STATE OF CALIFORNIA — STATE AND CONSUMER SERVICES AGENCY

GRAY DAVIS, Governor

State of California Department of Consumer Affairs

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

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12602
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005623

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: RUSSO First: JENNEFER Middle: ALLYN

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.
1000 W. CARSON STREET
City: TORRANCE State: CA Zip Code: 90509 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.]
2496 1/2 SILVER RIDGE AVENUE
City: LOS ANGELES State: CA Zip Code: 90039 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?
IF YES, PLEASE GIVE DATE PREVIOUS APPLICATION WAS SUBMITTED. ☐ Yes ☒ No

02 DEC

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
Cornell University	Ithaca, NY ~~107~~ USA	8/90 - 6/94

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
George Washington University	Washington, DC USA	8/97 - 5/01	MD

DOCTOR OF MEDICINE DEGREE, as referenced above.

Name of Medical School	Address of Medical School	Exact Date of Issuance
George Washington University	Washington, DC	5

*** 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
DC001
School Code

L1A

07A-100 (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

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)
USMLE STEP 1		
USMLE STEP 2		
USMLE STEP 3		

Written Examination ☐ ☐ ☐

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

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.

License Data LGS ☐ ☐ ☐ ☐

Jurisdiction	License Number	Date of Issuance	Dates of Practice in that Jurisdiction

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: _____

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

Other Professional Licenses ☐

RECEIVED 02 DEC 10 PM 1:18 CALIFORNIA MEDICAL BOARD LICENSING PROGRAMS

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

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.

Postgraduate Training ☒ 2005 ☐

Facility Name	Address	Categorial Specialty Area	Dates of Attendance
HARBOR-UCLA	1000 W. CARSON ST, TORRANCE, CA 90509	OBSTETRICS & GYNECOLOGY	6/01 – NOW

☐ ☐ ☐ ☐

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: Jennefer Allyn Russo

DATE OF BIRTH:

L1B

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?

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

Yes ☐ No ☑

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.

02 DEC 10 AM 8:13

RECEIVED BOARD OF CALIFORNIA

DEFENSE PROGRAM

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: Jennefer Allyn Russo

DATE OF BIRTH:

L1C

[redacted]

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 Los Angeles

The applicant, Jennifer Allyn Russo (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.**

RECEIVED OCT 31 2002 MEDICAL BOARD OF CALIFORNIA

SIGNATURE OF APPLICANT: _____ (PLEASE SIGN FULL NAME, NOT INITIALS)

Signed and sworn to before me this 30th day of October, 2002 (MONTH) (YEAR)

_____
SIGNATURE OF NOTARY PUBLIC

Harbor-UCLA Medical Center
ADDRESS Torrance CA 90509

My commission expires 2/26/05

NOTARY SEAL

L1D

07A-100 (Rev. 3/01)

12-9-02

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

03 JAN 22 AM 8:54

LICENSING PROGRAM

CERTIFICATE OF MEDICAL EDUCATION

MEDICAL SCHOOL: PLEASE COMPLETE THIS FORM IN THE ENGLISH LANGUAGE.

This certifies that Jennefer Russo (FULL NAME OF APPLICANT) ____ (U.S. SOCIAL SECURITY NO.) ____ (DATE OF BIRTH-MM/DD/YYYY)

enrolled in George Washington Univ. (NAME OF MEDICAL SCHOOL) Washington, DC (LOCATION)

on the 20th day of ~~August~~ May (MONTH), ~~2001~~ 1997 (YEAR) and was granted the following credits on enrollment:

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 the applicant attended in this institution 4 (NUMBER OF YEARS) years of resident instruction of 144 (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 the applicant:

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

the above mentioned medical school on the 20th day of May (MONTH), 2001 (YEAR).

Anatomy	Embryology	Physical Medicine
Otolaryngology	Histology	Therapeutics
Obstetrics and Gynecology	Human Sexuality as defined in Section 2090	Neuroanatomy
Radiology, including Radiation Safety	Medicine	Child Abuse Detection and Treatment
Tropical Medicine	Surgery, including Orthopedic Surgery	Geriatric Medicine
Physiology	Urology	Pediatrics
Biochemistry	Psychiatry	Pharmacology
Pathology, Bacteriology and Immunology	Neurology	Anesthesia
Ophthalmology	Alcoholism and Chemical Dependency	Spousal or Partner Abuse Detection & Treatment**
Dermatology	Preventive medicine, including Nutrition	Family Medicine***
		Pain Management and End-of-Life Care****

* 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.

** ONLY applicable to medical students who enrolled in medical school on or after September 1, 1994.

*** 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 June 1, 2000.

MEDICAL SCHOOL SEAL MUST BE IMPRINTED BELOW.

ATTENTION MEDICAL SCHOOL: *The person who signs this form MAY NOT be related to the applicant by blood, marriage or adoption.*

Only the President, Dean, or Registrar may sign this form. If that signature authority is being delegated to another person, evidence of that 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.

Signed and the school seal affixed this 10 day of January (MONTH), 2003 (YEAR).

BY Mabel L. Gall
PRESIDENT, DEAN, OR REGISTRAR

L2

07A-100-L2 (Rev. 3/01)

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

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 that 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	First Name	Middle Initial
RUSSO	JENNIFER	A

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

Current Address: 2496 1/2 SILVER RIDGE AVENUE

City: LOS ANGELES, State: CA, Zip Code: 90039

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:	Address of Facility:	
Harbor-UCLA Medical Center	1000 W. Carson St. Torrance, CA 90509	
Name of Program Director: Andre Bieniarz, M.D.		Telephone Number: (310) 222-3565
Signature of Program Director: Andre Bieniarz MD		Date Signed: 4/30/03
List Categorical Specialty Area of Training Completed by Trainee: Obstetrics and Gynecology	Date Training Commenced: June 24, 2001	Date Training Completed: June 23, 2002

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:	Name of Facility:
Carol D. Berkowitz, M.D.	Harbor-UCLA Medical Center

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

City: State: Zip Code: Telephone Number: (310) 222-2911

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:	Date Signed:
	2/4/03

L3A

07A-100-L3 (Rev. 3/01)

State of California Department of 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

ELIGIBILITY FOR REDUCED INITIAL LICENSE FEE

(If you are enrolled in an ACGME/RCPSC postgraduate training program at the time of licensure, you are entitled to a reduced initial license fee. This form is used to certify current participation in a training program.)

This is to certify that Jennefer Russo ; _____
(Name of Applicant) (U.S. Social Security Number)

_____ is in an approved ACGME/RCPSC postgraduate training position that
(Date of Birth-MM/DD/YYYY)

commenced on 6 (Month) 24 (Day) 01 (Year) and is expected to be completed on

7 (Month) 31 (Day) 05 (Year) in Obstetrics and Gynecology (Type of Training)

at Harbor-UCLA Medical Center
(Name and Address of Facility)
1000 W. Carson St, Torrance, CA

ATTENTION DIRECTORS OF MEDICAL EDUCATION: THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE, OR ADOPTION.

Only the Director of Medical Education may sign this form. If that signature authority is being delegated to another person, evidence of that 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.

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 RCPSC to offer the type and level of training completed by the applicant and that the applicant is being trained in an approved ACGME or RCPSC program position.

Carol D. Berkowitz, M.D.
(Type or print name of Director of Medical Education)

Carol D. Berkowitz
(Signature of Director of Medical Education)

9/26/02 (Date)

(310) 222-2903 (Telephone Number)

RECEIVED
MEDICAL BOARD OF
CALIFORNIA
02 DEC 10 AM 8:13
LICENSING PROGRAM

OFFICIAL HOSPITAL SEAL, OR NOTARY SEAL (WITH DATE AND NOTARY'S SIGNATURE) MUST BE AFFIXED IN THE BOX AT THE LEFT.

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

L4

000632 312 63010100002 000820670 070708
BANK OF AMERICA 140 GA ST TREAS-DEPT OF CONSUMER AFFAIRS

52 805.00

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

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 [illegible] PHYSICIAN AND SURGEON

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: [signature] DATE: 6/12/08

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

AMOUNT DUE NOW	DELINQ FEE IF POSTMARKED AFTER 09/30/08
$805.00	$885.50
VOLUNTARY FEE = $	$
TOTAL ENCLOSED = $ 805.00	$

LICENSE NO. 82067 EXPIRES 08/31/08

ACTIVE JENNEFER ALLYN RUSSO
LOGAN HEIGHTS FAMILY HEALTH CTR
1809 NATIONAL AVENUE
SAN DIEGO CA 92113-2196

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]
Signature required here

63010100000100002000820670010831080008050000088550

<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?>

____YES OR X NO

SUMMARY OF RENEWAL FEES OWED

2006 RENEWAL FEE:	$
2008 RENEWAL FEE:	$
2010 RENEWAL FEE:	$786.00
PENALTY FEE:	$391.50
DELQ FEE:	$78.00
TOTAL FEES:	$1,255.50

FINANCIAL INTEREST STATEMENT

Health Facility Name	Address

MEDICAL BOARD OF CALIFORNIA LICENSE RENEWAL PHYSICIAN AND SURGEON APPLICATION

F. ____YES,I WISH TO CONTRIBUTE $25 FOR th THE FAMILY PHYSICIAN TRAINING PROGRAM.

H. ____YES I WISH TO CONTRIBUTE $50 FOR THE B.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 SECOND PAGE 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 X [signature] 0083069

LICENSE NO. A82067

EXPIRES 08/31/10

FEE OWED $1,255.50

DELINQ FEE IF POSTMARKED AFTER «DlqDate»

$
$
$

TOTAL $1255.50

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

STREET 73 Wyoming St

CITY Pittsburgh STATE PA

ZIP 15211

G. FINANCIAL INTEREST STATEMENT

I certify under penalty of perjury that I have disclosed on this renewal application form the names of those health-related facilities in which I or my family have a financial interest.

Signature required X [signature]

JENNEFER RUSSO
1809 NATIONAL AVE.
SAN DEIGO, CA 92113

STATE DEPARTMENT OF CONSUMER AFFAIRS
INTERNET CASHIERING SYSTEM
MEDICAL BOARD OF CALIFORNIA
SUPPLEMENTAL INFORMATION REPORT
From Date: 08/29/2012 To Date: 08/29/2012

ATRISUPPINF

10-AUG-15 15:36:21

Person Id : 974327 Name : Russo,Jennefer

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 : 974327 8

Application Summary

License Type:	**Physician and Surgeon A**
License Number:	**82067**
File Number:	
Application:	**Physician's and Surgeon's Renewal**
Application Number:	
Application Date:	

Personal Detail

First Name:	**JENNEFER**
Middle Name:	**ALLYN**
Last Name:	**RUSSO**
Birthdate:	
Gender:	**Female**

Addresses

License Related Addresses

Confidential Address (Optional)

Name:	**RUSSO, JENNEFER ALLYN**
Address:	

License Specific Public/Mailing Address (Required)

Name:	**RUSSO, JENNEFER ALLYN**
Address:	**700 S TUSTIN ST** **ORANGE, CA** **92866**
Phone Number:	
E-mail Address:	

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 - 30-39 Hours** **Other - None** **Patient Care - 10-19 Hours** **Research - 1-9 Hours** **Teaching - 1-9 Hours** **Telemedicine - None**
Patient Care Practice Location	**Zip: 92866 County: ORANGE**
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**

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: