STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY

PETE WILSON, Governor

State of California Department of Consumer Affairs

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

MAY 92 11 15

009465

APPLICATION FOR PHYSICIAN AND SURGEON'S EXAMINATION OR LICENSURE

5/92

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

MBC USE ONLY

1. Name: Last / First / Middle
   Stabinsky, Seth Alan

2. Other names you have used (include maiden name):
   none

3. Social Security Number
   See disclosure statement on LIC

4. Address: Number and Street/Rural Route (include apartment number, if any)
   37 Cross Road
   City / State / ZIP Code / Country
   Stamford, Connecticut 06905 U.S.A.

5. Telephone Number: Home / Work

6. Date of Birth: Mo. Day Yr

Place of Birth:

7. Sex: [ ] Female [X] Male

8. Are you a U.S. citizen? [X] Yes [ ] No
   If you are a Foreign Medical Graduate you must provide an original Certificate of Naturalization, Declaration of Intent to become a U.S. citizen or a full unrestricted license to practice medicine in a state or country

9. Have you ever filed an application for examination or licensure in California? [ ] Yes [X] No
   If YES, give date previous application was submitted

MBC USE ONLY: PERSONAL DATA 005330 480 11/92 MAY 15 1992 SEPULVEDA

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

Name	Address	Period of Attendance From (Mo./Yr.)	To (Mo./Yr.)
Brandeis University	South St. Waltham, Ma. 02254	8/78	5/82

NON-MEDICAL EDUCATION

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

Course	Yes	No	Name of College or University
Chemistry	X		Brandeis University
Physics	X		Brandeis University
Biology or Zoology	X		Brandeis University

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

Name	Address	Place Where Instruction Received	Period of Attendance From (Mo./Yr.)	To (Mo./Yr.)
Mount Sinai	One Gustave Levy Place	New York, N.Y.	8/83	5/87

MEDICAL EDUCATION — CME [✓] TRANS. [✓]

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

Name of Medical School / Address of Medical School / Exact Date of Issuance

School Code: NY047

Mount Sinai School of Medicine One Gustave Levy Place New York, N.Y. 10029 5/29/87

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

L1A

07A 100 (REV. 7/91)

MBC USE ONLY

13. Have you taken any of the following written examinations: National Boards, other State Boards, FLEX, ECFMG Certification? [X] Yes [ ] No

If YES, list name, location, date and result of examination. Submit certification of scores from each examination agency. Applicants who hold ECFMG certification will need to submit an original valid ECFMG certificate for examination and licensure.

WRITTEN EXAMINATION

Name	Location	Date	Result
NBME part I	Mount Sinai N.Y.C.	1985	
NBME part II	Mount Sinai N.Y.C.	1987	
NBME part III	Einstein N.Y.C.	1988	

14. Have you satisfactorily completed at least one year of qualifying postgraduate training in U.S. or Canadian facilities? [X] Yes [ ] No
(Note: Do not complete Form L3 (s) to document training received in research or clinical fellowship programs)

If YES, list name and address of all facilities. Submit an original Certificate of Completion of ACGME Postgraduate Training (Form L3) from each facility

POSTGRADUATE TRAINING

Name	Address	Type of Service	Period of Attendance From (Mo/Yr)	To (Mo/Yr)
BMHC/Albert Einstein	Bronx, N.Y.	OBGYN pgy-1	7/87	6/88
St. Barnabas Med Ctr	Livingston, N.J.	OBGYN	7/88	6/91

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

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

15. Have you been licensed to practice medicine in any state or country? [X] Yes [ ] No

If YES, list state or country, license number, date issued and dates of practice in issuing agency's jurisdiction [illegible] submit a Letter of Good Standing from each state in which you are licensed or have been licensed. Please include temporary, limited, or provisional licenses.

LICENSE DATA

State or Country	License Number	Date of Issuance	Dates of Practice in Issuing Agency's Jurisdiction From (Mo/Yr)	To (Mo/Yr)	LGS	CE
New York	174809-1	7/88	7/88	7/89	☑	☐
New Jersey	MA 52661	1/89	1/89	6/91	☑	☐
Connecticut	030085	11/89	7/91	present	☑	☐
					☐	☐

16. Has any disciplinary action ever been filed or taken regarding any healing arts license which you now hold or have ever held? Include any disciplinary actions by the U.S. Military, U.S. Public Health Service or other U.S. federal governmental entity. Yes No

If yes, give details below.

State	Date	Charge	Disposition

L1B

MBC USE ONLY

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

If yes, give details below.

State or Country	Date of Denial	Reason for Denial

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

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

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

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

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

If yes, give details below.

Violation and Location	Date	Penalty or Disposition

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

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

If yes, give details below.

Violation and Location	Date	Penalty or Disposition

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

L1C

I hereby declare under penalty of perjury under the laws of the State of California, that the photo of myself attached hereto, was taken

on or about _____ 19__;

my age then being _____ years;

color of hair _____;

color of eyes _____;

height _____ ft. _____ in.;

weight _____ lbs.;

identifying marks _____

NOTE: All items in this application are mandatory; some are voluntary. Failure to provide any of the requested information will result in the application being rejected as incomplete. The information provided will be used to determine qualification for licensure, per Section 2080 of the Business and Professions Code which authorizes the collection of this information requiring the issuance or denial of a license by the Board may be transmitted to any other medical licensing authority, [illegible] applicants have the right to review their application subject to the provisions of the Information Practices Act. The Physician [illegible] is the custodian of records.

STATE OF Connecticut

COUNTY OF Fairfield

Jack Alan Stabinsky, M.D

the person referred to in the foregoing application for physician and surgeon's [illegible] understands all requirements thereon and that the statements made herein are true [illegible] the laws of the State of California.

He requests that the Medical Board of California [illegible] for examination, postgraduate training or licensure in California, including the [illegible] made by any individual or agency, relative to their training and qualifications [illegible] required by the Board [illegible] in his file.

Signed and sworn to before me this 20th day of April 19 85

Signature of [illegible]

NOTARY SEAL

Address 502 E. Stevens Plain Rd. Danbury CT 06810

My commission expires MY COMMISSION EXPIRES 10-01-88

L1D

STATE OF CALIFORNIA--STATE AND CONSUMER SERVICES AGENCY

PETE WILSON, Governor

State of California Department of Consumer Affairs

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

MAY 13 12 07 PM '92

CERTIFICATE OF MEDICAL EDUCATION

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

This certifies that Seth Alan Stabinsky *
FULL NAME OF APPLICANT

of 163 E. Rocks Rd. Norwalk, Ct. enrolled in Mount Sinai School of Medicine
ADDRESS WHEN ENROLLED — NAME OF MEDICAL SCHOOL

New York, New York on the _____ day of Sept. 1, 19 83
LOCATION — MONTH — YEAR

and was granted the following credits on enrollment:

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

Brandeis University — 8/78-5/82
EDUCATIONAL INSTITUTION — DATES

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

MEDICAL SCHOOL — TOTAL CREDITS — DATES

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

☒ he was granted the degree ~~Bachelor~~/Doctor of Medicine by

OR ☐ he withdrew from

the above-mentioned medical school on the 29th day of May 1987.

SPECIFY NUMBER — NUMBER OF WEEKS — MONTH

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

[redacted]

Signed and the college seal affixed this 5th day of May, 1990.

BY [signature]
REGISTRAR — PRESIDENT, SECRETARY, DEAN

Medical School Seal MUST Be Imprinted Partially on the Photograph.

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

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

L2

STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY

PETE WILSON, Governor

Consumer Affairs

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

92 MAY 11 AM 10: 17

RECEIVED SACRAMENTO MEDICAL BOARD OF CALIFORNIA MAY 13 10 36 AM '92

CERTIFICATE OF COMPLETION OF ACGME/CCME POSTGRADUATE TRAINING

To be completed by the facility for every medical school graduate completing postgraduate training in the United States or Canada. Do not complete if photograph of applicant is not attached on the reverse side. Also, please print or type information on the form.

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

Last Name Of Trainee: Stabinsky First Name: Seth Middle Initial: A.

Current Address: 37 Cross Road Phone Number: (203) 977-8649

City: Stamford State: Connecticut Zip Code: 06905

PART 2: *To be completed by facility.*

Completion of this form will certify that the individual named in Part 1 above and whose photograph is attached to this form, formally completed an accredited postgraduate training program at this facility. The following information is provided to certify "satisfactory" completion. See reverse side of Form for definition of "satisfactory".

Name of Facility: Bronx Municipal Hospital Center/Albert Einstein College of Medicine

Address of Facility: Pelham Parkway South & Eastchester Rd. Bronx, N.Y. 10461

Name of Program Director: Irwin Merkatz, M.D. Phone Number: ( )

Signature of Program Director: M. I.R. MERKATZ Date Signed: 5-5-92.

List Categorical Specialty Area of Training Completed by Trainee: OBGYN PGY-1 Date Training Commenced: 7/1/87 Date Training Completed 6/30/88

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

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

(OVER)

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

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

Name of Director of Medical Education: Donna Cuddeback

Phone Number: (212) 918-3230

Facility Name: Bronx Municipal Hospital Center

Date Form Completed: April 30, 1992

Facility Address: Pelham Parkway South & Eastchester Rd. Bronx, N.Y. 10461

City: Bronx State: New York Zip Code: 10461

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

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

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

Signature of Director of Medical Education: Donna A. Cuddeback

Donna A. Cuddeback
Associate Director

Date Signed: April 30, 1992

OFFICE OF MEDICAL STAFF AFFAIRS
BRONX MUNICIPAL HOSPITAL CENTER
PELHAM PARKWAY STAFF LOUNGE NO. 103
BRONX, NEW YORK 10461
EASTCHESTER RD.

[redacted]

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

Maria D. Fagan

1992

L3B

STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY

PETE WILSON, Governor

Consumer Affairs

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

92 MAY 14 AM 10: 18

MAY 13 10 02 AM '92

CERTIFICATE OF COMPLETION OF ACGME/CCME POSTGRADUATE TRAINING

To be completed by the facility for every medical school graduate completing postgraduate training in the United States or Canada. Do not complete if photograph of applicant is not attached on the reverse side. Also, please print or type information on the form.

PART 1: To be completed by applicant/trainee.

Last Name Of Trainee: Stabinsky First Name: Seth Middle Initial: A.

Current Address: 37 Cross Road Phone Number: (203) 977-8649

City: Stamford State: Connecticut Zip Code: 06905

PART 2: To be completed by facility.

Completion of this form will certify that the individual named in Part 1 above and whose photograph is attached to this form, formally completed an accredited postgraduate training program at this facility. The following information is provided to certify "satisfactory" completion. See reverse side of Form for definition of "satisfactory".

Name of Facility: Saint Barnabas Medical Center

Address of Facility: Old Short Hills Road Livingston, N.J. 07039

Name of Program Director: James L. Breen, M.D. Phone Number: (201) 533-5280

Signature of Program Director: X [signature] Date Signed:

List Categorical Specialty Area of Training Completed by Trainee: OBGYN Date Training Commenced: 7/1/88 Date Training Completed 6/30/91

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

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

(OVER)

L3A

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

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

Name of Director of Medical Education: Arthur Maron, M.D.

Phone Number: (201) 533-577[illegible]

Facility Name: Saint Barnabas Medical Center

Date Form Completed: 5-5-92

Facility Address: Old Short Hills Road

City: Livingston State: New Jersey Zip Code: 07039

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

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

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

Signature of Director of Medical Education: Arthur Maron MD

Date Signed: 5-5-92

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

[redacted]

L3B

STATE DEPARTMENT OF CONSUMER AFFAIRS
INTERNET CASHIERING SYSTEM
MEDICAL BOARD OF CALIFORNIA
SUPPLEMENTAL INFORMATION REPORT
From Date: 11/11/2008 **To Date:** 11/11/2008

ATRISUPPINF

18-SEP-14 13:32:25

Person Id : 614883 **Name :** Stabinsky,Seth

Question	Answer
I Have Completed Cme And Can Document An Average Of 25 Hours Of Approved Cme Each Calendar Year Resulting In A Minimum Of 100 Hours Over The Last 4 Years.	YES
I Have Completed 12 Hours Of Pain Management And End-Of-Life Care (Must Be Completed By December 31, 2006).	YES
I Am Exempt From The Completion Of 12 Hours Of Pain Management And End-Of-Life Care Continuing Education Requirement Because I Am A Radiologist Or Pathologist.	NO
Only For General Internists And Family Physicians Who Have 25% Of Their Patient Population Aged 65 Years Or Older: I Have Completed At Least 20% Of The Required Cme In Geriatric Medicine Or The Care Of Older Patients. Click No If Not Applicable.	NO
Enter Name/Address Of Facility Where You Or Your Immediate Family Hold Financial Interest. Type "None", If None Held.	NONE
I Certify Under Penalty Of Perjury Under The Laws Of The State Of California That The Information Contained In This Application Is True And Correct.	YES
I Have Read My Profile On The Medical Board Web Site At Www.Medbd.Ca.Gov And Acknowledge The Information Contained Therein As Current And Accurate.	YES

Total Questions Asked For Person : 614883 7

ATRISUPPINF

18-SEP-14 13:34:26

Person Id : 614883 **Name :** Stabinsky,Seth

Question	Answer
I Have Completed Cme And Can Document Not Less Than 50 Hours Of Approved Cme For The Two-Year Period Immediately Preceding The Expiration Date Of My License. Or I Meet The Conditions Which Would Exempt Me From All Or Part Of The Requirements.	YES
I Have Completed 12 Hours Of Pain Management And End-Of-Life Care.	YES
I Am Exempt From The Completion Of 12 Hours Of Pain Management And End-Of-Life Care Continuing Education Requirement Because I Am A Radiologist Or Pathologist.	NO
Only For General Internists And Family Physicians Who Have 25% Of Their Patient Population Aged 65 Years Or Older: I Have Completed At Least 20% Of The Required Cme In Geriatric Medicine Or The Care Of Older Patients. Click No If Not Applicable.	NO
Enter Name/Address Of Facility Where You Or Your Immediate Family Hold Financial Interest. Type "None", If None Held.	NONE
I Certify Under Penalty Of Perjury Under The Laws Of The State Of California That The Information Contained In This Application Is True And Correct.	YES
I Have Read My Profile On The Medical Board Web Site At Www.Mbc.Ca.Gov And Acknowledge The Information Contained Therein As Current And Accurate.	YES
Since You Last Renewed Your License, Have You Had Any License Disciplined By A Government Agency Or Other Disciplinary Body; Or, Have You Been Convicted Of Any Crime In Any State, The U S A And Its Territories, Military Court Or A Foreign Country?	NO

Total Questions Asked For Person : 614883 8

ATRISUPPINF

18-SEP-14 13:35:29

Person Id : 614883 **Name :** Stabinsky,Seth

Question	Answer
I Have Completed Cme And Can Document Not Less Than 50 Hours Of Approved Cme For The Two-Year Period Immediately Preceding The Expiration Date Of My License. Or I Meet The Conditions Which Would Exempt Me From All Or Part Of The Requirements.	YES
I Have Completed 12 Hours Of Pain Management And End-Of-Life Care.	YES
I Am Exempt From The Completion Of 12 Hours Of Pain Management And End-Of-Life Care Continuing Education Requirement Because I Am A Radiologist Or Pathologist.	NO
Only For General Internists And Family Physicians Who Have 25% Of Their Patient Population Aged 65 Years Or Older: I Have Completed At Least 20% Of The Required Cme In Geriatric Medicine Or The Care Of Older Patients. Click No If Not Applicable.	NO
Enter Name/Address Of Facility Where You Or Your Immediate Family Hold Financial Interest. Type "None", If None Held.	NONE
I Certify Under Penalty Of Perjury Under The Laws Of The State Of California That The Information Contained In This Application Is True And Correct.	YES
I Have Read My Profile On The Medical Board Web Site At Www.Mbc.Ca.Gov And Acknowledge The Information Contained Therein As Current And Accurate.	YES
Since You Last Renewed Your License, Have You Had Any License Disciplined By A Government Agency Or Other Disciplinary Body; Or, Have You Been Convicted Of Any Crime In Any State, The U S A And Its Territories, Military Court Or A Foreign Country?	NO

Total Questions Asked For Person : 614883 8