered by Lutheran Medical Center; 150 55th St.; Bklyn, NY 11220 (NAME AND ADDRESS OF FACILITY)

from October 2, (DATE) 19 78 thru October 31, (DATE) 19 78 in the clinical area of Cardiology (CLINICAL AREA). That the above named student successfully completed this clerkship on October 31, (DATE) 19 78.

Anthony Caccese, M.D. being duly sworn, says 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.

This facility [X] is [ ] is not affiliated with a U.S. or foreign medical school.

Name of U.S. or foreign medical school if affiliated: SUNY-Health Science Center-Brooklyn

This facility [X] does have an ACGME-accredited residency program in the areas of: Medicine, OB/Gyn, Pa
[ ] does not have an ACGME-accredited residency program.

OFFICIAL HOSPITAL SEAL

Anthony Caccese, M.D., Director of Medicine
TYPE OR PRINT NAME OF INSTRUCTOR OR FACILITY PROGRAM DIRECTOR

Lutheran Medical Center
Address: Number and Street

150 55th Street, Brooklyn, New York, 11220
City State Zip Code

PHONE NUMBER 718-630-7350

Anthony Caccese
SIGNATURE OF INSTRUCTOR/FACILITY PROGRAM DIRECTOR

NOTE: IN ABSENCE OF OFFICIAL HOSPITAL SEAL, THE INSTRUCTOR OR PROGRAM DIRECTOR MUST SIGN THE FORM IN THE PRESENCE OF A NOTARY PUBLIC WHO AFFIXES HIS OFFICIAL NOTARY SEAL.

Signed and sworn to before me this _____ day of _____, 19____

NOTARY SEAL

NOTARY PUBLIC

ADDRESS

My commission expires _____

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 Junior and Senior Year Clinical Rotations forms.

07A-100-L6 (REV. 7/91)

L6

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

Department of Consumer Affairs

MEDICAL BOARD OF CALIFORNIA

1426 HOWE AVENUE, SUITE 54, SACRAMENTO, CALIFORNIA 95825-3236
(916) 920-6411

RECEIVED
SACRAMENTO
MEDICAL BOARD
OF CALIFORNIA
94 JUN 17 PM 2:11

CERTIFICATE OF CLINICAL TRAINING

Complete one certificate for each clerkship, signed by the instructor or facility program director.

ONLY ROTATIONS IN WHICH THE APPLICANT PARTICIPATED IN DIRECT, HANDS-ON DIAGNOSIS OR TREATMENT OF PATIENTS, IN A CLINICAL SETTING MAY BE REPORTED ON THIS FORM. IF ROTATIONS WERE COMPLETED DURING THE JUNIOR OR SENIOR YEAR OF MEDICAL SCHOOL BUT DO NOT SATISFY THIS REQUIREMENT, THEY SHOULD NOT BE REPORTED ON THIS FORM BECAUSE THEY DO NOT SATISFY CLINICAL TRAINING REQUIREMENTS.

This is to certify that SAMUEL AUERBACH (STUDENT'S NAME), a student of Universidad del Noeste (MEDICAL SCHOOL), participated in a clerkship offered by Brookdale Hosp. Med. Ctr.; Linden Blvd. at Brookdale Plaza Bklyn, N.Y. 11212-3198 (NAME AND ADDRESS OF FACILITY)

from August 1, (DATE) 19 78 thru September 30, (DATE) 19 78 in the clinical area of General Surgery (CLINICAL AREA). That the above named student successfully completed this clerkship on September 30, (DATE) 19 78.

_____ being duly sworn, says 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.

This facility ☑ is ☐ is not affiliated with a U.S. or foreign medical school.

Name of U.S. or foreign medical school if affiliated: _____

This facility ☒ does have an ACGME-accredited residency program in the areas of: SURGERY

☐ does not have an ACGME-accredited residency program.

Alvin I. Kahn, M.D., F.A.C.P.
TYPE OR PRINT, NAME OF INSTRUCTOR OR FACILITY PROGRAM DIRECTOR

[OFFICIAL HOSPITAL SEAL]

The Brookdale Hospital Medical Center
Address: Number and Street

Linden Blvd., Brooklyn, New York 11212
City State ZIP Code

PHONE NUMBER (718) 240-5721

Alvin Kahn M.D.
SIGNATURE OF INSTRUCTOR/FACILITY PROGRAM DIRECTOR

NOTE: IN ABSENCE OF OFFICIAL HOSPITAL SEAL, THE INSTRUCTOR OR PROGRAM DIRECTOR MUST SIGN THE FORM IN THE PRESENCE OF A NOTARY PUBLIC WHO AFFIXES HIS OFFICIAL NOTARY SEAL.

Signed and sworn to before me this _____ day of _____, 19____

[NOTARY SEAL]

_____
NOTARY PUBLIC

_____
ADDRESS

My commission expires _____

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 Junior and Senior Year Clinical Rotations forms.

L6

07A-100.16 (REV. 7/91)

STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY

PETE WILSON, Governor

Consumer Affairs

MEDICAL BOARD OF CALIFORNIA

1426 HOWE AVENUE, SUITE 54, SACRAMENTO, CALIFORNIA 95825-3236
(916) 920-6411

BOARD OF MEDICAL QUALITY ASSURANCE

RECEIVED
SACRAMENTO
MEDICAL BOARD
OF CALIFORNIA

94 JUN 30 PM 1:46

DIV. OF LICENSING

CERTIFICATE OF CLINICAL TRAINING

Complete one certificate for each clerkship signed by the instructor or facility program director.

ONLY ROTATIONS IN WHICH THE APPLICANT PARTICIPATED IN DIRECT, HANDS-ON DIAGNOSIS OR TREATMENT OF PATIENTS, IN A CLINICAL SETTING MAY BE REPORTED ON THIS FORM. IF ROTATIONS WERE COMPLETED DURING THE JUNIOR OR SENIOR YEAR OF MEDICAL SCHOOL BUT DO NOT SATISFY THIS REQUIREMENT, THEY SHOULD NOT BE REPORTED ON THIS FORM BECAUSE THEY DO NOT SATISFY CLINICAL TRAINING REQUIREMENTS.

This is to certify that Samuel Auerbach MD (STUDENT'S NAME), a student of Universidad del Noreste (MEDICAL SCHOOL), participated in a clerkship offered by Manhattan Eye, Ear & Throat Hospital; 210 E. 64th St; NY, NY 10021 (NAME AND ADDRESS OF FACILITY)

from July 3, (DATE) 19 78 thru July 31, (DATE) 19 78 in the clinical area of Otolaryngology (CLINICAL AREA). That the above named student successfully completed this clerkship on July 31 (DATE) 19 78.

Simon C. Parisier MD being duly sworn, says he is/was not 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.

This facility ☑ is ☐ is not affiliated with a U.S. or foreign medical school.

Name of U.S. or foreign medical school if affiliated: Cornell

This facility ☑ does have an ACGME-accredited residency program in the areas of: Otolaryngology

☐ does not have an ACGME-accredited residency program.

OFFICIAL HOSPITAL SEAL

Simon C. Parisier MD (Current chairman who reviewed Dr. Auerbach's file)
TYPE OR PRINT NAME OF INSTRUCTOR OR FACILITY PROGRAM DIRECTOR

210 East 64 St
Address: Number and Street

NY NY 10021
City State ZIP Code

PHONE NUMBER 2128389200

Simon C. Parisier
SIGNATURE OF INSTRUCTOR/FACILITY PROGRAM DIRECTOR

NOTE: IN ABSENCE OF OFFICIAL HOSPITAL SEAL, THE INSTRUCTOR OR PROGRAM DIRECTOR MUST SIGN THE FORM IN THE PRESENCE OF A NOTARY PUBLIC WHO AFFIXES HIS OFFICIAL NOTARY SEAL.

Signed and sworn to before me this _____ day of _____, 19____

NOTARY SEAL

_____
NOTARY PUBLIC

_____
ADDRESS

My commission expires _____

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 Junior and Senior Year Clinical Rotations forms.

07A-100-16 (REV. 7/91)

L6

STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY

PETE WILSON, Governor

RECEIVED SACRAMENTO BOARD OF MEDICAL QUALITY ASSURANCE 94 JUL -7 AM 9:47 DIVISION OF LICENSING

MEDICAL BOARD OF CALIFORNIA

1426 HOWE AVENUE, SUITE 54, SACRAMENTO, CALIFORNIA 95825-3236
(916) 920-6411

RECEIVED SACRAMENTO MEDICAL BOARD OF CALIFORNIA 94 JUL -6 PM 2:56

CERTIFICATE OF CLINICAL TRAINING

Complete a separate certificate for each clerkship, signed by the instructor or facility program director.

ONLY ROTATIONS IN WHICH THE APPLICANT PARTICIPATED IN DIRECT, HANDS-ON DIAGNOSIS OR TREATMENT OF PATIENTS, IN A CLINICAL SETTING MAY BE REPORTED ON THIS FORM. IF ROTATIONS WERE COMPLETED DURING THE JUNIOR OR SENIOR YEAR OF MEDICAL SCHOOL BUT DO NOT SATISFY THIS REQUIREMENT, THEY SHOULD NOT BE REPORTED ON THIS FORM BECAUSE THEY DO NOT SATISFY CLINICAL TRAINING REQUIREMENTS.

This is to certify that SAMUEL AUERBACH (STUDENT'S NAME), a student of Universidad del Noreste (MEDICAL SCHOOL), participated in a clerkship offered by Coney Island Hospital 2601 Ocean Parkway; Bklyn, NY 11236 (NAME AND ADDRESS OF FACILITY)

from February 1, 1979 (DATE) thru June 22, 1979 (DATE) in the clinical area of Internal Medicine (CLINICAL AREA). That the above named student successfully completed this clerkship on June 22, 1979 (DATE).

_____ being duly sworn, says 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.

This facility [X] is [ ] is not affiliated with a U.S. or foreign medical school.

Name of U.S. or foreign medical school if affiliated: DOWNSTATE - SUNY @ HSCB

This facility [X] does have an ACGME-accredited residency program in the areas of: _____

[ ] does not have an ACGME-accredited residency program.

OFFICIAL HOSPITAL SEAL

Sandor A. Friedman, M.D.
TYPE OR PRINT NAME OF INSTRUCTOR OR FACILITY PROGRAM DIRECTOR

2601 Ocean Parkway
Address, Number and Street

Brooklyn, New York 11235
City State Zip Code

PHONE NUMBER (718) 615-5448

Sandor A. Friedman
SIGNATURE OF INSTRUCTOR/FACILITY PROGRAM DIRECTOR

NOTE: IN ABSENCE OF OFFICIAL HOSPITAL SEAL, THE INSTRUCTOR OR PROGRAM DIRECTOR MUST SIGN THE FORM IN THE PRESENCE OF A NOTARY PUBLIC WHO AFFIXES HIS OFFICIAL NOTARY SEAL.

Signed and sworn to before me this 28th day of June, 1994

NOTARY SEAL

Sharon Walder
NOTARY PUBLIC

CSH, 2601 Ocean Pkwy Bklyn Ny 11235
ADDRESS

SHARON WALDER
Notary Public, State of New York
No. 24-4869581
Qualified in Kings County
Commission Expires Nov. 24, 1994

My commission expires _____

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 Junior and Senior Year Clinical Rotations forms.

L6

07A-100-L6 (REV. 7/91)

STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY

PETE WILSON, Governor

Department of Consumer Affairs

MEDICAL BOARD OF CALIFORNIA

1426 HOWE AVENUE, SUITE 54, SACRAMENTO, CALIFORNIA 95825-3236
(916) 920-6171

BOARD OFFICE
INITIAL
APPLICANCE

RECEIVED
SACRAMENTO
MEDICAL BOARD
OF CALIFORNIA
94 JUL -6 PM 2:56

94 JUL -7 AM 9:47

DIVISION OF LICENSING

CERTIFICATE OF CLINICAL TRAINING

Complete one certificate for each clerkship, signed by the instructor or facility program director.

ONLY ROTATIONS IN WHICH THE APPLICANT PARTICIPATED IN DIRECT, HANDS-ON DIAGNOSIS OR TREATMENT OF PATIENTS, IN A CLINICAL SETTING MAY BE REPORTED ON THIS FORM. IF ROTATIONS WERE COMPLETED DURING THE JUNIOR OR SENIOR YEAR OF MEDICAL SCHOOL BUT DO NOT SATISFY THIS REQUIREMENT, THEY SHOULD NOT BE REPORTED ON THIS FORM BECAUSE THEY DO NOT SATISFY CLINICAL TRAINING REQUIREMENTS.

This is to certify that SAMUEL AUERBACH (STUDENT'S NAME), a student of Universidad del Noreste (MEDICAL SCHOOL), participated in a clerkship offered by Coney Island Hospital; 2601 Ocean Parkway; Bklyn, NY 11236 (NAME AND ADDRESS OF FACILITY)

from February 1, (DATE) 19 80 thru February 29 (DATE) 19 80 in the clinical area of Internal Medicine (CLINICAL AREA). That the above named student successfully completed this clerkship on February 29, (DATE) 19 80

_____ being duly sworn, says 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.

This facility [XX] is [ ] is not affiliated with a U.S. or foreign medical school.

Name of U.S. or foreign medical school if affiliated: DOWNSTATE - SUNY @ HSCB

This facility [XX] does have an ACGME-accredited residency program in the areas of: _____

[ ] does not have an ACGME-accredited residency program.

[OFFICIAL HOSPITAL SEAL]

Sandor A. Friedman, M.D.
TYPE OR PRINT, NAME OF INSTRUCTOR OR FACILITY PROGRAM DIRECTOR

2601 Ocean Parkway
Address: Number and Street

Brooklyn, New York 11235
City State ZIP Code

PHONE NUMBER (718) 615-5448

SIGNATURE OF INSTRUCTOR/FACILITY PROGRAM DIRECTOR

NOTE: IN ABSENCE OF OFFICIAL HOSPITAL SEAL, THE INSTRUCTOR OR PROGRAM DIRECTOR MUST SIGN THE FORM IN THE PRESENCE OF A NOTARY PUBLIC WHO AFFIXES HIS OFFICIAL NOTARY SEAL.

Signed and sworn to before me this 28th day of June, 19 94

Sharon Walder
NOTARY PUBLIC

[NOTARY SEAL]

CTH, 2601 Ocean Pkwy Bklyn NY 11235
ADDRESS

SHARON WALDER
Notary Public, State of New York
No. 24-4869581
Qualified in Kings County
Commission Expires Nov. 24, 1994

My commission expires _____

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 Junior and Senior Year Clinical Rotations forms.

L6

07A-100-16 (REV. 7/91)

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?

___YES OR ✓ NO

SUMMARY OF RENEWAL FEES OWED		FINANCIAL INTEREST STATEMENT	
		Health Facility Name	Address
2009 Renewal Fee	808.00		
Delinquent Fee			
Penalty Fee			
TOTAL FEES:	$808.00		

MEDICAL BOARD OF CALIFORNIA LICENSE RENEWAL PHYSICIAN AND SURGEON APPLICATION

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

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

D. CONTINUING MEDICAL EDUCATION (CME) CERTIFICATION STATEMENT

I CERTIFY UNDER PENALTY OF PERJURY UNDER THE LAWS OF CALIFORNIA TO THE FOLLOWING STATEMENT:

I CERTIFY THAT I DO MEET EACH OF THE CONTINUING MEDICAL EDUCATION REQUIREMENTS LISTED ON THE SECOND PAGE OF THIS FORM OR THAT I MEET THE CONDITIONS WHICH WOULD EXEMPT ME FROM ALL OR PART OF THE REQUIREMENTS OR I HOLD A PERMANENT CME WAIVER.

Signature required Samuel Louis Auerbach MD 0080624

LICENSE NO. A 53310

EXPIRES 8/31/09

FEE OWED $ 808.00

DELINQ FEE IF POSTMARKED AFTER _____

$ _____

$ _____

$ _____

TOTAL ENCLOSED

E. FOR ADDRESS CHANGE ONLY

IF YOUR ADDRESS SHOWN IS INCORRECT, CORRECT IT BELOW.

STREET 913 MOHAWK STREET

CITY LAS VEGAS STATE NV

ZIP 89107

PHONE NUMBER ( ) 805 953 5848

G. FINANCIAL INTEREST STATEMENT

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

Signature required Samuel Louis Auerbach MD

Dr. SAMUEL LOUIS AUERBACH
PO BOX 090365
BROOKLYN, NY 11209

STATE DEPARTMENT OF CONSUMER AFFAIRS
INTERNET CASHIERING SYSTEM
MEDICAL BOARD OF CALIFORNIA
SUPPLEMENTAL INFORMATION REPORT
From Date: 09/01/2011 **To Date:** 09/01/2011

ATRISUPPINF

26-SEP-14 13:42:18

Person Id : 540734 **Name :** Auerbach,Samuel

Question	Answer
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.	YES
I Have Completed 12 Hours Of Pain Management And End-Of-Life Care.	YES
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.	NO
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.	NO
Enter Name/Address Of Facility Where You Or Your Immediate Family Hold Financial Interest. Type "None", If None Held.	NONE
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.	YES
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.	YES
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?	NO

Total Questions Asked For Person : 540734 8

STATE DEPARTMENT OF CONSUMER AFFAIRS
INTERNET CASHIERING SYSTEM
MEDICAL BOARD OF CALIFORNIA
SUPPLEMENTAL INFORMATION REPORT
From Date: 06/13/2013 **To Date:** 06/13/2013

ATRISUPPINF

26-SEP-14 13:40:35

Person Id : 540734 **Name :** Auerbach,Samuel

Question	Answer
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.	YES
I Have Completed 12 Hours Of Pain Management And End-Of-Life Care.	YES
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.	NO
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.	NO
Enter Name/Address Of Facility Where You Or Your Immediate Family Hold Financial Interest. Type "None", If None Held.	NONE
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.	YES
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.	YES
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?	NO

Total Questions Asked For Person : 540734 8