Department of Consumer Affairs

License Details

The Department of Consumer Affairs encourages you to verify the license statuses of any licensees that may appear in a 'Related License' section below. You can verify these licensees by selecting 'New Search' and conducting a new search using the 'Search by Personal or Business Name' option. Please note that the 'Related License' section will only appear below if this license is related to another license. Not all licensees have a related license.

If the License Details below include 'Date of Graduation', the month and date of graduation may not be available. In this instance it will be displayed as '01/01/YYYY' where YYYY represents the year of graduation. Please note that not all license types disclose 'Date of Graduation' on the License Details screen.

Press "Previous Record" to display the previous license.

Press "Next Record" to display the next license.

Press "Search Results" to return to the Search Results list.

Press "New Search Criteria" to do another search of this type.

Press "New Search" to start a new search.

License Number: 23897 *Current Date: 08/28/2015 03:28 PM*

Name:	**BERMAN, RONALD**
License Type:	**Physician and Surgeon A**
License Status:	**License Renewed & Current**
Expiration Date:	**05/31/2017**
School Name:	**CA014 - UNIVERSITY OF CALIFORNIA, LOS ANGELES SC**
Date of Graduation:	**01/01/1969**
Original Issuance Date:	**02/22/2002**

Addresses

Address of Record (Required)	Address	101 W MCKNIGHT WAY # B133 GRASS VALLEY , CA NEVADA 95949 United States View on a map

Survey Information

The following information is self-reported by the licensee and has not been verified by the Board.

Are you retired?	**No**
Activities in Medicine	**Administration - 1-9 Hours**
	Patient Care - 20-29 Hours
Patient Care Practice Location	**Zip: 95949 County: NEVADA**
Patient Care Secondary Practice Location	**Zip: 95816 County: SACRAMENTO**
Telemedicine Practice Location	**Not Identified**
Telemedicine Secondary Practice Location	**Not Identified**
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**
Cultural Background	**Declined to Disclose**
Foreign Language Proficiency	**Declined to Disclose**
Gender	**Male**

Public Record Actions

Administrative Disciplinary Actions	**None found**
Court Order	**None found**

Misdemeanor Conviction	None found
Probationary License	None found
Felony Conviction	None found
Malpractice Judgment	None found
Hospital Disciplinary Action	None found
License Issued with Public Letter of Reprimand (Non-Disciplinary)	None found
Administrative Citation Issued	None found
Administrative Action Taken by Other State or Federal Government	None found
Arbitration Award	None found

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STATE OF CALIFORNIA — STATE AND CONSUMER SERVICES AGENCY

GRAY DAVIS, Governor

MEDICAL BOARD OF CALIFORNIA

1426 Howe Avenue, Suite 54, Sacramento, CA 95825-3236
TEL: (916) 263-2499/FAX: (916) 263-2487 Internet: www.medbd.ca.gov

RECEIVED SACRAMENTO MEDICAL BOARD OF CALIFORNIA

530

M112770

APPLICATION FOR PHYSICIAN'S AND SURGEON'S LICENSE

Please READ all instructions prior to completing this application. ALL questions on this application must be answered, and all supporting documents must be submitted as per instructions. Please type or print neatly. When space provided is insufficient, attach additional sheets of paper. All attachments are considered part of the application.

FALSIFICATION OR MISREPRESENTATION OF ANY ITEM OR RESPONSE ON THIS APPLICATION OR ANY ATTACHMENT HERETO IS A SUFFICIENT BASIS FOR DENYING OR REVOKING A LICENSE.

MBC USE ONLY — Personal Data

1. NAME: Last: Berman First: Ronald Middle: (None)

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

3. U.S. Social Security Number*

4A. (PUBLIC ADDRESS; will be released by the Board to the public): Number and Street/P.O. Box/Rural Route/Apartment Number, if any.
18734 Bambi Court

City: Grass Valley State: California Zip Code: 95949 Country: USA

4B. (CONFIDENTIAL ADDRESS): Number and Street/Rural Route/Apartment Number, if any. [Applicants must provide a confidential street address if a P. O. Box is used as the Public Address in #4A above.]
18734 Bambi Court

City: Grass Valley State: California Zip Code: 95949 Country: USA

5. Telephone Number:
Home: (
Work: ( )

6. California Driver's License Number (optional):
NUMBER EXPIRATION

7. Date of Birth (Month/Day/Year) and **Place of Birth:**

8. Sex: ☑ Male ☐ Female

9. Are you a U.S. citizen? ☑ Yes ☐ No

10. Have you ever filed an application for Physician's and Surgeon's examination or licensure in California? ☑ Yes ☐ No

IF YES, PLEASE GIVE DATE PREVIOUS APPLICATION WAS SUBMITTED. Awarded 8/14/70 (License A-23897)

11. List the names and locations 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. Transcripts will not be returned.

MBC USE ONLY — Pre-Medical Education

Name	City, State, Country	Dates of Attendance
Univ. of Calif @ Berkeley	Berkeley, Ca. (USA)	1960 – 1964

12. List the names and locations 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 8 1/2" x 11" photocopy (original diploma will be returned).

MBC USE ONLY — Medical Education: L2 Trans

School Name	City, State, Country	Dates of Attendance	Degree Awarded
Univ. of California @ Los Angeles	Los Angeles, Ca. (USA)	1964 – 1969	M.D.

DOCTOR OF MEDICINE DEGREE, as referenced above.

Name of Medical School	Address of Medical School	Exact Date of Issuance
U.C.L.A.	Los Angeles, California	June 14, 1969

*** MANDATORY DISCLOSURE OF U.S. SOCIAL SECURITY NUMBERS**
Disclosure of your U.S. social security number 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 will be used exclusively for tax enforcement purposes, for purposes of compliance with any judgment or order for family support in accordance with Section 17520 of the Family 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 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.

MBC USE ONLY: CA014 School Code

L1A

07A-160 (Rev. 3/01)

MBC USE ONLY

13. **Have you taken any of the following written examinations: National Boards, other state boards, USMLE, SPEX, FLEX, ECFMG or LMCC?** ☑ Yes ☐ No

Written Examination

IF YES, LIST NAME, LOCATION, DATE AND RESULT OF EACH EXAMINATION; FAILURES MUST ALSO BE DISCLOSED. EACH EXAMINATION AGENCY MUST SUBMIT AN ORIGINAL OFFICIAL **EXAMINATION HISTORY REPORT** DIRECTLY TO THE MEDICAL BOARD OF CALIFORNIA. **THESE REPORTS WILL NOT BE RETURNED.**

Examination	Date	Result (Pass/Fail)
Flex	1969-70	

14. **Have you ever been licensed to practice medicine in any state, territory, province, country, or U.S. federal jurisdiction?** ☑ Yes ☐ No

License Data

IF YES, LIST THE JURISDICTION, LICENSE NUMBER, DATE ISSUED AND DATES OF PRACTICE IN THAT JURISDICTION. PLEASE INCLUDE PERMANENT, TEMPORARY, TRAINING, PROVISIONAL, LIMITED LICENSE, OR PERMIT. AN ORIGINAL OFFICIAL **LETTER OF GOOD STANDING (LGS)**, OR COMPARABLE LICENSE HISTORY CERTIFICATION, IS REQUIRED FOR EACH PERMANENT, TEMPORARY, TRAINING, PROVISIONAL, LIMITED LICENSE, OR PERMIT OBTAINED IN ANY U.S. STATE, U.S. OR CANADIAN TERRITORY, CANADIAN PROVINCE, OR U.S. FEDERAL JURISDICTION. EACH LGS, OR COMPARABLE CERTIFICATION, SHOULD BE MAILED BY THE ISSUING AUTHORITY DIRECTLY TO THE MEDICAL BOARD OF CALIFORNIA.

LGS

Jurisdiction	License Number	Date of Issuance	Dates of Practice in that Jurisdiction
California	A-23897	Aug. 14, 1970	1969-70
Hawaii	2295	June 22, 1973	1970-1998

15. **Do you hold any other professional license in any state, territory, province, country, or U.S. federal jurisdiction?** ☐ Yes ☑ No

IF YES: PROFESSION: ______________________, LICENSE NO.: ______________, JURISDICTION: ______________

Other Professional Licenses

HAS THIS LICENSE EVER BEEN REVOKED, OR SUBJECT TO DISCIPLINE? IF YES, PLEASE PROVIDE ALL OFFICIAL DOCUMENTATION REGARDING THE MATTER IN ADDITION TO A WRITTEN EXPLANATION. YOU ARE ALSO REQUIRED TO REPORT ANY MATTER THAT IS PENDING OR IN WHICH CHARGES HAVE BEEN DROPPED OR EXPUNGED.

Yes No

16A. **Are you currently, or have you ever been, a participant in a postgraduate training program in a facility in the U.S. or Canada? (You must include every residency, internship, and fellowship, whether or not completed.)** ☑ Yes ☐ No

Postgraduate Training

IF YES, LIST NAMES AND ADDRESSES OF ALL FACILITIES. SUBMIT AN ORIGINAL **CERTIFICATE OF COMPLETION OF ACGME/RCPSC POSTGRADUATE TRAINING (FORM L3A)** FROM EACH FACILITY. (DO NOT COMPLETE FORM L3As 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	Categorial Specialty Area	Dates of Attendance
UCLA Harbor General Hospital	Torrance, California	Rotating Internship	6/24/69 - 6/23/70
Univ. of Hawaii Kapiolani Medical Center Queens Medical Center	Honolulu, Hawaii	OB/GYN	7/70 - 6/25/73

QUESTIONS 16B through 23:

If you answer YES to any of the following questions, please provide ALL official documentation regarding the matter in addition to your written personal explanations. An applicant must provide official hearing/court documents and original letters of explanation from medical schools or training program directors. If these documents are not provided with the application, they will be requested before review of the application can proceed. APPLICANTS ARE REQUIRED TO REPORT ANY MATTER THAT IS PENDING OR IN WHICH CHARGES HAVE BEEN DROPPED OR EXPUNGED.

16B. **Have you ever withdrawn from, or been suspended, dismissed or expelled from a medical school or postgraduate training program OR have you ever taken a leave of absence from such a school or program?**

IF YOU ANSWERED YES, BOTH APPLICANT AND SCHOOL/PROGRAM MUST PROVIDE DETAILS ON A SEPARATE ATTACHMENT.

Yes No

NAME OF APPLICANT: Berman, [redacted]ald

DATE OF BIRTH: [redacted]

MBC USE ONLY

License Data

For all of the below, also include any disciplinary actions by the U.S. Military, U.S. Public Health Service, or other U.S. federal governmental entity.

17A. 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?

17B. Has any disciplinary action ever been filed or taken, including but not limited to, informal or confidential discipline, consent orders, or letters of warning, regarding any healing arts license which you now hold or have ever held?

17C. Is any such action as described above pending?

17(A) Yes No ☑

17(B) Yes No ☐

17(C) Yes No ☑

IF YOU ANSWERED YES TO 17A, 17B OR 17C, PROVIDE DETAILS ON A SEPARATE ATTACHMENT.

18. 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 YOU ANSWERED YES, PROVIDE DETAILS ON A SEPARATE ATTACHMENT.

19. 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, territory, country, or U.S. federal jurisdiction, or is any such action pending?

IF YOU ANSWERED YES, PROVIDE DETAILS ON A SEPARATE ATTACHMENT.

Yes No ☑

20. Have you ever voluntarily surrendered a license to practice medicine or any other 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?

IF YOU ANSWERED YES, PROVIDE DETAILS ON A SEPARATE ATTACHMENT.

Yes No ☑

21. 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?

YOU MUST DISCLOSE ANY INFORMAL OR CONFIDENTIAL DISCIPLINARY ACTION.

Yes No ☑

22. 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.

FOR ALL OF THE BELOW, 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.

23A. Have you ever been convicted of, or pled nolo contendere to, ANY violation (include every misdemeanor or felony) of any local, state, or federal law of any state, territory, country, or U.S. federal jurisdiction?

23B. Is any criminal action related to the above pending?

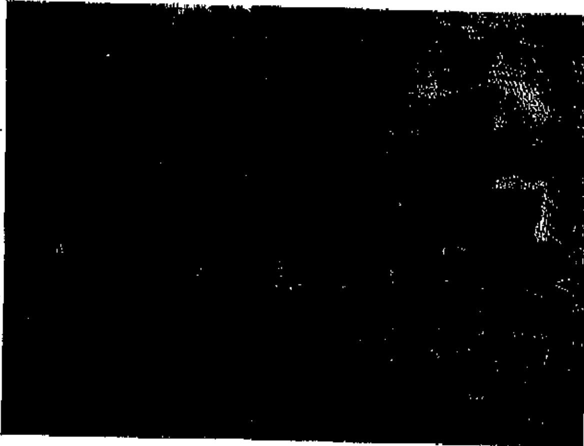
23 (A) Yes No ☐

23 (B) Yes No ☑

IF YOU ANSWERED YES TO 23A OR 23B, PROVIDE DETAILS ON A SEPARATE ATTACHMENT.

NAME OF APPLICANT: Berman, Ronald

DATE OF BIRTH:



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 Chief of the Licensing Program is the custodian of records.

Applicant Declaration/Signature *and* NOTARY

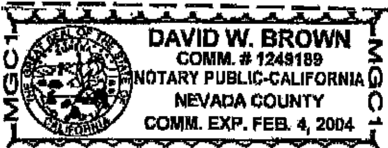
STATE OF California

COUNTY OF Nevada

The applicant, Ronald Berman (PLEASE PRINT FULL NAME), ______ (DATE OF BIRTH) being first duly sworn upon his/her oath deposes and says: that I am the person herein named subscribing to this application; that I have read the complete application, know the full content thereof, and declare under penalty of perjury, that all of the information contained herein and evidence or other credentials submitted herewith are true and correct; that I am 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 I am aware and that I am 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 UNDERSTAND THAT FALSIFICATION OR MISREPRESENTATION OF ANY ITEM OR RESPONSE ON THIS APPLICATION OR ANY ATTACHMENT HERETO IS A SUFFICIENT BASIS FOR DENYING OR REVOKING A LICENSE.**

SIGNATURE OF APPLICANT: [signature]
(PLEASE SIGN FULL NAME, NOT INITIALS)

Signed and sworn to before me this 16th day of OCT. (MONTH) 2001 (YEAR)



NOTARY SEAL

[signature] David W Brown 95949
SIGNATURE OF NOTARY PUBLIC

101 W. McKnight Way Grass Valley, CA
ADDRESS

My commission expires ■/4/2004

CERTIFICATES OF MORAL CHARACTER

PREFERABLY REGISTERED PHYSICIANS AND SURGEONS LICENSED BY THE CALIFORNIA BOARD OF MEDICAL EXAMINERS
WHO HAVE KNOWN APPLICANT FOR AT LEAST ONE YEAR

THIS CERTIFIES that I have been personally acquainted with Ronald Berman M.D.,
for 5 years and that I know him to be of good moral character and hereby recommend him to the Board of Medical Examiners of the State of California as more worthy to be licensed to practice as a physician and surgeon in the State of California.

Name Edward A. Langdon, M.D. Address UCLA School of Medicine, Los Angeles, Calif. 90024
Graduated from U. of Michigan date September 1945 Licensed in California (State) No. A16712

THIS CERTIFIES that I have been personally acquainted with Ronald Berman M.D.,
for 5 years and that I know him to be of good moral character and hereby recommend him to the Board of Medical Examiners of the State of California as most worthy to be licensed to practice as a physician and surgeon in the State of California.

Name Joshua S. Golden, M.D. Address UCLA School of Medicine, Los Angeles, Calif. 90024
Graduated from UC San Francisco date June 1955 Licensed in California (State) No. A16872

CERTIFICATE OF MEDICAL EDUCATION

The following certificate must be filled out, signed and sealed by the President, Dean or Secretary of each medical school wherein the applicant pursued his professional course and granted the medical diploma or certificate of completion to this applicant. Courses pursued in medical schools other than the one which granted the applicant his medical diploma must be submitted each on a supplemental copy of this form (duly certified) by the officers of said school or schools. One certificate of medical education to be completed by EACH medical school wherein the applicant studied.

THIS CERTIFIES That Ronald Berman (Name) of 4674 Waliki Place, Honolulu Hawaii (Address when matriculated)
matriculated in University of California School of Medicine (Name of medical school or college), Los Angeles, California 90024 (Location)
on 14th day of June 1964, and was granted the following credits on matriculation:
Freshman (Specify whether entered Freshman or with advanced credit)
based upon the following credentials: BA - 6/64 - UCBerkeley (Give a transcript of premedical education and advanced credit if any)

The undersigned further certifies that the records of this Institution show that PRIOR TO COMMENCING THE STUDY OF MEDICINE the applicant herein referred to has completed ...... course of College grade including the subjects of PHYSICS, CHEMISTRY and BIOLOGY, and that he has attended in this institution 35 courses (Number) terms of courses* of lectures of 5196 hrs. (Number) weeks* each, completing the following schedule totaling at least 4000 hours in the subjects required by the Business and Professions Code of California as set forth hereunder, and that he will be ~~was~~ granted the degree of BACHELOR OF DOCTOR of Medicine‡ (Specify which degree) on the 15th day of June 1969

ANATOMY
- Embryology
- Histology
- Neuro-anatomy

PHYSIOLOGY

PSYCHO-BIOLOGY

MEDICINE
- Pediatrics
- Psychiatry
- Neurology
- Dermatology
- Physical Medicine
- Therapeutics
- Tropical Medicine

BIOCHEMISTRY

PATHOLOGY, BACTERIOLOGY AND IMMUNOLOGY

PHARMACOLOGY

PREVENTIVE MEDICINE
- Hygiene and Sanitation

SURGERY, *including*
- Orthopedic Surgery
- Urology
- Ophthalmology
- Radiology
- Anesthesia
- Otolaryngology
- Obstetrics and Gynecology

Signed and the college seal affixed this 20th day of May 1969

[SEAL]

By Janice L. Haralson

* The California law requires completion of no less than four student courses of professional instruction, each of not less than 32 weeks (Section 2192).
‡ If a degree was granted, please give definite information. If no degree or diploma was granted "strike out" the entire line.

STATE OF CALIFORNIA — STATE AND CONSUMER SERVICES AGENCY

GRAY DAVIS, Governor

Consumer Affairs

MEDICAL BOARD OF CALIFORNIA

1426 Howe Avenue, Suite 54, Sacramento, CA 95825-3236
(916) 263-2499/FAX (916) 263-2487 Internet: www.medbd.ca.gov

RECEIVED MEDICAL BOARD OF CALIFORNIA

CERTIFICATE OF COMPLETION OF ACGME/RCPSC POSTGRADUATE TRAINING

To be completed by the facility for every medical school graduate completing postgraduate training in the United States or Canada.

ATTENTION PROGRAM DIRECTORS AND DIRECTORS OF MEDICAL EDUCATION: THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE OR ADOPTION. Only the Program Director and the Director of Medical Education may sign this form. If that signature authority is being delegated to another person, evidence of the delegation must be attached to this form (may be a photocopy). Such delegation must be on official letterhead and must be dated within the last 12 months.

PART 1: To be completed by the APPLICANT.

LAST NAME of Applicant: Berman | First Name: Ronald | Middle Initial: (No middle name)

U.S. Social Security Number: | Date of Birth: MM/DD/YYYY: | Telephone Number: Home: ( ) Work: ( ) Same

Current Address: 18734 Bambi Court

City: Grass Valley | State: California | Zip Code: 95949-8921

PART 2: To be completed by the PROGRAM DIRECTOR

ATTENTION PROGRAM DIRECTOR! *Do not sign and date this form before the last day of any postgraduate training year which will be used by the applicant to qualify for licensure.* Completion of this form will certify that the individual named in PART 1 above completed a period of accredited postgraduate training at this facility. If a period of training WAS NOT completed in a satisfactory manner, please provide a separate detailed narrative explanation. The following information is provided to certify "satisfactory" completion. PLEASE SEE THE REVERSE FOR A DEFINITION OF "SATISFACTORY."

Name of Facility: Harbor-UCLA Medical Center | Address of Facility: 1000 W. Carson St., Torrance CA 90509

Name of Program Director: Jerrold A. Turner, M.D. | Telephone Number: (310) 222-2903

Signature of Program Director: [signature] | Date Signed: 12/10/01

List Categorical Specialty Area of Training Completed by Trainee: Rotating Internship | Date Training Commenced: 6/24/69 | Date Training Completed: 6/23/70

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): Obstetrics 16 weeks, Gynecology 8 weeks, Surgery 4 weeks, Anesthesiology 4 weeks, Psychiatry 4 weeks, Emergency Medicine 4 weeks, General Medicine Wards 8 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: Jerrold A. Turner, M.D. | Name of Facility: Harbor-UCLA Medical Center

Address of Facility: 1000 W. Carson St., Torrance CA 90509

City: | State: | Zip Code: | Telephone Number: (310) 222-2903

PART 4: Signature of DIRECTOR OF MEDICAL EDUCATION certifying satisfactory completion of training.

Attention: Director of Medical Education! *Do not sign and date this form before the last day of any postgraduate training year which will be used by the applicant to qualify for licensure. This form may be signed by the current Director of Medical Education; it does not need to be signed by the person who was the Director of Medical Education at the time of the training listed above.*

Notice to Applicant: If this form is used to verify postgraduate training beyond that which is required for licensure, this form can be signed by the Director of Medical Education and the Program Director before the final day of training. However, if you are licensed after the date upon which training was completed AND if the form was signed before the final day of the training year, a new form must be completed and submitted to the Medical Board of California.

HOSPITAL OR NOTARY SEAL

OFFICIAL HOSPITAL SEAL OR NOTARY SEAL, DATE AND SIGNATURE MUST BE AFFIXED IN THE BOX TO THE LEFT TO CERTIFY 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 RCPSC to offer the type and level of training completed by the applicant and that the applicant was trained in an approved ACGME or RCPSC program position.

Signature of Director of Medical Education: [signature] | Date Signed: 12/10/01

L3A

FORM 31-A

Please Follow Directions

RETURN THIS APPLICATION TO SACRAMENTO, CALIFORNIA

This application, with CERTIFIED CHECK for $40.00 and photographic copy of diploma to be no less than 7½ inches by 10 inches and no larger than 8½ inches by 11 inches, or other evidence of final, successful and entire completion of instruction and training required by a school approved by the Board, must be filed in the OFFICE OF THE BOARD, Sacramento, Cal., at least two weeks prior to the date of meeting of the Board as specified on the enclosed mimeographed list of dates. [See instructions re foreign documents.]

The filing of this application does not grant any special privilege to open an office or to conduct any method of treating the sick or afflicted in the State of California. [See Sections 2141 to 2141 of the Business and Professions Code printed at the bottom of page 4 of this blank.]

NO temporary certificates or special permits to practice are issued.

All credentials from foreign institutions must be translated INTO ENGLISH over the seal and signature of the consul of the country wherein such documents may have been issued. The English translation must be attached to the original, or to a photostatic copy thereof, and said consul must certify that said institution is recognized or approved by the authorities in the country wherein it is located. See bottom next page for additional information. Further information will be sent on request.

Application filed 5/27/69
Fee paid ✓ 2037 — 20[illegible]
Diploma filed [illegible]
Diploma verified ______ 574
By ______

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA

Application for a Written Examination for a Physician's and Surgeon's Certificate (Class A)

I, Ronald Berman (Full name, no initials) hereby apply for a written examination for a physician's and surgeon's certificate in California and submit the following statements regarding my preliminary, premedical and medical educational qualifications in conformance with the requirements of the Business and Professions Code of the State of California and the rules adopted by the Board of Medical Examiners.

Name in full Ronald Berman P. O. address [illegible]

Date of birth ______ Month ______ Day ______ Year ______ Age at this date 26

Are you a citizen of the United States? Give particulars [illegible]

Send certificate, if issued, to [illegible] (Applicant will give full directions and notify the Board of every change of address)

I have received a diploma, evidencing PRELIMINARY EDUCATION, from [illegible] High School (School) [illegible] (Location) John F. [illegible] (Principal) on the 11th day of June 1961, and this diploma was procured in the regular course of instruction, comprising a full four years' resident high school course, or its equivalent as prescribed by law, and in addition to said diploma I have successfully completed, prior to commencing the study of medicine, a two-year resident course of COLLEGE GRADE including the PREMEDICAL subjects of:*

A. Chemistry Yes (Yes or no) College U. C. (Name) Berkeley (Location) from Sept 1961 to June 1963 (Date of completion)

B. Physics Yes (Yes or no) College U. C. (Name) Berkeley (Location) from Sept 1961 to June 1962 (Date of completion)

C. Biology Yes (Yes or no) College U. C. (Name) Berkeley (Location) from Sept 1961 to June 1963 (Date of completion)

I hold the Collegiate (Academic) degree of Bachelor of Arts granted by ______ on the 10th day of June 1964.

MEDICAL EDUCATION.—Applicant will give the name and location of each institution attended, specifying each such course of instruction, giving the date of beginning and ending of each. The law requires a RESIDENT course of at least 4 academic years.

I entered the UCLA School of Medicine (Name of medical school) in the 1st year (Whether first year) class on the 14th of September (Date) 1964

1ST COURSE in UCLA School of Med. (Freshman) (Name of medical college) Los Angeles, California (Location of medical college (city, address and state)) From the 14th day of September 1964, to the 11th day of June 1965

2D COURSE in UCLA School of Medicine (Sophomore) (Name of medical college) Los Angeles, California (Location of medical college (city, address and state)) From the 13th day of September 1965, to the ______ day of June 1966

3D COURSE in UCLA School of Medicine (Junior) (Name of medical college) Los Angeles, California (Location of medical college (city, address and state)) From the 11th day of September 1967, to the 7th day of June 1968

4TH COURSE in UCLA School of Medicine (Senior) (Name of medical college) Los Angeles, California (Location of medical college (city, address and state)) From the ______ day of September 1968, to the ______ day of June 1969

5TH COURSE in ______ (Name of medical college) ______ (Location of medical college (city, address and state)) From the ______ day of ______ 19__, to the ______ day of ______ 19__

6TH COURSE in Univ of California Los Angeles School of Med (Name of medical college) (Location of medical college (city, address and state)) From the ______ day of ______ 19__, to the ______ day of ______ 19__

I will be granted the degree of Doctor of Medicine (Bachelor or Doctor of Medicine) by UCLA (Name of institution granting degree) located at Los Angeles State of Calif on the [illegible] day of June 1969

I further state that I am the identical person to whom was granted the diploma or certificate of completion presented herewith, that the same was procured in the regular course of instruction without fraud or misrepresentation and that the diploma or certificate of completion presented is the genuine diploma or certificate of completion of said institution.

I further state that, as a resident student, I have completed the courses, and subjects as set forth on page 3 of this application and as evidenced by any other documents I submit and that I have been licensed in no State except as follows:

______ State ______ Date ______ State ______ Date ______ State ______ Date

that no application either for admission to an examination or for a certificate to practice medicine has been denied me except as follows:

______ State ______ Date ______ State ______ Date ______ State ______ Date

and that no certificate to practice medicine and surgery, issued to me by any State or Territory of the U. S., or by the licensing authority of a foreign country, has been revoked or suspended except as follows:

______ State ______ Date ______ 19__ Reason of ______

and that I have not been charged with a violation of a United States statute or a State statute or the law of any foreign country except as follows:

______

* Applicants matriculating in a medical school after January 1, 1933 must show the completion [illegible] two-year resident course of college grade including the subjects of Chemistry

I further depose and state that I have taken postgraduate [illegible] in the following institutions:

a. ______ Name ______ Location ______ from ______ 19 __, to ______

b. ______ Name ______ Location ______ from ______ 19 __, to ______

I have been serving an INTERNESHIP in the following hospitals:

a. Harbor General Hosp Name Torrance Calif Location from June 23 1969 to June 23, 1970

b. ______ Name ______ Location ______ from ______ 19 __, to ______

SECTION 2192 OF THE B & P CODE PROVIDES THAT BEFORE A PHYSICIAN'S AND SURGEON'S CERTIFICATE MAY BE ISSUED, SATISFACTORY EVIDENCE OF THE COMPLETION OF A YEAR'S INTERNESHIP IN A HOSPITAL APPROVED BY THE BOARD MUST BE FILED.

I further depose and state that prior to the date of this application I have not filed an application to practice any system of healing the sick and/or afflicted under the laws of California, and that I have not practiced as an itinerant physician nor have I been connected directly or indirectly with any medical concern, company, institute, advertising specialty or advertising specialist except as follows:

None
Answer

and furthermore I agree, should a certificate be granted me by the Board of Medical Examiners of the State of California, that I will not become an itinerant doctor nor become connected either directly or indirectly with any medical concern, company, institute, or advertising specialty or advertising specialist and that I will familiarize myself with all the provisions of the California laws relating to the treatment or care of the sick and afflicted and narcotic regulations both Federal and State.

I hereby declare that the photo of myself, attached hereto, was taken on or about the ______ day of ______ 19__, my age then being ______ years, and my physical description then being as follows:

native of ______

color of hair ______ ; color of eyes ______

height ______ (heavy / medium / light) weight ______ lbs.

marks ______

Fingerprint Classification ______

STATE OF California

COUNTY OF Los Angeles } ss.

Ronald Birman ______ being duly sworn, says __he is the person referred to in the foregoing application for a physician's 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 are strictly true in every respect and that __he is not suffering from any ailment transmissible to others and that __he has never been and is not now addicted to the use of narcotic drugs.

Ronald Birman
Signature of applicant IN FULL (Do not USE INITIALS ONLY)

Signed and sworn to before me this 26 day of May 19 69

Jeanne L. Johnson
Notary Public

Address Los Angeles California

[SEAL]

My commission expires ______ 19__

The applicant who presents a medical diploma from a FOREIGN MEDICAL SCHOOL, must meet additional requirements outlined in Sections 2193 and 2193.5 of the Business and Professions Code. SEND FOR OUR FORM 172-17). Canadian medical school graduates exempted by Chap. 281, Statutes 1939, effective September 19, 1939.

Every applicant for a "physician and surgeon certificate," shall present to the Board satisfactory evidence that BEFORE BEGINNING THE STUDY OF MEDICINE HE HAS COMPLETED A TWO-YEAR COLLEGE COURSE WHICH INCLUDES AT LEAST ONE YEAR OF WORK, OF COLLEGE GRADE, IN EACH OF THE SUBJECTS OF PHYSICS, CHEMISTRY, AND BIOLOGY. An applicant matriculating after January 1, 1934, shall present evidence satisfactory to the Board of having completed a three-year resident course of college grade including the subjects of physics, chemistry and biology.

STATE DEPARTMENT OF CONSUMER AFFAIRS
INTERNET CASHIERING SYSTEM
MEDICAL BOARD OF CALIFORNIA
SUPPLEMENTAL INFORMATION REPORT
From Date: 04/30/2009 **To Date:** 04/30/2009

ATRISUPPINF

20-AUG-15 15:33:19

Person Id : 521867 **Name :** Berman,Ronald

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 : 521867 8

STATE DEPARTMENT OF CONSUMER AFFAIRS
INTERNET CASHIERING SYSTEM
MEDICAL BOARD OF CALIFORNIA
SUPPLEMENTAL INFORMATION REPORT
From Date: 05/04/2011 **To Date:** 05/04/2011

ATRISUPPINF

20-AUG-15 15:25:03

Person Id : 521867 **Name :** Berman,Ronald

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 : 521867 8

STATE DEPARTMENT OF CONSUMER AFFAIRS
INTERNET CASHIERING SYSTEM
MEDICAL BOARD OF CALIFORNIA
SUPPLEMENTAL INFORMATION REPORT
From Date: 04/26/2013 **To Date:** 04/26/2013

ATRISUPPINF

20-AUG-15 15:28:35

Person Id : 521867 **Name :** Berman,Ronald

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 : 521867 8

Application Summary

License Type:	**Physician and Surgeon A**
License Number:	**23897**
File Number:	
Application:	**Physician's and Surgeon's Renewal**
Application Number:	
Application Date:	

Personal Detail

First Name:	**RONALD**
Last Name:	**BERMAN**
Birthdate:	**/**/****
Gender:	**Male**

Addresses

License Related Addresses

Address of Record (Required)

Warning: **In order to protect your privacy and identity, address will not be displayed.**

Confidential Address

Warning: **In order to protect your privacy and identity, address will not be displayed.**

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**
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:	**Yes**

Attachments

Physician Survey

Are you retired?	**No**
Activities in Medicine	**Administration - 1-9 Hours** **Patient Care - 20-29 Hours**
Patient Care Practice Location	**Zip: 95949 County: NEVADA**
Telemedicine Practice Location	**Zip: County:**
Patient Care Secondary Practice Location	**Zip: 96816 County: SACRAMENTO**
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**
Cultural Background	**European**
Foreign Language Proficiency	**None**
Web Site Profile	**Cultural Background - No** **Foreign Language Proficiency - No** **Gender - Yes**

E-mail:

Fees

Biennial Renewal Fee	**$783.00**
DUE TO CURES FUND	**$12.00**
Steven M. Thompson Physician Corps Loan Repayment 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:

1427737388895