MEDICAL BOARD OF CALIFORNIA
Licensing Program

2012 NOV 21 AM 8:

APPLICATION

LICENSING PROGRAM

(Please Check All That Apply)
- ☑ Physician's and Surgeon's License
- ☐ Postgraduate Training Authorization Letter (PTAL)
- ☐ Update Application: ATS #_____
- ☐ Limited Practice License

(Please Check One)
- ☑ U.S. or Canadian Medical School Graduate
- ☐ International Medical School Graduate

PERSONAL INFORMATION

Type or Print Legibly

MBC Use Only

1. Legal Name	Last: Ireland	First: Luu	Middle: Doan
2. Other Names/Alias	Doan, Luu Cortes		
3. United States Social Security Number	___ ___ ___ ___ ___ ___ ___ ___ ___	4. Gender	Male ☑ Female
5. Date of Birth (mm/dd/yyyy)	__/__/____	6. Place of Birth (City, State/Country)	
7. Public/Mailing Address If you are using a P.O. Box please include a confidential street address on a separate sheet of paper. The address of record will be posted on the Medical Board's Web site once you have obtained a license.	Mailing Address (30 characters maximum per line, including spaces): 3131 Flanagan Drive Mailing Address continued (30 characters maximum per line, including spaces): City: Simi Valley, State/Province: CA, Zip/Postal Code: 93063, Country: USA		
8. Telephone Numbers	Home #: ( )	Work #: ( )	Cell #:
9. E-mail Address			

Personal Information ☐

10. Have you ever filed an application for a Physician's and Surgeon's License or a PTAL in California that has been withdrawn, abandoned, or denied?	☐ Yes	☑ No
11. Have you previously held a Physician's and Surgeon's License in California? If yes, please provide license number: _____ Expired: _____	☐ Yes	☑ No

Prev License ☐

EXAMINATIONS

Exams ☐

12. Have you ever been found to have engaged in irregular behavior during an examination?	Yes	No
13. Have you ever been subject to an investigation by an examination entity?	Yes	No
14. Are you certified by the Educational Commission for Foreign Medical Graduates? If yes, please provide the Certificate Issue Date: _____	Yes	No

15. List all of the following examinations you have taken: **USMLE, FLEX, NBME, LMCC and/or STATE BOARDS**
(Use the *Addendum to Question #15 Form* if additional space is needed)

Examination	Date (mm/yyyy)	Result (Pass/Fail)
USMLE Step 1	06/2007	
USMLE Step 2 CS	12/2008	
USMLE Step 2 CK	12/2008	
USMLE Step 3	12/2010	

☐ ☐ ☐ ☐ ☐

907.50 0002617 BS Cashiering Use Only CA/MA School Code

L1A

07A-100 (Rev. 10/2012)

MEDICAL EDUCATION

MBC Use Only

NOTE: To be eligible for a PTAL or License, all schools attended must be on the Board's list of recognized or approved medical schools. If you did not attend or graduate from a recognized or approved medical school you may be eligible for licensure pursuant to Section 2135.7 of the Business and Professions Code (effective 1/2013). To view the Board's list, please refer to our Web site at: http://www.mbc.ca.gov/applicant/schools_recognized.html.

16. List each medical school that you have attended.

Medical School Name	Mailing Address	Attendance Dates (mm/dd/yyyy)		L2 ☐ Trans ☐ School Code
David Geffen School of Medicine at the University of California, Los Angeles (UCLA)	10833 LeConte Ave.	Start	08/01/2005	CA1 4A
	Los Angeles, CA 90095	End	06/05/2009	
		Start		☐ ☐
		End		
		Start		☐ ☐
		End		

17. School of Graduation	Title of Degree Awarded	Issue Date of Degree (mm/dd/yyyy)	Diploma
David Geffen School of Medicine at UCLA	MD	06/05/2000	☐

UNUSUAL CIRCUMSTANCES DURING MEDICAL SCHOOL

Unusual Circumstances

18. Did you ever take a leave of absence during medical school?	Yes ☐ No ☐
19. Were you ever placed on probation?	Yes ☐ No ☐
20. Were you ever disciplined or placed under investigation?	Yes ☐ No ☐
21. Were any negative reports ever filed by your instructors?	Yes ☐ No ☐
22. Were any limitations or special requirements imposed on you because of questions of academic or disciplinary problems, or for any other reason?	Yes ☐ No ☐

ACGME/RCPSC ACCREDITED POSTGRADUATE TRAINING

Postgraduate Training

23. Have you participated in any ACGME-accredited postgraduate training in the United States or RCPSC-accredited postgraduate training in Canada? ***List every program in which you have participated or are currently participating, regardless of whether the program was completed or any credit was granted.*** (Use the *Addendum to Question #23 Form* if additional space is needed)

(If NO please skip to question # 33) ☑ Yes ☐ No

Facility Name	City, State/Province	Specialty	Training Dates (mm/dd/yyyy)	
Brown University/Women and Infants Hospital	Providence, RI	OB/GYN	Start	06/20/2009
			End	06/14/2013
			Start	
			End	
			Start	
			End	
			Start	
			End	

APPLICANT: (Print Name) Luu Doan Ireland

DATE OF BIRTH: (mm/dd/yyyy)

L1B

A "yes" response to questions 18-22 requires a signed and dated written explanation.

UNUSUAL CIRCUMSTANCES DURING POSTGRADUATE TRAINING

MBC Use Only

24. Have you ever received partial or no credit for a postgraduate training program?	Yes	No
25. Have you ever taken a leave of absence or break from your training?	Yes	No
26. Have you ever been terminated, dismissed or expelled from a program?	Yes	No
27. Have you ever resigned from a program?	Yes	No
28. Were you ever placed on probation for any reason?	Yes	No
29. Were you ever disciplined or placed under investigation?	Yes	No
30. Were any incident reports ever filed by instructors?	Yes	No
31. Were any limitations or special requirements placed upon you for clinical performance, professionalism, medical knowledge, discipline, or for any other reason?	Yes	No
32. Have you ever had a postgraduate training program contract not be renewed or offered for a following year?	Yes	No

MEDICAL LICENSE

License

33. Have you ever held, or do you currently hold a medical license in any U.S. state, U.S. territory or Canadian province? ***List medical license information below. It is not necessary to list temporary, training, or provisional licenses.***
(Use the *Addendum to Question #33 Form* if additional space is needed)

☑ Yes ☐ No

State/Province	License Number	Issue Date (mm/dd/yyyy)	Expiration Date (mm/dd/yyyy)	Dates of Practice (mm/yyyy to mm/yyyy)
Rhode Island	LP 01661	06/01/2009	06/30/2013	06/2009-6/2013

Limited

ABMS CERTIFICATION

ABMS

34. Are you currently certified by a Member Board of the American Board of Medical Specialties? ☐ Yes ☑ No

Member Board	Certificate Number	Expiration Date (mm/yyyy)

35. Has your certification ever been suspended or revoked? ☐ Yes ☐ No

36. Is there any action currently pending against you? ☐ Yes ☐ No

APPLICANT: (Print Name) Luu Doan Ireland

DATE OF BIRTH: (mm/dd/yyyy) [redacted]

L1C

A "yes" response to questions 24-32 and 35-36 requires a signed and dated written explanation.

UNUSUAL CIRCUMSTANCES DURING POSTGRADUATE TRAINING

24. Have you ever received partial or no credit for a postgraduate training program?	
25. Have you ever taken a leave of absence or break from your training?	
26. Have you ever been terminated, dismissed or expelled from a program?	
27. Have you ever resigned from a program?	
28. Were you ever placed on probation for any reason?	
29. Were you ever disciplined or placed under investigation?	
30. Were any incident reports ever filed by instructors?	—
31. Were any limitations or special requirements placed upon you for clinical performance, professionalism, medical knowledge, discipline, or for any other reason?	
32. Have you ever had a postgraduate training program contract not be renewed or offered for a following year?	

MEDICAL LICENSE

33. Have you ever held, or do you currently hold a medical license in any U.S. state, U.S. territory or Canadian province? ***List medical license information below. It is not necessary to list temporary, training, or provisional licenses.*** (Use the *Addendum to Question #33 Form* if additional space is needed)	☐ Yes ☒ No

State/Province	License Number	Issue Date (mm/dd/yyyy)	Expiration Date (mm/dd/yyyy)	Dates of Practice (mm/yyyy to mm/yyyy)
RI	LP01661 Provisional/Training	6/30/2009	6/30/2013	6/2009 - 6/2013

ABMS CERTIFICATION

34. Are you currently certified by a Member Board of the American Board of Medical Specialties?	☐ Yes ☒ No

Member Board	Certificate Number	Expiration Date (mm/yyyy)

35. Has your certification ever been suspended or revoked?	
36. Is there any action currently pending against you?	

APPLICANT (Print Name) | DATE OF BIRTH (mm/dd/yyyy)

L1C

A "yes" response to questions 24-32 and 35-36 requires a signed and dated written explanation.

MEDICAL BOARD OF CALIFORNIA
Licensing Program

2012 JAN -9 P 3:

PROGRAM

APPLICATION ADDENDUM FOR FORM L1C

DECLARATION

The applicant, Luu Doan Ireland
Please print full name (First, Middle, Last) Date of Birth (mm/dd/yyyy)

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), or 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, alcohol and/or substance 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, in any investigation or proceeding, to the organizations, individuals or groups listed above any information which is material to this application or any subsequent licensure.

I UNDERSTAND THAT ANY OMISSION, 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.

SIGNATURE: _____ **DATE:** 12/28/12

MBC Use Only
Applicant Name & DOB ☑
Applicant Signature & Date ☑
Applicant's Signature ☑
Applicant's Name & Notary Date ☑
Notary Signature & Seal ☑

NOTARY SECTION

SIGNATURE OF APPLICANT: _____
(DO NOT SIGN EXCEPT IN THE PRESENCE OF NOTARY – Please sign full name)

State of Rhode Island

County of Providence

Subscribed and sworn to (or affirmed) before me on this 28th day of December, 2012,

by, Luu Doan Ireland MD proved to me on the basis of satisfactory evidence
(Print applicant's name)

to be the person who appeared before me.

Linda Tuccerio
SIGNATURE OF NOTARY PUBLIC

NOTARY SEAL

DEA CERTIFICATION

MBC Use Only DEA

37. Are you currently registered with the Drug Enforcement Agency (DEA)?	☑ Yes ☐ No

DEA Number	State of Issue	Expiration Date (mm/yyyy)
AP 3275080-23D	Rhode Island	06/2013

38. Have your DEA privileges ever been denied, suspended, restricted, or terminated?	Yes No
39. Have you ever entered into any arrangement, agreement or plea in lieu of federal prosecution with the DEA to resolve an alleged violation of a federal or state drug statute or regulation?	Yes No

MALPRACTICE HISTORY

Malpractice History

40. Has a claim or an action ever been filed against you for the practice of medicine that resulted in a malpractice settlement?	Yes No
41. Has a judgment or arbitration ever been awarded in the amount of $30,000 or more?	Yes No

DISCIPLINARY HISTORY

Disciplinary History

These questions refer to discipline by any hospital, Military or Public Health Service, State Board, or other Governmental Agency of any U.S. state or territory, Canadian province, or foreign country.

42. Have you ever withdrawn an application for medical licensure in lieu of denial, disciplinary action, or for any other similar reason?	Yes No
43. Have you ever been denied a license to practice medicine?	Yes No
44. Is any denial pending against you?	Yes No
45. Have you ever had any license to practice medicine subjected to any disciplinary action?	Yes No
46. Is any disciplinary action pending against any of your licenses to practice medicine?	Yes No
47. Have you ever surrendered a license to practice medicine?	Yes No
48. Have you ever had any license to practice medicine revoked, suspended, or placed on probation?	Yes No
49. 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
50. Have you ever been charged with, or been found to have committed unprofessional conduct, professional incompetence, gross negligence, or repeated negligent acts by any medical licensing board or hospital?	Yes No
51. Have you ever resigned from a medical staff in lieu of disciplinary or administrative action?	Yes No
52. Is any disciplinary action pending against your hospital or staff privileges?	Yes No
53. Have you ever had staff privileges in a hospital terminated, denied, suspended, limited, revoked, or not renewed?	Yes No
54. Have you ever had any healing arts license or certificate disciplined by another state or federal territory?	Yes No

APPLICANT: (Print Name) Luu Doan Ireland

DATE OF BIRTH: (mm/dd/yyyy)

L1D

A "yes" response to questions 38-54 requires a signed and dated written explanation.

CRIMINAL RECORD HISTORY

MBC Use Only

Applicants who answer "NO" to the questions below, but have a previous conviction or plea, may have their application denied for knowingly falsifying the application. If in doubt as to whether a conviction should be disclosed, it is best to disclose the conviction on the application.

For each conviction disclosed, you must submit certified copies of the arresting agency report, certified copies of the court documents, including a plea form and court docket, and a signed and dated descriptive explanation of the circumstances surrounding the conviction of disciplinary action (i.e., dates and location of the incident and all circumstances surrounding the incident). If the documents were purged by the arresting agency and/or court, a letter of explanation from these agencies is required. In addition, you may submit evidence of rehabilitation.

Criminal History

55. Have you ever been convicted of, or pled guilty or nolo contendere to **ANY** offense in the United States, its territories, or a foreign country? ***This includes every citation, infraction, misdemeanor and/or felony, including traffic violations. Convictions that were adjudicated in the juvenile court or convictions under California Health and Safety Code sections 11357(b), (c), (d), (e), or section 11360(b) which are two years or older should NOT be reported. Convictions that were later expunged from the record of the court or set aside pursuant to section 1203.4 of the California Penal Code or equivalent non-California law MUST be disclosed.***	
56. Exclusive of juvenile court adjudications and criminal charges dismissed under section 1000.3 of the California Penal Code or equivalent non-California laws, or convictions under California Health and Safety Code section 11357(b), (c), (d), (e), or section 11360(b) which are two years or older, have you had a charge or conviction that was set aside or later expunged from the record of the court?	
57. Is any criminal action pending against you, or are you currently awaiting judgment and sentencing following entry of a plea or jury verdict?	
58. Are you a registered sex offender?	

PRACTICE IMPAIRMENT OR LIMITATIONS

If you give an affirmative answer to any of the questions below, 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 eligible for licensure. Please note that a Limited Practice License may be available. Please refer to the *Application Information for a Limited Practice License* for further information.

Limitations

59. Have you ever been enrolled in, required to enter into, or participated in any drug, alcohol, or substance abuse recovery program or impaired practitioner program?	
60. Have you ever been treated for or had a recurrence of a diagnosed addictive disorder?	
61. Have you ever been diagnosed with an emotional, mental, or behavioral disorder that may impair your ability to practice medicine safely?	
62. Have you ever been diagnosed with a neurological or other physical condition that may impair your ability to practice medicine safely?	
63. Do you have any other condition that may in any way impair or limit your ability to practice medicine safely?	
64. Do you suffer from a progressive disorder or a health condition that will likely result in a general decline in health or function that may impair or limit your ability to practice medicine safely?	

APPLICANT: Luu Doan Ireland (Print Name)

DATE OF BIRTH: (mm/dd/yyyy)

L1E

A "yes" response to questions 55-64 requires a signed and dated written explanation.

PHOTOGRAPH

MBC Use Only

Photograph

Notice: All items in this application 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 licensing 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.

DECLARATION

Applicant Name & DOB

The applicant, Luu Doan Ireland
Please print full name (First, Middle, Last)
Date of Birth (mm/dd/yyyy)

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), or 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, alcohol and/or substance 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, in any investigation or proceeding, to the organizations, individuals or groups listed above any information which is material to this application or any subsequent licensure.

I UNDERSTAND THAT ANY OMISSION, 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.

Applicant Signature & Date

SIGNATURE: Luu Ireland DATE: 11/13/12

NOTARY SECTION

Applicant Signature

SIGNATURE OF APPLICANT: Luu Ireland
(DO NOT SIGN EXCEPT IN THE PRESENCE OF NOTARY – Please sign full name)

State of RHODE ISLAND

County of PROVIDENCE

Applicant Name & Notary Date

Subscribed and sworn to (or affirmed) before me on this 13th day of NOVEMBER, 2012,

by, Luu Doan Ireland proved to me on the basis of satisfactory evidence
(Print applicant's name)

to be the person who appeared before me.

Notary Signature & Seal

Linda Lacasse
SIGNATURE OF NOTARY PUBLIC

NOTARY SEAL

L1F

LN

STATE AND CONSUMER SERVICES AGENCY- *Department of Consumer Affairs* — EDMUND G. BROWN JR., *Governor*

MEDICAL BOARD OF CALIFORNIA

Licensing Program

CERTIFICATE OF MEDICAL EDUCATION

Check one: ☑ U.S. or Canadian Medical School Graduate ☐ International Medical School Graduate

Type or Print Legibly

APPLICANT INFORMATION

MBC Use Only

NAME: Last	First	Middle
DOAN	LUU	Curtes

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Medical School of Graduation
		UCLA

MEDICAL SCHOOL: PLEASE COMPLETE THIS FORM IN THE ENGLISH LANGUAGE

Medical School Information

Name of Medical School	DAVID GEFFEN SCHOOL OF MEDICINE, UNIV OF CALIFORNIA LOS ANGELES
State/Province/Country	LOS ANGELES, CA
Did the applicant complete an English Language program?	☐ Yes ☑ No

The undersigned further certifies that the records of this institution show that the applicant attended in this institution 4 *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). **The standard duration of the curriculum at this institution is 4 years.**

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 graduated from medical school on or after June 30, 1999
*** ONLY applicable to medical students who enrolled in medical school on or after June 1, 2000

Dates of Attendance

Date the applicant enrolled in medical school:	08 / 1 / 2005
Date the applicant was issued the diploma of Bachelor/Doctor of Medicine:	06 / 5 / 2009
Date the applicant withdrew from medical school (if applicable):	/ /

UNUSUAL CIRCUMSTANCES DURING MEDICAL SCHOOL

Unusual Circumstances

Any "Yes" response below requires a signed and dated letter of explanation by school official.

1. Did this applicant ever take a leave of absence from his/her medical education?	☐ Yes ☐ No
2. Was this applicant ever placed on probation?	☐ Yes ☐ No
3. Was this applicant ever disciplined or placed under investigation?	☐ Yes ☐ No
4. Were any negative reports regarding this applicant ever filed by instructors?	☐ Yes ☐ No
5. Were any limitations or special requirements imposed on this applicant because of questions of academic or disciplinary problems, or for any other reason?	☐ Yes ☐ No

MEDICAL SCHOOL OFFICIAL CERTIFICATION

AFFIX MEDICAL SCHOOL SEAL

I certify that I am the President, Dean, or Registrar and hereby declare under penalty of perjury under the laws of the State of California that the above statements are true and correct.

Linda Cuesta — PRINTED NAME OF SCHOOL OFFICIAL

Registrar — TITLE OF SCHOOL OFFICIAL

Linda Cuesta — SIGNATURE OF SCHOOL OFFICIAL

4/16/12 — DATE

Signature & Seal

Attention Medical School. THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE OR ADOPTION. Only the President, Dean, or Registrar may sign this form. If 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

L2

NOTE: The completed form must be mailed directly from the medical school to the Board to be acceptable.

07A-100 (Rev 10/2012)

MEDICAL BOARD OF CALIFORNIA
Licensing Program

CURRENT POSTGRADUATE TRAINING ENROLLMENT

Check one: ☑ U.S. or Canadian Medical School Graduate ☐ International Medical School Graduate

APPLICANT INFORMATION (Type or Print Legibly)

NAME: Last	First	Middle
Ireland	Luu	Doan

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Medical School of Graduation
	XXX - XX -	David Geffen School of medicine at University of California, Los Angeles

PROGRAM DIRECTOR TO COMPLETE ACGME OR RCPSC TRAINING INFORMATION

Facility Name	Women & Infants Hospital		
Facility Address	101 Dudley St., Providence, RI 02905		
Specialty Area	OB/GYN	ACGME 10-digit Program # http://www.acgme.org/adspublic	1204321269
Dates of Training (mm/dd/yyyy)	Start Date: 06/24/2009	Anticipated Completion Date:	06/23/2013

PROGRAM DIRECTOR OFFICIAL CERTIFICATION

NOTE: The completed Form L4 must be mailed directly from the program to the Board to be acceptable.

I hereby declare under penalty of perjury under the laws of the State of California that the information contained on this form is true and correct. I further certify that the training program is accredited by the ACGME or the RCPSC to offer the type and level of training to the above named applicant and that the applicant is actively participating in a slotted position in an accredited ACGME or RCPSC postgraduate training program.

GARY FRISHMAN MD — PRINT NAME OF PROGRAM DIRECTOR

GFRISHMAN@WIHRI.ORG — Email Address

Gary F — SIGNATURE OF PROGRAM DIRECTOR (Signature Stamp Is Not Acceptable)

11/19/2012 — DATE

401-274-1122 X1845 — Phone 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.

NOTE: If a hospital seal is not available, the program director shall also sign in the section below in the presence of a notary public.

SIGNATURE OF PROGRAM DIRECTOR: Gary F (Please sign full name in presence of notary)

State of RHODE ISLAND

County of PROVIDENCE

Subscribed and sworn to (or affirmed) before me on this 11th day of NOVEMBER, 2012,

by, GARY FRISHMAN, MD (Print program director's name) proved to me on the basis of satisfactory evidence

to be the person who appeared before me.

Lynda Ducasse — SIGNATURE OF NOTARY PUBLIC

HOSPITAL or NOTARY SEAL

MBC Use Only

Personal Data ☐

Program Verified ☐

Program Director's Signature & Date ☐

Program Director's Signature ☐

Notary Signature & Seal ☑

Hospital Seal ☐

L4

NOTE: The completed form must be mailed directly from the program to the Board to be acceptable.

Application Summary

License Type:	**Physician and Surgeon A**
License Number:	**125002**
File Number:	
Application:	**Physician's and Surgeon's Renewal**
Application Number:	
Application Date:	

Personal Detail

First Name:	**LUU**
Middle Name:	**DOAN**
Last Name:	**IRELAND**
Birthdate:	
Gender:	**Female**

Addresses

License Related Addresses

Confidential Address (Optional)

Name: **IRELAND, LUU DOAN**

Address: **UCLA DEPARTMENT OF OB/GYN**
10833 LE CONTE AVE. ROOM 27-139 CHS
LOS ANGELES, CA
900951740

License Specific Public/Mailing Address (Required)

Name: **IRELAND, LUU DOAN**

Address: **UCLA DEPT OF OB-GYN**
10833 LE CONTE AVE RM 27-139 CHS
LOS ANGELES, CA
900951740

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** **Other - None** **Patient Care - 20-29 Hours** **Research - 20-29 Hours** **Teaching - 20-29 Hours** **Telemedicine - None**
Patient Care Practice Location	**Zip: 90095 County: LOS ANGELES**
Telemedicine Practice Location	**Zip: County:**
Patient Care Secondary Practice Location	**Zip: 92506 County: RIVERSIDE**
Telemedicine Secondary Practice Location	**Zip: County:**
Current Training Status	**Fellow**
Areas of Practice	**Obstetrics and Gynecology - Primary**
Board Certifications	**None**
Postgraduate Training Years	**5 Years**
Cultural Background	**Other (not listed)**

Foreign Language Proficiency	**Spanish**
Web Site Profile	**Foreign Language Proficiency - Yes**
	Gender - Yes

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: