

DEPARTMENT OF
**Consumer
Affairs**

BOARD OF MEDICAL EXAMINERS, SACRAMENTO
1020 H STREET, SACRAMENTO, CALIFORNIA 95814
TELEPHONE: MEDICAL EXAMINERS
Application and Examinations (916) 322-3040

AUG 7 2 25 PM '75

APPLICATION FOR PHYSICIAN'S AND SURGEON'S CERTIFICATE
BASED ON NATIONAL BOARD CREDENTIALS
CLASS C

U2669

U2670

U2671

(Please type or print neatly. When space provided is insufficient, attach additional sheets.)

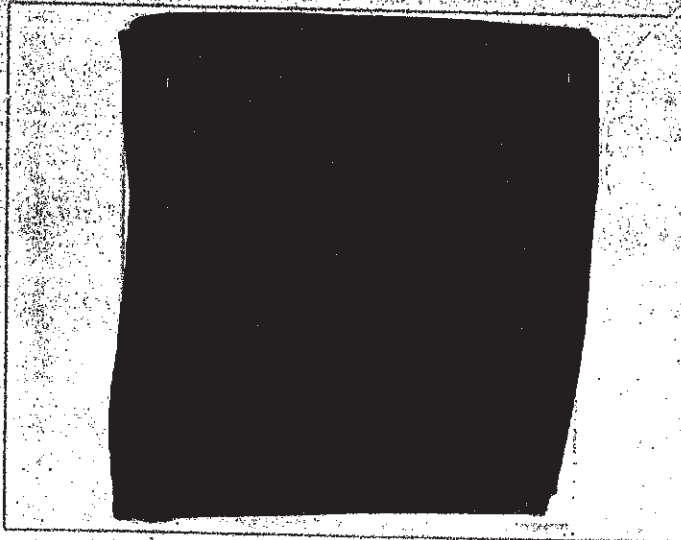
1. NAME: Last <u>Sheehan</u> First <u>Katharine</u> Middle <u>Leah</u> Maiden <u>—</u>				2. Social Security No. <u>—</u>	
3. List other names, if any, you have used: <u>none</u>					
4. Address: Street and No. (Rural Route) <u>4007 Everts Street</u>			City <u>San Diego</u>	State <u>Cal</u>	Zip Code <u>92109</u>
5. Name you wish on License: <u>Katharine L. Sheehan</u>				Birthdate: (Month - Day - Year) <u>—</u>	
6. Premedical Education: Name of College or University: <u>Wellesley College</u>				Location: <u>Wellesley, Mass.</u>	
Period of attendance: From: <u>9-67</u> To: <u>6-70</u>		Check premed courses successfully completed: <input checked="" type="checkbox"/> Chemistry <input checked="" type="checkbox"/> Physics <input checked="" type="checkbox"/> Biology or Zoology			
7. Medical School:					
Year	Name of Institution	Location	From	To	
1st	<u>Loyola U. School of Medicine</u>	<u>Maywood, Ill.</u>	<u>7/70-6/74</u>	<u>6/74</u>	
2nd					
3rd					
4th					
5th					
6th					
8. Doctor of Medicine Degree granted by: <u>LOYOLA U. OF CHICAGO, STRITCH SCH OF MED</u>			Date <u>6-9-74</u>	For office use only School Code: <u>IL 43</u>	
9. 1st Year Postgraduate Training (Internship):					
Location: <u>Michael Reese Hosp. - Chicago</u>		Type of Service: <u>straight internal medicine</u>	From: <u>7/74</u>	To: <u>7/75</u>	
10. List all States in which you have been licensed to practice medicine: <u>none</u>					
11. Has any disciplinary action ever been taken regarding any license which you now hold or ever held? If Yes, indicate below:					
State	Date	Charge	Disposition		
12. Have you ever been denied a license to practice medicine in any State or Country? If Yes, indicate below:					
State or Country	Date of Denial	Reason for Denial			
13. Are you now or have you ever been addicted to narcotic drugs?					

14. Have you ever been convicted of, pled guilty or nolo contendere to a violation of any Federal, State or Local law relating to the manufacture, distribution or dispensing of controlled substances/narcotics, or to drug addiction?

15. Have you ever been convicted of, pled guilty or nolo contendere to any offense, misdemeanor or felony in any state? (Except violations of traffic laws resulting in fines of \$50.00 or less.)

16. If you answered "Yes" to either No. 14 or No. 15 above, please provide the following information:

Violation and Location	Date	Penalty/Disposition



Applicant: Please complete the following:

Height: _____ Ft. _____ In. Weight: _____ Lbs.

Hair color: _____ Eye color: _____

Identifying marks: _____

NOTE--APPLICANT WILL SIGN THIS STATEMENT IN PRESENCE OF NOTARY PUBLIC.

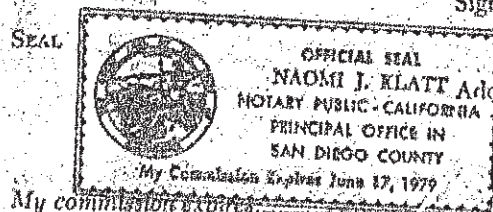
"I hereby certify (or declare), under penalty of perjury, that the foregoing information contained in this application and any attachments is true and correct, and that the attached photo and duplicate copy are a true likeness of myself, the applicant identified herein."

Signature of Applicant Katharine W. Sherman, MD

Date 7/29/75

Subscribed and sworn to before me this 29th day of July, 1975

Signature of Notary Naomi J. Klatt



My commission expires _____

Address 225 W. Dickinson, San Diego, Ca



BOARD OF MEDICAL EXAMINERS

1020 N STREET, SACRAMENTO, CALIFORNIA 95814

TELEPHONE (916) 322-6040

CERTIFICATE OF EDUCATION

This Certifies That Katharine L. Sheehan Full name of applicant
 enrolled in Loyola University of Chicago Stritch School of Medicine Name of medical school (college)
 on the 20 day of September 1970
 Month Year

☒ as a Freshman.☐ with advanced standing based on _____

Please specify

The undersigned further certifies that official transcripts on file show that prior to completing the study of medicine the applicant herein referred to completed at least a two-year residence course of college grade including:

☒ PHYSICS ☒ CHEMISTRY ☒ BIOLOGY (or) ZOOLOGY (Check course(s) completed)

at Wellesley College and that he attended while at this

Please indicate school

medical school (college) _____ courses of lectures of 9 months weeks each.

Specify number

Specify number of weeks

completing _____ hours in the subjects below listed, and that he/she:

Total hours

☒ was granted the degree Bachelor of Medicine

☐ left the above mentioned medical school (college) for the following reason(s):

on the 8 day of June 1974
 Month Year

Please indicate which of the following courses of study were successfully undertaken by the applicant:

<input checked="" type="checkbox"/> Anatomy	<input checked="" type="checkbox"/> Preventive medicine	<input checked="" type="checkbox"/> Medicine
<input checked="" type="checkbox"/> Embryology	<input checked="" type="checkbox"/> Hygiene and sanitation	<input checked="" type="checkbox"/> Pediatrics
<input checked="" type="checkbox"/> Histology	<input checked="" type="checkbox"/> Radiology, including roentgenologic technique and radiation safety	<input checked="" type="checkbox"/> Psychiatry
<input checked="" type="checkbox"/> Neuroanatomy	<input type="checkbox"/> Urology	<input checked="" type="checkbox"/> Neurology
<input checked="" type="checkbox"/> Physiology	<input type="checkbox"/> Optthalmology	<input type="checkbox"/> Dermatology
<input type="checkbox"/> Psychobiology	<input type="checkbox"/> Anesthesia	<input type="checkbox"/> Physical medicine
<input checked="" type="checkbox"/> Biochemistry	<input type="checkbox"/> Otolaryngology	<input type="checkbox"/> Therapeutics
<input checked="" type="checkbox"/> Pathology, bacteriology and immunology	<input checked="" type="checkbox"/> Obstetrics and gynaecology	<input checked="" type="checkbox"/> Tropical medicine
<input checked="" type="checkbox"/> Pharmacology		<input checked="" type="checkbox"/> Surgery, including orthopedic surgery

Signed and the College seal affixed this 28 day

of May 1975
 Month Year

By Emilia M. Medley
 Registrar

{ AFFIX SEAL }
 HERE

STATE DEPARTMENT OF CONSUMER AFFAIRS
INTERNET CASHIERING SYSTEM
MEDICAL BOARD OF CALIFORNIA
SUPPLEMENTAL INFORMATION REPORT
From Date: 06/16/2009 To Date: 06/16/2009

ATRISUPPINF

13-FEB-15 14:11:32

Person Id : 584597

Name : Sheehan, Katharine

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 : 584597

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STATE DEPARTMENT OF CONSUMER AFFAIRS
INTERNET CASHIERING SYSTEM
MEDICAL BOARD OF CALIFORNIA
SUPPLEMENTAL INFORMATION REPORT
From Date: 06/14/2011 To Date: 06/14/2011

ATRISUPPINF

13-FEB-15 14:13:29

Person Id : 584597

Name : Sheehan,Katharine

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 NO

Continuing Education Requirement Because I Am A Radiologist Or Pathologist.

Only For General Internists And Family Physicians Who Have 25% Of Their Patient Population Aged 65 NO

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.

Enter Name/Address Of Facility Where You Or Your Immediate Family Hold Financial Interest. Type NONE

"None", If None Held.

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

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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 : 584597

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STATE DEPARTMENT OF CONSUMER AFFAIRS
INTERNET CASHIERING SYSTEM
MEDICAL BOARD OF CALIFORNIA
SUPPLEMENTAL INFORMATION REPORT
From Date: 04/02/2013 To Date: 04/02/2013

ATRISUPPINF

13-FEB-15 14:14:46

Person Id : 584597

Name : Sheehan,Katharine

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 : 584597

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