



BOARD OF MEDICAL QUALITY ASSURANCE

1430 HOWE AVENUE, SACRAMENTO, CA 95825

TELEPHONE:

Applications and Examinations (916) 920-6411

RECEIVED
SACRAMENTO
BOARD OF MEDICAL
QUALITY ASSURANCE



APPLICATION FOR PHYSICIAN'S AND SURGEON'S CERTIFICATE

BASED ON NATIONAL BOARD CREDENTIALS

CLASS G

000035

132.08

(Please type or print neatly. When space provided is insufficient, attach additional sheets.)

1. NAME: Last <u>FERRIS</u> First <u>Mary</u> Middle <u>Elina</u> Maiden <u>---</u>				2. Telephone No.	
3. List other names, if any, you have used: <u>none</u>					
4. Address: Street and No./Rural Route <u>30 Zane St.</u>			City <u>Long Beach</u>	State <u>Calif.</u>	Zip Code <u>90805</u>
5. Name you wish on License: <u>Mary Elina Ferris, M.D.</u>				Birthdate: (Month - Day - Year) <u>---</u>	
6. Premedical Education: Name of College or University <u>UCLA, UCSB, Johns Hopkins University</u>				Location <u>Los Angeles, Santa Barbara</u>	
Period of attendance: From: <u>10/69</u> To: <u>6/76</u>		Check premed courses successfully completed: <u>and Baltimore, Md.</u>			
		<input checked="" type="checkbox"/> Chemistry		<input checked="" type="checkbox"/> Physics	
		<input checked="" type="checkbox"/> Biology or Zoology			
7. Medical School:					
Year	Name of Institution	Location	From	To	
1st	<u>University of California</u>	<u>San Francisco</u>	<u>10/76</u>	<u>---</u>	
2nd	<u>"</u>	<u>"</u>	<u>---</u>	<u>---</u>	
3rd	<u>"</u>	<u>"</u>	<u>---</u>	<u>---</u>	
4th	<u>"</u>	<u>"</u>	<u>---</u>	<u>5/80</u>	
5th					
6th					
8. Doctor of Medicine Degree granted by: <u>Regents of the University of California</u>			Date <u>6/29/80</u>	For office use only School Code: <u>CA 002</u>	
9. 1st Year Postgraduate Training (Internship): <u>sch of med</u>					
Location		Type of Service	From	To	
<u>University of Calif. IRVINE MEDICAL CENTER</u>		<u>Family Medicine Residency</u>	<u>7/1/80</u>	<u>6/30/81</u>	
10. List all States in which you have been licensed to practice medicine: <u>none</u>					
11. Has any disciplinary action ever been taken regarding any license which you now hold or ever held? Yes <u>---</u> No <u>---</u>					
If Yes, indicate below:					
State	Date	Charge	Disposition		
12. Have you ever been denied a license to practice medicine in any State or Country? Yes <u>---</u> No <u>---</u>					
If Yes, indicate below:					
State or Country	Date of Denial	Reason for Denial			
13. Are you now or have you ever been addicted to narcotic drugs? Yes <u>---</u> No <u>---</u>					

14. Have you ever been convicted of, or pled nolo contendere to a violation of any Federal, State or Local law relating to the manufacture, distribution or dispensing of controlled substances/narcotics; or to drug addiction?

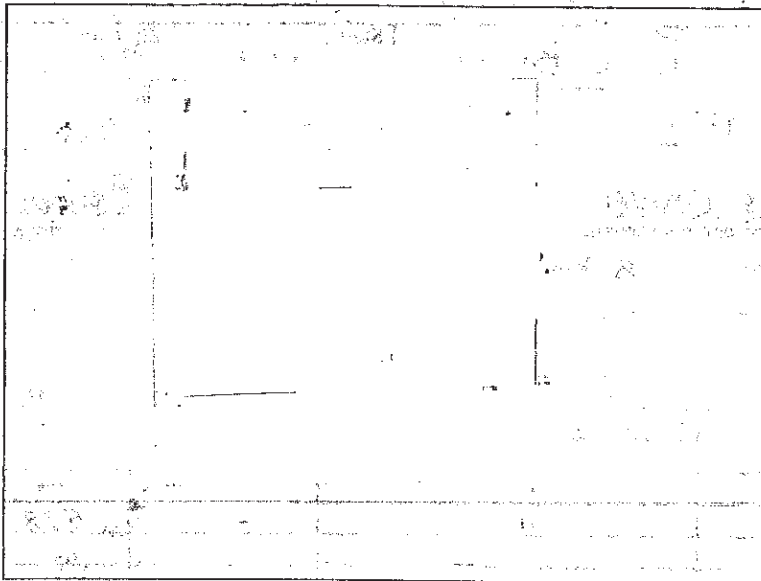
15. Have you ever been convicted of, or pled nolo contendere to any offense, misdemeanor or felony in any state? (Except violations of traffic laws resulting in fines of \$50.00 or less.)

16. If you answered "Yes" to either No. 14 or No. 15 above, please provide the following information:

Violation and Location	Date	Penalty/Disposition

17. Have you ever had staff privileges in a hospital suspended or revoked? If "Yes", please explain on another sheet of paper.

18. Have you ever voluntarily surrendered your license to practice in another state?



Applicant: Please complete the following:

Height: ___ Ft. In. Weight: ___ Lbs.

Hair color: ___ Eye color: ___

Identifying marks: _____

NOTE: The information on this application is required and maintained pursuant to Section 2312 of the Business and Professions Code. All items in this application are mandatory, none are voluntary. Failure to provide any of the requested information will result in the application being rejected as incomplete. The information provided will be used to determine qualification for licensure. Applicants have the right to review their applications subject to the provisions of the California Public Records Act.

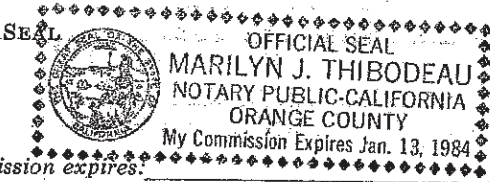
NOTE: APPLICANT WILL SIGN THIS STATEMENT IN PRESENCE OF NOTARY PUBLIC.

"I hereby certify (or declare), under penalty of perjury, that the foregoing information contained in this application and any attachments is true and correct, and that the attached photo and duplicate copy are a true likeness of myself, the applicant identified herein."

Signature of Applicant Maryelina Ferrus
Date 6/29/81

Subscribed and sworn to before me this 29th day of June 1981

Signature of Notary Marilyn J. Thibodeau
Address UCIMC, Orange, CA



My commission expires: _____



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1430 HOWE AVENUE, SACRAMENTO, CA 95825
APPLICATIONS AND EXAMINATIONS
(916) 920-6411



PLEASE FORWARD TO YOUR MEDICAL SCHOOL
CERTIFICATE OF EDUCATION

This Certifies That MARY ELINA FERRIS, M.D.
enrolled in UNIVERSITY OF CALIF., SAN FRANCISCO School of Medicine
on the 23 day of September 19 76

- as a Freshman.
with advanced standing based on

The undersigned further certifies that official transcripts on file show that prior to completing the study of medicine the applicant herein referred to completed at least a two-year resident course of college grade including:

- PHYSICS CHEMISTRY BIOLOGY (or) ZOOLOGY

at John Hopkins Univ. & Univ. of Calif. Santa Barbara, and that he attended while at this medical school (college)

14 courses of lectures of 12 weeks each, at least completing 4,000 hours in the subjects below listed, and that he/she:

- was granted the degree Bachelor Doctor of Medicine.

- left the above-mentioned medical school (college) for the following reason(s):

on the 29 day of June 19 81

Please indicate which of the following courses of study were successfully undertaken by the applicant:

- Anatomy Dermatology Preventive medicine, including nutrition Otolaryngology
Embryology Physical medicine Obstetrics and gynecology
Histology Therapeutics Radiology, including

A SEPARATE COURSE IN EACH OF THE SUBJECTS LISTED IS NOT REQUIRED. HOWEVER, THE COURSE OF STUDY COMPLETED BY THE CANDIDATE SHALL HAVE PROVIDED ADEQUATE INSTRUCTION IN ALL OF THE AREAS LISTED.

- immunology Pharmacology Anesthesia detection and treatment

Signed and the College seal affixed this 23rd day

AFFIX SEAL HERE

of April 19 81

By H. Ann... Secretary, Dean

**STATE DEPARTMENT OF CONSUMER AFFAIRS
INTERNET CASHIERING SYSTEM
MEDICAL BOARD OF CALIFORNIA
SUPPLEMENTAL INFORMATION REPORT**

From Date: 12/19/2012 To Date: 12/19/2012

ATRISUPPINF

29-MAR-16 14:24:17

Person Id : 593955 **Name :** Ferris, Mary

Question	Answer
I Have Completed Cme And Can Document Not Less Than 50 Hours Of Approved Cme For The Two-Year Period Immediately Preceding The Expiration Date Of My License. Or I Meet The Conditions Which Would Exempt Me From All Or Part Of The Requirements.	YES
I Have Completed 12 Hours Of Pain Management And End-Of-Life Care.	YES
I Am Exempt From The Completion Of 12 Hours Of Pain Management And End-Of-Life Care Continuing Education Requirement Because I Am A Radiologist Or Pathologist.	NO
Only For General Internists And Family Physicians Who Have 25% Of Their Patient Population Aged 65 Years Or Older: I Have Completed At Least 20% Of The Required Cme In Geriatric Medicine Or The Care Of Older Patients. Click No If Not Applicable.	NO
Enter Name/Address Of Facility Where You Or Your Immediate Family Hold Financial Interest. Type "None", If None Held.	NONE
I Certify Under Penalty Of Perjury Under The Laws Of The State Of California That The Information Contained In This Application Is True And Correct.	YES
I Have Read My Profile On The Medical Board Web Site At www.mbc.ca.gov And Acknowledge The Information Contained Therein As Current And Accurate.	YES
Since You Last Renewed Your License, Have You Had Any License Disciplined By A Government Agency Or Other Disciplinary Body, Or, Have You Been Convicted Of Any Crime In Any State, The U S A And Its Territories, Military Court Or A Foreign Country?	

Total Questions Asked For Person : 593955 **8**

Application Summary

12/17/14 5:08 PM

Page 1 of 3

License Type: **Physician and Surgeon G**
License Number: **45336**
File Number:
Application: **Physician's and Surgeon's Renewal**
Application Number:
Application Date: **12/17/2014 (mm/dd/yyyy)**

Personal Detail

First Name: **MARY**
Middle Name: **ELINA**
Last Name: **FERRIS**
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.

Confidential Address

Warning:

In order to protect your privacy and identity, address will not be displayed.

Questions

Since you last renewed your license, have you had any license disciplined by a government agency or other disciplinary body, or, have you been convicted of any crime in any state, the U.S.A. and its territories, military court or a foreign country?

Have you successfully completed, and can document, the mandatory courses and hours of CME within the last two years, or you meet the conditions which would exempt you from all or part of the CME requirements, or you hold a permanent CME waiver?

Yes



1418864923451

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 - 40+ Hours

Other - None

Patient Care - 30-39 Hours

Research - None

Teaching - 1-9 Hours

Telemedicine - None

Patient Care Practice Location

Zip: 93106 County: SANTA BARBARA

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

Family Medicine - Primary

Other - Not Listed - Secondary

Board Certifications

American Board of Family Medicine - Family Medicine

Postgraduate Training Years

3 Years

Cultural Background

Decline to State

Foreign Language Proficiency

Spanish

Web Site Profile

Cultural Background - No

Foreign Language Proficiency - No

Gender - Yes

E-mail:

Fees

Biennial Renewal Fee

\$783.00



1418864923451

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:



Department of Consumer Affairs

RECEIPT

894035

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

Name:	FERRIS, MARY ELINA
Transaction Date:	12/17/2014 17:09
Application Number:	
Complaint Number:	
License Type:	8002
License Number:	45336
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.
