**STATE DEPARTMENT OF CONSUMER AFFAIRS**
**INTERNET CASHIERING SYSTEM**
**MEDICAL BOARD OF CALIFORNIA**
**SUPPLEMENTAL INFORMATION REPORT**
**From Date:** 05/23/2013 **To Date:** 05/23/2013

**ATRISUPPINF**
**25-MAR-16 09:51:36**

**Person Id :** 550994 **Name :** Van Ooy,D. Michelle

| 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 :** 550994 8

# Application Summary



| | |
|---|---|
| License Type: | **Physician and Surgeon A** |
| License Number: | **68693** |
| File Number: | |
| Application: | **Physician's and Surgeon's Renewal** |
| Application Number: | |
| Application Date: | **06/12/2015 (mm/dd/yyyy)** |

## Personal Detail

| | |
|---|---|
| First Name: | **D. MICHELLE** |
| Middle Name: | **MARIA** |
| Last Name: | **VAN OOY** |
| 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.** |

## 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**<br>**Other - None**<br>**Patient Care - 40+ Hours**<br>**Research - None**<br>**Teaching - 40+ Hours**<br>**Telemedicine - None** |
| Patient Care Practice Location | **Zip: 94115 County: SAN FRANCISCO** |
| 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 | **4 Years** |
| Cultural Background | **European** |
| Foreign Language Proficiency | **Spanish** |
| Web Site Profile | **Cultural Background - No**<br>**Foreign Language Proficiency - Yes**<br>**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
dca
DEPARTMENT OF CONSUMER AFFAIRS

dca BREEZE

## Department of Consumer Affairs

# RECEIPT

1301615

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

| | |
|---|---|
| Name: | VAN OOY, D. MICHELLE MARIA |
| Transaction Date: | 06/12/2015 13:32 |
| Application Number: | |
| Complaint Number: | |
| License Type: | 8002 |
| License Number: | 68693 |
| 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.

State of California Department of Consumer Affairs

RECEIVED
MEDICAL BOARD OF
CALIFORNIA
99 FEB 16 AM 8:29
LICENSING PROGRAM

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

# CERTIFICATE OF MEDICAL EDUCATION

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

This certifies that D. Michelle M. Van Ooy (FULL NAME OF APPLICANT) of Brooklyn, NY (ADDRESS WHEN ENROLLED) enrolled in SUNY-HSC @ Brooklyn (NAME OF MEDICAL SCHOOL) Brooklyn, NY (LOCATION) on the 26 day of August (MONTH) 1991 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 CA @ Santa Cruz (EDUCATIONAL INSTITUTION) 1989-1991 (DATES)

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

SUNY-HSC @ Brooklyn (MEDICAL SCHOOL) _____ (TOTAL CREDITS) _____ (DATES)

The undersigned further certifies that the records of this institution show that ☒ She ☐ he attended in this institution 4 (SPECIFY NUMBER) years of resident instruction of at least 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:

☒ She was granted the degree Bachelor/Doctor of Medicine by **OR** ☐ he withdrew from the above mentioned medical school on the 5 day of May (MONTH), 19 95

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
Alcoholism and Chemical Dependency
Preventive medicine, including Nutrition
Physical Medicine
Therapeutics
Neuroanatomy
Child Abuse Detection and Treatment
Geriatric Medicine
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 4 day of Feb, 1999

BY Asst Dean + Registrar (PRESIDENT, SECRETARY, DEAN)

L2

07A-100-1.2 (Rev. 2/97)

STATE OF CALIFORNIA — STATE AND CONSUMER SERVICES A

PETE WILSON, *Governor*

State of California Department of Consumer Affairs

RECEIVED MEDICAL BOARD OF CALIFORNIA
99 FEB 17 AM 8:33
LICENSING PROGRAM

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

SACRAMENTO MEDICAL BOARD
99 FEB 16 PM 4:30

# 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.

**PART 1: To be completed by the applicant\trainee.**

| Last Name of Trainee | First Name | Middle Initial |
|---|---|---|
| Van Ooy | D. Michelle | M. |

Current Address: 7717 Ridge Blvd #2

Social Security Number:

City: Brooklyn State: NY Zip Code: 11209

Telephone Number:

**PART 2: To be completed by the 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. PLEASE SEE THE REVERSE FOR A DEFINITION OF "SATISFACTORY."

Name of Facility: SUNY Health Science Center at Brooklyn OR

Address of Facility: 450 Clarkson Avenue Box 24

Name of Program Director: John G. Boyce, M.D

Telephone Number: (718) 270-2081

Signature of Program Director: John G. Boyce

Date Signed: 2-2-99

List Categorical Specialty Area of Training Completed by Trainee: OBSTETRICS AND Gynecology

Date Training Commenced: 07/01/95

Date Training Completed: 06/30/98

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):

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

Name of the Director of Medical Education: Roland Matthews, M.D.

Facility Name: SUNY Health Science

Facility Address: 450 Clarkson Avenue Box 24

City: Brooklyn State: NY Zip Code: 11203

Telephone Number: (718) 270-3117

**PART 4: Signature of Director of Medical Education certifying satisfactory 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 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: Roland Matthews

Date Signed: 2-2-99

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

Clara B. Martin

CLARA B. MARTIN
Notary Public, State of New York
No. 24-4772887
Qualified in Kings County
Commission Expires March 30, 2000

07A-100-L3 (Rev. 2/97)

L3A

State of California Department of Consumer Affairs

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

# CERTIFICATION STATEMENT

This is to certify that D. Michelle M. Van Ooy
(Name of Physician)

is in an approved ACGME/CCME postgraduate training position that commenced on July 1, 1995 and is expected to be completed on June 30, 1999 in OB/GYN Residency
Month Day Year (Type of Training)

at State University of New York Health Science Center @ Brooklyn
(Name and Address of Facility)
450 Clarkson Avenue - Box 24 - Brooklyn, NY 11203

Clara B. Martin
CLARA B. MARTIN
Notary Public, State of New York
No. 24-4772887
Qualified in Kings County
Commission Expires March 30, 2000

*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."

Roland Matthews, M.D
(Type or print name of Director of Medical Education)

Roland Matthews
(Signature of Director of Medical Education)

JANUARY 28, 1999
(Date)

718-270-3117
(Telephone Number)

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

07A-107-L4 (2/97)

**L4** (formerly Form L9)

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

Consumer Affairs

RECEIVED MEDICAL BOARD OF CALIFORNIA 99 MAR -5 AM 8:09 LICENSING PROGRAM

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

RECEIVED MEDICAL BOARD OF CALIFORNIA 99 SEP 24 AM 10:51

017274 #300 5/14/99

# APPLICATION FOR PHYSICIAN AND SURGEON'S EXAMINATION OR LICENSURE

014018

**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.**

3/14/00

MBC USE ONLY

**1. Name:** Last: Van Ooy First: D. Michelle Middle: Maria

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

**3.** Social Security Number◆

**4.** Address: Number and Street/Rural Route (include apartment number, if any): 7717 Ridge Blvd., Apt. #2

**5.** Sex: ☒ Female ☐ Male

City: Brooklyn State: NY Zip Code: 11209 Country: USA

**6.** Telephone Number: Home: Work:

**7.** Date of Birth: Mo/Day/Yr

Place of Birth:

**8.** California Driver's License Number, if applicable: NUMBER NA 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 California | Berkeley, CA | 1982-1986 |
| State University of CA | San Francisco, CA | 1987-1988 |
| University of California | Santa Cruz, CA | 1988-1991 |

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

| Course | Yes | No | Name of College or University |
|---|---|---|---|
| Chemistry | ✓ | | University of CA, Santa Cruz / State U. of CA, SF |
| Physics | ✓ | | University of CA, Santa Cruz |
| Biology or Zoology | ✓ | | University of CA, Santa Cruz |

**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 |
|---|---|---|---|---|
| State University of New York | 450 Clarkson Ave Bklyn, NY 11203 | Brooklyn, NY | 1991-1995 | M.D. |

**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 |
|---|---|---|
| State University of NY @ Brooklyn | 450 Clarkson Ave Brooklyn 11203 | May 1995 |

◆ 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.

NY 051 School Code

L1A

07A-100 (Rev. 9/97)

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.

Written Examination

| Examination | Location | Date | Result | |
|---|---|---|---|---|
| USMLE STEP 1 | Brooklyn, NY | May 1993 | | ☑ |
| USMLE STEP 2 | Brooklyn, NY | May 1995 | | ☑ |
| USMLE STEP 3 | New York, NY | May 1997 | | ☑ |
| | | | | ☐ |

**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.

License Data

LGS

| State or Country | License Number | Date of Issuance | Dates of Practice in that Jurisdiction | |
|---|---|---|---|---|
| New York | 208464 | 9/29/97 | 9/29/97 - current | ☑ |
| | | | | ☐ |
| | | | | ☐ |
| | | | | ☐ |

**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.**

Postgraduate Training

| Facility Name | Address | Type of Service | Dates of Attendance | |
|---|---|---|---|---|
| State University of NY Health Science Center | 450 Clarkson Ave Brooklyn NY 11203 | Resident of OB/GYN | July 1995 - June 1997 | ☑ |
| | | | | ☐ |
| | | | | ☐ |
| | | | | ☐ |

**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? Yes 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. Yes No

License Data

| State | Date | Charge | Disposition | |
|---|---|---|---|---|
| | | | | ☑ |
| | | | | ☐ |

L1B

MBC USE ONLY

**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.

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 |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

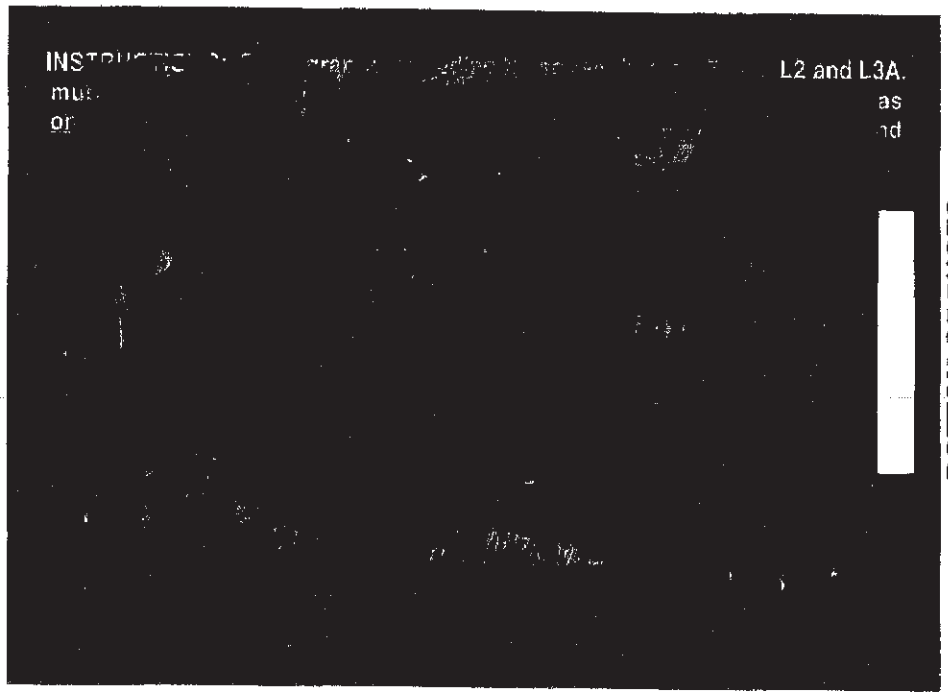


**PHOTO DECLARATION**

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

_____ _____, 19_____;

my age then being _____ years;

my color of hair_____

my color of eyes_____;

my height _____ ft. _____ in.;

my weight _____ _____ lbs.;

and identifying marks are

_____

_____

_____.

***Signature of Applicant:***

**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.**

Applicant Declaration/Signature and NOTARY

STATE OF New York )

COUNTY OF Kings )

The applicant, D. Michelle M. Van Ooy, MD, 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:** _____
**(PLEASE WRITE FULL NAME, NOT INITIALS)**

Signed and sworn to before me this 12TH day of FEBRUARY, 1999.

Clara B. Martin
SIGNATURE OF NOTARY PUBLIC

450 Clarkson Ave - Box 24
ADDRESS Brooklyn, NY 11203

My commission expires 3/30/2000

CLARA B. MARTIN
Notary Public, State of New York
Commission Expires March 30, 2000

NOTARY SEAL

CLARA B. MARTIN
Notary Public, State of New York
No. 24-4772887
Qualified in Kings County

L1D

07A-100 (Rev. 9/97)