

### 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



APPLICATION FOR PHYSICIAN'S AND SURGEON'S

Please <u>READ</u> 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

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Sex: 🗍 Male 🔏	Y Female	9. Are you a U.S. citizen	? 7	Yes D No	يم ا
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Please submit official transcript	ts with the school seal affixed for each	school attended, <b>Transcrip</b>	al, postsecondary instructi its will not be returned.	on was réceived:- :	; Pr
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2) an origin:	al medical diploma and a 8 1/2" x 11" pho	eu, ano, Xocopy (original diploma will be	returned).		
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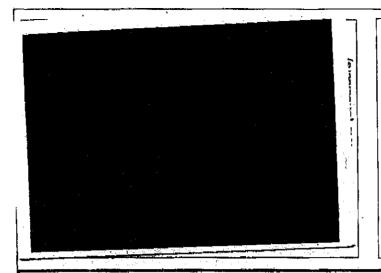
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MBC USE ONLY For all of the below, also include any disciplinary actions by the U.S. Military, U.S. Public Health Service, or other U.S. federal governmental 17A. Have you ever been charged with, or been found to have committed, unprofessional conduct, 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) 17(B) IF YOU ANSWERED YES TO 17A, 17B OR 17C, PROVIDE DETAILS ON A SEPARATE ATTACHMENT. 17(C) 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 BEPARATE 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. Ø 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 IF YOU ANSWERED YES, PROVIDE DETAILS ON A SEPARATE ATTACHMENT. Ø 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? 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. ဏ္ဍ 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 EXPUNSED, OR WHERE A STAY OF EXECUTION HAS BEEN ISSUED. 23A. Have you ever been convicted of, or pled noto 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) IF YOU ANSWERED YES TO 23A OR 23B, PROVIDE DETAILS ON A 23(B) SEPARATE ATTACHMENT.

NAMEOFAPPLICANT: Jennefer Allyn Russo

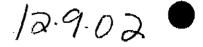
DATE OF BIRTH;

L<sub>1</sub>C



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
Cat 1.
STATE OF California
COUNTY OF Das Clagelles
The applicant, Jennefer Alun Pusso (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, ar 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 aloohol abuse or dependency requested by that Board in connection with this application; or any further or future investigation by that Board necessary for determine my medical competence, professional conduct, or physical or mental ability to safely engage in the precisional conduct, or physical or mental ability to safely engage in the precision of groups listed above any Information which is material to this application or any subsequent licensure. I INDERESTATE ATTACHMENT HERETO IS A SUFFICIENT BASIS FOR DENYING OR RESPONSE ON THIS APPLICATION OR MISREPRESENTATION OF ANY ITEM OR RESPONSE ON THIS APPLICATION OR ATTACHMENT HERETO IS A SUFFICIENT BASIS FOR DENYING OR REVOKING A LICENSE.
(PLEASE SIGN FULL NAME, NOT INITIALS)
Signed and swom to before me this 30 th day of Actober, 2002
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And the same of th
07A-100 (Rev. 3/01) My commission expires



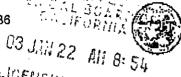


07A-100-L2 (Rev. 3/01)

#### 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 MEDICAL EDUCATION TO FROM PROGRAM

MEDICAL SCHOOL: PLEASE COMPLETE THIS FORM IN THE ENGLISH LANGUAGE.
This certifies that
enrolled in GEOVAC WAShington WIV. WAShington, DC  NAME OF MEDICAL SCHOOL 1007
on the 20 day of A 2001 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  **T ** NUMBER OF YEARS**  **PARS***  **PARS**  **PAR
years of resident instruction of 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 , 2001
Anatomy Otolaryngology Obstetrics and Gynecology Radiology, including Radiation Safety Tropical Medicine Surgery, including Orthopedic Surgery Physiology Blochemistry Pathology, Bacteriology and Immunology Ophthalmology Dermatology Preventive medicine, including Nutrition  Embryology Physical Medicine Therapeutics Neuroanatomy Child Abuse Detection and Treatment Gerlatric Medicine Pediatrics Pathology, Pathology Physiology Ph
* 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.
ATTENTION MEDICAL SCHOOL: The person who signs this form MAY NOT be related to the applicant by blood, marriage or adoption.  Coly the President, Deam, or Registrarmay sign this form. If that signature authority is being delegated to mother 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 O day of January 2013  PRESIDENT, DEAN, OR REGISTRAR



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

#### **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

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Current Address: 240 61/2 SILVE City LOS ANGELES	State A		Zip Code 90039		e Market in the second
DART 2: To be completed by the URACRAI	M DIRECTOR				III ha 145 and be 14
ATTENTION PROGRAM DIRECTOR! Do not applicant to qualify for licensure. Complete postgraduate training at this facility. If a penarative explanation. The following inform OF "SATISFACTORY."	t sign and date this following this form will consider this form will consider MAS.	ertify that the indivi	a satisfactory manner, ple a satisfactory manner, ple " completion. PLEASE SE	ase provide a separa EE THE REVERSE FO	ate detailed OR A DEFINITION
Name of Facility:			Address of Facility: 1000		
Harbor-UCLA Medical Cente	er		Torra	nce, CA 9050	9
Name of Program Director:	<b>M</b> P		<u>ر</u>	Telephone Number: (310)222-356	E
Andre Bienia	arz, m.D.		<del>{ </del>	0 310 222-356	2
Signature of Program Director	CH W.			W/30/03	
List Categorical Specialty Area of Training Completed		-	Commenced:	T .	,
Obstetrics and Gynecology	7	June	24, 2001	June 23. 2	002
If the training was rotating or transitional, list the speci GENERAL MEDICINE TRAINING REQUIREMENT):	ing rotations and the numbe	er orwesks spent in ea	Milost Heritaner Out	en besiden er omfall men en eftige	•
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PART 3: To be completed by the DIRECTO	R OF MEDICAL EDUC	ATION and affixed	with the official facility se	eal,	
Name of the Director of Medical Education:			Name of Facility:	<i>.</i>	-
Carol D. Berkowitz, M.I	D.		Harbor-UCLA M	ledical Cente	<u>y.                                      </u>
Address of Facility:	<del></del>				-
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City	State	,	Zip Code	Telephoné Nymber.	ሰላ ነ
the state of the s				(310) 222-2	ATT
PART 4: Signature of DIRECTOR OF MEDI	CAL EDUCATION certi	ifying satisfactory	completion of training.	the desired of the	
Attention: Director of Medical Educationi, Do no licensure. This form may be signed by the current to the training listed above.	Strector of Medical Education	an; it does not need to	oe argined by me herauti was war		
Notice to Applicant: If this form is used to verify p the Program Director before the final day of training the training year, a new form must be completed an	i. However, if you are licens	séa suel fué dam Abou	For licensure, this form can be s which training was completed A	igned by the Director of N ND if the form was signed	ledical Education and d before the final day of
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FOSFITAL OR NOTARY SEAL	times want connect and t	hat the training new	inder the laws of the State of gram is approved by the ACI loant and that the applicant of RCPSC program position.	GME of the Kupou t	DOUGHTHE CARENING
lž fi	Signature of Director of	LMedical Education	4	Date Signed:	
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#### 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.)

(Name of Applicantity)  (U.S. Social Security Number)  Is in an approved ACGME/RCPSC postgraduate training position that  O	This is to certify that Jennefer Russ	D :
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NOTE:

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

4

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.

BANK OF ANERICA 148 CA ST TREAS-DEPT OF CONSHIER HEALTH Address

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STATE OF CA	LIFORNIA		
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Department of	PHYSICIAN AND	SURGEON	
Consumer Affairs	D. Courting the Madical	Education (CME) Certification	Statement   1 CERTIFY UNDER PENALTY OF
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\$25 FOR THE FAMILY PHYSICIAN TRAINING PROGRAM	CONTINUING MEDICAL EDUCA WHICH WOULD EXEMPT ME	TION REQUIREMENTS LISTED ON THE BACK INTO THE PROPERTY OF THE REQUIREMENTS	OF THIS FORM OR THAT I MEET THE CONDITIONS OR I HOLD A PERMANENT CME WAIVER.
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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 US A and its territories, military court or a foreign country?> YES SUMMARY OF RENEWAL FEES OWED FINANCIAL INTEREST STATEMENT 2006 RENEWAL FEE: S Health Facility Name Address 2008 RENEWAL FEE: S 2010 RENEWAL FEE: \$786.00 PENALTY FEE: \$391.50 DELO FEE: \$78.00 TOTAL FEES: \$1,255.50 MEDICAL BOARD OF CALIFORNIA LICENSE RENEWAL PHYSICIAN AND SURGEON APPLICATION D. CONTINUING MEDICAL EDUCATION (CME) CERTIFICATION STATEMENT LORRTIFY UNDER PENALTY OF PERJURY UNDER THE LAWS OF CALIFORNIA TO THE FOLLOWING STATEMENT: F. \_\_\_\_YES,I WISH TO CONTRIBUTE \$25 FOR IN THE FAMILY PHYSICIAN TRAINING PROGRAM. 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. H. -----YDS I WISH TO CONTRIBUTE \$50 FOR THE B.M. THOMPSON LOAN REPAYMENT PROGRAM. 0083969 Signature required E. FOR ADDRESS CHANGE ONLY IF YOUR APPOPERS SHOWN IS INCORRECT, CORRECT IT BELOW. FEE OWED DELINO FEE IF LICENSE NO. **EXPIRES** \$1,256,50 A82067 08/31/10 AFTER «DigDate» TOTAL FINANCIAL INTEREST STATEMENT JENNEFER RUSSO I carlify 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. 1809 NATIONAL AVE. SAN DEIGO, CA 92113 Signature required

# 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

974327

ATRISUPPINF	
10-AUG-15 15:36:2	•

Total Questions Asked For Person:

Person Id:	974327	Name :	Russo,Jennefer		
Question			An	swer	
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I Am Exempt F	rom The Completion C	f 12 Hours Of F	Pain Management And End-Of-Life Care Radiologist Or Pathologist.	YES NO	
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Contained In T	his Application is True	And Correct.	f The State Of California That The Informat		
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# Application Summary

6/26/14 4:31 PM	Page 1 of 3
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: Address:	RUSSO, JENNEFER ALLYN
License Specific Public/Mailing Addres Name:	ss (Required) 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

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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?

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

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

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Steven M.	Thompson	Physician	Corps Loan
	of 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: