001479

OF CALIFORNIA—AGRICULTURE AND SERVICES AGENCY

EDMUND G. BROWN JR., Governor

DEPARTMENT OF Consumer Affairs

BOARD OF MEDICAL QUALITY ASSURANCE

1430 HOWE AVENUE, SACRAMENTO, CALIFORNIA 95825
TELEPHONE:
Applications and Examinations (916) 322-5040

RECEIVED SACRAMENTO BOARD OF MEDICAL QUALITY ASSURANCE
APR 17 9 21 AM '80

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

007799 — 1 Hy/on NO RES LTR

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

1. NAME: Last: Leb First: Michael Middle: R. Maiden:
2. Telephone No.:
3. List other names, if any, you have used:
4. Address: Street and No./Rural Route: 431 Veteran Ave. City: Los Angeles State: Ca. Zip Code: 90024
5. Name you wish on License: Michael R. Leb
   Birthdate: (Month - Day - Year)
6. Premedical Education: Name of College or University: UNIVERSITY OF MIAMI Location: CORAL GABLES, FLA.
   Period of attendance: From: 1970 To: 1974
   Check premed courses successfully completed: ☑ Chemistry ☑ Physics ☑ Biology or Zoology
7. Medical School:

Year	Name of Institution	Location	From	To
1st	UNIV OF MIAMI	MIAMI, FL.	1974	1975
2nd	"	"	1975	1976
3rd	"	"	1976	1977
4th	"	"	1977	1978
5th				
6th				

8. Doctor of Medicine Degree granted by: UNIVERSITY OF MIAMI SCHOOL OF MEDICINE Date: 6-4-78
   For office use only School Code: FL002
9. 1st Year Postgraduate Training (Internship): UCLA - SAN FERNANDO VALLEY PROGRAM

Location	Type of Service	From	To
SEPULVEDA, CA.	INTERNAL MEDICINE	6-78	6-79

10. List all States in which you have been licensed to practice medicine:
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 ___

07A-161 (REV. 4-76)

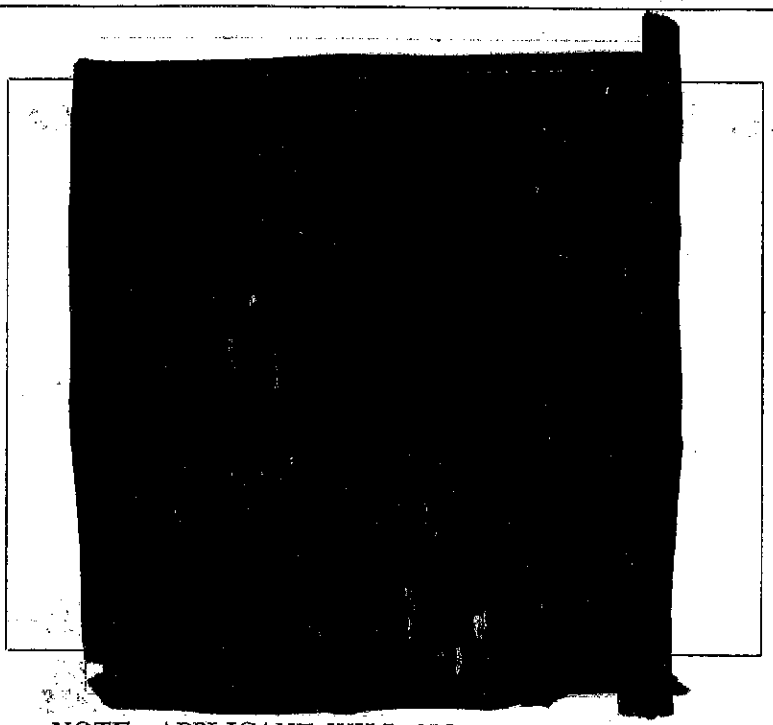
(Over)

14. Have you ever been convicted of, pled guilty or 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?	Yes	No
15. Have you ever been convicted of, pled guilty or nolo contendere to any offense, misdemeanor or felony in any state? (Except violations of traffic laws resulting in fines of $50.00 or less.)	Yes	No

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? Yes No
If yes, please explain on another sheet of paper.



Applicant: Please complete the following:

Height: __Ft. __In. Weight: __Lbs.

Hair color: __ Eye color:

Identifying marks: _____

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

"I hereby certify (or declare), under penalty of perjury, 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 Michael R. Lobb

Date April 10, 1980

Subscribed and sworn to before me this 10TH day of APRIL 1980.

Signature of Notary Ernest Bell

SEAL

Address WADSWORTH V.A. MEDICAL CENTER, L.A. CA. 90073

My commission expires: August 5, 1983

OFFICIAL SEAL
ERNEST BELL
NOTARY PUBLIC - CALIFORNIA
LOS ANGELES COUNTY
My comm. expires AUG 5, 1983

42175-556 5-76 10M ① ◊ OSP

STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY EDMUND G. BROWN JR., Governor

DEPARTMENT OF Consumer Affairs

BOARD OF MEDICAL QUALITY ASSURANCE

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

RECEIVED SACRAMENTO BOARD OF MEDICAL QUALITY ASSURANCE
SEP 25 12 03 PM '79

PLEASE FORWARD TO YOUR MEDICAL SCHOOL

CERTIFICATE OF EDUCATION

This Certifies That Michael Robin Leb, M.D.
Full name of applicant

enrolled in University of Miami School of Medicine
Name of medical school (college)

on the 16 day of September 19 74.
Month Year

☒ 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:

☒ PHYSICS ☒ CHEMISTRY ☒ BIOLOGY (or) ZOOLOGY (Check course(s) completed)

at University of Miami, and that he attended while at this
Please indicate school

medical school (college) 4 year courses of lectures of 9 months weeks each,
Specify number Specify number of weeks

completing NA hours in the subjects below listed, and that he/she:
Total hours

☒ was granted the degree { ~~Bachelor~~ / Doctor } of Medicine

☐ left the above mentioned medical school (college) for the following reason(s):

_____

_____

on the 4 day of June 19 78.
Month Year

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

✓ Anatomy	___ Preventive medicine	✓ Medicine
✓ Embryology	___ Hygiene and sanitation	✓ Pediatrics
✓ Histology	✓ Radiology, including roentgenologic technique and radiation safety	✓ Psychiatry
✓ Neuroanatomy	___ Urology	✓ Neurology
✓ Physiology	✓ Ophthalmology	___ Dermatology
✓ Psychobiology	✓ Anesthesia	___ Physical medicine
✓ Biochemistry	___ Otolaryngology	___ Therapeutics
✓ Pathology, bacteriology and immunology	✓ Obstetrics and gynecology	___ Tropical medicine
✓ Pharmacology		✓ Surgery, including orthopedic surgery

Signed and the College seal affixed this 20 day

of September 19 79
Month Year

[Affix Seal Here]

By _____
President, Secretary, Dean

Associate Dean for Student Affairs

07A-32 (REV. 6-79) 62452-656 7-78 5M ◊ OSP

Application Summary

License Type:	**Physician and Surgeon G**
License Number:	**41857**
File Number:	
Application:	**Physician's and Surgeon's Renewal**
Application Number:	
Application Date:	**02/09/2016 (mm/dd/yyyy)**

Application Questions

Have you served or are you currently serving in the military?	**N**

Personal Detail

First Name:	**MICHAEL**
Middle Name:	**R**
Last Name:	**LEB**
Birthdate:	****/**/******
Gender:	**Male**

Addresses

License Related Addresses

Address of Record (Required)

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

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?	
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 - None** **Other - None** **Patient Care - 30-39 Hours** **Research - None** **Teaching - None** **Telemedicine - None**
Patient Care Practice Location	**Zip: 90250 County: LOS ANGELES**
Telemedicine Practice Location	**Zip: County:**
Patient Care Secondary Practice Location	**Zip: 90034 County: LOS ANGELES**
Telemedicine Secondary Practice Location	**Zip: County:**
Current Training Status	**Not in Training**
Areas of Practice	**Obstetrics and Gynecology - Primary**
Board Certifications	**None**
Postgraduate Training Years	**9+ Years**
Cultural Background	**European**
Foreign Language Proficiency	**Spanish**
Web Site Profile	**Foreign Language Proficiency - 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
dca
DEPARTMENT OF CONSUMER AFFAIRS

dca BREEZE

Department of Consumer Affairs

RECEIPT

18404650

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

Name:	LEB, MICHAEL R
Transaction Date:	02/09/2016 19:37
Application Number:	
Complaint Number:	
License Type:	8002
License Number:	41857
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.

Medical Board of California – Physician's and Surgeon's Initial Renewal

LICENSEE NAME	LICENSE NO.	EXPIRATION DATE	AMOUNT DUE NOW
LEB, MICHAEL R	**G41857**	**03/31/14**	**$808.00**

LICENSEE MUST CHECK CORRECT BOXES

- "H" ☑ Completed Continuing Education
- "E" ☑ Change of Address (fill in reverse side)
- "I" ☐ Conviction Disclosure – Yes
- "J" ☑ 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 Michael R Leb MD Date 1/5/14

ENTER YOUR PHONE NUMBER FOR REFERENCE:

( ) –

630107000007000060004185740103311400080800000088600

CHANGE OF MAILING ADDRESS **LEB, MICHAEL R** **G41857**

01222014 20001767 20070018

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)

12954 HAWTHORNE BLVD

#100

City HAWTHORNE State CA Zip 90250 –

PO Box (if used, must provide a confidential physical street address, above)

City State Zip –

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?

____YES OR ___X___NO

SUMMARY OF RENEWAL FEES OWED		FINANCIAL INTEREST STATEMENT Health Facility Name	Address
2012 Renewal Fee	808.00		
Delinquent Fee			
Penalty Fee			
TOTAL FEES:	$808.00 GOOD UNTIL 4/30/12		

MEDICAL BOARD OF CALIFORNIA LICENSE RENEWAL PHYSICIAN AND SURGEON APPLICATION

F. _____ YES I WISH TO CONTRIBUTE $25 FOR THE FAMILY PHYSICIAN TRAINING PROGRAM.

H. _____ YES I WISH TO CONTRIBUTE $50 FOR THE S.M. THOMPSON LOAN REPAYMENT PROGRAM.

D. CONTINUING MEDICAL EDUCATION (CME) CERTIFICATION STATEMENT
I CERTIFY UNDER PENALTY OF PERJURY UNDER THE LAWS OF CALIFORNIA TO THE FOLLOWING STATEMENT:

I CERTIFY THAT I DO MEET EACH OF THE CONTINUING MEDICAL EDUCATION REQUIREMENTS LISTED ON THE SECOND PAGE OF THIS FORM OR THAT I MEET THE CONDITIONS WHICH WOULD EXEMPT ME FROM ALL OR PART OF THE REQUIREMENTS OR I HOLD A PERMANENT CME WAIVER.

Signature required Michael R Leb 0084063

LICENSE NO. 41857

EXPIRES 3/31/12

FEE OWED $ 808.00

DELINQ FEE IF POSTMARKED AFTER ____

$ ____
$ ____
$ ____

TOTAL ENCLOSED $ 808.00

E. FOR ADDRESS CHANGE ONLY
IF YOUR ADDRESS SHOWN IS INCORRECT, CORRECT IT BELOW.

STREET 11101 Venice BLVD

CITY Los Angeles STATE CA

ZIP 90034

PHONE NUMBER (310) 840-5757

G. FINANCIAL INTEREST STATEMENT

I CERTIFY UNDER PENALTY OF PERJURY THAT I HAVE DISCLOSED ON THIS RENEWAL APPLICATION FORM THE NAMES OF THOSE HEALTH-RELATED FACILITIES IN WHICH I OR MY FAMILY HAVE A FINANCIAL INTEREST OR I CERTIFY UNDER PENALTY OF PERJURY I HAVE NO FINANCIAL INTEREST TO DISCLOSE.

Signature required Michael R Leb

Dr. MICHAEL R LEB
819 SOUTH VERMONT AVENUE
LOS ANGELES, CA 90005

4-13-12