

MEDICAL BOARD OF CALIFORNIA LICENSING PROGRAM

1426 Howe Averue, Sacramento, CA 95825-3236 17 CE (816) 263-2499

002770 \$1808.00 \$1,3199



OF CALIFORNIPLICATION FOR PHYSICIAN AND SURGEON 99 SEP -2 PM 1: 33 **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.

1. Name: Last NUCATOLA	PEBORA H	Middle LYNN	
2. Other names you have used (include		3. Social Security Number◆	
4. Address: Number and Street/Rural R		5. Sex: X Female 1	J Male
City		Code Country	
LOS ANGELE		90068 US	: A
6. Telephone Number: Home: / Work:	7. Date of Birth: Mo/Day/Yr Place of Birth:	8. California Driver's License Numb	er, il applicable: XPIRATION
9. Are you a U.S. citizen?		<u> </u>	res 🗇 No
If you are an international medical school of	graduate, you must provide an original full and unrest	ricted license to practice medicine in	
	citizenship, OR an official Declaration of Intent to be on for physician and surgeon examination or lic		Yes 🗖 No
IF YES, PLEASE GIVE DATE PREVIOUS APPLI	CATION WAS SUBMITTED AND ATTACH ANY APPLICATION	MATERIALS YOU MAY HAVE RETAINED.	LOS NO 140
	of all colleges or universities attended where		a Dicesse
instruction was received. Please sub	mit official transcripts with the school seal affix	ed for each school attended.	EE WINCHED
Name	Address	Dates of Attenda	ince
UNIVERSITY OF WISCONSIN	750 UNIVERSITY AVENUE MADISON, WI 5 8706	8190-6194	and the second of the second s
NASSAU COMMUNITY COLLEGE	1 EDUCATION DRIVE GARDEN CITY, NY 11530	. CUMMER 1991	
11B. Check whether the following p	remedical courses were successfully complete	d and show where completed:	
Course Yes No	Name of College or	University	
Chemistry ×	NIVERSITY OF WISCONSIN		
	INIVERSITY OF WISCONS		
	ADELPHI UNIVERSITY	1 (
	of all schools where professional medical instru	ction was received, and where a	annlicable the
degree awarded. PLEASE SUBMIT: 1)	an original Certificate of Medical Education (Form L2 d from <u>each</u> school attended; and 2) an original med	and official transcripts with the sign	ature of the
School Name A	ddress Place of Instruction	Dates of Attendance	Degree Awarded
STATEUNIVERSITY OF 450 CLAP NEW YORK-BROOKLYN BROOKLY	IN NA 11703 BEOOKTAN WA	8194-6198	M.D.
DOCTOR OF MEDICINE DEGREE, as referend	ed above. (Note: A U.S. graduate may, in lieu of the orig	inal, submit an official certified photoc	opy that nas the
school seal affixed and the signature of the re Name of Medical School	egistrar certifying authenticity.) Address of Medical School		
STATE UNIVERSITY OF NY	USO CLARKSON	AVENUE Exact Date :	
HEALTH SCIENCE CENTER AT	BROOKLYN RRAMELYN NY 1		198
exclusively for tax enforcement purposes, for purposes a and institutions Code, or for vertication of licensure or a is reciprocal with the requesting state. If you fall to discit	Y NUMBERS ployer identification number [FEIN], if you are a partnership) is mandal (ico)(2)(C)) authorize collection of your social security number. Your so f compliance with any judgment or order for family support in accordat (artifination status by a licensing or examination entity which ublizes a tase your social security number or your FEIN, your application for initial seases a \$100 manular entity to the property of the	lory. Section 30 of the Business and scial security number or FEIN will be used noe with Section 11350.8 of the Welfare	13/ [

will be reported to the Franchise Tex Board, which may assess a \$100 penalty against you.

witten examinations: National Board

3. Have your	aken any of th	a following written	allman a barrett a see	1 4			23 1
MCC?	even quà bin	e following written examina	itions: National Bo	ards, other state boards			da a
	SOCATION DATE	CCC			_ 2 9	Yes 🗖 No) []
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Examina	lion	Locatio	THE PRI A ST	Date		No	
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•	1	BROOKLYN, NE		6196			
SHLE STI	EP 2	BROOKLYN, NE	EW YORK	3198			7 j 7 jaj 7 jaj
SMLE STI	EP 3	POMONA, CALIT	FORNIA	12198	}		

A						·	13
VES LIST STATE	ever been licer	nsed to practice medicine in	any state or coun	гу?		Yes 🔀 No	
GOOD STANDING	: OR COUNTRY, LI 3 FROM EACH STA	CENSE NUMBER, DATE ISSUED A	ND DATES OF PRACTIC	IN EACH ISSUING AGENCY!	S JURISDICTION. S	UBMIT A LETTER	10 au
State or Cour	ntrv	ATE IN WHICH YOU ARE OR HAVE License Number					- M 1
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A. Are you o	currently, or ha	ive you ever been, a partici	pant in a postgradu	ate training program in	a facility in the	U.S.	
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Name of Claimant	Location of Court		Brief Description of the	ne Facts		}
				P.,		
•		,				
			medicine or any other healing		sion to ta	ake
examination in any st 'ES, give details belov		federal jurisdiction, o	r is any such action pending	?	Yes	No
State or Country	Date of Denial		Reason for Der	fal		
And the same by Market and the same and the	- Landania			- Alle Andrews		
. Have you ever volu	ntarily surrendered a	license to practice in	the healing arts in this or ar	y other state, or volunta	ríly	
rendered your narcoti ency, or is any such a	c (controlled substan	nce) permit (state or f	ederal) to any licensing boar	d or any other	es	No
· · · · · · · · · · · · · · · · · · ·		nospital denied susp	ended, limited, revoked or no			· IVO
ciplinary cause, or re	signed from a medica	al staff in lieu of discip	plinary or administrative action	n, or is any such action		
nding?			1 AANG 1914-1914-1914-1914-1914-1914-1914-1914		Yes	No
			your ability to practice medic			- 1.5 A
uding but not limited t	o, any of the followin	ig?		`	Yes	No
IF YES, PLEASE C	HECK THE APPROPRIATE	BOX(ES) BELOW:				
☐ A condition	which required admi	ission to an inpatient	psychiatric treatment facility	,		5
☐ Alcohol or a	chemical substance of mental or behavioral	dependency or addict	tion.			
Other (expl				4		ŀ
ANY OF THE BOXES CHEC	CKED ABOVE, PLEASE SUI	BMIT COMPLETE <u>OFFICIAL</u>	INPATIENT AND OUTPATIENT TREA	TMENT RECORDS, EVIDENCE	OF ONGO	ING.
	AND A DESCRIPTION AND MORE	N EXPLANATION.				
ABILITATION TREATMENT,	AND A PERSONAL WHILLE					
ESTION 22: For a	ny positive respons	se to the following o	juestion, please provide <u>Al</u>	L official documentat	<u>ion</u> rega	arding ti
ESTION 22: For a tter in addition to wi	ny positive respons itten explanations.	se to the following o	uestion, please provide <u>Al</u> plicant should also provid	L official documentate e official hearing/cour	<u>ion</u> reg: t docum	arding ti ients an
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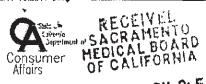
NOTARY SEAL

My commission expires

07A-100 (Rev. 9/97)

Signed and sworn to before me this

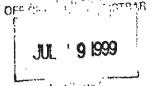
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Comm. # 1169200
NOTARY PUBLIC-CALIFGINIA
LOS Angeles County
My Comm. Expires Jan. 23, 2002



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MEDICAL BOARD OF CALIFORNIA LICENSING PROGRAM

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





CERTIFICATE OF MEDICAL EDUCATION

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

This certifies that Deborah Lynn Nucatola of	enrolled in
FULL NAME OF APPLICANT ADDRESS WHEN ENROLLED SUNY HSCB BYDOK-LYD BYDOK-LYD NY	
NAME OF MARICAL SCHOOL LOCATION	
on the 22 day of 14007 1974 and was granted the following credits on enrollment:	
MONTH Comments of the contract	
Premedical Education: **Two years of preprofessional postsecondary education, including the subjects of physics, chemistry, and biology (Business and Professions Code Section 2088).	
EDUCATIONAL INSTITUTION DATES	
Advanced Credits: Credits previously obtained at an approved medical, dental, or osteopathic school.	
MEDIGAL SCHOOL TOTAL CREDITS DATES	p-11,
The undersigned further certifies that the regords of this institution show that She attended in this institution	
years of resident instruction of 1905 136 weeks each, completing at least 4,000 hours, of which at least 80 percent	
NUMBER OF WEEKS	· uotuui
attendance is required, in the subjects set forth hereunder (Business and Professions Code Section 2089), and that:	
TC. T.	
DShe was granted the degree Bachelor Doctor of Medicine by OR D_he withdrew from	
the above mentioned medical school on the 21 day of MQY 19 78	
MONTH	_1
Anatomy Dermatology Preventive medicine, including Nutrition	- '
Otelaryngology Embryology Physical Medicine Obstetrics and Gynecology Histology Therapeutics	
Radiology, including Radiation Safety . Human Sexuality as defined in Section 2090 Neuroanatomy	
Tropical Medicine Medicine Medicine Child Abuse Detection and Treatment Physiology Surgery, including Orthopedic Surgery Geriatric Medicine	
Biochemistry Urology Pediatrics	
Pathology, Bacteriology and Immunology Psychiatry Pharmacology	
Ophthalmology Anesthesia	
Alcoholism and Chemical Dependency Family Medicine • .	Tarra
Spousal or Partner Abuse Detection &	
• Each school where professional medical instruction was received MUST complete those forms. If more than one asked was attended abateauries of this blank forms.	
these forms. If more than one school was attended, photocopies of this blank for be made and used. Note that photograph and all entries to the form must be original.	m may ninal.
◆◆ 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	or .
September 1, 1994.	
TRANSCRIPTS FOR ALL ADVANCED CREDITS AND MEDICAL SCHOOL OF	PREDITS
MUST BE SUPPLIED WITH THIS CERTIFICATE	M
Medical School Seat MUST be imprinted Partially on the Photograph.	
Signed and treschool seal affixed this 23 day of July 1979.	
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MEDICAL BOARD OF CALIFORNIA LICENSING PROGRAM

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



CERTIFICATION STATEMENT

his is to certify that <u>Deb</u>	Name of Physician)
in an approved ACGME/CCM	ME postgraduate training position that commenced on
June 24	, 1998 and is expected to be completed
n June 30 2	2002 in Obstetrics/Gynecology Year (Type of Training)
t Los Angeles County+Univer	ersity of Southern California Medical Center me and Address of Facility)
1200 North State Street, Los	
	AFFIX OFFICIAL HOSPITAL SEAL OR NOTARY SEAL IN THE BOX AT THE LEFT.
	<u>j</u>
above statements are true and CCME to offer the type and	of perjury under the laws of the State of California that the discovered and the facility is approved by the ACGME or the level of training completed by the applicant and that the din an approved ACGME or CCME program position."
Edward T. Wong, M Type or print name of Director of Medic	I.D. ical Education)
Signature of Director of Medical Educat	(no pros)
August 30, 1999	

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

formerly

STATE DEPARTMENT OF CONSUMER AFFAIRS INTERNET CASHIERING SYSTEM MEDICAL BOARD OF CALIFORNIA

SUPPLEMENTAL INFORMATION REPORT From Date: 04/20/2007 To Date: 04/20/2007

ATRISUPPINF

17-JUL-15 15:00:39
Person Id: 552283

Name:

Nucatola.Deborah

Question Answer YES 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. Have Completed 12 Hours Of Pain Management And End-Of-Life Care (Must Be Completed By YES December 31, 2006). Am Exempt From The Completion Of 12 Hours Of Pain Management And End-Of-Life Care NO Continuing Education Requirement Because | 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 Gerlatile 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. Certify Under Penalty Of Perjury Under The Laws Of The State Of California That The Information YES Contained in This Application is True And Correct, I Have Read My Profile On The Medical Board Web Site At Www.Medbd.Ca.Gov And Acknowledge YES The Information Contained Therein As Current And Accurate. 7 Total Questions Asked For Person: 552283

STATE DEPARTMENT OF CONSUMER AFFAIRS INTERNET CASHIERING SYSTEM MEDICAL BOARD OF CALIFORNIA SUPPLEMENTAL INFORMATION REPORT From Date: 04/03/2009 To Date: 04/03/2009

ATRISUPPINF 17-JUL-15 15:05:17

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552283

Name:

Nucatola, Deborah

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

Total Questions Asked For Person:

552283

STATE DEPARTMENT OF CONSUMER AFFAIRS INTERNET CASHIERING SYSTEM MEDICAL BOARD OF CALIFORNIA SUPPLEMENTAL INFORMATION REPORT

From Date: 03/29/2011 To Date: 03/29/2011

ATRISUPPINF

17-JUL-15 15:06:17

Person Id:

552283

Name:

Nucatola.Deborah

Question Answer I Have Completed Cme And Can Document Not Less Than 50 Hours Of Approved Cme For The Two-YES 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. I Have Completed 12 Hours Of Pain Management And End-Of-Life Care. YES NO 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. 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 Gerlatric 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 Perlury Under The Laws Of The State Of California That The Information Contained In This Application is True And Correct. I Have Read My Profile On The Medical Board Web Site At Www.Mbc.Ca.Gov And Acknowledge The YES Information Contained Therein As Current And Accurate. Since You Last Renewed Your License, Have You Had Any License Disciplined By A Government NO Agency Or Other Disciplinary Body: Or, Have You Been Convicted Of Any Crime in Any State, The U.S.

Total Questions Asked For Person:

A And its Territories, Military Court Or A Foreign Country?

552283

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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 17-JUL-15 15:07:15

Person Id :	552283	Name:	Nucatola,Deborah	
Question			Answer	
Year Period Im		Expiration D	s Than 50 Hours Of Approved Cme For The Two- Date Of My License, Or I Meet The Conditions equirements.	YES
			nd End-Of-Life Care.	YES TO THE STATE OF THE STATE O
	rom The Completion Of 12 ucation Requirement Becar		Pain Management And End-Of-Life Care Radiologist Or Pathologist.	NO
Only For Gene Years Or Olde	eral Internists And Family P	hysicians V ast 20% Of	vho Have 25% Of Their Patient Population Aged 65 The Required Cme in Geriatric Medicine Or The	NO
Enter Name/Ad"None", If None		ou Or Your	Immediate Family Hold Financial Interest. Type	NONE
Contained In T	This Application is True And	Correct.	Of The State Of California That The Information	YES
Information Co	ontained Therein As Curren	t And Accu		YES
Agency Or Oth		lave You Be	lad Any License Disciplined By A Government sen Convicted Of Any Crime In Any State, The U S untry?	NO

8

Total Questions Asked For Person: 552283

Application Summary 4/14/15 5:44 AM Page 1 of 3 License Type: Physician and Surgeon A License Number: 70101 File Number: Application: Physician's and Surgeon's Renewal Application Number: Application Date: Personal Detail First Name: **DEBORAH** Middle Name: LYNN Last Name: **NUCATOLA** **/**/*** Birthdate: Gender: Female Addresses License Related Addresses Address of Record (Required) Warning: In order to protect your privacy and identity, address will not be displayed. Confidential Address In order to protect your privacy and identity, Warning: address will not be displayed. Questions Since you last renewed your license, have No

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?

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

4/14/15 5:44 AM Page 2 of 3

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 - 40+ Hours

Other - None

Patient Care - 10-19 Hours

Research - 1-9 Hours

Teaching - 1-9 Hours

Telemedicine - None

Patient Care Practice Location

Zip: 90033 County: LOS ANGELES

Telemedicine Practice Location

Zip: County:

Patient Care Secondary Practice Location

Zip: 91302 County: LOS ANGELES

Telemedicine Secondary Practice Location

Zip: County:

Current Training Status

Not in Training

Areas of Practice

Obstetrics and Gynecology - Primary

Board Certifications

None

Postgraduate Training Years

6 Years

Cultural Background

White

Foreign Language Proficiency

Spanish

Web Site Profile

Cultural Background - No

Foreign Language Proficiency - Yes

Gender - Yes

E-mail:

Foos

Biennial Renewal Fee

\$783.00

DUE TO CURES FUND

\$12.00

4/14/15 5:44 AM

Page 3 of 3

Steven M.	Thompson	Physician	Corps	Loan
Repaymen	it Program	-	,	

\$25.00

Total Amount Due:

\$820.00

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: