



BOARD OF MEDICAL QUALITY ASSURANCE

1430 HOWE AVENUE, SACRAMENTO, CA 95826

TELEPHONE:

Applications and Examinations (916) 920-6411

RECEIVED
SACRAMENTO
BOARD OF MEDICAL
QUALITY ASSURANCE



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

CLASS G

AUG 14 8 19 AM '81
152247 6.55
\$204.00
150720

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

1. NAME: Last First Middle Maiden ROTHMAN STEPHEN L. GABRIEL				2. Telephone No.	
3. List other names, if any, you have used:					
4. Ad. 9514 OAKMORE RD., LOS ANGELES, CA 90035		City Los Angeles		State CA Zip Code 90035	
5. Name you wish on License: Stephen L. Gabriel Rothman				Birthdate: (Month - Day - Year)	
6. Premedical Education: Name of College or University YESHIVA College				Location NYC	
Period of attendance: From: 1957 To: 1963		Check premed courses successfully completed: <input checked="" type="checkbox"/> Chemistry <input type="checkbox"/> Physics <input type="checkbox"/> Biology or Zoology			
7. Medical School:					
Year	Name of Institution	Location	From	To	
1st	Albert Einstein Col of Med	Bronx NY	Sept 1963	June 1967	
2nd	"	"	June 1964	Oct	
3rd	"	"	Sept 1965	June 1967	
4th	"	"	Sept 1966	June 1967	
5th					
6th					
8. Doctor of Medicine Degree granted by: Albert Einstein Coll. of Med			Date June 1967	For office use only School Code: NY046	
9. 1st Year Postgraduate Training (Internship):					
Location Mount Sinai Hospital NYC		Type of Service Int. Med	From July 1967	To June 1968	
10. List all States in which you have been licensed to practice medicine: Corn Florida					
11. Has any disciplinary action ever been taken regarding any license which you now hold or ever held? If Yes, indicate below:					
State	Date	Charge	Disposition		
12. Have you ever been denied a license to practice medicine in any State or Country? If Yes, indicate below:					
State or Country	Date of Denial	Reason for Denial			
13. Are you now or have you ever been addicted to narcotic drugs?					

14. 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/narcotics, or to drug addiction?

15. Have you ever been convicted of, or pled 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.

18. Have you ever voluntarily surrendered your license to practice in another state?



Applicant: Please complete the following:

Height: ___ Ft. ___ In. Weight: ___ Lbs.

Hair color: ___ Eye color: ___

Identifying marks: _____

NOTE: The information on this application is required and maintained pursuant to Section 2312 of the Business and Professions Code. 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. Applicants have the right to review their applications subject to the provisions of the California Public Records Act.

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

"I hereby certify (or declare), under penalty of perjury, under the laws of the State of California, 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 Steve Nolan Browman

Date June 22, 1982

Subscribed and sworn to before me this 22nd day of June 1982



Signature of Notary Kathryn L. Watson
 Kathryn L. Watson
 Address 400 No. Roxbury Dr.
Beverly Hills, Ca 90210

My commission expires: April 1, 1983

STATE DEPARTMENT OF CONSUMER AFFAIRS
 INTERNET CASHIERING SYSTEM
 MEDICAL BOARD OF CALIFORNIA
 SUPPLEMENTAL INFORMATION REPORT
 From Date: 11/07/2012 To Date: 11/07/2012

ATRISUPPINF

21-MAR-16 11:10:45

Person Id : 594620

Name : Rothman, Stephen

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. NO

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. 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.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 : 594620

8

(DO NOT DETACH)

Medical Board of California – Physician's and Surgeon's Initial Renewal

1-76626/820.00

11/13/14

B3

LICENSEE NAME
ROTHMAN, STEPHEN L

LICENSE NO.
G46280

EXPIRATION DATE
01/31/15

AMOUNT DUE NOW
\$820.00

AMOUNT DUE IF POSTMARKED AFTER MARCH 02, 2015
\$898.00

LICENSEE MUST CHECK CORRECT BOXES

"H" Completed Continuing Education

"E" Change of Address (fill in reverse side)

"I" Conviction Disclosure – Yes

"J" Conviction Disclosure – No

"F" Family Physician Training Program (\$25)

"G" Financial Interest Statement

"D" SIGNATURE REQUIRED

I declare under penalty of perjury under the laws of the State of California that all statements, answers, and representations on this form, including supplementary attached hereto, are true, complete and accurate.

Signature *Step ROTHMAN* Date 11/27/14

ENTER YOUR PHONE NUMBER FOR REFERENCE:

____ - ____ - [] ____

63010700000700006000462804010131150008200000089800

CHANGE OF MAILING ADDRESS

ROTHMAN, STEPHEN L

G46280

Street Address (this address is public information except when a PO Box is used for the public address of record; this address then becomes confidential)

City _____ State _____ Zip _____ - _____

PO Box (if used, must provide a confidential physical street address, above)

City _____ State _____ Zip _____ - _____