STATE OF CALIFORNIA — STATE AND CONSUMER SERVICES AGENCY — GEORGE DEUKMEJIAN, Governor

BOARD OF MEDICAL QUALITY ASSURANCE

1430 HOWE AVENUE
SACRAMENTO, CA 95825
(916)

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APPLICATION FOR PHYSICIAN AND SURGEON'S EXAMINATION AND LICENSURE

008804 127.50

007801 306.50

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.**

BMQA USE ONLY

PERSONAL DATA

1. Name: Last: Levy First: Adam Middle: Vincent
2. Other names you have used: (Last only) Espinoza-Levy
3. Address: Number and Street/Rural Route (include apartment number, if any): [redacted]
   City: [redacted] State: [redacted] ZIP Code: [redacted] Country: USA
4. Telephone Number: Home: [redacted] Work: [redacted]
5. Date of Birth: Mo/Day/Yr: [redacted]
6. Sex: ☐ Female ☑ Male
7. Are you a U.S. citizen? ☑ Yes ☐ No
   Submit a certified copy of birth certificate, Certificate of Naturalization, Declaration of Intention to become U.S. citizen (INS Form N300), VISA documents, or license to practice medicine.
8. Have you ever filed an application in California? ☐ Yes ☑ No
   If YES, give date of previous application:
9. List name and address of all colleges or universities attended other than schools where professional medical instruction was received. Submit an official transcript from each school attended.

NON-MEDICAL EDUCATION

Name	Address	Period of Attendance From (Mo/Yr)	To (Mo/Yr)
University of Calif. Santa Cruz	Santa Cruz, Ca. 95064	9/75	6/76
" " "	" " "	9/77	6/80

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

Course	Yes	No	Name of College or University
Chemistry	✓		University of California · Santa Cruz
Physics	✓		" " " "
Biology	✓		" " " "
Zoology	✓		" " " "

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

Name	Address	Place Where Instruction Received	Period of Attendance From (Mo/Yr)	To (Mo/Yr)
University of Southern California	2025 Zonal Los Angeles CA	McKibben Hall 90033	9/80	5/84

MEDICAL EDUCATION

CME TRANS.

12. Doctor of Medicine Degree granted by: (submit original medical diploma and a photocopy)

Name of Medical School	Address of Medical School	Exact Date of Issuance
University of Southern California School of Medicine	2025 Zonal Ave Los Angeles, CA 90033	May 8, 1984

CA006

School Code

13. Have you taken any of the following written examinations: National Boards, ECFMG, FMGEMS, FLEX, MSKP, MCAT, other related medical competency examinations? ☒ Yes ☐ No

If YES, list name, location, date and result of examination. Submit certification of scores from each examination agency.

WRITTEN EXAMINATION

Name	Location	Date	Result
National Boards I	Ambassador, Los Angeles	6/82	[redacted]
" " II	" " " "	4/84	[redacted]
" " III	" " " "	3/85	[redacted]

14. Have you received qualifying postgraduate training in U.S. or Canadian facilities? ☒ Yes ☐ No

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

POSTGRADUATE TRAINING

Name	Address	Type of Service	Period of Attendance From (Mo/Yr)	To (Mo/Yr)
University of Southern Calif. Los Angeles County Med. Ctr	1200 N. State St. L.A. CA. 90033	OB GYN	6/24/84	6/24/85
VALLEY MEDICAL CENTER	445 S. Cedar Ave FRESNO, CA 93702	Rotating " "	6/24/85	6/22/86

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

If YES, list state or country, license number, date issued and dates of practice in issuing agency's jurisdiction for each. Submit a Letter of Good Standing from each state in which you are licensed or have been licensed.

LICENSE DATA

State or Country	License Number	Date of Issuance	Dates of Practice in Issuing Agency's Jurisdiction From (Mo/Yr)	To (Mo/Yr)

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LICENSE DATA (continued)

16. Has any disciplinary action ever been 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

17. Have you ever been denied a license, permission to practice medicine or 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 ever voluntarily surrendered a license to practice in the healing arts in another state?

☐ Yes ☐ No If yes, please explain on a separate sheet of paper.

19. 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 If yes, please explain on a separate sheet of paper.

GENERAL DATA

20. Are you now, or were you in the past, addicted to controlled substances, such as narcotics or alcohol?

☐ Yes ☐ No

21. 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, or to drug addiction? ☐ Yes ☐ No

If yes, give details below:

Violation and Location	Date	Penalty or Disposition

22. 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 If yes, give details below:

Violation and Location	Date	Penalty or Disposition

You are required to list any conviction that has been set aside and dismissed under Section 1203.45 Penal Code or under any other provision of law.

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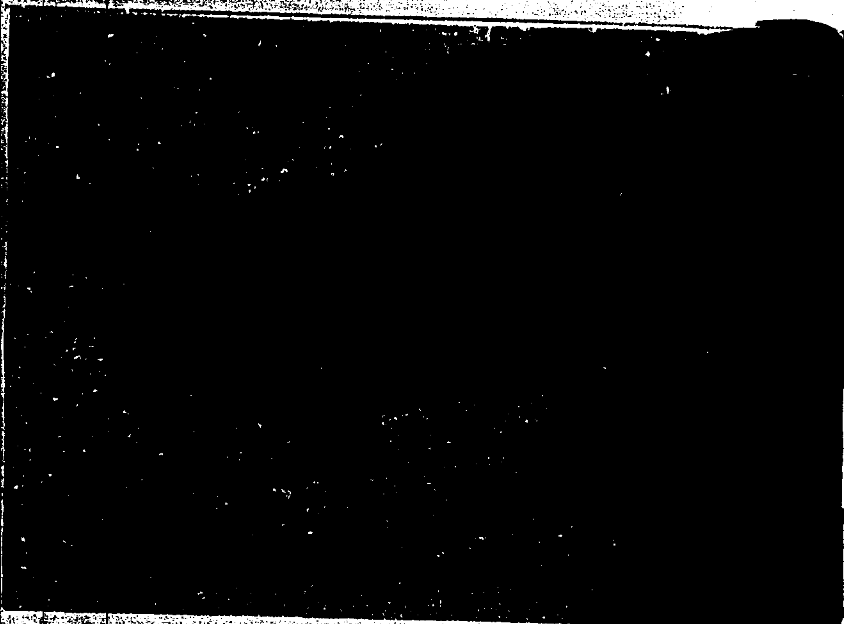


I hereby declare under penalty of perjury unde the laws of the State of California, that the phot of myself attached hereto, was taken

on or about ________, 19__

my age then being ____ years;

color of hair ________;

color of eyes ________;

height ____ ft. ____ in. ____;

weight ________ lbs.;

identifying marks ________

NOTE: All items in this application are mandatory; none are voluntary. Failure to provide any of the requested information will result in the applicatior being rejected as incomplete. The information provided will be used to determine qualification for licensure, per Section 2080 of the Busines: and Professions Code which authorizes the collection of this information. Applicants have the right to review their application subject to the provisions of the Information Practices Act. The Program Manager of the Division of Licensing is the custodian of records.

STATE OF California)
COUNTY OF Fresno)
)

Adam Vincent Levy being duly sworn, says __he is the person referred to in the foregoing application for a physician and surgeon's certificate in California and that __he has carefully read and thoroughly understands all the requirements therein and that the statements made herein and all attachments are true and correct under penalty of perjury under the laws of the State of California.

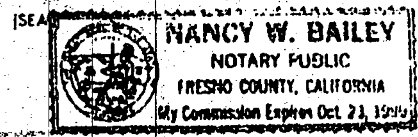
__He requests that the Division of Licensing, Board of Medical Quality Assurance, initiate a review of the records to determine their eligibility for examination, postgraduate training or licensure in California. In making this request, __he authorizes the release of any information or records held by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

Adam Vincent Levy
Signature of applicant in FULL (Do not use INITIALS ONLY)

Signed and sworn to before me this 24th day of March, 1987

Signature of Notary Public Nancy W. Bailey

[SEAL]



Address 445 S. Cedar Avenue Fresno, Ca 93702

My commission expires 10/23/1990

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STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY GEORGE DEUKMEJIAN, Governor

BOARD OF MEDICAL QUALITY ASSURANCE

1430 HOWE AVENUE, SACRAMENTO, CALIFORNIA 95825
(916) 920-6411

CERTIFICATE OF MEDICAL EDUCATION

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

This certifies that Adam Vincent Levy (FULL NAME OF APPLICANT)

of [redacted] (ADDRESS WHEN ENROLLED) enrolled in University of Southern California (NAME OF MEDICAL SCHOOL)

2025 Zonal, Los Angeles (LOCATION) on the 9th day of September (MONTH) 19 80 (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).

University of California - Santa Cruz (EDUCATIONAL INSTITUTION) 9/75-6/76, 9/77-6/80 (DATES)

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

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

The undersigned further certifies that the records of this institution show that he attended in this institution 4 years (SPECIFY NUMBER) courses of resident instruction of 36 (NUMBER OF WEEKS) weeks each, completing at least 4,000 hours, of which at least 80 percent actual attendance is required, in the subjects set forth hereunder (Business and Professions Code Section 2089), and that

XX he was granted the degree ~~XXXXX~~/Doctor of Medicine by
☐ he withdrew from

the above mentioned medical school on the 8th day of May (MONTH) 19 84

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

Signed and the college seal affixed this 18th day of March, 19 87

BY *William E. Nerlich* 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 ...

WILLIAM E. NERLICH, M.D.
ASSOCIATE DEAN, STUDENT AFFAIRS
USC SCHOOL OF MEDICINE
1975 ZONAL AVE., KAM 100-B
LOS ANGELES, CA 90033

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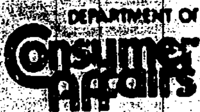
STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY GEORGE DEUKMEJIAN, Governor



BOARD OF MEDICAL QUALITY ASSURANCE

1430 HOWE AVENUE, SACRAMENTO, CALIFORNIA 95825
(916) 920-6411

CERTIFICATE OF COMPLETION OF ACGME 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 below. Please type or print.

This is to certify that Adam Vincent Levy
NAME OF APPLICANT

a graduate of University of Southern California
NAME OF MEDICAL SCHOOL

O.K.

commenced postgraduate training in Los Angeles County - University of Southern California Med Ctr., 1200 N. State St. Los Angeles 90033
NAME AND ADDRESS OF FACILITY

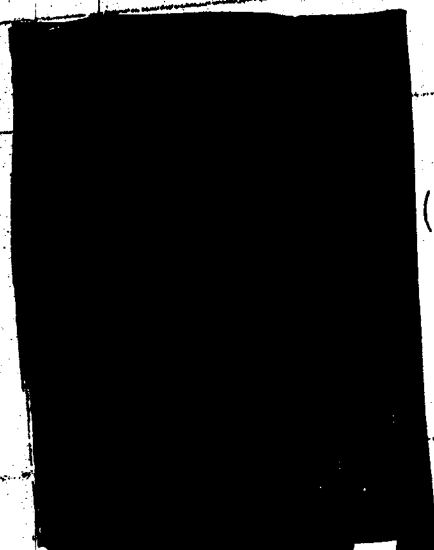
on June 24, 1984, and completed such training

on June 24, 1985. This training consisted of 11 months of actual

clinical instruction and is approved by the Accreditation Council for Graduate Medical Education (ACGME) or the Coordinating Council of Medical Education of the Canadian Medical Association (CCME) and consisted of the following rotations:
(List rotations completed. If service was not rotating, indicate type of straight training performed. NOTE—To qualify for licensure in California, graduates of foreign medical schools must have completed at least four months of postgraduate training in general medicine. ACGME or CCME residencies in family practice, internal medicine, surgery, pediatrics, and ob/gyn would normally satisfy this requirement.)

ROTATION	LENGTH OF ROTATION
COMPLETE OBSTETRICS-GYNECOLOGY	there are 13 four-week rotations

16 weeks Obstetrics, 8 weeks High Risk, 12 weeks Gynecology, 4 weeks Therapeutics Abortion, 4 weeks Medical Intensive Care, 4 weeks Newborn Intensive Care, 4 weeks vacation.



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

(AFFIX SEAL OF HOSPITAL OR NOTARY PUBLIC)

NAME Ralph C. Jung, M.D.
DIRECTOR OF MEDICAL EDUCATION

ADDRESS LAC/USC MEDICAL CENTER
1200 North State Street, Box 540
Los Angeles, CA 90033

PHONE NUMBER 213 226-6931

DATE March 26, 1987

SIGNATURE [signature]

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STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY GEORGE DEUKMEJIAN, Governor

BOARD OF MEDICAL QUALITY ASSURANCE
1430 HOWE AVENUE, SACRAMENTO, CALIFORNIA 95825
(916) 920-6411

CERTIFICATE OF COMPLETION OF ACGME 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 below. Please type or print.

This is to certify that Adam Vincent Levy (NAME OF APPLICANT)

a graduate of University of Southern California (NAME OF MEDICAL SCHOOL)

commenced postgraduate training in Valley Medical Center O.K. (NAME AND ADDRESS OF FACILITY)

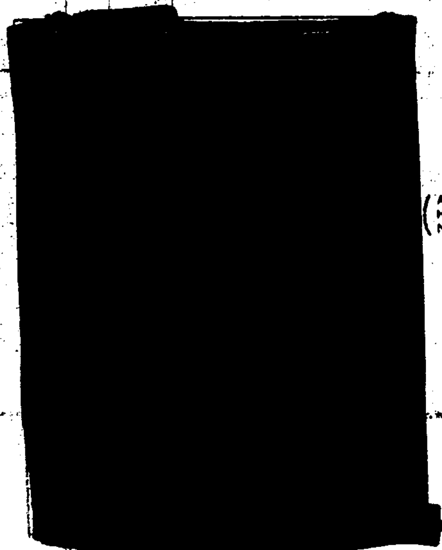
445 S. Cedar Ave. FRESNO CA.

on June 24, 1985, and completed such training

on June 22, 1986. This training consisted of 12 months of actual clinical instruction and is approved by the Accreditation Council for Graduate Medical Education (ACGME) or the Coordinating Council of Medical Education of the Canadian Medical Association (CCME) and consisted of the following rotations:

(List rotations completed. If service was not rotating, indicate type of straight training performed. NOTE—To qualify for licensure in California, graduates of foreign medical schools must have completed at least four months of postgraduate training in general medicine. ACGME or CCME residencies in family practice, internal medicine, surgery, pediatrics, and ob/gyn would normally satisfy this requirement.)

ROTATION	LENGTH OF ROTATION
Obstetrics/Gynecology	24 weeks
Pediatrics	4 weeks
Medicine	8 weeks
Anesthesiology	4 weeks
Surgery	12 weeks



(AFFIX SEAL OF HOSPITAL OR NOTARY PUBLIC)

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

NAME Richard A. Lockwood, M.D. (DIRECTOR OF MEDICAL EDUCATION)

ADDRESS 445 S. Cedar
Fresno, California 93702

PHONE NUMBER (209) 453-5005

DATE 3-19-87

SIGNATURE [signature]

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