COPY

Dunny M. Clark, M.D.
President

Telephone (502) 429-8046
Fax (502) 429-9923

KENTUCKY BOARD OF MEDICAL LICENSURE

Hurstbourne Office Park
310 Whittington Parkway, Suite 1B
Louisville, Kentucky 40222

To: Samuel L. Auerbach, M.D.

Date: March 26, 2001

This is to advise you that your application for medical licensure in Kentucky was incomplete by the Board deadline, therefore, it will not be presented to the Kentucky Board of Medical Licensure at its March 22, 2001 meeting. Your application will be presented at the next regularly scheduled meeting on June 28, 2001 **provided we receive the following items by June 8, 2001:**

__X__ Form 1 – Verification of Medical Education

__X__ Form 2 – Verification of Postgraduate Training

__X__ Form 3 – Verification of Licensure

__X__ Form 4 & 4A – Hospital Affiliations List & Hospital Affiliations

__X__ Form 5 – Reference Letters

__X__ Exam Score Report (FLEX,NBME,NBOME,USMLE,LMCC,State)

__X__ Explanation Letter-Gap of Time 10-91 to 6-93

__X__ HIV/AIDS Education Requirement

__X__ Form 6 - Waiver

__X__ National Practitioner Data Bank

__X__ Other-5th Pathway – Suny Buffalo needs to complete Form 1-Verification of Medical Education
Please Provide your DEA #

The above forms can be downloaded from our web site at: www.state.ky.us/agencies/kbml/index.htm

If you no longer desire licensure in the state, please contact this office so that we may remove your application from our files. ***Please be advised that your incomplete application will remain in this office for one year. After one year, all incomplete files are destroyed.*** **NO faxes** will be acknowledged. If you have any questions regarding the above, please contact this office between 8:00 am and 12:30 pm EST.

EDUCATION PAYS

Kentucky Boar I of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, KY 40222

RECEIVED
DEC 06 2000
K.B.M.L.

Journal 58
$250

Application for License to Practice Medicine/Osteopathy by Endorsement

NOTE: Application must be legible and fully completed with all requested information and documentation supplied. **Initial licensure fee of $250.00 must accompany application. This fee is non-refundable.**

1. Name in Full:
SAMUEL (first) LOUIS (middle) AUERBACH (last) MD (degree)

2. Address1:Practice address in Kentucky(If known):
Street: UNKNOWN AT PRESENT
City, State: _____ Zipcode: _____

3. Address 2: Mailing address (**All correspondence regarding application will be sent to this address**):
Street: 18615 BURBANK BLVD
City, State: TARZANA, CA Zipcode: 91356

4. Social Security Number: 128-48-7731
5. Work#: ( ) 818-609-9070
6. Home#: ( ) 805-953-5848

7. Date of Birth: 8-30-55
8. Birthplace BROOKLYN, NY

9. Have you ever applied for or been issued a Kentucky medical license? ☐ Yes ☐ No If Yes, # _____

10. Specify reason for requiring medical licensure in Kentucky: JOB OPPORTUNITY

11. Specialty: GYN/OB + INT. MED American Specialty Board Certification: _____

12. Specify your type of practice: (check one)

☐ Hospital Base	☐ Occupational Medicine	☐ Instructor	☐ Military
☐ Admin. Medicine	☐ Research	☐ Resident/Fellow	☐ Emergency Medicine
☑ Private Practice	☐ Inactive/Semi-Retired	☐ Locum Tenens	

13. Indicate your ECFMG number:(International Medical Graduates only) 312-430-2

14. List the name, location and dates of attendance of every college and medical/osteopathic school you have attended:

Name	Location	Dates (From-To)	Degree
NYU	NYC, NY	9-72 to 6-76	BA
UNIV. DEL NORESTE	TAMPICO TAMPS MEXICO	8-76 to 6-80	MD

15. In what state or Canadian province did you receive your **original license** to practice medicine/osteopathy?

State/Province	License #	Date of Issuance	Current? Yes/No
NEW YORK	191774	3-23-93	YES

16. List all other states and Canadian provinces where you **currently hold or ever held** any type of medical/osteopathic license:

State/Province	Type	License #	Date of Issuance	Current? Yes/No
CALIFORNIA	MD	A053310	7-27-94	Yes
NEVADA	MD	7617	11-22-95	Yes
NEWJERSEY	MD	MA65075	12-2-96	Yes

17. List all internship, residency and fellowship programs you have completed since medical/osteopathic school graduation: *(Please list in chronological order)*

INTERNSHIP: (List US and Canadian only) PLEASE SEE ADDENDUM #1

Hospital: _____ City, State: _____

Specialty: _____ To – From: _____

RESIDENCY: (List US and Canadian only)

Hospital: _____ City, State: _____

Specialty: _____ To – From: _____

RESIDENCY: (List US and Canadian only)

Hospital: _____ City, State: _____

Specialty: _____ To – From: _____

18. *In chronological order*, list all locations where you have practiced medicine/osteopathy since obtaining your original licensure. Also list and explain dates of all extended absence periods. **Please attach additional sheets if necessary.**

Location, City, State	Type of Activity	Dates (From-To)
PLEASE SEE ADDENDUM #2		

19. Indicate which licensing examination(s) you have taken. Include all attempts, locations, scores, and dates. Be exact, including all attempts and failures.

Type (FLEX,NBME,USMLE,LMCC,etc)	Location	Score	Date
FLEX	NEW YORK	PART II (x2) 75	12-90
FLEX	NEW YORK	PART I (x4) 75	12-92

POST-GRADUATE MEDICAL TRAINING

9/19/94 - 9/18/95	Preceptorship (Fellowship), Breast Disease Melvin Silverstien, M.D., Medical Director/ Van Nuys, California
7/1/93 - 6/30/94	Fellowship. Advanced Pelvic, Gynecologic & Oncologic Surgery S.U.N.Y. at Buffalo, Hospital Corsortium
7/89 - 9/91	Resident, Obstetrics & Gyencology University of Southern Alabama Medical Center Mobile, Alabama
8/88 - 6/89	Resident, Obstetrics & Gynecology Lutheran Medical Center Brooklyn, New York
7/87 - 6/88	Resident, Obstetrics &Gynecology Albany Medical Center Albany, New York
7/86 - 6/87	Resident, Obstetrics & Gynecology S.U.N.Y. at Syracuse, New York Johnson City, New York
7/85 - 6/86	Resident, Internal Medicine Mount Sinai Hospital Bronx VA Medical Center New York, New York
7/84 - 6/85	Resident, Internal Medicine Millard Fillmore Hospital Buffalo, New York

MEDICAL EDUCATION

7/83 - 6/84	Fifth Pathway Program S.U.N.Y. - Buffalo
8/76 - 6/80	Universidad Del Noreste Tampico, Mexico M.D. Degree

37003 — 3-21-02

License # — Date Issued

TP # — Date Issued

AUERBACH, Samuel L. — 08-30-55 — Brooklyn NY

Name — DOB — NAT

18615 Burbank Blvd.
Tarzana, CA 91356

Address

Suny Buffalo (03106) - 1984
~~Univ Del Noreste, Mexico (07905)-1980~~

Medical School, Year Graduated

NY — OBG — 4

Endorsed — Specialty — Status

1/8/01 — 128-48-7731

Acknowledged — SS#

$250 #585 12/6/00

Fees paid — Fees Paid

TP Approved

Board Approved 3-21-02

IBL Mar/June/Sept/Dec 3/26/01 7-10-01

BL Mar/June/Sept/Dec 12-5-01

Samuel Auerbach

Authorized Persons

To Complete Application:

Form 1- Medical Education – ~~school~~ Suny Buffalo, ~~Univ Del Noreste, Mexico~~
Form 2 – Postgraduate Training
Form 3 – Licensure Verification ~~NY~~, CA, ~~NY~~, ~~NJ~~, ~~AL~~
Form 4A- Hospital Affiliations # ~~2~~ 1
Form 4 – Hospital Affiliations List
Form 5 – References ~~1~~ 2
Form 6 – Waiver
AMA
Form 7 – DEA # BA6319289
Form 8 – Federation
National Practitioner Data Bank
USMLE/FLEX/NBME/NBOME/LMCC/State Board Exam _____
Photograph
~~ECFMG~~
5th Pathway - Suny Buffalo
AIDS Affidavit Signed _____
AIDS Course Completed _____

Temporary Permit Information

Location: _____

_____

_____

Start Date: _____

Mail To : _____

_____

3/21/02

Samuel Auerbach

Authorized Persons

To Complete Application: ~~school~~ Suny Buffalo
New Del Norte, Mexico

Form 1- Medical Education –
Form 2 – Postgraduate Training
Form 3 – Licensure Verification ~~HI, CA, NV, NJ~~ ~~AL~~
Form 4A- Hospital Affiliations # ~~2~~ 1
Form 4 – Hospital Affiliations List
Form 5 – References ~~1~~ 2
Form 6 – Waiver
AMA
Form 7 – DEA # BA6319289
Form 8 – Federation
National Practitioner Data Bank
USMLE/FLEX/NBME/NBOME/LMCC/State Board Exam _____
Photograph
~~ECFMG~~
5th Pathway - Suny Buffalo
AIDS Affidavit Signed _____
AIDS Course Completed _____

Time Gap
10-91 - 6-93
✓ ltr from phys.
Vitro Okla
10-95 - 3-96
vacation
7-80 - 6-83
family members limits

Temporary Permit Information

Location: _____

_____

_____

Start Date: _____

Mail To : _____

_____

Tampico, Tamaulipas, Augst 30, 2001

KENTUCKY BOARD OF MEDICAL LICENSURE
310 WHITTINGTON PARKWAY; SUITE 1B
LOUISVILLE, KENTUCKY
40222

In reference to your letter in which you requested us to give information about the studies of MR. AUERBACH ADLER SAMUEL LOUIS, with Identification Number:**100632**, his studies took place in our Institution, but we are sorry to inform you that he is in debt with this University and we are not able to send you this certification.

So I really appreciate if you can send us the update address of MR. AUERBCH, to inform him about this situation

Any further information or comments please contact with our office or to the following telephone numbers (12) 28-11-56, 28-11-38, or by mail to P.O. BOX 130, Mc Allen, Texas 78505-0130.

Very truly yours,
"POR MI PATRIA, CIENCIA Y PROGRESO"

LIC. MARIO A. LIZARRAGA BOLIO
DIRECTOR GENERAL DE SERVICIOS ESCOLARES

ml.
DEUDA.DOC

E-MAIL: escolar@une.edu.mx

UNIVERSIDAD DEL NORESTE

DIRECCION GENERAL DE SERVICIOS ESCOLARES
(AUTORIZACION GOBIERNO DEL ESTADO DECRETO 359 DE DICIEMBRE 14 1977)

RECEIVED
OCT 0 1 2001
K.B.M.L.

Tampico, Tamaulipas a 30 de Agosto del 2001

KENTUCKY BOARD OF MEDICAL LICENSURE
310 WHITTINGTON PARKWAY; SUITE 1B
LOUISVILLE, KENTUCKY
40222

En respuesta a su atenta carta en la cual solicita una certificación de los estudios que realizó en nuestra Institución el alumno: AUERBACH ADLER SAMUEL LOUIS , con clave No. **100632**, nos permitimos informarle que no será posible enviarle la certificación solicitada, ya que el alumno tiene un adeudo con esta Universidad.

Por lo que le agradeceré que si ustedes tienen la dirección actual del Sr. AUERBACH, nos la hagan saber lo antes posible para hacerle sabar tal situación.

Para cualquier aclaración o comentario al respecto, estamos a sus órdenes en nuestras oficinas, o en el teléfono y fax (12)228-11-56, 228-11-38, Ext. 1106, o puede escribirnos al P.O. BOX 130 McAllen, Texas 78505-0130, USA.

ATENTAMENTE
"POR MI PATRIA, CIENCIA Y PROGRESO"

LIC. MARIO A. LIZARRAGA BOLIO
DIRECTOR GENERAL DE SERVICIOS ESCOLARES

DIRECCION GENERAL DE
SERVICIOS ESCOLARES

E-MAIL: escolar@une.edu.mx

PROL. AV. HIDALGO No. 63 3, COL. NUEVO AEROPUERTO, APDO POSTAL 184 ó 469 TELS./FAX: 228-11-56, 228-11-38 EXT. 106 TAMPICO, TAM. MEXICO

SAMUEL AUERBACH, M.D.
19615 Burbank Blvd., Suite 214
Tarzana, California 91356
(800) 821-2399 (beeper)
(818) 609-9070

11-25-00

Please Note:

Addendum # 2 Will follow shortly

Thanks

Samuel Auerbach MD

SAMUEL AUERBACH

[Category I]

Please answer all questions on this application. Category I will help the Board determine if you meet the essential eligibility requirements for licensure by virtue of your background, education, training and experience. If you are qualified to practice under Category I, Category II will be reviewed to help the Board determine if you are qualified to practice safely and competently, with or without reasonable modification.

If you answer "Yes" to any of the questions, you must attach a complete written explanation of the event(s) or condition(s), including dates, names, addresses, circumstances, and results along with your returned application.

NOTE: Intentional false answers or misrepresentation in applying for or procuring a license, registration or reactivation in Kentucky are grounds for disciplinary action, including denial or revocation of license, and are reported to the National Practitioner Data Bank and/or appropriate national professional credentialing organization.

1. Have you ever been dismissed from, resigned while under investigation or failed to complete an academic year at a medical school or a postgraduate training program?
   ☐ Yes ☑ No
2. Have you ever been denied a license or denied the privilege of taking a licensure examination by any State, Federal or International licensure jurisdiction?
   ☐ Yes ☑ No
3. Have you ever had any license, certificate, registration or other privilege to practice as a health care profession denied, revoked, suspended, or restricted by a State, Federal, or International authority, or have you ever surrendered such credential to avoid or in connection with action by such jurisdiction?
   ☐ Yes ☑ No
4. Has any hospital, hospital medical staff or any other health care entity ever revoked, suspended, restricted, limited, reprimanded, placed on probation or otherwise disciplined your staff privileges?
   ☐ Yes ☑ No
5. Have you ever resigned your privileges or failed to renew privileges at a licensed hospital or from the medical staff of the hospital, while under investigation or while you were subject to disciplinary proceedings by the hospital?
   ☐ Yes ☑ No
6. Have you ever been removed, suspended, expelled or disciplined by any professional medical association or society?
   ☐ Yes ☑ No
7. Has the Drug Enforcement Administration or any other state or International drug licensure/enforcement authority ever denied, revoked, suspended, restricted, limited, or otherwise disciplined a controlled substance registration certificate issued to you?
   ☐ Yes ☑ No
8. Have you ever voluntarily or involuntarily surrendered a medical or osteopathic license, or controlled substance registration certificate issued to you?
   ☐ Yes ☑ No

RECEIVED
DEC 0 6 2000
K.B.M.L.

9. Have you ever been or are you currently under investigation by any State, Federal or International licensure authority or any drug licensure/enforcement authority?
☐ Yes ☑ No

10. Are any legal proceedings regarding licensure presently pending against you by any State, Federal or International licensure authority or any drug licensure/enforcement authority?
☐ Yes ☑ No

11. Have you ever been convicted of a felony or misdemeanor by any State, Federal or International court? Are any criminal charges presently pending against you in any of those courts?
☐ Yes ☑ No

12. To your knowledge, are you the subject of an investigation for a criminal act?
☐ Yes ☑ No

13. Have you ever had to pay a judgement in a malpractice action or other civil action against your medical practice or are any malpractice or other civil actions against your medical practice presently pending in any court? **(If yes, see enclosed Medical Malpractice Form)**
☐ Yes ☑ No

*****Affidavit of Applicant*****

I hereby state that the information contained in this application is true, accurate, and complete to the best of my knowledge and belief. I understand that under Kentucky law the submission of any false, fraudulent or forged statement, document or other matter in connection with this application is grounds for criminal prosecution and the denial of licensure. I authorize the Board (KBML) or its agents to obtain from other sources any information necessary for determining my qualifications for licensure. I also authorize them to furnish any information they may now or in the future have concerning my qualifications and fitness to practice medicine/osteopathy to any person, institution, association, school, hospital or government entity.

Samuel Louis Auerbach
(Signature of Applicant)

Subscribed and sworn to before me by Samuel Auerbach this 1st day of December, 2000
(month,year)

Sheryl S. Baca
(Signature of Notary)

My commission expires: Aug. 30, 2002

Seal of Notary

SHERYL S. BACA
Commission # 1194978
Notary Public - California
Los Angeles County
My Comm. Expires Aug 30, 2002

"Only the applicant and person authorized by applicant may call regarding th[redacted]ation or be given information during the credentialing process."
Specify name of authorized person: SAMUEL LOUIS AUERBACH

RECEIVED
DEC 06 2000
K.B.M.L.

[Category II]

The answers to these questions are exempt from public disclosure under KRS 61.878(1)(a) and (l) and KRS 311.619 and shall be subject to inspection only upon order of a court of competent jurisdiction, except that no court shall authorize the inspection by any party of any materials pertaining to civil litigation beyond that which is provided by the Kentucky Rules of Civil Procedure governing pretrial discovery. The answers to these questions may be considered by the Board (KBML) and may be disclosed in any contested case proceeding, including a Show Cause proceeding, or appeal of a licensing decision based upon them.
If applicable, these questions should be read to include the clause, "Other than what is known already to the Kentucky Physicians Health Foundation – Impaired Physician Program..."
"Illegal drug use" means the use of an illegally obtained controlled substance or dangerous drug; the term "illegal drug use" also means the use of a legally obtained controlled substance or dangerous drug which is not taken in accordance with the direction of the licensed health care professional who prescribed the controlled substance or dangerous drug.

1. Do you currently, or have you had within the past 5 years, any physical, mental, or emotional condition which impaired, or might reasonably impair your ability to practice your health care profession safely and competently?
   ☐ Yes ☑ No
2. Within the past 5 years, have you been admitted to any hospital or other in-patient care facility for any physical, mental or emotional condition which impaired, or might reasonably be considered to impair, your ability to practice your health care profession safely and competently?
   ☐ Yes ☑ No
3. Do you currently have, or have you had within the past 5 years, a dependency on or abuse of the use of alcohol or drugs, which impaired, or might reasonably impair, your ability to practice your health care profession safely and competently?
   ☐ Yes ☑ No
4. Within the past 5 years, have you engaged in the excessive use of alcohol or illegal drugs, or received any in-patient or outpatient or individual therapy/treatment or been hospitalized for alcoholism, or illegal use, or been arrested for a DUI (Driving Under The Influence)?
   ☐ Yes ☑ No
5. Within the past 5 years, have you been the subject of any chemical substance screening test which resulted in an indication of the presence in your body of any controlled substance, any dangerous drug, or alcohol level above .10% BAC? (This does not include those drugs taken by you as a result of a legitimate health care diagnosis, and prescribed for you in good faith by another licensed health care professional.)
   ☐ Yes ☑ No

Affidavit of Applicant

I hereby state that the information contained in this application is true, accurate, and complete to the best of my knowledge and belief. I understand that under Kentucky law the submission of any false, fraudulent or forged statement, document or other matter in connection with this application is grounds for criminal prosecution and the denial of licensure. I authorize the Board (KBML) or its agents to obtain from other sources any information necessary for determining my qualifications for licensure. I also authorize them to furnish any information they may now or in the future have concerning my qualifications and fitness to practice medicine/osteopathy to any person, institution, association, school, hospital or government entity.

Samuel Louis Auerbach
(Signature of Applicant)

SAMUEL LOUIS AUERBACH
(Print Name)

Subscribed and sworn to before me by Samuel L. Auebach this 1st day of December, 2000
(month, year)

Sheryl S. Baca
(Signature of Notary)

Seal of Notary

My commission expires: Aug. 30, 2002

SHERYL S. BACA
Commission # 1194978
Notary Public - California
Los Angeles County
My Comm. Expires Aug 30, 2002

SAMUEL LOUIS AUERBACH MD

Clinical Clerkships:

Manhattan Eye, Ear & Throat Hosp. 210 E. 64th St. NY, NY 10021	Otolaryngology - ENT 7-3-78 to 7-31-78 4 wks
Brookdale Hosp. Med. Center Linden Blvd. at Brookdale Plaza Bklyn, NY 11212	General Surgery 8-1-78 to 9-30-78 9 wks
Lutheran Med. Ctr. 150-55th Street Bklyn, NY 11220	Cardiology 10-2-78 to 10-31-78 4 wks
Brookdale Hosp. Med. Ctr. same as above	Pulmonary Medicine 11-1-78 to 11-30-78; 4 wks
Brookdale Hosp. Med. Ctr. same as above	Ophthalmology 12-1-78 to 12-29-78; 4 wks
Coney Island Hosp. 2601 Ocean Parkway Bklyn, NY 11236	Int. Med. & Cardiology 2-1-79 to 6-22-79 20 wks
Nassau Hosp. now Winthrop Univ. Hosp. 259 1st. St. Mineola, NY 11501	Ob/Gyn 7-2-79 to 8-31-79 9 wks
St. Vincents Hosp. Med. Ctr. 355 Bard Ave. SI, NY 10310	Pediatrics 9-3-79 to 10-19-79 7 wks
L.I.C.H. 340 Henry St. Bklyn, NY 11201	Ob/Gyn 10-22-79 to 12-7-79 7 wks
Coney Island Hospital same as above	Internal Medicine 2-1-80 to 2-29-80; 4 wks
Brookdale Hosp. Med. Ctr. same as above	General Surgery 3-3-80 to 3-31-80; 4 wks
St. Vincents Hosp. Med. Ctr. same as above	Urology 4-1-80 to 5-30-80; 9 wks

Name: SAMUEL LOUIS AUERBACH MD

Clinical Clerkship Form

International Medical Graduates Only PLEASE SEE ATTACHED

During medical school were any clinical clerkships completed in the United States or Canada? YES If Yes, please complete the following.

Institution and Address	Clinical Rotation	Dates of Rotation	Number of Weeks of Rotation

For Board Use Only Medical School	For Board Use Only ACGME	For Board Use Only JCAH

Signature: Samuel Louis Auerbach Date: 11/14/01

RECEIVED
NOV 16 2001
K.B.M.L.

SAMUEL AUERBACH MD
18615 BURBANK BLVD
SUITE #214
TARZANA, CA 91356

November 14, 2001

Re: Samuel Louis Auerbach MD
Application for Kentucky Medical Licensure by Endorsement

Dear Kentucky State Board of Medical Examiners, & Staff:

This letter addresses the periods of time that you asked about in your letter of 9-24-01.

I participated in a family leave from 7-80 to 6-83. I was involved in family matters that included care for family members who had failing health.

During the period of time from 10/91 to 6/93 I was active in the establishment of Vitex Oils Inc. My energies were focused into making this business venture a success.

From the period of 10/95 to 2/96 I took some vacation time for myself. I had just completed my Fellowship. I also used some of the time to complete clerical work and plan my future.

Please inform me if additional information is needed.

Sincerely,

Samuel Louis Auerbach MD

mm:SA

SAMUEL LOUIS AUERBACH MD

Clinical Clerkships:

Manhattan Eye, Ear & Throat Hosp. 210 E. 64th St. NY, NY 10021	Otolaryngology - ENT 7-3-78 to 7-31-78 4 wks
Brookdale Hosp. Med. Center Linden Blvd. at Brookdale Plaza Bklyn, NY 11212	General Surgery 8-1-78 to 9-30-78 9 wks
Lutheran Med. Ctr. 150-55th Street Bklyn, NY 11220	Cardiology 10-2-78 to 10-31-78 4 wks
Brookdale Hosp. Med. Ctr. same as above	Pulmonary Medicine 11-1-78 to 11-30-78; 4 wks
Brookdale Hosp. Med. Ctr. same as above	Ophthalmology 12-1-78 to 12-29-78; 4 wks
Coney Island Hosp. 2601 Ocean Parkway Bklyn, NY 11236	Int. Med. & Cardiology 2-1-79 to 6-22-79 20 wks
Nassau Hosp. now Winthrop Univ. Hosp. 259 1st. St. Mineola, NY 11501	Ob/Gyn 7-2-79 to 8-31-79 9 wks
St. Vincents Hosp. Med. Ctr. 355 Bard Ave. SI, NY 10310	Pediatrics 9-3-79 to 10-19-79 7 wks
L.I.C.H. 340 Henry St. Bklyn, NY 11201	Ob/Gyn 10-22-79 to 12-7-79 7 wks
Coney Island Hospital same as above	Internal Medicine 2-1-80 to 2-29-80; 4 wks
Brookdale Hosp. Med. Ctr. same as above	General Surgery 3-3-80 to 3-31-80; 4 wks
St. Vincents Hosp. Med. Ctr. same as above	Urology 4-1-80 to 5-30-80; 9 wks

SAMUEL LOUIS AUERBACH
18615 BURBANK BLVD.
SUITE # 214
TARZANA, CA 91356

RECEIVED
NOV 16 2001
K.B.M.L.

November 14, 2001

Re: Samuel Louis Auerbach MD

To: Kentucky Board of Ledical Licensure - Privileges (Form 4)

Dear Doctors:

As per your request on FORM 4 this letter is written to list some of the privileges that have been granted. This can be confirmed by your FORM 4A which has been completed by Dr. Mesler - Medical Director. Please note that Dr. Mesler is the Medical Director at both Encino Urgent Care and its sister facility American Lancaster in Palmldale. I have not had hospital privileges over the past five years. I have practiced at the facilities noted.

Aspiration of Cysts
Biopsy of Multiple sites
Circumcision
Contraceptive Care
Cystometrics
D & C for Incomplete Abortion
Endometrial Biopsy
I & D of Abcess
Tubal Ligation
Wound revision

Breast Biopsy
Conization - Cervical
Colposcopy
Culdocentesis
D & C
Early Obstetrical care
Hysteroscopy
Laceration repair
Ultrasonography

Please contact me for additional information if needed.

Sincerely,

Samuel Louis Auerbach MD

mm:SA

Form 4

Hospital/Clinic Affiliation Form

Physicians Name SAMUEL LOUIS AUERBACH MD M.D. / D.O.

List all hospitals/clinics other than training where you have practiced medicine within the last five (5) years and send Form 4A to each. ***(This should also include moonlighting and all locum tenens assignments.)***

Dates (From – To)	Hospital/Clinic/Office Name	Complete Address	Indicate Locum Tenens, Moonlighting or Type of Privileges
JAN 95 to Present	URGENT CARE MEDICAL CLINIC ON VENTURA BLVD INC	18055 VENTURA BLVD ENCINO CA 91316	See attached from facility
JAN 98 to Present	AMERICAN LANCASTER HEALTH GROUP	1037 W. AVEN PALMDALE, CA 93551	See attached from facility

RECEIVED
NOV 16 2001
K.B.M.L.

Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, Kentucky 40222

Form 1

RECEIVED
NOV 0 1 2001
K.B.M.L.

Verification of Medical Education

--No substitutes will be accepted in lieu of this form--

To Applicant: In applying for a license to practice medicine/osteopathy in the Commonwealth of Kentucky, the Kentucky Board of Medical Licensure requires this form be completed by the Dean or Registrar of the medical school where you graduated. This form must be sent from the reference source to the Board at the above address.

Name: SAMUEL LOUIS AUERBACH (M.D./D.O.) Graduation Date: 5/20/84
(please print)

Address: 18615 BURBANK BLVD; STE #214 TARZANA CA 91356

Samuel Louis Auerbach M.D./D.O.
(Signature)

To Reference Source: Please complete this form, sign, seal and return to the Board (KBML) at the above stated address. Any fees for completion of this form should be collected from the applicant. If you have any additional information that should be considered by this Board (KBML) prior to issuance of a license to this applicant, please provide this information to the Board (KBML) by writing to the above address. Please affix the Seal of the Medical School or have the form Notarized by a school official.

It is hereby certified that SAMUEL LOUIS AUERBACH

attended the U. AT BUFFALO-NBS FIFTH PATHWAY PROGRAM

located at BUFFALO NY for a period of 1 years.

Dates of attendance: 8-15-83 → 5-20-84 Degree: MD

Date of graduation: 6-1-84

Signature of Dean or Registrar

Seal of the medical school

Sworn to and subscribed before me this _____ day of _____, 19___

Seal of Notary

Notary Public

Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, Kentucky 40222

Form 1

RECEIVED
OCT 3 1 2001
K.B.M.L.

Verification of Medical Education

••No substitutes will be accepted in lieu of this form••

To Applicant: In applying for a license to practice medicine/osteopathy in the Commonwealth of Kentucky, the Kentucky Board of Medical Licensure requires this form be completed by the Dean or Registrar of the medical school where you graduated. This form must be sent from the reference source to the Board at the above address.

Name: SAMUEL LOUIS AUERBACH M.D./D.O. GraduationDate: 6-6-80
(please print)

Address: 18015 BUBBANK BLVD; SUITE #214 TARZANA, CA 91356

Samuel Louis Auerbach M.D./D.O.
(Signature)
Samuel Louis Auerbach MD (10/16/01)

****

To Reference Source: Please complete this form, sign, seal and return to the Board (KBML) at the above stated address. Any fees for completion of this form should be collected from the applicant. If you have any additional information that should be considered by this Board (KBML) prior to issuance of a license to this applicant, please provide this information to the Board (KBML) by writing to the above address. Please affix the Seal of the Medical School *or* have the form Notarized by a school official.

It is hereby certified that SAMUEL LOUIS AUERBACH
attended the UNIVERSIDAD DEL NORESTE A.C.
located at TAMPICO, TAMAULIPAS, MEXICO. for a period of 4 years.
Dates of attendance: 16/Ago/76 - 02/Jun/80 Degree: DIPLOMA DE MEDICO CIRUJANO Y PARTERO.
Date of graduation: 06 de Junio de 1980.

Seal of the medical school

LIC. MARIO A. LIZARRAGA BOLIO
Signature of Dean or Registrar
DIRECTOR GENERAL DE SERV. ESC.

DIRECCION GENERAL DE SERVICIOS ESCOLARES

Sworn to and subscribed before me this _____ day of _____, 19___

Seal of Notary

Notary Public

Form 2

Kentucky Board of Medical Licensure
310 Whittington Parkway, #1B
Louisville, KY 40222

Postgraduate Training Verification

Applicant's Authorization: I authorize the release of information from my postgraduate training program listed below to be forwarded to the Kentucky Board of Medical Licensure.

Applicant's signature: Samuel Louis Auerbach

Print or type name: SAMUEL LOUIS AUERBACH

Name of institution: Millard Fillmore Hospital

Instructions to the Program Director: This form must not be completed more than thirty (30) days prior to the completion of training program if less than one year for American medical graduates and less than three (3) years for International medical graduates. Please complete this form, sign, seal and return to the Board at the above stated address. Any fees for completion of this form should be collected from the applicant. Please affix the seal of the hospital or have form notarized by a hospital official.

Name of Institution: Kaleida Health / Millard Fillmore Hosp.

If name of Institution was different when applicant attended, please enter name: Millard Fillmore Hosp.

Enrollment and participation: Our records indicate that Samuel Louis Auerbach (Type or print applicant's name) participated in the following program:

Program type (Internship, Residency, Fellowship)	PGY (1,2,3,4)	Department	Dates Attended (Month/Day/Year)		Completed Yes/No	Accredited By: ACGME, AOA, Etc..
Internship	Pgy 1	Int Medicine	7 / 1 / 84	6 / 30 / 85	yes	yes
			/ /	/ /		
Fellowship		Advanced Pelvic	7 / 1 / 93	6 / 30 / 94	yes	yes
		Gyn. Surgery	/ /	/ /		
			/ /	/ /		

-Over-

Form 2 - Continued

Applicant's Name: SAMUEL LOUIS AUERBACH MD

Unusual circumstances: The following questions apply to unusual circumstances that occurred during any part of the applicant's medical education. Please mark the appropriate response. ****If you answer yes to any of these questions, please enclose an explanation.**

QUESTIONS

	Yes	No
1. Did the applicant take any leave of absences or breaks form his/her post-graduate training?	☐	☑
2. Was the applicant ever placed on probation?	☐	☑
3. Was the applicant ever disciplined or under investigation?	☐	☑
4. Were there negative reports ever filed by instructors regarding the applicant?	☐	☑
5. Were any limitations or special requirements imposed on the applicant because of questions of academic incompetence or disciplinary problems?	☐	☑

6. During the applicant's participation, our postgraduate medical training ☐ was accredited by: ☒ ACGME ☐ Other: _____

Comments: _____

_____

Certification: I hereby certify that the above information is correct, to the best of my knowledge.

~~Program Director~~'s Signature: Marcia A. Brierley CPCS

Print Name: Marcia A. Brierley

Academic Title: Director, Medical Staff & Educ.

Telephone: (716) 887-4806 Today's Date: 10/23/01

Affix Institutional Seal Here

(If the institution does not have a seal, this form must be notarized.)

these programs are no longer functioning
Information taken from hospital records

Form 2

Kentucky Board of Medical Licensure
310 Whittington Parkway, #1B
Louisville, KY 40222

Postgraduate Training Verification

Applicant's Authorization: I authorize the release of information from my postgraduate training program listed below to be forwarded to the Kentucky Board of Medical Licensure.

Applicant's signature: Samuel Louis Auerbach

Print or type name: SAMUEL LOUIS AUERBACH

Name of institution: State University of New York at Buffalo

Instructions to the Program Director: This form must not be completed more than thirty (30) days prior to the completion of training program if less than one year for American medical graduates and less than three (3) years for International medical graduates. Please complete this form, sign, seal and return to the Board at the above stated address. Any fees for completion of this form should be collected from the applicant. Please affix the seal of the hospital or have form notarized by a hospital official.

Name of Institution: UNIVERSITY AT BUFFALO
OFFICE OF MEDICAL EDUCATION
RM 40 BEB
3435 MAIN ST.
BUFFALO, NY 14214

If name of Institution was different when applicant attended, please enter name:

Enrollment and participation: Our records indicate that Samuel L. Auerbach participated in the following program:
(Type or print applicant's name)

Program type (Internship, Residency, Fellowship)	PGY (1,2,3,4)	Department	Dates Attended (Month/Day/Year)		Completed Yes/No	Accredited By: ACGME, AOA, Etc.
FIFTH PATHWAY	——	SURGERY	8/15/83	9/11/83	✓	LCME
		RADIOLOGY	9/12/83	10/7/83	✓	
		PSYCHIATRY	10/10/83	12/4/83	✓	
		MEDICINE	12/5/83	1/29/84	✓	
		GYN	1/30/84	3/26/84	✓	
		MEDICINE	3/27/84	5/20/84	✓	

-Over-

Form 2 - Continued

Applicant's Name: SAMUEL LOUIS AUERBACH

Unusual circumstances: The following questions apply to unusual circumstances that occurred during any part of the applicant's medical education. Please mark the appropriate response. **If you answer yes to any of these questions, please enclose an explanation.

QUESTIONS	Yes	No
1. Did the applicant take any leave of absences or breaks form his/her post-graduate training?	☐	☑
2. Was the applicant ever placed on probation?	☐	☑
3. Was the applicant ever disciplined or under investigation?	☐	☑
4. Were there negative reports ever filed by instructors regarding the applicant?	☐	☑
5. Were any limitations or special requirements imposed on the applicant because of questions of academic incompetence or disciplinary problems?	☐	☑

6. During the applicant's participation, our F:AH PATHWAY postgraduate medical training ☐ was accredited by: ☐ ACGME ☐ Other: LCME

Comments: _____

Certification: I hereby certify that the above information is correct, to the best of my knowledge.

Program Director's Signature: [signature]

Print Name: D NADLER MD

Academic Title: ASSOC. DEAN

Telephone: (716) 829 2802 Today's Date: 6-22-01

Affix Institutional Seal Here

(If the institution does not have a seal, this form must be notarized.)

RECEIVED
NOV 13 2001
K.B.M.L.

Form 2

Kentucky Board of Medical Licensure
310 Whittington Parkway, #1B
Louisville, KY 40222

Postgraduate Training Verification

Applicant's Authorization: I authorize the release of information from my postgraduate training program listed below to be forwarded to the Kentucky Board of Medical Licensure.

Applicant's signature: Samuel Louis Auerbach

Print or type name: SAMUEL LOUIS AUERBACH

Name of Institution: University of South AL Dept. of OB/GYN

Instructions to the Program Director: This form must not be completed more than thirty (30) days prior to the completion of training program if less than one year for American medical graduates and less than three (3) years for International medical graduates. Please complete this form, sign, seal and return to the Board at the above stated address. Any fees for completion of this form should be collected from the applicant. Please affix the seal of the hospital or have form notarized by a hospital official.

Name of Institution: Univ. of South AL Dept. of OB/GYN

If name of Institution was different when applicant attended, please enter name: _____

Enrollment and participation: Our records indicate that Samuel L. Auerbach, MD (Type or print applicant's name) participated in the following program:

Program type (Internship, Residency, Fellowship)	PGY (1,2,3,4)	Department	Dates Attended (Month/Day/Year)		Completed Yes/No	Accredited By: ACGME, AOA, Etc.
Residency	3,4	OB/GYN	7/1/89	9/30/91	Yes	
			/ /	/ /		
			/ /	/ /		
			/ /	/ /		
			/ /	/ /		

-Over-

RECEIVED
NOV 13 2001
K.B.M.L.

Applicant's Name: SAMUEL LOUIS AUERBACH MD

Form 2 - Continued

Unusual circumstances: The following questions apply to unusual circumstances that occurred during any part of the applicant's medical education. Please mark the appropriate response. ****If you answer yes to any of these questions, please enclose an explanation.**

QUESTIONS

	Yes	No
1. Did the applicant take any leave of absences or breaks form his/her post-graduate training?	☐	☒
2. Was the applicant ever placed on probation?	☐	☒
3. Was the applicant ever disciplined or under investigation?	☐	☒
4. Were there negative reports ever filed by instructors regarding the applicant?	☒	☐
5. Were any limitations or special requirements imposed on the applicant because of questions of academic incompetence or disciplinary problems?	☒	☐

6. During the applicant's participation, our postgraduate medical training ☐ was accredited by: ☒ ACGME ☐ Other: _____

(#5)

Comments: As a result of fund of knowledge & Professional Demeanor issues, Dr. Auerbach was required to complete 3 extra months of training

Certification: I hereby certify that the above information is correct, to the best of my knowledge.

Program Director's Signature: [signature]

Print Name: SC Lynn, JR

Academic Title: Assoc Prof

Telephone: (718) 415-1566 Today's Date: 10/23/01

Affix Institutional Seal Here

(If the institution does not have a seal, this form must be notarized.)

Form 2

Kentucky Board of Medical Licensure
310 Whittington Parkway, #1B
Louisville, KY 40222

RECEIVED
JUN 28 2001
K.B.M.L.

Postgraduate Training Verification

Applicant's Authorization: I authorize the release of information from my postgraduate training program listed below to be forwarded to the Kentucky Board of Medical Licensure.

Applicant's signature: Samuel Louis Auerbach

Print or type name: SAMUEL LOUIS AUERBACH

Name of institution: ALBANY MEDICAL CENTER

Instructions to the Program Director: This form must not be completed more than thirty (30) days prior to the completion of training program if less than one year for American medical graduates and less than three (3) years for International medical graduates. Please complete this form, sign, seal and return to the Board at the above stated address. Any fees for completion of this form should be collected from the applicant. Please affix the seal of the hospital or have form notarized by a hospital official.

Name of Institution: ALBANY MEDICAL CENTER

If name of Institution was different when applicant attended, please enter name: _____

Enrollment and participation: Our records indicate that SAMUEL L. AUERBACH, MD (Type or print applicant's name) participated in the following program:

Program type (Internship, Residency, Fellowship)	PGY (1,2,3,4)	Department	Dates Attended (Month/Day/Year)		Completed Yes/No	Accredited By: ACGME, AOA, Etc..
RESIDENCY	1	OB/GYN	07/01/87	06/30/88	Yes	ACGME
			/ /	/ /		
			/ /	/ /		
			/ /	/ /		
			/ /	/ /		

-Over-

RECEIVED
JUN 28 2001
K.B.M.L.

Applicant's Name: SAMUEL LOUIS AUERBACH MD

Form 2 - Continued

Unusual circumstances: The following questions apply to unusual circumstances that occurred during any part of the applicant's medical education. Please mark the appropriate response. ****If you answer yes to any of these questions, please enclose an explanation.**

QUESTIONS

	Yes	No
1. Did the applicant take any leave of absences or breaks form his/her post-graduate training?	☐	☒
2. Was the applicant ever placed on probation?	☐	☒
3. Was the applicant ever disciplined or under investigation?	☐	☒
4. Were there negative reports ever filed by instructors regarding the applicant?	☐	☒
5. Were any limitations or special requirements imposed on the applicant because of questions of academic incompetence or disciplinary problems?	☐	☒

6. During the applicant's participation, our postgraduate medical training ☐ was accredited by: ☒ ACGME ☐ Other: _____

Comments: _____

Certification: I hereby certify that the above information is correct, to the best of my knowledge.

Program Director's Signature: Ian H. Porter

Print Name: IAN H. PORTER

Academic Title: PROF. PEDIATRICS

Telephone: (518 262-3589 Today's Date: 6.21.01

Affix Institutional Seal Here

(If the institution does not have a seal, this form must be notarized.)

RECEIVED Form 2

JUN 28 2001

K.B.M.L.

Kentucky Board of Medical Licensure
310 Whittington Parkway, #1B
Louisville, KY 40222

Postgraduate Training Verification

Applicant's Authorization: I authorize the release of information from my postgraduate training program listed below to be forwarded to the Kentucky Board of Medical Licensure.

Applicant's signature: Samuel Louis Auerbach

Print or type name: SAMUEL LOUIS AUERBACH

Name of institution: LUTHERAN MEDICAL CENTER

Instructions to the Program Director: This form must not be completed more than thirty (30) days prior to the completion of training program if less than one year for American medical graduates and less than three (3) years for International medical graduates. Please complete this form, sign, seal and return to the Board at the above stated address. Any fees for completion of this form should be collected from the applicant. Please affix the seal of the hospital or have form notarized by a hospital official.

Name of Institution: Lutheran Medical Center, 150 55th Street, Brooklyn, New York, 11220

If name of Institution was different when applicant attended, please enter name: _____

Enrollment and participation: Our records indicate that Samuel L. Auerbach, MD participated in the following program:
(Type or print applicant's name)

Program type (Internship, Residency, Fellowship)	PGY (1,2,3,4)	Department	Dates Attended (Month/Day/Year)		Completed Yes/No	Accredited By: ACGME, AOA, Etc..
Residency	3	Ob/Gyn	8/24/88	6/30/89	Yes	ACGME
			/ /	/ /		
			/ /	/ /		
			/ /	/ /		
			/ /	/ /		

-Over-

Applicant's Name: SAMUEL LOUIS AUERBACH MD

Form 2 - Continued

Unusual circumstances: The following questions apply to unusual circumstances that occurred during any part of the applicant's medical education. Please mark the appropriate response. ****If you answer yes to any of these questions, please enclose an explanation.**

QUESTIONS

	Yes	No
1. Did the applicant take any leave of absences or breaks form his/her post-graduate training?	☐	☑
2. Was the applicant ever placed on probation?	☐	☑
3. Was the applicant ever disciplined or under investigation?	☐	☑
4. Were there negative reports ever filed by instructors regarding the applicant?	☐	☑
5. Were any limitations or special requirements imposed on the applicant because of questions of academic incompetence or disciplinary problems?	☐	☑

RECEIVED
OCT 22 2001
K.B.M.L.

6. During the applicant's participation, our postgraduate medical training ☐ was accredited by: ☐ ACGME ☑ Other: NOT Accredited

Comments: _____

Certification: I hereby certify that the above information is correct, to the best of my knowledge.

Program Director's Signature: _____

Print Name: M J SILVERSTEIN, MD

Academic Title: Professor of Surgery

Telephone: (323) 865-3535 Today's Date: 10/15/01

Affix Institutional Seal Here

(If the institution does not have a seal, this form must be notarized.)

Form 2

Kentucky Board of Medical Licensure
310 Whittington Parkway, #1B
Louisville, KY 40222

RECEIVED
OCT 22 2001
K.B.M.L.

Postgraduate Training Verification

Applicant's Authorization: I authorize the release of information from my postgraduate training program listed below to be forwarded to the Kentucky Board of Medical Licensure.

Applicant's signature: Samuel Louis Auerbach

Print or type name: SAMUEL LOUIS AUERBACH

Name of Institution: _____

Instructions to the Program Director: This form must not be completed more than thirty (30) days prior to the completion of training program if less than one year for American medical graduates and less than three (3) years for International medical graduates. Please complete this form, sign, seal and return to the Board at the above stated address. Any fees for completion of this form should be collected from the applicant. Please affix the seal of the hospital or have form notarized by a hospital official.

Name of Institution: The Breast Center

If name of Institution was different when applicant attended, please enter name: _____

Enrollment and participation: Our records indicate that Samuel Louis Auerbach participated in the following program:
(Type or print applicant's name)

Program type (Internship, Residency, Fellowship)	PGY (1,2,3,4)	Department	Dates Attended (Month/Day/Year)		Completed Yes/No	Accredited By: ACGME, AOA, Etc..
Fellowship		Breast Surgery	9/19/94	9/18/95	Yes	
			/ /	/ /		
			/ /	/ /		
			/ /	/ /		
			/ /	/ /		

-Over-

Form 2 - Continued

Applicant's Name: SAMUEL LOUIS AUERBACH MD

Unusual circumstances: The following questions apply to unusual circumstances that occurred during any part of the applicant's medical education. Please mark the appropriate response. ****If you answer yes to any of these questions, please enclose an explanation.**

QUESTIONS	Yes	No
1. Did the applicant take any leave of absences or breaks form his/her post-graduate training?	☐	☒
2. Was the applicant ever placed on probation?	☐	☒
3. Was the applicant ever disciplined or under investigation?	☐	☒
4. Were there negative reports ever filed by instructors regarding the applicant?	☐	☒
5. Were any limitations or special requirements imposed on the applicant because of questions of academic incompetence or disciplinary problems?	☐	☒

6. During the applicant's participation, our postgraduate medical training ☐ was accredited by: ☒ ACGME ☐ Other: _____

Comments: _____

Certification: I hereby certify that the above information is correct, to the best of my knowledge.

Program Director's Signature: [signature]

Print Name: DONALD M. ZAROU, M.D.

Academic Title: Chair of Ob/Gyn

Telephone: (718) 630-7350 Today's Date: 6/25/01

Affix Institutional Seal Here

(If the institution does not have a seal, this form must be notarized.)

STATE OF ALABAMA MEDICAL LICENSURE COMMISSION

POST OFFICE BOX 887 MONTGOMERY, ALABAMA 36101-0887 Phone: (334)242-4153
JERRY N. GURLEY, M.D., CHAIRMAN/EXECUTIVE OFFICER • CINDY D. WEBER, EXECUTIVE ASSISTANT

KENTUCKY BOARD OF MEDICAL LICENSURE
310 WHITTINGTON PARKWAY, SUITE 1B
LOUISILLE, KY 40222

RECEIVED
OCT 25 2001
K.B.M.L.

VERIFICATION OF ALABAMA MEDICAL LICENSURE

Name of Licensee (as it appears in our records):

SAMUEL LOUIS AUERBACH

Date of Birth:	**08/30/1955**
Soc Sec #:	**128487731**
License#:	**MD. 00024126**
Current Status:	**ACTIVE IN RENEWAL**
Date Issued:	**06/27/2001**
Basis of License:	**FLEX/NY**
Expiration Date:	**12/31/2001**
Medical School:	**SCH OF MED UNIV OF NORTHEAST TAMPICO**
Location:	**TAMPICO**
Date From/To:	**8/76-6/80**

Disciplinary Actions:

[SEAL]

[✓] NO
[ ] Yes, See Attached
[ ] Other, See Attached

Signature: _____

Jerry N. Gurley, M.D.
Chairman, Medical Licensure
Commission of Alabama

Date: **October 23, 2001**

To expedite the verification process, the above is the standard format used by the Medical Licensure Commission of Alabma. Verification information can also be obtained by accessing our web site at **http://www.albme.org/**

Completed by: _____
Verification Clerk

RECEIVED

OCT 18 2001

K.B.M.L.

STATE OF ALABAMA MEDICAL LICENSURE COMMISSION

POST OFFICE BOX 887 MONTGOMERY, ALABAMA 36101-0887 Phone: (334)242-4153
JERRY N. GURLEY, M.D., CHAIRMAN/EXECUTIVE OFFICER • CINDY D. WEBER, EXECUTIVE ASSISTANT

KENTUCKY BOARD OF MEDICAL LICENSURE
310 WHITTINGTON PARKWAY, STE 1B
LOUISVILLE, KY 40222

VERIFICATION OF ALABAMA MEDICAL LICENSURE

Name of Licensee (as it appears in our records):

SAMUEL LOUIS AUERBACH

Date of Birth:	**08/30/1955**
Soc Sec #:	**128487731**
License#:	**MD. 00024126**
Current Status:	**ACTIVE**
Date Issued:	**06/27/2001**
Basis of License:	**FLEX/NY**
Expiration Date:	**12/31/2001**
Medical School:	**SCH OF MED UNIV OF NORTHEAST TAMPICO**
Location:	**TAMPICO**
Date From/To:	**8/76-6/80**

Disciplinary Actions:

[SEAL]

[X] NO
[ ] Yes, See Attached
[ ] Other, See Attached

Signature: _____

Jerry N. Gurley, M.D.
Chairman, Medical Licensure
Commission of Alabama

Date: **October 16, 2001**

To expedite the verification process, the above is the standard format used by the Medical Licensure Commission of Alabma. Verification information can also be obtained by accessing our web site at **http://www.albme.org/**

Completed by: _____
Verification Clerk

Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, Kentucky 40222

RECEIVED Form 3

SEP 1 1 2001

K.B.M.L.

Verification of Licensure

To Applicant: In applying for a license to practice medicine/osteopathy in the Commonwealth of Kentucky, the Kentucky Board of Medical Licensure requires **each** state or Canadian province where you currently hold or have ever held a medical license complete this form. My signature below is your authority to release any and all information in your files, favorable or otherwise regarding myself.

Name of Applicant: Samuel Louis Auerbach (NEW JERSEY) M.D./D.O. License No: MA65075
(Please print)

Address: 18615 Burbank Blvd; Suite #214; Tarzana CA 91356

Samuel Louis Auerbach M.D./D.O.
(Signature)

****

To Reference Source: Please complete this form, sign, seal and return to the Board (KBML) at the above stated address. Any fees for completion of this form should be collected from the physician. All applicants have signed a general release, which relieves anyone of any liability for information furnished in good faith.

• • • Please Type or Print All Information • • •

State of: New Jersey License No: MA65075

Issue Date: 12-2-96 Expiration Date: 10-31-01

Basis for Licensure: Flex Endorsement

Current Status: Active

Limitations: None

Derogatory: None

LICENSE IN GOOD STANDING
NO DEROGATORY INFORMATION

Board Seal

Signed: William V. Roeder

Title: WILLIAM V. ROEDER, EXEC. DIR.

SEP 0 6 2001

THE UNIVERSITY OF THE STATE OF NEW YORK
THE STATE EDUCATION DEPARTMENT
DIVISION OF PROFESSIONAL LICENSING SERVICES
CERTIFICATION & VERIFICATION UNIT
89 WASHINGTON AVENUE
ALBANY, NEW YORK 12234

RECEIVED
SEP 10 2001
K.B.M.L.

THIS IS TO CERTIFY THAT ACCORDING TO THE RECORDS OF THE DIVISION OF PROFESSIONAL LICENSING SERVICES, NEW YORK STATE EDUCATION DEPARTMENT, ALBANY, NEW YORK, AUERBACH SAMUEL LOUIS
WAS ISSUED LICENSE/CERTIFICATE NUMBER 191774 FOR THE PRACTICE OF MEDICINE ON 03/23/93.

OUR RECORDS ALSO INDICATE THE FOLLOWING INFORMATION:
DATE OF BIRTH: 08/30/55
SCHOOL ATTENDED: UNIVERSITY DEL NORESTE
DATE OF GRADUATION: 06/06/80
DEGREE EARNED: PHY&SR

PROGRAM WAS ACCEPTABLE IN ACCORDANCE WITH THE NYS REGULATIONS OF THE COMMISSIONER OF EDUCATION. REQUIREMENTS MET AT THE TIME OF LICENSURE.

BASIS OF LICENSURE:

DATE	COMP1	COMP2	FLEX EXAMINATION
12/92	00075		
12/90	00072	00075	

EXMS TAKEN=09

A LICENSE IS VALID DURING THE LIFE OF THE HOLDER UNLESS REVOKED, ANNULLED OR SUSPENDED BY THE BOARD OF REGENTS. A LICENSEE MUST REGISTER PERIODICALLY WITH THIS DEPARTMENT TO PRACTICE IN THIS STATE

CURRENTLY REGISTERED: YES REG PERIOD ENDS: 07/31/03
ADDRESS: P O BOX 090365 BROOKLYN NY 11209-0000

DEROGATORY INFORMATION: NO CHARGES HAVE BEEN PREFERRED AGAINST THIS LICENSEE.
COMMENTS:

I FRANK GEBOSKY, PRINCIPAL CLERK, DIVISION OF PROFESSIONAL LICENSING SERVICES OF THE NEW YORK STATE EDUCATION DEPARTMENT, DO HEREBY STATE THAT AS PRINCIPAL CLERK OF SAID DIVISION, I HAVE LEGAL CUSTODY OF THE OFFICIAL RECORDS OF THE DIVISION OF PROFESSIONAL LICENSING SERVICES AND TO THE BEST OF MY KNOWLEDGE, THE AFORESAID INFORMATION IS TRUE AND CORRECT.

SEAL

Frank Gebosky 08/29/01
PRINCIPAL CLERK

OP026 056

STATE AND CONSUMER SERVICES AGENCY

GRAY DAVIS, Governor

State of California Department of Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM
1426 HOWE AVE, SUITE 58
SACRAMENTO CA 95825-3236
TELEPHONE: (916) 263-2382
FAX: (916) 263-2944

www.medbd.ca.gov

August 29, 2001

KENTUCKY BOARD OF MEDICAL LICENSURE
HURSTBOURNE OFFICE PARK
310 WHITTINGTON PKWY STE 1B
LOUISVILLE KY 40222-4916

RECEIVED
SEP 07 2001
K.B.M.L.

To Whom It May Concern:

In response to your inquiry a standard search of available records in this office has been performed. The following indicates the results of that search:

Physician:	SAMUEL LOUIS AUERBACH
License No.:	A 53310
Issued:	July 27, 1994
Exam Type:	A written examination
Expiration Date:	August 31, 2001
Status:	Renewed/current

If a discipline status is listed, you may obtain information concerning this action by contacting the Board's Enforcement Program, Central File Room, 1426 Howe Avenue, Sacramento, CA 95825-3236 or by faxing your request to the Central File Room at (916) 263-2420.

M. Elizabeth Ware

M. ELIZABETH WARE
Chief, Division of Licensing

SEAL

Nevada State Board of Medical Examiners

VERIFICATION OF LICENSURE

This is to certify that the records of the Nevada State Board of Medical Examiners indicate the following information regarding:

Samuel L Auerbach, M.D.
18615 Burbank Blvd #214
Tarzana CA 91356

LICENSE TYPE:	Medical Doctor		
LICENSE NUMBER:	7617	CURRENT STATUS:	Active
EFFECTIVE DATE:	11/22/1995	DISCIPLINARY ACTION:	NONE
EXPIRATION DATE:	06/30/2003	EXAMINATION LICENSED BY *:	FX

* KEY:	FX	= Federation Licensing Examination
	NB	= National Boards
	USMLE	= United States Medical Licensing Examination
	LMCC	= Canadian Medical Licensing Examination
	State Abbreviation	= If Licensed by a State's Basic Sciences Examination

We are not in a position to advise whether the above person is currently under investigation by the Nevada State Board of Medical Examiners. Until such time as an investigation of any person licensed by the board is culminated by the filing of a formal complaint, we are not in a position to reveal the facts or the nature of any investigation. We have, however, searched our records and do not find that any formal disciplinary action has been taken against the above person by the board.

To expedite the verification of licensure process, the above is the standard format for verification of licensure of all persons licensed by the Nevada State Board of Medical Examiners.

Larry D. Lessly, J.D., Executive Director

Dated: 08/24/2001

1105 Terminal Way, Suite 301 • (775) 688-2559 • Fax 688-2321
Mailing Address: Post Office Box 7238 • Reno, Nevada 89510

DEPARTMENT OF VETERANS AFFAIRS
Medical Center
130 West Kingsbridge Road
Bronx, New York 10468

July 4, 2001

In Reply Refer To: 526 (00ED/IM)

Kentucky Board of Medical Licensure
310 Whittington Parkway, #1B
Louisville, KY 40222

SUBJ: Residency Verification

Dear Sir or Madam:

The verification of the resident/fellow in question is complete. After a complete review of this individuals personnel records for the time period requested, I can verify that this individual completed the training for such time in the correct subspecialty, at the Bronx VAMC. If you have any questions or comments, please feel free to contact me at (718) 584-9000/x6906.

RE: Samuel L. Auerbach, M.D.

SS#: 128-48-7731

PERIOD: 71/85 ⟶ 6/30/86

PROGRAM: Medical Service/Internal Medicine

Sincerely,

David Jaipersaud
Clinical Programs Coordinator

United *Health Services*

July 11, 2001

Kentucky Board of Medical Licensure
310 Whittington Parkway, 1B
Louisville, KY 40222

United
Health Services
Hospitals

RE: Samuel Auerbach, MD

This letter is to confirm that **Samuel Auerbach, MD** successfully completed the following program at United Health Services Hospitals:

Internal Medicine Residency
Dates: July 1, 1986 to June 30, 1987

If you have any further questions, do not hesitate to contact me at 607-763-6674.

Sincerely,

James Jewell, MD
Director Internal Medicine Residency

Wilson Memorial Regional
Medical Center
33-57 Harrison Street
Johnson City, New York 13790
607.763.6000

Form 4A

Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, Kentucky 40222

RECEIVED
DEC 0 5 2001
K.B.M.L.

Hospital/Clinic Affiliation Form

To Applicant: In applying for a license to practice medicine in the Commonwealth of Kentucky, the Kentucky Board of Medical Licensure requires this form to be completed by the hospital administration in each hospital/clinic where you have practiced medicine during the five (5) years preceding your application. My signature below is your authority to release any and all information in your files, favorable or otherwise regarding myself.

Name: SAMUEL LOUIS ALTERBACH M.D./D.O. Samuel Louis Alterbach
(Please print) (Signature)

Address: 18615 BURBANK BLVD ; TARZANA CA 91356

****

To Reference Source: Please complete this form, sign and return to the Board at the above stated address. The processing time for licensure depends on timely receipt of critical forms such as this. All applicants have signed a general release, which relieves anyone of liability for information furnished in good faith. ***No Substitutions will be accepted in lieu of this form. All other forms submitted will be returned.***

1. What privileges were extended to the applicant? FULL OUTPATIENT SURGICAL PROCEDURES
2. Affiliation Dates: From JANUARY 1995 To PRESENT
3. Were any limitations imposed on such privileges? NO If ***"Yes"***, please explain briefly and attach certified copies of any documentation pertaining to such action. N/A
4. Were privileges ever revoked, suspended, restricted, limited, reprimanded, placed on probation or otherwise disciplined? NO If ***"Yes"***, please explain briefly and attach certified copies of any documentation pertaining to such action. N/A

Derogatory Information, if any: NONE

Comments, if any: EXCEPTIONAL DIAGNOSTICIAN

NO Seal

Seal of Hospital
(If no seal, so indicate)

Signature [signature]
Title MEDICAL DIRECTOR - MORRIS MESLER MD
Hospital AMERICAN LANCASTER HEALTH GROUP INC.
Address 1037 WEST AVE. N
PALMDALE, CA 93551
Date NOVEMBER 30, 2001

AMERICAN LANCASTER HEALTH GROUP INC.

1037 W. AVE N #103
PALMDALE, CALIFORNIA 93551
(805) 272-4591
Fax (805) 272-3995

MORRIS MESLER, M D
Medical Director

SAM AUERBACH, M.D
OBGYN/Internist

November 30, 2001

Re: Samuel Louis Auerbach MD

To: Kentucky Board of Ledical Licensure

From: Morris Mesler MD
Medical Director

Dear Doctors:

This letter is written in response to your FORM 4A. I have had an association with Dr. Auerbach since January 1995. Since that time he has practiced Ambulatory Gynecology and Breast Care at this facility. This has included a multitude of ambulatory surgical procedures.

Dr. Auerbach has proven to be an excellent physician. He has never had any restrictions placed on the procedures he was given privileges to perform.

If you have any further questions please do not hesitate to contact me.

Sincerely,

Morris Mesler MD
Medical Direstor

cr:MM

AMERICAN LANCASTER HEALTH GROUP INC.

1037 W. AVE N #103
PALMDALE, CALIFORNIA 93551
(805) 272-4591
Fax (805) 272-3995

MORRIS MESLER, M.D.
Medical Director

SAM AUERBACH, M.D.
OBGYN/Internist

November 30, 2001

Re: Samuel Louis Auerbach MD

To: Kentucky Board of Ledical Licensure

From: Morris Mesler MD
Medical Director

Dear Doctors:

Listed below are some of the procedures performed:

D & C
I & D of Abcess – Multiple sites
Biopsy of Multiple sites
Cervical Conization
Endometrial Biopsy
Ultrasonography
Colposcopy
D & C for Incomplete Abortion
Tubal Ligation
Contrceptive Care
Breast Biopsy
Aspiration of Cysts
Hysteroscopy
Laceration repair
Circumcision
Wound revision
Early Obstetrical care
Culdocentesis
Cystometry
Repair of Muscle Lacerations

Please contact me for additional information if needed.

Sincerely,

Morris Mesler MD
Medical Direstor

cr:MM

AMERICAN LANCASTER HEALTH GROUP INC.

1037 W. AVE N #103
PALMDALE, CALIFORNIA 93551
(805) 272-4591
Fax (805) 272-3995

MORRIS MESLER, M.D
Medical Director

SAM AUERBACH, M.D
OBGYN/Internist

November 30, 2001

Re: Samuel Louis Auerbach MD
AMERICAN LANCASTER HEALTH GROUP & ENCINO URGENT CARE Clinics

To: Kentucky Board of Ledical Licensure

From: Morris Mesler MD - Medical Director

Dear Doctors:

This letter is in reply to your **FORM 4A**. I have now completed your FORM 4A for both Encino Urgent Care & American Lancaster Health Group where Dr. Auerbach has conducted his private practice since1995. These two separate clinics offer the same medical services. I am the Medical Director at both locations.

Since these clinics offer the same services & Dr. Auerbach conducts his practice between both of them I felt that filling out the FORM 4A for the American Lancaster clinic was redundant. It was my understanding that Dr. Auerbach, per your instruction, had also sent you a letter explaining the "sister relationship" that these clinics have.

In trying to assist him in obtaining his Kentucky license I have filled out the FORM 4A with attached letters for the American Lancaster clinic. I hope that this fulfills the requirements. I apologize for any misunderstanding. I hope that the Kentucky Board will be able to use this letter to reevaluate presenting his application for medical licensure so that it can be issued this December.

Thank you for your time and cooperation with regards to this situation. If you have any further questions please do not hesitate to contact me.

Sincerely,

Morris Mesler MD
Medical Director

cr:MM

SAMUEL LOUIS AUERBACH
18615 BURBANK BLVD.
SUITE # 214
TARZANA, CA 91356

November 30, 2001

Re: Samuel Louis Auerbach MD;
RECONDIER PRESENTING FOR LICENSURE IN DECEMBER 2001

To: Kentucky Board of Ledical Licensure - Privileges (Form 4)

Dear Doctors:

As per your request FORM 4A was completed and forwarded to you by Dr. Mesler for the Encino Urgent Care facility. As instructed, I sent a written letter to you on 11-14-01 stating that **Dr. Mesler is the Medical Director at both ENCINO URGENT CARE & its sister facility AMERICAN LANCASTER HEALTH GROUP**.

I spoke with Ms. Cinnamon who informed me that my application was incomplete. FORM 4A needed to be completed for the American Lancaster Health Group Facility. In earlier conversations I had informed Ms. Cinnamon that my private practice was located at both facilities & as I was instructed, I sent a letter on 11-14-01 (see enclosed copy) stating this.

In an attempt to comply with the Medical Boards wishes I have had Dr. Mesler (the Medical Director at BOTH Encino Urgent Care & American Lancaster) complete the **FORM 4A** for the **American Lancaster** facility. I have also asked him to enclose a letter stating the relationship between the facilities.

I hope this will complete my application process & serve to clear up any miscommunication that existed. On this basis I am requesting that you please **reconsider presenting** my application for **Medical Licensure** at your meeting this **December 2001.**

Please contact me for additional information if needed.

Sincerely, Samuel Louis Auerbach

Samuel Louis Auerbach MD

mm:SA

SAMUEL LOUIS AUERBACH
18615 BURBANK BLVD.
SUITE # 214
TARZANA, CA 91356

November 14, 2001

Re: Samuel Louis Auerbach MD

To: Kentucky Board of Ledical Licensure - Privileges (Form 4)

Dear Doctors:

As per your request on FORM 4 this letter is written to list some of the privileges that have been granted. This can be confirmed by your FORM 4A which has been completed by Dr. Mesler - Medical Director. Please note that Dr. Mesler is the Medical Director at both Encino Urgent Care and its sister facility [redacted] in Palmdale. I have not had hospital privileges over the past five years. I have practiced at the facilities noted.

Aspiration of Cysts
Biopsy of Multiple sites
Circumcision
Contraceptive Care
Cystometrics
D & C for Incomplete Abortion
Endometrial Biopsy
I & D of Abcess
Tubal Ligation
Wound revision

Breast Biopsy
Conization - Cervical
Colposcopy
Culdocentesis
D & C
Early Obstetrical care
Hysteroscopy
Laceration repair
Ultrasonography

Please contact me for additional information if needed.

Sincerely,

Samuel Louis Auerbach MD

mm:SA

Form 4A

Kentucky Board of Medical Licensur
310 Whittington Parkway, Suite 1B
Louisville, Kentucky 40222

RECEIVED
NOV 16 2001
K.B.M.L.

Hospital/Clinic Affiliation Form

To Applicant: In applying for a license to practice medicine in the Commonwealth of Kentucky, the Kentucky Board of Medical Licensure requires this form to be completed by the hospital administration in each hospital/clinic where you have practiced medicine during the five (5) years preceding your application. My signature below is your authority to release any and all information in your files, favorable or otherwise regarding myself.

Name: SAM AUERBACH M.D. MD _____
(Please print) (Signature)

Address: 18615 Burbank Blvd Tarzana CA 91356

****

To Reference Source: Please complete this form, sign and return to the Board at the above stated address. The processing time for licensure depends on timely receipt of critical forms such as this. All applicants have signed a general release, which relieves anyone of liability for information furnished in good faith. ***No Substitutions will be accepted in lieu of this form. All other forms submitted will be returned.***

1. What privileges were extended to the applicant? FULL OUT PATIENT SURGICAL PROCEDURES
2. Affiliation Dates: From JAN 1995 To PRESENT
3. Were any limitations imposed on such privileges? NO If *"Yes"*, please explain briefly and attach certified copies of any documentation pertaining to such action. N A
4. Were privileges ever revoked, suspended, restricted, limited, reprimanded, placed on probation or otherwise disciplined? NO If *"Yes"*, please explain briefly and attach certified copies of any documentation pertaining to such action. N A

Derogatory Information, if any: NONE

Comments, if any: QUALITY PHYSICIAN

Signature Mary Meeks, MS
Title MED. CAL DIRECTOR
Hospital URGENT CARE MED GRP
Address 18055 VENTURA BLVD
ENCINO, CA 91316
Date NOV. 7, 2001

Seal of Hospital
(If no seal, so indicate)
NO SEAL

Form 5

Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, KY 40222

RECEIVED
NOV 16 2001
K.B.M.L.

Reference Form

To applicant: The Kentucky Board of Medical Licensure requires completion of two (2) Reference Forms from reference sources. These forms must be sent from the reference source to the Board at the above address.

In addition, the forms must meet the following criteria:
(a) Recent (no older than 6 months)
(b) Original signature
(c) Sent by licensed physician familiar with your practice. It is preferable that one be sent by the Program Director for those who recently completed residency training, or the last hospital where staff privileges were held.

Please be sure to indicate your name below for identification purposes.

Name of applicant: Samuel Louis Auerbach, MD
(Please print)

****

To reference source: Please complete this form, sign and return to the Board at the above stated address. All applicants have signed a general release, which relieves anyone of any liability for information furnished in good faith.

From: Joseph D. Boggs, Jr. MD
(Full name – Please print)

Northridge Hosp. Emergency Dept 14508 Sherman Circle, Mission Hills, CA 91405
(Address) (City, State, Zipcode)

Telephone: (818) 908-8630

1. How long have you known the applicant? 10 yrs
2. In what capacity are you acquainted with him/her? Colleague - Co-worker

		Yes	No	Not Applicable
3.	Have you ever received reports of poor practice by this physician or have you discussed concerns you had about his/her practice with medical staff officers at a hospital?	☐	☑	☐
4.	Have you ever received reports of poor relationships between this physician and other members of hospital medical staff?	☐	☑	☐
5.	Are you aware of any derogatory information about this physician with respect to his/her ability to practice medicine?	☐	☑	☐

-Over-

→ Note: If you answer "NO" to questions 10, 11 or 13, please give an explanation.

		Yes	No	Not Applicable
6.	Does he/she have, or has he/she had in the past, any mental or physical illness or personal problems that interfere with his/her medical practice?	☐	☑	☐
7.	Has he/she ever abused alcohol or drugs or shown any signs of chemical dependency?	☐	☑	☐
8.	Are you aware of any lawsuits having to do with his/her medical practice that this physician has either lost or settled out of court?	☐	☑	☐
9.	Are you aware of any restrictions, limitations or other actions of any nature taken against this physician by a hospital or other health related entity?	☐	☑	☐
10.	Does this physician accept medical staff and hospital policies and function willingly according to these policies?	☑	☐	☐
11.	Does he/she enjoy professional respect among his/her colleagues and in the community where he/she practices?	☑	☐	☐
12.	Are you sorry to see this physician leave your community?	☑	☐	☐
13.	Do you recommend him/her for unrestricted medical licensure in Kentucky?	☑	☐	☐

Comments: Excellent Candidate.

Signature Joseph O Bazzo MD

Title Staff Emergency Physician

Hospital Northridge Hosp. Sherman Way Camp

Date 11/13/01

Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, KY 40222

RECEIVED
AUG 27 2001
K.B.M.L.

Form 5

Reference Form

To applicant: The Kentucky Board of Medical Licensure requires completion of two (2) Reference Forms from reference sources. These forms must be sent from the reference source to the Board at the above address.

In addition, the forms must meet the following criteria:
(a) Recent (no older than 6 months)
(b) Original signature
(c) Sent by licensed physician familiar with your practice. It is preferable that one be sent by the Program Director for those who recently completed residency training, or the last hospital where staff privileges were held.

Please be sure to indicate your name below for identification purposes.

Name of applicant: SAMUEL LOUIS AUERBACH MD
(Please print)

****

To reference source: Please complete this form, sign and return to the Board at the above stated address. All applicants have signed a general release. which relieves anyone of any liability for information furnished in good faith.

From: MORRIS MESLER MD
(Full name – Please print)
18055 VENTURA Blvd - ENCINO, CA 91316
(Address) (City, State, Zipcode)
Telephone: (818) 881 8117

1. How long have you known the applicant? 7 YEARS
2. In what capacity are you acquainted with him/her? Professional

		Yes	No	Not Applicable
3.	Have you ever received reports of poor practice by this physician or have you discussed concerns you had about his/her practice with medical staff officers at a hospital?	☐	☒	☐
4.	Have you ever received reports of poor relationships between this physician and other members of hospital medical staff?	☐	☒	☐
5.	Are you aware of any derogatory information about this physician with respect to his/her ability to practice medicine?	☐	☒	☐

-Over-

→ Note: If you answer "NO" to questions 10, 11 or 13, please give an explanation.

		Yes	No	Not Applicable
6.	Does he/she have, or has he/she had in the past, any mental or physical illness or personal problems that interfere with his/her medical practice?	☐	☒	☐
7.	Has he/she ever abused alcohol or drugs or shown any signs of chemical dependency?	☐	☒	☐
8.	Are you aware of any lawsuits having to do with his/her medical practice that this physician has either lost or settled out of court?	☐	☒	☐
9.	Are you aware of any restrictions, limitations or other actions of any nature taken against this physician by a hospital or other health related entity?	☐	☒	☐
10.	Does this physician accept medical staff and hospital policies and function willingly according to these policies?	☒	☐	☐
11.	Does he/she enjoy professional respect among his/her colleagues and in the community where he/she practices?	☒	☐	☐
12.	Are you sorry to see this physician leave your community?	☒	☐	☐
13.	Do you recommend him/her for unrestricted medical licensure in Kentucky?	☒	☐	☐

Comments: Highly ethical + professional demeanor -- Quality physician

URGENT CARE MEDICAL CLINIC
ON VENTURA BLVD., INC.
18055 VENTURA BLVD.
ENCINO, CA 91316
(818) 881-8117 • FAX 818 996-8972

Signature [signature]
Title Medical Director
Hospital Urgent Care Medical Clinic
Date 8/23/2001

WH

RECEIVED

OCT 15 2001

K.B.M.L.

Form 6

Release and Waiver of Rights Form

I, SAMUEL LOUIS AUERBACH MD, hereby authorize the following individuals and entities to release all information (documented, oral or other) about me in their possession to the Kentucky Board of Medical Licensure (KBML) or its agents:

1. All medical/osteopathic schools which I have attended.

2. All hospitals or other health care facilities at which I have ever held staff privileges, whether full or limited, temporary or permanent; and all hospitals or other health care facilities at which I have ever received training.

3. All medical/osteopathic societies, specialty boards, and other medical/osteopathic organizations with which I have been associated.

4. All other state or Canadian licensure boards, federal health agencies, and federal and state drug control agencies.

5. All licensed physicians, nurses or other health care professionals of any state or Canadian province.

6. All attorneys who have participated in civil or criminal actions in which I was named party.

I hereby release the above-named individuals and entities from all liability for the release of information to the Board (KBML) or its agents.

I further authorize the Board (KBML) or any of its duly authorized agents, to make any investigations that they deem necessary to secure information concerning me which is relevant to the requirements for licensure. I further authorize them to release such information they may now or in the future have, concerning me to (i) any federal, state, county or local governmental entity, (ii) any hospital or other health care facility, or (iii) any other person upon a showing that the release of the information is vital to the health, safety and welfare of the general public.

I hereby make this release and waiver of rights for the purpose of allowing the Board (KBML) to carry out its duties pursuant to my request for a license to practice medicine/osteopathy in the Commonwealth of Kentucky; and further, for the purpose of allowing the Board (KBML) to carry out its duties in regard to my continued licensure.

This release and waiver of rights has no expiration date and shall remain effective during my licensure in the Commonwealth of Kentucky.

10-5-01
Date

Samuel Louis Auerbach M.D.
Applicant

Sworn to and Subscribed Before Me By Samuel Louis Auerbach MD on this the 5 day of October, 2001

Seal

Ann Epstein
Notary Public

My Commission expires: ANN EPSTEIN No. 434634764 Notary Public, State of New York Qualified in Richmond County My Commission Expires Feb. 28, 2003

American Medical Association

Physicians dedicated to the health of America

Division of Survey and Data Resources
515 North State Street
Chicago, Illinois 60610
http://www.ama-assn.org/amaprofiles

AMA Physician Profile

Name and Mailing Address:

SAMUEL LOUIS AUERBACH MD
18615 BURBANK BLVD
TARZANA CA 91356-2649

Primary Office Address:

SAME AS MAILING ADDRESS

Phone: 1-818-609-9070

Birthdate: 08/30/1955
Birthplace: UNKNOWN

Physician's Major Professional Activity: OFFICE BASED PRACTICE

Practice Specialties Self Designated by the Physician:

Primary Specialty: OBSTETRIC & GYNECOLOGY
Secondary Specialty: INTERNAL MEDICINE

AMA membership: NON-MEMBER

Following Data Provided by the Primary Sources

Medical School:

UNIV DEL NORESTE, ESC DE MED, TAMPICO, TAMAULIPAS, MEXICO (VERIFIED)

Year of Graduation: 1980 (VERIFIED)

Current and/or Prior Medical Training Programs Accredited by the Accreditation Council for Graduate Medical Education (ACGME):

Institution: WILSON MEM REG MED CTR **Specialty :** INTERNAL MEDICINE	**State:** NEW YORK 07/1986 - 06/1987 (VERIFIED)
Institution: ALBANY MED CTR HOSP **Specialty :** OBSTETRIC & GYNECOLOGY	**State:** NEW YORK 07/1987 - 06/1988 (VERIFIED)
Institution: UNIV OF SO AL MED CTR **Specialty :** OBSTETRIC & GYNECOLOGY	**State:** ALABAMA 07/1989 - 09/1991 (VERIFIED)

AMA Physician Profile (continued)

It is mutually agreed between the American Medical Association (AMA) and the requesting organization that this Physician Profile (see reverse) is provided to the requesting organization with the understanding that (1) the information on the Profile will be treated with total confidentiality; (2) that such information is granted solely to the requesting organization and is granted as a non-exclusive limited license, consistent with and limited to the specific purposes set forth on the Physician Profile request form or other agreement; and (3) that no Physician Profile or information contained therein will be sold, provided to, released, copied, extracted or otherwise usurped for use by any other party, entity, organization or government agency. **Disclosure, sale or resale of Physician Profiles or the information contained therein to any third party, whether or not affiliated with the requesting organization, is strictly prohibited except that this prohibition shall not apply with respect to: disclosures required by federal or state government agencies (including, without limitation, disclosure to the physician about whom any such data relates), judicial authorities under court order, federal regulatory bodies with jurisdiction over the requesting organization, or disclosures otherwise required under federal or state law; *provided however,* that if the requesting organization is served with a subpoena or other legal process requiring the production or disclosure of Physician Profiles, then the requesting organization, to the extent reasonably practicable before complying, will promptly notify AMA and permit AMA to intervene and contest disclosure or production time and circumstances permitting.** Upon a breach of any of the foregoing covenants or upon the effective date of any statute, regulation or court decision mandating any disclosure whatsoever of such Profile information by the requesting organization, such license to use and possess the Profile shall be automatically and immediately terminated and the Profile and any information or data contained thereon or, in any way, derived therefrom shall be returned to the AMA immediately, but, in no event, later than 48 hours after such automatic termination.

AMA makes no representations or warranties either, expressed or implied, as to the accuracy, completeness or timeliness of the information contained in Physician Profiles and assumes no responsibility for any errors or omissions contained therein. Furthermore, no warranty, express or implied, is created by providing information through Physician Profiles. The AMA does not endorse in any way the individuals described in the Physician Profiles; and in no event shall the AMA be liable to the requesting organization or anyone else for any decision made or action taken in reliance on such information.

American Medical Association

Physicians dedicated to the health of America

Division of Survey and Data Resources
515 North State Street
Chicago, Illinois 60610
http://www.ama-assn.org/amaprofiles

AMA Physician Profile

Current and/or Prior Medical Training Programs Accredited by the Accreditation Council for Graduate Medical Education (ACGME):

Institution: KALEIDA HLTH SYS-M FILLMORE	**State:** NEW YORK
Specialty : INTERNAL MEDICINE	07/1984 - 06/1985 (NOT YET VERIFIED)
Institution: VET AFFAIRS MED CTR	**State:** NEW YORK
Specialty : INTERNAL MEDICINE	07/1985 - 06/1986 (NOT YET VERIFIED)
Institution: LUTHERAN MED CTR	**State:** NEW YORK
Specialty : OBSTETRIC & GYNECOLOGY	08/1988 - 06/1989 (VERIFIED)

Note: Additional information, used for appointments and privileges, is not solicited, nor is it received from the residency program director(s). If additional information is required, please contact the program director(s).

National Board of Medical Examiners (NBME) Certification Year: NONE REPORTED TO DATE

License(s): State	MD/ DO	Date Granted	Expiration Date	Status	License Type	Last Reported
NEW JERSEY	MD	12/02/1996	06/30/2001	ACTIVE	UNLIMITED	06/01/2001
NEVADA	MD	11/22/1995	06/30/2001	ACTIVE	UNLIMITED	04/30/2001
CALIFORNIA	MD	07/27/1994	08/31/2001	ACTIVE	UNLIMITED	04/10/2001
NEW YORK	MD	03/23/1993	07/31/2001	ACTIVE	UNLIMITED	07/01/2001

Note: When the specific month and day are unknown, the date will display the default value of "01." Not all licensing boards maintain or provide full date values. Please contact the appropriate licensing board directly for this information.

ECFMG Certfication:

Applicant Number: 03124302

Note: The Educational Commission for Foreign Medical Graduates (ECFMG) applicant identification number does not imply current ECFMG certification status. To verify ECFMG status, contact the ECFMG Certification Verification Service in writing at P.O. Box 13679, Philadelphia, PA 19101.

Federal Drug Enforcement Administration:

AS OF 06/01/2001, FEDERAL DEA REGISTRATION IS VALID. EXPIRATION DATE IS 06/30/2004.

Note: Many states require their own controlled substances registration/license. Please check with your state licensing authority as the AMA does not maintain this information.

AMA Physician Profile (continued)

It is mutually agreed between the American Medical Association (AMA) and the requesting organization that this Physician Profile (see reverse) is provided to the requesting organization with the understanding that (1) the information on the Profile will be treated with total confidentiality; (2) that such information is granted solely to the requesting organization and is granted as a non-exclusive limited license, consistent with and limited to the specific purposes set forth on the Physician Profile request form or other agreement; and (3) that no Physician Profile or information contained therein will be sold, provided to, released, copied, extracted or otherwise usurped for use by any other party, entity, organization or government agency. **Disclosure, sale or resale of Physician Profiles or the information contained therein to any third party, whether or not affiliated with the requesting organization, is strictly prohibited except that this prohibition shall not apply with respect to: disclosures required by federal or state government agencies (including, without limitation, disclosure to the physician about whom any such data relates), judicial authorities under court order, federal regulatory bodies with jurisdiction over the requesting organization, or disclosures otherwise required under federal or state law; *provided however*, that if the requesting organization is served with a subpoena or other legal process requiring the production or disclosure of Physician Profiles, then the requesting organization, to the extent reasonably practicable before complying, will promptly notify AMA and permit AMA to intervene and contest disclosure or production time and circumstances permitting.** Upon a breach of any of the foregoing covenants or upon the effective date of any statute, regulation or court decision mandating any disclosure whatsoever of such Profile information by the requesting organization, such license to use and possess the Profile shall be automatically and immediately terminated and the Profile and any information or data contained thereon or, in any way, derived therefrom shall be returned to the AMA immediately, but, in no event, later than 48 hours after such automatic termination.

AMA makes no representations or warranties either, expressed or implied, as to the accuracy, completeness or timeliness of the information contained in Physician Profiles and assumes no responsibility for any errors or omissions contained therein. Furthermore, no warranty, express or implied, is created by providing information through Physician Profiles. The AMA does not endorse in any way the individuals described in the Physician Profiles; and in no event shall the AMA be liable to the requesting organization or anyone else for any decision made or action taken in reliance on such information.

American Medical Association

Physicians dedicated to the health of America

Division of Survey and Data Resources
515 North State Street
Chicago, Illinois 60610
http://www.ama-assn.org/amaprofiles

AMA Physician Profile

Specialty Board Certification(s):

Specialty Board Certification(s) by one or more of the 24 boards recognized by the American Board of Medical Specialties (ABMS) and the American Medical Association (AMA) through the Liaison Committee on Specialty Boards, as reported by the ABMS:

Certifying Board: TO DATE, THERE HAVE BEEN NO BOARD CERTIFICATIONS REPORTED.
Certificate:
Certificate Type:
Effective: **Expiration:** **Last Reported:**

Note: **For certification dates, a default value of "01" appears in the month field if data was not provided to AMA. Please contact the appropriate specialty board directly for this information.**

Medicare/Medicaid Sanction(s):

TO DATE, THERE HAVE BEEN NO SUCH SANCTIONS REPORTED TO THE AMA BY THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.

Other Federal Sanction(s):

TO DATE, THERE HAVE BEEN NO FEDERAL SANCTIONS REPORTED TO THE AMA BY ANY BRANCH OF THE US MILITARY, THE VETERAN'S ADMINSTRATION OR THE US PUBLIC HEALTH SERVICE.

Additional Information:

TO DATE, THERE IS NO ADDITIONAL INFORMATION FOR THIS PHYSICIAN ON FILE.

The content of the AMA Physician Profile is intended to assist with credentialing. Appropriate use of the AMA Physician Masterfile data contained on this Profile by an organization would meet the primary source verification requirements of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the American Accreditation HealthCare Commission/URAC. The Physician Masterfile meets the National Committee for Quality Assurance (NCQA) standards for verification of medical education, residency training, board certification, DEA status, and Medicare/Medicaid sanctions.

If you note any discrepancies, please mark them on a copy of the profile and mail or fax to:

Division of Survey and Data Resources
Attn: Physician Profile Unit
515 N. State Street
Chicago, IL 60610
312 464-5199
312 464-5900 (fax)

AMA Physician Profile (continued)

It is mutually agreed between the American Medical Association (AMA) and the requesting organization that this Physician Profile (see reverse) is provided to the requesting organization with the understanding that (1) the information on the Profile will be treated with total confidentiality; (2) that such information is granted solely to the requesting organization and is granted as a non-exclusive limited license, consistent with and limited to the specific purposes set forth on the Physician Profile request form or other agreement; and (3) that no Physician Profile or information contained therein will be sold, provided to, released, copied, extracted or otherwise usurped for use by any other party, entity, organization or government agency. **Disclosure, sale or resale of Physician Profiles or the information contained therein to any third party, whether or not affiliated with the requesting organization, is strictly prohibited except that this prohibition shall not apply with respect to: disclosures required by federal or state government agencies (including, without limitation, disclosure to the physician about whom any such data relates), judicial authorities under court order, federal regulatory bodies with jurisdiction over the requesting organization, or disclosures otherwise required under federal or state law; *provided however,* that if the requesting organization is served with a subpoena or other legal process requiring the production or disclosure of Physician Profiles, then the requesting organization, to the extent reasonably practicable before complying, will promptly notify AMA and permit AMA to intervene and contest disclosure or production time and circumstances permitting.** Upon a breach of any of the foregoing covenants or upon the effective date of any statute, regulation or court decision mandating any disclosure whatsoever of such Profile information by the requesting organization, such license to use and possess the Profile shall be automatically and immediately terminated and the Profile and any information or data contained thereon or, in any way, derived therefrom shall be returned to the AMA immediately, but, in no event, later than 48 hours after such automatic termination.

AMA makes no representations or warranties either, expressed or implied, as to the accuracy, completeness or timeliness of the information contained in Physician Profiles and assumes no responsibility for any errors or omissions contained therein. Furthermore, no warranty, express or implied, is created by providing information through Physician Profiles. The AMA does not endorse in any way the individuals described in the Physician Profiles; and in no event shall the AMA be liable to the requesting organization or anyone else for any decision made or action taken in reliance on such information.

Kentucky Board of Medical Licensure
310 Whittington Parkway, #1B
Louisville, KY 40222

RECEIVED
SEP 13 2001
K.B.M.L.

****DEA Status Request****

Name	Samuel Louis Auerbach, M.D.
Street Address	1037 W. Avenue North, #103
City, State, Zipcode	Palmdale, CA 93551
Birthdate	08/30/1955
Social Security Number	128-48-7731
DEA Number	BA6319289

A SEARCH HAS BEEN MADE OF THE FILES OF DEA.
NO RECORDS HAVE BEEN FOUND WHICH DISCLOSE A
DRUG-RELATED FELONY OR MISDEMEANOR CONVICTION
FOR THE INDIVIDUAL IDENTIFIED ABOVE.

SEP - 7 2001

MARK W. CAVERLY, G/S

National Practitioner Data Bank
Healthcare Integrity and Protection Data Bank

P.O. Box 10832
Chantilly, VA 20153-0832

www.npdb-hipdb.com

RECEIVED
OCT 30 2001
K.B.M.L.

DCN: 5500000023092419
Process Date: 10/12/2001, 15:42

RESPONSE TO INFORMATION DISCLOSURE REQUEST

A. REQUESTOR IDENTIFICATION

Requestor Name: AUERBACH, SAMUEL LOUIS
Telephone: (818)609-9070

Address: 18615 BURBANK BLVD

City, State, ZIP: TARZANA, CA 91356
Country:

B. PAYMENT INFORMATION

Account Number: XXXXXXXXXXXX7155
Expiration Date: 02/2002
Transaction Date: 10/12/2001
Transaction Number: 5500000023092419
Total Charge: $ 10.00

C. SUBJECT ON WHOM DISCLOSURE IS REQUESTED

Subject Name: AUERBACH, SAMUEL LOUIS
Gender: MALE
Date of Birth: 08/30/1955

Other Name(s) Used:

Organization Name:
Organization Type: MEDICAL GROUP/PRACTICE (365)
Organization Type Description:

Work Address: 18615 BURBANK BLVD; SUITE #214

City, State, ZIP: TARZANA, CA 91356
Country:

Home Address: 18615 BURBANK BLVD

City, State, ZIP: TARZANA, CA 91356
Country:

Social Security Numbers (SSN): 128-48-7731

Professional School(s) & Year (s) of Graduation: UNIVERSIDAD DEL NORESTE 1980

National Practitioner Data Bank
Healthcare Integrity and Protection Data Bank

P.O. Box 10832
Chantilly, VA 20153-0832

www.npdb-hipdb.com

RECEIVED
OCT 30 2001
K.B.M.L.

Occupation/Field of Licensure (Code):	ALLOPATHIC PHYSICIANS (MD) (010)
State License Numbers, State of Licensure: Other, as specified:	24126, AL
Physician Specialty:	OBSTETRICS & GYNECOLOGY (50)
Occupation/Field of Licensure (Code):	ALLOPATHIC PHYSICIANS (MD) (010)
State License Numbers, State of Licensure: Other, as specified:	MA65075, NJ
Physician Specialty:	OBSTETRICS & GYNECOLOGY (50)
Occupation/Field of Licensure (Code):	ALLOPATHIC PHYSICIANS (MD) (010)
State License Numbers, State of Licensure: Other, as specified:	7617, NV
Physician Specialty:	OBSTETRICS & GYNECOLOGY (50)
Occupation/Field of Licensure (Code):	ALLOPATHIC PHYSICIANS (MD) (010)
State License Numbers, State of Licensure: Other, as specified:	A053310, CA
Physician Specialty:	OBSTETRICS & GYNECOLOGY (50)
Occupation/Field of Licensure (Code):	ALLOPATHIC PHYSICIANS (MD) (010)
State License Numbers, State of Licensure: Other, as specified:	191774, NY
Physician Specialty:	OBSTETRICS & GYNECOLOGY (50)
Drug Enforcement Administration (DEA) Numbers:	BA6319289
National Provider Identifiers (NPI):	
Federal Employer Identification Numbers (FEIN):	
Unique Physician Identification Numbers (UPIN):	F90764

D. SEARCH RESULT

Based on the subject identification information provided by you in Section C above, a search of the NPDB has located the following 0 report(s).

Recipients should verify that the subject identified in Section C is, in fact, the subject of interest.

Copies of these reports are enclosed for restricted/limited use as prescribed by Title IV of Public Law 99-660, as amended. Recipients should verify that the subject identified in Section B of the report(s) is, in fact, the subject of interest. Information from the NPDB is confidential and must be used solely for the purpose for which it was disclosed. ANY PERSON WHO VIOLATES THE CONFIDENTIALITY PROVISIONS AS SPECIFIED IN TITLE IV IS SUBJECT TO A CIVIL MONEY PENALTY OF UP TO $11,000 FOR EACH VIOLATION. Subjects of reports who obtain information about themselves from the NPDB are permitted to share that information with anyone they choose.

National Practitioner Data Bank
Healthcare Integrity and Protection Data Bank

P.O. Box 10832
Chantilly, VA 20153-0832

www.npdb-hipdb.com

DCN: 5500000023092419
Process Date: 10/12/2001, 15:42

RESPONSE TO INFORMATION DISCLOSURE REQUEST

A. REQUESTOR IDENTIFICATION

Requestor Name: AUERBACH, SAMUEL LOUIS
Telephone: (818)609-9070

Address: 18615 BURBANK BLVD

City, State, ZIP: TARZANA, CA 91356
Country:

B. PAYMENT INFORMATION

Account Number: XXXXXXXXXXXX7155
Expiration Date: 02/2002
Transaction Date: 10/12/2001
Transaction Number: 5500000023092419
Total Charge: $ 10.00

C. SUBJECT ON WHOM DISCLOSURE IS REQUESTED

Subject Name: AUERBACH, SAMUEL LOUIS
Gender: MALE
Date of Birth: 08/30/1955

Other Name(s) Used:

Organization Name:
Organization Type: MEDICAL GROUP/PRACTICE (365)
Organization Type Description:

Work Address: 18615 BURBANK BLVD; SUITE #214

City, State, ZIP: TARZANA, CA 91356
Country:

Home Address: 18615 BURBANK BLVD

City, State, ZIP: TARZANA, CA 91356
Country:

Social Security Numbers (SSN): 128-48-7731

Professional School(s) & Year (s) of Graduation: UNIVERSIDAD DEL NORESTE 1980

National Practitioner Data Bank
Healthcare Integrity and Protection Data Bank

P.O. Box 10832
Chantilly, VA 20153-0832

www.npdb-hipdb.com

Occupation/Field of Licensure (Code):	ALLOPATHIC PHYSICIANS (MD) (010)
State License Numbers, State of Licensure: Other, as specified:	24126, AL
Physician Specialty:	OBSTETRICS & GYNECOLOGY (50)
Occupation/Field of Licensure (Code):	ALLOPATHIC PHYSICIANS (MD) (010)
State License Numbers, State of Licensure: Other, as specified:	MA65075, NJ
Physician Specialty:	OBSTETRICS & GYNECOLOGY (50)
Occupation/Field of Licensure (Code):	ALLOPATHIC PHYSICIANS (MD) (010)
State License Numbers, State of Licensure: Other, as specified:	7617, NV
Physician Specialty:	OBSTETRICS & GYNECOLOGY (50)
Occupation/Field of Licensure (Code):	ALLOPATHIC PHYSICIANS (MD) (010)
State License Numbers, State of Licensure: Other, as specified:	A053210, CA
Physician Specialty:	OBSTETRICS & GYNECOLOGY (50)
Occupation/Field of Licensure (Code):	ALLOPATHIC PHYSICIANS (MD) (010)
State License Numbers, State of Licensure: Other, as specified:	191774, NY
Physician Specialty:	OBSTETRICS & GYNECOLOGY (50)
Drug Enforcement Administration (DEA) Numbers:	BA6319289
National Provider Identifiers (NPI):	
Federal Employer Identification Numbers (FEIN):	
Unique Physician Identification Numbers (UPIN):	F90764

D. SEARCH RESULT

Based on the subject identification information provided by you in Section C above, a search of the HIPDB has located the following 0 report(s).

Recipients should verify that the subject identified in Section C is, in fact, the subject of interest.

Copies of these reports are enclosed for restricted/limited use as prescribed by Section 1128E of the Social Security Act. Recipients should verify that the subject identified in Section B of the report(s) is, in fact, the subject of interest. Information from the HIPDB is confidential and must be used solely for the purpose for which it was disclosed. Subjects of reports who obtain information about themselves from the HIPDB are permitted to share that information with anyone they choose.

FEDERATION LICENSING EXAMINATION (FLEX)
Certified Transcript of Scores

This Transcript was prepared by the Federation of State Medical Boards

Kentucky Board of Medical Licensure
ATTN: Lana Cinnamon, Med Licensure Coordinator
The Hurstbourne Office Park
310 Whittington Parkway
Suite 1B
Louisville, KY 40222

RECEIVED
SEP 0 4 2001
K.B.M.L.

EXAMINEE: Auerbach, Samuel Louis
USMLE ID#: 2-145-594-4
DOB: 08 / 30 / 1955
ALTERNATE NAME(S):

It is certified that the above named physician took the Federation Licensing Examination on the date(s) entered below for the State Medical Licensing Board(s) listed and obtained the following scores:

FIN: 550830013 **Date of Certification:** 08/30/2001

Date of Exam	State Exam Taken For	State ID	Comp 1	Comp 2
12 / 1992	NEW YORK	00187	75	
6 / 1992	NEW YORK	00153	73	
12 / 1991	NEW YORK	00430	74	
6 / 1991	NEW YORK	00739	73	
12 / 1990	NEW YORK	00328	72	75
6 / 1990	NEW YORK	00303	73	74

COMPONENT 1 of FLEX is designed to evaluate measurable aspects of the knowledge and understanding of basic and clinical sciences, with specific emphasis on principles and mechanisms underlying disease and modes of therapy.

COMPONENT 2 of FLEX is designed to assess the additional cognitive abilities required of physicians who will ultimately assume independent responsibilities for the general health care of patients.

A search of the Board Action Data Bank of the Federation of State Medical Boards (FSMB) reveals no reported information on the above-named examinee.

FEDERATION LICENSING EXAMINATION (FLEX)
Certified Transcript of Scores

This Transcript was prepared by the Federation of State Medical Boards

RECEIVED
SEP 0 4 2001
K.B.M.L.

Kentucky Board of Medical Licensure
ATTN: Lana Cinnamon, Med Licensure Coordinator
The Hurstbourne Office Park
310 Whittington Parkway
Suite 1B
Louisville, KY 40222

EXAMINEE: Auerbach, Samuel Louis
USMLE ID#: 2-145-594-4
DOB: 08 / 30 / 1955
ALT. NAME(S):

It is certified that the above named physician took the Federation Licensing Examination on the date(s) entered below for the State Medical Licensing Board(s) listed and obtained the following scores:

FIN: 550830013 **Date of Certification: 8/30/01**

Examination Date:	06/83	12/82
State Taken For:	005	005
BASIC SCIENCE		
Anatomy:	69.00	62.00
Physiology:	64.00	64.00
Biochemistry:	69.00	67.00
Pathology:	77.00	72.00
Microbiology:	69.00	67.00
Pharmacology:	76.00	74.00
Behavioral Science:	70.00	76.00
Basic Science Avg:	70.57	68.85
CLINICAL SCIENCE		
Medicine:	74.00	76.00
Surgery:	75.00	69.00
Obstetrics:	76.00	76.00
Public Health:	75.00	72.00
Pediatrics:	82.00	69.00
Psychiatry:	70.00	69.00
Clinical Science Avg:	75.33	71.83
Clinical Comp Avg:	73.57	73.25
Flex Weighted Avg:	73.00	72.00

A search of the Board Action Data Bank of the Federation of State Medical Boards (FSMB) reveals no reported information on the above-named examinee.

EDUCATIONAL COMMISSION for FOREIGN MEDICAL GRADUATES

PHILADELPHIA OFFICE
3624 MARKET STREET, PHILADELPHIA, PENNSYLVANIA 19104-2685, U.S.A.
TELEPHONE: 215-386-5900 • FAX: 215-386-3185 • INTERNET: www.ecfmg.org

RECEIVED
SEP 10 2001
K.B.M.L.

State Board Code:
018
Please include this number on all requests

Executive Director
Board of Medical Licensure
310 Whittington Parkway
Louisville, KY 40222

ECFMG CERTIFICATION STATUS REPORT

ECFMG/USMLE Identification Number: 0-312-430-2
Applicant's Name: Samuel Louis Auerbach
Applicant's Date of Birth: 08/30/1955
ECFMG Certified: No

Certificate Issued Date: N/A
English Test Valid Through Date: N/A
Clinical Skills Assessment Valid Through Date: N/A

Passing Performance on Medical Science Examination for Certification:

Examination Type	Date	Component	Two-Digit Score	Three-Digit Score	Comments
ECFMG 1-DAY	01/26/1983	MEDICAL SCIENCE	75		

Most Current Passing Performance on Clinical Assessment for Certification: N/A

Most Current Passing Performance on English Test: JANUARY 1983

Name of Medical School and Country:

Degree Year:

† Medical Education Credential Status: Incomplete

This information is reported directly from ECFMG computer records and is current as of 09/07/2001.

* The purpose of this Status Report is to indicate whether this individual is ECFMG certified. This status report is not a complete history of all examinations this individual may have taken. It reflects only passing scores on the examination(s) used to fulfill the Medical Science Examination requirement for ECFMG certification. It also includes the most current passing performance on the Clinical Skills Assessment (CSA), regardless of whether CSA was required for ECFMG certification.

† Since July 1986, ECFMG has verified medical school credentials directly with the medical schools or through a reasonable alternative which has been approved by the ECFMG Medical Education Credentials Committee.

Important Note:
Requesting organizations must secure and retain the physician's signed authorization to obtain certification information. Organizations may not resell the information or make it available to any party beyond the initial request as authorized by the physician. The information may only be used to confirm ECFMG certification for the purpose for which the physician provided authorization.

018

ECFMG is an organization committed to promoting excellence in international medical education.

Form 8

Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, KY 40222

Federation Disciplinary Request

- ***Return this form to the Kentucky Board of Medical Licensure for processing***

To Applicant: In applying for a license to practice medicine in the Commonwealth of Kentucky, the Kentucky Board of Medical Licensure requires a disciplinary search from the Federation of State Medical Boards. My signature below is your authority to release any and all information in your files, favorable or otherwise, regarding myself.

Samuel Louis Auerbach MD
Physician's Signature

SAMUEL LOUIS AUERBACH
Name

18615 BURBANK BLVD
Address

TARZANA, CA 91356
City, State & Zipcode

8-30-55
Date of Birth

128-48-7731
Social Security Number

UNIVERSIDAD DEL NORESTE; TAMPICO TAMPS MEXICO
Medical School & Location

6-80 312-430-2
Date of Graduation E.C.F.M.G. #

Please place this with my application for licensure in Kentucky (Form #7 + #8)

Thanks

S Auerbach MD

S AUERBACH MD

K118

RECEIVED

NOV 16 2001

K.B.M.L.

Kentucky HIV/AIDS Education Affidavit of Reasonable Cause

I, SAMUEL LOUIS AUERBACH MD, request that the Board (KBML) defer my
(Name)

HIV/AIDS education requirement for initial professional licensure (KRS 214.615) for the following reason,

Please explain in detail: ANTICIPATION OF EMPLOYMENT; I DID NOT GET LISTING OF COURSES TILL RECENTLY. I DO NOT HAVE COMPUTER ACCESS. WILL FULFILL THIS REQUIREMENT AS SOON AS POSSIBLE

I understand that the deferment is valid for six (6) months from the date of the issuance of my temporary permit to practice medicine and is **not renewable.** I further understand that within this six months I must send to the Board (KBML), a copy of a certificate showing completion of a Kentucky Cabinet for Health Services approved HIV/AIDS course for a full and unrestricted license to be issued.

Signature: Samuel Louis Auerbach Date: 11/16/01

Printed Name: SAMUEL LOUIS AUERBACH MD

Social Security Number: 128-48-7731

→ This form must be sent to Board (KBML) in order for you to receive a six-month extension. Please retain a copy of this affidavit for your records.

Mail this form to the following address:

Medical Licensure Coordinator
Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, KY 40222
(502) 429-8046

THIS IS A PERMANENT CERTIFICATE

Nursing Spectrum

A Division of Gannett Satellite Information Network, Inc.
Division of Continuing Education, 2002 Renaissance Blvd., Suite 120
King of Prussia, PA 19406

On this date of February 27, 2002 we award:

samuel auerbach
18615 burbank blvd suite #214
tarzana, ca 91356

License: pending (ky)

2.0 contact hours for the study of:

Kentucky HIV/AIDS Requirement for Healthcare Professionals

This independent study for continuing education contact hours is provided by Nursing Spectrum Division of Continuing Education, which is accredited as a provider of continuing education in nursing by the American Nurses' Credentialing Center's Commission on Accreditation and by the State of Florida, Board of Nursing (Provider number FBN 2904), by the American Association of Critical-Care Nurses (0009259), by the New Jersey Department of Education Professional Development (provider ID 961), and by the California Board of Registered Nursing (Provider # CEP 13213).

AACN Category: A

Kentucky Provider: KY CHS #1002-1511-M

THIS IS A PERMANENT CERTIFICATE

RECEIVED
MAR 0 4 2002
K.B.M.L.

Were you able to print this certificate?

- **YES (return to the Nursing Spectrum homepage)**
- **NO (request a certificate from our CE office)**

RECEIVED

FEB 24 2003

K.B.M.L.

For Office Use Only: $125.00 [✓] Check# 133
$175.00 [ ] Check#_____
$225.00 [ ] Check#_____

Application for Renewal of Kentucky Medical/Osteopathic License for Year 2003

Registration Fee: $125.00

Late Registration (After March 1, but before April 1) may be made by payment of an additional $50.00 penalty fee. After April 1, 2003, you will be imposed an additional $100.00 fee.

Name: Samuel L. Auerbach, M.D. **Kentucky License No: 37003**

Mailing Address: 18615 Burbank Blvd
Tarzana, CA 91356-2649

1) Please indicate any changes/updates to mailing address as listed above:

Street: _____

(Mailing address must be a street address; Post office address will no longer be accepted.)

City & State: _____ Zip Code: _____

2) Practice Address if Different from Mailing Address: _____

_____

(Practice address must be a street address; Post office address will no longer be accepted.)

City & State: _____ Zip Code: _____

3) Principal KY Practice County: - Percent of Practice in that County: - %

(a.) List other KY counties in which you practice and percentage of practice occurring in each county:

County: - , _____%

County: - , _____%

County: - , _____%

(b.) Average total number of hours worked per week: -

4) Office Telephone Number: (702) 252-7296

5) E-Mail Address (For Office Use Only): -

6) Do you intend to practice medicine in Kentucky? [X] Yes [ ] No
If "NO" please specify reason for registering your Kentucky license: _____

7) Do you currently have hospital staff privileges within the Commonwealth of Kentucky? [ ] Yes [X] No

8) Specialty: **Obstetrics/Gynecology**

9) Type of Practice:

[ ] Hospital Based
[ ] Faculty
[ ] Administrative Medicine
[ ] Resident/Fellow
[X] Private Practice
[ ] Occupational Medicine
[ ] Military
[ ] Research
[ ] Emergency Medicine
[ ] Retired
[ ] Semi-Retired
[ ] Locum Tenens
[ ] Public Health/Government

Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, KY 40222
Telephone: (502) 429-8046
www.kbml.org

Continuing Medical Education Information

Continuing Medical Education (CME) regulation 201 KAR 9:310 requires all medical and osteopathic physicians wishing to maintain their Kentucky medical license to obtain 60 hours of CME every three years. This is the final year of the current three-year cycle (January 1, 2000 through December 31, 2002). Thirty of these required hours must be in Category 1 accredited by the Accreditation Council on Continuing Medical Education or the American Osteopathic Association and thirty hours may consist of non-supervised personal activities. Two of the total 60 hours must be acquired in a HIV/AIDS course approved by the Kentucky Cabinet for Health Services. **Please do not send documentation of your CME credits to the Board unless requested.**

Request For Extension To Complete Required CME Hours

If you have not satisfied the CME requirements as stated above, you may request an extension of time. According to 201 KAR 9:310. section 4, "The Board may grant an extension of time to a physician who for sufficient cause has not yet received continuing medical education requirements for the cycle."
In order to request an extension, please complete the section below, sign, date and return to the Board with the enclosed renewal form.

Please grant an extension to complete the Continuing Medical Education hours required for the CME cycle January 1, 2000 – December 31, 2002. I did not complete the required hours because: (please provide explanation)

_____

_____

_____

_____ _____
Printed Name Kentucky License Number

_____ _____
Signature Date

RECEIVED
FEB 24 2003
K.B.M.L.

Danny M. Clark, M.D.
President

Telephone (502) 429-8046
Fax (502) 429-9923

KENTUCKY BOARD OF MEDICAL LICENSURE

Hurstbourne Office Park
310 Whittington Parkway, Suite 1B
Louisville, Kentucky 40222
www.kbml.org

Continuing Medical Education Certification Form

(1.) Name: SAMUEL L. AUERBACH (2.) License Number: 37003

(3.) Address: 18615 BURBANK BLVD; TARZANA CA 91356

According to the Continuing Medical Education (CME) regulation 201 KAR 9:310, for each (3) year CME cycle, a licensee shall complete:

(a) *A total of sixty (60) hours of CME, if his/her license has been renewed for each year of a CME cycle;*
(b) *If his/her license has not been renewed for each year of a CME cycle, licensee shall complete twenty (20) hours of CME for each year for which his/her license has been renewed.*
(c) *A licensee whose initial licensure was granted the first year of the CME cycle for which verification is submitted: completion of (60) hours of CME before the end of the cycle;*
(d) *A licensee whose initial licensure was granted the second year of the CME cycle for which a verification is submitted: completion of forty (40) hours of CME before the end of the cycle;*
(e) *A licensee whose initial licensure was granted the third year of the CME cycle for which verification is submitted; completion if twenty (20) hours of CME before the end of the cycle.*

In order to comply with this requirement, please answer the following:

1. Have you completed your CME requirements for the CME cycle ***1/1/2000 – 12/31/2002***?
   Yes ☒ No ☐

2. Did you have an active Kentucky medical license during the years of the CME cycle ***1/1/2000 – 12/31/2002***?

First year of cycle	(1/1/2000 – 12/31/2000)	Yes ☐	No ☒
Second year of cycle	(1/1/2001 – 12/31/2001)	Yes ☐	No ☒
Third year of cycle	(1/1/2002 – 12/31/2002)	Yes ☒	No ☐

3. Did you obtain initial licensure in Kentucky during the years of the CME cycle ***1/1/2000 – 12/31/2002***?

First year of cycle	(1/1/2000 – 12/31/2000)	Yes ☐	No ☒
Second year of cycle	(1/1/2001 – 12/31/2001)	Yes ☐	No ☒
Third year of cycle	(1/1/2002 – 12/31/2002)	Yes ☒	No ☐

Samuel L. Auerbach
Signature

2-14-03
Date

** Years of the cycle will change each CME cycle

EDUCATION PAYS

Application for Registration of Kentucky Medical/Osteopathic License for Year 2003

Name: Samuel L. Auerbach, M.D. **License No: 37003**

The answers to these questions are exempt from public disclosure under KRS 61.878(1)(a) and KRS 311.619 and shall be subject to inspection only upon order of a court of competent jurisdiction, except that no court shall authorize the inspection by any party of any materials pertaining to civil litigation beyond that which is provided by the Kentucky Rules of Civil Procedure governing pretrial discovery. The answers to these questions may be considered by the Board and may be disclosed in any contested case proceeding, including a Show Cause proceeding, or appeal of a licensing decision based upon them.

"Illegal drug use" means the use of an illegally obtained controlled substance or dangerous drug; the term "illegal drug use" also means the use of a legally obtained controlled substance or dangerous drug which is not taken in accordance with the direction of the licensed health care professional who prescribed the controlled substance or dangerous drug.

(1.) Since you last registered, have you suffered from or been treated for any medical and/or psychiatric condition which might impair your ability to continue to practice medicine?
☐Yes ☒No

(2.) Since you last registered, have you suffered from or been treated for drug or alcohol abuse and/or dependency?
☐Yes ☒No

I hereby state that the information contained in this application is true, accurate and complete to the best of my knowledge and belief. I understand any false information on my application may subject my license to disciplinary action pursuant to KRS 311.595.

Applicant Signature: Samuel L. Auerbach Date: 02-14-03

If You Answer "Yes" To Questions (1) Or (2) Please Attach A Written Explanation.

Only Completed Applications Will Be Processed; Incomplete Applications Or Applications Received Without Payment Will Be Returned

Application for Registration of Kentucky Medical/Osteopathic License for Year 2003

Name: Samuel L. Auerbach, M.D. **KY License No: 37003**

1) Since you last registered have you had any license, certificate, registration or other privilege to practice as a health care professional denied, revoked, suspended, probated, restricted, reprimanded, limited, or subjected to any other disciplinary action, by a state medical/osteopathic licensing board, or Federal, or International authority?
☐Yes ☒No

2) Since you last registered have you surrendered such credential, or placed it into an inactive status, to avoid disciplinary action or in connection with or in anticipation of a disciplinary investigation/action by the licensing authority of such jurisdiction?
☐Yes ☒No

3) Since you last registered have you been or are you currently under investigation by any State medical/osteopathic licensing board, Federal or International licensure authority or any drug licensure/enforcement authority?
☐Yes ☒No

4) Since you last registered has the Drug Enforcement Administration (DEA), or any state or International drug licensure/enforcement authority denied, revoked, suspended, restricted, limited, or otherwise disciplined a controlled substance registration certificate issued to you?
☐Yes ☒No

5) Since you last registered have you voluntarily or involuntarily surrendered a medical or osteopathic license, or controlled substance registration certificate issued to you?
☐Yes ☒No

6) Since you last registered has any hospital, hospital medical staff or any other health care entity revoked, suspended, restricted, limited, reprimanded, placed on probation or otherwise disciplined your staff privileges?
☐Yes ☒No

7) Since you last registered have you resigned your privileges or failed to renew privileges at a licensed hospital or from the medical staff of the hospital or any other health care entity, while under investigation or while you were subject to disciplinary proceedings by any of the entities notes above?
☐Yes ☒No

8) Since you last registered are any legal proceedings regarding licensure presently pending against you by any State, Federal or International licensure authority or any drug licensure/enforcement authority?
☐Yes ☒No

9) Since you last registered have you been removed, suspended, expelled or disciplined by any professional medical association or society?
☐Yes ☒No

10) Since you last registered have you been convicted of a felony or misdemeanor by any State, Federal or International court? Are any criminal charges presently pending against you in any of those courts?
☐Yes ☒No

11) Since you last registered to your knowledge, are you the subject of an investigation for a criminal act?
☐Yes ☒No

12) Since you last registered have you had to pay a judgment in a malpractice action or other civil action against your medical practice or are any malpractice or other civil actions against your medical practice presently pending in any court?
☐Yes ☒No

13) Are you currently in default on any student loan repayment obligations payable to the financial aid programs administered by the Kentucky Higher Education Assistance Authority?
☐Yes ☒No

I hereby state that the information contained in this application is true, accurate and complete to the best of my knowledge and belief. I understand any false information on my application may subject my license to disciplinary action pursuant to KRS 311.595.

Applicant Signature: Samuel L. Auerbach **Date:** 2-14-03

If you answer "Yes" to question 10 - 22, please attach a written explanation.

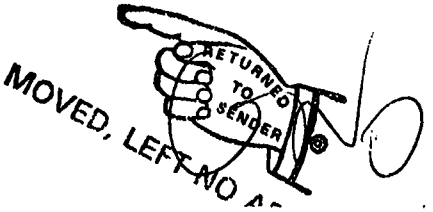
Only Completed Applications Will Be Processed; Incomplete Applications Or Applications Received Without Payment Will Be Returned

KENTUCKY
BOARD OF MEDICAL LICENSURE
HURSTBOURNE OFFICE PARK
310 WHITTINGTON PARKWAY, SUITE 1B
LOUISVILLE, KY 40222

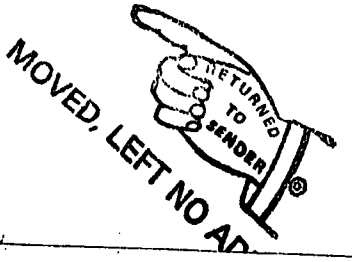
37003

PRESC
FIRST-CL
U.S. PO
PA
LOUISVI
Permit N

no alternate address



Samuel L. Auerbach, M.D.
18615 Burbank Blvd
Tarzana, CA 91356-2649



40222-4941 23