State of California Department of Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM
1425 Howe Avenue
Sacramento, CA 95825-3236
(916) 263-2499

MEDICAL BOARD OF CALIFORNIA
00 JAN 31 AM 8:55
LICENSING PROGRAM

SACRAMENTO MEDICAL BOARD OF CALIFORNIA
00 JAN 28 PM 12:36

CERTIFICATE OF MEDICAL EDUCATION

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

This certifies that Abolghassem Masud Gohari (FULL NAME OF APPLICANT) of ______ (ADDRESS WHEN ENROLLED) enrolled in Tehran University of Medical Sciences (NAME OF MEDICAL SCHOOL) Tehran, Iran (LOCATION)

on the ______ day of ______ (MONTH) 19 62 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, dental, or osteopathic school.**

______ MEDICAL SCHOOL ______ TOTAL CREDITS ______ DATES

The undersigned further certifies that the records of this institution show that __he attended in this institution ______ (SPECIFY NUMBER) years of resident instruction of ______ (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 OR [ ] __he withdrew from

the above mentioned medical school on the ______ day of ______ (MONTH), 19 69

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
	Alcoholism and Chemical Dependency	Family Medicine**
		Spousal or Partner Abuse Detection & Treatment***

* 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 the form must be original.

** ONLY applicable to medical students who graduate from medical school on or after May 1, 1998

*** ONLY applicable to medical students who enrolled in medical school on or after September 1, 1994.

TRANSCRIPTS FOR ALL ADVANCED CREDITS AND MEDICAL SCHOOL CREDITS MUST BE SUPPLIED WITH THIS CERTIFICATE.

Medical School Seal MUST be imprinted Partially on the Photograph.

Signed and the school seal affixed this 2nd day of Jan., 19 2000

BY S.M.Ghodsi, M.D.Vice Chancellor for Research [signature: S.M. Ghodsi]
PRESIDENT, SECRETARY, DEAN

L2

State of California Department of Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM
1426 Howe Avenue, Sacramento, CA 95825-3236
(916) 263-2499

CERTIFICATE OF COMPLETION OF ACGME/CCME POSTGRADUATE TRAINING

To be completed by the facility for every medical school graduate completing postgraduate training in the United States or Canada.

PART 1: To be completed by the applicant/trainee.

Last Name of Trainee	First Name	Middle Initial
GOHARI	ABOLGHASSEN	M

Current Address:	Social Security Number
216 CORAL AVE	

City	State	Zip Code	Telephone Number:
GOLDSTON	NC	27252	

PART 2: To be completed by the facility. Completion of this form will certify that the individual named in PART 1 above and whose photograph is attached to this form, formally completed an accredited postgraduate training program at this facility. The following information is provided to certify "satisfactory" completion. PLEASE SEE THE REVERSE FOR A DEFINITION OF "SATISFACTORY."

Name of Facility	Address of Facility	
Johns HOpkins Medical Institution	600 N. Wolfe St., Baltimore, MD 21287	
Name of Program Director: O.D. Huggins MD		Telephone Number: (410) 955 2017
Signature of Program Director:		Date Signed: 11/20/99
List Categorical Specialty Area of Training Completed by Trainee: OB/GYN	Date Training Commenced: 1/1/73	Date Training Completed: 6/30/73

If the training was rotating or transitional, list the specific rotations and the number of weeks spent in each (SEE THE REVERSE FOR INFORMATION ON SATISFYING THE GENERAL MEDICINE TRAINING REQUIREMENT):

N/A

PART 3: To be completed by the Director of Medical Education and affixed with the official facility seal.

Name of the Director of Medical Education:	Facility Name:	
Harold Fox, MD, Professor & Director	JHU, Department of Gynecology/Obstetrics	
Facility Address: 600 N. Wolfe Street, Phipps Bldg, Room 264		
City: Baltimore	State: MD	Zip Code: 21287
		Telephone Number: (410) 614-1780

[redacted]

PART 4: Signature of Director of Medical Education certifying satisfactory completion of training.

ATTENTION PROGRAM DIRECTOR!
IF TRAINEE IS IN HIS/HER FIRST YEAR OF POSTGRADUATE TRAINING, DO NOT SIGN OR DATE THE STATEMENT BELOW UNTIL AFTER THE COMPLETION OF THE TRAINEE'S LAST DAY OF TRAINING.

I hereby declare under penalty of perjury under the laws of the State of California that the above statements are true and correct and that the training program 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.

Signature of Director of Medical Education:	Date Signed:
Harold Fox MD	1/31/2000

OFFICIAL HOSPITAL SEAL OR NOTARY SEAL, DATE AND SIGNATURE MUST BE AFFIXED TO CERTIFY TRAINING.

L3A

STATE OF CALIFORNIA — STATE AND CONSUMER SERVICES AGENCY

GRAY DAVIS, Governor

State of California Department of Consumer Affairs

RECEIVED SACRAMENTO MEDICAL BOARD OF CALIFORNIA 00 JUL -7 PM 1:35

MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM
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(916) 263-2499

RECEIVED MEDICAL BOARD OF CALIFORNIA LICENSING PROGRAM 00 JUL -7 PM 1:16

CERTIFICATE OF COMPLETION OF ACGME/CCME POSTGRADUATE TRAINING

To be completed by the facility for every medical school graduate completing postgraduate training in the United States or Canada.

PART 1: To be completed by the applicant/trainee.

Last Name of Trainee	First Name	Middle Initial
GOHARI	ABOLGHASSEM	M

Current Address: 298 EAST SALISBURY ST. — Social Security Number:

City: PITTSBORO — State: NC — Zip Code: 27312 — Telephone Number:

PART 2: To be completed by the facility. Completion of this form will certify that the individual named in PART 1 above and whose photograph is attached to this form, formally completed an accredited postgraduate training program at this facility. The following information is provided to certify "satisfactory" completion. PLEASE SEE THE REVERSE FOR A DEFINITION OF "SATISFACTORY."

Name of Facility: Providence Hospital — Address of Facility: 1150 Varnum St., NE Washington, DC 20017

Name of Program Director: Robert Simmons, MD — Telephone Number: (202) 269-7761

Signature of Program Director: Robert Simmons, MD — Date Signed: 5/30/2000

List Categorical Specialty Area of Training Completed by Trainee: Obstetrics & Gynecology — Date Training Commenced: July 1, 1973 — Date Training Completed: June 30, 1976

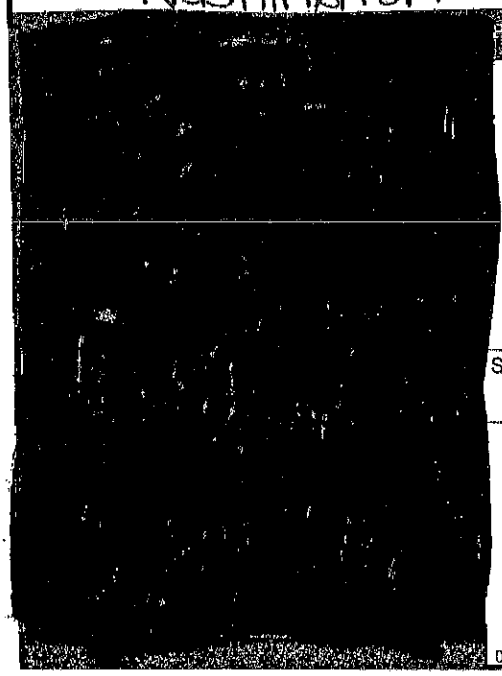
If the training was rotating or transitional, list the specific rotations and the number of weeks spent in each (SEE THE REVERSE FOR INFORMATION ON SATISFYING THE GENERAL MEDICINE TRAINING REQUIREMENT):

PART 3: To be completed by the Director of Medical Education and affixed with the official facility seal.

Name of the Director of Medical Education: Robert Simmons, M.D. — Facility Name: Providence Hospital

Facility Address: 1150 Varnum St., NE

City: Washington — State: DC — Zip Code: 20017 — Telephone Number: (202) 269-7761



PART 4: Signature of Director of Medical Education certifying satisfactory completion of training.

ATTENTION PROGRAM DIRECTOR!
IF TRAINEE IS IN HIS/HER FIRST YEAR OF POSTGRADUATE TRAINING, DO NOT SIGN OR DATE THE STATEMENT BELOW UNTIL AFTER THE COMPLETION OF THE TRAINEE'S LAST DAY OF TRAINING.

I hereby declare under penalty of perjury under the laws of the State of California that the above statements are true and correct and that the training program 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.

Signature of Director of Medical Education: Robert Simmons — Date Signed: 6/4/2000

OFFICIAL HOSPITAL SEAL OR NOTARY SEAL, DATE AND SIGNATURE MUST BE AFFIXED TO CERTIFY TRAINING.

L3A

State of California Department of Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM
1426 Howe Avenue
Sacramento, CA 95825-3236
(916) 263-2499

OFFICIAL BREAKDOWN OF UNDERGRADUATE CLINICAL CLERKSHIPS

FOR ABOLGHASSEM MASUD GOHARI, M.D.
TYPE OR PRINT FULL NAME OF APPLICANT

ONLY UNDERGRADUATE CLINICAL CLERKSHIPS IN WHICH THE APPLICANT PARTICIPATED IN DIRECT, HANDS-ON DIAGNOSIS OR TREATMENT OF PATIENTS IN A CLINICAL SETTING SHOULD BE REPORTED ON THIS FORM. ANY CLINICAL CLERKSHIPS COMPLETED THAT DO NOT MEET THE ABOVE CRITERIA SHOULD NOT BE REPORTED ON THIS FORM AS THEY WILL NOT SATISFY CALIFORNIA'S CLINICAL TRAINING REQUIREMENTS.

UNDERGRADUATE CLINICAL CLERKSHIPS

(Please list all applicable training in the area below and on the reverse side of this form. List training in date order commencing with the first clinical year of training.)

CLINICAL SUBJECT AREA	FACILITY NAME AND ADDRESS	DATES OF ATTENDANCE FROM — TO (Month/Day/Year)	WEEKS OR WEEKLY HOURS OF CREDIT
Internal Med. Externship	Imam Khomeini Hospital	From 9/23/65 To 1/20/66	16 Weeks
Surgery Externship	Sina Hosp.	From 1/21/66 To 3/20/66	8 Weeks
Orthopedics Ext.	Imam Khomeini Hosp.	From 4/4/66 To 5/5/66	4
Urology Ext.	Imam Khomeini	From 5/5/66 To 6/5/66	4
Pediatrics Ext.	Pediatric Center	From 9/23/66 To 12/21/66	12
Dermatology Ext.	Razi Hosp.	From 12/22/66 To 1/20/67	4
Gynecology Ext.	Mirza Koochak Khan Hosp.	From 9/23/67 To 11/21/67	8
Neurology Ext.	Imam Khomeini Hosp.	From 11/22/67 To 12/21/67	4
Psychiatry Ext.	Roozbeh Hosp.	From 12/22/67 To 1/20/68	4
Ophthalmology Ext.	Farabi Hosp.	From 1/21/68 To 2/19/68	4

THE COMPLETION OF THIS FORM IS REQUIRED ONLY OF INTERNATIONAL MEDICAL SCHOOL GRADUATES

OFFICIAL BREAKDOWN OF UNDERGRADUATE CLINICAL CLERKSHIPS

FOR ABOL GHASSEM MASUD GOHARI, M.D
TYPE OR PRINT FULL NAME OF APPLICANT

MEDICAL SCHOOL: SEE REVERSE SIDE FOR INSTRUCTIONS.

UNDERGRADUATE CLINICAL CLERKSHIPS (Continued from the front of this form.)

CLINICAL SUBJECT AREA	FACILITY NAME AND ADDRESS	DATES OF ATTENDANCE FROM -- TO (Month/Day/Year)	WEEKS OR WEEKLY HOURS OF CREDIT
Inf. Med. Ext.	Imam Khomeini Hosp.	From 1/21/67 To 2/19/67	4
E.N.T Ext.	Amir Alam Hosp.	From 5/5/67 To 6/5/67	4
Radiology Ext.	Imam Khomeini Hosp.	From 4/4/67 To 5/5/67	4
Health Ext.	Rural Field	From 2/20/67 To 3/20/67	4
Internal Med. Internship	Imam Khomeini Hosp.	From 3/21/68 To 7/21/68	16
Surgery Internship	Sina Hosp.	From 7/23/68 To 10/22/68	12
E.N.T. Int.	Farabi Hosp.		4
Psychiatry Int.	Amir Alam Hosp.		4
Ophthalmology Int.	Farabi Hosp.		4
Gynecology Int.	Mirza Koochak Khan Hosp.	From 10/23/68 To 12/21/68	8
Dermatology Int.	Razi Hosp.		4
Inf. Med. Int.	Imam Khomeini		4

Pediatrics Int. for 12 weeks & Health Int. for 4 weeks.

MEDICAL SCHOOL SEAL

I, S.M.Ghodsi, M.D. Vice Chancellor Research for
FULL NAME of Dean or Registrar (Please TYPE OR PRINT)

declare under penalty of perjury, that I am/was the Dean or Registrar for the student named above and that I have carefully read this form and that the statements made herein are strictly true in every respect.

S.M.Ghodsi
Signature

Jan. 5, 2000
Date

L5B

07A-100-L5B (Rev. 3/99)

STATE OF CALIFORNIA — STATE AND CONSUMER SERVICES AGENCY

GRAY DAVIS, Governor

State of California Department of Consumer Affairs

REC'D SACRAMENTO MEDICAL BOARD OF CALIFORNIA

MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM
1426 Howe Avenue, Sacramento, CA 95825-3236
(916) 263-2499

8607
508 2/4/00

00 JAN 31 AM 11:29

APPLICATION FOR PHYSICIAN AND SURGEON'S LICENSURE

Please 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 as per instructions.
Please type or print neatly. When space provided is insufficient, attach additional sheets of paper.

MBC USE ONLY

1. Name: Last: GOHARI First: ABOLGHASSEN Middle: MASOUD

2. Other names you have used (include maiden name):

3. Social Security Number◆

4. Address: Number and Street/Rural Route (Include apartment number, if any): 298 EAST SALISBURY ST.

5. Sex: ☐ Female ☑ Male

City: PITTSBORO State: NC Zip Code: 27312 Country: USA

6. Telephone Number: Home: Work:

7. Date of Birth: Mo/Day/Yr

Place of Birth: Daragaz, Iran

8. California Driver's License Number, If applicable: NUMBER EXPIRATION

9. Are you a U.S. citizen? ☒ Yes ☐ No

If you are an international medical school graduate, you must provide an original full and unrestricted license to practice medicine in another state or country, OR official documentation of U.S. citizenship, OR an official Declaration of Intent to become a U.S. citizen.

10. Have you ever filed an application for physician and surgeon examination or licensure in California? ☐ Yes ☒ No

IF YES, PLEASE GIVE DATE PREVIOUS APPLICATION WAS SUBMITTED AND ATTACH ANY APPLICATION MATERIALS YOU MAY HAVE RETAINED. _____

11A. List the names and addresses of all colleges or universities attended where pre-professional, postsecondary instruction was received. Please submit official transcripts with the school seal affixed for each school attended.

Name	Address	Dates of Attendance
In Iran, pre-medical and medical school education were combined into one program,	listed below in Section 12.	

11B. Check whether the following premedical courses were successfully completed and show where completed.

Course	Yes	No	Name of College or University
Chemistry	✓		Tehran University, Tehran, Iran
Physics	✓		Tehran University, Tehran, Iran
Biology or Zoology	✓		Tehran University, Tehran, Iran

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LICENSING PROGRAMS

12. List the names and addresses of all schools where professional medical instruction was received, and, where applicable, the degree awarded. **PLEASE SUBMIT: 1)** an original Certificate of Medical Education (Form L2) and official transcripts with the signature of the dean or registrar and the school seal affixed from each school attended; **and 2)** an original medical diploma and a photocopy.

School Name	Address	Place of Instruction	Dates of Attendance	Degree Awarded
Tehran University	Inghelab Ave Tehran, Iran	Tehran, Iran	1962-1969	6-30-69

DOCTOR OF MEDICINE DEGREE as referenced above. (Note: A U.S. graduate may, in lieu of the original, submit an official certified photocopy that has the school seal affixed and the signature of the registrar certifying authenticity.)

Name of Medical School	Address of Medical School	Exact Date of Issuance
Tehran University	Inghelab Ave Tehran, Iran	6-30-69

◆ MANDATORY DISCLOSURE OF SOCIAL SECURITY NUMBERS

Disclosure of your social security number (or federal employer identification number [FEIN], if you are a partnership) is mandatory. Section 30 of the Business and Professions Code and Public Law 94-455 (42 USCA 405(c)(2)(C)) authorize collection of your social security number. Your social security number or FEIN will be used exclusively for tax enforcement purposes, for purposes of compliance with any judgment or order for family support in accordance with Section 11350.6 of the Welfare and Institutions Code, or for verification of licensure or examination status by a licensing or examination entity which utilizes a national examination and where licensure is reciprocal with the requesting state. If you fail to disclose your social security number or your FEIN, your application for initial licensure will not be processed AND you will be reported to the Franchise Tax Board, which may assess a $100 penalty against you.

1RA01 School Code

L1A

07A-100 (Rev. 3/99)

MBC USE ONLY

13. Have you taken any of the following written examinations: National Boards, other state boards, USMLE, SPEX, FLEX, or LMCC? ☒ Yes ☐ No

IF YES, LIST NAME, LOCATION, DATE AND RESULT OF EXAMINATION. SUBMIT AN ORIGINAL OFFICIAL EXAMINATION HISTORY REPORT FROM EACH EXAMINATION AGENCY. APPLICANTS WHO HOLD CERTIFICATION THROUGH THE EDUCATIONAL COMMISSION FOR FOREIGN MEDICAL GRADUATES (ECFMG) WILL NEED TO SUBMIT AN ORIGINAL VALID ECFMG CERTIFICATE PRIOR TO LICENSURE.

Examination	Location	Date	Result
FLEX	Washington, D.C.	1974	

14. Have you ever 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 EACH ISSUING AGENCY'S JURISDICTION. SUBMIT A LETTER OF GOOD STANDING FROM EACH STATE IN WHICH YOU ARE OR HAVE BEEN LICENSED. PLEASE INCLUDE TEMPORARY, TRAINING, OR PROVISIONAL LICENSES.

State or Country	License Number	Date of Issuance	Dates of Practice in that Jurisdiction
DC	7299	1974	Residency Training 1973-1976
MD	D18165	1975	1976 - Present
VA	0101028051	1976	I have not practiced in Virginia

15A. Are you currently, or have you ever been, a participant in a postgraduate training program in a facility in the U.S. or Canada? ☒ Yes ☐ No

IF YES, LIST NAMES AND ADDRESSES OF ALL FACILITIES. SUBMIT AN ORIGINAL CERTIFICATE OF COMPLETION OF ACGME/CCME POSTGRADUATE TRAINING (FORM L3A) FROM EACH FACILITY. (DO NOT COMPLETE FORM L3A/BS TO DOCUMENT TRAINING RECEIVED IN RESEARCH FELLOWSHIP PROGRAMS.) ALL TRAINING MUST BE LISTED, REGARDLESS OF WHETHER IT WAS SATISFACTORILY COMPLETED OR WILL BE USED TO MEET LICENSING REQUIREMENTS.

Facility Name	Address	Type of Service	Dates of Attendance
St. Joseph's Hospital	Pittsburgh, PA (Now CLOSED)	Rotating Internship	1/72 - 12/72
Johns Hopkins Hospital	600 North Wolfe Baltimore MD 21205	OB&GYN Residency	1/73 - 6/73
Providence Hospital	1150 Varnum St SW Washington DC 20017	OB&GYN Residency	7/73 - 6/76

QUESTIONS 15B through 21: For any positive response to the following questions, please provide ALL official documentation regarding the matter in addition to written explanations. If applicable, an applicant should also provide official hearing/court documents and original letters of explanation from medical school or training program directors or other appropriate authorities. APPLICANTS ARE ALSO REQUIRED TO REPORT ANY MATTER THAT IS PENDING OR IN WHICH CHARGES HAVE BEEN DROPPED OR EXPUNGED.

15B. Have you ever withdrawn from, or been suspended, dismissed or expelled from a medical school or postgraduate training program? Yes No

16. Have you ever been charged with, or been found to have committed, unprofessional conduct, professional incompetence, gross negligence or repeated negligent acts or malpractice by any medical licensing board, other agency, or hospital or has any disciplinary action ever been filed or taken regarding any healing arts license which you now hold or have ever held, or is any such action pending? Include any disciplinary actions by the U.S. Military, U.S. Public Health Service or other U.S. federal governmental entity. IF YES, GIVE DETAILS BELOW. Yes No

State	Date	Charge	Disposition

L1B

ONLY

17. Has a claim or action for damages ever been filed against you in the course of the practice of medicine or any other healing art which resulted in a malpractice settlement, judgement or arbitration award of over $30,000.00? Yes No

IF YES, GIVE DETAILS BELOW.

Name of Claimant	Location of Court	Brief Description of the Facts
Adelia Bennett	Prince George's County, MD	Separate detail explanation attached
Carrie L. Combs	Montgomery County, MD	Separate detail explanation attached

18. Have you ever been denied a license, permission to practice medicine or any other healing art, or denied permission to take an examination in any state, country, or U.S. federal jurisdiction, or is any such action pending? Yes No

IF YES, GIVE DETAILS BELOW.

State or Country	Date of Denial	Reason for Denial

19. Have you ever voluntarily surrendered a license to practice in the healing arts in this or any other state, or voluntarily surrendered your narcotic (controlled substance) permit (state or federal) to any licensing board or any other agency, or is any such action pending? Yes No

20. Have you ever had staff privileges in a hospital denied, suspended, limited, revoked or not renewed for medical disciplinary cause, or resigned from a medical staff in lieu of disciplinary or administrative action, or is any such action pending? Yes No

21. Do you have any condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety, including but not limited to, any of the following? Yes No

IF YES, PLEASE CHECK THE APPROPRIATE BOX(ES) BELOW:

- ☐ A condition which required admission to an inpatient psychiatric treatment facility.
- ☐ Alcohol or chemical substance dependency or addiction.
- ☐ Emotional, mental or behavioral disorder.
- ☐ Other (explain): _____

FOR ANY OF THE BOXES CHECKED ABOVE, PLEASE SUBMIT COMPLETE OFFICIAL INPATIENT AND OUTPATIENT TREATMENT RECORDS, EVIDENCE OF ONGOING REHABILITATION TREATMENT, AND A PERSONAL WRITTEN EXPLANATION.

QUESTION 22: For any positive response to the following question, please provide ALL official documentation regarding the matter in addition to written explanations. If applicable, an applicant should also provide official hearing/court documents and original letters of explanation from appropriate authorities.

22. Have you ever been convicted of or pled nolo contendere to any violation (including misdemeanors and felonies) of any federal, state or local law of any state, the United States, or a foreign country or any violation relating to the possession, use, illegal sale, transportation, manufacture, distribution or dispensing of controlled substances, or is any such action pending? *(Exclude violations of traffic laws, including speeding, which resulted in fines of $300.00 or less.)* If YES, give details below. Yes No

YOU ARE REQUIRED TO LIST ANY CONVICTION THAT HAS BEEN SET ASIDE AND DISMISSED OR EXPUNGED, OR WHERE A STAY OF EXECUTION HAS BEEN ISSUED.

Violation and Location	Date	Penalty or Disposition

L1C

TOP OF PHOTO

BOTTOM OF PHOTO

...CAL BOARD OF
...LIFORNIA
...NSING PROGRAM

PHOTO DECLARATION

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;

my color of hair ____;

my color of eyes ____;

my height ____ ft. _____ in.;

my weight ____ lbs.;

and identifying marks are

_____ _____

_____ _____

_____

Signature of Applicant

Notice: All items in this application are mandatory; none are voluntary. 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 licensure 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 or law enforcement agencies. You have the right to review your application subject to the provisions of the Information Practices Act. The Program Manager of the Licensing Program is the custodian of records.

STATE OF Maryland

COUNTY OF Montgomery

Applicant Declaration/Signature and NOTARY

The applicant, ABOLGHASSEM MASUD GOHARI, M.D, being first duly sworn upon his/her
PRINT FULL NAME OF APPLICANT

oath deposes and says: that he/she is the person herein named subscribing to this application; that he/she has read the complete application, knows the full content thereof, and declares that all of the information contained herein and evidence or other credentials submitted herewith are true and correct; that he/she is 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 the applicant is aware and that the applicant is the lawful holder thereof. Further, I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past, present and future), 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 and/or alcohol abuse or dependency, requested by that Board in connection with this application; or any further or future investigation by that Board necessary to determine my 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 to the organizations, individuals or groups listed above any information which is material to this application or any subsequent licensure. I further acknowledge that falsification or misrepresentation of any item or response on this application is adequate to deny the same or to hold a hearing to revoke the same, if issued.

SIGNATURE OF APPLICANT: Abolghassem M. Gohari, MD
(PLEASE WRITE FULL NAME, NOT INITIALS)

Signed and sworn to before me this 18th day of October, 19 99

Joyce Keeze
SIGNATURE OF NOTARY PUBLIC

NOTARY SEAL

9605 Shady Grove Ct, Gaithersburg, MD 20877
ADDRESS

My commission expires 9/1/2001

07A-100 (Rev. 3/99)

L1D

Department of Consumer Affairs

PHYSICIAN AND SURGEON

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 BACK 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 HERE: A.M. Gohari DATE: _____

LICENSE NO.	EXPIRES	AMOUNT DUE NOW	DELINQ. FEE IF POSTMARKED AFTER 11/30/06
C 50604	10/31/06	$790.00	$869.00
	VOLUNTARY FEE +	$	$
	TOTAL ENCLOSED =	$	$

ACTIVE ABOLGHASSEN MASUD GOHARI
5915 GREENBELT RD
COLLEGE PARK MD 20740

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

STREET _____

CITY _____ STATE _____ ZIP _____

PHONE NUMBER ( ) _____

G. FINANCIAL INTEREST STATEMENT

I CERTIFY UNDER PENALTY OF PERJURY THAT I HAVE DISCLOSED ON THIS RENEWAL APPLICATION FORM (SEE REVERSE FOR SPACE) 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 A.M. Gohari

6301030000030000400050604801103106000790000008690O

[redacted]

STATE DEPARTMENT OF CONSUMER AFFAIRS
INTERNET CASHIERING SYSTEM
MEDICAL BOARD OF CALIFORNIA
SUPPLEMENTAL INFORMATION REPORT
From Date: 07/25/2008 **To Date:** 07/25/2008

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09-MAR-16 09:20:09

Person Id : 572737 **Name :** Gohari,Abolghassen

Question	Answer
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
I Have Completed 12 Hours Of Pain Management And End-Of-Life Care (Must Be Completed By December 31, 2006).	YES
I Have Completed Cme And Can Document An Average Of 25 Hours Of Approved Cme Each Calendar Year Resulting In A Minimum Of 100 Hours Over The Last 4 Years.	YES
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.Medbd.Ca.Gov And Acknowledge The Information Contained Therein As Current And Accurate.	YES

Total Questions Asked For Person : 572737 7

License Details

The Department of Consumer Affairs encourages you to verify the license statuses of any licensees that may appear in a 'Related License' section below. You can verify these licensees by selecting 'New Search' and conducting a new search using the 'Search by Personal or Business Name' option. Please note that the 'Related License' section will only appear below if this license is related to another license. Not all licensees have a related license.

If the License Details below include 'Date of Graduation', the month and date of graduation may not be available. In this instance it will be displayed as '01/01/YYYY' where YYYY represents the year of graduation. Please note that not all license types disclose 'Date of Graduation' on the License Details screen.

Press "Previous Record" to display the previous license.

Press "Next Record" to display the next license.

Press "Search Results" to return to the Search Results list.

Press "New Search Criteria" to do another search of this type.

Press "New Search" to start a new search.

License Number: 50604 *Current Date: 03/07/2016 11:37 AM*

Name:	GOHARI, ABOLGHASSEM MASUD
License Type:	Physician and Surgeon C
License Status:	License Surrendered
Secondary Status:	Administrative Action Taken by Other State or Federal Govt
School Name:	IRA01 - TEHRAN UNIVERSITY OF MEDICAL SCIENCES AN
Date of Graduation:	06/19/1969
Original Issuance Date:	06/20/2001

Addresses

Address of Record (Required)	Address	5915 GREENBELT RD COLLEGE PARK , MD PRINCE GEORGES 20740 United States View on a map

Survey Information

The following information is self-reported by the licensee and has not been verified by the Board.

Are you retired?	Not Identified
Activities in Medicine?	No activities identified
Patient Care Practice Location	Not identified
Patient Care Secondary Practice Location	Not identified
Telemedicine Practice Location	Not identified
Telemedicine Secondary Practice Location	Not identified
Current Training Status	Not in Training
Areas of Practice	No areas of practice identified
Board Certifications	American Board of Obstetrics and Gynecology - Obstetrics and Gynecology
Postgraduate Training Years	4 Years
Cultural Background	Declined to Disclose
Foreign Language Proficiency	Persian (Farsi)
Gender	Male

Public Record Actions

Administrative Disciplinary Actions	Found (1)
Court Order	None found
Misdemeanor Conviction	None found
Probationary License	None found

Felony Conviction	None found
Malpractice Judgment	None found
Hospital Disciplinary Action	None found
License Issued with Public Letter of Reprimand (Non-Disciplinary)	None found
Administrative Citation Issued	None found
Administrative Action Taken by Other State or Federal Government	Found (1)
Arbitration Award	None found
Malpractice Settlements	None found

Previous Record Next Record Search Results New Search Criteria Print

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License Details - Public Record Actions - Administrative Action Taken by Other State or Federal Government

Press "Back" to return to the previous screen.

Name:	GOHARI, ABOLGHASSEM MASUD
License:	C 50604
Jurisdiction:	MARYLAND BOARD OF PHYSICIANS
Description of Action:	MARYLAND MEDICAL LICENSE REPRIMANDED, PLACED ON A MINIMUM OF ONE YEAR PROBATION AND ASSESSED A FINE, EFFECTIVE 01/07/14 PROBATION TERMINATED.
Date of Action:	12/19/2012
Document URL:	http://www2.mbc.ca.gov/BreezePDL/default.aspx?licenseType=C&licenseNumber=50604&name=GOHARI, ABOLGHASSEM MASUD

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