# MEDICAL BOARD OF CALIFORNIA
Licensing Program

RECEIVED MEDICAL BOARD OF CALIFORNIA
2012 AUG 10 PM 2:39

## 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 | First | Middle |
|---|---|---|
| CANSINO | CATHERINE | DIANE |

| Other names you have used (include maiden name): | 2. U.S. Social Security Number |
|---|---|
| | |

| 3. Place of Birth | 4. Date of Birth |
|---|---|
| PHILADELPHIA, PENNSYLVANIA | |

5. Gender: ☐ Male ☑ Female

6. Public/Mailing Address: 6129 RENWELL LANE
(Please note: this information is public)
(30 characters maximum per line, including spaces)

| City | State/Province | Zip/Postal Code | Country |
|---|---|---|---|
| COLUMBUS | OHIO | 43230 | USA |

| 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<br>Previous license number, if any: |
|---|---|
| 9. E-mail Address (optional): | |

### MEDICAL EDUCATION

11. LIST EACH MEDICAL SCHOOL THAT YOU HAVE ATTENDED.

| School Name | City, State/Province, Country | Dates of Attendance |
|---|---|---|
| UNIVERSITY OF TOLEDO | TOLEDO, OHIO, USA | 8/1998-6/2002 |
| | | |
| | | |

| 12. School of Graduation | Degree Awarded | Date of Graduation |
|---|---|---|
| UNIVERSITY OF TOLEDO | DOCTOR OF MEDICINE | 06-07-2002 |

### 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 | |
|---|---|---|
| USMLE STEP 1 | 6/20/2000 | |
| USMLE STEP 2 | 10/25/2001 | |
| USMLE STEP 3 | 10/16/2002 | |

07/30/12 $1299.00 WEB
Cashiering Use Only

04043
School Code

L1A

07A-100 (Rev. 03/11)

**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.**

| Facility Name | Address | Specialty Area | Dates of Attendance | Postgraduate Training |
|---|---|---|---|---|
| JOHNS HOPKINS UNIVERSITY | 600 N. WOLFE ST, BALTIMORE, MD 21287 | OBSTETRICS AND GYNECOLOGY | 7/1/2002-6/30/2006 | ☑ |
| JOHNS HOPKINS UNIVERSITY | 4940 EASTERN AVE, BALTIMORE, MD 21224 | FAMILY PLANNING * not ACGME-accredited | 7/1/2006-6/30/2008 | ☑ |
| | | | | ☐ |
| | | | | ☐ |
| | | | | ☐ |

**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 |
| Were you ever placed on probation? | YES | NO |
| 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.**

| Jurisdiction | License Number | Date of Issuance | Dates of Practice in Medical Jurisdiction | License Date |
|---|---|---|---|---|
| MARYLAND | D0064402 | 04-19-2006 | 7/1/02-6/30/2008 | ☑ |
| ILLINOIS | 036120284 | 03-06-2008 | 4/2008 | ☑ |
| NEW MEXICO | MD2008-0671 | 08/18/2008 | 9/2008-6/2010 | ☑ |
| OHIO | 35.095223 | 05-05-2010 | 7/1/2010 TO PRESENT | ☑ |
| | | | | ☐ |

**APPLICANT:** CATHERINE DIANE CANSINO

**DATE OF BIRTH:**

## 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 |
|---|---|---|
| OBSTETRICS AND GYNECOLOGY | 12/31/2016 | 9011279 |
| | | |

## 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 ☑

**APPLICANT:** CATHERINE DIANE CANSINO

**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 |

**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, CATHERINE DIANE CANSINO (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 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.** [ u ] **(PLEASE INITIAL BOX)**

**SIGNATURE OF APPLICANT:** Catherine Cansino
(Please sign full name – in presence of notary)

State of Ohio

County of Franklin

Catherine Diane Cansino

Subscribed and sworn to (or affirmed) before me on this 6e day of August, 20 12, by

Catherine Diane Cansino
(Notary to print name of applicant.)

proved to me on the basis of satisfactory evidence to be the person who appeared before me.

Signature Julie A Radabaugh

NOTARIAL SEAL STATE OF OHIO

Julie A. Radabaugh
Notary Public, State of Ohio
My Commission Expires 04-25-20

L1E

STATE AND CONSUMER SERVICES AGENCY- *Department of Consumer Affairs* — EDMUND G. BROWN JR., *Governor*

# MEDICAL BOARD OF CALIFORNIA

**Licensing Program**

MEDICAL BOARD OF CALIFORNIA
2012 OCT -2 AM 10: 3

## CERTIFICATE OF MEDICAL EDUCATION LICENSING

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

This certifies that CATHERINE DIANE CANSINO ; _____
Full Name of Applicant — U.S. Social Security Number

_____ . enrolled in Medical College of Ohio NKA University of Toledo
Date of Birth — Name of Medical School

located Toledo OH USA on 08/24/1998.
State/Province Country — Enrollment Date

The undersigned further certifies that the records of this institution show that the applicant attended in this institution 4 years of resident instruction, 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 Sections 2089,2089.5, 2089.7,2090, 2091.1,2091.2) and that the applicant

| | | |
|---|---|---|
| Anatomy | Embryology | Physical Medicine |
| Otolaryngology | Histology | Therapeutics |
| Obstetrics and Gynecology | Human Sexuality | Neurocanatomy |
| Radiology, Including Radiation Safety | Medicine | Child Abuse Detection and Treatment |
| Tropical Medicine | Surgery, including Orthopedic Surgery | Geriatric Medicine |
| Physiology | Urology | Podiatrics |
| Biochemistry | Psychiatry | Pharmacology |
| Pathology, Bacteriology, and Immunology | Neurology | Anesthesia |
| Ophthalmology | Alcoholism and Chemical Dependency | Spousal Partner Abuse Detection & Treatment* |
| Dermatology | Preventative Medicine, Including Nutrition | Family Medicine** |
| | | Pain Management and End-of-Life-Care*** |

* 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.

☒ was granted the degree of Bachelor/Doctor of Medicine on the 7 day of Jun , 2002.
☐ withdrew from medical school on ____ day of _____ , _____ .

***Unusual Circumstances***

| | Responses | |
|---|---|---|
| Did this individual ever take a leave of absence from their medical education? | Yes | No |
| Was this individual ever placed on probation? | Yes | No |
| Was this individual ever disciplined or under investigation? | Yes | No |
| Were any incident reports regarding this individual ever filed by instructors? | Yes | No |
| Were any limitations or special requirements imposed on this individual because of questions of academic or disciplinary problems, or for any other reason? | Yes | No |

**A "Yes" response to ANY of the above questions requires the medical school to provide a written explanation on a separate attachment.**

| Medical School Seal Must Be Imprinted Below | Attention Medical School: Only the President, Dean, or Registrar may sign this form. If the signature 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 25 day of Sept , 2012 . |
| | Printed Name and Title of School Official: Sherri Armstrong University Registrar |
| | Signature: Sherri Armstrong |

L2

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

# Application Summary



| | |
|---|---|
| License Type: | **Physician and Surgeon C** |
| License Number: | **55562** |
| File Number: | |
| Application: | **Physician's and Surgeon's Renewal** |
| Application Number: | |
| Application Date: | **12/20/2013 (mm/dd/yyyy)** |

## Personal Detail

| | |
|---|---|
| First Name: | **CATHERINE** |
| Middle Name: | **DIANE** |
| Last Name: | **CANSINO** |
| Birthdate: | |
| Gender: | **Female** |

## Addresses

**License Related Addresses**

**Confidential Address (Optional)**

Name:

Phone Number:

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

| | |
|---|---|
| Name: | **CANSINO, CATHERINE DIANE** |
| Address: | **6129 RENWELL LANE**<br>**COLUMBUS, OH**<br>**43230** |
| Phone Number: | |
| E-mail Address: | |

## Questions

| | |
|---|---|
| Since you last renewed your license, have you had any license disciplined by a government agency or other disciplinary body, or, have you been convicted of any crime in any state, the U.S.A. and its territories, military court or a foreign country? | **No** |

| | |
|---|---|
| Have you successfully completed, and can document, the mandatory courses and hours of CME within the last two years, or you meet the conditions which would exempt you from all or part of the CME requirements, or you hold a permanent CME waiver? | **No** |
| I certify under penalty of perjury, under the laws of California, that I have disclosed the names of those health-related facilities in which I or my family have a financial interest OR I declare under penalty of perjury I have no financial interests to disclose. | **No** |

## Family Physician Training Program Voluntary Fee

| | |
|---|---|
| Voluntary Fee: | **No** |

## Attachments

## Physician Survey

| | |
|---|---|
| Are you retired? | **No** |
| Activities in Medicine | **Administration - 10-19 Hours**<br>**Patient Care - 20-29 Hours**<br>**Teaching - 1-9 Hours** |
| Patient Care Practice Location | **Zip: 95817 County: SACRAMENTO** |
| Telemedicine Practice Location | **Zip: County:** |
| Patient Care Secondary Practice Location | **Zip: County:** |
| Telemedicine Secondary Practice Location | **Zip: County:** |
| Current Training Status | **Not in Training** |
| Areas of Practice | **Obstetrics and Gynecology - Primary** |
| Board Certifications | **American Board of Obstetrics and Gynecology - Obstetrics and Gynecology** |
| Postgraduate Training Years | **6 Years** |
| Cultural Background | **Filipino** |
| Foreign Language Proficiency | **Tagalog** |
| Web Site Profile | **Cultural Background - No**<br>**Foreign Language Proficiency - No**<br>**Gender - Yes** |

E-mail:

## Fees

| | |
|---|---|
| Biennial Renewal Fee | **$783.00** |

| | |
|---|---|
| Steven M. Thompson Physician Corps Loan Repayment Program | **$25.00** |
| Total Amount Due: | **$808.00** |

Applications are not considered submitted for processing until payment is received.

## Attestation

I declare under penalty of perjury under the laws of the State of California that all statements, answers, and representations provided, including supplementary attached hereto, are true, complete and accurate.

Signature: Date:

STATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS

dca BREEZE

# Department of Consumer Affairs

## RECEIPT

168526

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

| | |
|---|---|
| Name: | CANSINO, CATHERINE DIANE |
| Transaction Date: | 12/20/2013 09:42 |
| Application Number: | |
| Complaint Number: | |
| License Type: | 8002 |
| License Number: | 55562 |
| Payment Description: | Physician's and Surgeon's Renewal |
| Fee Paid: (US $) | 808.00 |
| Remaining Balance: (US $) | 0.00 |

Please print and save this receipt for your records.

This receipt is provided as a record for the above named licensee/applicant.

Illegal use or alteration of this receipt may result in criminal prosecution.

# Application Summary



| | |
|---|---|
| License Type: | **Physician and Surgeon C** |
| License Number: | **55562** |
| File Number: | |
| Application: | **Physician's and Surgeon's Renewal** |
| Application Number: | |
| Application Date: | **12/10/2015 (mm/dd/yyyy)** |

## Application Questions

| | |
|---|---|
| Have you served or are you currently serving in the military? | **N** |

## Personal Detail

| | |
|---|---|
| First Name: | **CATHERINE** |
| Middle Name: | **DIANE** |
| Last Name: | **CANSINO** |
| Birthdate: | ****/**/****** |
| Gender: | **Female** |

## Addresses

**License Related Addresses**

**Address of Record (Required)**

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

## Questions

| | |
|---|---|
| Since you last renewed your license, have you had any license disciplined by a government agency or other disciplinary body, or, have you been convicted of any crime in any state, the U.S.A. and its territories, military court or a foreign country? | **No** |
| Have you successfully completed, and can document, the mandatory courses and hours of CME within the last two years, or you meet the conditions which would exempt you from all or part of the CME requirements, or you hold a permanent CME waiver? | **Yes** |

| | |
|---|---|
| I certify under penalty of perjury, under the laws of California, that I have disclosed the names of those health-related facilities in which I or my family have a financial interest OR I declare under penalty of perjury I have no financial interests to disclose. | **Yes** |

## Family Physician Training Program Voluntary Fee

| | |
|---|---|
| Voluntary Fee: | **No** |

## Attachments

## Physician Survey

| | |
|---|---|
| Are you retired? | **No** |
| Activities in Medicine | **Administration - 1-9 Hours**<br>**Other - None**<br>**Patient Care - 20-29 Hours**<br>**Research - 1-9 Hours**<br>**Teaching - 1-9 Hours**<br>**Telemedicine - None** |
| Patient Care Practice Location | **Zip: 95817 County: SACRAMENTO** |
| Telemedicine Practice Location | **Zip: County:** |
| Patient Care Secondary Practice Location | **Zip: County:** |
| Telemedicine Secondary Practice Location | **Zip: County:** |
| Current Training Status | **Not in Training** |
| Areas of Practice | **Obstetrics and Gynecology - Primary** |
| Board Certifications | **American Board of Obstetrics and Gynecology - Obstetrics and Gynecology** |
| Postgraduate Training Years | **6 Years** |
| Cultural Background | **Filipino** |
| Foreign Language Proficiency | **Tagalog** |
| Web Site Profile | **Cultural Background - No**<br>**Foreign Language Proficiency - No**<br>**Gender - No** |
| E-mail: | |

## Fees

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

| | |
|---|---|
| Steven M. Thompson Physician Corps Loan Repayment Program | **$25.00** |
| Total Amount Due: | **$820.00** |

Applications are not considered submitted for processing until payment is received.

## Attestation

I declare under penalty of perjury under the laws of the State of California that all statements, answers, and representations provided, including supplementary attached hereto, are true, complete and accurate.

Signature: Date:

STATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS

dca BREEZE

# Department of Consumer Affairs

## RECEIPT

1750539

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

| | |
|---|---|
| Name: | CANSINO, CATHERINE DIANE |
| Transaction Date: | 12/10/2015 09:08 |
| Application Number: | 14237388 |
| Complaint Number: | |
| License Type: | 8002 |
| License Number: | 55562 |
| Payment Description: | Physician's and Surgeon's Renewal |
| Fee Paid: (US $) | 820.00 |
| Remaining Balance: (US $) | 0.00 |

Please print and save this receipt for your records.

This receipt is provided as a record for the above named licensee/applicant.

Illegal use or alteration of this receipt may result in criminal prosecution.