STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY

GEORGE DEUKMEJIAN, G

DEPARTMENT OF

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

000712 433.00 7/81

JUL 20 11 42 AM '88
SACRAMENTO BOARD OF MEDICAL QUALITY ASSURANCE

APPLICATION FOR PHYSICIAN AND SURGEON'S EXAMINATION OR LICENSURE

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

1. Name: Last NGUYEN First SON Middle HONG

PERSON DATA

2. Other names you have used:

3. Social Security Number
See disclosure statement on L1C

4. Address: Number and Street/Rural Route (include apartment number, if any)
8404 EAST SARATOGA Street.
City ANAHEIM State CA ZIP Code 92808 Country

5. Telephone Number: Home Work

6. Date of Birth: Mo/Day/Yr

7. Sex: ☐ Female ☑ Male

8. 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.

9. Have you ever filed an application for examination or licensure in California? ☐ Yes ☑ No
If YES, give date of previous application:

10. 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.

Name	Address	Period of Attendance From (Mo/Yr)	Period of Attendance To (Mo/Yr)
Fullerton College	Fullerton California	09/1979	09/1981
Univ. of California IRVINE	Irvine California	09/1981	06/1983

NON-MEDI EDUCATI

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)	Period of Attendance To (Mo/Yr)
College of Medecine Univ. of California Irvine	Irvine California	Irvine	09/1983	06/1987

MEDICAL EDUCATIO
CME TR

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
College of Medicine, University of California IRVINE	IRvine California.	06/13/1987

School Coc

L1

BMQA USE ONLY

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.

Name	Location	Date	Result
National Boards Part I	IRVING	09/85	
National Boards Part II	IRVINE	09/86	
National Boards Part III	los Angeles - USC	03/88	

WRITTEN EXAMINATION ☑ ☐ ☐ ☐

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 (Form L3 ... om each facility.

Name	Address	Type of Service	Period of Attendance	
			From (Mo/Yr)	To (Mo/Yr)

POSTGRADUATE TRAINING ☐ ☐ ☐ ☐

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.

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

LICENSE DATA

LGS	CE
☐	☐
☐	☐
☐	☐
☐	☐

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

☑ ☐ ☐ ☐

000275

L1B

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?

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

19. Have you ever voluntarily surrendered a license to practice in the healing arts in another state?

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

20. Have you ever had staff privileges at a hospital denied, suspended or revoked, or resigned from a medical staff in lieu of disciplinary action? Yes If yes, please explain on a separate sheet of paper.

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

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, or to drug addiction? Yes

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.)

If yes, give details below:

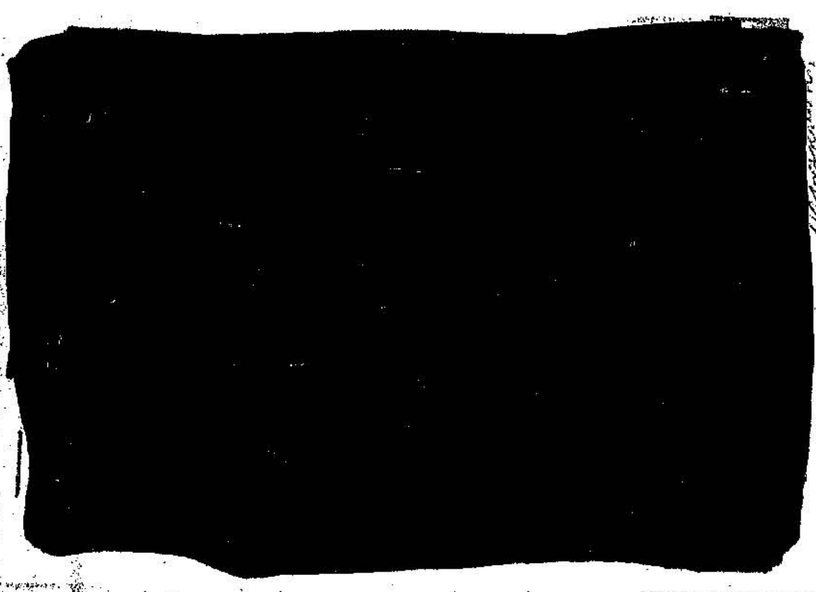
Violation and Location	Date	Penalty or Disposition

You are required to list any conviction that has been set aside and dismissed under Section 1203.4 Penal Code or under any other provision of law.

"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

07A-100



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

on or about

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 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. Information regarding the issuance or denial of a license by the Board may be transmitted to any other medical licensing authority or the Federation of State Medical Boards. 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 Los Angeles)

SON HONG NGUYEN 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 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.

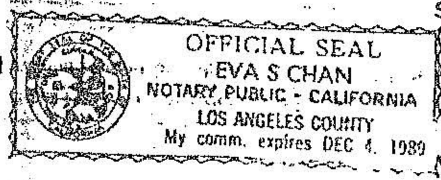
__He requests that the Division of Licensing, Board of Medical Quality Assurance, initiate a review of the records to determine their eligibility for examination, postgraduate training or licensure in California. In making this request, __he authorizes the release of any information or records held by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

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

Signed and sworn to before me this 15th day of July 19

Signature of Notary Public Eva S Chan

[SEAL]



Address 1975 Zonal Ave Rm-420 Los Angeles

My commission expires Dec. 4, 1989

07A-100

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 SON HONG NGUYEN
(FULL NAME OF APPLICANT)

of Irvine California (ADDRESS WHEN ENROLLED) enrolled in College of Medicine University of Calif. Irv (NAME OF MEDICAL SCHOOL)

IRVINE (LOCATION) on the 5 day of September (MONTH) 1983 (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).

Fullerton College and University of California Irvine (EDUCATIONAL INSTITUTION) 09/79 - 06/83 (DATES)

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

MEDICAL SCHOOL — TOTAL CREDITS — DATES

The undersigned further certifies that the records of this institution show that ___he attended in this institution approx 35 (SPECIFY NUMBER) courses of resident instruction of approx 12 (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

☒ ___he was granted the degree Bachelor/Doctor of Medicine by

☐ ___he withdrew from

the above mentioned medical school on the 13 day of June (MONTH) 19 87.

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

Signed and the college seal affixed this 11 day of July, 19 88.

BY [signature]
Laurel Bartenstein, Deputy 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.

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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 SON HONG NGUYEN
NAME OF APPLICANT

a graduate of University of California, Irvine
NAME OF MEDICAL SCHOOL

formally commenced an accredited postgraduate training program at LOS ANGELES COUNTY - USC MEDICAL CENTER 1200 North State Street, Los Angeles, CA
NAME AND ADDRESS OF FACILITY

in Obstetrics-Gynecology
SPECIALTY

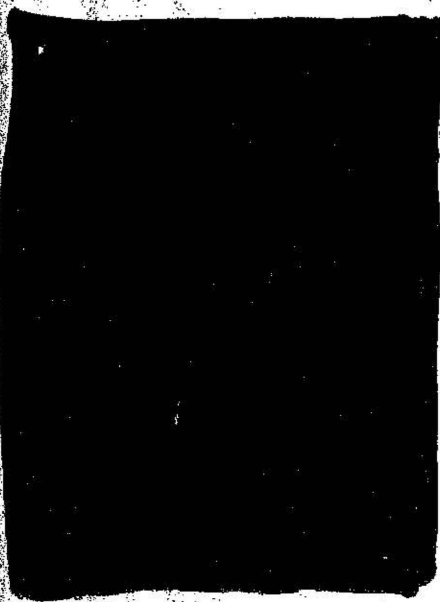
on June 24, 19 87, and completed such training on June 23, 19 88.

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
	there are 13 four-week rotations

8 weeks Gynecology, 16 weeks Obstetrics, 8 weeks High Risk, 4 weeks New Born, 4 weeks vacation, 4 weeks Medical Intensive Care Unit, 4 weeks Obstetrics Clinics, 4 weeks Endo/Infertility.



(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 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 June 23, 1988

SIGNATURE

L3

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

CERTIFICATION STATEMENT

This is to certify that Son Hong Nguyen, M.D. (Name of Physician) is in an ACGME/CCME postgraduate training position that commenced on July 1, 1988 and is expected to be completed on June 30, 1991 in Obstetrics-Gynecology (Type of Training)

at Los Angeles County-University of Southern California Medical Center (Name and Address of Facility)

1200 North State Street, Los Angeles, CA 90033

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

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

SIGNATURE OF DIRECTOR OF MEDICAL EDUCATION

June 23, 1988
DATE

213 226-6931
PHONE NUMBER

07M-71 (3-87)

L9

STATE DEPARTMENT OF CONSUMER AFFAIRS
INTERNET CASHIERING SYSTEM
MEDICAL BOARD OF CALIFORNIA
SUPPLEMENTAL INFORMATION REPORT
From Date: 01/05/2010 **To Date:** 01/05/2010

ATRISUPPINF

13-FEB-15 14:20:56

Person Id : 606570 **Name :** Nguyen,Son

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 : 606570 8

G. Financial Interest Statement

Please print or type the name(s) and address(es) of each health-related facility in which you or your immediate family have a financial interest. If more space is needed, please attach additional listings. If you have no interests to declare, please write "none" in the area below and sign your name on the front of this document at G.

Health-Related Facility Name	Address
NONE	

1062012 10003940 10010000

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
PO BOX 942520
SACRAMENTO CA 94258-0520

SMBCLS 02/28/05

License Renewal Application
Physician and Surgeon

PART 3

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? PLEASE READ INSTRUCTIONS BEFORE ANSWERING I. ☐ YES J. ☒ NO

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

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. [signature] DATE: 12/21/2011

LICENSE NO.	EXPIRES		AMOUNT DUE NOW	DELINQ FEE IF POSTMARKED AFTER 04/30/12
63695	03/31/12		$808.00	$886.00
		VOLUNTARY FEE =	$	$
		TOTAL ENCLOSED =	$ 808.00	$

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

STREET ______
CITY ______ STATE ______ ZIP ______
PHONE NUMBER ( )

ACTIVE SON HONG NGUYEN
3772 TIBBETTS STE # A
RIVERSIDE CA 92506

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] Signature required here

OVER

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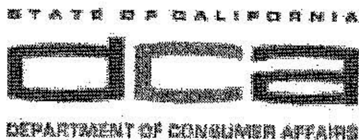
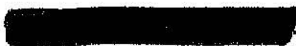


Department of Consumer Affairs

RECEIPT
169076

Thank you for using the BreEZe System to submit your application.

Name:	NGUYEN, SON HONG
Transaction Date:	12/20/2013 13:00
	
Complaint Number:	
License Type:	8002
License Number:	63695
Payment Description:	Physician's and Surgeon's Renewal
Fee Paid: (US $)	808.00
Remaining Balance: (US $)	0.00

Please print and save this receipt for your records.

This receipt is provided as a record for the above named licensee/applicant.

Illegal use or alteration of this receipt may result in criminal prosecution.

Have you successfully completed, and can document, the mandatory courses and hours of CME within the last two years, or you meet the conditions which would exempt you from all or part of the CME requirements, or you hold a permanent CME waiver?	**Yes**
I certify under penalty of perjury, under the laws of California, that I have disclosed the names of those health-related facilities in which I or my family have a financial interest OR I declare under penalty of perjury I have no financial interests to disclose.	**Yes**

Family Physician Training Program Voluntary Fee

Voluntary Fee:	**No**

Attachments

Physician Survey

Are you retired?	**No**
Activities in Medicine	**Administration - 1-9 Hours** **Other - None** **Patient Care - 30-39 Hours** **Research - None** **Teaching - 1-9 Hours** **Telemedicine - None**
Patient Care Practice Location	**Zip: 92506 County: RIVERSIDE**
Telemedicine Practice Location	**Zip: County:**
Patient Care Secondary Practice Location	**Zip: County:**
Telemedicine Secondary Practice Location	**Zip: County:**
Current Training Status	**Not in Training**
Areas of Practice	**Obstetrics and Gynecology - Primary**
Board Certifications	**American Board of Obstetrics and Gynecology - Obstetrics and Gynecology**
Postgraduate Training Years	**4 Years**
Foreign Language Proficiency	**Vietnamese**
Web Site Profile	**Cultural Background - No** **Foreign Language Proficiency - No** **Gender - No**

Fees

Biennial Renewal Fee	**$783.00**
Steven M. Thompson Physician Corps Loan Repayment Program	**$25.00**
Total Amount Due:	**$808.00**

Applications are not considered submitted for processing until payment is received.

Attestation

I declare under penalty of perjury under the laws of the State of California that all statements, answers, and representations provided, including supplementary attached hereto, are true, complete and accurate.

Signature: Date:

Application Summary

License Type: Physician and Surgeon G

License Number: 63695

Application: Physician's and Surgeon's Renewal

Application Date: 12/20/2013 (mm/dd/yyyy)

Personal Detail

First Name: SON

Middle Name: HONG

Last Name: NGUYEN

Addresses

License Related Addresses

License Specific Public/Mailing Address (Required)

Name: NGUYEN, SON HONG

Address: 3772 TIBBETTS STE # A

RIVERSIDE, CA

92506

Questions

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**

1387573215199