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

State of California Department of Consumer Affairs

MEDICAL BOARD OF CALIFORNIA

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

94 MAR 32 PM — DIVISION OF LICENSING

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.**

MBC USE ONLY

012384 66.00 5/3/94 010989 673.00 234.00 4/1/94

1. Name: Last: Francis First: Jennifer Middle: Ann

PERSONAL DATA

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

3. Social Security Number — See disclosure statement on L1C

4. Address: Number and Street/Rural Route (include apartment number, if any): 47 Lake Pines

City: Irvine State: CA ZIP Code: 92720 Country: USA

5. Telephone Number: Home W

6. Date of Birth: Mo/Day/Yr — Place of Birth:

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 previous application was submitted:

10. List name and address of all colleges or universities attended where pre-professional, postsecondary instruction was received. Please submit an official sealed transcript for each school attended.

NON-MEDICAL EDUCATION

Name	Address	Period of Attendance From (Mo/Yr)	To (Mo/Yr)
University of CA, Los Angeles	Los Angeles CA	9/83	12/87
University of CA, Irvine	Irvine CA 92714	9/92	~~12/92~~ 9/85

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 CA, Los Angeles
Physics	X		Univ. of CA, Los Angeles
Biology or Zoology	X		Univ of CA, Los Angeles

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 sealed transcripts from each school attended.

MEDICAL EDUCATION — CME TRANS

Name	Address	Place Where Instruction Received	Period of Attendance From (Mo/Yr)	To (Mo/Yr)
University of CA, Irvine	Irvine CA 92714	Irvine CA	9/88	6/92

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.)

CA 615 — School Code

Name of Medical School	Address of Medical School	Exact Date of Issuance
University of California, Irvine Medical School	Irvine CA 92714	June 13, 1992

NOTE: APPLICANT MUST PROVIDE NAME, ADDRESS AND DATE OF ISSUANCE OF DEGREE.

L1A

MBC 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. Applicants who hold ECFMG certification will need to submit an original valid ECFMG certificate for examination and licensure.

WRITTEN EXAMINATION

Name	Location	Date	Result
National Board - part I	UniV CA, Irvine	6/90	
National Board - part II	UniV CA, Irvine	9/91	
National Board - part III	Harbor UCLA	5/93	

14. Have you satisfactorily completed at least one year of qualifying postgraduate training in U.S. or Canadian facilities? ☒ Yes ☐ No
(Note: Do not complete Form L3 (s) to document training received in research or clinical fellowship programs)

POSTGRADUATE TRAINING

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)
University CA, Irvine	101 City Drive Orange CA	Obstetrics/Gynecology	7/92	6/93

QUESTIONS 14A–23 For any positive response to these questions, applicant should provide, in addition to written explanations, any documentation regarding the matter.

14A. Have you ever withdrawn from, or been suspended, dismissed or expelled from, a medical school or postgraduate training program? Yes ☒ No

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

LICENSE DATA

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. Please include temporary, limited, or provisional licenses.

LGS CE

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

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

MBC USE ONLY

LICENSE DATA (continued)

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

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. Yes No

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

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? Yes No

GENERAL DATA

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

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

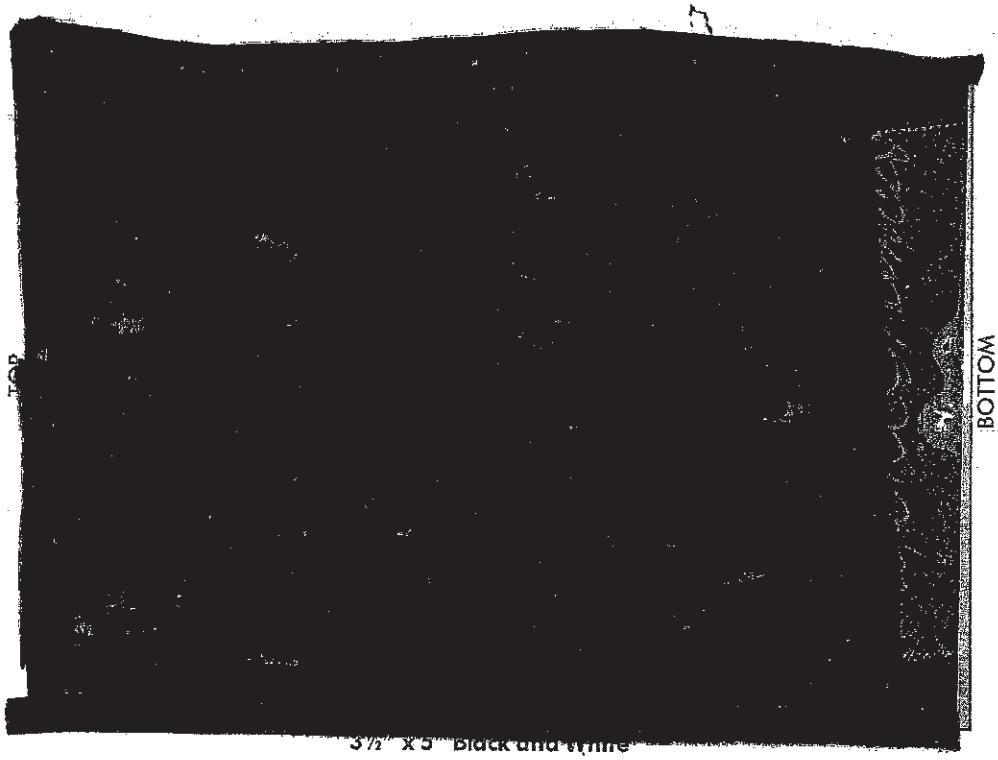
YOU ARE REQUIRED TO LIST ANY CONVICTION THAT HAS BEEN SET ASIDE AND DISMISSED UNDER SECTION 1203.4 OF THE PENAL CODE OR UNDER ANY OTHER PROVISION OF LAW. A SEPARATE LETTER EXPLAINING THE DETAILS OF THE OFFENSE IS ALSO REQUIRED, IN ADDITION TO CERTIFIED COURT DOCUMENTS.

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



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.

NOTARIZATION PORTION

STATE OF California)

COUNTY OF Orange)

Jennifer Ann Francis being duly sworn, says She is the person referred to in
PRINT FULL NAME OF APPLICANT

the foregoing application for a physician and surgeon's certificate in California and that She 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.

She 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, She 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 A Francis MD
Signature of applicant: (Write FULL name, not initials)

Signed and sworn to before me this 24th day of March, 1994.

Signature of Notary Public Theresa L. Mayers

Address 4543 Campus Dr Irvine CA 92715

[NOTARY SEAL]
OFFICIAL SEAL
THERESA L. MAYERS
NOTARY PUBLIC-CALIFORNIA
ORANGE COUNTY
MY COMMISSION EXPIRES
APRIL 11, 1995

My commission expires 4-11-95

07A 100 (REV. 7/91)

L1D

STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY

PETE WILSON, *Governor*

State of California 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 Ann Francis
FULL NAME OF APPLICANT

of Irvine
ADDRESS WHEN ENROLLED

enrolled in Univ of California Irvine School of medicine
NAME OF MEDICAL SCHOOL

Irvine, Ca
LOCATION

on the 6th day of Sept.
MONTH

19 88
YEAR

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, Los Angeles
EDUCATIONAL INSTITUTION

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 4
SPECIFY NUMBER
years of resident instruction of approx 52
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

OR

☒ She was granted the degree Bachelor/Doctor of Medicine by
☐ he withdrew from
the above-mentioned medical school on the 13th day of June
MONTH
19 92

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
Preventive medicine, including Nutrition
Physical Medicine
Therapeutics
Neuroanatomy
Child Abuse Detection and Treatment
Geriatric Medicine
Pediatrics
Pharmacology
Anesthesia

[redacted]

Signed and the college seal affixed this 28 day of January 19 94

BY [signature] MD
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 photographs and all entries to the form must be original.

L2

07A-100-L2 (REV. 7/91)

State of California Department of Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
1426 HOWE AVENUE, STE. 54
SACRAMENTO, CA 95825-3236
(916) 263-2499

CERTIFICATION STATEMENT

This is to certify that Jennifer Ann Francis (Name of Physician) is in an approved ACGME/CCME postgraduate training position that commenced on July 1, 19 92 and is expected to be completed on June 30, 19 96 in OB Gyn (Type of Training) at UC Irvine Medical Center, Dept. of OB Gyn (Name and Address of Facility) 101 The City Drive, Orange, CA 92668

(AFFIX OFFICIAL HOSPITAL SEAL OR NOTARY PUBLIC SEAL)

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.

Alberta Manetta
Type or print name of Director of Medical Education

A Manetta, MD
Signature of Director of Medical Education

1/28/94
Date

(714) 856-5798
Phone Number

NOTE: Do not use this form in lieu of Form L3 "Certificate of Completion of ACGME Postgraduate Training"

L9

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

State of California Department of Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
1426 HOWE AVENUE
SACRAMENTO, CALIFORNIA 95825-3236

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. Do not complete if photograph of applicant is not attached on the reverse side. Also, please print or type information on the form.

PART 1: *To be completed by applicant/trainee.*

Last Name Of Trainee: Francis | First Name: Jennifer | Middle Initial: A

Current Address: 47 Lake Pines | Phone Number: (

City: Irvine | State: CA | Zip Code: 92720

PART 2: *To be completed by 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. See reverse side of Form for definition of "satisfactory".

Name of Facility: University of California, Irvine Medical Center (OK)

Address of Facility: 101 The City Drive Orange CA 92668

Name of Program Director: Kirk A. Keegan, Jr MD | Phone Number: (714) 456-6707

Signature of Program Director: Kirk A. Keegan Jr | Date Signed: 1/25/94

List Categorical Specialty Area of Training Completed by Trainee: OB Gyn | Date Training Commenced: 07/01/92 | Date Training Completed 06/30/93

If the training was rotating or transitional, list in the space provided below, the specific rotations and the number of weeks spent in each:

Note: To qualify for licensure in California, applicants who are graduates of a foreign medical school must complete at least four months of postgraduate training in general medicine as part of the one-year requirement. Applicants who are graduates of a U.S. or Canadian medical school, who have not completed the one-year of postgraduate training required for licensure by July 1, 1990, must also complete four-months of training in general medicine as part of the one year required for licensure. The 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 of Licensing to make a determination regarding its acceptability.

(OVER)

L3A

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

Name of Director of Medical Education: Alberto Manetta MD

Phone Number: 714 856-5798

Facility Name: University of California, Irvine

Date Form Completed: 1/25/94

Facility Address: 101 The City Drive

City: Orange State: CA Zip Code: 92668

The individual signing this form is formally certifying and documenting, under penalty of perjury, that the physician received instruction appropriate for the particular postgraduate level and that they satisfactorily completed the training program in accordance with the accepted standards and the criteria defined as equating to "satisfactory" performance as described below. In cases where the Director of Medical Education is certifying the completion of the minimum one-year of training required for licensure, he or she will personally be attesting to the fact that the physician/trainee has acquired the skill and qualifications necessary to safely assume the unrestricted practice of medicine in this state.

Definition of "Satisfactory": The physician performed at an adequate level based on evidence of satisfactory progressive scholarship and professional growth including demonstrated ability to assume graded and increasing responsibility for patient care.

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: A Manetta MD

Date Signed: 1/28/94

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

[redacted]

L3B

Application Summary

License Type:	**Physician and Surgeon G**
License Number:	**78782**
File Number:	
Application:	**Physician's and Surgeon's Renewal**
Application Number:	
Application Date:	**12/08/2013 (mm/dd/yyyy)**

Personal Detail

First Name:	**JENNIFER**
Middle Name:	**ANN**
Last Name:	**MCNULTY**
Birthdate:	**(mm/dd/yyyy)**
Gender:	**Female**

Addresses

License Related Addresses

Confidential Address (Optional)

Name:	**MCNULTY, JENNIFER ANN**
Address:	

License Specific Public/Mailing Address (Required)

Name:	**MCNULTY, JENNIFER ANN**
Address:	**2888 LONG BEACH BLVD # 400** **LONG BEACH, CA** **90806**
E-mail Address:	

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?	

1386562230327

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** **Other - None** **Patient Care - 30-39 Hours** **Research - 1-9 Hours** **Teaching - 1-9 Hours** **Telemedicine - None**
Patient Care Practice Location	**Zip: 90806 County: LOS ANGELES**
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** **Other - Not Listed - Secondary**
Board Certifications	**American Board of Obstetrics and Gynecology - Maternal and Fetal Medicine** **American Board of Obstetrics and Gynecology - Obstetrics and Gynecology**
Postgraduate Training Years	**9+ Years**
Cultural Background	**White**
Foreign Language Proficiency	**Spanish**

Web Site Profile

Cultural Background - No

Foreign Language Proficiency - No

Gender - Yes

E-mail:

Fees

Biennial Renewal Fee	**$783.00**
Steven M. Thompson Physician Corps Loan Repayment Program	**$25.00**
Total Amount Due:	**$808.00**

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

149026

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

Name:	MCNULTY, JENNIFER ANN
Transaction Date:	12/08/2013 20:11
Application Number:	
Complaint Number:	
License Type:	8002
License Number:	78782
Payment Description:	Physician's and Surgeon's Renewal
Fee Paid: (US $)	808.00
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	AMOUNT DUE IF POSTMARKED AFTER MARCH 01, 2016
MCNULTY, JENNIFER A	**G78782**	**01/31/16**	**$820.00**	**$898.00**

LICENSEE MUST CHECK CORRECT BOXES

- "H" [X] Completed Continuing Education
- "E" [ ] Change of Address (fill in reverse side)
- "I" [ ] Conviction Disclosure – Yes
- "J" [X] Conviction Disclosure – No
- "F" [ ] Family Physician Training Program ($25)
- "G" [X] Financial Interest Statement-**Read instructions above**

"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 Jennifer McNulty Date 10/20/15

ENTER YOUR PHONE NUMBER FOR REFERENCE:

_____

630107000007000060007878200101311600082000000898000

CHANGE OF MAILING ADDRESS **MCNULTY, JENNIFER A** **G78782**

11252015 20001305 20010014

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