



BOARD OF MEDICAL QUALITY ASSURANCE

1430 HOWE AVENUE, SACRAMENTO, CALIFORNIA 95825

TELEPHONE:

Applications and Examinations (916) 322-5040

003091



APPLICATION FOR PHYSICIAN'S AND SURGEON'S CERTIFICATE  
 BASED ON NATIONAL BOARD CREDENTIALS  
 CLASS G

00972

PC  
 144.00  
 PG

(Please type or print neatly. When space provided is insufficient, attach additional sheets.)

1. NAME: Last <u>CHIN</u> First <u>HOMER</u> Middle <u>GEE</u> Maiden					2. Telephone No. _____																																				
3. List other names, if any, you have used: _____																																									
4. Address: Street and No./Rural Route <u>5002 MERRIMAC COURT</u>				City <u>SAN DIEGO</u>		State <u>CALIF.</u>																																			
						Zip Code <u>92117</u>																																			
5. Name you wish on License: <u>HOMER GEE CHIN, M.D.</u>					Birthdate: (Month - Day - Year)																																				
6. Premedical Education: Name of College or University <u>UNIVERSITY OF CALIFORNIA, BERKELEY</u>					Location <u>BERKELEY, CALIF.</u>																																				
Period of attendance: From: <u>SEPT. 1969</u> To: <u>JUNE 1973</u>			Check premed courses successfully completed: <input checked="" type="checkbox"/> Chemistry <input checked="" type="checkbox"/> Physics <input checked="" type="checkbox"/> Biology or Zoology																																						
7. Medical School:																																									
<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th>Year</th> <th>Name of Institution</th> <th>Location</th> <th>From</th> <th>To</th> </tr> </thead> <tbody> <tr> <td>1st</td> <td><u>UNIVERSITY OF CALIFORNIA, LOS ANGELES</u></td> <td><u>LOS ANGELES, CALIF.</u></td> <td><u>9/24/73</u></td> <td><u>9/24/74</u></td> </tr> <tr> <td>2nd</td> <td><u>UNIVERSITY OF CALIF., LOS ANGELES</u></td> <td><u>LOS ANGELES, CALIF.</u></td> <td><u>9/25/74</u></td> <td><u>9/25/75</u></td> </tr> <tr> <td>3rd</td> <td><u>UNIVERSITY OF CALIF., LOS ANGELES</u></td> <td><u>LOS ANGELES, CALIF.</u></td> <td><u>9/26/75</u></td> <td><u>9/26/76</u></td> </tr> <tr> <td>4th</td> <td><u>UNIVERSITY OF CALIF., LOS ANGELES</u></td> <td><u>LOS ANGELES, CALIF.</u></td> <td><u>9/26/76</u></td> <td><u>6/17/77</u></td> </tr> <tr> <td>5th</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>6th</td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>							Year	Name of Institution	Location	From	To	1st	<u>UNIVERSITY OF CALIFORNIA, LOS ANGELES</u>	<u>LOS ANGELES, CALIF.</u>	<u>9/24/73</u>	<u>9/24/74</u>	2nd	<u>UNIVERSITY OF CALIF., LOS ANGELES</u>	<u>LOS ANGELES, CALIF.</u>	<u>9/25/74</u>	<u>9/25/75</u>	3rd	<u>UNIVERSITY OF CALIF., LOS ANGELES</u>	<u>LOS ANGELES, CALIF.</u>	<u>9/26/75</u>	<u>9/26/76</u>	4th	<u>UNIVERSITY OF CALIF., LOS ANGELES</u>	<u>LOS ANGELES, CALIF.</u>	<u>9/26/76</u>	<u>6/17/77</u>	5th					6th				
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8. Doctor of Medicine Degree granted by: <u>UNIVERSITY OF CALIFORNIA, LOS ANGELES</u> <u>SCHOOL OF MEDICINE</u>					Date <u>6/17/77</u>	For office use only School Code: <u>CA.14</u>																																			
9. 1st Year Postgraduate Training (Internship): <u>UNIVERSITY HOSPITAL</u> <u>UNIVERSITY OF CALIFORNIA, SAN DIEGO</u>																																									
Location <u>SAN DIEGO, CALIF.</u>			Type of Service <u>OBSTETRICS - GYNECOLOGY</u>		From <u>JUNE 23, 1977</u>	To <u>JUNE 23, 1978</u>																																			
10. List all States in which you have been licensed to practice medicine: <u>NONE</u>																																									
11. Has any disciplinary action ever been taken regarding any license which you now hold or ever held? If Yes, indicate below:																																									
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12. Have you ever been denied a license to practice medicine in any State or Country? If Yes, indicate below:																																									
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13. Are you now or have you ever been addicted to narcotic drugs?																																									

JUN 23 1977  
 JUN 23 1978  
 3 05 PM  
 ED. SACRAMENTO  
 BO. OF MEDICINE  
 DIV. OF ASSURANCE

14. Have you ever been convicted of, pled guilty or nolo contendere to a violation of any Federal, State or Local law relating to the manufacture, distribution or dispensing of controlled substances/narcotics, or to drug addiction?

15. Have you ever been convicted of, pled guilty or nolo contendere to any offense, misdemeanor or felony in any state? (Except violations of traffic laws resulting in fines of \$50.00 or less.)

16. If you answered "Yes" to either No. 14 or No. 15 above, please provide the following information:

Violation and Location	Date	Penalty/Disposition

17. Have you ever had staff privileges in a hospital suspended or revoked? If yes, please explain on another sheet of paper.

*Homer Geo Chin*



Applicant: Please complete the following:

Height:    Ft.    In. Weight:    Lbs.

Hair color:        Eye color:

Identifying marks: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

NOTE—APPLICANT WILL SIGN THIS STATEMENT IN PRESENCE OF NOTARY PUBLIC.

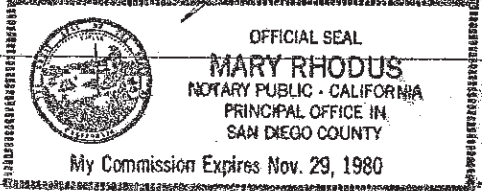
"I hereby certify (or declare), under penalty of perjury, that the foregoing information contained in this application and any attachments is true and correct, and that the attached photo and duplicate copy are a true likeness of myself, the applicant identified herein."

Signature of Applicant *Homer Geo Chin*  
 Date JUNE 24, 1978

Subscribed and sworn to before me this 24 day of June 1978.

Signature of Notary *Mary Rhodes*  
3342 Rosecrans, San Diego

Address \_\_\_\_\_



My commission expires: 11/29/80



BOARD OF MEDICAL QUALITY ASSURANCE

1430 HOWE AVENUE, SACRAMENTO, CALIFORNIA 95825  
 ALLIED HEALTH PROFESSIONS (916) 322-5043  
 APPLICATIONS AND EXAMINATIONS (916) 322-5040



PLEASE FORWARD TO YOUR MEDICAL SCHOOL

CERTIFICATE OF EDUCATION

This Certifies That Homer Gee Chin

enrolled in University of California, Los Angeles School of Medicine

on the 24 day of September 19 73

as a Freshman.

with advanced standing based on \_\_\_\_\_  
 Please specify

The undersigned further certifies that official transcripts on file show that prior to completing the study of medicine the applicant herein referred to completed at least a two-year resident course of college grade including:

PHYSICS  CHEMISTRY  BIOLOGY (or) ZOOLOGY (Check course(s) completed)  
 at University of California, Berkeley, and that he attended while at this  
 medical school (college) 40 courses of lectures of 143 weeks each,  
 completing 5259 hours in the subjects below listed, and that he/she:

was granted the degree { Bachelor } of Medicine  
 { Doctor }

left the above mentioned medical school (college) for the following reason(s):

on the 17 day of June 19 77

Please indicate which of the following courses of study were successfully undertaken by the applicant:

- |  |  |   |
|--|--|---|
| <input checked="" type="checkbox"/> Anatomy                                | <input checked="" type="checkbox"/> Preventive medicine  | <input checked="" type="checkbox"/> Medicine                              |
| <input checked="" type="checkbox"/> Embryology                             | <input checked="" type="checkbox"/> Hygiene and sanitation   | <input checked="" type="checkbox"/> Pediatrics                            |
| <input checked="" type="checkbox"/> Histology                              | <input checked="" type="checkbox"/> Radiology, including roentgenologic technique and radiation safety | <input checked="" type="checkbox"/> Psychiatry                            |
| <input checked="" type="checkbox"/> Neuroanatomy                           | <input checked="" type="checkbox"/> Urology  | <input checked="" type="checkbox"/> Neurology                             |
| <input checked="" type="checkbox"/> Physiology                             | <input checked="" type="checkbox"/> Ophthalmology  | <input checked="" type="checkbox"/> Dermatology                           |
| <input checked="" type="checkbox"/> Psychobiology                          | <input checked="" type="checkbox"/> Anesthesia   | <input checked="" type="checkbox"/> Physical medicine                     |
| <input checked="" type="checkbox"/> Biochemistry                           | <input checked="" type="checkbox"/> Otolaryngology   | <input checked="" type="checkbox"/> Therapeutics                          |
| <input checked="" type="checkbox"/> Pathology, bacteriology and immunology | <input checked="" type="checkbox"/> Obstetrics and gynecology  | <input checked="" type="checkbox"/> Tropical medicine                     |
| <input checked="" type="checkbox"/> Pharmacology                           |  | <input checked="" type="checkbox"/> Surgery, including orthopedic surgery |

Signed and the College seal affixed this 16 day

of June 19 78

By Farker L. Okinaga  
 President, Secretary, Dean

[ AFFIX SEAL ]  
 [ HERE ]

STATE DEPARTMENT OF CONSUMER AFFAIRS  
 INTERNET CASHIERING SYSTEM  
 MEDICAL BOARD OF CALIFORNIA  
 SUPPLEMENTAL INFORMATION REPORT  
 From Date: 05/12/2012 To Date: 05/12/2012

ATRISUPPINF

21-MAR-16 11:27:58

Person Id : 588697

Name : Chin,Homer

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?	

Total Questions Asked For Person : 588697

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## Application Summary

4/24/14 11:47 AM

Page 1 of 3

License Type: **Physician and Surgeon G**  
License Number: **37250**  
File Number:  
Application: **Physician's and Surgeon's Renewal**  
Application Number:  
Application Date: **04/24/2014 (mm/dd/yyyy)**

### Personal Detail

First Name: **HOMER**  
Middle Name: **GEE**  
Last Name: **CHIN**  
Birthdate: **(mm/dd/yyyy)**  
Gender: **Male**

### Addresses

#### License Related Addresses

##### Confidential Address (Optional)

Name:

Address:

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

Name: **CHIN, HOMER GEE**

Address: **200 W ARBOR DR # 8433**

**SAN DIEGO, CA**

**92103**

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?



1398385244141

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 - None**

**Teaching - 1-9 Hours**

**Telemedicine - 1-9 Hours**

Patient Care Practice Location **Zip: 92037 County: SAN DIEGO**

Telemedicine Practice Location **Zip: 92037 County: SAN DIEGO**

Patient Care Secondary Practice Location **Zip: 92103 County: SAN DIEGO**

Telemedicine Secondary Practice Location **Zip: 92103 County: SAN DIEGO**

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 **9+ Years**

Cultural Background **Chinese**

Foreign Language Proficiency **None**

Web Site Profile **Cultural Background - Yes**

**Foreign Language Proficiency - Yes**

**Gender - Yes**

E-mail:



**Fees**

Biennial Renewal Fee	<b>\$783.00</b>
DUE TO CURES FUND	<b>\$12.00</b>
Steven M. Thompson Physician Corps Loan Repayment Program	<b>\$25.00</b>
Total Amount Due:	<b>\$820.00</b>

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:



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Department of Consumer Affairs

RECEIPT

406028

Thank you for using the BreEZe System to submit your application.

Name:	CHIN, HOMER GEE
Transaction Date:	04/24/2014 11:48
Application Number:	
Complaint Number:	
License Type:	8002
License Number:	37250
Payment Description:	Physician's and Surgeon's Renewal
Fee Paid: (US \$)	820.00
Remaining Balance: (US \$)	0.00

Please print and save this receipt for your records.

This receipt is provided as a record for the above named licensee/applicant.

Illegal use or alteration of this receipt may result in criminal prosecution.

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