



BOARD OF MEDICAL QUALITY ASSURANCE

1430 HOWE AVENUE, SACRAMENTO, CALIFORNIA 95825

APPLICATIONS AND EXAMINATIONS (916) 520-6411



APPLICATION FOR PHYSICIAN'S AND SURGEON'S CERTIFICATE

BASED ON NATIONAL BOARD CREDENTIALS

CLASS C

000510  
3/13/80

PLEASE TYPE OR PRINT NEATLY. WHEN SPACE PROVIDED IS INSUFFICIENT, ATTACH ADDITIONAL SHEETS.

1. NAME: LAST FIRST MIDDLE MAIDEN I.E. TELEPHONE NO.

FURGERSON DOROTHY LOUISE

2. LIST OTHER NAMES, IF ANY, YOU HAVE USED:

3. ADDRESS: STREET AND NO./RURAL ROUTE CITY STATE ZIP CODE

1475 De Rosa Way #151 San Jose CA 95128

4. NAME YOU WISH ON LICENSE: BIRTHDATE: MONTH, DAY, YEAR

DOROTHY L. FURGERSON

5. PREMEDICAL EDUCATION: NAME OF COLLEGE OR UNIVERSITY LOCATION

Stanford University Stanford CA

PERIOD OF ATTENDANCE:

FROM: 7/66 TO: 6/68

CHECK PREMED COURSES SUCCESSFULLY COMPLETED:

CHEMISTRY  PHYSICS  BIOLOGY OR ZOOLOGY

6. MEDICAL SCHOOL:

YEAR	NAME OF INSTITUTION	LOCATION	FROM	TO
1	University of Arizona College of Medicine	Tucson, Arizona	8/80	6/81
2	"	"	8/81	6/82
3	"	"	8/82	6/83
4	"	"	8/83	6/84
5	"	"		

7. DOCTOR OF MEDICINE DEGREE GRANTED BY: DATE FOR OFFICE USE ONLY

University of Arizona College of Medicine 5/12/84

8. 1ST YEAR POSTGRADUATE TRAINING/INTERNSHIP:

LOCATION	TYPE OF SERVICE	FROM	TO
Prose Hospital San Jose, CA	Family Practice	8/84	6/85

9. LIST ALL STATES IN WHICH YOU HAVE BEEN LICENSED TO PRACTICE MEDICINE:

CA, AZ

10. HAS ANY DISCIPLINARY ACTION EVER BEEN TAKEN REGARDING ANY LICENSE WHICH YOU NOW HOLD OR HAVE EVER HELD?

IF YES INDICATE

STATE DATE CHANGE DISPOSITION

11. 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

12. ARE YOU NOW OR HAVE YOU EVER BEEN ADMITTED TO NARCOTIC DRUGS?

14. HAVE YOU EVER BEEN CONVICTED OF, OR PLED GUILTY OR CONTENDERS TO A VIOLATION OF ANY FEDERAL, STATE OR LOCAL LAW RELATING TO THE MANUFACTURE, DISTRIBUTION OR DISPENSING OF CONTROLLED SUBSTANCES (MARIJUANA OR TO DRUG ADDICTION)?

15. HAVE YOU EVER BEEN CONVICTED OF, OR PLED GUILTY OR CONTENDERS 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 15 ABOVE, PLEASE PROVIDE THE FOLLOWING INFORMATION:

VIOLATION AND LOCATION	DATE	PENALTY/SUSPENSION

17. HAVE YOU EVER HAD STAFF PRIVILEGES IN A HOSPITAL SUSPENDED OR REVOKED? IF "YES" PLEASE EXPLAIN ON ANOTHER SHEET OF PAPER.

18. HAVE YOU EVER VOLUNTARILY SUSPENDED YOUR LICENSE TO PRACTICE IN ANOTHER STATE?



LAST  
THE

APPLICANT, PLEASE COMPLETE THE FOLLOWING:  
 HEIGHT:  FT  IN WEIGHT:  LBS  
 HAIR COLOR:  EYE COLOR:   
 IDENTIFYING MARKS:

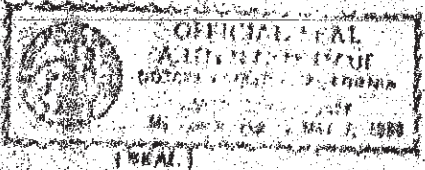
...ICATION IS REQUIRED AND MAINTAINED PURSUANT TO SECTION ...  
 ...SSIONS CODE. ALL ITEMS IN THIS APPLICATION ARE ...  
 ... FAILURE TO PROVIDE ANY OF THE REQUESTED INFORMATION ...  
 ... ON BEING RESPECTED AS INCOMPLETE. THE INFORMATION ...  
 ... EXAMINE QUALIFICATION FOR LICENSES. APPLICANTS HAVE ...  
 ... APPLICATIONS SUBJECT TO THE PROVISIONS OF THE CALIFORNIA ...

STATEMENT IN PRESENCE OF NOTARY PUBLIC.  
 "I HEREBY CERTIFY (OR DECLARE), UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA, 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 *[Signature]*

DATE

SUBSCRIBED AND SWORN TO BEFORE ME THIS



SIGNATURE OF NOTARY *[Signature]*  
 ATTESTED *[Signature]*

MY COMMISSION EXPIRES



BOARD OF MEDICAL QUALITY ASSURANCE

1430 HOWE AVENUE, SACRAMENTO, CALIFORNIA 95825



PLEASE FORWARD TO YOUR MEDICAL SCHOOL

CERTIFICATE OF MEDICAL EDUCATION

THIS CERTIFIES THAT DOROTHY LOUISE FORGERSON  
NAME OF APPLICANT  
 OF THE W. LAMARSON 542 Tucson ENROLLED IN University of Arizona  
ADDRESS WHEN ENROLLED NAME OF MEDICAL SCHOOL  
Tucson, Arizona ON THE 4th DAY OF August 1987  
LOCATION MONTH 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).

Stanford University

1976-1980

EDUCATIONAL INSTITUTION

DATE

**ADVANCED CREDITS.** CREDITS PREVIOUSLY OBTAINED AT AN APPROVED MEDICAL SCHOOL \*

<small>MEDICAL SCHOOL</small>	<small>TOTAL CREDITS</small>	<small>DAYS</small>
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TRANSCRIPTS OF PREMEDICAL EDUCATION, ADVANCED CREDITS, AND MEDICAL SCHOOL CREDITS MUST BE SUPPLIED WITH THIS CERTIFICATE

THE UNDERSIGNED FURTHER CERTIFIES THAT THE RECORDS OF THIS INSTITUTION SHOW THAT SHE  
 ATTENDED IN THIS INSTITUTION four years ~~NUMBER~~ OF RESIDENT INSTRUCTION OF 9-12 months  
PERIOD NUMBER OF YEARS  
 EACH YEAR, COMPLETING AT LEAST 2,000 HOURS, OF WHICH AT LEAST 80 PERCENT ACTUAL ATTENDANCE  
 IS REQUIRED, IN THE SUBJECTS SET FORTH HEREUNDER (BUSINESS AND PROFESSIONS CODE SECTION  
 2088), AND THAT SHE WAS GRANTED THE DEGREE ~~DOCTOR~~ DOCTOR OF MEDICINE BY THE ABOVE MENTIONED  
 MEDICAL SCHOOL ON THE 12th DAY OF May 1983  
DATE

- |  |  |  |
|--|--|--|
| <input checked="" type="checkbox"/> ANATOMY                                | <input checked="" type="checkbox"/> ORTHOPAEDY                                     | PREVENTIVE MEDICINE, INCLUDING NUTRITION         |
| <input checked="" type="checkbox"/> COLONYTHOLOGY                          | <input checked="" type="checkbox"/> EMBRYOLOGY                                     | PHYSICAL MEDICINE                                |
| <input checked="" type="checkbox"/> GYNECOLOGY AND OBSTETRICS              | <input checked="" type="checkbox"/> HISTOLOGY                                      | THERAPEUTICS                                     |
| <input checked="" type="checkbox"/> RADIOLOGY, INCLUDING RADIATION SAFETY  | <input checked="" type="checkbox"/> HUMAN HEREDITARY AS AS DEFINED IN SECTION 2088 | NEUROANATOMY                                     |
| <input checked="" type="checkbox"/> TROPICAL MEDICINE                      | <input checked="" type="checkbox"/> MEDICINE                                       | CHILD ABUSE DETECTION AND TREATMENT              |
| <input checked="" type="checkbox"/> PHYSIOLOGY                             | <input checked="" type="checkbox"/> SURGERY, INCLUDING ORTHOPEDIC SURGERY          | GERIATRIC MEDICINE                               |
| <input checked="" type="checkbox"/> MICROBIOLOGY                           | <input checked="" type="checkbox"/> UROLOGY  | <input checked="" type="checkbox"/> NEONATOLOGY  |
| <input checked="" type="checkbox"/> PATHOLOGY, BACTERIOLOGY AND IMMUNOLOGY | <input checked="" type="checkbox"/> PSYCHIATRY                                     | <input checked="" type="checkbox"/> PHARMACOLOGY |
| <input checked="" type="checkbox"/> OPHTHALMOLOGY                          | <input checked="" type="checkbox"/> NEUROLOGY                                      | <input checked="" type="checkbox"/> ANESTHESIA   |

[ AFFIX SEAL HERE ]

SIGNED AND THE COLLEGE SEAL AFFIXED THIS 11 DAY OF June 1987  
 BY Andrew M. Goldner, Ph.D. PRESTERY, SECRETARY, ETC.  
 Andrew M. Goldner, Ph.D., Associate Dean

\*EACH MEDICAL SCHOOL ATTENDED MUST COMPLETE ONE OF THESE FORMS COVERING PERIOD OF ATTENDANCE.

STATE DEPARTMENT OF CONSUMER AFFAIRS  
 INTERNET CASHIERING SYSTEM  
 MEDICAL BOARD OF CALIFORNIA  
 SUPPLEMENTAL INFORMATION REPORT  
 From Date: 01/07/2009 To Date: 01/07/2009

ATRISUPPINF

22-JUL-15 09:05:53

Person Id : 601085

Name : Furgerson,Dorothy

Question	Answer
I 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.	YES
I Have Completed 12 Hours Of Pain Management And End-Of-Life Care (Must Be Completed By December 31, 2006).	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 :

601085

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STATE DEPARTMENT OF CONSUMER AFFAIRS  
INTERNET CASHIERING SYSTEM  
MEDICAL BOARD OF CALIFORNIA  
SUPPLEMENTAL INFORMATION REPORT  
From Date: 01/13/2011 To Date: 01/13/2011

ATRISUPPINF

22-JUL-15 09:07:00

Person Id : 601085

Name : Furgerson,Dorothy

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 : 601085

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STATE DEPARTMENT OF CONSUMER AFFAIRS  
INTERNET CASHIERING SYSTEM  
MEDICAL BOARD OF CALIFORNIA  
SUPPLEMENTAL INFORMATION REPORT  
From Date: 12/16/2012 To Date: 12/16/2012

ATRISUPPINF

22-JUL-15 09:15:44

Person Id : 601085

Name : Furgerson,Dorothy

Question	Answer
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
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
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
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

Total Questions Asked For Person : 601085

8

12062014 10004609 10020014

Street Address (this address is public information except when a PO Box is used for the public address of record; this address then becomes confidential)

Grid for street address input

City

Grid for city input

State

Grid for state input

Zip

Grid for zip input

PO Box (if used, must provide a confidential physical street address, above)

Grid for PO box input

City

Grid for city input

State

Grid for state input

Zip

Grid for zip input

Medical Board of California – Physician's and Surgeon's Initial Renewal

LICENSEE NAME

FURGERSON, DOROTHY L

LICENSE NO.

G55843

EXPIRATION DATE

01/31/15

AMOUNT DUE NOW

\$820.00

AMOUNT DUE IF POSTMARKED AFTER MARCH 02, 2015

\$898.00

LICENSEE MUST CHECK CORRECT BOXES
'H' [X] Completed Continuing Education
'E' [ ] Change of Address (fill in reverse side)
'I' [ ] Conviction Disclosure -- Yes
'J' [X] Conviction Disclosure -- No
'F' [X] Family Physician Training Program (\$25)
'G' [X] Financial Interest Statement

"D" SIGNATURE REQUIRED
I declare under penalty of perjury under the laws of the State of California that all statements, answers, and representations on this form, including supplementary attached hereto, are true, complete and accurate.
Signature Dorothy L Furgeson MD Date 12-1-14

63010700000700006000558437010131150008200000089800