2-0138 $425
30a-0154 #8290

STATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS

OSTEOPATHIC MEDICAL BOARD OF CALIFORNIA

1300 NATIONAL DRIVE, SUITE 150
SACRAMENTO, CA 95834-1991
Phone: (916) 928-8390 Fax: (916) 928-8392
www.ombc.ca.gov

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BIENNIAL LICENSE RENEWAL FORM

2013 JUN 17 PM 4:43

OSTEOPATHIC MEDICAL BOARD OF CALIFORNIA

DOUBLE-SIDED FORM - COMPLETE BOTH SIDES
PLEASE READ THE ENCLOSED INFORMATION FOR LICENSE RENEWAL PRIOR TO COMPLETING THE FOLLOWING QUESTIONS AND RETURN THE ENTIRE SIGNED FORM WITH THE RENEWAL FEE TO THE ADDRESS SHOWN BELOW.

ROB20A
06/01/10

TYPE	LICENSE NO	LICENSE EXPIRES
20A	12007	07/31/13

05/07/13
05/07/13

PRINT NAME CRAIG ANTHONY HARTMAN, DO
DAYTIME PHONE [redacted]

1. ☒ $425 Active, (Retired, Residency/Fellowship) License
(Includes $25 fee pursuant to B&P Code Section 2436.5)
(Delinquency fee $100)

Active - CME Required (attach documentation)
Active Retired - CME Required (attach documentation)
Residency/Fellowship (attach verification from program)

☐ $325 Inactive License
(Includes $25 fee pursuant to B&P Code Section 2436.5)
(Delinquency Fee $75)

No practice privileges in California-No CME required.
Available to In-State or Out-of-State Practitioners

2. Public Access Address: 5380 S. RAINBOW BLVD. SUITE 108 (required) Phone: (702) 220-3223 (optional)
City: LAS VEGAS State: NV Zip: 89118
E-Mail Address : [redacted] (optional)
Mailing Address: [redacted] (address only) Phone: [redacted]
City: [redacted] State: [redacted] Zip: [redacted]

3. SINCE YOUR LAST RENEWAL:

		YES	NO
a.	Have you been convicted or pled guilty to any crime? "Conviction" includes a plea of no contest and any conviction that has been set aside or deferred. pursuant to Sections 1000 or 1203.4. of the Penal Code (or set aside pursuant to similar statute in another State), including infractions, misdemeanor and felonies. Traffic infractions do not need to be disclosed unless the infractions involved alcohol or controlled substances.	☐	☒
b.	Has any governmental entity taken any disciplinary action against any of your health care related licenses? (Discipline includes, but is not limited to suspension, revocation, voluntary surrender, probation, public reprimand or any other restrictions.)	☐	☒
c.	Do you have any physical, mental, emotional or behavioral disorder that would impair your ability to practice medicine safely?	☐	☒

(AFTER COMPLETING BOTH SIDES, RETURN ENTIRE FORM AND MAKE CHECK PAYABLE TO OSTEOPATHIC MEDICAL BOARD.)

OSTEOPATHIC MEDICAL BOARD
1300 NATIONAL DRIVE, SUITE 150
SACRAMENTO, CA 95834-1991

I certify under penalty of perjury that all statements, including those attached hereto are true and correct. I further acknowledge I have read and understand the rules pertaining to CME and I am aware my license will not be renewed if the requirement is not met.

Signature [signature] Date 6-10-13

5/07/13 8510 20A 12007
5/07/13

LICENSE RENEWAL APPLICATION
PHYSICIAN AND SURGEON

5/07/13
5/07/13

ACTIVE
DELINQUENT FEE IF POSTMARKED AFTER 07/31/13

LICENSE NO	LICENSE EXPIRES	AMOUNT DUE	
20A 12007	07/31/13	$425.00	$525.00

1. Current License Status is
ACTIVE

I AM RENEWING
A.( ) ACTIVE
B.( ) INACTIVE

CRAIG ANTHONY HARTMAN, DO
[redacted]

OVER

85100000010000016000120071010731130004250000052500

IF YOU ARE IN CALIFORNIA & RENEWING ACTIVE, YOU MUST COMPLETE THE FINANCIAL INTEREST STATEMENT

DISCLOSURE OF FINANCIAL INTERESTS

Business and Professions Code Section 2426 (formerly 2097), requires all physicians to report to OMBC any financial interests they or their immediate family may have in health-related facilities located in California. This information will be available to other government agencies, public and private third party payers. In order to comply with this mandate, please complete the financial interest statement below.

	HEALTH-RELATED FACILITIES NAMES(S)	ADDRESS
a.		
b.		
c.		

The Osteopathic Medical Board requires completion of Sections I, II, III, IV and V pursuant to B&P Code Sections 2425.1 and 2425

I Postgraduate Training

Indicate the total number of years of postgraduate training (approved by the Accreditation Council for Graduate Medical Education, the American Board of Medical Specialties, or the American Osteopathic Association), you have completed: 4

II Current Training Status

O Resident O Fellow X Not in Training

III Practice Activities

Please indicate hours per week for each of the following activities:

	None	1-9	10-19	20-29	30-39	40+
Patient Care						X
Research	X					
Teaching			X			
Administration			X			
Other	X					

O Retired

IV Practice Location

If you provide patient care please write in the zip code of your primary practice location: Zip Code: 89118

V Medical Practice

DO NOT ABBREVIATE. PLEASE WRITE FULL NAME OF CERTIFYING BOARD

A) Please indicate your primary Board certification AMERICAN OSTEOPATHIC BOARD OF OBSTETRICS AND GYNECOLOGY

B) Please indicate your secondary Board certification _____

C) Please indicate any other Board certification you have _____

Completion of Sections VI, VII, and VIII is optional

VI Cultural/Ethnic Background (OPTIONAL)

Please indicate your cultural/ethnic background
(You may select more than one:)

O African-American/Black/African
X Caucasian/White/European/Middle Eastern
O American Indian/Native American/Alaskan Native
O Other
O Decline to State

Native Hawaiian/Pacific Islander (Please specify below):

O Fijian O Hawaiian
O Filipino O Samoan
O Guamanian O Tongan
O Other Pacific Islander

Asian (Please specify below):

O Cambodian O Laotian/Hmong
O Chinese O Pakistani
O Indian O Thai
O Indonesian O Vietnamese
O Japanese O Other Asian
O Korean

Latino/Hispanic (Please specify below):

O Central American O Puerto Rican
O Cuban O South American
O Mexican O Other Hispanic

VII Foreign Language Fluency (OPTIONAL)

Indicate all that apply:

O American Sign Language O French O Japanese O Other Chinese O Spanish
O Arabic O German O Korean O Other Sign Language O Tagalog
O Armenian O Hebrew O Lao O Polish O Thai
O Cambodiam O Hmong O Other (non-English) O Portuguese O Turkish
O Cantonese O Ilacano O Mandarin O Russian O Vietnamese
O Farsi O Italian O Mien O Samoan O Decline to state

VIII Website Profile (OPTIONAL)

Do you want the following information included in your personal profile on the Board's Website?

Cultural/Ethnic Background O Yes X No
Foreign Language Fluency O Yes X No

Department of Consumer Affairs
Osteopathic Medical Board of California
1300 National Drive, Suite 150
Sacramento, CA 95834
(916) 928-8390 Fax (916) 928-8392
www.dca.ca.gov/osteopathic

RECEIVED
2011 AUG 15 PM 1:45
OSTEOPATHIC MEDICAL BOARD
CALIFORNIA

APPLICATION FOR OSTEOPATHIC PHYSICIAN'S AND SURGEON'S CERTIFICATE

Please read all instructions prior to completing this application. All questions on this application must be answered. In addition to this form, other essential application requirements must be completed.

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.

Please type or print legibly. If space provided is insufficient, attach additional sheets.

1. NAME: Last: HARTMAN	First: CRAIG	Middle: ANTHONY
OTHER NAMES USED if any:		2. SOCIAL SECURITY NO: [redacted]
3. DATE OF BIRTH: [redacted]	4. PLACE OF BIRTH: [redacted]	5. SEX: Male ☒ Female ☐
6. ADDRESS: [redacted]		
MAILING ADDRESS if different:		
7. CONTACT INFORMATION FOR APPLICATION PROCESS: Daytime Phone Number: [redacted] E-Mail address: [redacted]		8. Are you a US citizen? Yes ☒ No ☐

9. PRE-OSTEOPATHIC COLLEGE(S)	ADDRESS	DATES OF ATTENDANCE
PEPPERDINE UNIVERSITY	24255 PCH MALIBU, CA 90263	AUGUST 1988 - MAY 1992

10. OSTEOPATHIC COLLEGE(S)	ADDRESS	DATES OF ATTENDANCE:
NOVA SOUTHEASTERN COLLEGE	3301 COLLEGE AVE, FT. LAUDERDALE	AUGUST 1993 - MAY 1997
OF OSTEOPATHIC MEDICINE	FL 33314-7796	DATE OF DEGREE: MAY 27, 1997

11. POSTGRADUATE TRAINING INTERNSHIP (AOA) Hospital Name	Address	Type of Service	Dates of Attendance
RIVERSIDE-HENRY FORD HOSPITAL (CLOSED)		OB/GYN TRACK INTERNSHIP	JULY '97 - JUNE '98
RESIDENCY/FELLOWSHIP: RIVERSIDE-HENRY FORD HOSPITAL (CLOSED)		Dates of Service: JULY 1998 - JUNE 2001	

12. BOARD CERTIFIED: Yes ☒ No ☐ DATE CERTIFIED: NAME OF CERTIFYING BOARD: AMERICAN OSTEOPATHIC BOARD OF OB/GYN

13. LIST ALL WRITTEN EXAMINATIONS TAKEN e.g. NBOME, State Written Boards, USMLE, FLEX etc.

STATE WHICH EXAMINATIONS AND WHERE TAKEN	DATE COMPLETED
NBOME 1	6/6/95
NBOME 2	3/11/97
NBOME 3	2/17/98

14. LIST ALL STATES IN WHICH YOU ARE NOW LICENSED OR HAVE EVER BEEN LICENSED TO PRACTICE OSTEOPATHIC MEDICINE

*Written examination, reciprocity, National Boards, etc.

STATE	DATE LICENSED	* HOW LICENSED	LICENSE NUMBER
MICHIGAN	7/9/98	NATIONAL BOARDS	5101013398
NEVADA	11/2003	NATIONAL BOARDS	1136

15. Have you ever applied for but did not take the California Osteopathic Medical Board Examination? If Yes, when? Yes ☐ No ☒

16. Have you ever taken the California Osteopathic Medical Board Examination? If Yes, when? Yes ☐ No ☒

17. Have you ever withdrawn from, or been suspended, dismissed or expelled from a medical school or postgraduate training? If Yes, attach explanation. Yes ☐ No ☒

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, judgment or arbitration award of over $30,000.00? Yes ☐ No ☒

19. Has there ever been any peer group or professional association inquiry or action involving your practice or relationship with patients alleging unprofessional conduct, wrongdoing or negligence? Yes ☐ No ☒

20. Have you ever withdrawn an application from any hospital, public entity or licensing agency? If Yes, When? 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? Yes ☐ No ☒

22. Have you ever had a medical or any healing art license restricted, suspended, revoked, disciplined or denied in any state? Yes ☐ No ☒

23. Have you ever been denied permission to practice medicine or any healing art in any state? Yes ☐ No ☒

24. 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 TREATMENT RECORDS, EVIDENCE OF ONGOING REHABILITATION TREATMENT, AND A PERSONAL WRITTEN EXPLANATION.

25. Have you ever been charged, convicted of, pled guilty or nolo contendere to a misdemeanor or felony in any state? (Do not include traffic violations or citations resulting in fines of $250 or less.) You must include all convictions, including those that have been set aside, and dismissed or expunged, or where a stay of execution has been issued. Yes ☐ No ☒

26. Is any criminal action related to the above now pending? Yes ☐ No ☒

27. Do you have a Drug Enforcement Administration (DEA) number? Yes ☒ No ☐

28. If yes, what is the DEA number and in what state was it issued? BH5964095 NEVADA

29. Has any DEA number ever been restricted, suspended or revoked? Yes ☐ No ☒

IF YOU HAVE ANSWERED "YES" TO ANY OF THE ABOVE QUESTIONS, ATTACH DETAILED EXPLANATION AND SUPPORTING DOCUMENTS.

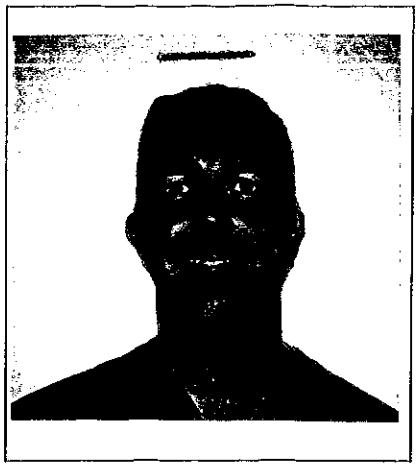
CERTIFICATION

I CERTIFY UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT THE INFORMATION PROVIDED IN THIS APPLICATION IS TRUE AND CORRECT.

Signature of Applicant

Date 8/12/11

"Disclosure of your social security number is mand[illegible]. Section 30 of the Business and Professions Code an[illegible]. L. 94-455 (42 U.S.C.A. 405 (c) (2) (C)) authorizes 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 11350.6 of the Welfare and Institutions Code, or for verification of licensure or examination status by a licensing or examination entity which utilized a national examination and where licensure is reciprocal with the requesting state. If you fail to disclose your social security number, you will be reported to the Franchise Tax Board, which may assess a $100 penalty against you."



INFORMATION COLLECTION AND ACCESS

Agency requesting information: Osteopathic Medical Board of California, 1300 National Drive, Suite 150, Sacramento, CA 95834, (916) 928-8390.

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 Executive Director is the custodian of records.

APPLICANT DECLARATION/SIGNATURE and NOTARY

STATE OF Nevada

COUNTY OF Clark

The applicant, CRAIG HARTMAN, DO (PLEASE PRINT FULL NAME), 07-26-1970 (DATE OF BIRTH), being first duly sworn upon his/her 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 Osteopathic 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 produced without fraud or misrepresentation or any mistake of which the applicant is aware and that the applicant is the lawful holder thereof. Applicant further states that he/she authorizes all hospitals, institutions, or organizations, his/her references, agencies (local, state, federal or foreign), to release to the Osteopathic 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 the Board in connection with this application; or any further or future investigation by the Board necessary to determine my medical competence, professional conduct or physical or mental ability to safely engage in the practice of osteopathic medicine. He/she further authorizes the Osteopathic 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. He/she further acknowledges 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: C J L DO

Signed and sworn to before me this 12th day of August (month), 2011 (year).

Signature of Notary Public

Notary Seal

RYAN LAHENEY
NOTARY PUBLIC
STATE OF NEVADA
My Commission Expires: 5-6-15
Certificate No: 11-4665-1

5130 Fort Apache, #215
Address

Las Vegas, NV 89148

My Commission expires 05-06-2015

OMB.1