Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM
1426 Howe Avenue, Suite 54
Sacramento, CA 95825-3236
(916) 263-2382 FAX (916) 263-2487
www.caldocinfo.ca.gov

MEDICAL BOARD OF CALIFORNIA 08 JAN 18 PM LICENSING PROGRAM

INITIAL AND UPDATE APPLICATION FOR PHYSICIAN'S AND SURGEON'S LICENSE *OR* POSTGRADUATE TRAINING AUTHORIZATION LETTER

Application for (please check one): ☑ License ☐ PTAL - or - ☐ Update

			MBC Use Only
1. NAME: Last: SAEED	First: BUSHRA	Middle:	
Other names you have used (include maiden name): BUSHRA FATIMA SIDDIQI		2. U.S. Social Security Number	
3. Place of Birth		4. Date of Birth	
5. Gender: ☐ Male ☑ Female			
6. Public/Mailing Address: 7004 SHADOW BROOK (Please note: this information is public) (30 characters maximum per line, including spaces) TEXARKANA, TX 75503 USA — City, State/Province, Zip/Postal Code, Country			
7. Telephone Numbers: (include area code)	Home	Work	Cell
8. California Driver's License Number (optional):	10. Have you ever filed an Application for Physician's and Surgeon's License, or PTAL, in California? ☑ Yes ☐ No. Previous license number, if any:		Personal Data ☐
9. E-mail Address (optional): [redacted]			

MEDICAL EDUCATION

11. LIST EACH MEDICAL SCHOOL THAT YOU HAVE ATTENDED.

School Name	City, State/Province, Country	Dates of Attendance	L2 Transcript
DOW MEDICAL COLLEGE	KARACHI, PAKISTAN	05/1986 — 03/1992	☑ ☑
			☐ ☐
			☐ ☐

12. School of Graduation	Degree Awarded	Date of Graduation	Diploma
DOW MEDICAL COLLEGE	M.B.B.S.	03/1992	☑ 3-15-92

EXAMINATIONS

13. LIST ALL OF THE FOLLOWING EXAMINATIONS YOU HAVE TAKEN: USMLE, FLEX, NBME, ECFMG, SPEX, STATE BOARDS and/or QME in Canada

Examination	Date	Result (Pass/Fail)	Exams
USMLE STEP 1	10/1997		☑
USMLE STEP 2	08/1995		☑
USMLE STEP 3	06/2005		☑

Cashiering Use Only	School Code	
3508 1-18-08 93250	PAK 03	L1A

07A-100 (Rev. 12/05)

[illegible] 17-80 164105

A "yes" response to Questions 14 through 38 requires a written explanation on a separate sheet of paper along with any supporting materials.

ACGME/RCPSC ACCREDITED POSTGRADUATE TRAINING

MBC Use Only

14. **Please list each ACGME/RCPSC accredited postgraduate training program in which you have participated. You must include each internship, residency and fellowship, whether or not the program was completed or credit granted.**

Postgraduate Training

Facility Name	Address	Specialty Area	Dates of Attendance	
- SOUTHWEST OKLAHOMA	4427 WEST GORE BLVD,	FAMILY PRACTICE	07-01-03 — 02-26-04	☑
FAMILY PRACTICE RESIDENCY	LAWTON, OK 73505			☐
- AHEC SOUTHWEST (UAMS)	300 EAST, SIXTH ST	FAMILY PRACTICE	07-01-05 — PRESENT	☑
FAMILY PRACTICE RESIDENCY	TEXARKANA, AR 71854			☐
				☐

POSTGRADUATE TRAINING: (These questions are to be answered by ALL applicants)

Did you ever take a leave of absence or break from your training?	YES	NO	☑
Have you ever been terminated, dismissed or expelled from a program?	YES	NO	☑
Have you ever resigned from a training program?	YES	NO	O/K ☐
Were you ever placed on probation?	YES	NO	O/K ☐
Were you ever disciplined or placed under investigation?	YES	NO	☑
Were any incident reports ever filed by instructors?	YES	NO	☑
Were any limitations or special requirements placed upon you for clinical performance, discipline, or for any other reason?	YES	NO	☑
Have you ever had a postgraduate training program contract not be renewed or offered for a following year?	YES	NO	☑

MEDICAL LICENSURE

15. **Please list all medical licenses (other than training licenses) that have ever been issued by any state or territory in the United States or Canadian province.**

License Data

Jurisdiction	License Number	Date of Issuance	Dates of Practice in that Jurisdiction	
				☐
				☐
				☐
				☐
				☐

APPLICANT: BUSHRA SAEED

DATE OF BIRTH:

L1B

ABMS CERTIFICATIONS

MBC Use Only

ABMS

16. Are you currently certified by a Member Board of the American Board of Medical Specialties? YES ☐ NO ☒

Member Board	Expiration Date	Certificate Number

MALPRACTICE HISTORY

Malpractice

17. Has a claim or an action ever been filed against you for the practice of medicine which resulted in a malpractice settlement, judgment, or arbitration award of $30,000 or more? YES ☐ NO ☒

PRACTICE IMPAIRMENT OR LIMITATIONS

Limitations

18. Have you been enrolled in, required to enter into, or participated in any drug or alcohol recovery program or impaired practitioner program? YES ☐ NO ☐

19. Have you been treated for or had a recurrence of a diagnosed addictive disorder? YES ☐ NO ☐

20. Have you been diagnosed with an emotional, a mental, or behavioral disorder which impairs your ability to practice medicine safely? YES ☐ NO ☐

21. Have you ever been diagnosed with a neurological or other physical condition that would impair your ability to practice medicine safely? YES ☐ NO ☐

22. Do you have any other condition which in any way impairs or limits your ability to practice medicine safely? YES ☐ NO ☐

If you do receive ongoing treatment or participate in a monitoring program, the Board will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure.

CRIMINAL RECORD HISTORY

Criminal Record

23. Have you ever been convicted of, or pled guilty or nolo contendere to ANY offense in any state in the United States or foreign country?

This includes a citation, infraction, misdemeanor and/or felony, etc. If "YES" attach a list of each offense by arrest and conviction dates, violation, and court of jurisdiction (name and address). Matters in which you were diverted, deferred, pardoned, pled nolo contendere, or if the conviction was later expunged from the record of the court or set aside under Penal Code Section 1203.4 MUST be disclosed. If you are awaiting judgment and sentencing following entry of a plea or jury verdict, you MUST disclose the conviction; you are entitled to submit evidence that you have been rehabilitated. Serious traffic convictions such as reckless driving, driving under the influence of alcohol and/or drugs, hit and run, evading a peace officer, failure to appear, driving while the license is suspended or revoked MUST be reported. This list is not all-inclusive. If in doubt as to whether a conviction should be disclosed, it is better to disclose the conviction on the application.

For each conviction disclosed, you must submit with the application certified copies of the arresting agency report, certified copies of the court documents, and a descriptive explanation of the circumstances surrounding the conviction of disciplinary action (i.e., dates and location of incident and all circumstances surrounding the incident). This letter must accompany the application. If documents were purged by arresting agency and/or court, a letter of explanation from these agencies is required.

Applicants who answer "NO" to the question but have a previous conviction or plea, may have their application denied or license revoked for knowingly falsifying the application. YES ☐ NO ☒

OK

APPLICANT: BUSHRA SAEED

DATE OF BIRTH:

L1C

CRIMINAL RECORD HISTORY (cont'd)

MBC Use Only
Criminal Record

24. Is any criminal action pending against you?	YES	NO	☐
25. Are you required to register as a Sex Offender?	YES	NO	☒

DISCIPLINARY HISTORY

Discipline

These questions refer to discipline by any U.S. military or public health service, state board or other governmental agency of any U.S. state, territory, Canadian province, or country.

26. Have you ever been denied a license to practice medicine?	YES	NO	☐
27. Is any denial pending against you?	YES	NO	☐
28. 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?	YES	NO	☐
29. Have you ever had any license to practice medicine revoked, suspended, or placed on probation?	YES	NO	☐
30. Have you ever had any license to practice medicine subjected to any action including but not limited to informal or confidential discipline, consent orders, letters of warning, letters of reprimand, or citation?	YES	NO	☐
31. Have you ever had any license to practice medicine subjected to any other disciplinary action?	YES	NO	☐
32. Is any disciplinary action pending against any of your licenses to practice medicine?	YES	NO	☐
33. Have you ever had staff privileges in a hospital terminated, denied, suspended, limited, revoked, or not renewed?	YES	NO	☐
34. Have you ever resigned from a medical staff in lieu of disciplinary or administrative action?	YES	NO	☐
35. Is any disciplinary action pending against your hospital staff privileges?	YES	NO	☐
36. Have you ever surrendered a license to practice medicine?	YES	NO	☐
37. Have your DEA privileges ever been denied, suspended, restricted, or terminated?	YES	NO	☐
38. Have you ever entered into any arrangement or plea or agreement in lieu of a federal prosecution for a drug violation regulated by the DEA?	YES	NO	☐

APPLICANT: BUSHRA SAEED

DATE OF BIRTH:

L1D

MARTHA BAKER
NOTARY PUBLIC- STATE OF ARKANSAS
COUNTY OF MILLER
Commission Exp 02-24-2016
Commission # 12346356

Notice: All items in this application, except #8 and #9 are mandatory. 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 law enforcement agencies. You have the right to review your application subject to the provisions of the Information Practices Act. The Chief of the Licensing Program is the custodian of records.

The applicant, BUSHRA SAEED, _____ being first duly sworn upon his/her
(PLEASE PRINT FULL NAME) (DATE OF BIRTH)

oath deposes and says: that I am the person herein named subscribing to this application; that I have read the complete application, know the full content thereof, and declare under penalty of perjury, that all of the information contained herein and evidence or other credentials submitted herewith are true and correct; that I am 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 I am aware and that I am 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 any 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 UNDERSTAND THAT FALSIFICATION OR MISREPRESENTATION OF ANY ITEM OR RESPONSE ON THIS APPLICATION OR ANY ATTACHMENT HERETO IS A SUFFICIENT BASIS FOR DENYING OR REVOKING A LICENSE. BS (PLEASE INITIAL BOX)

SIGNATURE OF APPLICANT: Bushra Saeed.
(Please sign full name)

State of Arkansas

County of Miller

Subscribed and sworn to (or affirmed) before me on

this 10th day of January, 2008,

by Bushra Saeed

personally known to me or proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.

MARTHA BAKER
NOTARY PUBLIC- STATE OF ARKANSAS
COUNTY OF MILLER
My Commission Exp 02-24-2016
Commission # 12346356

Martha Baker
SIGNATURE OF NOTARY PUBLIC

L1E

STATE OF CALIFORNIA — STATE AND CONSUMER SERVICES AGENCY GRAY DAVIS, Governor

Consumer Affairs

EDICAL BOARD OF CALIFORNIA

1426 Howe Avenue, Suite 54, Sacramento, CA 95825-3236
TEL: (916) 263-2499/FAX: (916) 263-2487 Internet: www.medbd.ca.gov (TK)

APPLICATION UPDATE FOR PHYSICIAN'S AND SURGEON'S LICENSE

Please READ all instructions prior to completing this application. ALL questions on this application must be answered, and all supporting documents must be submitted as per instructions. Please type or print neatly. When space provided is insufficient, attach additional sheets of paper. All attachments are considered part of the application. FALSIFICATION OR MISREPRESENTATION OF ANY ITEM OR RESPONSE ON THIS APPLICATION OR ANY ATTACHMENT HERETO IS A SUFFICIENT BASIS FOR DENYING OR REVOKING A LICENSE.

1. NAME: Last	First	Middle	MBC USE ONLY
SAEED	BUSHRA		Personal Data

2. Other names you have used (include maiden name):	3. U.S. Social Security Number*
BUSHRA FATIMA SIDDIQI	

4A. (PUBLIC ADDRESS; will be released by the Board to the public): Number and Street/P.O. Box/Rural Route/Apartment Number, if any.
150 PALM VALLEY BLVD # 1090

City	State	Zip Code	Country
SAN JOSE	CA	95123	USA.

4B. (CONFIDENTIAL ADDRESS): Number and Street/Rural Route/Apartment Number, if any. [Applicants must provide a confidential street address if a P. O. Box is used as the Public Address in #4A above.]
SAME AS ABOVE in 4A.

City	State	Zip Code	Country

5. Telephone Number:	6. California Driver's License Number (optional):
Home: ( )	NUMBER EXPIRATION
Work: ( )	
7. Date of Birth (Month/Day/Year) and Place of Birth:	8. Sex: ☐ Male ☒ Female

9. Have you ever been licensed to practice medicine in any state, territory, province, country, or U.S. federal jurisdiction? ☒ Yes ☐ No

IF YES, LIST THE JURISDICTION, LICENSE NUMBER, DATE ISSUED AND DATES OF PRACTICE IN THAT JURISDICTION. PLEASE INCLUDE PERMANENT, TEMPORARY, TRAINING, PROVISIONAL, LIMITED LICENSE, OR PERMIT. AN ORIGINAL OFFICIAL LETTER OF GOOD STANDING (LGS), OR COMPARABLE LICENSE HISTORY CERTIFICATION, IS REQUIRED FOR EACH PERMANENT, TEMPORARY, TRAINING, PROVISIONAL, LIMITED LICENSE, OR PERMIT OBTAINED IN ANY U.S. STATE, U.S. OR CANADIAN TERRITORY, CANADIAN PROVINCE, OR U.S. FEDERAL JURISDICTION. EACH LGS, OR COMPARABLE CERTIFICATION, SHOULD BE MAILED BY THE ISSUING AUTHORITY DIRECTLY TO THE MEDICAL BOARD OF CALIFORNIA.

Jurisdiction	License Number	Date of Issuance	Dates of Practice in that Jurisdiction
STATE OF OKLAHOMA	23390 (Training License).	7-1-2003	7-1-2003 to 2-26-2004

10. Do you hold any other professional license in any state, territory, province, country, or U.S. federal jurisdiction? ☒ Yes ☐ No

PROFESSION: MEDICINE LICENSE NO.: 24277-S JURISDICTION: PAKISTAN.

For all of the below, also include any disciplinary actions by the U.S. Military, U.S. Public Health Service, or other U.S. federal governmental entity.

13A. 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?

13B. Has any disciplinary action ever been filed or taken, including but not limited to, informal or confidential discipline, consent orders, or letters of warning, regarding any healing arts license which you now hold or have ever held?

13C. Is any such action as described above pending?

IF YOU ANSWERED YES TO 13A, 13B OR 13C, PROVIDE DETAILS ON A SEPARATE ATTACHMENT.

13 (A)	Yes	☐ No
13 (B)	Yes	☐ No
13 (C)	Yes	☐ No

14. 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, territory, country, or U.S. federal jurisdiction, or is any such action pending?

MBC USE ONLY — License Data — LGS — Other Professional Licenses

surrendered your narcotic (controlled substance) permit (state or federal) to any licensing board or any other agency, or is any such action pending?

IF YOU ANSWERED YES, PROVIDE DETAILS ON A SEPARATE ATTACHMENT.

Yes ☐ No ☑

16. 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?

YOU MUST DISCLOSE ANY INFORMAL OR CONFIDENTIAL DISCIPLINARY ACTION.

Yes ☐ No ☑

17. 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.

FOR ALL OF THE 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.

18A. Have you ever been convicted of, or pled nolo contendere to, ANY violation (include every misdemeanor or felony) of any local, state, or federal law of any state, territory, country, or U.S. federal jurisdiction?

18 (A) Yes ☐ No ☑

18B. Is any criminal action related to the above pending?

IF YOU ANSWERED YES TO 18A OR 18B, PROVIDE DETAILS ON A SEPARATE ATTACHMENT.

18 (B) Yes ☐ No ☑

Applicant Declaration/Signature and NOTARY

STATE OF CALIFORNIA

COUNTY OF SANTA CLARA

The applicant, BUSHRA SAEED (PLEASE PRINT FULL NAME) _____ (DATE OF BIRTH), being first duly sworn upon his/her oath deposes and says: that I am the person herein named subscribing to this application; that I have read the complete application, know the full content thereof, and declare under penalty of perjury, that all of the information contained herein and evidence or other credentials submitted herewith are true and correct; that I am 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 I am aware and that I am 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 UNDERSTAND THAT FALSIFICATION OR MISREPRESENTATION OF ANY ITEM OR RESPONSE ON THIS APPLICATION OR ANY ATTACHMENT HERETO IS A SUFFICIENT BASIS FOR DENYING OR REVOKING A LICENSE.**

SIGNATURE OF APPLICANT: Bushra Saeed
(PLEASE SIGN FULL NAME, NOT INITIALS)

Signed and sworn to before me this 15th day of JUNE, 2005 BY BUSHRA SAEED
MONTH YEAR

PRAVINCHANDRA U. BHATT
Commission # 1444506
Notary Public - California
Santa Clara County
My Comm. Expires Nov 6, 2007

NOTARY SEAL

PRAVINCHANDRA U BHATT
SIGNATURE OF NOTARY PUBLIC

124 BLOSSOM HILL RD, SAN JOSE CA 95123
ADDRESS

My commission expires 11.06.07

L8B

STATE OF CALIFORNIA – STATE AND CONSUMER SERVICES AGENCY — ARNOLD SCHWARZENEGGER, Governor

Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM
1426 Howe Avenue, Suite 54
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04 FEB 17 PM 1:31
LICENSING PROGRAM

APPLICATION FOR PHYSICIAN'S AND SURGEON'S LICENSE

Please READ all instructions prior to completing this application. ALL questions on this application must be answered, and all supporting documents must be submitted as per instructions. Please type or print neatly. When space provided is insufficient, attach additional sheets of paper. All attachments are considered part of the application.

UU5178505.00 2/20/04

FALSIFICATION OR MISREPRESENTATION OF ANY ITEM OR RESPONSE ON THIS APPLICATION OR ANY ATTACHMENT HERETO IS A SUFFICIENT BASIS FOR DENYING OR REVOKING A LICENSE.

MBC USE ONLY

1. NAME: Last: SAEED — First: BUSHRA — Middle:

2. Other names you have used (include maiden name): BUSHRA FATIMA SIDDIQI

3. U.S. Social Security Number*:

4A. (PUBLIC ADDRESS; will be released by the Board to the public): Number and Street/P.O. Box/Rural Route/Apartment Number, if any. 150 Palm Valley Blvd # 1090

City: San Jose — State: CA — Zip Code: 95123 — Country: USA

4B. (CONFIDENTIAL ADDRESS): Number and Street/Rural Route/Apartment Number, if any. [Applicants must provide a confidential street address if a P. O. Box is used as the Public Address in #4A above.] as above in 4A.

City — State — Zip Code — Country

5. Telephone Number:
Home: (
Work: (

6. California Driver's License Number (optional):
NUMBER — EXPIRATION

7. Date of Birth (Month/Day/Year) and **Place of Birth:**

8. Sex: ☐ Male ☑ Female

9. Are you a U.S. citizen? ☐ Yes ☑ No
Permanet Resident - This Year applying for US citizenship

10. Have you ever filed an application for Physician's and Surgeon's examination or licensure in California? ☐ Yes ☒ No

IF YES, PLEASE GIVE DATE PREVIOUS APPLICATION WAS SUBMITTED. _____

11. List the names and locations 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. **Transcripts will not be returned.**

Name	City, State, Country	Dates of Attendance
KHATOON-E-PAKISTAN	KARACHI, PAKISTAN	4/1981 ~ 3/1983
ST. JOSEPH'S COLLEGE	KARACHI, PAKISTAN.	8/1983 ~ 6/1985

12. List the names and locations 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 8 1/2" x 11" photocopy (original diploma will be returned).

School Name	City, State, Country	Dates of Attendance	Degree Awarded
DOW MEDICAL COLLEGE	KARACHI, PAKISTAN.	5/1986 ~ 3/1992	M.B.B.S

DOCTOR OF MEDICINE DEGREE, as referenced above.

Name of Medical School	Address of Medical School	Exact Date of Issuance
DOW MEDICAL COLLEGE	Civil Hospital Karachi - Babae Urdu Rd.	7-15-92

* **MANDATORY DISCLOSURE OF U.S. SOCIAL SECURITY NUMBERS**
Disclosure of your U.S. social security number 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 will be used exclusively for tax enforcement purposes, for purposes of compliance with any judgment or order for family support in accordance with Section 17520 of the Family 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 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.

MBC USE ONLY
School Code

L1A

L-100 Web (Revised 11/03)

Personal Data
Pre-Medical Education
Medical Education
L2 Trans

MBC USE ONLY

13. Have you taken any of the following written examinations: National Boards, other state boards, USMLE, SPEX, FLEX, ECFMG or LMCC? ☑ Yes ☐ No

Written Examination

IF YES, LIST NAME, LOCATION, DATE AND RESULT OF EACH EXAMINATION; FAILURES MUST ALSO BE DISCLOSED. EACH EXAMINATION AGENCY MUST SUBMIT AN ORIGINAL OFFICIAL EXAMINATION HISTORY REPORT DIRECTLY TO THE MEDICAL BOARD OF CALIFORNIA. THESE REPORTS WILL NOT BE RETURNED.

Examination	Date	Result (Pass/Fail)
USMLE Step 1	10/97	
USMLE Step 2	3/95	
USMLE Step 2.	8/95	
USMLE Step 3	12/2001	

14. Have you ever been licensed to practice medicine in any state, territory, province, country, or U.S. federal jurisdiction? ☑ Yes ☐ No

License Data

IF YES, LIST THE JURISDICTION, LICENSE NUMBER, DATE ISSUED AND DATES OF PRACTICE IN THAT JURISDICTION. PLEASE INCLUDE PERMANENT, TEMPORARY, TRAINING, PROVISIONAL, LIMITED LICENSE, OR PERMIT. AN ORIGINAL OFFICIAL **LETTER OF GOOD STANDING (LGS)**, OR COMPARABLE LICENSE HISTORY CERTIFICATION, IS REQUIRED FOR **EACH** PERMANENT, TEMPORARY, TRAINING, PROVISIONAL, LIMITED LICENSE, OR PERMIT OBTAINED IN ANY U.S. STATE, U.S. OR CANADIAN TERRITORY, CANADIAN PROVINCE, OR U.S. FEDERAL JURISDICTION. EACH LGS, OR COMPARABLE CERTIFICATION, SHOULD BE MAILED BY THE ISSUING AUTHORITY DIRECTLY TO THE MEDICAL BOARD OF CALIFORNIA.

LGS

Jurisdiction	License Number	Date of Issuance	Dates of Practice in that Jurisdiction
State of Oklahoma	23390 Training License	7-1-2003	7-1-03 - present.
	* Already requested the Oklahoma Board to send official response to CA Board.		

15. Do you hold any other professional license in any state, territory, province, country, or U.S. federal jurisdiction? ☑ Yes ☐ No

IF YES: PROFESSION: Medicine, LICENSE NO.: 24277-S, JURISDICTION: Pakistan

Other Professional Licenses

HAS THIS LICENSE EVER BEEN REVOKED, OR SUBJECT TO DISCIPLINE? IF YES, PLEASE PROVIDE ALL OFFICIAL DOCUMENTATION REGARDING THE MATTER IN ADDITION TO A WRITTEN EXPLANATION. YOU ARE ALSO REQUIRED TO REPORT ANY MATTER THAT IS PENDING OR IN WHICH CHARGES HAVE BEEN DROPPED OR EXPUNGED.

Yes ☐ No ☐

16A. Are you currently, or have you ever been, a participant in a postgraduate training program in a facility in the U.S. or Canada? (You must include every residency, internship, and fellowship, whether or not completed.) ☑ Yes ☐ No

Postgraduate Training

IF YES, LIST NAMES AND ADDRESSES OF ALL FACILITIES. SUBMIT AN ORIGINAL **CERTIFICATE OF COMPLETION OF ACGME/RCPSC POSTGRADUATE TRAINING (FORM L3A)** FROM EACH FACILITY. (DO NOT COMPLETE FORM L3As 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	Categorial Specialty Area	Dates of Attendance
S.W. Oklahoma Family Practice	4427 W. Gore Blvd., Lawton, OK 73505	Family Practice PGY-1	7-1-03 to present

QUESTIONS 16B through 23:
If you answer YES to any of the following questions, please provide ALL official documentation regarding the matter in addition to your written personal explanations. An applicant must provide official hearing/court documents and original letters of explanation from medical schools or training program directors. If these documents are not provided with the application, they will be requested before review of the application can proceed. APPLICANTS ARE REQUIRED TO REPORT ANY MATTER THAT IS PENDING OR IN WHICH CHARGES HAVE BEEN DROPPED OR EXPUNGED.

16B. Have you ever withdrawn from, or been suspended, dismissed or expelled from a medical school or postgraduate training program OR have you ever taken a leave of absence from such a school or program?

IF YOU ANSWERED YES, BOTH APPLICANT AND SCHOOL/PROGRAM MUST PROVIDE DETAILS ON A SEPARATE ATTACHMENT.

Yes ☐ No ☑

MBC USE ONLY

License Data

For all of the below, also include any disciplinary actions by the U.S. Military, U.S. Public Health Service, or other U.S. federal governmental entity.

17A. 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?

17B. Has any disciplinary action ever been filed or taken, including but not limited to, informal or confidential discipline, consent orders, or letters of warning, regarding any healing arts license which you now hold or have ever held?

17C. Is any such action as described above pending?

17(A)	Yes	No	☐
17(B)	Yes	No	☐
17(C)	Yes	No	☐

IF YOU ANSWERED YES TO 17A, 17B OR 17C, PROVIDE DETAILS ON A SEPARATE ATTACHMENT.

18. 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 YOU ANSWERED YES, PROVIDE DETAILS ON A SEPARATE ATTACHMENT.

19. 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, territory, country, or U.S. federal jurisdiction, or is any such action pending?

Yes No ☐

IF YOU ANSWERED YES, PROVIDE DETAILS ON A SEPARATE ATTACHMENT.

20. Have you ever voluntarily surrendered a license to practice medicine or any other 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 ☐

IF YOU ANSWERED YES, PROVIDE DETAILS ON A SEPARATE ATTACHMENT.

21. 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 ☐

YOU MUST DISCLOSE ANY INFORMAL OR CONFIDENTIAL DISCIPLINARY ACTION.

22. 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.

FOR ALL OF THE 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.

23A. Have you ever been convicted of, or pled nolo contendere to, ANY violation (include every misdemeanor or felony) of any local, state, or federal law of any state, territory, country, or U.S. federal jurisdiction?

23B. Is any criminal action related to the above pending?

23 (A)	Yes	No	☐
23 (B)	Yes	No	☐

IF YOU ANSWERED YES TO 23A OR 23B, PROVIDE DETAILS ON A SEPARATE ATTACHMENT.

Top of Photo (Head)

Bottom of Photo (Shoulders)

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 Chief of the Licensing Program is the custodian of records.

Applicant Declaration/Signature and NOTARY

STATE OF CALIFORNIA

COUNTY OF SANTA CLARA

The applicant, BUSHRA SAEED (PLEASE **PRINT** FULL NAME) _____ (DATE OF BIRTH), being first duly sworn upon his/her oath deposes and says: that I am the person herein named subscribing to this application; that I have read the complete application, know the full content thereof, and declare under penalty of perjury, that all of the information contained herein and evidence or other credentials submitted herewith are true and correct; that I am 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 I am aware and that I am 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 UNDERSTAND THAT FALSIFICATION OR MISREPRESENTATION OF ANY ITEM OR RESPONSE ON THIS APPLICATION OR ANY ATTACHMENT HERETO IS A SUFFICIENT BASIS FOR DENYING OR REVOKING A LICENSE.**

SIGNATURE OF APPLICANT: Bushra Saeed (PLEASE **SIGN** FULL NAME, NOT INITIALS)

Signed and sworn to before me this 16th day of January (MONTH) 2004 (YEAR)

LOLITA HEER
Comm. # 1455571
NOTARY PUBLIC - CALIFORNIA
Santa Clara County
My Comm. Expires Dec. 9, 2007

NOTARY SEAL

Lolita Heer
SIGNATURE OF NOTARY PUBLIC

5669 Snell Ave, San Jose, CA 95123
ADDRESS

My commission expires December 9 2007

L1D

07A-100 Web (Revised 11/03)

Ref. No. St-19/2004/-84   Dated 16th Feb., 2004

STATE OF CALIFORNIA – STATE AND CONSUMER SERVICES AGENCY   ARNOLD SCHWARZENEGGER, Governor

Consumer Affairs

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MEDICAL BOARD OF CALIFORNIA

1426 Howe Avenue, Suite 54
Sacramento, CA 95825-3236
(916) 263-2382 FAX (916) 263-2487
www.medbd.ca.gov

MEDICAL BOARD OF CALIFORNIA 04 FEB 18 PM 2:30 LICENSING PROGRAM

CERTIFICATE OF MEDICAL EDUCATION

MEDICAL SCHOOL: PLEASE COMPLETE THIS FORM IN THE ENGLISH LANGUAGE.

This certifies that BUSHRA SAEED (FULL NAME OF APPLICANT); U.S. SOCIAL SECURITY NO. ______ DATE OF BIRTH-MM/DD/YYYY ______

enrolled in DOW MEDICAL COLLEGE (NAME OF MEDICAL SCHOOL) KARACHI, PAKISTAN (LOCATION)

on the 15th day of MAY (MONTH), 1986 (YEAR) and was granted the following credits on enrollment:

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

DOW MEDICAL COLLEGE, KARACHI (MEDICAL SCHOOL) ______ (TOTAL CREDITS) ______ (DATES)

The undersigned further certifies that the records of this institution show that the applicant attended in this institution 6 (NUMBER OF YEARS) years of resident instruction of 265 (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 the applicant:

☒ was granted the degree Bachelor/Doctor of Medicine by **OR** ☐ withdrew from

the above mentioned medical school on the 15th day of MARCH (MONTH), 1992 (YEAR).

Anatomy	Embryology	Physical Medicine
Otolaryngology	Histology	Therapeutics
Obstetrics and Gynecology	Human Sexuality as defined in Section 2090	Neuroanatomy
Radiology, including Radiation Safety	Medicine	Child Abuse Detection and Treatment
Tropical Medicine	Surgery, including Orthopedic Surgery	Geriatric Medicine
Physiology	Urology	Pediatrics
Biochemistry	Psychiatry	Pharmacology
Pathology, Bacteriology and Immunology	Neurology	Anesthesia
Ophthalmology	Alcoholism and Chemical Dependency	Spousal or Partner Abuse Detection & Treatment**
Dermatology	Preventive medicine, including Nutrition	Family Medicine***
		Pain Management and End-of-Life Care****

* 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.
** ONLY applicable to medical students who enrolled in medical school on or after September 1, 1994.
*** 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 June 1, 2000.

MEDICAL SCHOOL SEAL MUST BE IMPRINTED BELOW.

DOW MEDICAL COLLEGE KARACHI

ATTENTION MEDICAL SCHOOL: *The person who signs this form* ***MAY NOT*** *be related to the applicant by blood, marriage or adoption.*

Only the President, Dean, or Registrar may sign this form. If that signature authority is being delegated to another person, evidence of that delegation must be attached to this form (may be a photocopy). Such delegation must be on official letterhead and must be dated within the last 12 months.

Signed and the school seal affixed this 12th day of February (MONTH), 2004 (YEAR)

BY: PROF. MASOOD HAMEED KHAN PRINCIPAL
PRESIDENT, DEAN, OR REGISTRAR

Principal, Dow Medical College & Civil Hospital, Karachi

12/02/2004

L2

07A-100-L2 (Rev. 11-26-03)

JA

STATE OF CALIFORNIA -- STATE AND CONSUMER SERVICES AGENCY — ARNOLD SCHWARZENEGGER, *Governor*

Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM
1426 Howe Avenue, Suite 54
Sacramento, CA 95825-3236
(916) 263-2382 FAX (916) 263-2487
www.caldocinfo.ca.gov

CERTIFICATE OF COMPLETION OF ACGME/RCPSC 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

NAME: Last	First	Middle
SAEED	BUSHRA	

U.S. Social Security Number	Date of Birth	Telephone Number
		Home (Work (

Public/Mailing Address: 7004 SHADOW BROOK

City	State/Province	Zip/Postal Code
TEXARKANA	TX	75503

Medical School of Graduation: DOW MEDICAL COLLEGE

PART 2: TO BE COMPLETED BY THE PROGRAM DIRECTOR

ATTENTION PROGRAM DIRECTOR: Do not sign and date this form before the last day of any postgraduate training year which will be used by the applicant to qualify for licensure. Completion of this form will certify that the individual named in PART 1 above satisfactorily completed a period of accredited postgraduate training at this facility and that the trainee has acquired the skill and qualifications necessary to safely assume the unrestricted practice of medicine in this state.

Name of Facility:	ACGME 10 digit Program number: (www.acgme.org)
Southwest Oklahoma Family Medicine Residency	1203921659

Address of Facility:	Telephone #:
1202 NW Arlington Ave Lawton OK 73507	580·248·4797

Categorical Specialty Area of Training	Start Date of Training	End Date (or anticipated completion date) of Training
Family Medicine	07/01/2003	02/27/2004

UNUSUAL CIRCUMSTANCES:

Did the trainee ever take a leave of absence or break from their training?	YES	NO
Was the trainee ever terminated, dismissed or expelled?	YES	NO
Did the trainee ever resign?	YES	NO
Was the trainee ever placed on probation? academic for failed rotation	YES	NO
Was the trainee ever disciplined or placed under investigation?	YES	NO
Were any incident reports regarding this trainee ever filed by instructors?	YES	NO
Were any limitations or special requirements placed upon the trainee for clinical incompetence, disciplinary problems or for any other reason?	YES	NO
Did the program decline to renew or offer the trainee a postgraduate training program contract for a following year?	YES	NO

A "Yes" response to ANY of the above questions requires the program director to provide a written explanation on a separate attachment.

L3A

DEFINITION OF "SATISFACTORY" COMPLETION OF TRAINING

The program director signing this form is formally certifying and documenting under penalty of perjury that the trainee received instruction appropriate for the particular postgraduate level and that he/she satisfactorily completed periods of training in accordance with the accepted standards and the criteria defined as equating to "satisfactory" performance as described below. The program director will personally be attesting to the fact that the trainee has acquired the skill and qualifications necessary to safely assume the unrestricted practice of medicine in this state.

"SATISFACTORY" IS DEFINED AS: THE TRAINEE PERFORMED AT AN ADEQUATE LEVEL BASED ON EVIDENCE OF SATISFACTORY PROGRESSIVE GROWTH INCLUDING DEMONSTRATED ABILITY TO ASSUME GRADED AND INCREASING RESPONSIBILTY FOR PATIENT CARE.

GENERAL MEDICINE TRAINING REQUIREMENT

To qualify for licensure in California, applicants who are graduates of an international medical school must complete **at least four months** of postgraduate training in GENERAL MEDICINE as part of the requirement. Applicants who are graduates of a U.S. or Canadian medical school, who have not completed postgraduate training required for licensure by July 1, 1990, must also complete four months of training in GENERAL MEDICINE prior to 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.

I hereby certify as the program director, that the individual named in Part 1

☐ **has completed** ☒ **has not completed**

a minimum of four months of general medicine as part of this postgraduate training program accredited by the ACGME or the RCPSC.

SIGNATURE OF PROGRAM DIRECTOR

ATTENTION PROGRAM DIRECTOR: THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE, OR ADOPTION. If that signature authority is being delegated to another person, evidence of that delegation must be attached to this form (may be a photocopy). Each delegation must be on official letterhead and must be dated within the last 12 months.

HOSPITAL SEAL

OFFICIAL HOSPITAL SEAL MUST BE AFFIXED IN THE BOX TO THE LEFT TO CERTIFY TRAINING

The training program is accredited by the ACGME or the RCPSC to offer the type and level of training completed by the applicant, and the applicant was trained in an accredited ACGME or RCPSC program position. I hereby declare under penalty of perjury under the laws of the State of California that the statements are true and correct.

DAN F CRISWELL MD

PRINT NAME OF PROGRAM DIRECTOR

SIGNATURE OF PROGRAM DIRECTOR
Signature Stamp is Not Acceptable

1/22/08

DATE SIGNED

If a hospital seal is not available, the program director shall sign this form in the presence of a notary public.

State of Oklahoma

County of Comanche

Subscribed and sworn to (or affirmed) before me on

this 22nd day of January, 20 08,

by Dan Criswell, MD

personally known to me or proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.

NOTARY SEAL
KELLIE MCSPARREN
NOTARY
07000970
EXP. 01/26/11
PUBLIC
STATE OF OKLAHOMA

Kellie McSparren

SIGNATURE OF NOTARY PUBLIC

L3B

164105 JA

STATE OF CALIFORNIA -- STATE AND CONSUMER SERVICES AGENCY ARNOLD SCHWARZENEGGER, *Governor*

Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
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CERTIFICATE OF COMPLETION OF ACGME/RCPSC 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

NAME: Last	First	Middle
SAEED	BUSHRA	

U.S. Social Security Number	Date of Birth	Telephone Number
		Home Work (

Public/Mailing Address: 7004 SHADOW BROOK

City	State/Province	Zip/Postal Code
TEXARKANA	TX	75503

Medical School of Graduation: DOW MEDICAL COLLEGE

PART 2: TO BE COMPLETED BY THE PROGRAM DIRECTOR

ATTENTION PROGRAM DIRECTOR: Do not sign and date this form before the last day of any postgraduate training year which will be used by the applicant to qualify for licensure. Completion of this form will certify that the individual named in PART 1 above satisfactorily completed a period of accredited postgraduate training at this facility and that the trainee has acquired the skill and qualifications necessary to safely assume the unrestricted practice of medicine in this state.

Name of Facility:	ACGME 10 digit Program number: (www.acgme.org)
AHEC SW FAMILY MEDICINE RESIDENCY	1200421527

Address of Facility:	Telephone #:
300 E 6TH TEXARKANA AR 71854	870-779-6086

Categorical Specialty Area of Training	Start Date of Training	End Date (or anticipated completion date) of Training
FAMILY MEDICINE	07/01/2005	06/30/2008

UNUSUAL CIRCUMSTANCES:

Did the trainee ever take a leave of absence or break from their training?	YES	NO
Was the trainee ever terminated, dismissed or expelled?	YES	NO
Did the trainee ever resign?	YES	NO
Was the trainee ever placed on probation?	YES	NO
Was the trainee ever disciplined or placed under investigation?	YES	NO
Were any incident reports regarding this trainee ever filed by instructors?	YES	NO
Were any limitations or special requirements placed upon the trainee for clinical incompetence, disciplinary problems or for any other reason?	YES	NO
Did the program decline to renew or offer the trainee a postgraduate training program contract for a following year?	YES	NO

A "Yes" response to ANY of the above questions requires the program director to provide a written explanation on a separate attachment.

L3A

DEFINITION OF "SATISFACTORY" COMPLETION OF TRAINING

The program director signing this form is formally certifying and documenting under penalty of perjury that the trainee received instruction appropriate for the particular postgraduate level and that he/she satisfactorily completed periods of training in accordance with the accepted standards and the criteria defined as equating to "satisfactory" performance as described below. The program director will personally be attesting to the fact that the trainee has acquired the skill and qualifications necessary to safely assume the unrestricted practice of medicine in this state.

"SATISFACTORY" IS DEFINED AS: THE TRAINEE PERFORMED AT AN ADEQUATE LEVEL BASED ON EVIDENCE OF SATISFACTORY PROGRESSIVE GROWTH INCLUDING DEMONSTRATED ABILITY TO ASSUME GRADED AND INCREASING RESPONSIBILTY FOR PATIENT CARE.

GENERAL MEDICINE TRAINING REQUIREMENT

To qualify for licensure in California, applicants who are graduates of an international medical school must complete **at least four months** of postgraduate training in GENERAL MEDICINE as part of the requirement. Applicants who are graduates of a U.S. or Canadian medical school, who have not completed postgraduate training required for licensure by July 1, 1990, must also complete four months of training in GENERAL MEDICINE prior to 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.

I hereby certify as the program director, that the individual named in Part 1

☑ **has completed** ☐ **has not completed**

a minimum of four months of general medicine as part of this postgraduate training program accredited by the ACGME or the RCPSC.

SIGNATURE OF PROGRAM DIRECTOR

ATTENTION PROGRAM DIRECTOR: THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE, OR ADOPTION. If that signature authority is being delegated to another person, evidence of that delegation must be attached to this form (may be a photocopy). Each delegation must be on official letterhead and must be dated within the last 12 months.

HOSPITAL SEAL	OFFICIAL HOSPITAL SEAL MUST BE AFFIXED IN THE BOX TO THE LEFT TO CERTIFY TRAINING

The training program is accredited by the ACGME or the RCPSC to offer the type and level of training completed by the applicant, and the applicant was trained in an accredited ACGME or RCPSC program position. I hereby declare under penalty of perjury under the laws of the State of California that the statements are true and correct.

RUSSELL MAYO MD

PRINT NAME OF PROGRAM DIRECTOR

MD

SIGNATURE OF PROGRAM DIRECTOR
Signature Stamp Is Not Acceptable

01/15/08

DATE SIGNED

If a hospital seal is not available, the program director shall sign this form in the presence of a notary public.

State of _____

County of _____

Subscribed and sworn to (or affirmed) before me on

this _____ day of _____, 20_____,

by _____

personally known to me or proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.

NOTARY SEAL

_____
SIGNATURE OF NOTARY PUBLIC

L3B

Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
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Sacramento, CA 95825-3236
(916) 263-2382 FAX (916) 263-2487
www.caldocinfo.ca.gov

CERTIFICATE OF CURRENT POSTGRADUATE TRAINING ENROLLMENT

At the time of licensure, you may be entitled to a reduced initial license fee if you are actively participating in a slotted position in an ACGME/RCPSC accredited postgraduate training program.

NOTE: This form may not be used in lieu of the Form L3A-B, "Certificate of Completion of ACGME/RCPSC Postgraduate Training."

NAME: Last	First	Middle
SAEED	BUSHRA	

U.S. Social Security Number	Date of Birth	Medical School of Graduation:
		DOW MEDICAL COLLEGE

This is to certify that the above applicant is actively participating in an ACGME or RCPSC accredited postgraduate training position that started on JULY (Month) 01 (Day) 2005 (Year) **and is expected to be completed on** JUNE (Month) 30 (Day) 2008 (Year) **in** FAMILY MEDICINE (Categorical Specialty Area of Training)

at AHEC SW FAMILY MEDICINE RESIDENCY PROGRAM (Name of Facility)

located at 300 E 6TH, TEXARKANA, AR 71854 (Address of Facility)

The 10 digit ACGME Program #: 1 2 0 0 4 2 1 5 2 7 (Refer to http://www.acgme.org/adspublic)

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 above program is accredited by the ACGME or the RCPSC to offer the type and level of training completed by the applicant and that the applicant is being trained in an accredited ACGME or RCPSC postgraduate training position.

RUSSELL MAYO MD
PRINT NAME OF PROGRAM DIRECTOR

Russell Mayo MD
SIGNATURE OF PROGRAM DIRECTOR – Signature Stamp Is Not Acceptable

01/14/2007
DATE

870-779-6080
TELEPHONE NUMBER

ATTENTION PROGRAM DIRECTOR: THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE, OR ADOPTION.

Only the Program Director may sign this form. If that signature authority is being delegated to another person, evidence of that delegation must be attached to this form (may be a photocopy). Such delegation must be on official letterhead and must be dated within the last 12 months.

If a hospital seal is not available, the program director shall sign this form in the presence of a notary public.

State of _____

County of _____

Subscribed and sworn to (or affirmed) before me on

this _____ day of _____, 20_____,

by _____

personally known to me or proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.

Hospital or Notary Seal

_____
SIGNATURE OF NOTARY PUBLIC

OFFICIAL HOSPITAL SEAL OR NOTARY SEAL (WITH JURAT COMPLETED ABOVE) MUST BE AFFIXED IN THE BOX AT THE LEFT

L4

STATE OF CALIFORNIA -- STATE AND CONSUMER SERVICES AGENCY — ARNOLD SCHWARZENEGGER, Governor

Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
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1426 Howe Avenue, Suite 54
Sacramento, CA 95825-3236
(916) 263-2382 FAX (916) 263-2487
www.medbd.ca.gov

OFFICIAL BREAKDOWN OF UNDERGRADUATE CLINICAL CLERKSHIPS

(The completion of this form is required only of international medical school graduates. Please complete this form in the English language.)

Name of Applicant (type or print FULL name):	U.S Social Security Number:
BUSHRA SAEED	— — —
	Date of Birth-MM/DD/YYYY:

Only undergraduate clerkships in which the applicant participated in **DIRECT, HANDS-ON DIAGNOSIS OR TREATMENT OF PATIENTS IN A CLINICAL SETTING should be reported on this form. Any clinical clerkships completed that do not meet the above criteria should NOT be reported on this form as they will NOT satisfy California's clinical training requirements.**

UNDERGRADUATE CLINICAL CLERKSHIPS

(Please list ALL clinical training completed prior to issuance of your medical degree in the area below and on the reverse of this form. List training in date/chronological order, commencing with the first clinical year of training.)

CLINICAL SUBJECT AREA	FACILITY NAME AND ADDRESS	DATES OF ATTENDANCE FROM –TO (Month/Day/Year)	WEEKS OR WEEKLY HOURS OF CREDIT
SURGICAL UNIT III	PROF. KISHWAR NAZII (CHK)	10-22-88 -TO 11-13-88	3 WEEKS ✓
MEDICAL UNIT V	PROF SHAFI QURAISHY (CHK)	11-14-88 - TO 12-6-88	3 ✓
SURGICAL UNIT	PROF M. SARWAR (LGH)	12-12-88 TO 01-5-89	4 ✓
SURGICAL UNIT II	PROF KARIM SIDDIQUI (CHK)	1-14-89 TO 1-25-89	2 ✓
MEDICAL UNIT IV	PROF K. MEMON (CHK)	2-15-89 TO 3-6-89	3 ✓
MEDICAL UNIT	PROF ASLAM ARAIN (LGH)	3-8-89 TO 3-27-89	3 ✓

ATTENTION DEANS OR REGISTRARS: THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE, OR ADOPTION.

Only the Dean or Registrar may sign this form. If that signature authority is being delegated to another person, evidence of that delegation must be attached to this form (may be a photocopy). Such delegation must be on official letterhead and must be dated within the last 12 months.

MEDICAL SCHOOL SEAL

I, PROF. MASOOD HAMEED KHAN
FULL NAME of Dean or Registrar (Please TYPE OR PRINT)

declare under penalty of perjury, that I am/was the Dean or Registrar for the student named above and that I have carefully read this form and that the statements made herein are strictly true in every respect.

Signature of Dean or Registrar

12.02.2004
Date

L5A

07A-100-L5B (Revised 11-26-03)

OFFICIAL BREAKDOWN OF UNDERGRADUATE CLINICAL CLERKSHIPS

(Continued from the front of this form. If additional space is needed, you may photocopy this side of the form; however, original signatures and seals (below) will be required on all photocopies submitted.)

Name of Applicant (type or print FULL name):	U.S. Social Security Number:
BUSHRA SAEED	Date of Birth-MM/DD/YYYY:

UNDERGRADUATE CLINICAL CLERKSHIPS

CLINICAL SUBJECT AREA	FACILITY NAME AND ADDRESS	DATES OF ATTENDANCE FROM --TO (Month/Day/Year)	WEEKS OR WEEKLY HOURS OF CREDIT
SURGICAL UNIN V	PROF M.A.NOORANI (CHK)	3-08-89 TO 3-27-89	3 WEEKS ✓
PAEDIATRICS UNIT I	PROF GHAFFAR BILLOO (CHK)	4-16-89 TO 5-10-89	3 ✓
ORTHOPAEDICS	PROF MANZOOR MEMON (LGH)	10-11-89 TO 10-30-89	3 ✓
GYNAECOLOGY	PROF K. NOORANI (LGH)	11-4-89 TO 11-20-89	3 ✓
CASUALTY	PROF IQBAL AHMED (CHK)	11-21-89 TO 12-01-89.	2
RADIOLOGY	PROF MATEEN (CHK)	12-01-89 TO 12-10-89	2 ✓
E.N.T	PROF M.JALISI (CHK)	12-11-89 TO 12-30-89	3 ✓
GYNAECOLOGY UNIT I	PROF NAGIS SOOMRO (CHK)	01-28-90 TO 02-20-90	3 ✓
OPHTHALMOLOGY	PROF SHARIFUL HASSAN (CHK)	03-25-90 TO 04-25-90	4 ✓
NEUROLOGY	PROF AKHTER AHMED (CHK)	05-3-90 TO 05-22-90	3 ✓

ATTENTION DEANS OR REGISTRARS: THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE, OR ADOPTION.

Only the Dean or Registrar may sign this form. If that signature authority is being delegated to another person, evidence of that delegation must be attached to this form (may be a photocopy). Such delegation must be on official letterhead and must be dated within the last 12 months.

MEDICAL SCHOOL SEAL

I, PROF. MASOOD HAMEED KHAN
FULL NAME of Dean or Registrar (Please TYPE OR PRINT)

declare under penalty of perjury, that I am/was the Dean or Registrar for the student named above and that I have carefully read this form and that the statements made herein are strictly true in every respect.

PRINCIPAL, Civil Medical College
Signature of Dean or Registrar
KARACHI

12-02-2004
Date

RECEIVED FEB 18 PM 3:30 CALIFORNIA MEDICAL BOARD LICENSING PROGRAM

L5B

4-MAY-2004

13.

07A-100-L5B (Revised 11-26-03)

OFFICIAL BREAKDOWN OF UNDERGRADUATE CLINICAL CLERKSHIPS

(Continued from the front of this form. If additional space is needed, you may photocopy this side of the form; however, original signatures and seals (below) will be required on all photocopies submitted.)

Name of Applicant (type or print FULL name):	U.S. Social Security Number:
BUSHRA SAEED.	
	Date of Birth-MM/DD/YYYY:

UNDERGRADUATE CLINICAL CLERKSHIPS

CLINICAL SUBJECT AREA	FACILITY NAME AND ADDRESS	DATES OF ATTENDANCE FROM –TO (Month/Day/Year)	WEEKS OR WEEKLY HOURS OF CREDIT
COMMUNITY MEDICINE	PROF ZUBAIR (CHK)	05-25-90 TO 07-20-90	3 WEEKS ✓
PEDIATRICS UNIT I	PROF A.G. BILLOO (CHK)	12-01-90 TO 01-05-91	4 ✓
MEDICAL UNIT II	PROF A.N. CHOUDHRY (CHK)	01-05-91 TO 02-06-91	4 ✓
E.N.T	PROF K. KHAN (LGH)	03-19-91 TO 04-16-91	4 ✓
GYNAECOLOGY UNIT II	PROF N.J. SAMAD (CHK)	04-20-91 TO 05-18-91	4 ✓
OPHTHALMOLOGY.	PROF. M. AHMED (LGH)	05-20-91 TO 06-17-91	4 ✓
MEDICAL UNIT V	PROF S. QURAISHY (CHK)	06-18-91 TO 07-14-91	4
ORTHOPAEDIC UNIT II	PROF. U. SOOMRO (CHK)	07-15-91 TO 08-16-91	4
SURGICAL UNIT I	PROF R.G. ASHAR (CHK)	08-18-91 TO 09-16-91	4 ✓
SURGICAL UNIT V.	PROF M.A. NOORANI. (CHK).	09-17-91 TO 10-13-91	4 ✓

ATTENTION DEANS OR REGISTRARS: THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE, OR ADOPTION.

Only the Dean or Registrar may sign this form. If that signature authority is being delegated to another person, evidence of that delegation must be attached to this form (may be a photocopy). Such delegation must be on official letterhead and must be dated within the last 12 months.

MEDICAL SCHOOL SEAL

I, Prof. MASOOD HAMEED KHAN
FULL NAME of Dean or Registrar (Please TYPE OR PRINT)

declare under penalty of perjury, that I am/was the Dean or Registrar for the student named above and that I have carefully read this form and that the statements made herein are strictly true in every respect.

PRINCIPAL, [illegible] Civil [illegible]
Signature of Dean or Registrar
KARACHI

12-02-2004
Date

L5B

13 Nov 2004

07A-100-L5B (Revised 11-26-03)

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

PART B

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

License Renewal Application
Physician and Surgeon

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

D **Continuing Medical Education (CME) Certification Statement:** I CERTIFY UNDER PENALTY OF PERJURY UNDER THE LAWS OF CALIFORNIA TO THE FOLLOWING STATEMENT: I CERTIFY THAT I DO MEET EACH OF THE CONTINUING MEDICAL EDUCATION REQUIREMENTS LISTED ON THE 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 Bushra DATE: 05-14-13

LICENSE NO.	EXPIRES	AMOUNT DUE NOW	DELINQ FEE IF POSTMARKED AFTER 07/30/13
A 103396	06/30/13	$808.00	$886.00
	VOLUNTARY FEE =	$	$
	TOTAL ENCLOSED =	$ 808.00	$

ACTIVE BUSHRA SAEED
4088 AUTINORI COURT
SAN JOSE CA 95148

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

STREET _____

CITY _____ STATE _____ ZIP _____

PHONE NUMBER ( ) _____

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.

Bushra
Signature required here

OVER

63010100000100002001033968010630130008080000088600

05212013 10002707 10010028

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

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
"none"	

(DO NOT DETACH)

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 JULY 30, 2015
SAEED, BUSHRA	**A103396**	**06/30/15**	**$820.00**	**$898.00**

LICENSEE MUST CHECK CORRECT BOXES

- "H" ☑ Completed Continuing Education
- "E" ☐ Change of Address (fill in reverse side)
- "I" ☐ Conviction Disclosure – Yes
- "J" ☑ Conviction Disclosure – No
- "F" ☐ Family Physician Training Program ($25)
- "G" ☑ Financial Interest Statement-**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 Bushra Date 05-07-15

ENTER YOUR PHONE NUMBER FOR REFERENCE:

( ) - -

630101000001000020010339680106301500082000000089800

CHANGE OF MAILING ADDRESS **SAEED, BUSHRA** **A103396**

05122015 20001382 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 -