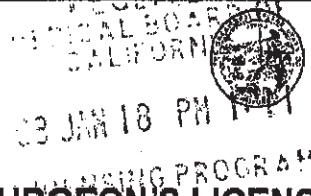




MEDICAL BOARD OF CALIFORNIA
 LICENSING PROGRAM
 1426 Howe Avenue, Suite 54
 Sacramento, CA 95825-3236
 (916) 263-2382 FAX (916) 263-2487
 www.caldocinfo.ca.gov



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

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

MEDICAL EDUCATION

11. LIST EACH MEDICAL SCHOOL THAT YOU HAVE ATTENDED.

School Name	City, State/Province, Country	Dates of Attendance	L2 Transcript
<u>DOW MEDICAL COLLEGE</u>	<u>KARACHI, PAKISTAN</u>	<u>05/1986 - 03/1992</u>	<input checked="" type="checkbox"/> <input checked="" type="checkbox"/>
			<input type="checkbox"/> <input type="checkbox"/>
			<input type="checkbox"/> <input type="checkbox"/>
12. School of Graduation	Degree Awarded	Date of Graduation	Diploma
<u>DOW MEDICAL COLLEGE</u>	<u>M.B.B.S.</u>	<u>03/1992</u>	<input checked="" type="checkbox"/>

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
<u>USMLE STEP 1</u>	<u>10/1997</u>		<input checked="" type="checkbox"/>
<u>USMLE STEP 2</u>	<u>08/1995</u>		<input checked="" type="checkbox"/>
<u>USMLE STEP 3</u>	<u>06/2005</u>		<input checked="" type="checkbox"/>

<u>3508</u>	<u>1-18-08</u>	<u>93250</u>	<u>PAX 03</u>	L1A
Cashiering Use Only			School Code	

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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	<input checked="" type="checkbox"/>
SOUTHWEST OKLAHOMA	4427 WEST GORE BLVD,	FAMILY PRACTICE	07-01-03 — 02-26-04	<input checked="" type="checkbox"/>
FAMILY PRACTICE RESIDENCY	LAWTON, OK 73505			<input type="checkbox"/>
RHEC SOUTHWEST (UAMS)	300 EAST, SIXTH ST	FAMILY PRACTICE	07-01-05 — PRESENT	<input checked="" type="checkbox"/>
FAMILY PRACTICE RESIDENCY	TEXARKANA, AR 71854			<input type="checkbox"/>
				<input type="checkbox"/>
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	<input checked="" type="checkbox"/>
Have you ever been terminated, dismissed or expelled from a program?		YES	NO	<input checked="" type="checkbox"/>
Have you ever resigned from a training program?		YES	NO	<input checked="" type="checkbox"/>
Were you ever placed on probation?		YES	NO	<input checked="" type="checkbox"/>
Were you ever disciplined or placed under investigation?		YES	NO	<input checked="" type="checkbox"/>
Were any incident reports ever filed by instructors?		YES	NO	<input checked="" type="checkbox"/>
Were any limitations or special requirements placed upon you for clinical performance, discipline, or for any other reason?		YES	NO	<input checked="" type="checkbox"/>
Have you ever had a postgraduate training program contract not be renewed or offered for a following year?		YES	NO	<input checked="" type="checkbox"/>
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	<input type="checkbox"/>
				<input type="checkbox"/>
				<input type="checkbox"/>
				<input type="checkbox"/>
				<input type="checkbox"/>
				<input type="checkbox"/>
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 <input type="checkbox"/> | NO <input type="checkbox"/> |
| 19. Have you been treated for or had a recurrence of a diagnosed addictive disorder? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 20. Have you been diagnosed with an emotional, a mental, or behavioral disorder which impairs your ability to practice medicine safely? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 21. Have you ever been diagnosed with a neurological or other physical condition that would impair your ability to practice medicine safely? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 22. Do you have any other condition which in any way impairs or limits your ability to practice medicine safely? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |

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 | <input checked="" type="checkbox"/> |
| 25. Are you required to register as a Sex Offender? | YES | NO | <input checked="" type="checkbox"/> |

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 | <input type="checkbox"/> |
| 27. Is any denial pending against you? | YES | NO | <input type="checkbox"/> |
| 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 | <input type="checkbox"/> |
| 29. Have you ever had any license to practice medicine revoked, suspended, or placed on probation? | YES | NO | <input type="checkbox"/> |
| 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 | <input type="checkbox"/> |
| 31. Have you ever had any license to practice medicine subjected to any other disciplinary action? | YES | NO | <input type="checkbox"/> |
| 32. Is any disciplinary action pending against any of your licenses to practice medicine? | YES | NO | <input type="checkbox"/> |
| 33. Have you ever had staff privileges in a hospital terminated, denied, suspended, limited, revoked, or not renewed? | YES | NO | <input type="checkbox"/> |
| 34. Have you ever resigned from a medical staff in lieu of disciplinary or administrative action? | YES | NO | <input type="checkbox"/> |
| 35. Is any disciplinary action pending against your hospital staff privileges? | YES | NO | <input type="checkbox"/> |
| 36. Have you ever surrendered a license to practice medicine? | YES | NO | <input type="checkbox"/> |
| 37. Have your DEA privileges ever been denied, suspended, restricted, or terminated? | YES | NO | <input type="checkbox"/> |
| 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 | <input type="checkbox"/> |

APPLICANT:

BUSHRA SAEED

DATE OF BIRTH:

L1D



MARTHA BAKER
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 SAIED 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 Saied

(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 Saied

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



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 SAEED First BUSHRA Middle				MBC USE ONLY Personal Data
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	State	Zip Code	Country	MBC USE ONLY License Data
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	MBC USE ONLY License Data
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: <input type="checkbox"/> Male <input checked="" type="checkbox"/> Female		
9. Have you ever been licensed to practice medicine in any state, territory, province, country, or U.S. federal jurisdiction? 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.				
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
Jurisdiction	License Number	Date of Issuance	Dates of Practice in that Jurisdiction	LGS
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? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
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.				MBC USE ONLY License Data
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?				MBC USE ONLY License Data
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?

surrendered your license (with or without 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?

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

18 (A) Yes No

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

18 (B) Yes No

STATE OF CALIFORNIA
COUNTY OF SANTA CLARA

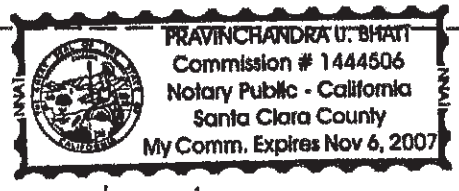


The applicant, BUSHRA SAEED (PLEASE PRINT FULL NAME) _____ (DATE OF BIRTH) _____ being first duly sworn upon his/her oath deposes and

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

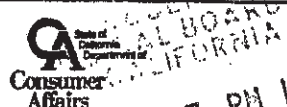


NOTARY SEAL

PRAVINCHANDRA U BHATT
SIGNATURE OF NOTARY PUBLIC
124 Blossom Hill Rd, San Jose
ADDRESS CA 95128

My commission expires 06-07

L8B



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



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.

005178 505.00 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			Personal Data
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.			
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: <input type="checkbox"/> Male <input checked="" type="checkbox"/> Female	9. Are you a U.S. citizen? Permanent Resident - This Year applying for U.S. Citizenship <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10. Have you ever filed an application for Physician's and Surgeon's examination or licensure in California? 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

Personal Data

-
-
-
-
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-
-
-
-
-
-

Pre-Medical Education

-
-
-

Medical Education

-
-
-

L2 Trans

DOCTOR OF MEDICINE DEGREE, as referenced above.

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

L1A

School Code

MISC 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

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	

Written Examination

14. 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	7-1-2003	7-1-03 or present.
	Training License		
* Already requested the Oklahoma Board for send official response to CA Board.			

License Data

LGS

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.: 24277-5, JURISDICTION: Pakistan

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

Other Professional Licenses

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

IF YES, LIST NAMES AND ADDRESSES OF ALL FACILITIES. SUBMIT AN ORIGINAL CERTIFICATE OF COMPLETION OF ACGME/RCFPC 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	Categorical 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

Postgraduate Training

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?

Yes No

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

NAME OF APPLICANT: BUSHRA SAEED DATE OF BIRTH: L1B

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

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

17(B) Yes No

17(C) Yes No

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?

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

Yes No

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?

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

Yes No

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?

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

Yes No

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?

YOU MUST DISCLOSE ANY INFORMAL OR CONFIDENTIAL DISCIPLINARY ACTION.

Yes No

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.

NAME OF APPLICANT:

BUSHRA SAEED

DATE OF BIRTH:

L1C

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, being first duly sworn
(PLEASE PRINT FULL NAME) (DATE OF BIRTH)

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 2004
MONTH YEAR



Lolita Heer
SIGNATURE OF NOTARY PUBLIC
5669 Green Ave, San Jose, CA 95123
ADDRESS

My commission expires December 9 2007 **L1D**

Ref. No. ST-19/2024/- 84

Dated 16th Feb., 2024

STATE OF CALIFORNIA - STATE AND CONSUMER SERVICES AGENCY

ARNOLD SCHWARZENEGGER, Governor



RECEIVED
FEB 18 AM 11:21

MEDICAL BOARD OF CALIFORNIA

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

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 KARACHI, PAKISTAN
NAME OF MEDICAL SCHOOL LOCATION

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

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

MEDICAL SCHOOL	TOTAL CREDITS	DATES
<u>DOW MEDICAL COLLEGE, KARACHI</u>		

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 weeks each, completing at least 4,000 hours, of which at least 80 percent actual
NUMBER OF WEEKS

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, 1992
MONTH YEAR

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
 Spousal or Partner Abuse Detection & Treatment**
 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.



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, 2024
MONTH YEAR

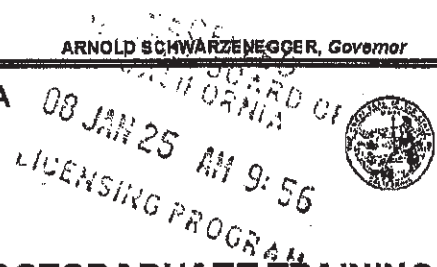
BY: PROF. MASOOD HANEED KHAN
PRESIDENT, DEAN, OR REGISTRAR
 KARACHI

L2

JA



MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM
1426 Howe Avenue, Suite 64
Sacramento, CA 95825-3236
(916) 263-2392 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 SAEED First BUSHRA Middle		
U.S. Social Security Number	Date of Birth	Telephone Number Home () Work ()
Public/Mailing Address 7004 SHADOW BROOK		
City TEXARKANA	State/Province Tx	Zip/Postal Code 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: Southwest Oklahoma Family Medicine	ACGME 10 digit Program number: (www.acgme.org) 1203921659
Address of Facility: 1202 NW Arlington Ave Lawton OK 73507	Telephone #: 580-248-4797
Categorical Specialty Area of Training: Family Medicine	Start Date of Training: 07/01/2003
	End Date (or anticipated completion date) of Training: 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? <i>academic for failed rotation</i>	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.



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 RESPONSIBILITY 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]
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	<p>OFFICIAL HOSPITAL SEAL MUST BE AFFIXED IN THE BOX TO THE LEFT TO CERTIFY TRAINING</p> <p>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.</p> <p><i>DAN F CRISWELL MD</i> PRINT NAME OF PROGRAM DIRECTOR</p> <p><i>[Signature]</i> SIGNATURE OF PROGRAM DIRECTOR Signature Stamp is Not Acceptable</p> <p><i>1/22/08</i> DATE SIGNED</p>
---------------	---

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

State of Oklahoma

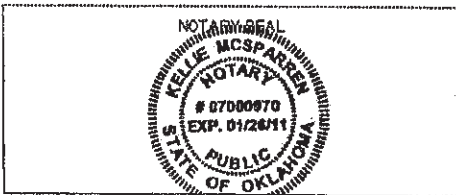
County of Comanche

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.



Kelle McSpaen
SIGNATURE OF NOTARY PUBLIC

L3B



MEDICAL BOARD OF CALIFORNIA

LICENSING PROGRAM
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Sacramento, CA 95825-3236
(916) 263-2382 FAX (916) 263-2487
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08 JAN 22 09:11:30
LICENSING PROGRAM



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	870-779-6080	
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 RESPONSIBILITY 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.

Russell Mayo MD
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

Russell Mayo 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



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 Sacramento, CA 95825-3236
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 MEDICAL BOARD OF CALIFORNIA
 08 JAN 22 AM 11:00



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 <u>SAEED</u> First <u>BUSHRA</u> Middle _____		
U.S. Social Security Number <u>1</u>	Date of Birth _____	Medical School of Graduation: <u>DOW MEDICAL COLLEGE</u>
This is to certify that the above applicant is actively participating in an ACGME or RCPSC accredited postgraduate training position that started on <u>JULY 01 2005</u> and is expected to be completed on <u>JUNE 30 2008</u> in <u>FAMILY MEDICINE</u> at <u>AHEC SW FAMILY MEDICINE RESIDENCY PROGRAM</u> located at <u>300 E 6TH, TEXARKANA AR 71854</u> <small>Month Day Year Month Day Year Name of Facility Address of Facility</small>		
The 10 digit ACGME Program #: <u>1 2 0 0 4 2 1 5 2 7</u> (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 _____

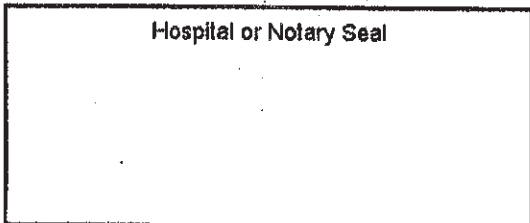
County of _____

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.



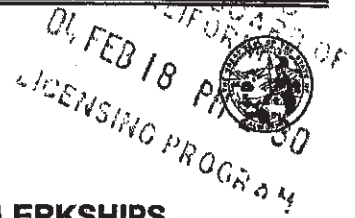
SIGNATURE OF NOTARY PUBLIC

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

L4



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 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): BUSHRA SAEED	U.S Social Security Number: _____
	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

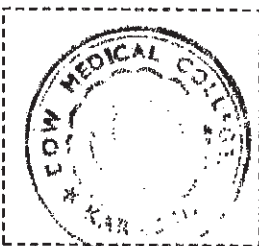
(Please list ALL clinical training completed prior to issuance of your medical degree in the area below and on the reverse of this form. List training in date/chronological order, commencing with the first clinical year of training.)

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. MEMUN (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



1. 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

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.)

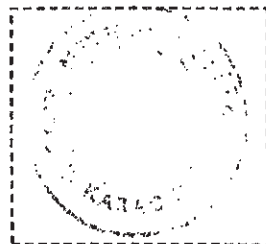
Name of Applicant (type or print FULL name): <div style="font-size: 1.2em; font-family: cursive;">BUSHRA SAEED</div>	U.S. Social Security Number:
	Date of Birth-MM/DD/YYYY:

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 UNIT V	PROF M.A. NOORANI (CHK)	3-08-89 TO 3-27-89	3 WEEKS ✓
PAEDIATRICS UNIT I	PROF GAFFAR BILLOO (CHK)	4-16-89 TO 5-10-89	3 ✓
ORTHO PAEDICS	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 (LHK)	12-11-89 TO 12-30-89	3 ✓
Gynaecology UNIT I	PROF NAQIS 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,
 Medical and Civil Hospital,
 Signature of Dean/Registrar, Government Medical College,
 KARACHI

12-02-2004
Date

REGISTRAR OF
 MEDICAL PROFESSIONS
 KARACHI
 FEB 18 PM 1:30
 CLERKSHIPS PROGRAM

L5B

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.)

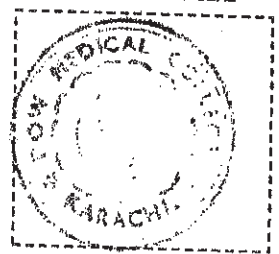
Name of Applicant (type or print FULL name): <div style="font-size: 1.2em; font-family: cursive;">BUSHRA SAEED.</div>	U.S. Social Security Number:
Date of Birth-MM/DD/YYYY: 	

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 (LHK)	07-15-91 TO 08-16-91	4
SURGICAL UNIT I	PROF R.G. ASHAR (LHK)	08-18-91 TO 09-16-91	4 ✓
SURGICAL UNIT V.	PROF M.A. NOORANI. (CHK)	09-17-91 TO 10-13-91	4 ✓

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 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 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,
UNIVERSITY OF KARACHI
Signature of Dean or Registrar at University of Karachi

12-02-2004
Date

OFFERED 18 FEB 2004
 12:30 PM
 REGISTRARS PROGRAM

L5B

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



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 YES NO

**License Renewal Application
Physician and Surgeon**

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

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

AMOUNT DUE NOW	DELINQ. FEE IF POSTMARKED AFTER 07/30/13
\$808.00	\$886.00
VOLUNTARY FEE = \$	\$
TOTAL ENCLOSED = \$ 808.00	\$

E. FOR ADDRESS CHANGE ONLY
IF YOUR ADDRESS SHOWN IS INCORRECT, CORRECT IT BELOW.
STREET _____
CITY _____ STATE _____ ZIP _____
PHONE NUMBER () _____

LICENSE NO. **A 103396** EXPIRES **06/30/13**
ACTIVE **BUSHRA SAIED**
4088 AUTINORI COURT
SAN JOSE CA 95148

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 here

OVER

63010100000100002001033968010630130008080000088600

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"	

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

