STATE OF CALIFORNIA — STATE AND CONSUMER SERVICES AGENCY

PETE WILSON, Governor

State of California Department of Consumer Affairs

RECEIVED SACRAMENTO BOARD OF MEDICAL QUALITY ASSURANCE
98 JUL -8 PM 1:36
DIVISION OF LICENSING

MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM
1426 Howe Avenue
Sacramento, CA 95825-3236
(916) 263-2499

RECEIVED SACRAMENTO MEDICAL BOARD OF CALIFORNIA
98 JUL -7 AM 11:40

CERTIFICATE OF MEDICAL EDUCATION

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

This certifies that Heather Ellen Quinn (FULL NAME OF APPLICANT) of San Diego (ADDRESS WHEN ENROLLED) enrolled in University of California @ San Diego (NAME OF MEDICAL SCHOOL) San Diego, CA (LOCATION)

on the 20th day of September (MONTH) 19 93 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).*

Stanford University (EDUCATIONAL INSTITUTION) 9/89-6/93 (DATES)

Advanced Credits: *Credits previously obtained at an approved medical, dental, or osteopathic school.•*

(MEDICAL SCHOOL) (TOTAL CREDITS) (DATES)

The undersigned further certifies that the records of this institution show that she attended in this institution 4 (SPECIFY NUMBER) years of resident instruction of 156 (NUMBER OF WEEKS) weeks ~~XXXX~~ 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:

☒ She was granted the degree ~~Bachelor~~/Doctor of Medicine by OR ☐ he withdrew from the above mentioned medical school on the 8th day of June (MONTH), 19 97.

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
	Alcoholism and Chemical Dependency	Family Medicine••
		Spousal or Partner Abuse Detection & Treatment•••

• 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**.

•• ONLY applicable to medical students who graduate from medical school on or after May 1, 1998

••• ONLY applicable to medical students who enrolled in medical school on or after September 1, 1994.

TRANSCRIPTS FOR ALL ADVANCED CREDITS AND MEDICAL SCHOOL CREDITS MUST BE SUPPLIED WITH THIS CERTIFICATE

Signed and the school seal affixed this 1st day of July, 19 98

BY Joyce Felder
Joyce Felder, Acting Registrar (PRESIDENT, SECRETARY, DEAN)

L2

Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM
1426 Howe Avenue, Sacramento, CA 95825-3236
(916) 263-2499

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.

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

Last Name of Trainee	First Name	Middle Initial
Quinn	Heather	E.

Current Address: 3851 Holland Drive

Social Security Number:

City	State	Zip Code	Telephone Number:
Santa Rosa	CA	95405	

PART 2: To be completed by the 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. PLEASE SEE THE REVERSE FOR A DEFINITION OF "SATISFACTORY."

Name of Facility	Address of Facility
Sutter Medcial Center of Santa Rosa	3324 Chanate Road Santa Rosa, CA 95404

Name of Program Director:	Telephone Number:
Marshall Kubota, MD	(707) 576-4075
Signature of Program Director	Date Signed: July 7, 1998 ✓

List Categorical Specialty Area of Training Completed by Trainee:	Date Training Commenced:	Date Training Completed:
Family Medicine ✓	07/01/97 ✓	07/01/98 ✓

If the training was rotating or transitional, list the specific rotations and the number of weeks spent in each (SEE THE REVERSE FOR INFORMATION ON SATISFYING THE GENERAL MEDICINE TRAINING REQUIREMENT):

Adult Medicine 12 weeks	Musc/Skel 4 weeks	Gyn 4 weeks
OB 12 weeks	Peds 8 weeks	Vac/Ed 4 weeks
Surgery 4 weeks	ER 4 weeks	

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

Name of the Director of Medical Education:	Facility Name:
Marshall Kubota, MD	Sutter Medical Center of Santa Rosa

Facility Address: 3324 Chanate Road

City	State	Zip Code	Telephone Number:
Santa Rosa	CA	95404	(707) 576-4075

PART 4: Signature of Director of Medical Education certifying satisfactory completion of training.

ATTENTION PROGRAM DIRECTOR!
IF TRAINEE IS IN HIS/HER FIRST YEAR OF POSTGRADUATE TRAINING, DO NOT SIGN OR DATE THE STATEMENT BELOW UNTIL AFTER THE COMPLETION OF THE TRAINEE'S LAST DAY OF TRAINING.

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

Signature of Director of Medical Education	Date Signed: July 7, 1998

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

L3A

State of California Department of Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM
1426 Howe Avenue
Sacramento, CA 95825-3236
(916) 263-2499

CERTIFICATION STATEMENT

This is to certify that Heather Ellen Quinn, MD
(Name of Physician)

is in an approved ACGME/CCME postgraduate training position that commenced on July 1, 19 97 and is expected to be completed on June (Month) 30 (Day) 2000 (Year) in Family Medicine
(Type of Training)

at Sutter Medical Center of Santa Rosa
(Name and Address of Facility)
3324 Chanate Road, Santa Rosa, CA 95404

AFFIX OFFICIAL HOSPITAL SEAL OR NOTARY SEAL IN THE BOX AT THE LEFT.

"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 is being trained in an approved ACGME or CCME program position."

Marshall Kubota,MD
(Type or print name of Director of Medical Education)

(Signature of Director of Medical Education)

7/3/98
(Date)

707.576.4075
(Telephone Number)

NOTE: Do not use this form in lieu of Form L3A, "Certificate of Completion of ACGME/CCME Postgraduate Training."

STATE OF CALIFORNIA — STATE AND CONSUMER SERVICES AGENCY

#53605

PETE WILSON, Governor

Consumer Affairs

98 JUL 17 PM 2:30

DIVISION OF LICENSING

RECEIVED
SACRAMENTO
MEDICAL BOARD
OF CALIFORNIA
LICENSING PROGRAMS

98 JUL 13 PM 1:11

98 JUL 14 AM 8:19

MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM

1426 Howe Avenue, Sacramento, CA 95825-3236
(916) 263-2499

APPLICATION FOR PHYSICIAN AND SURGEON'S EXAMINATION OR LICENSURE

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

MBC USE ONLY

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

3. Social Security Number: [redacted]

4. Address: Number and Street/Rural Route (include apartment number, if any): 3851 Holland Drive

5. Sex: ☒ Female ☐ Male

City	State	Zip Code	Country
Santa Rosa	CA	95404	USA

6. Telephone Number: Home: ( ) Work:

7. Date of Birth: Mo/Day/Yr

Place of Birth:

8. California Driver's License Number, if applicable: NUMBER EXPIRATION

9. Are you a U.S. citizen? ☒ Yes ☐ No

If you are an international medical school graduate, you must provide an original full and unrestricted license to practice medicine in another state or country, **OR** official documentation of U.S. citizenship, **OR** an official Declaration of Intent to become a U.S. citizen.

10. Have you ever filed an application for physician and surgeon examination or licensure in California? ☐ Yes ☒ No

IF YES, PLEASE GIVE DATE PREVIOUS APPLICATION WAS SUBMITTED AND ATTACH ANY APPLICATION MATERIALS YOU MAY HAVE RETAINED. _____

11A. List the names and addresses of all colleges or universities attended where pre-professional, postsecondary instruction was received. Please submit official transcripts with the school seal affixed for each school attended.

Name	Address	Dates of Attendance
Stanford	Stanford, CA	9/89-6/93

11B. Check whether the following premedical courses were successfully completed and show where completed:

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

12. List the names and addresses of all schools where professional medical instruction was received, and, where applicable, the degree awarded. **PLEASE SUBMIT: 1)** an original Certificate of Medical Education (Form L2) and official transcripts with the signature of the dean or registrar and the school seal affixed from each school attended; and 2) an original medical diploma and a photocopy.

School Name	Address	Place of Instruction	Dates of Attendance	Degree Awarded
U.C. San Diego	9500 Gilman	La Jolla, CA	9/93-6/97	MD

DOCTOR OF MEDICINE DEGREE, as referenced above. (Note: A U.S. graduate may, in lieu of the original, submit an official certified photocopy that has the school seal affixed and the signature of the registrar certifying authenticity.)

Name of Medical School	Address of Medical School	Exact Date of Issuance
U.C. San Diego	9500 Gilman La Jolla, CA	June 8, 1997

◆ MANDATORY DISCLOSURE OF SOCIAL SECURITY NUMBERS

Disclosure of your social security number (or federal employer identification number [FEIN], if you are a partnership) is mandatory. Section 30 of the Business and Professions Code and Public Law 94-455 (42 USCA 405(c)(2)(C)) authorize collection of your social security number. Your social security number or FEIN will be used exclusively for tax enforcement purposes, for purposes of compliance with any judgment or order for family support in accordance with Section 11350.6 of the Welfare and Institutions Code, or for verification of licensure or examination status by a licensing or examination entity which utilizes a national examination and where licensure is reciprocal with the requesting state. If you fail to disclose your social security number or your FEIN, your application for initial licensure will not be processed AND you will be reported to the Franchise Tax Board, which may assess a $100 penalty against you.

CA017

School Code

L1A

07A-100 (Rev. 9/97)

MBC USE ONLY

13. Have you taken any of the following written examinations: National Boards, other state boards, USMLE, SPEX, FLEX, or LMCC?

☒ Yes ☐ No

IF YES, LIST NAME, LOCATION, DATE AND RESULT OF EXAMINATION. SUBMIT AN ORIGINAL OFFICIAL EXAMINATION HISTORY REPORT FROM EACH EXAMINATION AGENCY. APPLICANTS WHO HOLD CERTIFICATION THROUGH THE EDUCATIONAL COMMISSION FOR FOREIGN MEDICAL GRADUATES (ECFMG) WILL NEED TO SUBMIT AN ORIGINAL VALID ECFMG CERTIFICATE PRIOR TO WRITTEN EXAMINATION AND LICENSURE.

Examination	Location	Date	Result
USMLE 1	San Diego	June 1995	
USMLE 2	San Diego	August 96	
USMLE 3	San Mateo	May 1998	

14. Have you ever 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 EACH ISSUING AGENCY'S JURISDICTION. SUBMIT A LETTER OF GOOD STANDING FROM EACH STATE IN WHICH YOU ARE OR HAVE BEEN LICENSED. PLEASE INCLUDE TEMPORARY, TRAINING, OR PROVISIONAL LICENSES.

State or Country	License Number	Date of Issuance	Dates of Practice in that Jurisdiction

15A. Are you currently, or have you ever been, a participant in a postgraduate training program in a facility in the U.S. or Canada?

☒ Yes ☐ No

IF YES, LIST NAMES AND ADDRESSES OF ALL FACILITIES. SUBMIT AN ORIGINAL CERTIFICATE OF COMPLETION OF ACGME/CCME POSTGRADUATE TRAINING (FORM L3A/B) FROM EACH FACILITY. (DO NOT COMPLETE FORM L3A/BS TO DOCUMENT TRAINING RECEIVED IN RESEARCH FELLOWSHIP PROGRAMS.) **ALL TRAINING MUST BE LISTED, REGARDLESS OF WHETHER IT WAS SATISFACTORILY COMPLETED OR WILL BE USED TO MEET LICENSING REQUIREMENTS.**

Facility Name	Address	Type of Service	Dates of Attendance
Sutter Medical Center of Santa Rosa	3324 Chanate Rd. Santa Rosa, Ca	Family Practice	07/01/97-06/30/98

QUESTIONS 15B through 21: For any positive response to the following questions, please provide ALL official documentation regarding the matter in addition to written explanations. If applicable, an applicant should also provide official hearing/court documents and original letters of explanation from medical school or training program directors or other appropriate authorities. APPLICANTS ARE ALSO REQUIRED TO REPORT ANY MATTER THAT IS PENDING OR IN WHICH CHARGES HAVE BEEN DROPPED OR EXPUNGED.

15B. Have you ever withdrawn from, or been suspended, dismissed or expelled from a medical school or postgraduate training program?

Yes No

16. Have you ever been charged with, or been found to have committed, unprofessional conduct, professional incompetence, gross negligence or repeated negligent acts or malpractice by any medical licensing board, other agency, or hospital or has any disciplinary action ever been filed or taken regarding any healing arts license which you now hold or have ever held, or is any such action pending? Include any disciplinary actions by the U.S. Military, U.S. Public Health Service or other U.S. federal governmental entity. IF YES, GIVE DETAILS BELOW.

Yes No

State	Date	Charge	Disposition

MBC USE ONLY

17. Has a claim or action for damages ever been filed against you in the course of the practice of medicine or any other healing art which resulted in a malpractice settlement, judgement or arbitration award of over $30,000.00? Yes No

IF YES, GIVE DETAILS BELOW.

Name of Claimant	Location of Court	Brief Description of the Facts

18. Have you ever been denied a license, permission to practice medicine or any other healing art, or denied permission to take an examination in any state, country, or U.S. federal jurisdiction, or is any such action pending? Yes No

IF YES, GIVE DETAILS BELOW.

State or Country	Date of Denial	Reason for Denial

19. Have you ever voluntarily surrendered a license to practice in the healing arts in this or any other state, or voluntarily surrendered your narcotic (controlled substance) permit (state or federal) to any licensing board or any other agency, or is any such action pending? Yes No

20. Have you ever had staff privileges in a hospital denied, suspended, limited, revoked or not renewed for medical disciplinary cause, or resigned from a medical staff in lieu of disciplinary or administrative action, or is any such action pending? Yes No

21. Do you have any condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety, including but not limited to, any of the following? Yes No

IF YES, PLEASE CHECK THE APPROPRIATE BOX(ES) BELOW:

- ☐ A condition which required admission to an inpatient psychiatric treatment facility.
- ☐ Alcohol or chemical substance dependency or addiction.
- ☐ Emotional, mental or behavioral disorder.
- ☐ Other (explain): _____

FOR ANY OF THE BOXES CHECKED ABOVE, PLEASE SUBMIT COMPLETE OFFICIAL INPATIENT AND OUTPATIENT TREATMENT RECORDS, EVIDENCE OF ONGOING REHABILITATION TREATMENT, AND A PERSONAL WRITTEN EXPLANATION.

QUESTION 22: For any positive response to the following question, please provide ALL official documentation regarding the matter in addition to written explanations. If applicable, an applicant should also provide official hearing/court documents and original letters of explanation from appropriate authorities.

22. Have you ever been convicted of or pled nolo contendere to any violation (including misdemeanors and felonies) of any federal, state or local law of any state, the United States, or a foreign country or any violation relating to the possession, use, illegal sale, transportation, manufacture, distribution or dispensing of controlled substances, or is any such action pending? *(Exclude violations of traffic laws, including speeding, which resulted in fines of $300.00 or less.)* If YES, give details below. Yes No

YOU ARE REQUIRED TO LIST ANY CONVICTION THAT HAS BEEN SET ASIDE AND DISMISSED OR EXPUNGED, OR WHERE A STAY OF EXECUTION HAS BEEN ISSUED.

Violation and Location	Date	Penalty or Disposition

L1C

BOTTOM OF PHOTO

PHOTO DECLARATION

I hereby declare under penalty of perjury under the laws of the State of California, that the photo of myself attached hereto, as taken on or about _____, 19___

my age then being ___ ___ years;

my color of hair ___ ___;

my color of eyes ___ ___;

my height ___ ft. ___ in.;

my weight ___ lbs.;

and identifying marks are _____

Signature of Applicant

Notice: All items in this application are mandatory; none are voluntary. Failure to provide any of the requested information will delay the processing of your application. The information provided will be used to determine your qualifications for licensure per Section 2080 of the California Business and Professions Code, which authorizes the collection of this information. The information on your application may be transferred to other medical licensing authorities, the Federation of State Medical Boards, or other governmental or law enforcement agencies. You have the right to review your application subject to the provisions of the Information Practices Act. The Program Manager of the Licensing Program is the custodian of records.

Applicant Declaration/Signature and NOTARY

STATE OF California)

COUNTY OF Sonoma)

The applicant, Heather Ellen Quinn, being first duly sworn upon his/her
PRINT FULL NAME OF APPLICANT

oath deposes and says: that ~~he/she~~ is the person herein named subscribing to this application; that ~~he/she~~ has read the complete application, knows the full content thereof, and declares that all of the information contained herein and evidence or other credentials submitted herewith are true and correct; that ~~he/she~~ is the lawful holder of the degree of Doctor of Medicine as prescribed by this application, that the same was procured in the regular course of instruction and examination, and that it, together with all the credentials submitted, were procured without fraud or misrepresentation or any mistake of which the applicant is aware and that the applicant is the lawful holder thereof. Further, I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past, present and future), business and professional associates (past, present and future), and all government agencies (local, state, federal or foreign) to release to the Medical Board of California or its successors any information, files or records, including medical records, educational records, and records of psychiatric treatment and treatment for drug and/or alcohol abuse or dependency, requested by that Board in connection with this application; or any further or future investigation by that Board necessary to determine my medical competence, professional conduct or physical or mental ability to safely engage in the practice of medicine. I further authorize the Medical Board of California or its successors to release to the organizations, individuals or groups listed above any information which is material to this application or any subsequent licensure. I further acknowledge that falsification or misrepresentation of any item or response on this application is adequate to deny the same or to hold a hearing to revoke the same, if issued.

SIGNATURE OF APPLICANT: Heather Ellen Quinn
(PLEASE WRITE FULL NAME, NOT INITIALS)

Signed and sworn to before me this 4th day of July, 19 98

ISABELLE VON TOBEL
COMM. # 1065751
Notary Public — California
SONOMA COUNTY
My Comm. Expires APR 13, 1999

NOTARY SEAL

Isabelle von Tobel
SIGNATURE OF NOTARY PUBLIC

3324 Cleveland Road
Santa Rosa, CA 95404
ADDRESS

My commission expires 4/13/99

07A-100 (Rev. 9/97)

L1D

A 66537

Heather Quinn, MD
5966 Curtisian Ave.
Boise, ID 83704

March 5, 2006

3/10/06

Re: license #A066537

Medical Board of California
1426 Howe Ave., Ste. 54
Sacramento, CA 95825-3236

Dear Medical Board:

This letter serves to inform you that I have moved to Idaho, permanently, and will no longer be practicing in California. My current address is as above. I will not be renewing my California license. Please let me know if there is anything further I need to do.

Sincerely,

Heather Quinn, MD

Consumer Affairs

MEDICAL BOARD OF CALIFORNIA LICENSE RENEWAL APPLICATION
PHYSICIAN AND SURGEON

SSN= *****5262

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

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

D. Continuing Medical Education (CME) Certification Statement: I CERTIFY UNDER PENALTY OF PERJURY UNDER THE LAWS OF CALIFORNIA TO THE FOLLOWING STATEMENT. I CERTIFY THAT I DO MEET EACH OF THE CONTINUING MEDICAL EDUCATION REQUIREMENTS LISTED ON THE BACK OF THIS FORM OR THAT I MEET THE CONDITIONS WHICH WOULD EXEMPT ME FROM ALL OR PART OF THE REQUIREMENTS OR I HOLD A PERMANENT CME WAIVER.

SIGNATURE REQUIRED HERE: _____ DATE: _____

LICENSE NO.	EXPIRES	AMOUNT DUE NOW	DELINQ. FEE IF POSTMARKED AFTER 06/30/06
A 66537	05/31/06	$790.00	$869.00
	VOLUNTARY FEE =	$	$
	TOTAL ENCLOSED =	$	$

ACTIVE HEATHER ELLEN QUINN
555 PETALUMA AVE STE A
SEBASTOPOL CA 95472

E. FOR ADDRESS CHANGE ONLY
IF YOUR ADDRESS SHOWN IS INCORRECT, CORRECT IT BELOW.

STREET 5966 Curtisian Ave
CITY Boise STATE ID ZIP 83704
PHONE NUMBER 208 375-8100

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

Signature required here

650101000001000020006653720105310600079000000086900