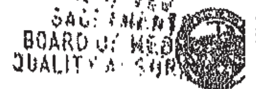
STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY

GEORGE DEUKMEJIAN, Governor

BOARD OF MEDICAL QUALITY ASSURANCE

1430 HOWE AVENUE
SACRAMENTO, CA 95825
(916) 920-6411



MAR 18 8 42 AM '88

APPLICATION FOR PHYSICIAN AND SURGEON'S EXAMINATION AND LICENSURE

011369 855.00 3/88

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.

305.50 3/87
008778

BMQA USE ONLY

1. Name: Last First Middle
Bettigole, Joel Benjamin

2. Other names you have used:
NA

3. Address: Number and Street/Rural Route (include apartment number, if any)
5832 Fallsview Ln. Dallas TX 75252
City State ZIP Code Country

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:

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)	To (Mo/Yr)
Harvard College	Cambridge, MA	9/52	6/56

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

Course	Yes	No	Name of College or University
Chemistry	✓		Harvard College
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)	To (Mo/Yr)
Albany Medical College	Albany, NY	Albany, NY	9/56	6/60

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

Name of Medical School	Address of Medical School	Exact Date of Issuance
Albany Medical College	Albany, NY	5/31/60

13. Have you taken any of the following written examinations: National Boards, ECFMG, FMGEMS, FLEX, MSKP, MCAT, other related medical competency examinations? [X] 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 Board	Albany, NY	7/1/61	

14. Have you received qualifying postgraduate training in U.S. or Canadian facilities? [X] 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)	To (Mo/Yr)
Bay State Medical Center (Springfield Hospital)	Springfield, MA	Rot int.	7/60	6/61
Boston Univ. Medical Center	Boston, MA	Res. OB-GYN	7/61	6/64

15. Have you been licensed to practice medicine in any state or country? [X] 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)	To (Mo/Yr)
Massachusetts	26760	9/21/61	9/21/61	9/81
Arizona	13105	9/30/81	10/81	9/85
Texas	G9566	2/22/86	2/86	Present
New York	17117	7/22/82	Never practiced in NY	

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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.

Yes No 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? Yes No

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?

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

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

Yes No

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? Yes No

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.)

Yes No 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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STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY

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 Joel B. Bettigole, MD (FULL NAME OF APPLICANT)

of Albany, NY (ADDRESS WHEN ENROLLED) enrolled in Albany Medical College (NAME OF MEDICAL SCHOOL)

Albany, NY (LOCATION) on the ______ day of Sept. (MONTH) 1956 (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).

______ EDUCATIONAL INSTITUTION ______ DATES

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

______ MEDICAL SCHOOL ______ TOTAL CREDITS ______ DATES

The undersigned further certifies that the records of this institution show that __he attended in this institution 4 (SPECIFY NUMBER) courses of resident instruction of 32 (NUMBER OF WEEKS) 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

- [x] __he was granted the degree Bachelor/Doctor of Medicine by
- [ ] __he withdrew from

the above mentioned medical school on the 31st day of May (MONTH) 1960.

Anatomy	Dermatology	Preventive medicine, including Nutrition
Otolaryngology	Embryology	Physical Medicine
Obstetrics and Gynecology	Histology	Therapeutics
Radiology, including Radiation Safety	Human Sexuality as defined in Section 2090	Neuroanatomy
Tropical Medicine	Medicine	Child Abuse Detection and Treatment
Physiology	Surgery, including Orthopedic Surgery	Geriatric Medicine
Biochemistry	Urology	Pediatrics
Pathology, Bacteriology and Immunology	Psychiatry	Pharmacology
Ophthalmology	Neurology	Anesthesia

Signed and the college seal affixed this 3rd day of March, 1988.

BY Sara J. Kremer, Director of Admissions and Registrar — 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 ... 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 in the form must be original.

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STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY

GEORGE DEUKMEJIAN, Governor

BOARD OF MEDICAL QUALITY ASSURANCE

1430 HOWE AVENUE, SACRAMENTO, CALIFORNIA 95825
(916) 920-6411

RECEIVED
SACRAMENTO
BOARD OF MEDICAL
QUALITY ASSURANCE

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 Joel B. Battigole, MD (NAME OF APPLICANT)

a graduate of Albany Medical College (NAME OF MEDICAL SCHOOL)

commenced postgraduate training in Boston City Hospital and Mass. Memorial Hospital, Boston, MA (NAME AND ADDRESS OF FACILITY)

on 7/1, 1961, and completed such training

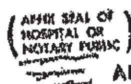
on 6/30, 1964. This training consisted of 36 months of actual clinical instruction and is approved by the Accreditation Council for Graduate Medical Education (ACGME) or the Coordinating Council of Medical Education of the Canadian Medical Association (CCME) and consisted of the following rotations:

(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 OB/GYN LENGTH OF ROTATION 36 months

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 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 Kenneth C. Edelin, M.D. (DIRECTOR OF MEDICAL EDUCATION)



ADDRESS 818 Harrison Avenue
Boston, MA 02118

PHONE NUMBER 424-5166

DATE March 1, 1988

SIGNATURE [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 Joel B. Bettigole, MD (NAME OF APPLICANT)

a graduate of Albany Medical College (NAME OF MEDICAL SCHOOL)

commenced postgraduate training in Springfield Hospital*, Springfield, MA (NAME AND ADDRESS OF FACILITY)
*as of 4/76
Baystate Medical Center, 759 Chestnut Street, Springfield, MA

on 7/1 1960, and completed such training

on 6/30 1961. 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
Rotating Internship	12 months

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(WITH 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 was trained in an approved ACGME or CCME program position.

NAME Martin I. Broder, M.D.

ADDRESS Chairman, Department of Medicine
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

PHONE NUMBER (413) 784-4000

DATE February 29, 1988

SIGNATURE Martin I Broder MD

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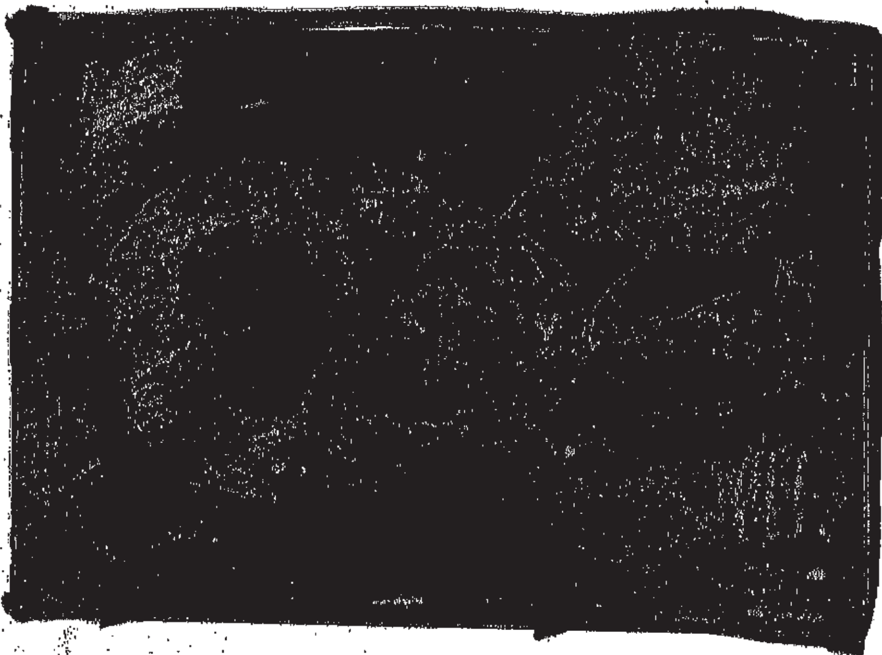

I hereby declare under penalty of perjury under the laws of the State of California, that the picture of myself attached hereto, was taken

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 Texas)
COUNTY OF Collin)

______ 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 the file.

Joel Benjamin Bettinger
Signature of applicant in FULL (Do not use INITIALS ONLY)

Signed and sworn to before me this 26 day of February , 19 8?

Signature of Notary Public Julie Ann Naylor
JULIE ANN NAYLOR

(SEAL)

Address 801 BAXTER DR PLANO TX. 75023

My commission expires 7-30-89

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