



BOARD OF MEDICAL QUALITY ASSURANCE

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



APPLICATION FOR PHYSICIAN AND SURGEON'S EXAMINATION AND LICENSURE

Aug 20 12 53 PM '87
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127.50
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002400
306.50
1.00
015

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.

1. Name: Last First Middle
ANGULIANO, FRANCISCO ERNESTO

2. Other names you have used:
NONE

3. Address: Number and Street/Rural Route (include apartment number, if any)
500 W. Hospital Road, Space #15
City State ZIP Code Country
French Camp, CA 95231 U.S.A.

BMQA USE ONLY

PERSONAL DATA

4. Telephone Number: Home Work 5. Date of Birth: Mo/Day/Yr

6. Sex: Female Male
7. Are you a U.S. citizen? Yes No
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.

8. Have you ever filed an application in California? Yes No
If YES, give date of previous application:

9. 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)
U.C. San Diego	La Jolla, CA 92093	9/73	6/76
San Diego Comm. College	3375 Camino del Rio South San Diego, CA 92108	9/77	6/78
U.C. San Diego	La Jolla, CA 92093	1/79	6/82

NON-MEDICAL EDUCATION

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

Course	Yes	No	Name of College or University
Chemistry	X		U.C. San Diego
Physics	X		U.C. San Diego
Biology	X		U.C. San Diego
Zoology	X		U.C. San Diego (equivalent)



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BMQA USE ONLY

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)	To (Mo/Yr)
U.C. Irvine	Irvine, CA	U.C. Irvine	9/82	6/86

MEDICAL EDUCATION

CME TRANS

<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

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

Name of Medical School Address of Medical School Exact Date of Issuance

Univ of CA at Irvine Cal Coll of med

06-14-86

CA015 School Code

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
MCAT	San Diego St. Univ.	3/81	
NBME Part I	U.C. Irvine	6/84	
NBME Part II	U.C. Irvine	9/85	
NBME Part III	U.C. San Francisco	3/87	

<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>
<input checked="" type="checkbox"/>

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 from each facility.

Name	Address	Type of Service	Period of Attendance	
			From (Mo/Yr)	To (Mo/Yr)
San Joaquin Gen. H.	French Camp, CA	Internal Medicine	6/86	6/87

POSTGRADUATE TRAINING

<input checked="" type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>

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)	To (Mo/Yr)

LGS CE

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

ALL

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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:

Table with 4 columns: State, Date, Charge, Disposition. Includes handwritten entries.

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?

If yes, give details below:

Table with 3 columns: State or Country, Date of Denial, Reason for Denial. Includes handwritten entries.

18. 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.

19. Have you ever had staff privileges in a hospital denied, suspended or revoked, or resigned from a medical staff in lieu of disciplinary action?

20. Are you now, or were you in the past, addicted to controlled substances, such as narcotics or alcohol?

Yes No

21. 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?

If yes, give details below:

Table with 3 columns: Violation and Location, Date, Penalty or Disposition. Includes handwritten entries.

22. 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:

Table with 3 columns: Violation and Location, Date, Penalty or Disposition. Includes handwritten entries.

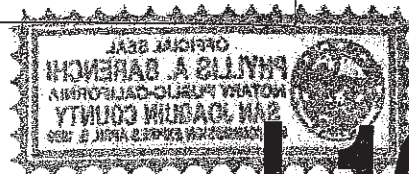
You are required to list any conviction that has been set aside and dismissed under Section 1203.4 Penal Code or under any other provision of law.

LICENSE DATA (continued)

Vertical column of checkboxes for license data.

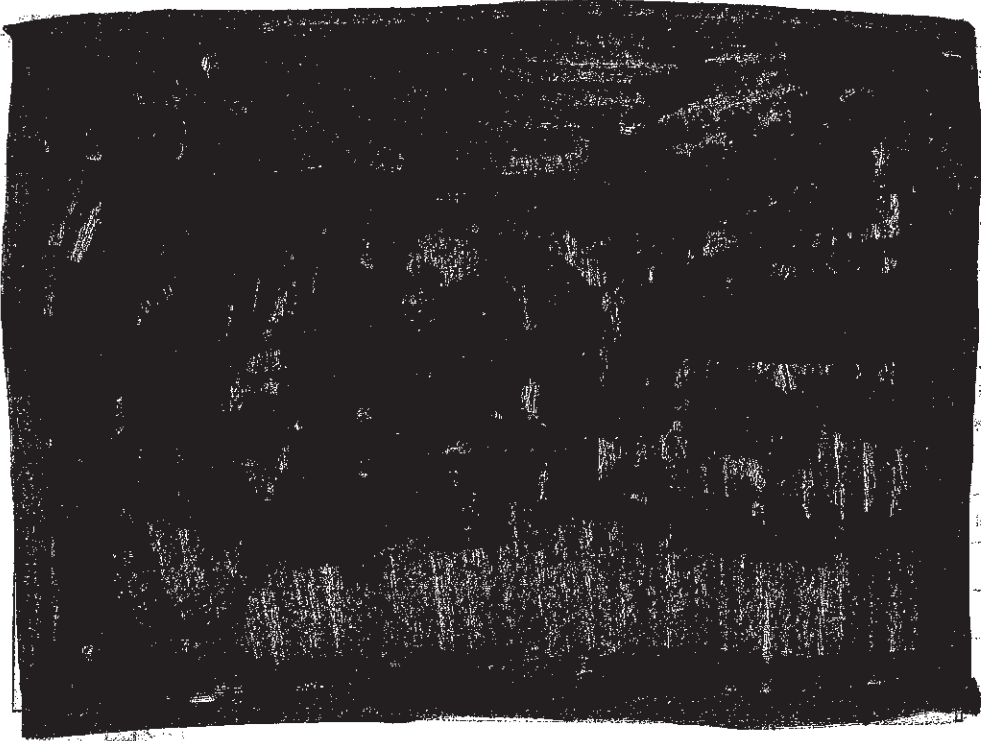
GENERAL DATA

Vertical column of checkboxes for general data.



L1C

Handwritten text '01 J' at the bottom left.



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 June 22, 1987, my age then being 33 years; color of hair Black; color of eyes Brown; height 5 ft. 5 in. 10; weight 175 lbs.; identifying marks NONE

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. 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 San Joaquin

Francisco E. Anguiano, M.D. 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, 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, 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.

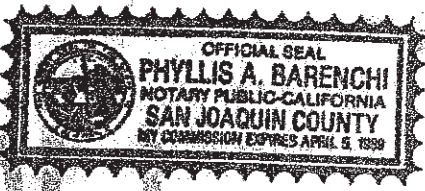
Francisco Ernesto Anguiano
 Signature of applicant in FULL (Do not use INITIALS ONLY)

Signed and sworn to before me this 17th day of July, 1987.

Signature of Notary Public Phyllis A. Barenchi

Address 500 W. Hospital Road

My commission expires April 5, 1989



L1D



BOARD OF MEDICAL QUALITY ASSURANCE

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



CERTIFICATE OF MEDICAL EDUCATION

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

This certifies that FRANCISCO ERNESTO ANGLIANO
of 4412 VERANO PL IRVINE, CA enrolled in University of California, Irvine California
College of Medicine, Irvine, CA 92717 on the 6 day of September 19 82

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 school.*

MEDICAL SCHOOL TOTAL CREDITS DATES

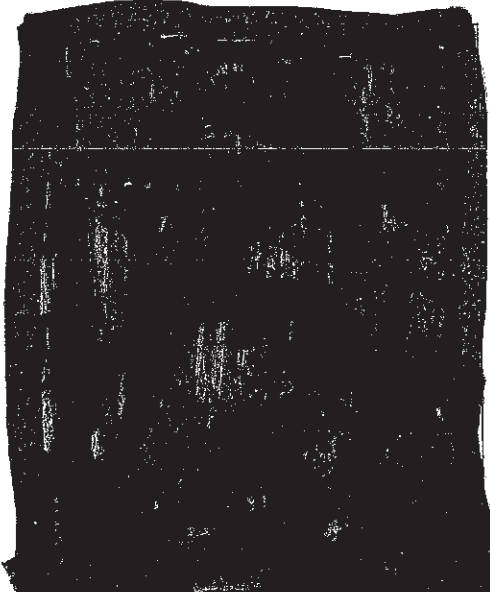
The undersigned further certifies that the records of this institution show that he attended in this institution approx. 35 courses of resident instruction of 12 weeks each, completing at least 4,000 hours, of which at least 80 percent actual attendance is required, in the subjects set forth hereunder (Business and Professions Code Section 2089), and that

he was granted the degree Bachelor/Doctor of Medicine by
he withdrew from
the above mentioned medical school on the 14 day of June 19 86

- Anatomy
Otolaryngology
Obstetrics and Gynecology
Radiology, including Radiation Safety
Tropical Medicine
Physiology
Biochemistry
Pathology, Bacteriology and Immunology
Ophthalmology

- Dermatology
Embryology
Histology
Human Sexuality as defined in Section 2090
Medicine
Surgery, including Orthopedic Surgery
Urology
Psychiatry
Neurology

- Preventive medicine, including Nutrition
Physical Medicine
Therapeutics
Neuroanatomy
Child Abuse Detection and Treatment
Geriatric Medicine
Pediatrics
Pharmacology
Anesthesia



Signed and the college seal affixed this 20 day of July, 19 87

BY Laurel Bartenstein, Deputy Registrar PRESIDENT, SECRETARY, DEAN

Medical School Seal MUST Be Imprinted Partially on the Photograph.

TRANSCRIPTS OF PREMEDICAL EDUCATION, ADVANCED CREDITS, AND MEDICAL SCHOOL CREDITS MUST BE SUPPLIED WITH THIS CERTIFICATE

* 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.

L2

STATE DEPARTMENT OF CONSUMER AFFAIRS
INTERNET CASHIERING SYSTEM
MEDICAL BOARD OF CALIFORNIA
SUPPLEMENTAL INFORMATION REPORT
From Date: 04/05/2013 To Date: 04/05/2013

ATRISUPPINF

23-MAR-16 08:12:47

Person Id : 605091

Name : Anguiano,Francisco

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. 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 : 605091

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Application Summary

2/18/15 10:04 AM

Page 1 of 3

License Type: **Physician and Surgeon G**
License Number: **61584**
File Number:
Application: **Physician's and Surgeon's Renewal**
Application Number:
Application Date: **02/18/2015 (mm/dd/yyyy)**

Personal Detail

First Name: **FRANCISCO**
Middle Name: **ERNESTO**
Last Name: **ANGUIANO**
Birthdate: ****/**/******
Gender: **Male**

Addresses

License Related Addresses

Address of Record (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



1424282672905

Attachments**Physician Survey**

Are you retired?	No
Activities in Medicine	Administration - None Other - None Patient Care - 40+ Hours Research - None Teaching - None Telemedicine - None
Patient Care Practice Location	Zip: 91911 County: SAN DIEGO
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	Obstetrics and Gynecology - Primary Obstetrics and Gynecology - Secondary
Board Certifications	American Board of Obstetrics and Gynecology - Obstetrics and Gynecology
Cultural Background	Mexican
Foreign Language Proficiency	Spanish
Web Site Profile	Cultural Background - Yes Foreign Language Proficiency - Yes
E-mail:	Gender - Yes feainc@cox.net

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

1424282672905

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:



Department of Consumer Affairs

RECEIPT

1035920

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

Name: ANGUIANO, FRANCISCO ERNESTO

Transaction Date: 02/18/2015 10:04

Application Number:

Complaint Number:

License Type: 8002

License Number: 61584

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.



Department of Consumer Affairs



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License Details - Public Record Actions - Administrative Citation Issued

Press "Back" to return to the previous screen.

Name:	ANGUIANO, FRANCISCO ERNESTO
License:	G 61584
Citation Number:	102011218725
Cause for Citation:	DURING THE CARE AND TREATMENT OF ONE PATIENT, YOU FAILED TO DOCUMENT A COMPLETE PHYSICAL EXAMINATION.
Fine Amount:	350.00
Date Resolved:	07/15/2013
Date Citation Issued:	06/27/2013
Document URL:	http://www2.mbc.ca.gov/BreezePDL/default.aspx?licenseType=G&licenseNumber=61584&name=ANGUIANO, FRANCISCO ERNESTO

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**MEDICAL BOARD OF CALIFORNIA**

Citation and Fine Program

**CITATION ORDER**

June 27, 2013

Francisco Ernesto Anguiano, M.D.
765 Medical Center Ct. Ste. 209
Chula Vista, CA 91911

Citation Order No: 10-2011-218725

CITATION AGAINST: Francisco Ernesto Anguiano, M.D.
LICENSE NUMBER: G-61584
VIOLATION: ~~Section 2266 of the Business and Professions Code - Failure to~~
Maintain Adequate & Accurate Medical Records

An investigation or inquiry has been conducted by the Medical Board of California. As a result, A. Renee Threadgill issues this citation in her official capacity as Chief of Enforcement of the Medical Board of California (hereinafter referred to as the "Board").

Citation

An administrative citation is hereby issued to you in accordance with Business and Professions Code Section 125.9 for violation of Section 2266 of the Business and Professions Code - Failure to Maintain Adequate & Accurate Medical Records.

License

License G-61584 was issued to you on October 19, 1987 and expires May 31, 2015.

Cause for Citation

During the care and treatment of one patient (R.K.), you failed to document a complete physical examination.

Francisco Ernesto Anguiano, M.D.
June 27, 2013
Page Two

Fine


WITHIN THIRTY (30) DAYS OF RECEIPT OF THIS CITATION, YOU ARE REQUIRED TO PAY AN ADMINISTRATIVE FINE IN THE AMOUNT OF \$350.00 AS PROVIDED BY TITLE 16 OF THE CALIFORNIA CODE OF REGULATIONS SECTIONS 1364.10 AND 1364.11 FOR VIOLATION OF SECTION 2266 OF THE BUSINESS AND PROFESSIONS CODE - FAILURE TO MAINTAIN ADEQUATE & ACCURATE MEDICAL RECORDS.

Payment of the administrative fine should be sent, in the form of check or money order, made payable to the Medical Board of California, to the following address: **Medical Board of California, Citation and Fine Program, Attn: Marco Armas, P. O. Box 15588, Sacramento, CA 95852.**

~~If you appeal this citation, the days given for compliance will be held in abeyance only for the violation(s) you contest. The time to correct all uncontested violations must be adhered to as given.~~

If you fail to notify the Board within the allotted time that you intend to appeal the citation, it shall be deemed a final order and shall not be subject to further administrative review. Any questions or concerns should be directed to Marco Armas, Analyst, at (916) 263-2482.

FAILURE TO COMPLY WITH THIS CITATION WILL RESULT IN DISCIPLINARY ACTION AGAINST YOUR LICENSE.


A. Renee Threadgill
Chief of Enforcement
Medical Board of California

6/27/2013
DATE

Attachments: Section 125.9, Business and Professions Code
Section(s) 2266 of the Business and Professions Code
Sections 1364.10 - 1364.15, Title 16, California Code of Regulations
Appeal Process and Information Sheet
Request for Informal Conference