STATE OF CALIFORNIA--STATE AND CONSUMER SERVICES AGENCY 010703 EDMUND G. BROWN JR., *Governor*

DEPARTMENT OF Consumer Affairs

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

RECEIVED
SACRAMENTO
BOARD OF MEDICAL
QUALITY ASSURANCE
Aug 11 2 34 PM '82

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

001485
$218.50

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

1. NAME: Last: Drummond-Hay, First: Leslie, Middle: Katherine, Maiden: —
2. Telephone No.:
3. List other names, if any, you have used: none
4. Address: Street and No./Rural Route: 1837 Santa Fe; City: Del Mar; State: Calif; Zip Code: 92014
5. Name you wish on License: Leslie K. Drummond-Hay; Birthdate: (Month - Day - Year)
6. Premedical Education: Name of College or University: University of California, Berkeley; Location: Berkeley, CA
   Period of attendance: From: 9-72 To: 6-76
   Check premed courses sucessfully completed: ☒ Chemistry ☒ Physics ☒ Biology or Zoology
7. Medical School:

Year	Name of Institution	Location	From	To
1st	University of Calif, San Francisco	San Francisco CA	8-77	6-78
2nd	" "	"	9-78	6-79
3rd	" "	"	6-79	6-80
4th	" "	"	6-80	6-81
5th				
6th				

8. Doctor of Medicine Degree granted by: University of California, San Francisco; Date: 6-28-81; For office use only School Code: CA002
9. 1st Year Postgraduate Training (Internship): University Hospital, 225 Dickinson

Location	Type of Service	From	To
University of California, San Diego	OBstetrics & Gynecology	6-24-81	6-27-82

10. List all States in which you have been licensed to practice medicine: none
11. Has any disciplinary action ever been taken regarding any license which you now hold or ever held? ☐ Yes ☐ No
    If Yes, indicate below:

State	Date	Charge	Disposition

12. Have you ever been denied a license to practice medicine in any State or Country? ☐ Yes ☐ No
    If Yes, indicate below:

State or Country	Date of Denial	Reason for Denial

13. Are you now or have you ever been addicted to narcotic drugs? ☐ 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/narcotics, or to drug addiction?

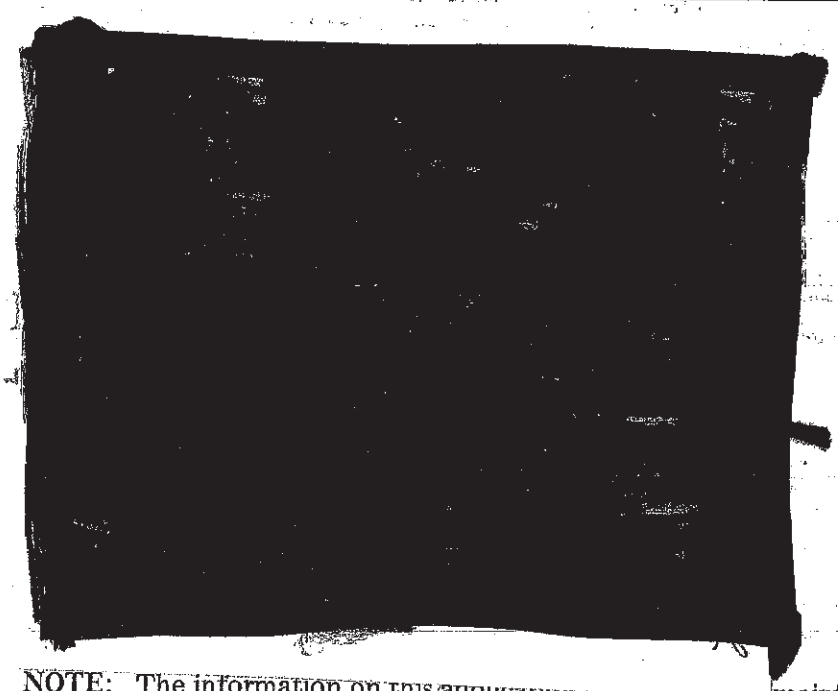
15. Have you ever been convicted of, or pled nolo contendere to any offense, misdemeanor or felony in any state? (Except violations of traffic laws resulting in fines of $50.00 or less.)

16. If you answered "Yes" to either No. 14 or No. 15 above, please provide the following information:

Violation and Location	Date	Penalty/Disposition

17. Have you ever had staff privileges in a hospital suspended or revoked? If "Yes", please explain on another sheet of paper.

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



Applicant: Please complete the following:

Height: _ Ft. _ In. Weight _ Lbs.

Hair color: _ Eye color: _

Identifying marks: _

NOTE: The information on this application is required and maintained pursuant to Section 2312 of the Business and Professions Code. All items in this application are mandatory, none are voluntary. Failure to provide any of the requested information will result in the application being rejected as incomplete. The information provided will be used to determine qualification for licensure. Applicants have the right to review their applications subject to the provisions of the California Public Records Act.

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

"I hereby certify (or declare), under penalty of perjury, under the laws of the State of California, that the foregoing information contained in this application and any attachments is true and correct, and that the attached photo and duplicate copy are a true likeness of myself, the applicant identified herein."

Signature of Applicant Julie K. Dunnett-Hu

Date 7-23-82

Subscribed and sworn to before me this 23 day of July 1982.

OFFICIAL SEAL
MARGARITA ESPARZA
NOTARY PUBLIC-CALIFORNIA
PRINCIPAL OFFICE IN
SAN DIEGO COUNTY
My Commission Expires Mar. 23, 1984

Signature of Notary Margarita Esparza

Address 225 Dickinson

My commission expires: 3-23-84

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(916) 920-6411

PLEASE FORWARD TO YOUR MEDICAL SCHOOL

CERTIFICATE OF EDUCATION

This Certifies That Leslie Katherine Drummond-Hay
(Full name of applicant)

enrolled in University of California, San Francisco Medical School
(Name of medical school (college))

on the 8 day of August (Month) 19 77 (Year).

[X] as a Freshman.

[ ] with advanced standing based on _____
(Please specify)

The undersigned further certifies that official transcripts on file show that prior to completing the study of medicine the applicant herein referred to completed at least a two-year resident course of college grade including:

[X] PHYSICS [X] CHEMISTRY [X] BIOLOGY (or) ZOOLOGY (Check course(s) completed)

at University of California at Berkeley
(Please Indicate school), and that he attended while at this medical school (college) at least 13 (Specify number) courses of lectures of 12 (Specify number of weeks) weeks each, completing 4000 (Total hours) hours in the subjects below listed, and that he/she:

[X] was granted the degree ~~Bachelor~~ Doctor of Medicine.

[ ] left the above-mentioned medical school (college) for the following reason(s):

_____

_____

on the 28 day of June (Month) 1981 (Year).

Please indicate which of the following courses of study were successfully undertaken by the applicant:

- [ ] Anatomy
- [ ] Embryology
- [ ] Histology
- [ ] Neuroanatomy
- [ ] Physiology
- [ ] Biochemistry
- [ ] Pathology, bacteriology and immunology
- [ ] Dermatology
- [ ] Physical medicine
- [ ] Therapeutics
- [ ] Tropical medicine
- [ ] Surgery, including orthopedic surgery
- [ ] Urology
- [ ] Ophthalmology
- [ ] Pharmacology
- [ ] Preventive medicine, including nutrition
- [ ] Radiology, including radiation safety
- [ ] Medicine
- [ ] Pediatrics
- [ ] Psychiatry
- [ ] Neurology
- [ ] Anesthesia
- [ ] Otolaryngology
- [ ] Obstetrics and gynecology
- [ ] Human sexuality as defined in Section 2192.3
- [ ] Child Abuse detection and treatment

[AFFIX SEAL HERE]

Signed and the College seal affixed this 23 day of July (Month) 1982 (Year).

By H. Harrison Sadler M.D.
(President, Secretary, Dean)

Associate Dean

STATE DEPARTMENT OF CONSUMER AFFAIRS
INTERNET CASHIERING SYSTEM
MEDICAL BOARD OF CALIFORNIA
SUPPLEMENTAL INFORMATION REPORT
From Date: 05/12/2012 **To Date:** 05/12/2012

ATRISUPPINF

15-APR-16 12:01:56

Person Id : 596206 **Name :** Drummond-Hay,Leslie

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?	NO

Total Questions Asked For Person : 596206 8

(DO NOT DETACH)

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 JULY 30, 2014
DRUMMOND-HAY, LESLIE K	**G48640**	**06/30/14**	**$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 L K Drummond-Hay MD Date 5/12/14

ENTER YOUR PHONE NUMBER FOR REFERENCE:

630107000007000060004864070106301400082000000089800

CHANGE OF MAILING ADDRESS **DRUMMOND-HAY, LESLIE K** **G48640**

05192014 20061121 20010012

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