State of California Department of Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM
1426 Howe Avenue, Sacramento, CA 95825-3236
(916) 263-2499

CERTIFICATE OF COMPLETION OF ACGME/CCME POSTGRADUATE TRAINING

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

PART 1: To be completed by the applicant/trainee.

Last Name of Trainee	First Name	Middle Initial
Goldberg	Alisa	B

Current Address	Social Security Number
20 Coolidge Street	

City	State	Zip Code	Telephone Number
Brookline	MA	02146	( )

PART 2: To be completed by the facility. Completion of this form will certify that the individual named in PART 1 above and whose photograph is attached to this form, formally completed an accredited postgraduate training program at this facility. The following information is provided to certify "satisfactory" completion. PLEASE SEE THE REVERSE FOR A DEFINITION OF "SATISFACTORY."

Name of Facility	Address of Facility
Brigham + Women's Hospital	75 Francis Street, Boston, MA 02115

Name of Program Director	Telephone Number
Robert J Barbieri, MD	(617) 732-5444

Signature of Program Director	Date Signed
Robert Barbieri	12/5/97

List Categorical Specialty Area of Training Completed by Trainee	Date Training Commenced	Date Training Completed
Obstetrics + Gynecology	6/20/94	6/30/98

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):

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	Facility Name
Robert Barbieri, MD	Brigham + Women's Hospital

Facility Address	City	State	Zip Code	Telephone Number
75 Francis Street	Boston	MA	02115	(617) 732-5444

PART 4: Signature of Director of Medical Education certifying satisfactory completion of training.

ATTENTION PROGRAM DIRECTOR!
IF TRAINEE IS IN HIS/HER FIRST YEAR OF POSTGRADUATE TRAINING, DO NOT SIGN OR DATE THE STATEMENT BELOW UNTIL AFTER THE COMPLETION OF THE TRAINEE'S LAST DAY OF 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 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.

Signature of Director of Medical Education	Date Signed
Robert Barbieri	12.24.97

OFFICIAL HOSPITAL SEAL OR NOTARY SEAL, DATE AND SIGNATURE MUST BE AFFIXED TO CERTIFY TRAINING.

Denise A. Dolan

DENISE A. DOLAN
Notary Public
My Commission Expires April 23, 2004

L3A

STATE OF CALIFORNIA — STATE AND CONSUMER SERVICES AGENCY

PETE WILSON, Governor

Consumer Affairs

RECEIVED MEDICAL BOARD OF CALIFORNIA

JAN 14 1998

MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM
1426 Howe Avenue
Sacramento, CA 95825-3236
(916) 263-2499

RECEIVED SACRAMENTO MEDICAL BOARD OF CALIFORNIA

98 JAN 13 AM 8:48

LICENSING PROGRAM CERTIFICATE OF MEDICAL EDUCATION

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

This certifies that Alisa Beth Goldberg (FULL NAME OF APPLICANT) of 5 Wellman St. (ADDRESS WHEN ENROLLED) enrolled in Harvard Medical School (NAME OF MEDICAL SCHOOL) Boston, MA (LOCATION)

on the 4 day of SEPTEMBER (MONTH) 19 90 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 2089).*

Case Western Reserve University (EDUCATIONAL INSTITUTION) 8/86 - 6/90 (DATES)

Advanced Credits: *Credits previously obtained at an approved medical, dental, or osteopathic school.*

(MEDICAL SCHOOL) (TOTAL CREDITS) (DATES)

The undersigned further certifies that the records of this institution show that She attended in this institution 4 (SPECIFY NUMBER) years of resident instruction of 36 (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:

☑ She was granted the degree Bachelor/Doctor of Medicine by OR ☐ he withdrew from

the above mentioned medical school on the 9 day of JUNE (MONTH) 19 94.

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
Alcoholism and Chemical Dependency
Preventive medicine, including Nutrition
Physical Medicine
Therapeutics
Neuroanatomy
Child Abuse Detection and Treatment
Geriatric Medicine
Pediatrics
Pharmacology
Anesthesia
Family Medicine**
Spousal or Partner Abuse Detection & Treatment***

* 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.

** 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 September 1, 1994.

TRANSCRIPTS FOR ALL ADVANCED CREDITS AND MEDICAL SCHOOL CREDITS MUST BE SUPPLIED WITH THIS CERTIFICATE

Signed and the school seal affixed this 8 day of January, 19 98

BY Carol A. Duffey, Registrar
CAROL A. DUFFEY, REGISTRAR (PRESIDENT, SECRETARY, DEAN)

L2

State of California Department of Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM
1426 Howe Avenue
Sacramento, CA 95825-3236
(916) 263-2499

CERTIFICATION STATEMENT

This is to certify that Alisa Beth Goldberg
(Name of Physician)

is in an approved ACGME/CCME postgraduate training position that commenced on June 20 1994 and is expected to be completed on June (Month) 30 (Day) 1998 (Year) in Obstetrics + Gynecology (Type of Training)

at Brigham + Women's Hospital; 75 Francis St; Boston, MA 02146
(Name and Address of Facility)

DEIDRE X. [illegible]
Notary Public
My Commission Expires April 23, 2002

AFFIX OFFICIAL HOSPITAL SEAL OR NOTARY SEAL IN THE BOX AT THE LEFT.

"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."

Robert Barbieri, MD
(Type or print name of Director of Medical Education)

Robert Barbieri
(Signature of Director of Medical Education)

12 15 97
(Date)

(617) 732-5444
(Telephone Number)

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

07A-107-L4 (2/97)

L4 (formerly Form L-9)

STATE OF CALIFORNIA — STATE AND CONSUMER SERVICES AGENCY

TD 4643

PETE WILSON, Governor

State of California, Department of Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM

1426 Howe Avenue, Sacramento, CA 95825-3236
(916) 263-2450

RECEIVED
SACRAMENTO
MEDICAL BOARD
OF CALIFORNIA
98 JAN 20 PM 2:00

APPLICATION FOR PHYSICIAN AND SURGEON'S EXAMINATION OR LICENSURE

024447

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.

MBC USE ONLY

1. Name (Last)	(First)	(Middle)
Grasso	Alan	Scott

2. Other names you have used (include maiden name): none

3. Social Security Number◆ [redacted] 026853

4. Address: Number and Street/Rural Route (include apartment number, if any): 75 Francis Street, Dept. OB/Gyn, ASBI-073-03

5. Sex: ☑ Female ☐ Male

City: Boston | State: MA | Zip Code: 02115 | Country: USA

6. Telephone Number
Home: [redacted]
Work: [redacted]

7. Date of Birth (Mo/Day/Yr): [redacted]
Place of Birth: [redacted]

8. California Driver's License Number, if applicable:
NUMBER: | EXPIRATION:

9. Are you a U.S. citizen? ☑ Yes ☐ No
If you are an international medical school graduate, you must provide an original full and unrestricted license to practice medicine in another state or country, OR official documentation of U.S. citizenship, OR an official Declaration of Intent to become a U.S. citizen.

10. Have you ever filed an application for physician and surgeon examination or licensure in California? ☐ Yes ☑ No
IF YES, PLEASE GIVE DATE PREVIOUS APPLICATION WAS SUBMITTED AND ATTACH ANY APPLICATION MATERIALS YOU MAY HAVE RETAINED.

11A. List the names and addresses 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.

Name	Address	Dates of Attendance
Case Western Reserve Univ.	PARDEE Hall, 10900 Euclid Ave Cleveland, OH 44106	Aug 1986 – June 1990

11B. Check whether the following premedical courses were successfully completed and show where completed:

Course	Yes	No	Name of College or University
Chemistry	✓		Case Western Reserve University
Physics	✓		Case Western Reserve University
Biology or Zoology	✓		Case Western Reserve University

12. List the names and addresses 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 photocopy.

School Name	Address	Place of Instruction	Dates of Attendance	Degree Awarded
Harvard Med.	25 Shattuck St Boston, MA 02115	Boston, MA	Sept 1990 – June 1994	M.D.

DOCTOR OF MEDICINE DEGREE, as referenced above. (Note: A U.S. graduate may, in lieu of the original, submit an official certified photocopy that has the school seal affixed and the signature of the registrar certifying authenticity.)

Name of Medical School	Address of Medical School	Exact Date of Issuance
Harvard Medical School	25 Shattuck St Boston, MA 02115	June 9, 1994

◆ MANDATORY DISCLOSURE OF SOCIAL SECURITY NUMBERS
Disclosure of your social security number (or federal employer identification number [FEIN], if you are a partnership) 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 or FEIN will be used exclusively for tax enforcement purposes, for purposes of compliance with any judgment or order for family support in accordance with Section 11350.6 of the Welfare and Institutions 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 or your FEIN, 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.

MA001
School Code

L1A

07A-100 (Rev. 9/97)

NBME USE ONLY

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

IF YES, LIST NAME, LOCATION, DATE AND RESULT OF EXAMINATION. SUBMIT AN ORIGINAL OFFICIAL EXAMINATION HISTORY REPORT FROM EACH EXAMINATION AGENCY. APPLICANTS WHO HOLD CERTIFICATION THROUGH THE EDUCATIONAL COMMISSION FOR FOREIGN MEDICAL GRADUATES (ECFMG) WILL NEED TO SUBMIT AN ORIGINAL VALID ECFMG CERTIFICATE PRIOR TO WRITTEN EXAMINATION AND LICENSURE.

Examination	Location	Date	Result
USMLE Part 1	Boston, MA	6/92	[redacted]
USMLE Part 2	Boston, MA	3/94	
USMLE Part 3	Boston, MA	6/95	

14. Have you ever 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 EACH ISSUING AGENCY'S JURISDICTION. SUBMIT A LETTER OF GOOD STANDING FROM EACH STATE IN WHICH YOU ARE OR HAVE BEEN LICENSED. PLEASE INCLUDE TEMPORARY, TRAINING, OR PROVISIONAL LICENSES.

State or Country	License Number	Date of Issuance	Dates of Practice in that Jurisdiction
Massachusetts	TRAINING/LIMITED 94-0835-98	6/20/94	6/20/94 - 6/30/98
Massachusetts	Permanent 154551	7/14/97	6/20/94 - 6/30/98

15A. Are you currently, or have you ever been, a participant in a postgraduate training program in a facility in the U.S. or Canada? ☑ Yes ☐ No

IF YES, LIST NAMES AND ADDRESSES OF ALL FACILITIES. SUBMIT AN ORIGINAL CERTIFICATE OF COMPLETION OF ACGME/CCME POSTGRADUATE TRAINING (FORM L3A/B) FROM EACH FACILITY. (DO NOT COMPLETE FORM L3A/Bs 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	Type of Service	Dates of Attendance
Brigham + Women's Hosp.	75 Francis Street Boston, MA 02115	Residency in Ob/Gyn	6/20/94 - 6/30/98

QUESTIONS 15B through 21: For any positive response to the following questions, please provide ALL official documentation regarding the matter in addition to written explanations. If applicable, an applicant should also provide official hearing/court documents and original letters of explanation from medical school or training program directors or other appropriate authorities. APPLICANTS ARE ALSO REQUIRED TO REPORT ANY MATTER THAT IS PENDING OR IN WHICH CHARGES HAVE BEEN DROPPED OR EXPUNGED.

15B. Have you ever withdrawn from, or been suspended, dismissed or expelled from a medical school or postgraduate training program? [redacted] Yes [redacted] No

16. 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 or has any disciplinary action ever been filed or taken regarding any healing arts license which you now hold or have ever held, or is any such action pending? Include any disciplinary actions by the U.S. Military, U.S. Public Health Service or other U.S. federal governmental entity. IF YES, GIVE DETAILS BELOW. [redacted] es [redacted] No

State	Date	Charge	Disposition

L1B

MBC USE ONLY

17. 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? [redacted] Yes [redacted] No

IF YES, GIVE DETAILS BELOW.

Name of Claimant	Location of Court	Brief Description of the Facts

18. 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, country, or U.S. federal jurisdiction, or is any such action pending? [redacted] Yes [redacted] No

IF YES, GIVE DETAILS BELOW.

State or Country	Date of Denial	Reason for Denial

19. Have you ever voluntarily surrendered a license to practice in the 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? [redacted] Yes [redacted] No

20. 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? [redacted] Yes [redacted] No

21. 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? [redacted] Yes [redacted] 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.

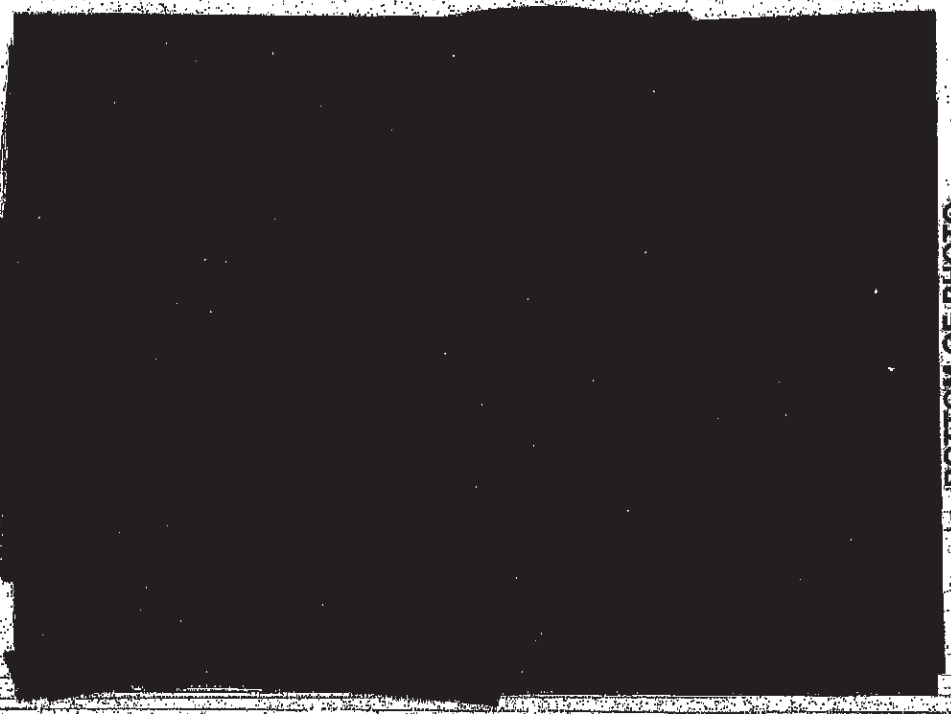
QUESTION 22: For any positive response to the following question, please provide ALL official documentation regarding the matter in addition to written explanations. If applicable, an applicant should also provide official hearing/court documents and original letters of explanation from appropriate authorities.

22. Have you ever been convicted of or pled nolo contendere to any violation (including misdemeanors and felonies) of any federal, state or local law of any state, the United States, or a foreign country or any violation relating to the possession, use, illegal sale, transportation, manufacture, distribution or dispensing of controlled substances, or is any such action pending? *(Exclude violations of traffic laws, including speeding, which resulted in fines of $300.00 or less.)* If YES, give details below. [redacted] Yes [redacted] No

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.

Violation and Location	Date	Penalty or Disposition

L1C



TOP OF PHOTO

BOTTOM OF PHOTO

PHOTO DECLARATION

I hereby declare under penalty of perjury under the laws of the State of California, that the photo of myself attached hereto, was taken on or about [redacted]

my age then being [redacted] years;

my color of hair [redacted]

my color of eyes [redacted]

my height [redacted] ft. [redacted] in.;

my weight [redacted] lbs.;

and identifying marks are [redacted]

Signature of Applicant:

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 Program Manager of the Licensing Program is the custodian of records.

STATE OF Massachusetts)

COUNTY OF Suffolk)

Applicant Declaration/Signature and NOTARY

The applicant, Alisa Beth Goldberg, being first duly sworn upon his/her
PRINT FULL NAME OF APPLICANT

oath deposes and says: that he/she is the person herein named subscribing to this application; that he/she has read the complete application, knows the full content thereof, and declares that all of the information contained herein and evidence or other credentials submitted herewith are true and correct; that he/she is 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 the applicant is aware and that the applicant is 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 further acknowledge that falsification or misrepresentation of any item or response on this application is adequate to deny the same or to hold a hearing to revoke the same, if issued.

SIGNATURE OF APPLICANT: Alisa Beth Goldberg
(PLEASE WRITE FULL NAME, NOT INITIALS)

Signed and sworn to before me this 7 day of January, 19 98

SIGNATURE OF NOTARY PUBLIC

NOTARY SEAL

DEIDRE K. DOLAN
Notary Public
My Commission Expires April 23, 2004

ADDRESS

My commission expires

L1D

07A-100 (Rev. 9/97)

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	

000935 204 63010106054 000656579 042108 93 0.00
BANK OF AMERICA 148 CA ST TREAS-DEPT OF CONSUMER AFFAIRS

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

SMBCLS 02/28/05

PART 3

State of California Department of Consumer Affairs

MEDICAL BOARD OF CALIFORNIA LICENSE RENEWAL APPLICATION
PHYSICIAN AND SURGEON

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

H. ☐ YES, I WISH TO CONTRIBUTE $50 FOR THE S.M. THOMPSON LOAN REPAYMENT PROGRAM

D. 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: _____ DATE: 4/14/08

	AMOUNT DUE NOW	DELINQ FEE IF POSTMARKED AFTER
VOLUNTARY FEE =	$	$
TOTAL ENCLOSED =	$	$

LICENSE NO. FE 65657

EXPIRES 05/31/08

RETIRED ALISA BETH GOLDBERG
1055 COMMONWEALTH AVE
BOSTON MA 02215

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

STREET _____

CITY _____ STATE _____ ZIP _____

PHONE NUMBER ( )

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 required here

63010106050106054000656579010531080000000000000000

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
25 25 00 NOK	

003323 23 63010106054 000656579 062110
BANK OF AMERICA 148 CA ST TREAS-DEPT OF CONSUMER AFFAIRS

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

SMBCLS 03/28/09

PART 2 ... 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

Physician and Surgeon

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

D. **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 _____ DATE: 6/11/2010

LICENSE NO.	EXPIRES	AMOUNT DUE NOW	DELINQ. FEE IF POSTMARKED AFTER 06/30/10
FE 65657	05/31/10	$25.00	$25.00
	VOLUNTARY FEE =	$	$
	TOTAL ENCLOSED =	$ 25.00	$

RETIRED ALISA BETH GOLDBERG
1055 COMMONWEALTH AVE
BOSTON MA 02215

E. **FOR ADDRESS CHANGE ONLY**
IF YOUR ADDRESS SHOWN IS INCORRECT, CORRECT IT BELOW.
STREET _____
CITY _____ STATE _____ ZIP _____
PHONE NUMBER ( )

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 required here

OVER

63010106050106054000656579010531100000250000002500

1282012 10003173 10016032

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

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

SMBCLS 02/28/05

PART 4 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

Delinquent Renewal Application
Physician and Surgeon

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

D 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: _____ DATE: 8/8/12

LICENSE NO.	EXPIRES	AMOUNT DUE NOW	DELINQ FEE IF POSTMARKED AFTER 06/30/12
FE 65657	05/31/12	$25.00	$25.00
	VOLUNTARY FEE =	$	$
	TOTAL ENCLOSED =	$	$

RETIRED ALISA BETH GOLDBERG
1055 COMMONWEALTH AVE
BOSTON MA 02215

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

STREET _____

CITY _____ STATE _____ ZIP _____

PHONE NUMBER ( )

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 required here

OVER

6301010605010605400065657901053112000025000000250O

Application Summary

License Type:	**Physician and Surgeon A**
License Number:	**65657**
File Number:	
Application:	**Physician's and Surgeon's Renewal**
Application Number:	
Application Date:	

Personal Detail

First Name:	**ALISA**
Middle Name:	**BETH**
Last Name:	**GOLDBERG**
Birthdate:	
Gender:	**Female**

Addresses

License Related Addresses

Confidential Address (Optional)

Name:

Address:

License Specific Public/Mailing Address (Required)

Name:	**GOLDBERG, ALISA BETH**
Address:	**1055 COMMONWEALTH AVE** **BOSTON, MA** **02215**
Phone Number:	

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:	**No**

Attachments

Physician Survey

Are you retired?	**No**
Activities in Medicine	**Administration - 10-19 Hours** **Patient Care - 10-19 Hours** **Research - 10-19 Hours** **Teaching - 10-19 Hours** **Telemedicine - None**
Patient Care Practice Location	**Zip: 02215 County: OUT OF STATE**
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	**6 Years**
Cultural Background	**White**
Foreign Language Proficiency	**Spanish**
Web Site Profile	**Cultural Background - No** **Foreign Language Proficiency - No** **Gender - Yes**

Fees

DUE TO CURES FUND	**$12.00**
Steven M. Thompson Physician Corps Loan Repayment Program	**$25.00**
Total Amount Due:	**$37.00**

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: