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

RECEIVED SACRAMENTO BOARD OF MEDICAL EXAMINERS 94 SEP -6 AM 11:11 DIVISION OF LICENSING

RECEIVED SACRAMENTO MEDICAL BOARD OF CALIFORNIA 94 SEP -2 AM 10:35

MEDICAL BOARD OF CALIFORNIA

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

Consumer Affairs

RECEIVED SEP -1 PM 1:15

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.**

MBC USE ONLY 002635 10-29-94 2nd 9-14-94

PERSONAL DATA

1. Name: Last HANSON First LARS Middle ERIK

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) #306 LYND AVE.

City ARCADIA State CALIFORNIA ZIP Code 91006 Country USA

5. Telephone Number: Home — Work —

6. Date of Birth: Mo/Day/Yr

Place of Birth:

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 previous application was submitted:

NON-MEDICAL EDUCATION

10. List name and address of all colleges or universities attended where pre-professional, postsecondary instruction was received. Please submit an official sealed transcript for each school attended.

Name	Address	Period of Attendance From (Mo/Yr)	Period of Attendance To (Mo/Yr)
STANFORD UNIVERSITY	STANFORD, CALIF. 94305	9/76	6/81
CALIFORNIA STATE POLYTECHNIC UNIVERSITY	3801 W. TEMPLE AVE., POMONA, CA. 91768	1/87	8/87

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

Course	Yes	No	Name of College or University
Chemistry	X		STANFORD + CALIF. STATE POLYTECH. UNIV.
Physics	X		CALIFORNIA STATE POLYTECHNIC UNIV.
Biology or Zoology	X		CALIFORNIA STATE POLYTECHNIC UNIV.

MEDICAL EDUCATION

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 sealed transcripts from each school attended.

Name	Address	Place Where Instruction Received	Period of Attendance From (Mo/Yr)	Period of Attendance To (Mo/Yr)
USC SCHOOL OF MEDICINE	1975 ZONAL AVE., KAM 100-B LOS ANGELES, CA. 90033	SEE ADDRESS	8/88	6/93

CME TRANS

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 SOUTHERN CALIFORNIA	1975 ZONAL AVE., KAM 100-B LOS ANGELES, CA. 90033	5/7/93	4065

NOTE: APPLICANT MUST PROVIDE NAME, ADDRESS AND DATE OF ISSUANCE OF DEGREE.

L1A

CAM6

MBC USE ONLY

WRITTEN EXAMINATION

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

If YES, list name, location, date and result of examination. Submit certification of scores from each examination agency. Applicants who hold ECFMG certification will need to submit an original valid ECFMG certificate for examination and licensure. ☒ Yes ☐ No

Name	Location	Date	Result
PART I - NATIONAL BOARD OF MED. EXAMINERS	USC SCHOOL OF MEDICINE	6/91	
PART II - USMLE	USC, LOMA LINDA UNIVERSITY AND LOMA LINDA CMV.	3/93, 9/93, 3/94	
PART III, USMLE	LOMA LINDA UNIV.	5/18/94	

POSTGRADUATE TRAINING

14. Have you satisfactorily completed at least one year of qualifying postgraduate training in U.S. or Canadian facilities?
(Note: Do not complete Form L3 (s) to document training received in research or clinical fellowship programs) ☒ 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)	To (Mo/Yr)
SAN BERNARDINO COUNTY MEDICAL CENTER	780 EAST GILBERT, SAN BERNARDINO, CA.	FAMILY MEDICINE	7/93	6/30/94

QUESTIONS 14A–23 For any positive response to these questions, applicant should provide, in addition to written explanations, any documentation regarding the matter.

14A. Have you ever withdrawn from, or been suspended, dismissed or expelled from, a medical school or postgraduate training program? Yes No

15. Have you been licensed to practice medicine in any state or country? Yes No

LICENSE DATA

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. Please include temporary, limited, or provisional licenses.

State or Country	License Number	Date of Issuance	Dates of Practice in Issuing Agency's Jurisdiction	
			From (Mo/Yr)	To (Mo/Yr)

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

MBC 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

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

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

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

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

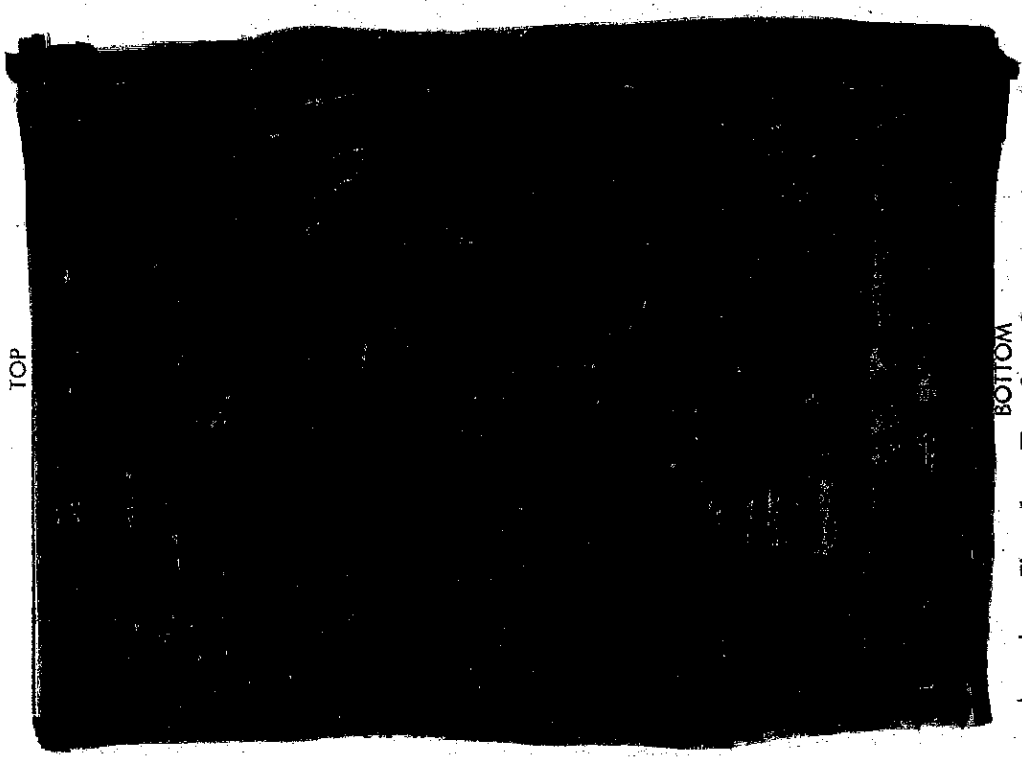
YOU ARE REQUIRED TO LIST ANY CONVICTION THAT HAS BEEN SET ASIDE AND DISMISSED UNDER SECTION 1203.4 OF THE PENAL CODE OR UNDER ANY OTHER PROVISION OF LAW. A SEPARATE LETTER EXPLAINING THE DETAILS OF THE OFFENSE IS ALSO REQUIRED, IN ADDITION TO CERTIFIED COURT DOCUMENTS.

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."

L1C



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.

NOTARIZATION PORTION

STATE OF CALIFORNIA)

COUNTY OF LOS ANGELES)

LARS ERIK HANSSON being duly sworn, says he is the person referred to in
PRINT FULL NAME OF APPLICANT

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.

Lars Hanson
Signature of applicant: (Write FULL name, not initials)

Signed and sworn to before me this 30th day of August, 19 94.

[NOTARY SEAL] OFFICIAL SEAL Edward J. Partridge III NOTARY PUBLIC - CALIFORNIA LOS ANGELES COUNTY My Comm. Expires Oct. 27, 1995

Signature of Notary Public

Address Arcadia, California

My commission expires October 27, 1995

L1D

07[illegible]100 (REV. 7/91)

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

State of California Department of Consumer Affairs

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

SACRAMENTO BOARD OF MEDICAL QUALITY ASSURANCE
94 AUG -9 AM 9:45
DIVISION OF LICENSING

RECEIVED
SACRAMENTO
MEDICAL BOARD
OF CALIFORNIA
94 AUG -8 AM 11:33

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: HANSON | First Name: LARS | Middle Initial: E

Current Address: 430 G LYND AVE. | Phone Number:

City: ARCADIA, | State: CA. | Zip Code: 91006

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: San Bernardino County Medical Center OK

Address of Facility: 780 E. Gilbert Street, San Bernardino, CA 92415-0935

Name of Program Director: Andre V. Blaylock, M.D. | Phone Number: (909) 387-7882

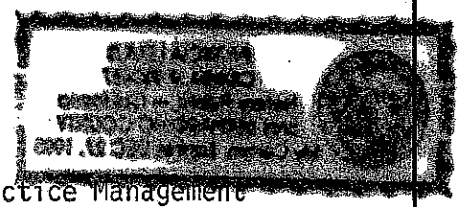
Signature of Program Director: Andre V. Blaylock | Date Signed: 7/26/94

List Categorical Specialty Area of Training Completed by Trainee: Family Practice | Date Training Commenced: July 1, 93 | Date Training Completed: June 30, 1994

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

Family Practice*	1 month
Internal Medicine	3 months
General Surgery	2 months
Pediatrics	2 months
Obstetrics/Gynecology	2 months
Orthopedics/Emergency Medicine	2 months

*Includes: Behavioral Science, Community Medicine and Practice Management



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)

L3A

State of California Department of Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
1426 HOWE AVENUE, STE. 54
SACRAMENTO, CA 95825-3236
(916) 263-2499

CERTIFICATION STATEMENT

This is to certify that Lars Hanson, MD (Name of Physician) is in an approved ACGME/CCME postgraduate training position that commenced on July 1, 19 93 and is expected to be completed on June 30, 19 96 in Family Practice (Type of Training) at San Bernardino County Medical Center (Name and Address of Facility)

780 E. Gilbert Street, San Bernardino, CA 92415-0935

(AFFIX OFFICIAL HOSPITAL SEAL OR NOTARY PUBLIC SEAL)

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 facility is approved by the ACGME or the CCME to offer the type and level of training completed by the applicant and that the applicant is being trained in an approved ACGME or CCME program position.

Andre V. Blaylock, MD
Type or print name of Director of Medical Education

Andre V. Blaylock
Signature of Director of Medical Education

June 30, 1994
Date

(909) 387-7882
Phone Number

OFFICIAL NOTARY SEAL
PATRICIA LEMUS
Notary Public — California
SAN BERNARDINO COUNTY
My Comm. Expires DEC 27,1995

NOTE: Do not use this form in lieu of Form L3 "Certificate of Completion of ACGME Postgraduate Training"

State of California
County of San Bernardino

Subscribed and sworn before me this 30th day of June 1994.

Patricia Lemus

L9

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

State of California Department of Consumer Affairs

MEDICAL BOARD OF CALIFORNIA

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

CERTIFICATE OF MEDICAL EDUCATION

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

This certifies that LARS ERIK HANSON (FULL NAME OF APPLICANT)

of 4306 LYND AVE, ARCADIA, CALIF. (ADDRESS WHEN ENROLLED) enrolled in Univ of Southern California School of Medicine (NAME OF MEDICAL SCHOOL)

1975 Zonal Ave (KAM 100B), Los Angeles, CA 90033 (LOCATION) on the 29 day of August (MONTH) 19 88 (YEAR)

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).

Stanford (EDUCATIONAL INSTITUTION) 1976-81 (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 4 (SPECIFY NUMBER) years of resident instruction of =36+ (NUMBER OF WEEKS) 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

OR
- [X] he was granted the degree ~~Bachelor~~ Doctor of Medicine by
- [ ] he withdrew from

the above-mentioned medical school on the 7 day of May (MONTH) 19 93

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

[redacted]

Signed and the college seal affixed this 22 day of July, 19 94

BY Frances L. Drew

FRANCES L. DREW, PRESIDENT, SECRETARY, DEAN
USC SCHOOL OF MEDICINE
2025 ZONAL AVENUE, KAM 100
LOS ANGELES, CA 90033

1975

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.

STU. AFFAIRS RECD 22 JUL 94

L2

PART 3: *To be completed by the Director of Medical Education and affixed with the official facility seal.*

Name of Director of Medical Education: Andre V. Blaylock, M.D.

Phone Number: (909) 387-7882

Facility Name: San Bernardino County Medical Center

Date Form Completed: 7/27/94

Facility Address: 780 E. Gilbert Street, San Bernardino, CA 92415-0935

City: San Bernardino State: CA Zip Code: 92415-0935

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: Andre V. Blaylock

Date Signed: July 27, 1994

State of California
County of San Bernardino ss.

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

Subscribed and sworn before me on this 4th day of August, 1994.

Patricia Lemus

Patricia Lemus, Notary Public

[redacted]

L3B

07A-100-L3 (Rev. 2/92)

License Details - Public Record Actions - Administrative Disciplinary Actions

Press "Back" to return to the previous screen.

Name:	HANSON, LARS ERIK
License:	G 79925
Case Number:	04200920259200
Description:	PUBLIC REPRIMAND.
Effective Date:	09/08/2011
Document URL:	http://www2.mbc.ca.gov/BreezePDL/default.aspx?licenseType=G&licenseNumber=79925&name=HANSON, LARS ERIK

Back