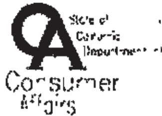

**MEDICAL BOARD OF CALIFORNIA**
**LICENSING PROGRAM**
1426 Howe Avenue
Sacramento, CA 95825-3236
(916) 263-2499

RECEIVED
SACRAMENTO
MEDICAL BOARD
OF CALIFORNIA

99 JAN 29 PM 3:29

# CERTIFICATE OF MEDICAL EDUCATION

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

This certifies that Jody Ellen Steinauer (FULL NAME OF APPLICANT) of 176 Pope St., San Francisco (ADDRESS WHEN ENROLLED) enrolled in University of California (NAME OF MEDICAL SCHOOL) San Francisco, CA (LOCATION) on the 7th day of September (MONTH) 19 92 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).*

University of California, Santa Cruz (EDUCATIONAL INSTITUTION) 9/87 - 12/91 (DATES)

**Advanced Credits:** *Credits previously obtained at an approved medical, dental, or osteopathic school.*•

MEDICAL SCHOOL ______ TOTAL CREDITS ______ DATES ______

The undersigned further certifies that the records of this institution show that She attended in this institution 5* (SPECIFY NUMBER) years of resident instruction of 33-48 (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:

*see letter of explanation

[X] She was granted the degree Bachelor/Doctor of Medicine by OR [ ] he withdrew from the above mentioned medical school on the 8th day of June (MONTH), 1997.

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.

Urology
Psychiatry
Neurology
Alcoholism and Chemical Dependency
Pediatrics
Pharmacology
Anesthesia
Family Medicine••
Spousal or Partner Abuse Detection & Treatment•••

- • 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**.
- •• ONLY applicable to medical students who graduate from medical school on or after May 1, 1998
- ••• ONLY applicable to medical students who enrolled in medical school on or after September 1, 1994.

TRANSCRIPTS FOR ALL ADVANCED CREDITS AND MEDICAL SCHOOL CREDITS MUST BE SUPPLIED WITH THIS CERTIFICATE

**Medical School Seal MUST be imprinted Partially on the Photograph.**

Signed and the school seal affixed this 26th day of January, 19 99.

BY Maxine Papadakis
PRESIDENT, SECRETARY, DEAN

**L2**

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

MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM
1426 Howe Avenue, Sacramento, CA 95825-3236
(916) 263-2499

# CERTIFICATE OF COMPLETION OF ACGME/COME POSTGRADUATE TRAINING

To be completed by the facility for every medical school graduate completing postgraduate training in the United States or Canada.

PART I — To be completed by the trainee.

| Last Name of Trainee | First Name | Middle Initial |
|---|---|---|
| Steinauer | Jody | E |

| Current Address | Social Security Number |
|---|---|
| 176 Pope St. | [redacted] |

| City | State | Zip Code | Telephone Number |
|---|---|---|---|
| San Francisco | CA | 94112 | [redacted] |

PART II — [illegible]

| Name of Facility | Address of Facility |
|---|---|
| University of California, San Francisco | 505 Parnassus Ave., Box 0132, SF, CA 94143 |

OK

| Name of Program Director | Telephone Number |
|---|---|
| A. Eugene Washington, M.D., M.Sc. | (415) 476-5192 |

| Signature of Program Director | Date Signed |
|---|---|
| [signature] | 1/8/99 |

| List Categorical Specialty/Area of Training Completed by Trainee | Date Training Commenced | Date Training Completed |
|---|---|---|
| OB/GYN | 6/21/97 | 6/20/98 |

If the training was rotating or transitional, list the specific rotations and the number of weeks spent in each (SEE THE REVERSE FOR INFORMATION ON SATISFYING THE GENERAL MEDICINE TRAINING REQUIREMENT):

Straight training in OB/GYN

PART III — To be completed by the Director of Medical Education and affixed with the official facility seal.

| Name of the Director of Medical Education | Facility Name |
|---|---|
| David M. Irby, Ph.D. | University of California, San Francisco |

| Facility Address |
|---|
| 500 Parnassus Ave., Box 0410 |

| City | State | Zip Code | Telephone Number |
|---|---|---|---|
| San Francisco | CA | 94143 | (415) 476-4561 |

PART IV — Signature of Director of Medical Education certifying trainee's completion of training.

**ATTENTION PROGRAM DIRECTOR!**
**IF TRAINEE IS IN HIS/HER FIRST YEAR OF POSTGRADUATE TRAINING, DO NOT SIGN OR DATE THE STATEMENT BELOW UNTIL AFTER THE COMPLETION OF THE TRAINEE'S LAST DAY OF TRAINING.**

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 COME to offer the type and level of training completed by the applicant and that the applicant was trained in an approved ACGME or COME program position.

| Signature of Director of Medical Education | Date Signed |
|---|---|
| [signature] | 1/13/99 |

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

7A-100 L3 (Rev. 2/97)

L3A

# MEDICAL BOARD OF CALIFORNIA
## LICENSING PROGRAM

1426 Howe Avenue, Sacramento, CA 95825-3236
(916) 263-2499

# APPLICATION FOR PHYSICIAN AND SURGEON'S EXAMINATION OR LICENSURE

012279

Please **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 as per instructions.
**Please type or print neatly. When space provided is insufficient, attach additional sheets of paper.**

MBC USE ONLY

**1. Name:** Last: Steinauer First: Jody Middle: Ellen 014404

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

**3.** Social Security Number◆ [redacted]

**4.** Address: Number and Street/Rural Route (include apartment number, if any): 176 Pope St.

**5.** Sex: ☒ Female ☐ Male

City: San Francisco State: CA Zip Code: 94112 Country: USA

**6.** Telephone Number: Home: [redacted] Work: ( )

**7.** Date of Birth: Mo/Day/Yr [redacted] Place of Birth: [redacted]

**8.** California Driver's License Number, if applicable: NUMBER EXPIRATION

**9.** Are you a U.S. citizen? ☒ Yes ☐ No

If you are an international medical school graduate, you must provide an original full and unrestricted license to practice medicine in another state or country, OR official documentation of U.S. citizenship, OR an official Declaration of Intent to become a U.S. citizen.

**10.** Have you ever filed an application for physician and surgeon examination or licensure in California? ☐ Yes ☒ No

IF YES, PLEASE GIVE DATE PREVIOUS APPLICATION WAS SUBMITTED AND ATTACH ANY APPLICATION MATERIALS YOU MAY HAVE RETAINED.

**11A.** List the names and addresses of all colleges or universities attended where pre-professional, postsecondary instruction was received. Please submit official transcripts with the school seal affixed for each school attended.

| Name | Address | Dates of Attendance |
|---|---|---|
| University of CA | Santa Cruz | 9/87 - 12/91 |

**11B.** Check whether the following premedical courses were successfully completed and show where completed:

| Course | Yes | No | Name of College or University |
|---|---|---|---|
| Chemistry | X | | University of CA, Santa Cruz |
| Physics | X | | same |
| Biology or Zoology | X | | same |

**12.** List the names and addresses of all schools where professional medical instruction was received, and, where applicable, the degree awarded. **PLEASE SUBMIT: 1)** an original Certificate of Medical Education (Form L2) and official transcripts with the signature of the dean or registrar and the school seal affixed from each school attended; **and 2)** an original medical diploma and a photocopy.

| School Name | Address | Place of Instruction | Dates of Attendance | Degree Awarded |
|---|---|---|---|---|
| University of CA | San Francisco | | 9/92 - 6/97 | MD |

DOCTOR OF MEDICINE DEGREE, as referenced above. (Note: A U.S. graduate may, in lieu of the original, submit an official certified photocopy that has the school seal affixed and the signature of the registrar certifying authenticity.)

| Name of Medical School | Address of Medical School | Exact Date of Issuance |
|---|---|---|
| University of California | San Francisco | June 8, 1997 |

◆ MANDATORY DISCLOSURE OF SOCIAL SECURITY NUMBERS

Disclosure of your social security number (or federal employer identification number [FEIN], if you are a partnership) is mandatory. Section 30 of the Business and Professions Code and Public Law 94-455 (42 USCA 405(c)(2)(C)) authorize collection of your social security number. Your social security number or FEIN will be used exclusively for tax enforcement purposes, for purposes of compliance with any judgment or order for family support in accordance with Section 11350.6 of the Welfare and Institutions Code, or for verification of licensure or examination status by a licensing or examination entity which utilizes a national examination and where licensure is reciprocal with the requesting state. If you fail to disclose your social security number or your FEIN, your application for initial licensure will not be processed AND you will be reported to the Franchise Tax Board, which may assess a $100 penalty against you.

School Code: CA 002

L1A

MBC USE ONLY

**13.** Have you taken any of the following written examinations: National Boards, other state boards, USMLE, SPEX, FLEX, or LMCC?

☒ Yes ☐ No

IF YES, LIST NAME, LOCATION, DATE AND RESULT OF EXAMINATION. SUBMIT AN ORIGINAL OFFICIAL EXAMINATION HISTORY REPORT FROM EACH EXAMINATION AGENCY. APPLICANTS WHO HOLD CERTIFICATION THROUGH THE EDUCATIONAL COMMISSION FOR FOREIGN MEDICAL GRADUATES (ECFMG) WILL NEED TO SUBMIT AN ORIGINAL VALID ECFMG CERTIFICATE PRIOR TO WRITTEN EXAMINATION AND LICENSURE.

| Examination | Location | Date | Result |
|---|---|---|---|
| USMLE | San Francisco | 6/94 | |
| USMLE | San Francisco | 5/97 | |
| USMLE | San Mateo | 5/98 | |
| | | | |

Written Examination

**14.** Have you ever 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 EACH ISSUING AGENCY'S JURISDICTION. SUBMIT A LETTER OF GOOD STANDING FROM EACH STATE IN WHICH YOU ARE OR HAVE BEEN LICENSED. PLEASE INCLUDE TEMPORARY, TRAINING, OR PROVISIONAL LICENSES.

| State or Country | License Number | Date of Issuance | Dates of Practice in that Jurisdiction |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

License Data

LGS

**15A.** Are you currently, or have you ever been, a participant in a postgraduate training program in a facility in the U.S. or Canada?

☒ Yes ☐ No

IF YES, LIST NAMES AND ADDRESSES OF ALL FACILITIES. SUBMIT AN ORIGINAL CERTIFICATE OF COMPLETION OF ACGME/CCME POSTGRADUATE TRAINING (FORM L3A) FROM EACH FACILITY. (DO NOT COMPLETE FORM L3A/BS TO DOCUMENT TRAINING RECEIVED IN RESEARCH FELLOWSHIP PROGRAMS.) **ALL TRAINING MUST BE LISTED, REGARDLESS OF WHETHER IT WAS SATISFACTORILY COMPLETED OR WILL BE USED TO MEET LICENSING REQUIREMENTS.**

| Facility Name | Address | Type of Service | Dates of Attendance |
|---|---|---|---|
| University of CA | San Francisco, CA | OB-Gyn | 6/97 - present |
| | | | |
| | | | |
| | | | |

Postgraduate Training

**QUESTIONS 15B through 21:** For any positive response to the following questions, please provide ALL official documentation regarding the matter in addition to written explanations. If applicable, an applicant should also provide official hearing/court documents and original letters of explanation from medical school or training program directors or other appropriate authorities. APPLICANTS ARE ALSO REQUIRED TO REPORT ANY MATTER THAT IS PENDING OR IN WHICH CHARGES HAVE BEEN DROPPED OR EXPUNGED.

**15B.** Have you ever withdrawn from, or been suspended, dismissed or expelled from a medical school or postgraduate training program?

[redacted] Yes [redacted] No

**16.** Have you ever been charged with, or been found to have committed, unprofessional conduct, professional incompetence, gross negligence or repeated negligent acts or malpractice by any medical licensing board, other agency, or hospital or has any disciplinary action ever been filed or taken regarding any healing arts license which you now hold or have ever held, or is any such action pending? 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.

[redacted] Yes [redacted] No

License Data

| State | Date | Charge | Disposition |
|---|---|---|---|
| | | | |
| | | | |

ATS 55246 Steinauer, Jody

MBC USE ONLY

License Data

17. Has a claim or action for damages ever been filed against you in the course of the practice of medicine or any other healing art which resulted in a malpractice settlement, judgement or arbitration award of over $30,000.00? Yes No
IF YES, GIVE DETAILS BELOW.

| Name of Claimant | Location of Court | Brief Description of the Facts |
| --- | --- | --- |
| | | |
| | | |
| | | |

18. Have you ever been denied a license, permission to practice medicine or any other healing art, or denied permission to take an examination in any state, country, or U.S. federal jurisdiction, or is any such action pending? Yes No
IF YES, GIVE DETAILS BELOW.

| State or Country | Date of Denial | Reason for Denial |
| --- | --- | --- |
| | | |
| | | |

19. Have you ever voluntarily surrendered a license to practice in the healing arts in this or any other state, or voluntarily surrendered your narcotic (controlled substance) permit (state or federal) to any licensing board or any other agency, or is any such action pending? Yes No

20. Have you ever had staff privileges in a hospital denied, suspended, limited, revoked or not renewed for medical disciplinary cause, or resigned from a medical staff in lieu of disciplinary or administrative action, or is any such action pending? Yes No

21. Do you have any condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety, including but not limited to, any of the following? Yes No

IF YES, PLEASE CHECK THE APPROPRIATE BOX(ES) BELOW:

- ☐ A condition which required admission to an inpatient psychiatric treatment facility.
- ☐ Alcohol or chemical substance dependency or addiction.
- ☐ Emotional, mental or behavioral disorder.
- ☐ Other (explain): ______

FOR ANY OF THE BOXES CHECKED ABOVE, PLEASE SUBMIT COMPLETE OFFICIAL INPATIENT AND OUTPATIENT TREATMENT RECORDS, EVIDENCE OF ONGOING REHABILITATION TREATMENT, AND A PERSONAL WRITTEN EXPLANATION.

**QUESTION 22:** For any positive response to the following question, please provide ALL official documentation regarding the matter in addition to written explanations. If applicable, an applicant should also provide official hearing/court documents and original letters of explanation from appropriate authorities.

22. Have you ever been convicted of or pled nolo contendere to any violation (including misdemeanors and felonies) of any federal, state or local law of any state, the United States, or a foreign country or any violation relating to the possession, use, illegal sale, transportation, manufacture, distribution or dispensing of controlled substances, or is any such action pending? *(Exclude violations of traffic laws, including speeding, which resulted in fines of $300.00 or less.)* If YES, give details below. Yes No

YOU ARE REQUIRED TO LIST ANY CONVICTION THAT HAS BEEN SET ASIDE AND DISMISSED OR EXPUNGED, OR WHERE A STAY OF EXECUTION HAS BEEN ISSUED.

| Violation and Location | Date | Penalty or Disposition |
| --- | --- | --- |
| | | |
| | | |
| | | |
| | | |

TOP OF PHOTO

BOTTOM OF PHOTO

**PHOTO DECLARATION**

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 [redacted] 19[redacted]

my age then being [redacted] years;

my color of hair [redacted];

my color of eyes [redacted];

my height [redacted] in.;

my weight [redacted] lbs.;

and identifying marks are [redacted]

Signature of Applicant

X J Steinauer

**Notice: All items in this application are mandatory; none are voluntary. Failure to provide any of the requested information will delay the processing of your application. The information provided will be used to determine your qualifications for licensure per Section 2080 of the California Business and Professions Code, which authorizes the collection of this information. The information on your application may be transferred to other medical licensing authorities, the Federation of State Medical Boards, or other governmental or law enforcement agencies. You have the right to review your application subject to the provisions of the Information Practices Act. The Program Manager of the Licensing Program is the custodian of records.**

STATE OF CALIFERNIA )

COUNTY OF SAN FRANCISCO )

Applicant Declaration/Signature *and* NOTARY

The applicant, Jody Ellen Steinauer, being first duly sworn upon his/her

**PRINT FULL NAME OF APPLICANT**

oath deposes and says: that he/she is the person herein named subscribing to this application; that he/she has read the complete application, knows the full content thereof, and declares that all of the information contained herein and evidence or other credentials submitted herewith are true and correct; that he/she is the lawful holder of the degree of Doctor of Medicine as prescribed by this application, that the same was procured in the regular course of instruction and examination, and that it, together with all the credentials submitted, were procured without fraud or misrepresentation or any mistake of which the applicant is aware and that the applicant is the lawful holder thereof. Further, I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past, present and future), business and professional associates (past, present and future), and all government agencies (local, state, federal or foreign) to release to the Medical Board of California or its successors any information, files or records, including medical records, educational records, and records of psychiatric treatment and treatment for drug and/or alcohol abuse or dependency, requested by that Board in connection with this application; or any further or future investigation by that Board necessary to determine my medical competence, professional conduct or physical or mental ability to safely engage in the practice of medicine. I further authorize the Medical Board of California or its successors to release to the organizations, individuals or groups listed above any information which is material to this application or any subsequent licensure. I further acknowledge that falsification or misrepresentation of any item or response on this application is adequate to deny the same or to hold a hearing to revoke the same, if issued.

**SIGNATURE OF APPLICANT:** Jody Ellen Steinauer

**(PLEASE WRITE FULL NAME, NOT INITIALS)**

Signed and sworn to before me this 5 day of JANUARY, 19 99.

MARIO CARMONA JR
Comm. # 1100914
NOTARY PUBLIC - CALIFORNIA
City & County of San Francisco
My Comm. Expires June 14, 2000

NOTARY SEAL

SIGNATURE OF NOTARY PUBLIC

ADDRESS

UCSF BOOKSTORE
UNIVERSITY OF CALIFORNIA SAN FRANCISCO
500 PARNASSUS AVENUE
SAN FRANCISCO, CA 94143-0230
1-800-546-2144

My commission expires 06.14.00

**L1D**

07A-100 (Rev. 9/97)

**MEDICAL BOARD OF CALIFORNIA**
**LICENSING PROGRAM**
1426 Howe Avenue
Sacramento, CA 95825-3236
(916) 263-2499

# CERTIFICATION STATEMENT

This is to certify that Jody Ellen Steinauer
(Name of Physician)

is in an approved ACGME/CCME postgraduate training position that commenced on

June 21, 19 97 and is expected to be completed

on June 20 2001 in Obstetrics and Gynecology
Month Day Year (Type of Training)

OK

at University of California, San Francisco
(Name and Address of Facility)

505 Parnassus Ave., Box 0132, San Francisco, CA 94143

*AFFIX OFFICIAL HOSPITAL SEAL OR NOTARY SEAL IN THE BOX AT THE LEFT.*

"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."

David M. Irby, Ph.D.
(Type or print name of Director of Medical Education)

David Irby
(Signature of Director of Medical Education)

1-13-99
(Date)

(415) 476-4561
(Telephone Number)

**NOTE:** Do not use this form in lieu of Form L3A, "Certificate of Completion of ACGME/CCME Postgraduate Training."

**L4** *(formerly Form L9)*

07A-107-L4 (2/97)

**STATE DEPARTMENT OF CONSUMER AFFAIRS**
**INTERNET CASHIERING SYSTEM**
**MEDICAL BOARD OF CALIFORNIA**
**SUPPLEMENTAL INFORMATION REPORT**
**From Date:** 08/01/2012 **To Date:** 08/01/2012

**ATRISUPPINF**

**29-MAR-16 14:02:08**

**Person Id :** 550244 **Name :** Steinauer,Jody

| 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? | |

**Total Questions Asked For Person :** 550244 8

# Application Summary



| | |
|---|---|
| License Type: | **Physician and Surgeon A** |
| License Number: | **67843** |
| File Number: | |
| Application: | **Physician's and Surgeon's Renewal** |
| Application Number: | |
| Application Date: | **08/04/2014 (mm/dd/yyyy)** |

## Personal Detail

| | |
|---|---|
| First Name: | **JODY** |
| Middle Name: | **ELLEN** |
| Last Name: | **STEINAUER** |
| Birthdate: | ****/**/****** |
| Gender: | **Female** |

## Addresses

**License Related Addresses**

**Confidential Address (Optional)**

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

**License Specific Public/Mailing Address (Required)**

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 - 1-9 Hours** |
| | **Patient Care - 20-29 Hours** |
| | **Research - 10-19 Hours** |
| | **Teaching - 10-19 Hours** |
| | **Telemedicine - None** |
| Patient Care Practice Location | **Zip: 94110 County:** |
| Telemedicine Practice Location | **Zip: County:** |
| Patient Care Secondary Practice Location | **Zip: County:** |
| Telemedicine Secondary Practice Location | **Zip: County:** |
| Current Training Status | **Not in Training** |
| Areas of Practice | **Obstetrics and Gynecology - Primary** |
| Board Certifications | **American Board of Obstetrics and Gynecology - Obstetrics and Gynecology** |
| Postgraduate Training Years | **6 Years** |
| Cultural Background | **White** |
| Foreign Language Proficiency | **None** |
| Web Site Profile | **Cultural Background - No** |
| | **Foreign Language Proficiency - No** |
| | **Gender - Yes** |
| E-mail: | |

## Fees

| | |
|---|---|
| Biennial Renewal Fee | **$783.00** |
| DUE TO CURES FUND | **$12.00** |

1407200529494

| | |
|---|---|
| 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:

# Department of Consumer Affairs

## RECEIPT

613246

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

| | |
|---|---|
| Name: | STEINAUER, JODY ELLEN |
| Transaction Date: | 08/04/2014 18:02 |
| Application Number: | |
| Complaint Number: | |
| License Type: | 8002 |
| License Number: | 67843 |
| 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.