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

DEPARTMENT OF Consumer Affairs

MEDICAL BOARD OF CALIFORNIA

1426 HOWE AVENUE, SUITE 54, SACRAMENTO, CA 95825-3236
(916) 920-6411

RECEIVED BOARD OF MEDICAL QUALITY ASSURANCE 91 FEB 26 PM 3:16 DIVISION OF LICENSING

RECEIVED SACRAMENTO MEDICAL BOARD FEB 22

423.00

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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.**

BMQA USE ONLY

1. Name: Last: CABEBE First: ABRAHAM Middle: CABICO

2. Other names you have used (include maiden name): NONE

3. Social Security Number
See disclosure statement on L1C

4. Address: Number and Street/Rural Route (include apartment number, if any): 984 JUNESONG WAY
City: SAN JOSE State: CA ZIP Code: 95133 Country: U.S.A.

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
If you are a Foreign Medical Graduate you must provide an original Certificate of Naturalization, Declaration of Intent to become a U.S. citizen or a full unrestricted license to practice medicine in a state or country.

9. Have you ever filed an application for examination or licensure in California? ☑ Yes ☐ No
If YES, give date of previous application: APRIL 14, 1983

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)	To (Mo/Yr)
ATENEO DE DAVAO COLLEGE	DAVAO CITY, PHILIPPINES	JUNE, 1971	APRIL, 1973
UNIVERSITY OF THE EAST	MANILA, PHILIPPINES	JUNE, 1973	MARCH, 1976

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

Course	Yes	No	Name of College or University
Chemistry	✓		ATENEO DE DAVAO COLLEGE AND UNIVERSITY OF THE EAST
Physics	✓		ATENEO DE DAVAO COLLEGE - DAVAO CITY, PHILIPPINES
Biology or Zoology	✓		UNIVERSITY OF THE EAST - MANILA, PHILIPPINES

11. List name and address of all schools where professional medical instruction was received. Submit an original Certificate of Medical Education (Form L2) and official transcripts from each school attended.

Name	Address	Place Where Instruction Received	Period of Attendance From (Mo/Yr)	To (Mo/Yr)
UNIVERSITY OF THE EAST MEDICAL CENTER	QUEZON CITY, PHILIPPINES	QUEZON CITY, PHILIPPINES	JUNE, 1976	MARCH, 1980

12. Doctor of Medicine Degree granted by: (submit original medical diploma and a photocopy; Note, a U.S. graduate may, in lieu of the original, submit an official certified photocopy that has the school seal affixed on the signature of the registrar certifying authenticity.)

Name of Medical School	Address of Medical School	Exact Date of Issuance	School Code
UNIVERSITY OF THE EAST RAMON MAGSAYSAY MEMORIAL MEDICAL CENTER	QUEZON CITY, PHILIPPINES	APRIL 16, 1980	

2/7/91

PERSONAL DATA | NON-MEDICAL EDUCATION | MEDICAL EDUCATION | CME TRANS

1A

BMQA USE ONLY

WRITTEN EXAMINATION

13. Have you taken any of the following written examinations: National Boards, other State Boards, FLEX, ECFMG Certification?

☑ Yes ☐ No

If YES, list name, location, date and result of examination. Submit certification of scores from each examination agency.

Name	Location	Date	Result
FLEX	CALIFORNIA	DEC., 1983	
ECFMG	SAN FRANCISCO, CALIFORNIA	JULY 21, 1982	

POSTGRADUATE TRAINING

14. Have you satisfactorily completed at least one year of 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.

Name	Address	Type of Service	Period of Attendance From (Mo/Yr)	Period of Attendance To (Mo/Yr)

LICENSE DATA

14A Have you ever withdrawn from or been suspended, dismissed or expelled from a medical school or postgraduate training program? If yes, please explain on a separate sheet of paper.

Yes No

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.

State or Country	License Number	Date of Issuance	Dates of Practice in Issuing Agency's Jurisdiction From (Mo/Yr)	To (Mo/Yr)
PHILIPPINES	52608	FEBRUARY 8, 1982	N/A	

LGS CE

16. Has any disciplinary action ever been filed or 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.

If yes, give details below:

Yes No

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? You must also list any **pending** actions or accusations. 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? 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

YOU ARE REQUIRED TO LIST ANY CONVICTION THAT HAS BEEN SET ASIDE AND DISMISSED UNDER SECTION 1203.4 OF THE PENAL CODE OR UNDER ANY OTHER PROVISION OF LAW. A SEPARATE LETTER EXPLAINING THE DETAILS OF THE OFFENSE IS ALSO REQUIRED.

If yes, give details below:

Violation and Location	Date	Penalty or Disposition

"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."

L1(

FIC

3½" x 5" Black and White

TOP BOTTOM

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)

COUNTY OF Santa Clara)

ABRAHAM C. CABEBE 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, Medical Board of California, 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 their file.

[signature]

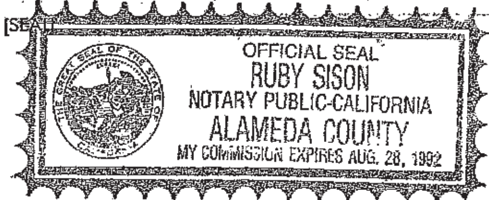
Signature of applicant in FULL (Do not use INITIALS ONLY)

Signed and sworn to before me this 20th day of February 1991

Signature of Notary Public Ruby Sison

Address 2528 Berryessa Rd. San Jose, Ca. 95132

[SEAL]



My commission expires August 28, 1992

L1D

19. Have you ever been convicted of, or pled no. ›ntendere to any violation of any law of any state, the United States, or a foreign country? If YES, explain below. ___ Yes ___ No

____

____

____

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.

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 ________; weight ________ lbs.

marks ___ ________

____

____

____

____

STATE OF CALIFORNIA
COUNTY OF SANTA CLARA } ss.

ABRAHAM C. CABEBE being duly sworn, says __he is the person referred to in the foregoing application for admission to examination for a physician's 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 are true and correct under penalty of perjury under the laws of the State of California.

[signature]
Signature of applicant IN FULL (Do not use INITIALS ONLY)

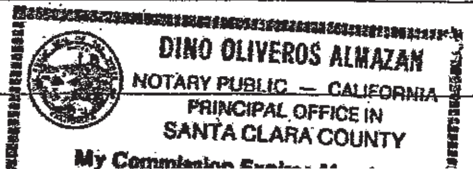
Signed and sworn to before me this 10th day of April, 1983

Dino Oliveros Almazan
Notary Public

545 Scottsville Ct San Jose CA 95133
Address

[SEAL]

My commission expires



STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY PETE WILSON, Govern

MEDICAL BOARD OF CALIFORNIA

1436 HOWE AVENUE, SACRAMENTO, CALIFORNIA 95825-3236

(916) 920-6411

APPLICATION UPDATE FOR 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 including photographs (See Form L7). Please type or print neatly. When space provided is insufficient, attached additional sheets of paper.

MBC USE ONLY

1. Name — Last: CABEBE — First: ABRAHAM — Middle: CABICO

PERSONAL DATA

2. Other names you have used: NONE

003405

3. Address: 984 JUNESONG WAY SAN JOSE, CA 95133

4. Telephone Number: Home / Work

5. Social Security Number (See disclosure statement on reverse)

POSTGRADUATE TRAINING

6. 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 (Form L3) from each facility if this has not been provided previously.

Name	Address	Type of Service	Period of Attendance From (Mo/Yr)	Period of Attendance To (Mo/Yr)
KING/DREW MEDICAL CENTER	12021 S. WILMINGTON LOS ANGELES, CA 90059	EMERGENCY MEDICINE	AUGUST, 1991	NOV. 1992

LICENSE DATA

7. 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 if requested or if this has not been provided previously.

State or Country	License Number	Date of Issuance	Dates of Practice in Issuing Agency's Jurisdiction From (Mo/Yr)	To (Mo/Yr)
PHILIPPINES	52608	FEBRUARY 8, 1982	10-24-91	10-24-94

LGS CE

QUESTIONS 8 - 15 — For any positive response to these questions, applicant should provide, in addition to written explanations any documentation regarding the matter.

8. 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

9. 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

10. 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

11. Have you ever voluntarily surrendered a license to practice in the healing arts in another state? Yes No

12. 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

STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY — PETE WILSON, Governor

MEDICAL BOARD OF CALIFORNIA
1426 HOWE AVENUE
SACRAMENTO, CALIFORNIA 95825-3236

92 NOV 20 PM 2:28

Nov 20 11 46 AM '92

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. Do not complete if photograph of applicant is not attached on the reverse side. Also, please print or type information on the form.

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

Last Name Of Trainee: CABEBE — First Name: ABRAHAM — Middle Initial: C.

Current Address: 20501 ANZA AVENUE, APT.#31 — Phone Number: (

City: TORRANCE — State: CA — Zip Code: 90503

PART 2: *To be completed by 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. See reverse side of Form for definition of "satisfactory".

Name of Facility: King/Drew Medical Center

Address of Facility: 12021 S. Wilmington Avenue Los Angeles CA 90059

Name of Program Director: Eugene Hardin, M.D. — Phone Number: (213) 603-3466

Signature of Program Director: [signature] — Date Signed: 11/3/92

List Categorical Specialty Area of Training Completed by Trainee: Emergence Medicine — Date Training Commenced: 8/26/91 — Date Training Completed: 11/25/92

If the training was rotating or transitional, list in the space provided below, the specific rotations and the number of weeks spent in each:

Rotation	Duration
Pediatrics	1 mo
Internal Medicine	3 mos
Emergency Medicine	2 mos
Neurology	1 mo
Neurosurgery ICU	1 mo
Neurosurgery	7 mos

Note: To qualify for licensure in California, applicants who are graduates of a foreign medical school must complete at least four months of postgraduate training in general medicine as part of the one-year requirement. Applicants who are graduates of a U.S. or Canadian medical school, who have not completed the one-year of postgraduate training required for licensure by July 1, 1990, must also complete four-months of training in general medicine as part of the one year required for licensure. The general medicine requirement may be satisfied by actual clinical practice where the applicant has direct patient care responsibilities in any particular specialty or sub-specialty area for at least four months. If the general medicine requirement is satisfied by training in a specialty area other than family practice, internal medicine, surgery, pediatrics or obstetrics and gynecology, the Program Director must submit a description of the type of training in sufficient detail to allow the Division of Licensing to make a determination regarding its acceptability.

(OVER)

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STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY — EDMUND G. BROWN JR., *Governor*

BOARD OF MEDICAL QUALITY ASSURANCE
1430 HOWE AVENUE, SACRAMENTO, CALIFORNIA 95825
Applications and Examinations (916) 920-6411

PLEASE FORWARD TO YOUR MEDICAL SCHOOL

CERTIFICATE OF MEDICAL EDUCATION

THIS CERTIFIES THAT ABRAHAM CABEBE (FULL NAME OF APPLICANT)

of 463 Plaza Isabelo delos Reyes, Samp, Mla. (ADDRESS WHEN ENROLLED) enrolled in UE RM Memorial Medical Center (NAME OF MEDICAL SCHOOL (COLLEGE))

Aurora Blvd., Quezon City, Philippines (LOCATION) on the 14th day of June (MONTH) 19 76.

and was granted the following credits on enrollment:

entered as freshman (SPECIFY WHETHER ENTERED FRESHMAN OR WITH ADVANCED CREDITS)

based upon the following credentials: transcript of records from U iversity of the East, Mla. (GIVE A TRANSCRIPT OF PREMED. EDUCATION OR ADVANCED CREDIT ABOVE OR ON AN ATTACHED PAPER)

The undersigned further certifies* that the records of this institution show that he attended *in this institution*†

4 years (SPECIFY NUMBER) courses of lectures of 10/12* (SPECIFY NUMBER OF WEEKS) months each, completing the following schedule totaling at least 4,000 hours in the subjects required by Article 4, Section 2089 of the California Business and Professions Code, relating to the practice of medicine, as set forth hereunder, and that he was granted the degree {XXXXXXXX / DOCTOR} of Medicine‡ by the above-mentioned Medical (College) on the 16th day of April 1980.

*4th year is one whole year of full time totating clinical clerkship in the ff.depts:

Med-2½mos.
Sur-2 "
Ped-2 "
Ob-Gy-2 "
EENT-1mo
Neuro-1 "
Comm. Med-2½mos.
12mos.

Anatomy -408	Dermatology*	Preventive medicine, including nutrition-	Otolaryngology
Embryology	Physical medicine*	Radiology, including radiation safety**	Obstetrics and gynecology -
Histology	Therapeutics*	Medicine-	Human sexuality as defined in Section 2090
Neuroanatomy	Tropical medicine*	Pediatrics -	Child abuse detection and treatment
Physiology	Surgery, including orthopedic surgery-	Psychiatry-	Geriatric medicine
Biochemistry -	Urology*	Neurology-	others-
Pathology, bacteriology and immunology -	Ophthalmology - Otolaryngolc	Anesthesia**	
	Pharmacology -		

* Included in Medicine
** Included in Surgery

Signed and the College seal affixed this 2nd day of March 19 83

[AFFIX SEAL HERE]

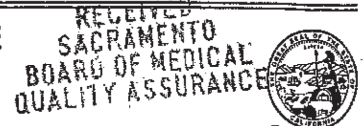
By ROSARIO M. CERDENA, M.D. (signature)
SECRETARY

* If premedical work has been completed state the time devoted thereto and institution where completed.
† Each medical school attended must complete one of these forms covering period of attendance.
‡ strike out the degree NOT CONFERRED.

07A-33 (Rev. 2/81)

envelope

STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY — 02304 — EDMUND G. BROWN JR., Governor



BOARD OF MEDICAL QUALITY ASSURANCE
1430 HOWE AVENUE, SACRAMENTO, CALIFORNIA 95825
APPLICATIONS AND EXAMINATIONS (916) 920-6411

RECEIVED SACRAMENTO BOARD OF MEDICAL QUALITY ASSURANCE
APR 14 12 08 PM '83

APPLICATION FOR A WRITTEN EXAMINATION OR FOR AN ORAL AND CLINICAL EXAMINATION

150405
30850

For Graduates of Foreign Medical Schools Applying Under Sections 2101 and 2102 of the California Business and Professions Code

ANSWER ALL QUESTIONS

1. Name: (Please print) First: ABRAHAM Middle: CABICO Last: CABEBE
2. Other Names you have used: NONE
3. Address: No. and Street: 984 JUNESONG WAY City: SAN JOSE State: CALIFORNIA Zip Code: 95133
4. Date of Birth: Mo./Day/Yr Citizen of: (Country) Telephone No.
5. Send California certificate, if issued, to: No. and Street: 984 Junesong way City: San Jose State: California Zip Code: 95133
6. Have you ever taken the Federal Licensing Examination (Flex)? NO Where? When?
7. Premedical Education—College/University

Name of College	Location	Period of Attendance From (mo./yr.)	To (mo./yr.)
UNIVERSITY OF THE EAST	MANILA, PHILIPPINES	JUNE, 1973	MARCH, 1976

8. Premed Courses (Required)

	Yes	No	College	Location	From (mo./yr.)	To (mo./yr.)
Chemistry	X		University of the East	Philippines	June, 1973	March, '75
Physics	X		Ateneo de Davao College	Philippines	June, 1971	March, '73
Biology	X		University of the East	Philippines	June, 1973	March, '76

9. Medical Education

	Course	Medical College	Location	From (mo./yr.)	To (mo./yr.)
1st	Medicine	* UERMMMC	PHILIPPINES	June, 1976	March, '77
2nd	Medicine	UERMMMC	PHILIPPINES	June, 1977	March, '78
3rd	Medicine	UERMMMC	PHILIPPINES	June, 1978	March, '79
4th	Medicine	UERMMMC	PHILIPPINES	April, 1979	March, '80
5th					
6th					

PHI 09 * UNIVERSITY OF THE EAST RAMON MAGSAYSAY MEMORIAL MEDICAL CENTER

10. Doctor of Medicine Degree Granted by: ATTACH ORIGINAL MEDICAL DEGREE

Name of Institution	Location	Exact Date of Issuance
* ~~UERMMMC~~ University of	QUEZON CITY, PHILIPPINES	APRIL 16, 1980

11. Internship in United States Hosp.

Name of Hospital	Location	From (mo./yr.)	To (mo./yr.)
NONE			

12. Postgraduate Instruction:

Name of Institution	Location	From (mo./yr.)	To (mo./yr.)
Brokenshire Memorial Hospital	Davao City, Philippines	May, 1980	April, 1981

13. Have you been licensed to practice medicine in any state or country? X Yes ___ No
If YES, where?

PHILIPPINES

14. Have you ever had a medical license suspended or revoked? ___ Yes ___ No
If YES, give details

15. Have you been denied a license to practice medicine by any state or country? ___ Yes ___ No
If YES, give details

16. Are you now, or have you ever been, addicted to narcotic drugs? ___ Yes ___ No

17. Have you ever been convicted of, or pled no contest to drug addiction? ___ Yes ___ No
If YES, explain below.

Charge	Date	Disposition

18. Have you ever been convicted of, or pled no contest to a violation of a federal, state or local law relating to the manufacture, distribution, or dispensing of controlled substances (narcotics)? ___ Yes ___ No
If YES, explain.

PART 3: *To be completed by the D[illegible]r of Medical Education and affixed with the offici[illegible] [illegible]acility seal.*

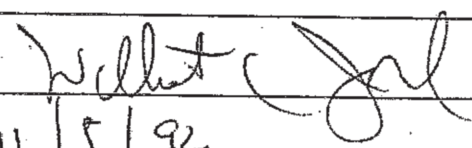
Name of Director of Medical Education:	Wilbert C. Jordan, M.D.	Phone Number:	(310) 603-8166
Facility Name:	King/Drew Medical Center	Date Form Completed:	Nov. 5, 1992
Facility Address:	12021 S. Wilmington Avenue		
City: Los Angeles	State: CA	Zip Code:	90059

The individual signing this form is formally certifying and documenting, under penalty of perjury, that the physician received instruction appropriate for the particular postgraduate level and that they satisfactorily completed the training program in accordance with the accepted standards and the criteria defined as equating to "satisfactory" performance as described below. In cases where the Director of Medical Education is certifying the completion of the minimum one-year of training required for licensure, he or she will personally be attesting to the fact that the physician/ trainee has acquired the skill and qualifications necessary to safely assume the unrestricted practice of medicine in this state.

Definition of "Satisfactory": The physician performed at an adequate level based on evidence of satisfactory progressive scholarship and professional growth including demonstrated ability to assume graded and increasing responsibility for patient care.

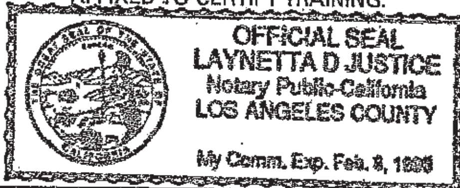
I hereby declare under penalty of perjury under the laws of the State of California that the above statements are true and correct and that the training program is approved by the ACGME or the CCME to offer the type and level of training completed by the applicant and that the applicant was trained in an approved ACGME or CCME program position.

Signature of Director of Medical Education:



Date Signed: 11/5/92

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



11/17/92

L3B

MBC USE ONLY

GENERAL DATA

13. 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

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, or to drug addiction?
☐ Yes ☒ No

15. Have you ever been convicted of, or pled nolo contendere to any offense, misdeameanor 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

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."

TOP

BOTTOM

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 OCTOBER, 19 92

my age then being 38, years;

color of hair BLACK;

color of eyes BROWN;

height 5 ft 5 in.;

weight 140 lbs.;

identifying marks MOLES OVER BRIDGE OF NOSE

STATE OF ______)
COUNTY OF ______)

ABRAHAM C. CABEBE 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.

[signature]
Signature of applicant in FULL (Do not use INITIALS ONLY)

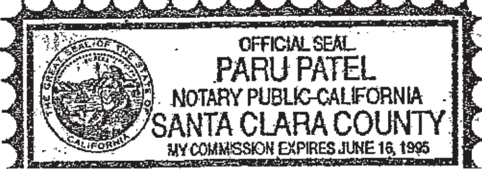
Signed and sworn to before me this 7 day of NOVEMBER, 19 92

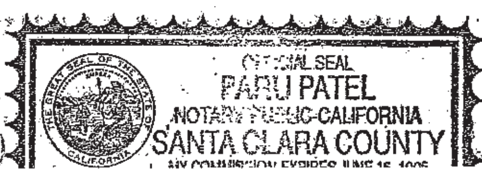
[SEAL]

Signature of Notary Public [signature]

Address 2528, BERRYESSA RD, S.J. CA 95132

My commission expires JUNE 16, 1995





18B

RETURN THE ENTIRE FORM TO THE RETURN ADDRESS ON THE BACK. MAKE A PHOTOCOPY FOR YOUR RECORDS.

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? PLEASE READ INSTRUCTIONS BEFORE ANSWERING I.☐ YES J.☑ NO

License Renewal Application
Physician and Surgeon

F.☐ YES, I WISH TO CONTRIBUTE $25 FOR THE FAMILY PHYSICIAN TRAINING 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: [signature] DATE: 09-07-2012

LICENSE NO.	EXPIRES	AMOUNT DUE NOW	DELINQ FEE IF POSTMARKED AFTER 11/30/12
A 51742	10/31/12	$808.00	$886.00
	VOLUNTARY FEE =	$	$
	TOTAL ENCLOSED =	$ 808.00	$

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

STREET ____________________

CITY ____________ STATE ______ ZIP ______

PHONE NUMBER (   )

ACTIVE ABRAHAM CABICO CABEBE
2160 COMMODORE DRIVE
SAN JOSE CA 95133

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] Signature required here

OVER

630101000001000020005174250110311200080800000886OO

09122012 10003195 10010032

G. Financial Interest Statement

Please print or type the name(s) and address(es) of each health-related facility in which you or your immediate family have a financial interest. If more space is needed, please attach additional listings. If you have no interests to declare, please write "none" in the area below and sign your name on the front of this document at G.

Health-Related Facility Name	Address
None	

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
PO BOX 942520
SACRAMENTO CA 94258-0520

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

LICENSEE NAME	LICENSE NO.	EXPIRATION DATE	AMOUNT DUE NOW	AMOUNT DUE IF POSTMARKED AFTER NOVEMBER 30, 2014
CABEBE, ABRAHAM C	A51742	10/31/14	$820.00	$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 ________ Date 10-17-2014

ENTER YOUR PHONE NUMBER FOR REFERENCE:

630101000001000020005174250110311400082000000089800

CHANGE OF MAILING ADDRESS **CABEBE, ABRAHAM C** **A51742**

10292014 20001457 20010015

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