PETE WILSON,



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

APPLICATION FOR PHYSICIAN AND SURGEON'S EXAMINATION OR LICENSURE

submitted with this application	e completing this application or instructions. Please type o	n. All questions on this ap r print neatly. When space	plication must be answered provided is insufficient, a	, and all supporting stach additional s	document musi heats of paper.
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4. Address: Number and Stre	et/Rural Route (include apartment n	umber Hemil	STATE OF STA	فسيميون ميته يستديرون مبسد سيفر	
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5. Telephone Number: Ho	me . Work	6. Date of Birth:	Mo/Day/Yr Place of Bir	h:	
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7. Sex: Female	8. Are you a U.S. citizen?				
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Y. Have you ever filed an application of the second of the	olication for examination or I	icensure in California?	X Y	!s □ No	
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10. List name and address of Please submit on official	all colleges or universities at sealed transcript for each sch	ended where pre-professio ool attended.	nal, postsecondary instruc	ion was received.	a de sopre de la companya de la comp
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Course	Yos No	Nan	se of College or University		
Physics		NYCI			
Biology or Zoology		14U		***************************************	[::• □ :-:
11. List name and address of Medical Education (Form	all schools where profession	of medical instruction was	eceived. Submit an origina	Certificate of	MEDICAL
Medical Education (Form	L2) and official sealed transc	ripts from each school atte	nded.		EDUCATION
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12. Doctor of Medicine Degree original, submit an official of	granted by: (submit original me ertified photocopy that has the	tical diplome and a photocol	TEXT TEXTS	ry, in lieu of the	
Name of Med	lical School	dress of Medical School	indure of the registrar certify		WEXO
		April 1 April 196	Exact Date of Issue		School Code
Universitud del Nore	te 7	Courses Vanna	' June 6,	TT OU	
NOTE: APPLICANT MUS	T PROVIDE NAME, ADDRE	SS AND DATE OF ISSU	ANCE OF DEGREE.		

07A-100 (REV. 7/91)

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Name	Location	Date	Ro	sult	
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(Note: Concreamplate Fol	completed at least one year of qu m 13 (s) to recument training received in of all facilities. Submit an original Certifi	ratearch or clinical fellowship progra	ms) Ye	ı □ No .	TRAIN.
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Name .	Address	Type of Service	From (Mo/Yr)	To (Ma/Yr)	
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QUESTIONS 14A-23 For an any decomentation regardi	y positive response to these ques	itions, applicant should provid	le, in addition to writ	ten explanations,	
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15. Have you been licensed	I to practice medicine in any state	or country?	X Ye	s No	ICES:
If YES, list state ar country, lie each state in which you are li	cense number, date issued and dates of pr censed or have been licensed. Please inclu	ractica in issulna agency's jurisdiction ide temporary, limited, or provisional	ror each, Submit a Letter o licenses	l Good Standing from	a gloria Spatial
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 Has any disciplinary ac include any disciplinary if yes, give details below. 	tion ever been filed or taken rega ractions by the U.S. Military, U.S.	ording any healing arts license Public Health Service or other	· U.S. federal govern	nental entity.	
State	n.i.	· Character	···· _} •···-·································	es No	
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if yes, give details below.			
State or Country	Date at Denial	Reason for Denial	
 Have you been charged with a by the U.S. military and are at 	unprofessional conduct o waiting final disposition b	or any other unlawful activity by any healing arts licensing authority or by that body? You must also list any pending actions or accurations.	
4		Yes , rio	
7. Have you ever voluntarily sur	rendered a license to pr	actice in the healing arts in another state? Yes No	
). Have you ever liad staff privi	locat in a hardial daria	ed, suspended or revoked, or resigned from a medical staff in lieu a	
discipinary actions		Yes No	i gr
. Are you now, or were you in alcohol?	the past, addicted to or	treated for addiction to controlled substances, such as parcotics or Yes No	
manufacture, distribution or d If yes, give details below. Violation and tecation	ispensing of controlled		
victorion and focation	Date	Penalty or Disposition	
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YOU ARE REQUIRED TO LIST 1203.4 OF THE PENAL CODE	ANY CONVICTION TE OR UNDER ANY O	lere to any offense, misdemeanor or felony of any state, the United ic laws resulting in fines of \$75.00 or less.) HAT HAS BEEN SET ASIDE AND DISMISSED UNDER DECTION THER PROVISION OF LAW. A SEPARATE LETTER EXPLAINING D. IN ADDITION TO CERTIFIED COURT DOCUMENTS.	
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MEDICAL BOARD OF CALIFORNIA LA LVEID 1426 HOWE AVENUE, SUITE 54, SACRAMENTO, CALIFORNIA MEDICAL BOARD (916) 9206411 UF CALIFORNIA



CERTIFICATE OF MEDICAL EDUCATION ANII 06

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	LOUIS AUERBACH MD			
Calle 16 #405 Col. Monte of Cd. Madero, Tamps M ADDRESS WIEN BAROLLE	e Verde ruti Mexico enrolled in	Universidad	del Noreste School	l of Medicin
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and was granted the following credits of	n enrollment:		,	
Premedical Education. physics, chemistry, and	Two years of preprofessional p biology (Business and Professions	ostsecondary educati Code Section 2088).	on, including the subjects of	
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MEDICAL BOARD OF/C



SACRAMENTO, CALIFONNES SET

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 of 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 Traince: AUERBACH	First Name:	SAMUEL		Middle Initial:	<u>L</u>
Current Address: 7725 SHORE P.S			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 nan accredited postgraduate training program at this facilities of Form for definition of "satisfactory", Name of Facility:	ity. The following info	and whose photograph mation is provided to	n is attached to th certify "satisfactor	is form, formally	rcompleted Sea reverse
Address of Facility: 3 Gales Circle	1	14-209			, , , , , , , , , , , , , , , , , , ,
Name of Program Director: Dr. Izzo			Phone 7/6 Number: (7/6	,88746	63
Signature of Program Director:			Date 7- Signed:	-21-94	
List Categorical Specialty Area of Training Completed by Trainee TATELNAL MEDICINE		raining 7-1-84	Date Training Completed	0 30	
If the training was rotating or transitional, list in the sp	ace provided below, th	ne specific rotations ar	nd the number of v	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 contraction of the con 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.

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PART 3: To be camplete Name of Director								
of Medical Education:	M. Luther M	Musselman, M	I, Ď.		Phor Num		, 88746	663
acility Name:	Hilland	Fillmore 14. 8 Orche	ospila!	*		Form pleted:	7/21/94	
acility Address:	3 Gales	s Orche				· · · · · · · · · · · · · · · · · · ·		, "
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94 JUL 12 PM 2: 33 CRAMENTO, CALIFORNIA 95825-3236

DIVISION OF LICENSING

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 of 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 L Initial.
Current 7725 SHORE PD			Phone Number: [
ciry: Brooklyn	State:	NY	Zip Code:	11209
PART 2:. To be completed by facility. Completion of this form will certify that the individual named in an accredited postgraduate training program at this facility. The facile of Form for definition of "satisfactory". DEPARTMENT OF VETERANS	ollowing into	rmation is provided to	eriny sansibly (4)	this form, formally completed tory" completion See reverse
Address of Facility. 130 West King bridge Ro	ad, Bro	nx, NY 10466	3	- W
Name of ROBERT L. JONES, M.D.	, Chief	of Staff	Phone Number: 7	18- ₁ 584-9000x6524
	CO5		Date Signed: /	7-5-94
List Catagorical Specialty Area of Training Internal Medicine Completed by Trainee:	. Comm		COMPICION	
If the training was rotating or transitional, list in the space prov	ided below, ti	he specific rotations a	nd the number of	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 who have not completed the one-year or postgreduate training required for licensure by only 1, 1550, indicates complete technical practice 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)

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

Name of Director of Medical Education:

A.J. ROWN

Facility Name: VAVEDICAL CENTER

Phone Aurabas: (,718,), 584-9000 x6905

Facility Address: 130 West: Kircsboxidae Road, Broxx, NY 10468

City: Broxx

State: NY

Zip Code: 10468

The Education this form is formally certifying and documenting, under penalty of perjury, that the physician received instruction appropriate

The individual signing this form is formally cartifying 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/traines has acquired the skill and qualifications necessary to safely assume the unrestricted practice of medicine in this state.

Definition of "Satisfactory": The physician parformed 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:

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

STATE OF CAUFORNIA - STATE AND CONSUMER SERVICES ASSESSED TO

RECEIVE GWILSON, G

SACRAMENTO MEDICAL BOARD OF CALIFORNIA



SACHARIENTO, AMERINA 95825-3238 DIVISION OF LIC NSING

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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.

a type intomation on the form.		
PART 1: To be completed by applicant/trainee. Last Name AUERBACH	First SAMUEL	Middle hintial:
Current Address 7725 SHORE R.D.		Phone Number:
cin Brooklyn	State: NY	Zip Code: //2.09
PART 2: To be completed by facility.		*
Completion of this form will certify that the individual named in Parl an accredited postgraduate training program at this facility. The follo side of form for definition of "satisfactory".	t 1 above and whose photograph wing information is provided to c	is attached to this form, formally completed ertify "satisfactory" completion. See reverse
Name & Facility: Wilson Memorial Regional Med	ical Center/Div. of	United Health Services Hosp.
Address of Facility: 33-57 Harrison Street, Johns	on City, New York 1	3790
Name of Program Director: Roy D.F. Gill, M.D.		Phone Number: 1607-1-763-6396
Signature of Program Director:	5	Date Signed: 6/7/94
List Categorical Specialty Area of Training Internal Medicine Completed by Traines:	Date Training 7/1/86 Commenced:	Date Training 6/30/87 Completed
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)

PART 3: To be completed by the Director of Medical Education and affixed with tije of Name of Director of Medical Education: Richard Wu. M.D. Phone Number: | 607 Facility Name: Wilson Mem. Regional Medical Cent :/ Plyon of UHSH **Date Form** Completed Facility Address: 33-57 Harrison Street. City Johnson City State: New York 13790 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 dilteria delined 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 ticensure, he or she will personally be attesting to the fact that the physician? trained 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 the the applicant was trained in an approved ACGME or CCME program position RICHARD HK. WU. M.) of Medical Education: Date Signed:

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DIVISION OF LICETEMOF 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

of taba imprimation on ma torm		
PART 1: To be completed by applicant/traines. Last Name Of Traines: AUERBACH	First* SAMUEL	Middle (nitial;
Current 1725 SHORE PD		Phone Number:
city: Brooklyn	State: NY	Zip Code: //209
PART 2: To be completed by facility. Completion of this form will certify that the individual named in Par an accredited postgraduate training program at this facility. The folio side of Form for definition of "satisfactory".	owing information is provided to	h is attached to this form, formally completed certify "satisfactory" completion. See reverse
Name of Facility: Albany Medical Center	Hospital	
Address of Facility: 47 New Scotland Ave		
Name of Program Director: Danjel C. Kredentser, p.		Phone Number: (5/8) 262-5587
Signature of Program Director: Myseum Burner		Date 6/7/94
List Categorical Specialty Area of Training Completed by Trainee: 0b/6yn Resident	Date Training 71/87	
If the training was rotating or transitional, list in the space provide	d below, the specific rotations a	nd the number of weeks spent in each.
1. St. Peters Hospital 1 - 4 months		
OAMC OB - 2 months		
· Medicine - 2 months		
· AMC Gyn - 2 months	•	
Note: To qualify for licensure in California, applicants who are goostgraduate training in general medicine as part of the one-year rewho have not completed the one-year of postgraduate training require general medicine as part of the one year required for licensure, what it the applicant has direct patient care responsibilities in any medicine requirement is satisfied by training in a specialty area of gynecology, the Program Director must submit a description of the a determination regarding its acceptability.	equirement, Applicants who are uired for licensure by July 1, 19 The general medicine requirement of the specialty or sub-specialty or sub-special or sub-spec	practicates of a close of candidate the complete four-months of training on the complete four-months of training tent may be satisfied by actual clinical practice alty area for at least four months. If the general medicine, surgery, padiatrics or obstetrics and

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Facility Name: Millard Fillmone Hospital Date Com Facility Address: 3 Gales Orch City: Buffalo Sur NY	ne 17/6 887 Form 7/21/	4663
Name of Director of Medical Education: M. Luther Musselman, M.D. Pho Nun Facility Name: Milland Fillmore lospital Date Com Facility Name: Milland Fillmore lospital Date Com Facility Address: 3 Gales Grak City: Buffalo State: WY Zip C The individual signifing this form is formally certifying and documenting, under penalty of perjury, that the phy for the particular postgraduate level and that they satisfactorily completed the training program in accords the criteria defined as equating to "satisfactory" performance as described below. In cases where the Director completion of the minimum one-year of training required for licenature, he or she will personally be at trained has acquired the skill and qualifications necessary to safely assume the unrestricted practice of me Delinitian, of "Satisfactory". The physician performed at an adequate level based on evidence of satisfactorial growth including demonstrated ability to assume graded and increasing responsibility for patie of the complete of training program is approved by the AGGME 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. Luther Musselman, M.D.	Sper: 1/16) 88 /	
Facility Name: Facility Name: File File File File File Facility Facilit	Sper: 1/16) 88 /	
The individual signing this form is formally certifying and documenting, under penalty of perjury, that the phy for the particular postgraduate level and that they satisfactorily completed the training program in accordance criteria defined as equating to "satisfactory" performance as described below, in cases where the Director criteria defined as equating to "satisfactory" performance as described below, in cases where the Director training required for licansure, he or she will personally be attrained has acquired the skill and qualifications necessary to safely assume the unrestricted practice of me Definition of "Satisfactory": The physician performed at an adequate level based on evidence of satisfactorial growth including demonstrated ability to assume graded and increasing responsibility for patients in the property 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. Luther Misselmuh, M.D.	Form	
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Signature of Director of Medical Education: M. Kuther Masselman, M. D.	econo in this state, .	_
of Medical Education: M. Luther Musselmah, M.D.		
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OFFICIAL HOSPITAL SEAL OR NOTARY.		
SEAL, DATE AND SIGNATURE MUST BE AFFIXED TO CERTIFY TRAINING.		
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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 of 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 Initiel.	L
Current T725 SHORE P.B.	· .		Phone Number: (
civi Brooklyn	State:	NY	Zip Code:	11209	
PART 2: To be completed by facility.					
Completion of this form will certify that the individual named in Pa an accredited postgraduate training program at this facility. The foll side of Form for definition of "satisfactory". DEPARTMENT OF VETERANS AF	lowing info	rmation is provided to	ertify "satisfact) رای	this form, formal cory completion	ly complete See revers
Address of Facility 130 West Kingebridge Road	d, Bro	nx. NY 10466	. 6	4V	
Name of Program Director: ROBERT L. JONES, M.D.,			Phone .	.8 ,584-90	00x6524
Signature of Program Director: Dle A fregel At	٠ ي		Date 7	-5-94	• .
List Categorical Specialty Area of Training Completed by Trainee: List Categorical Specialty Area of Training List Categorical Specialty	•	eining 7/1/85	Date Training Completed	⁹ 6/30/86	
If the training was rotating or transitional, list in the space provide	d below, th	a specific rotations an	d the number of	weeks spent m	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)



Management Committee of the Committee of

PARESETO be completed by the Director of Medical Education and affixed with the official facility seal. Name of Director of Medical Education: - A.J. RONAN VAMIDICAL CENTER 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 affects 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 parformed at an adequate level based on evidence of satisfactory prograssive 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 PA of Medical Education: OFFICIAL HOSPITAL SEAL OR NOTARY SEAL, DATE AND SIGNATURE MUST BE AFFIXED TO CERTIFY TRAINING.

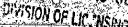
STATE AND CONSUMER SERVICES

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DIVISION OF LIC "NSIVIS

MEDICAL BOARD OF CALIFORNIA



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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.

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PART 1: To be completed by applicant/traines. Last Name Of Trainae: AUERBACH	First SAMUEL	Middle L.
Current 7725 SHORE P.D.	94	Phone Number:
civ. Brooklyn	State: NY	Zip Code: //2/09
PART 2: To be completed by facility. Completion of this form will certify that the individual named in Para an accredited postgraduate training program at this facility. The following of corm for definition of "satisfactory".	art 1 above and whose photograph lowing information is provided to c	is attached to this form, formally completed ertify "satisfactory" completion, See reverse
Name of Facility: Wilson Memoria! Regional Me Address of Facility: 33-57 Harrison Street, John		<u> </u>
Name of Roy D.F. Gill, M.D.		Phone (607) 763-6396
Signature of Signature of Program Director:	<u> </u>	Date Signed: 6/7/94
List Categorical Specialty Area of Training Internal Medicine Completed by Traines:	Date Training 7/1/86 Commenced:	Date Training 6/30/87 Completed
If the training was rotating or transitional, list in the space provide	d below, the specific rotations and	i 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 or sub-special or sub-spe 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.



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PARTID: To be completed by the Director of Madical Education and affixed with the off of Medical Education: Richard Wu, N.D. Wilson Mem. Regional Medical Cent :/ 014 of UHSH Date Form Facility Address: 33-57 Harrison Street Johnson City State: New York 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/ traines 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 prograssive scholarship and professional growth including demonstrated ability to assume graded and increasing responsibility for patient care. t hereby declare under penalty of parjury 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 pos of Medical Education:





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DIVISION OF LICENSE 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

PART 1: To be completed by applicant/trainee. Last Name AUERBACH	First Name:	SAMUEL		Middle L Initial: L
Current Address 7725 SHORE PD	To a state of the		Phone Number:	
city: Brooklyn	State:	NY	Zip Code:	11209
PART 2: To be complated by facility. Completion of this form will certify that the individual named in an accredited postgraduate training program at this facility. The side of Form for definition of "satisfactory".	following Infor	nation is provided t	iph is attached to o certify "satisfac	this form, formally completed story" completion. See reverse
Name of Facility Albany Medical Cent	er Hos	oital .		
Address of Facility: 47 New Scotland Av		4)	<u> </u>	The state of the s
Name of Program Director Daniel C. Kredentser,	garagaria de la segui a secu		Phone Number: (518, 262-5587
Signature of Myudur Bu			Date Signed:	6/7/94
List Categorical Specialty Area of Training Completed by Traines: Ob/Gyn Resident	Date Tra Commer		Date Trainir Completed	6/30/88
If the training was rotating or transitional, list in the space prov		•		of weeks spent in each.
1. St. Peters Hospital 1 - 4 mont	hs tota	il (b)	6yn	(8641 year)
OAMC OB - 2 months			-	,
· Medicine - 2 months			•	•
· AMC Gyn - 2 months				
· AMC USINB - 2 months				
Note To qualify for licensure in California, applicants who ar postgraduate training in general medicine as part of the one-yea	e graduates of	a foreign medical	school must con	nplete at least four months of
who have not completed the one-year of postgraduate training r	required for lice	nsure by July 1, 15	90, must also co	mplete four-months of training
in general medicine as part of the one year required for licensus where the applicant has direct patient care responsibilities in a				

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.

PART 3: (o be completed by the Director of Medical Edi of Medical Education: Number: (518) 262-3593 June 15. 43 New Scotland Avenue Albany New York 12208 Zip Code: The individual signing this form is formally cartifying 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/ trained 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 heraby 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. PAI Signature of Director of Medical Education: 🦥 June 15, 1994 Date Signed: OFFICIAL HOSPITAL SEAL OR NOTARY SEAL, DATE AND SIGNATURE MUST BE AFFIXED TO CERTIFY TRAINING.

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STATE OF CALIFO

MEDICAL BOARD OF CALIFORNIA 1428 HOWE AVENUE OF CALIFORNIA SACRAMENTO, CALIFORNIA 35826-3238 OF CALIFORNIA



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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 of 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. Phone Remove //209 State: 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". Lutheran Medical Center Name of Facility: 150 55th Street, Brooklyn, New York, 11220 Number: (718) 630-7350 Donald M. Zarou, M. D. Program Director: Date Signed: Program Director: List Categorical Specialty Data Training **Date Training** Area of Training Ob/Gyn 8/24/88 Completed. Completed by Trainee: Commenced: 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 integerial 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.

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PARTS: To be completed by the Director of Medical Education a	ind affixed with the offic	(a) (anilia: saal		
Name of Director of Medical Education: Vinceht J. Vigorita, M	A SAN TO THE SAN THE SAN TO THE SAN THE SAN TO THE SAN THE SAN TO THE SAN TO THE SAN TO THE SAN T	Phone	718, 630-738	
Facility Name: Liubillarian Medical Locato		Date Form Completed		A Signature
- Pacility Address: 150 55th Street, Brook	lyn, New York,	11220		
cky. Brooklyn	State: New Yor	ck Zip Code:	11220	
The individual signing this form is formally dertifying and document for the particular postgraduate level and that they satisfactorily of the criteria defined as equating to "satisfactory" performance as the completion of the minimum one year of training required for trainee has acquired the skill and qualifications necessary to safe	described below. In cas	as where the Director of	im the accepted sta Medical Education i	ndarda and
Definition of "Satisfactory": The physician performed at an economic professional growth including demonstrated ability to assume gra	faquate level based on ided and increasing res	evidence of satisfactor consibility for patient car	y progressive schol e.	larship and

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:

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

STATE OF CALIFORNIA-STATE AND CONSUMER BERVICES AGENCY





MEDICAL BOARD OF CALIFORNIA

1426 HOWE AVENUE SACRAMENTO, CALIFORNIA 95826-3238 **94,301,28, PHP: 27** 33,750 H of Licenship



CERTIFICATE OF COMPLETION OF ACGME/CCME POSTGRADUATE TRAINING

To be completed by the facility for overy medical school graduate completing postgraduate training in the United States of 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 SAMUEL	Middle L
Current 1725 SHORE RD		Phone Number:
city Brooklyn	State: NY	Zip Code: //209
PART 2: To be completed by facility. Completion of this form will certify that the individual named in Pe an accredited postgraduay? training program at this facility. The following form for definition of "satisfactory". Name of Facility:	lowing information is provided to	oh is attached to this form, formally completed certify "satisfactory" completion. See reverse
Address of Facility: 3 Calles Cisch	Buffalo NY	14209
Name of Jr S. Kefe		Phone 716, 887 4663
Signature of Proof an Director:		Date 7/21/71
List Categorical Specialty Advanced Puvic Area of Training Completed by Trainee: Survey	Date Training 7-/- 93	Date Training 6-30-94-
If the training was rotating or transitional, list in the space provide	d below, the specific rotations a	nd 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 fraining 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 synecology, 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)



PART 3: To be completed by the Director of Medical Education and affixed with the official facility seal Nams of Directors - Mr. Souther Musselman, M.D. Phone 76 887-4663 Milland Fillmore Hospital 3 Gales Orch: The individual signing this formally certifying and occumenting, 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. 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. PAF Signature of Director of Medical Education OFFICIAL HOSPITAL SEAL OR NOTARY SFAL, DATE AND SIGNATURE MUST AFFIXED TO CERTIFY TRAINING.

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

or type information on the form.			
PART To be completed by applicant/trainee. Last Name Of Trainee: AUERBACH	First SAMUEL		Middle L
Current TILS SHORE P.		Phone Number:	
city. Brooklyn	State: NY	Zip Code: //Z	209
PART 2: To be completed by facility. Completion of this form will certify that the individual named in Pa	irt 1 above and whose photograp	h is attached to this for	n, formally completed
an accredited postgraduate training program at this facility. The foll side of Form for definition of "satisfactory". Name of Facility: UNIVERSITY OF Sout		The DICAL	
Address of Facility: 2451 Fillin Gim		AL, 3661	フ
Name of Program Director: TAN H THORNEY	CROFT PHD MD	Phone Number: (205) 4	170-5815
Signature of Program Director:	11	Date 6/20 Signed:	194
List Categorical Specialty OBSTETRICS AND Y Completed by Trainee: 67 NECOHOGY	Date Training Commenced:	Date Training G Completed	-30-9年夏1
If the Taining was rotating or transitional, list in the space provide		STARTED 1	**
PROGRAM.		ahaat must samulata a	land four months -
Note: To qualify for licensure in California, applicants who are postgraduate training in general medicine as part of the one-year rewho have not completed the one-year of postgraduate training required for licensure where the applicant has direct patient care responsibilities in any medicine requirement is satisfied by training in a specialty area of gynecology, the Program Director must submit a description of the adetermination regarding its acceptability.	equirement. Applicants who are g juired for licensure by July 1, 199 The general medicine requirem particular specialty or sub-specia her than family practice, internal	raduates of a U.S. or Car O, must also complete fo ent may be satisfied by Ity area for at least four medicine, surgery, pedic	nadian medical school, our-months of training actual clinical practice months if the general orrics or obstetrics and

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PART 3: To be completed by the Director of Medical Education and affixed with the official facility	
Name of Director of Medical Education: IMV. H. THOENEYCEOFT PROSPRESS TO SERVICE STATE OF THE SECOND STATE OF THE SECOND	Phone 205 470 575
eacility Hame: University of South Alabana Medical Center	Date Form 6 - 20 -94-
Scilly Address: 2451 Fillinging SV MUK, A7. 36617	
ity. State:	Zip Code:
The particular postgraduate level and that they satisfactorily completed the training program is criteria defined as equating to "satisfactory" performance as described below. In cases where completion of the minimum one-year of training required for licensure, he or she will personable has acquired the skill and qualifications necessary to safely assume the unrestricted practical program of "Satisfactory": The physician performed at an adequate level based on evident of program of the completion of accounts of the physician performed at an adequate level based on evident of the completion of the physician performed at an adequate level based on evident of the physician performed at an adequate level based on evident of the physician performed at an adequate level based on evident of the physician performed at an adequate level based on evident of the physician performed at an adequate level based on evident of the physician performed at an adequate level based on evident of the physician performed at an adequate level based on evident of the physician performed at an adequate level based on evident of the physician performed at an adequate level based on evident of the physician performed at an adequate level based on evident of the physician performed at an adequate level based on evident of the physician performed at an adequate level based on evident of the physician performed at an adequate level based on evident of the physician performed at an adequate level based on evident of the physician performed at an adequate level based on evident of the physician performed at an adequate level based on evident of the physician performed at an adequate level based on evident of the physician performed at an adequate level based on the physician performed at an adequate level based on the physician performed at an adequate level based on the physician performed at an adequate level based on the physician performed at an adequate level based on the physician performed at an adequate level based on the physician per	re the Director of Medical Education is certify nally be attesting to the fact that the physicial ctics of medicine in this state.
hereby declare under penalty of perjury under the laws of the State of allifornia that the above statements are true and correct and that the aining program is approved by the ACGME or the CCME to offer the type of training completed by the applicant and that the applicant was alined in an approved ACGME or CCME program position.	
gnature of Director Medical Education:	
OFFICIAL HOSPITAL SEAL OR NOTARY SEAL, DATE AND SIGNATURE MUST BE AFFIXED TO CERTIFY TRAINING.	
Dr. Jan H. Thorneycroft appeared before me	
this 22 day of June 19 94.	



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MEDICAL BOARD OF CALIFORNIA

1226 HOWE AVENUE SUITE 349 SACKAMENTO CAUFORNIA 95823-3226



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 SATISTY THIS REQUIRE. MENT, THEY SHOULD NOT BE REPORTED ON THIS FORM BECAUSE THEY DO NOT SATISFY CLINICAL TRAINING REQUIREMENTS. REPORT OF JUNIOR YEAR CLINICAL ROTATIONS

			Dates of Attendonce	Weeks of	Service:	
Clinical Area	Type	Focility Name and Addiress	From To	Code	Separator	
OTOTARYNGOLOGY	α.	MANHATTAN EYE, EAR & THROAT HOSPITAL	7-3-78	ころのできる 地の地		
1.	:	210 E. 64th Street; NY, NY	10 7-31-78	4		
2. GENERAL SURGERY	Y R	BROOKDALE HOSPITAL MEDICAL CENTER LINDEN BLVD. AT BROOKDALE PLAZA BROOKLYN, NEW YORK	8-1-78 to 9-3 2 -78	6		
CARDIOLOGY	æ	LUTHERAN MEDICAL CENTER 150 55th Street; BROOKLYN, NY	10-2-78 to	4		
PULMONARY MEDICINE	C4	BROOKDALE HOSPITAL MEDICAL CENTER LINDEN BLVD. AT BROOKDALE HOSPITAL	11-1-78 to			
S. OPHTHALMOLOGY	<u>α</u>	BROOKDALE HOSPITAL MEDICAL CENTER LINDEN BLVD. AT BROOKDALE HOSPITAL	12-1-78 to	4		
INTERNAL MEDICINE	INE	LAND HOSPITAL. AN PARKWAY; BROOKLYN; NY	2-1-79 to	20		
7.			6-22-79			

Erner "E" for alective or "it" for required. Eighteen (18) weeks maximum altowable elective notati

MOTE-APPLICANT WILL SIGN THIS STATEMENT IN PRESENCE OF NOTARY, PUBLIC.

CHREEN A CLEATHER A "I hereby declare under penalty of perjury under the Jaws of the State of California that the foregoing in SHME - day of -- Jasone attachments are frue and correct." HUERBACH (ANER) Signed and sworn to before me this

5000 Revisional Revision of Notary Public ... Address _____

named above and that the has carefully read this form and that it DIDECTUR GENERAL IN SERV. ESC. being duly sworn, says he is/was the dean or registrar for the sit My commission expires

SAN SAN

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074-100g5A (REV. 7/91)

statements made herein ore strictly true in every respect.

(distrar (Write FULL Name)

Signature of Dear

05-14-94

LIC. MARIO A. LIZANRACA

STATE OF CAUFORNIA—STATE AND CONSUMER SERVICES AGENCY



MEDICAL BOARD OF CALIFORNIA

1426 HOWE AVENUE SUITE SA SACRAMEN



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

	S Signature Signature S Disease S S S S S S S S S S S S S S S S S S S						
Dates of Altendance Wee	130	9-7-79 to 10-19-79	10-22-79 7 Eo 12-7-79	$\frac{2-1-80}{10}$	3-2-80 4 to 3-31-80	4-1-80 80 to 5-30-80	
Focility Nome and Address	UNIV. HOSPITAL	ST. VINCENT'S HOSPITAL MEDICAL CENTER OF RICHMOND; 355 BARD AVE., SI, NY	LONG ISLAND COLLEGE HOSPITAL 340 HENRY STREET, BROOKLYN, NY	CONEY ISLAND HOSPITAL 2601 OCEAN PARKWAY; BROOKLYN, NY	BROOKDALE HOSPITAL MEDICAL CENTER LINDEN BLVD. AT BROOKDALE PLAZA RROOKLYN NY	ENT'S HOSPITAL MEDICAL CENTER OND, 355 BARD AVE., SI, NY	
Type*	~	ᅄ	[E]	EI EI	ш	Ω¢	
Clinical Area	OBSTETRICS & GYNECOLOGY	PEDIATRICS 2.	OBSTETRICS & GYNECOLOGY	INTERNAL MEDICINE	GENERAL SURGERY 5.	UROLOGY 6.	7.

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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 int

ABLER) all gettinetts are true and correct." HILE BACH!

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P. In Address 2

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- being duly sworn, says. - bo is/was the dean or tagistra. for the and that the statements made herein are strictly true in every ruspect. student named above and that he has carefully read this form

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Consumer Affairs

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OF CALIFORNIA

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CERTIFICATE OF ALMANDAL TRAINING
Complete one certificate for each clerkship, Alma Living participation or facility program director.

ONLY ROTATIONS IN WHICH THE APPLICANT PARTICIPATED IN DIRECT, HANDSON 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 SATISFI CLINICAL TRAINING REQUIREMENTS.

	This is to certify that SAMUEL AUERBACH , a
	Universidad del Noreste.
	clerkship offered by St. Vincent's Med. Ctr. of Richmond 355 Bard Ave., SI, NY 10310
	사용하다 한 경우 이 경우
	from April 1, 1980 thru May 30, 1980 in the clinical area of DATE SUCCERY Urology , That the above named student successfully completed this
	SURGERY/Urology That the above named student successfully completed this
	clerkship on DATE
	DENNIS A. BLOOMFIELD, MD being duly sworn, says _he be/was the
	individual instructor or program director for the student named above during the clerkship indicated and thathe has carefully read and completed this form and that the statements made herein are strictly true in every respect.
This facility	is affiliated with a U.S. or foreign medical school. This facility M does have an ACGME-accredited residency in the areas of:
Name of U.S.	or foreign medical school if affiliated: NEW YORK MEDKAL does not have an ACGME-accredited resid
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	PHONE NUMBER 718-876-2429 COMPANY SIGNATURE OF SERVICE PROCEDED AND RECTOR AN
	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 SEA1 ADDRESS
*	SEAL ADDRESS My commission expires
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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

STATE OF CAL	CRNIA—STATE AND CONSUMER SERVICE & GENCY
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	This is to certify that SAMUEL AUERBACH
	Student of UNIVERSIDAD DEL Noreste
	MBCAL SCHOOL , participated in a
	clerkship offered by Brookdale Hosp. Med. Ctr.; Linden Blvd. at Brookdale Plaza
	Bklyn, N.Y. 11212-3198
	from March 1, 19 80 thru march 31, 19 80 in the clinical area of
	Reference to the Control of the Cont
	General Surgery CUNCAL AREA That the above named student successfully completed this
	clerkship on March 31, 1980
	OATE
	being duly sworn, says he 53/was the
	individual instructor or program director for the student named above during the clerkship indicated and that the has carefully read and completed this form and that the statements made herein are strictly true in every respect.
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	is affiliated with a U.S. or foreign medical school. This facility a does have an ACGME-accredited residency program in the areas of: Sukect
ome of U.S. o	r foreign medical school if affiliated: does not have an ACGME-accredited residency of
	Alvin I. Kahn, MD., F.A.C.P.
OFFICIAL	Type or print, make of instruction or facility program director The Brookdale HOspital Medical Center
HOSPITAL	Address Number and Street
SEAL	Linden Blvd., Brooklyn, New York 11212
	PHONE NUMBER (718) 240-5721 Why Hall
	PHONE NUMBER 1101240-3721 SIGNATURE OF INSTRUCTOR/FACILITY PROGRAM DIRECTOR
	NOTE: IN ABSENCE OF OFFICIAL HOSPITAL SEAL, THE INSTRUCTOR OR PROGRAM

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,

NOTARY SEAL ADDRESS

My commission expires

NOTE: This form may be amitted 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.

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EMBOICAL BOARD OF CALIFORNIA PENUE, SUITE 54, SACRAMENTO, CALIFORNIA PSOTA PETE

(916) 920-5411

OF CALIFORNIA
94 JUN 30 CERTIFICATE OF CLINICAL TRAINING 28 PM 2: 54
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		This is to certify that SAMUBLI AUERBACH
		student of Universidad del Noreste
		MOCAL SCHOOL , participated in a
		clorkship offered by Long Island College Hospital; 340 Henry St.; Bklyn, NY 11201
		NAME AND ADDRESS OF FACRITY
		from October 22 19 79 December 7 19 79 in the clinical area of
		Obstetrics & Gynecology
		clerkship on
		SHELDON H. PUTTERMAN HI) being duly sworn, says _he (is/was the
in Williams		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.
	facility 🖔	affiliated with a U.S. or foreign medical school.
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	OFFICIA	
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	SEAL	340 HENRY ST. BIKLYNY 16201
		PHONE NUMBER 718/780 1245° South Sel fratter W
		NOTE: IN ABSENCE OF OFFICIAL HOSPITAL SEAL, THE INSTRUCTOR OR PROGRAM
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	藝	Signed and sworn to before me this day of
		NOTARY PUBLIC
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This form may be amitted 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.



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

SACRAMENTO MEDICALIFORNIA 94 JUN 20 PM 34 84



CERTIFICATE OF CLINICAL TRAINING

Complete one confilicate 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 HAME Universidad del Noreste
1 July 1	Merical school, porticipated in a, participated in a
	September 7, 1979 thru October 19, 1979 in the clinical area of Pediatrics
	CINICAL AREA
This facility [2]	ndividual instructor or program director for the student named above during the clerkship indicated and that She has arefully read and completed this form and that the statements made herein are strictly true in every respect.
	Is affiliated with a U.S. or foreign medical school. Is not affiliated with a U.S. or foreign medical school. In the areas of: does not have an ACGME-accredited residency proper in the areas of: does not have an ACGME-accredited residency proper in the areas of: does not have an ACGME-accredited residency proper in the areas of: does not have an ACGME-accredited residency proper in the areas of: does not have an ACGME-accredited residency proper in the areas of: does not have an ACGME-accredited residency proper in the areas of: does not have an ACGME-accredited residency proper in the areas of: does not have an ACGME-accredited residency proper in the areas of: does not have an ACGME-accredited residency proper in the areas of: does not have an ACGME-accredited residency proper in the areas of: does not have an ACGME-accredited residency proper in the areas of: does not have an ACGME-accredited residency proper in the areas of: does not have an ACGME-accredited residency proper in the areas of: does not have an ACGME-accredited residency proper in the areas of: does not have an ACGME-accredited residency proper in the areas of: does not have an ACGME-accredited residency proper in the areas of: does not have an ACGME-accredited residency proper in the areas of: does not have an ACGME-accredited residency proper in the areas of: does not have an ACGME-accredited residency proper in the areas of: does not have an ACGME-accredited residency proper in the areas of: does not have an ACGME-accredited residency proper in the areas of: does not have an ACGME-accredited residency proper in the areas of: does not have an ACGME-accredited residency proper in the areas of: does not have an ACGME-accredited residency proper in the areas of: does not have an ACGME-accredited residency proper in the areas of: does not have an ACGME-accredited residency proper in the areas of: does not have an ACGME-accredited residency proper in the areas of: does not have an ACGME-a
OFFICIAL HOSPITAL SEAL	TYPE OF PRINT, NAME OF INSTRUCTOR OF FACILITY PROGRAM DIRECTOR 355 BARD AVENUE Address: Number and Street STATEN ISLAND NEW YORK 10310
	PHONE NUMBER (718)876-4638 WELLEW CONSTRUCTOR/JACUF MOGRAM/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
	NOTARY SEAL ADDRESS Case Macalica ROSE O. MACALISO NOTARY Generalisoner of Deedi Chy of New York No. 5-580
	My commission expires Commission Expires Jon. 1,19.23

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.



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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.

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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.





BOARD OF MEDICAL BOARD OF CALIFORNIA FIECE VED BOARD OF MEDICAL SAME AVENUE, SUITE 34, SACRAMENTO, CALIFORNIA 95825-3234 CRAMENTO (916) 920-6411 MEDICAL BOARD GLI JUN 30 AM 9: 16 UF CALIFORNIA



Complete And Shift Edic 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.

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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 certilies the Junior and Senior Year Clinical Rotations forms.



BOARD OF CALIFORNIA SUITE S4, SACRAMENTO, CALIFORNIA 95025-3234 (916) 920-4411

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Complete one certificate for each LERAPIN for all by the Instructor or facility program director.

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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.



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A CELLONIAN CONTRACT	SACRAMENTO MEDICAL BOARD OF CALIFORNIA SIMILATE OF MEDICAL BOARD OF CALIFORNIA 95825-3236 SACRAMENTO, CALIFORNIA 95825-3236 SACRAMENTO, CALIFORNIA 95825-3236 SACRAMENTO OF CALIFORNIA 95825-3236 SACRAMENTO OF CALIFORNIA 95825-3236 SACRAMENTO OF CALIFORNIA OF CALIFORNIA OF CALIFORNIA OF CALIFORNIA OF CALIFORNIA OF CALIFORNIA 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.
	Student of Universidad del Noreste
	clerkship offered by Lutheran Medical Center; 150 55th St.; Bklyn, NY 11220
	HAME AND ADDRESS OF FACILITY
	from October 2, 19 78 thru October 31, 19 78 in the clinical area of
	Cardiology CINNCAL AREA . That the above named student successfully completed this
大 優	clerkship on October 31, 19.78
	17
	ACCOUNT OF THE PROPERTY OF THE
	Anthony Caccese, M.D.
	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 start.
**	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.
facility X	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. In affiliated with a U.S. or foreign medical school.
focility X	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. In affiliated with a U.S. or foreign medical school.
focility X	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. In this facility of does have an ACGME-accredited residency in the areas of: Nadicine, Oblition of the program of the areas of: Nadicine, Oblition of the program.
facility \(\oldsymbol{\text{S}} \) o of U.S. o OFFICIAL	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. In this facility of does have an ACGME-accredited residency in the areas of: Neglicine, Oblition of the areas of: Neglicine, Oblition of the areas of the ar
facility 🗽	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. In this facility of does have an ACGME-accredited residency in the areas of: Neglicine, Oblitum, of the areas of: Neglicine, of the areas of:
focility X ne of U.S. o OFFICIAL HOSPITAL	Anthony Caccese, M.D. 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. In this facility of does have an ACGME-accredited residency in the areas of: In the
focility X ne of U.S. o OFFICIAL HOSPITAL	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. In this facility of does have an ACGME-accredited residency in the areas of: Neglicity, Obj. byn. In the areas of: Neglicity, Obj. byn. Froreign medical school if affiliated: Swy. Heatth
focility X ne of U.S. o OFFICIAL HOSPITAL	Anthony Caccese, M.D. 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. In this facility of does have an ACGME-accredited residency in the areas of: In the
focility A	Anthony Caccese, M.D. 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. is affiliated with a U.S. or foreign medical school. is not affiliated with a U.S. or foreign medical school. if the areas of: Inaglicing Oblition of the statements made herein are strictly true in every respect. This facility does have an ACGME-accredited residency in the areas of: Inaglicing Oblition of the
focility See of U.S. o OFFICIAL HOSPITAL SEAL	Anthony Caccese, M.D. individual instructor or pragram 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. It is facility of does have an ACGME-accredited residency in the areas of: Inaducing, Obliving in the areas of: Inaducing, Obliving in the areas of: Inaducing, Obliving and the areas of: Inaducing, Obliving areas. Anthony Caccese, m.D. Director of Medicine The on friend Number and Street Lutheran Medical Center Address: Number and Street 150 55th Street, Brooklyn, New York, 11220 Chy Stony Stony PHONE NUMBER 718-630-7350 SIGNATURE OF HISTRYCTOR OR PROGRAM DIRECTOR MUST SIGN THE FORM IN THE PRESENCE OF A NOTARY PUBLIC WHO AFFIXES HIS OFFICIAL NOTARY SEAL,
focility A	Anthony Caccese, M.D. 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. is affiliated with a U.S. or foreign medical school. is not affiliated with a U.S. or foreign medical school. if the areas of: Inaglicing Oblition of the statements made herein are strictly true in every respect. This facility does have an ACGME-accredited residency in the areas of: Inaglicing Oblition of the

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 certilies the Junior and Senior Year Clinical Rotations forms.





MEDICAL BOARD OF CALIFORNIA

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



CERTIFICATE OF CLINICAL TRAINING

Complete one cartificate 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 of Universidad del Noeste
	clerkship offered by Brookdale Hosp. Ned. Ctr.; Linden Blvd. at Brookdale Plaza
	Bklyn, N.Y. 11212-3198
	from August 1, 19 78 thru September 30, 19 78 in the clinical area of
	General Surgery CUNCAL AREA Clerkship on September 30, 1978
	being duly sworn, says _he is/was the
	individual lastructor 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 🔽	
	r foreign medical school if affiliated: does not have an ACGME-accredited reside scy p
_	Alvin I. Kahn, M.D., F.A.C.P.
OFFICIAL	TYPE OR PRINT, NAME OF INSTRUCTOR OR FACILITY PROGRAM DIRECTOR The Brookdale Hospital Medical Center
HOSPITAI SEAL	Linden Blvd., Brooklyn, New York 11212
	PHONE NUMBER (718) 240-5721 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 PUBLIC
	SEAL ADORESS
	My commission expires

NOTE: This form may be emitted it all clinical training was done in the primary feaching 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.



HENCEL BOARD OF CAUFORNIA CONTROL OF SECONDA CONTRO SHALITY ASSUMENCE OF A PROCESSION



94 JUCERTIFICATES OF CLINICAL TRAINING 94 JUN 30 PH 1:46 Complete one certificate for each classified algered 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 cortify that Samuel Averbach MD
		STUDENT'S NAME
		MEDICAL SCHOOL
	A.	clerkship offered by Manhattan Eye, Ear & Throat Hospital: 210 E. 64th St: NY,NY 10021
		NAME AND ADDRESS OF FACRITY
		from July 3, 19 78 thru July 31, 19 78 in the clinical area of
		Otolaryngology . That the above named student successfully completed this
		Shertishin on July 31
		clerkship on July 31 19.78. Simon C. Parisis InD being duly sworn, says the is/was the individual instructor or program director for the student named above during the clerkship indirected and that the head
		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 f	ocility L	
Name		in the areas of: 24 for your or foreign medical school. in the areas of: 24 for your or foreign medical school if affiliated: Cornell does not have an ACGME-accredited residency are
		Since Control of gram.
	OFFICIAL	Simon C. Priser MB (Current Chroman who reviews of Type OR PRINT, NAME OF INSTRUCTOR OR FACILITY PROGRAM DIRECTOR Dr. Averbach's Life)
	HOSPITAL	210 Esse 64 fr
	SEAL	Address Number and Street Address Number and Street Any 10021 Cry Seet 2200 date
Name of the second		Cay 219 Stode
į.		PHONE NUMBER 2128389200 June C. Janes S. SIGNATURE OF INSTRUCTOR/FACILITY PROGRAM DIRECTOR
A [4]		NOTE: IN ABSENCE OF OFFICIAL HOSPITAL SEAL, THE INSTRUCTOR OR PROGRAM
		DIRECTOR MUST SIGN THE FORM IN THE PRESENCE OF A NOTARY PUBLIC WHO
	素	AFFIXES HIS OFFICIAL NOTARY SEAL.
		Signed and sworn to before me this day of
	#	NOTARY PURIC
: '''	2	SEAL 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.



MEDICAL BOARD OF CALIFORNIA

1426 HOWE AVENUE, SUITE 54, SACRAMENTO, CAUFORNIA, 98825-3236 (916) 920-6411





94 JUL - 7 AM 9: 47

CERTIFICATE OF CLINICAL TRAINING

34 JUL -6 PH 2.5

DIVISION COMPLETE ENSURATION of the control of the

ONLY ROTATIONS IN WHICH THE APPLICANT PARTICIPATED IN DIRECT, HANDSON 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	certify that
student o	Universidad del Noreste , participated in a
	Mocki Good Geney Island Hospital 2601 Ocean Parkway; Bklyn, NY 11236
ctorkship	NAME AND ADDRESS OF FACILITY
from	February 1, 1979 thru June 22, 19 79 in the clinical great of
Int	chal Medicine
	CIRNCAL AREA
clerkship	June 22, 19 79
	A DATE OF THE PROPERTY OF THE
individua	being duly sworn, says _he is/was the instructor or program director for the student named above during the clerkship indicated and that _he has
	ead and completed this form and that the statements made herein are strictly true in every respect.
This facility 🏋 is	This facility KEX does have an ACGME-accredited residency progr
is not	filiated with a U.S. or foreign medical school. in the areas of:
Name of U.S. or foreign DOWNSTATE - SI	nedical school if affiliated: does not have an ACGME-accredited residency p
DOWNSTATE - St	Sandor A. Friedman, M.D.
OFFICIAL	TYPE OR PRINT, HAME OF INSTRUCTOR OR FACILITY PROGRAM DIRECTOR
HOSPITAL (2601 Ocean Parkway
SEAL	Brooklyn, New York 11235
	City State 24 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 a	d sworm to before me this a day of
	Maron Walder
	OTARY ABURESS ADDRESS ADDRESS ADDRESS NOTARY Public, State of New York
or a light of the state of the	My commission expires No. 24-4869581 Qualified in Kings County Commission Expires Nov. 24, 1994
	Commission Evolve New Oa 16004

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 certilies the Junior and Senior Year Clinical Rotations forms.

This facility 🛣 is is no Name of U.S. or fore	T .	.S. or foreign medical school.	This facility XX does have an ACGME action the areas of:
downstaté -		Sandor A. Friedman, M.	gram. D
OFFICIAL HOSPITAL		Type on Print, Name of Instructor of 2601 Ocean Parkway	OR FACILITY PROGRAM DIRECTOR
SEAL		Address: Number Brooklyn, New York	and Sever 11235
	PHONE, NUMBER		LATURE OF INSTRUCTOR/FACRITY PROGRAM DIRECTOR
	NOTE: IN	ABSENCE OF OFFICIAL HOSPITA	L 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 🖂

NOTARY Si.At.

SHARON WALDER Notary Public, State of New York No. 24.4869581 Qualified in Kings County

My commission expires.

Commission Expires Nov. 24.
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 l the same country as the medical school and the medical school completes and certifies the Junior and Senior Year Clinical Potations forms.

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 USA and its territories, military court or a foreign country? SUMMARY OF RENEWAL FEES OWED FINANCIAL INTEREST STATEMENT **Health Facility Name** Address 808.00 2009 Renewal Fee Delinquent Fee Penalty Fee \$808.00 TOTAL FEES: MEDICAL BOARD OF CALIFORNIA LICENSE RENEWAL PHYSICIAN AND SURGEON APPLICATION D. CONTINUING MEDICAL EDUCATION (CME) CERTIFICATION STATEMENT. I CERTIFY UNDER PENALTY OF PERJURY UNDER THE LAWS OF CALIFORNIA TO THE FOLLOWING STATEMENT: P. YES I WISH'T PHYSICIAN TRAINING PRO CONTRIBUTE \$25 FOR THE FAMILY 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 WOUND EXEMPT ME FROM ALL) OR PART OF THE REQUIREMENTS OR I HOLD A PERMANENT CME WAIVER. YES I WISH TO CONTRIBUTE 150 FOR THE S.M. LOAN REPAYMENT PROGRAM H. YES I W THOMPSON LOAN R Signature required deling fee if FOR ADDRESS CHANGE ONLY LICENSE NO. EXPIRES **FEE OWED** POSTMARKED IF YOUR ADDRESS SHOWN IS INCORRECT, CORRECT IT A 53310 8/31/09 AFTER MOHAWK STREET LAS **TOTAL ENGLOSED** PHONE NUMBER (G. FINANCIAL INTEREST STATEMENT Dr. SAMUEL LOUIS AUERBACH I CERTIFY UNDER PENALTY OF PERJURY THAY 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 PO BOX 090365 **BROOKLYN, NY 11209** DISCLOSE.

Signature required

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

540734 Person Id:

Name:

Auerbach, Samuel

Question		Answer	
I Have Completed Cme And Can Docume Year Period Immediately Preceding The E Which Would Exempt Me From All Or Part	expiration Date Of My License. Or I to The Requirements.		YES
I Have Completed 12 Hours Of Pain Mana	gement And End-Of-Life Care.		YES
I Am Exempt From The Completion Of 12 Continuing Education Requirement Becau	Hours Of Pain Management And E se I Am A Radiologist Or Pathologi	nd-Of-Life Care st,	NO
Only For General Internists And Family Pr Years Or Older: I Have Completed At Lea Care Of Older Patients. Click No If Not Ap	nysicians Who Have 25% Of Their F ast 20% Of The Required Cme In G	Patient Population Aged 65	NO
Enter Name/Address Of Facility Where Yo "None", If None Held.		Financial Interest. Type	NONE
I Certify Under Penalty Of Perjury Under T Contained in This Application is True And		That The Information	YES
I Have Read My Profile On The Medical B Information Contained Therein As Current	oard Web Site At Www.Mbc.Ca.Go	v And Acknowledge The	YES
Since You Last Renewed Your License, H Agency Or Other Disciplinary Body; Or, H A And Its Territories, Military Court Or A F	lave You Had Any License Disciplin ave You Been Convicted Of Any Cr	ed By A Government ime In Any State, The U S	NO NO
Total Overstians Asked For Borgon	540734	8	

540734

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 I Have Completed Cme And Can Document Not Less Than 50 Hours Of Approved Cme For The Two-Year Period Immediately Preceding The Expiration Date Of My License. Or I Meet The Conditions Which Would Exempt Me From All Or Part Of The Requirements. I Have Completed 12 Hours Of Pain Management And End-Of-Life Care. I Am Exempt From The Completion Of 12 Hours Of Pain Management And End-Of-Life Care

Answer

YES NO

YES

NO

NONE

YES

YES

NO

Continuing Education Requirement Because I Am A Radiologist Or Pathologist.

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

Enter Name/Address Of Facility Where You Or Your Immediate Family Hold Financial Interest. Type "None", If None Held. I Certify Under Penalty Of Perjury Under The Laws Of The State Of California That The Information

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

Since You Last Renewed Your License, Have You Had Any License Disciplined By A Government Agency Or Other Disciplinary Body: Or, Have You Been Convicted Of Any Crime in Any State, The U.S. A And its Territories, Military Court Or A Foreign Country?

Total Questions Asked For Person: