STATE OF CALIFORNIA – STATE AND CONSUMER SERVICES AGENCY — ARNOLD SCHWARZENEGGER, Governor

Consumer Affairs

MEDICAL BOARD OF CALIFORNIA

LICENSING PROGRAM
1426 Howe Avenue, Suite 54
Sacramento, CA 95825-3236
(916) 263-2382 FAX (916) 263-2487
www.caldocinfo.ca.gov

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MEDICAL BOARD OF CALIFORNIA
07 AUG 29 PM 12:32
LICENSING PROGRAM

INITIAL AND UPDATE APPLICATION FOR PHYSICIAN'S AND SURGEON'S LICENSE *OR* POSTGRADUATE TRAINING AUTHORIZATION LETTER

Application for (please check one): ☒ License ☐ PTAL - or - ☐ Update

1. NAME: Last	First	Middle	MBC Use Only
CHAC	RICK	T	

Other names you have used (include maiden name):	2. U.S. Social Security Number
	___-___-___
3. Place of Birth	4. Date of Birth
	- -

5. Gender: ☒ Male ☐ Female

6. Public/Mailing Address: 11234 ANDERSON ST R21005 CP
(Please note: this information is public)
(30 characters maximum per line, including spaces)

City	State/Province	Zip/Postal Code	Country
LOMA LINDA	CA	92354	US

7. Telephone Numbers: (include area code)	Home	Work	Cell

8. California Driver's License Number (optional):	10. Have you ever filed an Application for Physician's and Surgeon's License, or PTAL, in California? ☐ Yes ☒ No
9. E-mail Address (optional):	Previous license number, if any:

Personal Data ☐

MEDICAL EDUCATION

11. LIST EACH MEDICAL SCHOOL THAT YOU HAVE ATTENDED.

School Name	City, State/Province, Country	Dates of Attendance
THE UNIVERSITY OF ARIZONA COLLEGE OF MEDICINE	TUCSON, AZ, US	7/24/00 - 5/14/2005

L2 Transcript ☐ ☐ ☐ ☐ ☐ ☐

12. School of Graduation	Degree Awarded	Date of Graduation
UofA COLLEGE OF MEDICINE	DOCTOR OF MEDICINE	5/14/2005

Diploma ☐

EXAMINATIONS

13. LIST ALL OF THE FOLLOWING EXAMINATIONS YOU HAVE TAKEN: USMLE, FLEX, NBME, ECFMG, SPEX, STATE BOARDS and/or QME in Canada

Examination	Date	Result (Pass/Fail)
USMLE STEP 1	6/25/2003	
USMLE STEP 2 CK	4/8/2005	
USMLE STEP 2 CS	3/21/2005	
USMLE STEP 3	10/12/2007, 10/13/2007	

Exams ☐ ☐ ☐

00113 Cashiering Use Only 82907 9005 A2001 School Code

L1A

07A-100 (Rev. 12/05)

A "yes" response to Questions 14 through 38 requires a written explanation on a separate sheet of paper along with any supporting materials.

ACGME/RCPSC ACCREDITED POSTGRADUATE TRAINING

MBC Use Only

14. **Please list each ACGME/RCPSC accredited postgraduate training program in which you have participated. You must include each internship, residency and fellowship, whether or not the program was completed or credit granted.**

Postgraduate Training

Facility Name	Address	Specialty Area	Dates of Attendance
WASHINGTON HOSP. CTR.	110 IRVING ST. NW	OB/GYN WASHINGTON, DC 20009	7/1/05 - 5/24/06
PHOENIX INT. RESIDENCY OB GYN	2601 E. ROOSEVELT ST.	OB/GYN PHOENIX, AZ 85008	4/9/07 - 6/30/07
LOMA LINDA UNIV. MED CTR	11234 ANDERSON ST LOMA LINDA, CA 92354	OB/GYN	7/1/07 - PRESENT

POSTGRADUATE TRAINING: (These questions are to be answered by ALL applicants)

Did you ever take a leave of absence or break from your training?	YES	NO
Have you ever been terminated, dismissed or expelled from a program?	YES	NO
Have you ever resigned from a training program?	YES	NO
Were you ever placed on probation?	YES	NO
Were you ever disciplined or placed under investigation?	YES	NO
Were any incident reports ever filed by instructors?	YES	NO
Were any limitations or special requirements placed upon you for clinical performance, discipline, or for any other reason?	YES	NO
Have you ever had a postgraduate training program contract not be renewed or offered for a following year?	YES	NO

MEDICAL LICENSURE

15. **Please list all medical licenses (other than training licenses) that have ever been issued by any state or territory in the United States or Canadian province.**

License Data

Jurisdiction	License Number	Date of Issuance	Dates of Practice in that Jurisdiction

APPLICANT: RICK T. CHAC MD

DATE OF BIRTH:

L1B

ABMS CERTIFICATIONS

MBC Use Only ABMS

16. Are you currently certified by a Member Board of the American Board of Medical Specialties? YES ☐ NO ☒

Member Board	Expiration Date	Certificate Number

MALPRACTICE HISTORY

Malpractice

17. Has a claim or an action ever been filed against you for the practice of medicine which resulted in a malpractice settlement, judgment, or arbitration award of $30,000 or more? YES ☐ NO ☐

PRACTICE IMPAIRMENT OR LIMITATIONS

Limitations

18. Have you been enrolled in, required to enter into, or participated in any drug or alcohol recovery program or impaired practitioner program? YES ☐ NO ☐

19. Have you been treated for or had a recurrence of a diagnosed addictive disorder? YES ☐ NO ☐

20. Have you been diagnosed with an emotional, a mental, or behavioral disorder which impairs your ability to practice medicine safely? YES ☐ NO ☐

21. Have you ever been diagnosed with a neurological or other physical condition that would impair your ability to practice medicine safely? YES ☐ NO ☐

22. Do you have any other condition which in any way impairs or limits your ability to practice medicine safely? YES ☐ NO ☐

If you do receive ongoing treatment or participate in a monitoring program, the Board will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure.

CRIMINAL RECORD HISTORY

Criminal Record

23. Have you ever been convicted of, or pled guilty or nolo contendere to ANY offense in any state in the United States or foreign country?

This includes a citation, infraction, misdemeanor and/or felony, etc. If "YES" attach a list of each offense by arrest and conviction dates, violation, and court of jurisdiction (name and address). Matters in which you were diverted, deferred, pardoned, pled nolo contendere, or if the conviction was later expunged from the record of the court or set aside under Penal Code Section 1203.4 MUST be disclosed. If you are awaiting judgment and sentencing following entry of a plea or jury verdict, you MUST disclose the conviction; you are entitled to submit evidence that you have been rehabilitated. Serious traffic convictions such as reckless driving, driving under the influence of alcohol and/or drugs, hit and run, evading a peace officer, failure to appear, driving while the license is suspended or revoked MUST be reported. This list is not all-inclusive. If in doubt as to whether a conviction should be disclosed, it is better to disclose the conviction on the application.

For each conviction disclosed, you must submit with the application certified copies of the arresting agency report, certified copies of the court documents, and a descriptive explanation of the circumstances surrounding the conviction of disciplinary action (i.e., dates and location of incident and all circumstances surrounding the incident). This letter must accompany the application. If documents were purged by arresting agency and/or court, a letter of explanation from these agencies is required.

Applicants who answer "NO" to the question but have a previous conviction or plea, may have their application denied or license revoked for knowingly falsifying the application. YES ☐ NO ☐

APPLICANT: _____ **DATE OF BIRTH:** _____

L1C

CRIMINAL RECORD HISTORY (cont'd)

MBC Use Only
Criminal Record

24. Is any criminal action pending against you? YES NO

25. Are you required to register as a Sex Offender? YES NO

DISCIPLINARY HISTORY

Discipline

These questions refer to discipline by any U.S. military or public health service, state board or other governmental agency of any U.S. state, territory, Canadian province, or country.

26. Have you ever been denied a license to practice medicine? YES NO

27. Is any denial pending against you? YES NO

28. 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? YES NO

29. Have you ever had any license to practice medicine revoked, suspended, or placed on probation? YES NO

30. Have you ever had any license to practice medicine subjected to any action including but not limited to informal or confidential discipline, consent orders, letters of warning, letters of reprimand, or citation? YES NO

31. Have you ever had any license to practice medicine subjected to any other disciplinary action? YES NO

32. Is any disciplinary action pending against any of your licenses to practice medicine? YES NO

33. Have you ever had staff privileges in a hospital terminated, denied, suspended, limited, revoked, or not renewed? YES NO

34. Have you ever resigned from a medical staff in lieu of disciplinary or administrative action? YES NO

35. Is any disciplinary action pending against your hospital staff privileges? YES NO

36. Have you ever surrendered a license to practice medicine? YES NO

37. Have your DEA privileges ever been denied, suspended, restricted, or terminated? YES NO

38. Have you ever entered into any arrangement or plea or agreement in lieu of a federal prosecution for a drug violation regulated by the DEA? YES NO

Notice: All items in this application, except #8 and #9, are mandatory. 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 law enforcement agencies. You have the right to review your application subject to the provisions of the Information Practices Act. The Chief of the Licensing Program is the custodian of records.

The applicant, RICK T. CHAC, [redacted], being first duly sworn upon his/her
(PLEASE PRINT FULL NAME) (DATE OF BIRTH)
oath deposes and says: that I am the person herein named subscribing to this application; that I have read the complete application, know the full content thereof, and declare under penalty of perjury, that all of the information contained herein and evidence or other credentials submitted herewith are true and correct; that I am 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 I am aware and that I am 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 any 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 UNDERSTAND THAT FALSIFICATION OR MISREPRESENTATION OF ANY ITEM OR RESPONSE ON THIS APPLICATION OR ANY ATTACHMENT HERETO IS A SUFFICIENT BASIS FOR DENYING OR REVOKING A LICENSE. [RC] **(PLEASE INITIAL BOX)**

SIGNATURE OF APPLICANT: _____
(Please sign full name)

State of California

County of San Bernardino

Subscribed and sworn to (or affirmed) before me on

this 24 day of July, 20 07,

by Rick T. Chac ----------

~~personally known to me~~ or proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.

NOTARY SEAL
TERESA L. MEINKEN
Commission # 1643059
Notary Public - California
San Bernardino County
My Comm. Expires Mar 1, 2010

_____
SIGNATURE OF NOTARY PUBLIC

L1E

STATE OF CALIFORNIA – STATE AND CONSUMER SERVICES AGENCY — ARNOLD SCHWARZENEGGER, *Governor*

Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815
(800) 633-2322 (916) 263-2382 FAX (916) 263-2487
www.mbc.ca.gov

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MEDICAL BOARD OF CALIFORNIA
2008 AUG 29 PM 2:09

CERTIFICATE OF MEDICAL EDUCATION

MEDICAL SCHOOL: PLEASE COMPLETE THIS FORM IN THE ENGLISH LANGUAGE

This certifies that RICK T. CHAC (Full Name of Applicant) _____ (U.S. Social Security Number)

_____ (Date of Birth) enrolled in _____ (Name of Medical School)

located in TUCSON, AZ USA (State/Province Country) on 07/24/2000. (Enrollment Date)

The undersigned further certifies that the records of this institution show that the applicant attended in this institution 5 years of resident instruction, 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 Sections 2089,2089.5, 2089.7,2090, 2091.1,2091.2) and that the applicant

Anatomy	Embryology	Physical Medicine
Otolaryngology	Histology	Therapeutics
Obstetrics and Gynecology	Human Sexuality	Neuroanatomy
Radiology, including Radiation Safety	Medicine	Child Abuse Detection and Treatment
Tropical Medicine	Surgery, including Orthopedic Surgery	Geriatric Medicine
Physiology	Urology	Pediatrics
Biochemistry	Psychiatry	Pharmacology
Pathology, Bacteriology, and Immunology	Neurology	Anesthesia
Ophthalmology	Alcoholism and Chemical Dependency	Spousal Partner Abuse Detection & Treatment*
Dermatology	Preventative Medicine, including Nutrition	Family Medicine**
		Pain Management and End-of-Life-Care***

* ONLY applicable to medical students who enrolled in medical school on or after September 1, 1994.
** 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 June 1, 2000.

☑ was granted the degree of ~~Bachelor~~/Doctor of Medicine on the 14th day of MAY, 2005.

☐ withdrew from medical school on ____ day of _____, _____.

Unusual Circumstances — **Responses**

Did this individual ever take a leave of absence from their medical education?	Yes	No
Was this individual ever placed on probation?	Yes	No
Was this individual ever disciplined or under investigation?	Yes	No
Were any incident reports regarding this individual ever filed by instructors?	Yes	No
Were any limitations or special requirements imposed on this individual because of questions of academic or disciplinary problems, or for any other reason?	Yes	No

A "Yes" response to ANY of the above questions requires the medical school to provide a written explanation on a separate attachment.

Medical School Seal Must Be Imprinted Below	Attention Medical School: Only the President, Dean, or Registrar may sign this form. If the signature is being delegated to another person, evidence of that delegation must be attached to this form (may be a photocopy). Such delegation must be on official letterhead and must be dated within the last 12 months.
	Signed and the school seal affixed this 28th day of August, 2008.
	By: NANCY HUFF ASSISTANT REGISTRAR (Printed Name and Title of School Official)
	Signature: Nancy Huff

L2

07A-100-L2 (Rev. 12/05)

STATE OF CALIFORNIA – STATE AND CONSUMER SERVICES AGENCY ARNOLD SCHWARZENEGGER, Governor

Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM
1426 Howe Avenue, Suite 54
Sacramento, CA 95825-3236
(916) 263-2382 FAX (916) 263-2487
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RECEIVED MEDICAL BOARD OF CALIFORNIA 07 AUG 13 AM 8:24 LICENSING PROGRAM

CERTIFICATE OF MEDICAL EDUCATION

MEDICAL SCHOOL: PLEASE COMPLETE THIS FORM IN THE ENGLISH LANGUAGE

This certifies that RICK T. CHAC (Full Name of Applicant); ___ (U.S. Social Security Number)

___/___/___ (Date of Birth), enrolled in THE UNIVERSITY OF ARIZONA COLLEGE OF MEDICINE (Name of Medical School)

located in TUCSON, AZ (State/Province Country) on 07/24/2000. (Enrollment Date)

The undersigned further certifies that the records of this institution show that the applicant attended in this institution 5 years of resident instruction, 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 Sections 2089,2089.5, 2089.7,2090, 2091.1,2091.2) and that the applicant

- Anatomy
- Otolaryngology
- Obstetrics and Gynecology
- Radiology, including Radiation Safety
- Tropical Medicine
- Physiology
- Biochemistry
- Pathology, Bacteriology, and Immunology
- Ophthalmology
- Dermatology
- Embryology
- Histology
- Human Sexuality
- Medicine
- Surgery, including Orthopedic Surgery
- Urology
- Psychiatry
- Neurology
- Alcoholism and Chemical Dependency
- Preventative Medicine, including Nutrition
- Physical Medicine
- Therapeutics
- Neuroanatomy
- Child Abuse Detection and Treatment
- Geriatric Medicine
- Pediatrics
- Pharmacology
- Anesthesia
- Spousal Partner Abuse Detection & Treatment*
- Family Medicine**
- Pain Management and End-of-Life Care***

* ONLY applicable to medical students who enrolled in medical school on or after September 1, 1994.
** 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 June 1, 2000.

☑ was granted the degree of ~~Bachelor~~ Doctor of Medicine on the 14th day of May, 2005.

☐ withdrew from medical school on ___ day of ___, ___.

Unusual Circumstances

	Responses	
Did this individual ever take a leave of absence from their medical education?	Yes	No
Was this individual ever placed on probation?	~~Yes~~	No
Was this individual ever disciplined or under investigation?	Yes	No
Were any incident reports regarding this individual ever filed by instructors?	Yes	No
Were any limitations or special requirements imposed on this individual because of questions of academic or disciplinary problems, or for any other reason?	Yes ☐	No

See Dean's letter

A "Yes" response to ANY of the above questions requires the medical school to provide a written explanation on a separate attachment.

Medical School Seal Must Be Imprinted Below	Attention Medical School: Only the President, Dean, or Registrar may sign this form. If the signature is being delegated to another person, evidence of that delegation must be attached to this form (may be a photocopy). Such delegation must be on official letterhead and must be dated within the last 12 months.
	Signed and the school seal affixed this 31ST day of July, 2007.
	By: NANCY HUFF ASSISTANT REGISTRAR (Printed Name and Title of School Official)
	Signature: Nancy Huff

L2

07A-100-L2 (Rev. 12/05)

NJ

STATE OF CALIFORNIA -- STATE AND CONSUMER SERVICES AGENCY

ARNOLD SCHWARZENEGGER, Governor

RECEIVED
07 AUG -8 A 11:36
LICENSING PROGRAM

Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM
1426 Howe Avenue, Suite 54
Sacramento, CA 95825-3236
(916) 263-2382 FAX (916) 263-2487
www.caldocinfo.ca.gov

CERTIFICATE OF COMPLETION OF ACGME/RCPSC 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

NAME: Last	First	Middle
CHAC	RICK	T

U.S. Social Security Number	Date of Birth	Telephone Number
		Home ( ) Work ( )

Public/Mailing Address: PO BOX 1211

City	State/Province	Zip/Postal Code
LOMA LINDA	CA	92354

Medical School of Graduation:

PART 2: TO BE COMPLETED BY THE PROGRAM DIRECTOR

ATTENTION PROGRAM DIRECTOR: Do not sign and date this form before the last day of any postgraduate training year which will be used by the applicant to qualify for licensure. Completion of this form will certify that the individual named in PART 1 above satisfactorily completed a period of accredited postgraduate training at this facility and that the trainee has acquired the skill and qualifications necessary to safely assume the unrestricted practice of medicine in this state.

Name of Facility:	ACGME 10 digit Program number: (www.acgme.org)
Washington Hospital Center	2201031067

Address of Facility:	Telephone #:
110 Irving St. NW Washington DC 20010	202 877 8035

Categorical Specialty Area of Training	Start Date of Training	End Date (or anticipated completion date) of Training
OB/GYN	07,01,2005	05,24,2006

11 mos

UNUSUAL CIRCUMSTANCES:

Did the trainee ever take a leave of absence or break from their training?	YES	NO
Was the trainee ever terminated, dismissed or expelled?	YES	NO
Did the trainee ever resign?	YES	NO
Was the trainee ever placed on probation?	YES	NO
Was the trainee ever disciplined or placed under investigation?	YES	NO
Were any incident reports regarding this trainee ever filed by instructors?	YES	NO
Were any limitations or special requirements placed upon the trainee for clinical incompetence, disciplinary problems or for any other reason?	YES	NO
Did the program decline to renew or offer the trainee a postgraduate training program contract for a following year?	YES	NO

A "Yes" response to ANY of the above questions requires the program director to provide a written explanation on a separate attachment.

L3A

DEFINITION OF "SATISFACTORY" COMPLETION OF TRAINING

The program director signing this form is formally certifying and documenting under penalty of perjury that the trainee received instruction appropriate for the particular postgraduate level and that he/she satisfactorily completed periods of training in accordance with the accepted standards and the criteria defined as equating to "satisfactory" performance as described below. The program director will personally be attesting to the fact that the trainee has acquired the skill and qualifications necessary to safely assume the unrestricted practice of medicine in this state.

"SATISFACTORY" IS DEFINED AS: THE TRAINEE PERFORMED AT AN ADEQUATE LEVEL BASED ON EVIDENCE OF SATISFACTORY PROGRESSIVE GROWTH INCLUDING DEMONSTRATED ABILITY TO ASSUME GRADED AND INCREASING RESPONSIBILTY FOR PATIENT CARE.

GENERAL MEDICINE TRAINING REQUIREMENT

To qualify for licensure in California, applicants who are graduates of an international medical school must complete at least four months of postgraduate training in GENERAL MEDICINE as part of the requirement. Applicants who are graduates of a U.S. or Canadian medical school, who have not completed postgraduate training required for licensure by July 1, 1990, must also complete four months of training in GENERAL MEDICINE prior to 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.

I hereby certify as the program director, that the individual named in Part 1

☒ **has completed** ☐ **has not completed**

a minimum of four months of general medicine as part of this postgraduate training program accredited by the ACGME or the RCPSC.

David D MD

SIGNATURE OF PROGRAM DIRECTOR

ATTENTION PROGRAM DIRECTOR: THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE, OR ADOPTION. If that signature authority is being delegated to another person, evidence of that delegation must be attached to this form (may be a photocopy). Each delegation must be on official letterhead and must be dated within the last 12 months.

HOSPITAL SEAL

OFFICIAL HOSPITAL SEAL MUST BE AFFIXED IN THE BOX TO THE LEFT TO CERTIFY TRAINING

The training program is accredited by the ACGME or the RCPSC to offer the type and level of training completed by the applicant, and the applicantw as trained in an accredited ACGME or RCPSC program position. I hereby declare under penalty of perjury under the laws of the State of California that the statements are true and correct.

DAVID DOWNING, M.D.

PRINT NAME OF PROGRAM DIRECTOR

David D MD

SIGNATURE OF PROGRAM DIRECTOR
Signature Stamp Is Not Acceptable

8/2/07

DATE SIGNED

If a hospital seal is not available, the program director shall sign this form in the presence of a notary public.

State of _____

County of _____

Subscribed and sworn to (or affirmed) before me on

this _____ day of _____, 20_____,

by _____

personally known to me or proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.

NOTARY SEAL

_____
SIGNATURE OF NOTARY PUBLIC

L3B

07A-100-L3 (Rev. 12/05)

NJ

STATE OF CALIFORNIA -- STATE AND CONSUMER SERVICES AGENCY ARNOLD SCHWARZENEGGER, Governor

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(916) 263-2382 FAX (916) 263-2487
www.caldocinfo.ca.gov

CERTIFICATE OF COMPLETION OF ACGME/RCPSC 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

NAME: Last	First	Middle
CHAC	RICK	T

U.S. Social Security Number	Date of Birth	Telephone Number
		Home ( ) Work ( )

Public/Mailing Address: PO BOX 1211

City	State/Province	Zip/Postal Code
LOMA LINDA	CA	92354

Medical School of Graduation: THE UNIVERSITY OF ARIZONA COLLEGE OF MEDICINE

PART 2: TO BE COMPLETED BY THE PROGRAM DIRECTOR

ATTENTION PROGRAM DIRECTOR: Do not sign and date this form before the last day of any postgraduate training year which will be used by the applicant to qualify for licensure. Completion of this form will certify that the individual named in PART 1 above satisfactorily completed a period of accredited postgraduate training at this facility and that the trainee has acquired the skill and qualifications necessary to safely assume the unrestricted practice of medicine in this state.

Name of Facility:	ACGME 10 digit Program number: (www.acgme.org)
MARICOPA MEDICAL CENTER	2200321328

Address of Facility:	Telephone #:
2601 E Roosevelt Drive Phx AZ	602 344 5444

Categorical Specialty Area of Training	Start Date of Training	End Date (or anticipated completion date) of Training
OB-GYN	4,4,2007	6,30,2007

2 mos 3 wks

UNUSUAL CIRCUMSTANCES:

Did the trainee ever take a leave of absence or break from their training?	YES	NO
Was the trainee ever terminated, dismissed or expelled?	YES	NO
Did the trainee ever resign?	YES	NO
Was the trainee ever placed on probation?	YES	NO
Was the trainee ever disciplined or placed under investigation?	YES	NO
Were any incident reports regarding this trainee ever filed by instructors?	YES	NO
Were any limitations or special requirements placed upon the trainee for clinical incompetence, disciplinary problems or for any other reason?	YES	NO
Did the program decline to renew or offer the trainee a postgraduate training program contract for a following year?	YES	NO

A "Yes" response to ANY of the above questions requires the program director to provide a written explanation on a separate attachment.

L3A

DEFINITION OF "SATISFACTORY" COMPLETION OF TRAINING

The program director signing this form is formally certifying and documenting under penalty of perjury that the trainee received instruction appropriate for the particular postgraduate level and that he/she satisfactorily completed periods of training in accordance with the accepted standards and the criteria defined as equating to "satisfactory" performance as described below. The program director will personally be attesting to the fact that the trainee has acquired the skill and qualifications necessary to safely assume the unrestricted practice of medicine in this state.

"SATISFACTORY" IS DEFINED AS: THE TRAINEE PERFORMED AT AN ADEQUATE LEVEL BASED ON EVIDENCE OF SATISFACTORY PROGRESSIVE GROWTH INCLUDING DEMONSTRATED ABILITY TO ASSUME GRADED AND INCREASING RESPONSIBILTY FOR PATIENT CARE.

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I hereby certify as the program director, that the individual named in Part 1

☐ **has completed** ☑ **has not completed**

a minimum of four months of general medicine as part of this postgraduate training program accredited by the ACGME or the RCPSC.

His 3 months at our Program Were in OB-GYN

SIGNATURE OF PROGRAM DIRECTOR

ATTENTION PROGRAM DIRECTOR: THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE, OR ADOPTION. If that signature authority is being delegated to another person, evidence of that delegation must be attached to this form (may be a photocopy). Each delegation must be on official letterhead and must be dated within the last 12 months.

HOSPITAL SEAL

OFFICIAL HOSPITAL SEAL MUST BE AFFIXED IN THE BOX TO THE LEFT TO CERTIFY TRAINING

The training program is accredited by the ACGME or the RCPSC to offer the type and level of training completed by the applicant, and the applicantw as trained in an accredited ACGME or RCPSC program position. I hereby declare under penalty of perjury under the laws of the State of California that the statements are true and correct.

R MICHAEL BRADY

PRINT NAME OF PROGRAM DIRECTOR

SIGNATURE OF PROGRAM DIRECTOR
Signature Stamp Is Not Acceptable

7-31-07

DATE SIGNED

If a hospital seal is not available, the program director shall sign this form in the presence of a notary public.

State of _____

County of _____

Subscribed and sworn to (or affirmed) before me on

this _____ day of _____, 20_____,

by _____

personally known to me or proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.

NOTARY SEAL

SIGNATURE OF NOTARY PUBLIC

L3B

NJ

STATE OF CALIFORNIA -- STATE AND CONSUMER SERVICES AGENCY

ARNOLD SCHWARZENEGGER, Governor

RECEIVED
2008 AUG 27 PM

Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815
(800) 633-2322 (916) 263-2382 FAX (916) 263-2487
www.mbc.ca.gov

CERTIFICATE OF COMPLETION OF ACGME/RCPSC 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

NAME: Last	First	Middle
Chac	Rick	T.

U.S. Social Security Number	Date of Birth	Telephone Number
		Home / Work

Public/Mailing Address: PO BOX 1211

City	State/Province	Zip/Postal Code
Loma Linda	CA	92354

Medical School of Graduation: University of Arizona

PART 2: TO BE COMPLETED BY THE PROGRAM DIRECTOR

ATTENTION PROGRAM DIRECTOR: Do not sign and date this form before the last day of any postgraduate training year which will be used by the applicant to qualify for licensure. Completion of this form will certify that the individual named in PART 1 above satisfactorily completed a period of accredited postgraduate training at this facility and that the trainee has acquired the skill and qualifications necessary to safely assume the unrestricted practice of medicine in this state.

Name of Facility:	ACGME 10 digit Program number: (www.acgme.org)
Loma Linda University Medical Center	2200521329

Address of Facility:	Telephone #:
11234 Anderson St. Loma Linda, CA 92354	909-558-8131

Categorical Specialty Area of Training	Start Date of Training	End Date (or anticipated completion date) of Training
Obstetrics & Gynecology	07 / 01 / 2007	05 / 15 / 2008

UNUSUAL CIRCUMSTANCES:

Did the trainee ever take a leave of absence or break from their training?	YES	NO
Was the trainee ever terminated, dismissed or expelled?	YES	NO
Did the trainee ever resign?	YES	NO
Was the trainee ever placed on probation?	YES	NO
Was the trainee ever disciplined or placed under investigation?	YES	NO
Were any incident reports regarding this trainee ever filed by instructors?	YES	NO
Were any limitations or special requirements placed upon the trainee for clinical incompetence, disciplinary problems or for any other reason?	YES	NO
Did the program decline to renew or offer the trainee a postgraduate training program contract for a following year?	YES	NO

A "Yes" response to ANY of the above questions requires the program director to provide a written explanation on a separate attachment.

L3A

DEFINITION OF "SATISFACTORY" COMPLETION OF TRAINING

The program director signing this form is formally certifying and documenting under penalty of perjury that the trainee received instruction appropriate for the particular postgraduate level and that he/she satisfactorily completed periods of training in accordance with the accepted standards and the criteria defined as equating to "satisfactory" performance as described below. The program director will personally be attesting to the fact that the trainee has acquired the skill and qualifications necessary to safely assume the unrestricted practice of medicine in this state.

"SATISFACTORY" IS DEFINED AS: THE TRAINEE PERFORMED AT AN ADEQUATE LEVEL BASED ON EVIDENCE OF SATISFACTORY PROGRESSIVE GROWTH INCLUDING DEMONSTRATED ABILITY TO ASSUME GRADED AND INCREASING RESPONSIBILTY FOR PATIENT CARE.

GENERAL MEDICINE TRAINING REQUIREMENT

To qualify for licensure in California, applicants who are graduates of an international medical school must complete **at least four months** of postgraduate training in GENERAL MEDICINE as part of the requirement. Applicants who are graduates of a U.S. or Canadian medical school, who have not completed postgraduate training required for licensure by July 1, 1990, must also complete four months of training in GENERAL MEDICINE prior to 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.

I hereby certify as the program director, that the individual named in Part 1
☒ has completed ☐ has not completed
a minimum of four months of general medicine as part of this postgraduate training program accredited by the ACGME or the RCPSC.

Melissa Kidder
SIGNATURE OF PROGRAM DIRECTOR

ATTENTION PROGRAM DIRECTOR: THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE, OR ADOPTION. If that signature authority is being delegated to another person, evidence of that delegation must be attached to this form (may be a photocopy). Each delegation must be on official letterhead and must be dated within the last 12 months.

HOSPITAL SEAL

OFFICIAL HOSPITAL SEAL MUST BE AFFIXED IN THE BOX TO THE LEFT TO CERTIFY TRAINING

The training program is accredited by the ACGME or the RCPSC to offer the type and level of training completed by the applicant, and the applicantw as trained in an accredited ACGME or RCPSC program position. I hereby declare under penalty of perjury under the laws of the State of California that the statements are true and correct.

Melissa Kidder, MD
PRINT NAME OF PROGRAM DIRECTOR

Melissa Kidder MD — 8-26-08
SIGNATURE OF PROGRAM DIRECTOR — **DATE SIGNED**
Signature Stamp Is Not Acceptable

If a hospital seal is not available, the program director shall sign this form in the presence of a notary public.

State of _____

County of _____

Subscribed and sworn to (or affirmed) before me on

this _____ day of _____, 20_____,

by _____

personally known to me or proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.

NOTARY SEAL

_____
SIGNATURE OF NOTARY PUBLIC

L3B

Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM
1426 Howe Avenue, Suite 54
Sacramento, CA 95825-3236
(916) 263-2382 FAX (916) 263-2487
www.caldocinfo.ca.gov

CERTIFICATE OF CURRENT POSTGRADUATE TRAINING ENROLLMENT

At the time of licensure, you may be entitled to a reduced initial license fee if you are actively participating in a slotted position in an ACGME/RCPSC accredited postgraduate training program.

NOTE: This form may not be used in lieu of the Form L3A-B, "Certificate of Completion of ACGME/RCPSC Postgraduate Training."

NAME: Last	First	Middle
CHAC	RICK	T.

U.S. Social Security Number	Date of Birth	Medical School of Graduation: UNIVERSITY OF ARIZONA COLLEGE OF MEDICINE.

This is to certify that the above applicant is actively participating in an ACGME or RCPSC accredited postgraduate training position that started on July 1, 2007 (Month Day Year) **and is expected to be completed on** June 30, 2010 (Month Day Year) **in** Obstetrics & Gynecology (Categorical Specialty Area of Training)

at Loma Linda University Medical Center (Name of Facility)

located at 11234 Anderson St. Loma Linda, CA 92354 (Address of Facility)

The 10 digit ACGME Program # : 2200521329 (Refer to http://www.acgme.org/adspublic)

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

Robert Wagner, M.D
PRINT NAME OF PROGRAM DIRECTOR

SIGNATURE OF PROGRAM DIRECTOR – Signature Stamp Is Not Acceptable

8-10-07
DATE

909 558-8131
TELEPHONE NUMBER

ATTENTION PROGRAM DIRECTOR: THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE, OR ADOPTION.

Only the Program Director may sign this form. If that signature authority is being delegated to another person, evidence of that delegation must be attached to this form (may be a photocopy). Such delegation must be on official letterhead and must be dated within the last 12 months.

If a hospital seal is not available, the program director shall sign this form in the presence of a notary public.

State of _____

County of _____

Subscribed and sworn to (or affirmed) before me on

this _____ day of _____, 20_____,

by _____

personally known to me or proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.

Hospital or Notary Seal

_____
SIGNATURE OF NOTARY PUBLIC

OFFICIAL HOSPITAL SEAL OR NOTARY SEAL (WITH JURAT COMPLETED ABOVE) MUST BE AFFIXED IN THE BOX AT THE LEFT

L4

STATE DEPARTMENT OF CONSUMER AFFAIRS
INTERNET CASHIERING SYSTEM
MEDICAL BOARD OF CALIFORNIA
SUPPLEMENTAL INFORMATION REPORT
From Date: 06/28/2012 **To Date:** 06/28/2012

ATRISUPPINF

29-MAR-16 10:01:58

Person Id : 1474243 **Name :** Chac,Rick

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.	YES
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 : 1474243 8

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 OCTOBER 30, 2014
CHAC, RICK T	A105379	09/30/14	$820.00	$898.00

LICENSEE MUST CHECK CORRECT BOXES

- "H" [X] Completed Continuing Education
- "E" [ ] Change of Address (fill in reverse side)
- "I" [ ] Conviction Disclosure – Yes
- "J" [X] 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 _____

ENTER YOUR PHONE NUMBER FOR REFERENCE:

( ) -

630101000001000020010537920109301400082000000089800

CHANGE OF MAILING ADDRESS **CHAC, RICK T** **A105379**

06302014 20001973 20010020

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