Consumer Affairs

**MEDICAL BOARD OF CALIFORNIA**
LICENSING PROGRAM
1426 Howe Avenue, Suite 54
Sacramento, CA 95825-3236
(916) 263-2382 FAX (916) 263-2487
www.caldocinfo.ca.gov

# INITIAL AND UPDATE APPLICATION FOR PHYSICIAN'S AND SURGEON'S LICENSE *OR* POSTGRADUATE TRAINING AUTHORIZATION LETTER

**Application for** (please check one): ☒ License ☐ PTAL - or - ☐ Update

| | | | |
|---|---|---|---|
| 1. NAME : Last: Tilley | First: Ian | Middle: Brent | MBC Use Only |
| Other names you have used (include maiden name): | 2. U.S. Social Security Number: ___ ___ ___ | | |
| 3. Place of Birth: Wyandotte, Michigan, USA | 4. Date of Birth: ___ ___ ___ | | |
| 5. Gender: ☒ Male ☐ Female | | | |
| 6. Public/Mailing Address: 612 Avery Street (Please note: this information is public) (30 characters maximum per line, including spaces) | | | |
| City: Decatur | State/Province: GA | Zip/Postal Code: 30030 | Country: USA |
| 7. Telephone Numbers: (Include area code) | Home: | Work: | Cell: |
| 8. California Driver's License Number (optional): | 10. Have you ever filed an Application for Physician's and Surgeon's License, or PTAL, in California? ☐ Yes ☒ No Previous license number, if any: | | |
| 9. E-mail Address (optional): | | | |

## MEDICAL EDUCATION

11. LIST EACH MEDICAL SCHOOL THAT YOU HAVE ATTENDED.

| School Name | City, State/Province, Country | Dates of Attendance |
|---|---|---|
| Emory University | Atlanta, GA, USA | July 1997 - May 2002 |
| | | |
| | | |

| 12. School of Graduation | Degree Awarded | Date of Graduation |
|---|---|---|
| Emory University | Doctor of Medicine | 13 May 2002 |

## EXAMINATIONS

13. LIST ALL OF THE FOLLOWING EXAMINATIONS YOU HAVE TAKEN: USMLE, FLEX, NBME, ECFMG, SPEX, STATE BOARDS and/or QME in Canada

| Examination | Date | Result (Pass/Fail) |
|---|---|---|
| USMLE Step 1 | July 2000 | |
| USMLE Step 2 | January 2002 | |
| USMLE Step 3 | October 2003 | |

805.00 11/7/05 002845 Cashiering Use Only

BA005 School Code

L1A

07A-100 (Rev. 07/05)

Personal Data ☑ L2 Transcript ☑ ☐ ☐ ☐ Diploma ☑ Exams ☑ ☑ ☐

**A "yes" response to Questions 14 through 38 requires a written explanation on a separate sheet of paper along with any supporting materials.**

## ACGME/RCPSC ACCREDITED POSTGRADUATE TRAINING

MBC Use Only

14. **Please list each ACGME/RCPSC accredited postgraduate training program in which you have participated. You must include each internship, residency and fellowship, whether or not the program was completed or credit granted.**

Postgraduate Training

| Facility Name | Address | Specialty Area | Dates of Attendance | |
|---|---|---|---|---|
| Emory University | 69 Jesse Hill Jr Atlanta, GA 30303 | Ob-Gyn | 1 July '02 – 30 June '06 (present) | ☑ |
| | | | | ☐ |
| | | | | ☐ |
| | | | | ☐ |
| | | | | ☐ |
| | | | | ☐ |

**POSTGRADUATE TRAINING:**

| | | | |
|---|---|---|---|
| Did you ever take a leave of absence or break from your training? | YES | NO | ☑ |
| Have you ever been terminated, dismissed or expelled from a program? | YES | NO | ☑ |
| Have you ever resigned from a training program? | YES | NO | ☑ |
| Were you ever placed on probation? | YES | NO | ☑ |
| Were you ever disciplined or placed under investigation? | YES | NO | ☑ |
| Were any incident reports ever filed by instructors? | YES | NO | ☑ |
| Were any limitations or special requirements placed upon you for clinical performance, discipline, or for any other reason? | YES | NO | ☑ |
| Have you ever had a postgraduate training program contract not be renewed or offered for a following year? | YES | NO | ☑ |

## MEDICAL LICENSURE

15. **Please list all medical licenses (other than training licenses) that have ever been issued by any state or territory in the United States or Canadian province.**

License Data

| Jurisdiction | License Number | Date of Issuance | Dates of Practice in that Jurisdiction | |
|---|---|---|---|---|
| Georgia, USA | 054520 | 1 April 2004 | 1 July 02 – present | ☐ |
| | | | | ☐ |
| | | | | ☐ |
| | | | | ☐ |
| | | | | ☐ |

**APPLICANT:** Iam Brent Tilley

**DATE OF BIRTH:**

L1B

## ABMS CERTIFICATIONS

MBC Use Only

ABMS

16. Are you currently certified by a Member Board of the American Board of Medical Specialties? YES ☐ NO ☒

| Member Board | Expiration Date | Certificate Number |
|---|---|---|
| | | |
| | | |

## MALPRACTICE HISTORY

Malpractice

17. Has a claim or an action ever been filed against you for the practice of medicine which resulted in a malpractice settlement, judgment, or arbitration award of $30,000 or more? YES NO

## PRACTICE IMPAIRMENT OR LIMITATIONS

Limitations

18. Have you been enrolled in, required to enter into, or participated in any drug or alcohol recovery program or impaired practitioner program? YES NO

19. Have you been treated for or had a recurrence of a diagnosed addictive disorder? YES NO

20. Have you been diagnosed with an emotional, a mental, or behavioral disorder which impairs your ability to practice medicine safely? YES NO

21. Have you ever been diagnosed with a neurological or other physical condition that would impair your ability to practice medicine safely? YES NO

22. Do you have any other condition which in any way impairs or limits your ability to practice medicine safely? YES NO

If you do receive ongoing treatment or participate in a monitoring program, the Board will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure.

## CRIMINAL RECORD HISTORY

Criminal Record

23. Have you ever been convicted of, or pled nolo contendere to ANY offense in any state in the United States or foreign country?

**This includes a citation, infraction, misdemeanor and/or felony, etc.** If "YES" attach a list of each offense by arrest and conviction dates, violation, and court of jurisdiction (name and address). Matters in which you were diverted, deferred, pardoned, pled nolo contendere, or if the conviction was later expunged from the record of the court or set aside under Penal Code Section 1203.4 MUST be disclosed. If you are awaiting judgment and sentencing following entry of a plea or jury verdict, you MUST disclose the conviction; you are entitled to submit evidence that you have been rehabilitated. Serious traffic convictions such as reckless driving, driving under the influence of alcohol and/or drugs, hit and run, evading a peace officer, failure to appear, driving while the license is suspended or revoked MUST be reported. This list is not all-inclusive. If in doubt as to whether a conviction should be disclosed, it is better to disclose the conviction on the application.

For each conviction disclosed, you must submit with the application certified copies of the arresting agency report, certified copies of the court documents, and a descriptive explanation of the circumstances surrounding the conviction of disciplinary action (i.e., dates and location of incident and all circumstances surrounding the incident). This letter must accompany the application. If documents were purged by arresting agency and/or court, a letter of explanation from these agencies is required.

**Applicants who answer "NO" to the question but have a previous conviction or plea, may have their application denied or license revoked for knowingly falsifying the application.** YES NO

**APPLICANT:** Ian Brent Tilley

**DATE OF BIRTH:**

L1C

## CRIMI L RECORD HISTORY (cont'd)

MBC Use Only

| | | | |
|---|---|---|---|
| 24. Is any criminal action pending against you? | YES | NO | Criminal Record ☐ |
| 25. Are you required to register as a Sex Offender? | YES | NO | ☑ |

## DISCIPLINARY HISTORY

Discipline

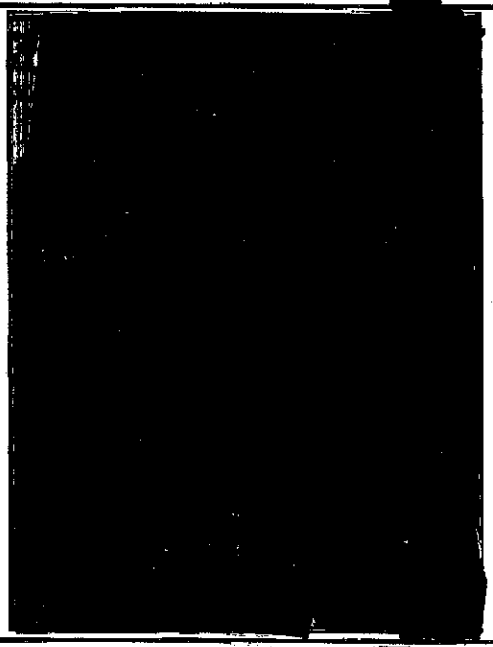
These questions refer to discipline by any U.S. military or public health service, state board or other governmental agency of any U.S. state, territory, Canadian province, or country.

| | | | |
|---|---|---|---|
| 26. Have you ever been denied a license to practice medicine? | YES | NO | ☑ |
| 27. Is any denial pending against you? | YES | NO | ☑ |
| 28. 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? | YES | NO | ☑ |
| 29. Have you ever had any license to practice medicine revoked, suspended, or placed on probation? | YES | NO | ☑ |
| 30. Have you ever had any license to practice medicine subjected to any action including but not limited to informal or confidential discipline, consent orders, letters of warning, letters of reprimand, or citation? | YES | NO | ☑ |
| 31. Have you ever had any license to practice medicine subjected to any other disciplinary action? | YES | NO | ☑ |
| 32. Is any disciplinary action pending against any of your licenses to practice medicine? | YES | NO | ☑ |
| 33. Have you ever had staff privileges in a hospital terminated, denied, suspended, limited, revoked, or not renewed? | YES | NO | ☑ |
| 34. Have you ever resigned from a medical staff in lieu of disciplinary or administrative action? | YES | NO | ☑ |
| 35. Is any disciplinary action pending against your hospital staff privileges? | YES | NO | ☑ |
| 36. Have you ever surrendered a license to practice medicine? | YES | NO | ☑ |
| 37. Have your DEA privileges ever been denied, suspended, restricted, or terminated? | YES | NO | ☑ |
| 38. Have you ever entered into any arrangement or plea or agreement in lieu of a federal prosecution for a drug violation regulated by the DEA? | YES | NO | ☑ |

**APPLICANT:** Ian Brent Tilley

**DATE OF BIRTH:**

L1D



**Notice: All items in this application, except #8 and #9, are mandatory. 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 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.**

The applicant, Ian Brent Tilley (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 any 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.** IBT **(PLEASE INITIAL BOX)**

**SIGNATURE OF APPLICANT:** Ian Tilley (Please sign full name)

State of Georgia

County of DeKalb

Subscribed and sworn to (or affirmed) before me on

this 9th day of November, 2005,

by Dr. Ian Tilley

personally known to me or proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.

NOTARY SEAL

Carole West
SIGNATURE OF NOTARY PUBLIC
Notary Public, DeKalb County, Georgia
My Commission Expires Feb. 6, 2009

L1E

Consumer Affairs

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11/17

05 DEC 15 AM 10:33

# CERTIFICATE OF MEDICAL EDUCATION

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

This certifies that Ian Brent Tilley ; ____
Full Name of Applicant — U.S. Social Security Number

__/__/____, enrolled in Emory University School of Medicine
Date of Birth — Name of Medical School

located in Atlanta, GA, USA on 08/01/1998.
State/Province Country — Enrollment Date

The undersigned further certifies that the records of this institution show that the applicant attended in this institution _____ years of resident instruction, 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 Sections 2089,2089.5, 2089.7,2090, 2091.1,2091.2) and that the applicant

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

* 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.

☒ was granted the degree of Bachelor/Doctor of Medicine on the 13 day of May, 2002.

☐ withdrew from medical school on ____ day of _____, _____.

## Unusual Circumstances

| | Responses | |
|---|---|---|
| Did this individual ever take a leave of absence from their medical education? | Yes | No |
| Was this individual ever placed on probation? | Yes | No |
| Was this individual ever disciplined or under investigation? | Yes | No |
| Were any incident reports regarding this individual ever filed by instructors? | Yes | No |
| Were any limitations or special requirements imposed on this individual because of questions of academic or disciplinary problems, or for any other reason? | Yes | No |

**A "Yes" response to ANY of the above questions requires the medical school to provide a written explanation on a separate attachment.**

Medical School Seal Must Be Imprinted Below

Attention Medical School: Only the President, Dean, or Registrar may sign this form. If the signature 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 30th day of November, 2005.

By: Annie James, Sr. Secretary
Printed Name and Title of School Official

Signature: Annie James

L2

STATE OF CALIFORNIA -- STATE AND CONSUMER SERVICES AGENCY — ARNOLD SCHWARZENEGGER, *Governor*


Consumer Affairs

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05 NOV 21 AM 9:14

# 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.

## PART 1: TO BE COMPLETED BY THE APPLICANT

| NAME: Last | First | Middle |
|---|---|---|
| Tilley | Ian | Brent |

| U.S. Social Security Number | Date of Birth | Telephone Number |
|---|---|---|
| | | Home / Work |

Public/Mailing Address: 612 Avery Street

| City | State/Province | Zip/Postal Code |
|---|---|---|
| Decatur | GA | 30030 |

Medical School of Graduation: Emory University School of Medicine

## 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 satisfactorily completed a period of accredited postgraduate training at this facility and that the trainee has acquired the skill and qualifications necessary to safely assume the unrestricted practice of medicine in this state.

| Name of Facility: | ACGME 10 digit Program number: (www.acgme.org) |
|---|---|
| EMORY UNIVERSITY | 2201221076 |

| Address of Facility: | Telephone #: |
|---|---|
| 412-69 JESSE HILL JR. DRIVE | 404-616-3540 |

| Categorical Specialty Area of Training | Start Date of Training | End Date (or anticipated completion date) of Training |
|---|---|---|
| GYNECOLOGY/OBSTETRICS | 07/01/2002 | 06/30/2006 |

## UNUSUAL CIRCUMSTANCES:

| | | |
|---|---|---|
| Did the trainee ever take a leave of absence or break from their training? | YES | NO |
| Was the trainee ever terminated, dismissed or expelled? | YES | NO |
| Did the trainee ever resign? | YES | NO |
| Was the trainee ever placed on probation? | YES | NO |
| Was the trainee ever disciplined or placed under investigation? | YES | NO |
| Were any incident reports regarding this trainee ever filed by instructors? | YES | NO |
| Were any limitations or special requirements placed upon the trainee for clinical incompetence, disciplinary problems or for any other reason? | YES | NO |
| Did the program decline to renew or offer the trainee a postgraduate training program contract for a following year? | YES | NO |

**A "Yes" response to ANY of the above questions requires the program director to provide a written explanation on a separate attachment.**

**L3A**

## DEFINITION OF "SATISFACTORY" COMPLETION OF TRAINING

The program director signing this form is formally certifying and documenting under penalty of perjury that the trainee received instruction appropriate for the particular postgraduate level and that he/she satisfactorily completed periods of training in accordance with the accepted standards and the criteria defined as equating to "satisfactory" performance as described below. The program director will personally be attesting to the fact that the trainee has acquired the skill and qualifications necessary to safely assume the unrestricted practice of medicine in this state.

"SATISFACTORY" IS DEFINED AS: THE TRAINEE PERFORMED AT AN ADEQUATE LEVEL BASED ON EVIDENCE OF SATISFACTORY PROGRESSIVE GROWTH INCLUDING DEMONSTRATED ABILITY TO ASSUME GRADED AND INCREASING RESPONSIBILTY FOR PATIENT CARE.

## GENERAL MEDICINE TRAINING REQUIREMENT

To qualify for licensure in California, applicants who are graduates of an international medical school must complete **at least four months** of postgraduate training in GENERAL MEDICINE as part of the requirement. Applicants who are graduates of a U.S. or Canadian medical school, who have not completed postgraduate training required for licensure by July 1, 1990, must also complete four months of training in GENERAL MEDICINE prior to licensure. The GENERAL MEDICINE requirement may be satisfied by actual clinical practice where the applicant has direct patient care responsibilities in any particular specialty or sub-specialty area for at least four months.

**I hereby certify as the program director, that the individual named in Part 1**

☐ **has completed** ☐ **has not completed**

**a minimum of four months of general medicine as part of this postgraduate training program accredited by the ACGME or the RCPSC.**

**SIGNATURE OF PROGRAM DIRECTOR**

**ATTENTION PROGRAM DIRECTOR:** THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE, OR ADOPTION. If that signature authority is being delegated to another person, evidence of that delegation must be attached to this form (may be a photocopy). Each delegation must be on official letterhead and must be dated within the last 12 months.

HOSPITAL SEAL

OFFICIAL HOSPITAL SEAL MUST BE AFFIXED IN THE BOX TO THE LEFT TO CERTIFY TRAINING

The training program is accredited by the ACGME or the RCPSC to offer the type and level of training completed by the applicant, and the applicant was trained in an accredited ACGME or RCPSC program position. I hereby declare under penalty of perjury under the laws of the State of California that the statements are true and correct.

B. DENISE RAYNOR, MD
**PRINT NAME OF PROGRAM DIRECTOR**

B. Denise Raynor
**SIGNATURE OF PROGRAM DIRECTOR**
**Signature Stamp Is Not Acceptable**

11/10/2005
**DATE SIGNED**

**If a hospital seal is not available, the program director shall sign this form in the presence of a notary public.**

State of Georgia

County of DeKalb

Subscribed and sworn to (or affirmed) before me on

this 10th day of November, 2005,

by B. Denise Raynor, MD

personally known to me or proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.

NOTARY SEAL

Carole West
SIGNATURE OF NOTARY PUBLIC

**Notary Public,** DeKalb County, Georgia

L3B

Consumer Affairs

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# CERTIFICATE OF CURRENT POSTGRADUATE TRAINING ENROLLMENT

At the time of licensure, you may be entitled to a reduced initial license fee if you are actively participating in a slotted position in an ACGME/RCPSC accredited postgraduate training program.

**NOTE:** This form may not be used in lieu of the Form L3A-B, "Certificate of Completion of ACGME/RCPSC Postgraduate Training."

NAME: Last Tilley First Ian Middle Brent

| U.S. Social Security Number | Date of Birth | Medical School of Graduation: |
|---|---|---|
| | | Emory University School of Medicine |

**This is to certify that the above applicant is actively participating in an ACGME or RCPSC accredited postgraduate training position that started on** 07 (Month) 01 (Day) 2002 (Year) **and is expected to be completed on** 06 (Month) 30 (Day) 2006 (Year) **in** GYNECOLOGY & OBSTETRICS (Categorical Specialty Area of Training)

**at** EMORY UNIVERSITY (Name of Facility)

**located at** 412-69 JESSE HILL JR DRIVE ATLANTA GA 30303 (Address of Facility)

**The 10 digit ACGME Program #:** 2201220176 (Refer to http://www.acgme.org/adspublic)

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 above program is accredited 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 accredited ACGME or RCPSC postgraduate training position.

B. DENISE RAYNOR, MD
PRINT NAME OF PROGRAM DIRECTOR

B. Denise Raynor
SIGNATURE OF PROGRAM DIRECTOR – Signature Stamp Is Not Acceptable

11/10/2005
DATE

404-616-3540
TELEPHONE NUMBER

**ATTENTION PROGRAM DIRECTOR: THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE, OR ADOPTION.**

Only the Program Director 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.

**If a hospital seal is not available, the program director shall sign this form in the presence of a notary public.**

State of Georgia

County of DeKalb

Subscribed and sworn to (or affirmed) before me on this 10th day of November, 2005,

by B. Denise Raynor, MD

personally known to me or proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.

Hospital or Notary Seal

Carole West
SIGNATURE OF NOTARY PUBLIC
Notary Public, DeKalb County, Georgia
My Commission Expires Feb. 8, 2009

**OFFICIAL HOSPITAL SEAL OR NOTARY SEAL (WITH JURAT COMPLETED ABOVE) MUST BE AFFIXED IN THE BOX AT THE LEFT**

**L4**

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 |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

002432 36 63010100002 000947200 021508 26 805.00
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

California Department of Consumer Affairs

## 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: 2/12/08

| LICENSE NO. | EXPIRES |
|---|---|
| 94720 | 03/31/08 |

| | AMOUNT DUE NOW | DELINQ FEE IF POSTMARKED AFTER 04/30/08 |
|---|---|---|
| | $805.00 | $885.50 |
| VOLUNTARY FEE = | $ | $ |
| TOTAL ENCLOSED = | $ 805.00 | $ |

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

ACTIVE IAN BRENT TILLEY
LAC & USC MEDICAL CENTER
1240 N MISSION ROAD ROOM L1009
LOS ANGELES CA 90033

6301010000010000200094720001033108000805000088550

STATE DEPARTMENT OF CONSUMER AFFAIRS
INTERNET CASHIERING SYSTEM
MEDICAL BOARD OF CALIFORNIA
SUPPLEMENTAL INFORMATION REPORT
From Date: 03/01/2010 To Date: 03/01/2010

ATRISUPPINF
22-JUL-15 09:42:54

Person Id : 1355407 Name : Tilley,Ian

| 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 :** 1355407 8

**STATE DEPARTMENT OF CONSUMER AFFAIRS**
**INTERNET CASHIERING SYSTEM**
**MEDICAL BOARD OF CALIFORNIA**
**SUPPLEMENTAL INFORMATION REPORT**
**From Date:** 03/26/2012 **To Date:** 03/26/2012

**ATRISUPPINF**
**22-JUL-15 09:40:25**

**Person Id :** 1355407 **Name :** Tilley,Ian

| 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 :** 1355407 8

# Application Summary



| | |
|---|---|
| License Type: | **Physician and Surgeon A** |
| License Number: | **94720** |
| File Number: | |
| Application: | **Physician's and Surgeon's Renewal** |
| Application Number: | |
| Application Date: | |

## Personal Detail

| | |
|---|---|
| First Name: | **IAN** |
| Middle Name: | **BRENT** |
| Last Name: | **TILLEY** |
| Birthdate: | |
| Gender: | **Male** |

## Addresses

### License Related Addresses

#### Confidential Address (Optional)

Name:

Address:

#### License Specific Public/Mailing Address (Required)

| | |
|---|---|
| Name: | **TILLEY, IAN BRENT** |
| Address: | **IRD ROOM 505**<br>**1200 N STATE STREET**<br>**LOS ANGELES, CA**<br>**90033** |
| 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 - 1-9 Hours**<br>**Patient Care - 40+ Hours**<br>**Teaching - 1-9 Hours** |
| Patient Care Practice Location | **Zip: 91105 County: LOS ANGELES** |
| 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**<br>**Foreign Language Proficiency - No** |

**Gender - No**

E-mail:

## Fees

| | |
|---|---|
| Biennial Renewal Fee | **$783.00** |
| Steven M. Thompson Physician Corps Loan Repayment Program | **$25.00** |
| Total Amount Due: | **$808.00** |

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: