STATE OF CALIFORNIA - STATE AND CONSUMER SERVICES AGENCY

RECEIVED
SACRAMENTO

GEORGE DEUKMEJIAN, Governor

DEPARTMENT OF Consumer Affairs

BOARD OF MEDICAL QUALITY ASSURANCE
1430 HOWE AVENUE
SACRAMENTO, CA 95825
(916)

'87 APR 6 A8:14

APPLICATION FOR PHYSICIAN AND SURGEON'S EXAMINATION AND LICENSURE

008804
137.50
007301
306.50

Read all instructions prior to completing this application. All questions on this application must be answered, and all supporting documents must be submitted with this application per instructions. **Please type or print neatly. When space provided is insufficient, attach additional sheets of paper.**

BMQA USE ONLY

PERSONAL DATA

1. Name: Last: Levy | First: Adam | Middle: Vincent

2. Other names you have used:
(Last only) Espinoza-Levy

3. Address: Number and Street/Rural Route (include apartment number, if any)
4985 East Butler Ave # 111

City: Fresno | State: Calif. | ZIP Code: 93727 | Country: USA

4. Telephone Number: Home | Work

5. Date of Birth: Mo/Day/Yr

6. Sex: ☐ Female ☒ Male

7. Are you a U.S. citizen? ☑ Yes ☐ No
Submit a certified copy of birth certificate, Certificate of Naturalization, Declaration of Intention to become U.S. citizen (INS Form N300), VISA documents, or license to practice medicine.

8. Have you ever filed an application in California? ☐ Yes ☑ No
If YES, give date of previous application:

NON-MEDICAL EDUCATION

9. List name and address of all colleges or universities attended other than schools where professional medical instruction was received. Submit an official transcript from each school attended.

Name	Address	Period of Attendance From (Mo/Yr)	Period of Attendance To (Mo/Yr)
University of Calif. Santa Cruz	Santa Cruz, Ca. 95061	9/75	6/76
" "	" "	9/77	6/80

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

Course	Yes	No	Name of College or University
Chemistry	✓		University of California - Santa Cruz
Physics	✓		" " " "
Biology	✓		" " " "
Zoology	✓		" " " "

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11. List name and address of all schools where professional medical instruction was received. Submit an original Certificate of Medical Education and official transcripts from each school attended.

Name	Address	Place Where Instruction Received	Period of Attendance From (Mo/Yr)	Period of Attendance To (Mo/Yr)
University of Southern California	2025 Zonal Ave Los Angeles, CA 90033	McKinnen Hall	9/80	5/84

12. Doctor of Medicine Degree granted by: (submit original medical diploma and a photocopy)

Name of Medical School: University of Southern California School of Medicine

Address of Medical School: 2025 Zonal Ave Los Angeles, CA 90033

Exact Date of Issuance: May 8, 1984

13. Have you taken any of the following written examinations: National Boards, ECFMG, FMGEMS, FLEX, MSKP, MCAT, other related medical competency examinations? ☑ Yes ☐ No

If YES, list name, location, date and result of examination. Submit certification of scores from each examination agency.

Name	Location	Date	Result
National Boards I	Ambassador, Los Angeles	6/82	
" II	" " "	4/84	
" III	" " "	3/85	

14. Have you received qualifying postgraduate training in U.S. or Canadian facilities? ☑ Yes ☐ No

If YES, list name and address of all facilities. Submit an original Certificate of Completion of ACGME Postgraduate Training from each facility.

Name	Address	Type of Service	Period of Attendance From (Mo/Yr)	Period of Attendance To (Mo/Yr)
University of Southern Cal. Los Angeles County Medical Center	1200 N. State St. Los Angeles, CA 90033	OB/GYN	6/24/84	6/24/85
Valley Medical Center	445 S. Cedar Ave Fresno, CA 93702	Rotating"	6/24/85	6/22/86

15. Have you been licensed to practice medicine in any state or country? ☐ Yes ☑ No

If YES, list state or country, license number, date issued and dates of practice in issuing agency's jurisdiction for each. Submit a Letter of Good Standing from each state in which you are licensed or have been licensed.

State or Country	License Number	Date of Issuance	Dates of Practice in Issuing Agency's Jurisdiction From (Mo/Yr)	Dates of Practice in Issuing Agency's Jurisdiction To (Mo/Yr)

BMOA USE ONLY

MEDICAL EDUCATION

CME ☑ TRANS. ☐

☐ ☐

☐ ☐

☐ ☐

☐ ☐

☐ ☐

☑

CA006
School Code

WRITTEN EXAMINATION

☐

☐

☑

☐

POSTGRADUATE TRAINING

☑

☑

☐

☐

LICENSE DATA

LCS ☐ CE ☐

☐ ☐

☐ ☐

☐ ☐

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BMQA USE ONLY

LICENSE DATA (continued)

16. Has any disciplinary action ever been taken regarding any healing arts license which you now hold or have ever held? Include any disciplinary actions by the U.S. Military, U.S. Public Health Service or other U.S. federal governmental entity.

☐ No ☐ Yes If yes, give details below.

State	Date	Charge	Disposition

17. Have you ever been denied a license, permission to practice medicine or any other healing arts, or permission to take an examination in any state, country, or U.S. federal jurisdiction?

If yes, give details below.

State or Country	Date of Denial	Reason for Denial

18. Have you ever voluntarily surrendered a license to practice in the healing arts in another state?

☐ No ☐ Yes If yes, please explain on a separate sheet of paper.

19. Have you ever had staff privileges in a hospital denied, suspended or revoked, or resigned from a medical staff in lieu of disciplinary action? ☐ No ☐ Yes If yes, please explain on a separate sheet of paper.

GENERAL DATA

20. Are you now, or were you in the past, addicted to controlled substances, such as narcotics or alcohol?

☐ No ☐ Yes

21. Have you ever been convicted of, or pled nolo contendere to a violation of any federal, state or local law relating to the manufacture, distribution or dispensing of controlled substances, or to drug addiction?

If yes, give details below.

Violation and Location	Date	Penalty or Disposition

22. Have you ever been convicted of, or pled nolo contendere to any offense, misdemeanor or felony of any state, the United States, or a foreign country? (except violations of traffic laws resulting in fines of $75.00 or less.)

☐ No ☐ Yes If yes, give details below.

Violation and Location	Date	Penalty or Disposition

You are required to list any conviction that has been set aside and dismissed under Section 1203.45 Penal Code or under any other provision of law.

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I hereby declare under penalty of perjury under the laws of the State of California, that the photo of myself attached hereto, was taken

on or about ____ 19__

my age then being ____ years;

color of hair ____;

color of eyes ____

height ____ ft. ____ in. ____;

weight ____ lbs.;

identifying marks ____

NOTE: All items in this application are mandatory; none are voluntary. Failure to provide any of the requested information will result in the application being rejected as incomplete. The information provided will be used to determine qualification for licensure, per Section 2080 of the Business and Professions Code which authorizes the collection of this information. Applicants have the right to review their application subject to the provisions of the Information Practices Act. The Program Manager of the Division of Licensing is the custodian of records.

STATE OF California)
)
COUNTY OF Fresno)

Adam Vincent Levy being duly sworn, says he is the person referred to in the foregoing application for a physician and surgeon's certificate in California and that he has carefully read and thoroughly understands all the requirements therein and that the statements made herein and all attachments are true and correct under penalty of perjury under the laws of the State of California.

He requests that the Division of Licensing, Board of Medical Quality Assurance, initiate a review of the records to determine their eligibility for examination, postgraduate training or licensure in California. In making this request, he authorizes the release of any information or records held by any individual or agency, relative to their training and qualifications as a physician and surgeon, upon request by the Board for use in evaluating their file.

(Adam Vincent Levy
Signature of applicant in FULL (Do not use INITIALS ONLY)

Signed and sworn to before me this 24th day of March, 1987

Signature of Notary Public Nancy W. Bailey

(SEAL) NANCY W. BAILEY
NOTARY PUBLIC
FRESNO COUNTY, CALIFORNIA
My Commission Expires Oct 23 1990

Address 445 S. Cedar Avenue Fresno Ca 93702

My commission expires 10/23/1990

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STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY

DEPARTMENT OF Consumer Affairs

GEORGE DEUKMEJIAN, Governor

BOARD OF MEDICAL QUALITY ASSURANCE
1430 HOWE AVENUE, SACRAMENTO, CALIFORNIA 95825
(916) 920-6411

CERTIFICATE OF MEDICAL EDUCATION

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

This certifies that Adam Vincent Levy
FULL NAME OF APPLICANT

of 4100 N. Baltimore, Monterey Park enrolled in University of Southern California
ADDRESS WHEN ENROLLED — NAME OF MEDICAL SCHOOL

2025 Zonal, Los Angeles on the 9th day of September 1980
LOCATION — MONTH — YEAR

and was granted the following credits on enrollment:

Premedical Education. Two years of preprofessional postsecondary education, including the subjects of physics, chemistry, and biology (Business and Professions Code Section 2088).

University of California, Santa Cruz — 9/75-6/76, 9/77-6/80
EDUCATIONAL INSTITUTION — DATES

Advanced Credits. Credits previously obtained at an approved medical school.*

n/a
MEDICAL SCHOOL — TOTAL CREDITS — DATES

The undersigned further certifies that the records of this institution show that he attended in this institution 4 years courses of resident instruction of 36 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

☒ he was granted the degree Bachelor / Doctor of Medicine by the above mentioned medical school on the 8th day of May 1984

☐ he withdrew from the above mentioned medical school on the ____ day of ____ 19____

ALL
Anatomy
Otolaryngology
Obstetrics and Gynecology
Radiology, including Radiation Safety
Tropical Medicine
Physiology
Biochemistry
Pathology, Bacteriology and Immunology
Ophthalmology

ALL
Dermatology
Embryology
Histology
Human Sexuality as defined in Section 2090
Medicine
Surgery, including Orthopedic Surgery
Urology
Psychiatry
Neurology

ALL
Preventive medicine, including Nutrition
Physical Medicine
Therapeutics
Neuroanatomy
Child Abuse Detection and Treatment
Geriatric Medicine
Pediatrics
Pharmacology
Anesthesia

[redacted]

Signed and the college seal affixed this 18th day of March, 19 87

BY William E. Herlich
PRESIDENT, SECRETARY, DEAN

Medical School Seal MUST Be Imprinted Partially on the Photograph.

TRANSCRIPTS OF PREMEDICAL EDUCATION, ADVANCED CREDITS, AND MEDICAL SCHOOL CREDITS MUST BE SUPPLIED WITH THIS CERTIFICATE

*Each school where professional medical instruction was received MUST complete one of these forms. If more than one school was attended, photocopies of this blank form may be made and used. Note that photograph and all entries to be completed by each school.

WILLIAM E. HERLICH, M.D.
ASSOCIATE DEAN, STUDENT AFFAIRS
USC SCHOOL OF MEDICINE
1975 ZONAL AVE., KAM 100-B
LOS ANGELES, CA 90033

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STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY GEORGE DEUKMEJIAN, Governor

DEPARTMENT OF Consumer Affairs

BOARD OF MEDICAL QUALITY ASSURANCE
1430 HOWE AVENUE, SACRAMENTO, CALIFORNIA 95825
(916) 920-6411

CERTIFICATE OF COMPLETION OF ACGME POSTGRADUATE TRAINING

To be completed by the facility for every medical school graduate completing postgraduate training in the United States or Canada. Do not complete if photograph of applicant is not attached below. Please type or print.

This is to certify that Adam Vincent Levy
NAME OF APPLICANT

a graduate of University of Southern California
NAME OF MEDICAL SCHOOL

commenced postgraduate training in Los Angeles County - University of Southern California Med Ctr., 1200 N. State St. Los Angeles 90033 O.K.
NAME AND ADDRESS OF FACILITY

on June 24, 19 84, and completed such training

on June 24, 19 85. This training consisted of 11 months of actual clinical instruction and is approved by the Accreditation Council for Graduate Medical Education (ACGME) or the Coordinating Council of Medical Education of the Canadian Medical Association (CCME) and consisted of the following rotations:

(List rotations completed. If service was not rotating, indicate type of straight training performed. NOTE—To qualify for licensure in California, graduates of foreign medical schools must have completed at least four months of postgraduate training in general medicine. ACGME or CCME residencies in family practice, internal medicine, surgery, pediatrics, and ob/gyn would normally satisfy this requirement.)

ROTATION	LENGTH OF ROTATION
COMPLETE OBSTETRICS-GYNECOLOGY	there are 13 four-week rotations

16 weeks Obstetrics, 8 weeks High Risk, 12 weeks Gynecology, 4 weeks Therapeutics Abortion, 4 weeks Medical Intensive Care, 4 weeks Newborn Intensive Care, 4 weeks vacation.

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

NAME Ralph C. Jung, M.D.
DIRECTOR OF MEDICAL EDUCATION

(AFFIX SEAL OF HOSPITAL OR NOTARY PUBLIC)

ADDRESS LAC/USC MEDICAL CENTER
1200 North State Street, Box 540
Los Angeles, CA 90033

PHONE NUMBER 213 226-6931

DATE March 20, 1987

SIGNATURE

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STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY

GEORGE DEUKMEJIAN, Governor

DEPARTMENT OF Consumer Affairs

BOARD OF MEDICAL QUALITY ASSURANCE
1430 HOWE AVENUE, SACRAMENTO, CALIFORNIA 95825
(916) 920-6411

CERTIFICATE OF COMPLETION OF ACGME POSTGRADUATE TRAINING

To be completed by the facility for every medical school graduate completing postgraduate training in the United States or Canada. Do not complete if photograph of applicant is not attached below. Please type or print.

This is to certify that Adam Vincent Levy (NAME OF APPLICANT),

a graduate of University of Southern California (NAME OF MEDICAL SCHOOL),

commenced postgraduate training in Valley Medical Center O.K. (NAME AND ADDRESS OF FACILITY)
445 S. Cedar Ave. FRESNO CA.

on June 24 19 85, and completed such training

on June 22 19 86. This training consisted of 12 months of actual clinical instruction and is approved by the Accreditation Council for Graduate Medical Education (ACGME) or the Coordinating Council of Medical Education of the Canadian Medical Association (CCME) and consisted of the following rotations:

(List rotations completed. If service was not rotating, indicate type of straight training performed. NOTE—To qualify for licensure in California, graduates of foreign medical schools must have completed at least four months of postgraduate training in general medicine. ACGME or CCME residencies in family practice, internal medicine, surgery, pediatrics, and ob/gyn would normally satisfy this requirement.)

ROTATION	LENGTH OF ROTATION
Obstetrics/Gynecology	24 weeks
Pediatrics	4 weeks
Medicine	8 weeks
Anesthesiology	4 weeks
Surgery	12 weeks

[redacted]

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

NAME Richard A. Lockwood, M.D.
(DIRECTOR OF MEDICAL EDUCATION)

(AFFIX SEAL OF HOSPITAL OR NOTARY PUBLIC)

ADDRESS 445 S. Cedar
Fresno, California 93702

PHONE NUMBER (209) 453-5005

DATE 3-19-87

SIGNATURE [signature]

L3

STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY GEORGE DEUKMEJIAN, Governor

DEPARTMENT OF Consumer Affairs

BOARD OF MEDICAL QUALITY ASSURANCE
1430 HOWE AVENUE, SACRAMENTO, CALIFORNIA 95825
(916) 920-6411

CERTIFICATION STATEMENT

This is to certify that Adam V. Levy (Name of Physician) is in an ACGME/CCME postgraduate training position that commenced on June 30, 1985 and is expected to be completed on June 30, 1989 in Obstetrics/Gyn (Type of Training) at Valley Medical Center (Name and Address of Facility) 445 S. Cedar Ave, Fresno Ca 93702

(AFFIX SEAL OF)
(HOSPITAL OR)
(NOTARY PUBLIC)

I hereby declare under penalty of perjury under the laws of the State of California that the above statements are true and correct and the facility is approved by the ACGME or the CCME to offer the type and level of training completed by the applicant and that the applicant is being trained in an approved ACGME or CCME program position.

Richard A. Lockwood, M.D.
TYPE OR PRINT NAME OF DIRECTOR OF MEDICAL EDUCATION

SIGNATURE OF DIRECTOR OF MEDICAL EDUCATION

April 24, 1987
DATE

(209) 453-5005
PHONE NUMBER

(3/87)

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STATE DEPARTMENT OF CONSUMER AFFAIRS
INTERNET CASHIERING SYSTEM
MEDICAL BOARD OF CALIFORNIA
SUPPLEMENTAL INFORMATION REPORT
From Date: 07/29/2010 **To Date:** 07/29/2010

ATRISUPPINF

20-AUG-15 15:20:06

Person Id : 604003 **Name :** Levy,Adam

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 : 604003 8

STATE DEPARTMENT OF CONSUMER AFFAIRS
INTERNET CASHIERING SYSTEM
MEDICAL BOARD OF CALIFORNIA
SUPPLEMENTAL INFORMATION REPORT
From Date: 07/28/2012 To Date: 07/28/2012

ATRISUPPINF

20-AUG-15 15:15:34

Person Id : 604003 **Name :** Levy,Adam

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 : 604003 8

Application Summary

License Type:	**Physician and Surgeon G**
License Number:	60035
File Number:	
Application:	**Physician's and Surgeon's Renewal**
Application Number:	
Application Date:	

Personal Detail

First Name:	**ADAM**
Middle Name:	**VINCENT**
Last Name:	**LEVY**
Birthdate:	**/**/****
Gender:	**Male**

Addresses

License Related Addresses

License Specific Public/Mailing Address (Required)

Warning:	**In order to protect your privacy and identity, address will not be displayed.**

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**
	Patient Care - 30-39 Hours
	Research - 1-9 Hours
	Teaching - 10-19 Hours
	Telemedicine - 1-9 Hours
Patient Care Practice Location	**Zip: 89102 County:**
Telemedicine Practice Location	**Zip: 89102 County:**
Patient Care Secondary Practice Location	**Zip: County:**
Telemedicine Secondary Practice Location	**Zip: County:**
Current Training Status	**Not in Training**
Areas of Practice	**Family Medicine - Secondary**
	Obstetrics and Gynecology - Primary
Board Certifications	**American Board of Obstetrics and Gynecology - Obstetrics and Gynecology**
Postgraduate Training Years	**5 Years**
Cultural Background	**Decline to State**
Foreign Language Proficiency	**Spanish**
Web Site Profile	**Cultural Background - No**
	Foreign Language Proficiency - Yes
	Gender - Yes
E-mail:	

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: