

OF THE STATE OF CALIFORNIA  
NATIONAL BOARD APPLICATION—CLASS G

Certificate Fee : 01607

Print or Type

1. Name: Last OLSGARD First EDWARD Middle CHARLES Maiden \_\_\_\_\_ 2. Social Security No. \_\_\_\_\_

3. Address: Street and Number/Rural Route 3208 STREET City SAN FRANCISCO State CALIFORNIA Zip Code No. 94110

4. Birth date: (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year) 12/10/30  Male  Female Color Eyes \_\_\_\_\_ Color Hair \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ U.S. Citizen?  Yes  No If U.S. Citizen, by  Birth  Naturalization

5. Preliminary Education (4-Year High School or Equivalent) Name of High School UNIVERSITY HIGH SCHOOL Location MINNEAPOLIS, MINNESOTA Period of Attendance From 9-1960 To 6-1964

6. Premedical Education—College or University Name of College UNIVERSITY OF MINNESOTA Location MINNEAPOLIS, MINNESOTA Period of Attendance From 9-1964 To 6-1968

7. Premedical degree  Yes  No Degree B.A. ; B.S. Date Granted June, 1968 ; June, 1970

Required Premed Courses	College	Location	Period of Attendance From	To
Chemistry	<u>UNIV OF MINNESOTA</u>	<u>APIS</u>	<u>Sept, 1964</u>	<u>June, 1968</u>
Physics	"	"	"	"
Biology	"	"	"	"

Medical School Course (Year)	Medical College	Location	Period of Attendance From	To
1st	<u>UNIVERSITY OF MINNESOTA</u>	<u>MINNEAPOLIS, MINNESOTA</u>	<u>9-1968</u>	<u>6-1969</u>
2nd	"	"	<u>9-1969</u>	
3rd	"	"		
4th	"	"		<u>6-1972</u>
5th	<u>MNH</u>			
6th				

8. Doctor of Medicine degree granted by Name of Institution UNIVERSITY OF MINNESOTA Location MINNEAPOLIS, MINNESOTA Exact Date of Issuance June 15, 1972

Attach proof of degree (copy of diploma or equivalent) If attended more than one school, proof of attendance at other school. (copy of transcript)

10. Post Graduate Education Name of Institution \_\_\_\_\_ Location \_\_\_\_\_ Period of Attendance From \_\_\_\_\_ To \_\_\_\_\_

11. Internship Name of Hospital SAN FRANCISCO GENERAL HOSPITAL Location SAN FRANCISCO, CALIFORNIA Period of Attendance From 6-21-72 To 6-21-73

Attach proof of internship (copy of internship certificate or equivalent)

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

State or Country	Year License Issued	Current Status of License			
		Active	Inactive	Suspended	Revoked
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If previous license ever suspended or revoked: License Issued by \_\_\_\_\_ Date of Suspension or Revocation \_\_\_\_\_ Charge \_\_\_\_\_

13. Have you been denied a license to practice medicine by any state or country?  Yes  No

State or Country	Date of Denial	Reason for Denial
_____	_____	_____

HAVE YOU EVER FAILED A WRITTEN OR ORAL EXAMINATION GIVEN BY THIS BOARD?  Yes  No

14. Are you now or have you ever been addicted to narcotic drugs? Yes  No
15. Have you ever been charged with drug addiction? Yes  No
- If yes:
- |  | <u>Charge</u> | <u>Date</u> |  | <u>Disposition</u> |
|--|---------------|-------------|--|--------------------|
|  |               |             |  |                    |
- Have you ever made an offer in compromise in connection with the Harrison Narcotic Law? Yes  No
16. Have you ever been convicted of or pled guilty or nolo contendere to any violation of any law of any state, the United States, or a foreign country? Yes  No
- If yes:
- |  | <u>Violation</u> | <u>Date</u> |  | <u>Penalty or Disposition</u> |
|--|------------------|-------------|--|-------------------------------|
|  |                  |             |  |                               |
17. Are you suffering from any ailment communicable to others? Yes  No



State of California }  
 County of SAN FRANCISCO } ss.

EDWARD CHARLES OLSGARD  
 applicant, being duly sworn says he is the person whose photo is attached, that he is the person named in and lawful holder of each diploma submitted herewith and that said diplomas were procured in the regular resident course of instruction and examination without fraud or misrepresentation; that he has read and understands all the requirements relating to this application and that all statements made herein are true.

Immediately below, the "DIPLOMATE" CERTIFICATE ON

NATIONAL BOARD OF MEDICAL EXAMINERS  
 OF THE  
 UNITED STATES OF AMERICA  
 Edward Charles Olsgard, M.D.

having satisfied all the requirements and having successfully passed the examinations is hereby declared a Diplomate of the National Board of Medical Examiners.

Attest: J. D. MYERS  
 Chairman of the Board

SEAL

JOHN P. HUBBARD  
 President of the Board

Philadelphia, Pa.  
 June 22, 1973

Cert. # 124087

I hereby apply for a physician's and surgeon's certificate in the State of California and submit the following credentials as required in Section 2194 of the Business and Professions Code and by the rules of the Board of Medical Examiners of the State of California.

Edward Charles Olsgard, M.D.  
 Signature of applicant in full—use no initials

Subscribed and sworn to before me this 4th day of June 1973



Gloria Gonzales  
 Signature of notary  
 2539 Mission St. San Fran. Ca

NATIONAL BOARD OF MEDICAL EXAMINERS

I, John P. Hubbard, M.D., President of the National Board of Medical Examiners and official custodian of the records of said Board, certify that the foregoing Diplomate Certificate No. 124087 will be ~~xxx~~ issued to Edward Charles Olsgard, M.D., on the 22nd day of June 19.73, and ~~has been~~ <sup>will be</sup> delivered to him; (2) that prior thereto said applicant filed with the National Board, his Medical Diploma; (3) that said applicant has passed examinations given by the National Board as follows:

	Location of examination	Month	Day	Month	Day	19	Total Grade
1st part	<u>Minneapolis, Minn.</u>	<u>June</u>	<u>16</u>	<u>June</u>	<u>17</u>	<u>19 70</u>	<del>XXXXXXXXXX</del>
2d part	<u>Minneapolis, Minn.</u>	<u>April</u>	<u>11</u>	<u>April</u>	<u>12</u>	<u>19 72</u>	<del>XXXXXXXXXX</del>
3d part	<u>San Francisco, Cal.</u>	<del>xxx</del> <u>March</u>	<u>7</u>	<del>xxx</del> <u>March</u>	<u>7</u>	<u>19 73</u>	<del>XXXXXXXXXX</del>

(4) that the complete record of said applicant's credentials and examination will be forwarded for inspection to the California Board on request; (5) that the "Diplomate" Certificate on the preceding page bears the original date of issue (if a Duplicate please add an explanatory note).

In testimony whereof witness my hand and seal

John P. Hubbard, M.D.  
Signature of executive officer  
Official title President

[SEAL]

dated at Philadelphia, Pennsylvania  
this 18th day of June 1973

Address 3930 Chestnut Street  
Philadelphia,  
Pennsylvania, 19104

It is hereby certified that EDWARD CHARLES OLSGARD entered the FRESHMAN Specify Freshman or later class in the Univ. of Minnesota Medical School Name Medical College on the 23rd day of September 19 68 Month

1. That as evidence of PRELIMINARY EDUCATION (high school) he presented graduation from University High School-Minneapolis, Minnesota

Specify documentary evidence and date of document

2. That as evidence of PREMEDICAL EDUCATION (college) he presented four years work from the College of Liberal Arts University of Minnesota

Specify documentary evidence and date of document, including number of units

\*3. That prior to commencing the course of the study of medicine he completed a one-year course of college grade in each of the subjects of Physics, Chemistry and Biology as shown on the accompanying certification.

Every application based on a certificate issued after January 1, 1919, must show that prior to commencing the last half of the second year in the study of medicine, he has completed one year of college grade in the subjects of Physics, Chemistry and Biology. After January 1, 1924, said course must have preceded the study of medicine. After September 21, 1951, an applicant must show the completion of a two-year college course, including the subjects of Physics, Chemistry and Biology prior to commencing the study of medicine and an applicant matriculating in a medical school after January 1, 1954, must show the completion of a three-year college course, including the subjects of Physics, Chemistry and Biology.

\* Strike out number 3 if course not of record in your institution, i.e., filed as matriculation requirement.

4. That he attended four Specify number courses of lectures given by this institution completed during a period of four Years and was issued the degree Doctor of Medicine Specify on the 6th <sup>15th</sup> day of June 1972 Month

Signed C. F. Liesenfelt  
C. F. LIESENFELT  
ASSISTANT DIRECTOR  
ADMISSIONS AND RECORDS  
UNIVERSITY OF MINNESOTA  
President/Dean/Secretary

{ SEAL OF SCHOOL }

of Univ. of Minnesota  
Name of school

this 9th day of May 19 73  
Month

to furnish information concerning his or her character, education and standing, on request of the Board.)

This certifies that I have been personally acquainted with EDWARD OLSGARD, M.D.,

for 1 years and that I know him to be of good moral character and hereby recommend him to the Board of Medical Examiners of the State of California as most worthy to be licensed to practice as a "physician and surgeon" in the State of California.

Name Salerno D. Newman M.D. Address 1246 15th Ave. San Francisco  
Graduated from Univ. Rochester (N.Y.) date 5/31 1973 Licensed in Calif. No. G11446  
JUNE 1963 State

This certifies that I have been personally acquainted with Edward Olgard, M.D.,

for 1 years and that I know him to be of good moral character and hereby recommend him to the Board of Medical Examiners of the State of California as most worthy to be licensed to practice as a "physician and surgeon" in the State of California.

Name Salmer J. Moore Address 4320 St. Anthony Rd. Oakland Calif.  
Graduated from Univ. of Southern Calif. date June 19 48 Licensed in Calif. No. A 13477  
State

**INFORMATION**

DEAR DOCTOR:

Answering your recent inquiry, we submit the following information regulating the issuance of a certificate to practice in California under the provisions of Section 2194 of the Business and Professions Code, with the suggestion that you carefully supply all the data required on this application blank.

National Board reciprocity applications are acted on at credential committee meeting held approximately once a week. Final action requires the affirmative vote of seven members of the Board.

**NOT TO BE USED FOR RECIPROCITY BASED ON ANOTHER STATE'S LICENSE — WRITE FOR APPROPRIATE APPLICATION.**

No **TEMPORARY CERTIFICATES** or **SPECIAL PERMITS** to practice are issued. The filing of an application does not grant applicant any special privileges, nor is any method of treating the sick or afflicted permitted in California without the lawful possession of a certificate issued by this Board and then only after said certificate has been recorded in the county wherein such practice is conducted. See sections 2141 to 2143 of the Business and Professions Code. Applicants must not establish offices nor circulate professional printed matter before a California certificate has been issued.

APPLICATION FEE of \$10.00 (foreign exchange to be added) preferably in any form other than a personal check (which must be held 2 weeks to clear bank) must accompany this application and be deposited in the office of the Board, 1020 N Street, Sacramento, California 95814, two weeks before any date shown on the accompanying dates for meetings for the current year. An additional \$100.00 to be paid if certificate is issued, together with the current initial fee as provided by law and the Board rules and regulations.

**PARTIALLY COMPLETED APPLICATIONS NOT ACCEPTABLE.**

All preliminary, premedical and professional training must have been "resident" courses in a school approved by the Board.

**THE BUSINESS AND PROFESSIONS CODE PROVIDES ADDITIONAL REQUIREMENTS THAT MUST BE COMPLETED BY GRADUATES OF FOREIGN MEDICAL SCHOOLS. APPLICANTS WHO ARE GRADUATES OF FOREIGN MEDICAL SCHOOLS SHOULD REQUEST INFORMATION REGARDING THE ADDITIONAL REQUIREMENTS PRIOR TO COMPLETING THIS APPLICATION.**

Section 2194 of the Business and Professions Code. An applicant, whose application is based on a diplomate certificate issued by the National Board of Medical Examiners of the United States, shall pay the fee provided by this chapter and, in addition to all other requirements provided for a physician's and surgeon's certificate, he shall file testimonials of good moral character satisfactory to the board and shall satisfy the board that the standard of the National Board of Medical Examiners on the date that the diplomate certificate was issued was in no degree or particular less than that which was required for a physician's and surgeon's certificate under this chapter on the same date.

He shall also satisfy the board that the diplomate certificate was procured without fraud or misrepresentation and that at no time has any certificate or license issued by any state of the United States or issued by a foreign country been revoked or annulled for unprofessional conduct.

The board may, in its discretion, with or without an oral examination, issue a certificate to an applicant who has complied with the requirements provided for a diplomate certificate.

+

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G  
Responding to your request dated

+

+



Department of Consumer Affairs



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### License Details - Public Record Actions - Administrative Disciplinary Actions

Press "Back" to return to the previous screen.

Name:	OLSGARD, EDWARD CHARLES
License:	G 25166
Case Number:	12 2012226067
Description:	ACCUSATION FILED. THE PHYSICIAN HAS NOT HAD A HEARING OR BEEN FOUND GUILTY OF ANY CHARGES.
Effective Date:	11/07/2014
Document URL:	<a href="http://www2.mbc.ca.gov/BreezePDL/default.aspx?licenseType=G&amp;licenseNumber=25166&amp;name=OLSGARD, EDWARD CHARLES">http://www2.mbc.ca.gov/BreezePDL/default.aspx?licenseType=G&amp;licenseNumber=25166&amp;name=OLSGARD, EDWARD CHARLES</a>

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RETURN THE ENTIRE FORM TO THE RETURN ADDRESS ON THE BACK, MAKE A PHOTOCOPY FOR YOUR RECORDS.

License Renewal Application  
Physician and Surgeon

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? PLEASE READ INSTRUCTIONS BEFORE ANSWERING I  YES J  NO

**D. Continuing Medical Education (CME) Certification Statement:** 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 BACK 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 HERE: [Signature] DATE: 4/20/12

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

AMOUNT DUE NOW	DELINQ FEE IF POSTMARKED AFTER 05/30/12
\$808.00	\$886.00
VOLUNTARY FEE = \$	\$
TOTAL ENCLOSED = \$	\$

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

STREET \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
PHONE NUMBER ( ) \_\_\_\_\_

LICENSE NO. 25166  
EXPIRES 04/30/12

ACTIVE EDWARD CHARLES OLSGARD  
2675 HARRIS STREET  
EUREKA CA 95503

**G. FINANCIAL INTEREST STATEMENT**  
I CERTIFY UNDER PENALTY OF PERJURY THAT I HAVE DISCLOSED ON THIS RENEWAL APPLICATION FORM (SEE REVERSE FOR SPACE) 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 here

OVER

63010700000700006000251660010430120008080000088600

**G. Financial Interest Statement**

Please print or type the name(s) and address(es) of each health-related facility in which you or your immediate family have a financial interest. If more space is needed, please attach additional listings. If you have no interests to declare, please write "none" in the area below and sign your name on the front of this document at G.

Health-Related Facility Name Address

Health-Related Facility Name	Address

STATE OF CALIFORNIA  
DEPARTMENT OF CONSUMER AFFAIRS  
PO BOX 942520  
SACRAMENTO CA 94258-0520

02212012 10002811 10010029

(DON'T BRUSH)

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

LICENSEE NAME  
OLSGARD, EDWARD C

LICENSE NO.  
G25166

EXPIRATION  
DATE  
04/30/14

AMOUNT  
DUE NOW  
\$820.00

34228

**LICENSEE MUST CHECK CORRECT BOXES**

"H"  Completed Continuing Education

"E"  Change of Address (fill in reverse side)

"I"  Conviction Disclosure – Yes

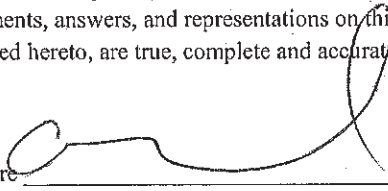
"J"  Conviction Disclosure – No

"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  Date 1/29/14

ENTER YOUR PHONE NUMBER FOR REFERENCE:

\_\_\_\_\_

628848

63010700000700006000251660010430140008200000089800

CHANGE OF MAILING ADDRESS

OLSGARD, EDWARD C

G25166

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

\_\_\_\_ - \_\_\_\_