STATE DEPARTMENT OF CONSUMER AFFAIRS
INTERNET CASHIERING SYSTEM
MEDICAL BOARD OF CALIFORNIA
SUPPLEMENTAL INFORMATION REPORT
From Date: 07/02/2013 **To Date:** 07/02/2013

ATRISUPPINF
15-APR-16 11:48:04

Person Id : 612786 **Name :** Hastings,Jennifer

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 : 612786 8

STATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS

dca BREEZE

Department of Consumer Affairs

RECEIPT

1437519

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

Name:	HASTINGS, JENNIFER LYNNE
Transaction Date:	08/11/2015 14:08
Application Number:	
Complaint Number:	
License Type:	8002
License Number:	72643
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.

Application Summary

License Type:	**Physician and Surgeon G**
License Number:	**72643**
File Number:	
Application:	**Physician's and Surgeon's Renewal**
Application Number:	
Application Date:	**08/11/2015 (mm/dd/yyyy)**

Personal Detail

First Name:	**JENNIFER**
Middle Name:	**LYNNE**
Last Name:	**HASTINGS**
Birthdate:	****/**/******
Gender:	**Female**

Addresses

License Related Addresses

Address of Record (Required)

Warning: **In order to protect your privacy and identity, address will not be displayed.**

Confidential Address

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?	**No**
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**

Attachments

Physician Survey

Are you retired?	**No**
Activities in Medicine	**Administration - 10-19 Hours**
	Other - None
	Patient Care - 10-19 Hours
	Research - None
	Teaching - 1-9 Hours
	Telemedicine - None
Patient Care Practice Location	**Zip: 95060 County:**
Telemedicine Practice Location	**Zip: County:**
Patient Care Secondary Practice Location	**Zip: 95060 County:**
Telemedicine Secondary Practice Location	**Zip: County:**
Current Training Status	**Not in Training**
Areas of Practice	**Family Medicine - Primary**
Board Certifications	**American Board of Family Medicine - Family Medicine**
Postgraduate Training Years	**4 Years**
Cultural Background	**White**
Foreign Language Proficiency	**Spanish**
Web Site Profile	**Cultural Background - Yes**
	Foreign Language Proficiency - Yes
	Gender - Yes
E-mail:	

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

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:

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

RECEIVED BOARD OF MEDICAL QUALITY ASSURANCE SEP 16 PM 1:51 DIVISION OF LICENSING

DEPARTMENT OF Consumer Affairs

MEDICAL BOARD OF CALIFORNIA

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

RECEIVED MEDICAL BOARD OF CALIFORNIA

401667 62300 200 S.B.

APPLICATION FOR PHYSICIAN AND SURGEON'S EXAMINATION OR LICENSURE

Read all instructions prior to completing this application. All questions on this application must be answered, and all supporting documents must be submitted with this application per instructions. **Please type or print neatly. When space provided is insufficient, attach additional sheets of paper.**

BMQA USE ONLY

1. Name: Last: HASTINGS First: Jennifer Middle: Lynne

2. Other names you have used (include maiden name):

3. Social Security Number
See disclosure statement on L1C

4. Address: Number and Street/Rural Route (include apartment number, if any)
891 Gandul Calle
City: Santa Rosa State: CA ZIP Code: 95409 Country: USA

5. Telephone Number: Home Work

6. Date of Birth: Mo/Day/Yr IL

7. Sex: ☒ Female ☐ Male

8. Are you a U.S. citizen? ☒ Yes ☐ No
If you are a Foreign Medical Graduate you must provide an original Certificate of Naturalization, Declaration of Intent to become a U.S. citizen or a full unrestricted license to practice medicine in a state or country.

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

PERSONAL DATA ✓

10. List name and address of all colleges or universities attended other than schools where professional medical instruction was received. Submit an official transcript from each school attended.

Name	Address	Period of Attendance From (Mo/Yr)	To (Mo/Yr)
Princeton University	Princeton, NJ	9/73	6/77
Univ of Pennsylvania, Philadelphia	Philadelphia PA	9/84	6/86
Harvard University	Cambridge, MA	6/74	8/74

NONMEDICAL EDUCATION ✓

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		Univ of Pennsylvania, Philadelphia PA
Physics	X		"
Biology or Zoology	X		"

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

Name	Address	Place Where Instruction Received	Period of Attendance From (Mo/Yr)	To (Mo/Yr)
Univ of CA, San Francisco	San Francisco, CA	San Francisco, CA	7/86	6/90

MEDICAL EDUCATION 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
Univ of California, San Francisco	San Francisco, CA	6/17/90	CA 002 ✓

C-9/19/91 NL

L1A

BMQA USE ONLY

13. Have you taken any of the following written examinations: National Boards, other State Boards, FLEX, ECFMG Certification? ☒ Yes ☐ No

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

Name	Location	Date	Result
National Boards Pt I	San Francisco	June, 1988	
Pt I	San Francisco	September, 1988	
II	San Francisco	April, 1990	
III	San Francisco	March 6, 1991	

WRITTEN EXAMINATION

14. Have you satisfactorily completed at least one year of qualifying postgraduate training in U.S. or Canadian facilities? ☒ Yes ☐ No

If YES, list name and address of all facilities. Submit an original Certificate of Completion of ACGME Postgraduate Training (Form L3) from each facility.

Name	Address	Type of Service	Period of Attendance	
			From (Mo/Yr)	To (Mo/Yr)
Community Hosp, Santa Rosa	3325 Chanate Rd Santa Rosa CA, 95404	Family Practice	July 90	July 93

POSTGRADUATE TRAINING

14A Have you ever withdrawn from or been suspended, dismissed or expelled from a medical school or postgraduate training program? If yes, please explain on a separate sheet of paper. Yes No

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

If YES, list state or country, license number, date issued and dates of practice in issuing agency's jurisdiction for each. Submit a Letter of Good Standing from each state in which you are licensed or have been licensed.

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

LICENSE DATA

LOS CE

16. Has any disciplinary action ever been filed or taken regarding any healing arts license which you now hold or have ever held? Include any disciplinary actions by the U.S. Military, U.S. Public Health Service or other U.S. federal governmental entity.

If yes, give details below: Yes No

State	Date	Charge	Disposition

L1B

F1D

BMQA USE ONLY

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

LICENSE DATA (continued)

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.

If yes, please explain on a separate sheet of paper. Yes No

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

If yes, please explain on a separate sheet of paper.

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

If yes, please explain on a separate sheet of paper. Yes No

21. Are you now, or were you in the past, addicted to or treated for addiction to controlled substances, such as narcotics or alcohol? Yes No

If yes, please explain on a separate sheet of paper.

GENERAL DATA

22. Have you ever been convicted of, or pled nolo contendere to a violation of any federal, state or local law relating to the manufacture, distribution or dispensing of controlled substances? Yes No

If yes, give details below:

Violation and Location	Date	Penalty or Disposition

23. Have you ever been convicted of, or pled nolo contendere to any offense, misdemeanor or felony of any state, the United States, or a foreign country? (except violations of traffic laws resulting in fines of $75.00 or less.) Yes No

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

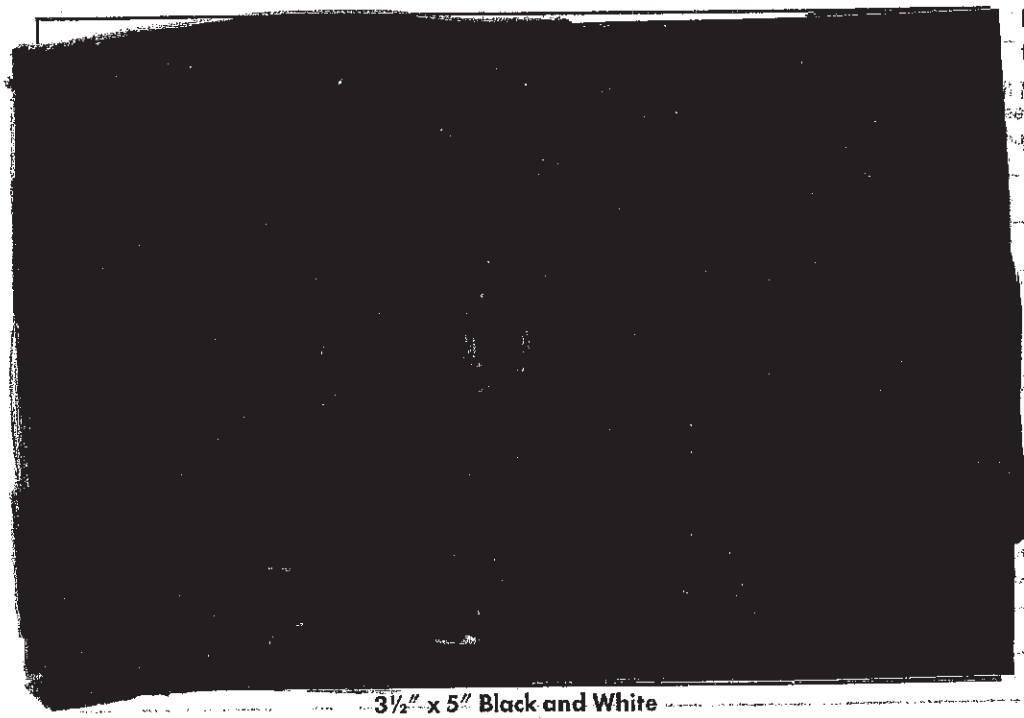
If yes, give details below:

Violation and Location	Date	Penalty or Disposition

"Disclosure of your social security number is mandatory. Section 30 of the Business and Professions Code and Pub. L. 94-455 (42 U.S.C.A. 405 (c) (2) (C)) authorizes collection of your social security number. Your social security number will be used exclusively for tax enforcement purposes. If you fail to disclose your social security number, you will be reported to the Franchise Tax Board, which may assess a $100 penalty against you."

L1C

FIC



3½" x 5" Black and White

I hereby declare under penalty of perjury under the laws of the State of California, that the photo of myself attached hereto, was taken

on or about ____, 19__

my age then being ____ years;

color of hair ____;

color of eyes ____;

height ____ ft. ____ in.;

weight ____ lbs.;

identifying marks ____

NOTE: All items in this application are mandatory; none are voluntary. Failure to provide any of the requested information will result in the application being rejected as incomplete. The information provided will be used to determine qualification for licensure, per Section 2080 of the Business and Professions Code which authorizes the collection of this information. Information regarding the issuance or denial of a license by the Board may be transmitted to any other medical licensing authority or the Federation of State Medical Boards. Applicants have the right to review their application subject to the provisions of the Information Practices Act. The Program Manager of the Division of Licensing is the custodian of records.

STATE OF California)

COUNTY OF Los Angeles)

Jennifer Hastings being duly sworn, says he is the person referred to in the foregoing application for a physician and surgeon's certificate in California and that he has carefully read and thoroughly understands all the requirements therein and that the statements made herein and all attachments are true and correct under penalty of perjury under the laws of the State of California.

He requests that the Division of Licensing, Medical Board of California, initiate a review of the records to determine their eligibility for examination, postgraduate training or licensure in California. In making this request, he authorizes the release of any information or records held by any individual or agency, relative to their training and qualifications as a physician and surgeon, upon request by the Board for use in evaluating their file.

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

Signed and sworn to before me this 25 day of April, 1991.

[SEAL]

OFFICIAL SEAL
EVELYN MEIER
Notary Public-California
LOS ANGELES COUNTY
My Commission Expires
May 28, 1994

Signature of Notary Public Evelyn Meier

Address 4023 Lincoln Ave, Culver City, Ca. 90232

My commission expires May 28, 1994

L1D

07A-100

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

DEPARTMENT OF Consumer Affairs

MEDICAL BOARD OF CALIFORNIA

1426 HOWE AVENUE, SUITE 54, SACRAMENTO, 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 Jennifer Lynne Hastings
FULL NAME OF APPLICANT

of 10 Woodland Ave, San Francisco CA ADDRESS WHEN ENROLLED enrolled in Univ of California, San Francisco NAME OF MEDICAL SCHOOL

San Francisco CA LOCATION on the 17 (28) day of June (July) MONTH 1986 (1990) YEAR per transcript

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).

Univ of Pennsylvania EDUCATIONAL INSTITUTION 9/84 – 6/86 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 She attended in this institution 13 SPECIFY NUMBER courses of resident instruction of 12 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

☒ She was granted the degree Bachelor/Doctor of Medicine by
☐ he withdrew from

the above mentioned medical school on the 17th day of June MONTH 1990.

Anatomy Dermatology

A SEPARATE COURSE IN EACH OF THE SUBJECTS LISTED IS NOT REQUIRED. HOWEVER THE COURSE OF STUDY COMPLETED BY THE CANDIDATE SHALL HAVE PROVIDED ADEQUATE INSTRUCTION IN ALL OF THE AREAS LISTED.

Ophthalmology Neurology Anesthesia

[redacted]

Signed and the college seal affixed this 17th day of July, 1991.

BY Emilie [illegible] M.D. Associate Dean
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

07A-100

STATE OF CALIFORNIA---STATE AND CONSUMER SERVICE[illegible]GENCY — GEORGE DEUKMEJIAN, *Governor*

DEPARTMENT OF Consumer Affairs

MEDICAL BOARD OF CALIFORNIA

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

CERTIFICATE OF COMPLETION OF ACGME 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 below. Please type or print.

This is to certify that Jennifer Lynne Hastings (NAME OF APPLICANT),

a graduate of Univ of California, San Francisco (NAME OF MEDICAL SCHOOL),

formally commenced an accredited postgraduate training program at Community Hospital, Santa Rosa (NAME AND ADDRESS OF FACILITY),

3325 Chanate Rd, Santa Rosa CA 95404 in Family Practice (SPECIALTY),

on July 1, 19 90, and satisfactorily completed such training on June 30, 19 91.
This training consisted of 12 months of actual clinical instruction and is approved by the Accreditation Council for Graduate Medical Education (ACGME) or the Coordinating Council of Medical Education of the Canadian Medical Association (CCME) and consisted of the following rotations:

(List rotations completed. If service was not rotating, indicate type of straight training performed. NOTE—To qualify for licensure in California, graduates of foreign medical schools must have completed at least four months of postgraduate training in general medicine. Effective July 1, 1990, all applicants who have not completed their one year of postgraduate training necessary for licensure will be required to complete at least four months of postgraduate training in general medicine as part of the one year requirement. This 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 to determine if it is acceptable.

ROTATION	LENGTH OF ROTATION
Medicine	3.0 months
Surgery	2.0 months
OB/GYN	3.0 months
Pediatrics	2.0 months
Emergency Room	1.0 months
Orientation	1.0 months
Vacation	1.0 months

[redacted]

AFFIX SEAL OF HOSPITAL OR NOTARY PUBLIC

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 was trained in an approved ACGME or CCME program position.

NAME Frank D. Dornfest, MD
DIRECTOR OF MEDICAL EDUCATION

ADDRESS 3324 Chanate Road

Santa Rosa, CA 95404

PHONE NUMBER (707) 576-4071

DATE July 18, 1991

SIGNATURE [signature]

L3

07-A100

STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY

GEORGE DEUKMEJIAN, *Governor*

DEPARTMENT OF Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
1426 HOWE AVE., STE. 54
SACRAMENTO, CA 95825-3236
(916) 920-6411

CERTIFICATION STATEMENT

This is to certify that Jennifer HASTINGS (Name of Physician) is in an approved ACGME/CCME postgraduate training position that commenced on July 1, 19 90 and is expected to be completed on June 30, 19 93 in Family Practice (Type of Training) at Community Hospital, Santa Rosa 3325 Chanate Rd, Santa Rosa CA 95404. (Name and Address of Facility)

(AFFIX SEAL OF)
(HOSPITAL OR)
(NOTARY PUBLIC)

1065/20

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.

Frank D. Dornfest, MD
Type or print name of Director of Medical Education

Signature of Director of Medical Education

July 18, 1991
Date

(707) 576-4071
Phone Number

L9

07M-71 (REV. 1/90)