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?

____YES OR ✓ NO

SUMMARY OF RENEWAL FEES OWED

2012 Renewal Fee	808.00
Delinquent Fee	
Penalty Fee	
TOTAL FEES:	$808.00

FINANCIAL INTEREST STATEMENT

Health Facility Name	Address

MEDICAL BOARD OF CALIFORNIA LICENSE RENEWAL PHYSICIAN AND SURGEON APPLICATION

F. _____ YES I WISH TO CONTRIBUTE $25 FOR THE FAMILY PHYSICIAN TRAINING PROGRAM.

H. _____ YES I WISH TO CONTRIBUTE $50 FOR THE S.M. THOMPSON LOAN REPAYMENT PROGRAM.

D. CONTINUING MEDICAL EDUCATION (CME) CERTIFICATION STATEMENT

I CERTIFY UNDER PENALTY OF PERJURY UNDER THE LAWS OF CALIFORNIA TO THE FOLLOWING STATEMENT:

I CERTIFY THAT I DO MEET EACH OF THE CONTINUING MEDICAL EDUCATION REQUIREMENTS LISTED ON THE SECOND PAGE OF THIS FORM OR THAT I MEET THE CONDITIONS WHICH WOULD EXEMPT ME FROM ALL OR PART OF THE REQUIREMENTS OR I HOLD A PERMANENT CME WAIVER.

Signature required Christine Cummings 0081564

LICENSE NO. A 46005

EXPIRES 12/31/12

TOTAL ENCLOSED

FEE OWED $ 808

DELINQ FEE IF POSTMARKED AFTER _____

$ _____
$ _____
$ _____

E. FOR ADDRESS CHANGE ONLY
IF YOUR ADDRESS SHOWN IS INCORRECT, CORRECT IT BELOW

STREET _____

CITY _____ STATE _____

ZIP _____

PHONE NUMBER ( ) _____

Dr. CHRISTINA ELIZABETH CUMMINGS

G. FINANCIAL INTEREST STATEMENT

I CERTIFY UNDER PENALTY OF PERJURY THAT I HAVE DISCLOSED ON THIS RENEWAL APPLICATION FORM THE NAMES OF THOSE HEALTH-RELATED FACILITIES IN WHICH I OR MY FAMILY HAVE A FINANCIAL INTEREST OR I CERTIFY UNDER PENALTY OF PERJURY I HAVE NO FINANCIAL INTEREST TO DISCLOSE.

Signature required Christine Cummings

ENTERED NOV 05 2012

Application Summary

License Type:	**Physician and Surgeon A**
License Number:	**46005**
File Number:	**45774**
Application:	**Physician's and Surgeon's Renewal**
Application Number:	
Application Date:	**09/25/2014 (mm/dd/yyyy)**

Personal Detail

First Name:	**CHRISTINA**
Middle Name:	**E**
Last Name:	**CUMMINGS**
Birthdate:	**/**/****
Gender:	**Female**

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?	
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	**Patient Care - 20-29 Hours**
	Teaching - 1-9 Hours
Patient Care Practice Location	**Zip: 90007 County: LOS ANGELES**
Telemedicine Practice Location	**Zip: 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 - Primary**
Board Certifications	**None**
Postgraduate Training Years	**3 Years**
Cultural Background	**African American**
Foreign Language Proficiency	**French**
	Spanish
Web Site Profile	**Cultural Background - Yes**
	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:

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

Department of Consumer Affairs

RECEIPT

719452

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

Name:	CUMMINGS, CHRISTINA E
Transaction Date:	09/25/2014 14:34
Application Number:	
Complaint Number:	
License Type:	8002
License Number:	46005
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.

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

DEPARTMENT OF Consumer Affairs

BOARD OF MEDICAL QUALITY ASSURANCE

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

RECEIVED SACRAMENTO BOARD OF MEDICAL QUALITY ASSURANCE
OCT 31 1 10 PM '88

APPLICATION FOR PHYSICIAN AND SURGEON'S EXAMINATION OR LICENSURE

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.**

000561 157.00 1/89

005266 305.50 11/88

BMQA USE ONLY

1. Name: Last: Cummings First: CHRISTINA Middle: Elizabeth

2. Other names you have used: CHRISTINA CUMMINGS TAYLOR

3. Social Security Number — See disclosure statement on LIC

4. Address: Number and Street/Rural Route (include apartment number, if any): 5081 Rincon Ave

City: SANTA ROSA State: CALIFORNIA ZIP Code: 95409 Country: USA

5. Telephone Number: Home Work

6. Date of Birth: Mo/Day/Yr

7. Sex: ☒ Female ☐ Male

8. Are you a U.S. citizen? ☒ Yes ☐ No U.S. Passport No. AA-178640

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. Cert of Citizenship

9. Have you ever filed an application for examination or licensure in California? ☐ Yes ☒ No
If YES, give date of previous application:

PERSONAL DATA

No Picture attached ☑

☑

10. 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)
UCLA	405 Hilgard Ave, LA, CA 90024	9/69 9/75	6/71 6/77
ST Lawrence College	790 Renée-Tremblay St. Ste Foy, PQ Canada	9/67	6/69
OREGON STATE UNIV.	Corvallis, Oregon 97331	9/77	6/82

NON-MEDICAL EDUCATION ☑ ☑ ☑

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)
DUKE	Durham, N.C.	Durham, N.C.	9/82	6/86

MEDICAL EDUCATION

CME	TRANS.
☑	☑
☐	☐
☐	☐
☑	

NC007 School Code

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

Name of Medical School: Duke University
Address of Medical School: Durham, North Carolina 27710
Exact Date of Issuance: Sept 1, 1986

C

L1A

JO

BMQA USE ONLY

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.

WRITTEN EXAMINATION

Name	Location	Date	Result
FLEX	Raleigh, NC	6/87	

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 (Form L3) from each facility.

POSTGRADUATE TRAINING

Name	Address	Type of Service	Period of Attendance From (Mo/Yr)	Period of Attendance To (Mo/Yr)
DUKE University	Durham, N.C.	Psychiatry Internship	7/14/86	2/28/87
Community Hospital	3325 Chanate SANTA Rosa, CA	Family Practice Internship	7/1/87	6/30/88

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.

LICENSE DATA

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)	LGS	CE
					☐	☐
					☐	☐
					☐	☐
					☐	☐

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

☒
☐
☐
☐

L1B

BMQA USE ONLY

LICENSE DATA (continued)

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 been charged with unprofessional conduct or any other unlawful activity by any healing arts licensing authority or by the U.S. military and are awaiting final disposition by that body?

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

19. 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.

20. 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.

GENERAL DATA

21. Are you now, or were you in the past, addicted to or treated for addiction to controlled substances, such as narcotics or alcohol? Yes No If yes, please explain on a separate sheet of paper.

22. 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

23. 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 1203.4 Penal Code or under any other provision of law.

"Disclosure of your social security number is mandatory. Section 30 of the Business and Professions Code and Pub. 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. 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."

L1C

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. Information regarding the issuance or denial of a license by the Board may be transmitted to any other medical licensing authority or the Federation of State Medical Boards. 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)
) ss.
COUNTY OF Sonoma)

Christina Elizabeth Cummings being duly sworn, says She is the person referred to in the foregoing application for a physician and surgeon's certificate in California and that She 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.

She 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, She 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.

Christina Elizabeth Cummings
Signature of applicant in FULL (Do not use INITIALS ONLY)

Signed and sworn to before me this 31st day of August, 1988

Signature of Notary Public JoAnn M. Burruel

[SEAL] OFFICIAL SEAL
JOANN M. BURRUEL
NOTARY PUBLIC-CALIFORNIA
PRINCIPAL OFFICE IN
SONOMA COUNTY
My Commission Expires Feb. 27, 1991

Address 410 5th St. Santa Rosa, Ca

My commission expires 2-27-91

07A-100

L1D

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 CHRISTINA ELIZABETH CUMMINGS (NAME OF APPLICANT),

a graduate of DUKE UNIVERSITY (NAME OF MEDICAL SCHOOL),

formally commenced an accredited postgraduate training program at DUKE UNIVERSITY, DURHAM (NAME AND ADDRESS OF FACILITY),

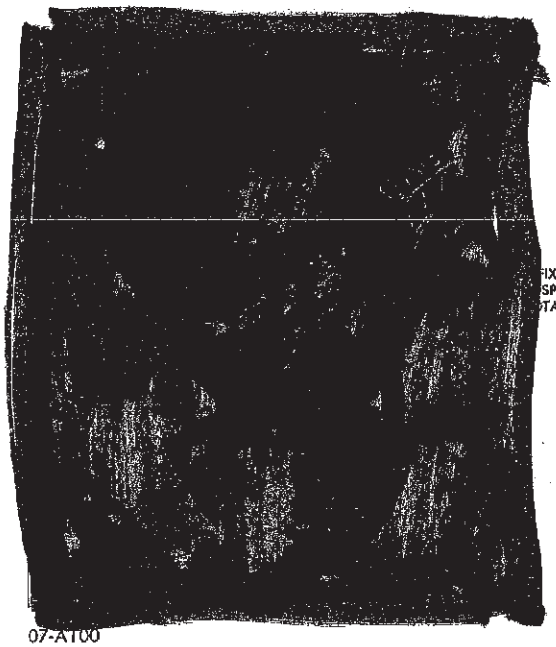
NORTH CAROLINA, in PSYCHIATRY (SPECIALTY),

on 7/14/86, 19 86, and completed such training on 2/28, 19 87.

This training consisted of 7 1/2 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: one 4 month and one 3½ month rotation in Psychiatric Rotation

(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
Resident in Psychiatry	7.14.86-2.28.87



07-A100

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 was trained in an approved ACGME or CCME program position.

NAME Mary C. Fendt Mary C Fendt
DIRECTOR OF MEDICAL EDUCATION

Administrator, Graduate Medical Education

ADDRESS Duke University Medical Center

House Staff Office Box 3951 Durham, NC 27710

PHONE NUMBER 919-684-3491

DATE 9.15.88

SIGNATURE Mary C Fendt

L3

GEORGE DEUKMEJIAN, Governor

STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY

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 CHRISTINA CUMMINGS, M.D. (NAME OF APPLICANT),

a graduate of DUKE UNIVERSITY (NAME OF MEDICAL SCHOOL),

formally commenced an accredited postgraduate training program at Community Hospital (NAME AND ADDRESS OF FACILITY) ok,

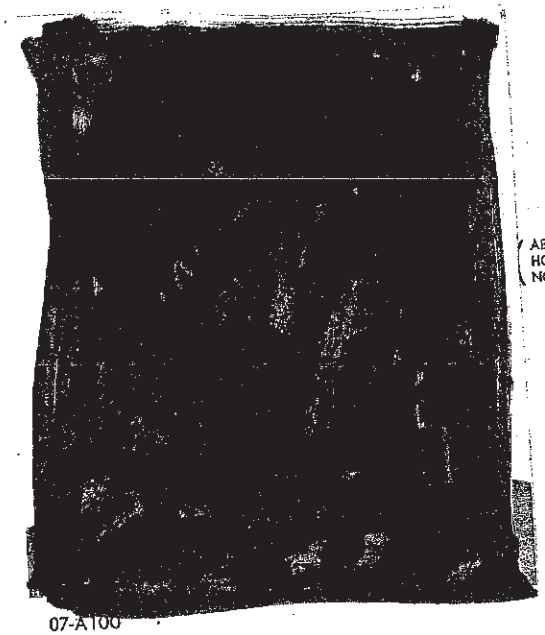
3325 Chanate Road, Santa Rosa, CA 95404 in Family Practice (SPECIALTY),

on July 1, 19 87, and completed such training on June 30, 19 88.

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
Medicine/Surgery	5.5 months
Perinatology	2.0 months
Emergency Room	1.0 month
Orientation	1.0 month
Pediatrics	1.0 month
Intensive Care Nursery	0.5 month
Pediatrics/Urgent Care	1.0 month
Vacation	1.0 month



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 Franklyn D. Dornfest, M.D.
DIRECTOR OF MEDICAL EDUCATION

(AFFIX SEAL OF HOSPITAL OR NOTARY PUBLIC)

ADDRESS Community Hospital
3325 Chanate Road
Santa Rosa, CA 95404

PHONE NUMBER (707) 544-3340

DATE 8/11/88

SIGNATURE [signature]

L3

07-A100