



BOARD OF MEDICAL QUALITY ASSURANCESACRAMENTO  
1430 HOWE AVENUE  
SACRAMENTO, CA 95825  
(916) 920-6411



SEP 15 1 31 PM '89

APPLICATION FOR PHYSICIAN AND SURGEON'S EXAMINATION OR LICENSURE

Read all instructions prior to completing this application. All questions on this application must be answered, and all supporting documents must be submitted with this application per instructions. Please type or print neatly. When space provided is insufficient, attach additional sheets of paper.

003578  
435.009/89  
006744 45,0012/89  
BMQA USE ONLY

1. Name: Diego First Mendez Middle Bautista Last

PERSONAL DATA

2. Other names you have used:  
Diego Fernando Mendez Bautista

3. Social Security Number  
See disclosure statement on LIC

4. Address: Number and Street/Rural Route (include apartment number, if any)  
P.O. Box 6445  
Corpus Christi, Texas City State ZIP Code 78466 - 6445 Country

5. Telephone Number: Home Work

6. Date of Birth: Mo/Day/Yr

7. Sex:  Female  Male

8. Are you a U.S. citizen?  Yes  No #11325829  
Submit a certified copy of birth certificate, Certificate of Naturalization, Declaration of Intention to become U.S. citizen (INS Form N300), VISA documents, or license to practice medicine.

9. Have you ever filed an application for examination or licensure in California?  Yes  No  
If YES, give date of previous application: 1985

10. List name and address of all colleges or universities attended other than schools where professional medical instruction was received. Submit an official transcript from each school attended.

Name	Address	Period of Attendance		NON-MEDICAL EDUCATION
		From (Mo/Yr)	To (Mo/Yr)	
San Diego Mesa Coll.	San Diego, California	6/73	6/76	<input checked="" type="checkbox"/>
Univ. Calif. San Diego	La Jolla, California	9/76	6/78	<input checked="" type="checkbox"/>
San Diego State Univ.	San Diego, California	9/85	5/87	<input checked="" type="checkbox"/>

11. List name and address of all schools where professional medical instruction was received. Submit an original Certificate of Medical Education and official transcripts from each school attended.

Name	Address	Place Where Instruction Received	Period of Attendance		CME TRANS.
			From (Mo/Yr)	To (Mo/Yr)	
Universidad Autonoma de Guadalajara (UAG)	Av. Patria 1201 Lomas del Valle Guadalajara, Jalisco, Mexico	U.A.G.	1/79	12/82	<input checked="" type="checkbox"/> <input checked="" type="checkbox"/>

12. Doctor of Medicine Degree granted by: (submit original medical diploma and a photocopy)  
Name of Medical School: Universidad Autonoma de Guadalajara  
Address of Medical School: Av. Patria 1201 Lomas Del Valle Guadalajara, Jalisco, Mexico  
Exact Date of Issuance: December 20, 1982

MEX14  
School Code

L1A

717

BMQA USE ONLY

13. Have you taken any of the following written examinations: National Boards, ECFMG, FMGEMS, FLEX, MSKP, MCAT, other related medical competency examinations?  Yes  No  
 If YES, list name, location, date and result of examination. Submit certification of scores from each examination agency.

WRITTEN EXAMINATION

Name	Location	Date	Result
E.C.M.G.	San Diego, Calif.	Jan. 1983	
F.L.E.X.	Washington	Dec. 1988	

14. Have you received qualifying postgraduate training in U.S. or Canadian facilities?  Yes  No  
 If YES, list name and address of all facilities. Submit an original Certificate of Completion of ACGME Postgraduate Training (Form L3) from each facility.

POSTGRADUATE TRAINING

Name	Address	Type of Service	Period of Attendance	
			From (Mo/Yr)	To (Mo/Yr)
Driscoll Foundation Children's Hospital	3533 S. Alameda	Pediatrics	7/89	6/90
D.F.C.H.	3533 S. Alameda	Pediatrics	7/88	6/89
D.F.C.H.	3533 S. Alameda	Pediatrics	7/87	6/88

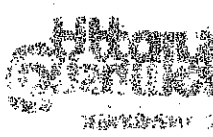
15. Have you been licensed to practice medicine in any state or country?  Yes  No  
 If YES, list state or country, license number, date issued and dates of practice in issuing agency's jurisdiction for each. Submit a Letter of Good Standing from each state in which you are licensed or have been licensed.

LICENSE DATA  
 LGS CE

State or Country	License Number	Date of Issuance	Dates of Practice in Issuing Agency's Jurisdiction	
			From (Mo/Yr)	To (Mo/Yr)
Washington	26159	Feb. 21 1989		
Mexico	1168567	July 2, 197		

16. Has any disciplinary action ever been taken regarding any healing arts license which you now hold or have ever held? Include any disciplinary actions by the U.S. Military, U.S. Public Health Service or other U.S. federal governmental entity.  
 Yes  No  If yes, give details below:

State	Date	Charge	Disposition



L1B



BMQA USE ONLY

17. Have you ever been denied a license, permission to practice medicine or any other healing arts, or permission to take an examination in any state, country, or U.S. federal jurisdiction? Yes No

If yes, give details below:

State or Country	Date of Denial	Reason for Denial

18. Have you been charged with unprofessional conduct or any other unlawful activity by any healing arts licensing authority or by the U.S. military and are awaiting final disposition by that body?

Yes No If yes, please explain on a separate sheet of paper.

19. Have you ever voluntarily surrendered a license to practice in the healing arts in another state?

Yes No If yes, please explain on a separate sheet of paper.

20. Have you ever had staff privileges in a hospital denied, suspended or revoked, or resigned from a medical staff in lieu of disciplinary action? Yes No If yes, please explain on a separate sheet of paper.

21. Are you now, or were you in the past, addicted to or treated for addiction to controlled substances, such as narcotics or alcohol? Yes No If yes, please explain on a separate sheet of paper.

22. Have you ever been convicted of, or pled nolo contendere to a violation of any federal, state or local law relating to the manufacture, distribution or dispensing of controlled substances, or to drug addiction? Yes No

If yes, give details below:

Violation and Location	Date	Penalty or Disposition

23. Have you ever been convicted of, or pled nolo contendere to any offense, misdemeanor or felony of any state, the United States, or a foreign country? (except violations of traffic laws resulting in fines of \$75.00 or less.)

Yes No If yes, give details below:

Violation and Location	Date	Penalty or Disposition
		120

You are required to list any conviction that has been set aside and dismissed under Section 1203.4 Penal Code or under any other provision of law.

"Disclosure of your social security number is mandatory. Section 30 of the Business and Professions Code and Pub. L. 94-455 (42 U.S.C.A. 405 (c) (2) (C)) authorizes collection of your social security number. Your social security number will be used exclusively for tax enforcement purposes. If you fail to disclose your social security number, you will be reported to the Franchise Tax Board, which may assess a \$100 penalty against you."

LICENSE DATA (continued)

GENERAL DATA



I hereby declare under penalty of perjury under the laws of the State of California, that the photo of myself attached hereto, was taken

on or about \_\_\_\_\_, 19\_\_

my age then being \_\_\_\_\_ years

color of hair \_\_\_\_\_

color of eyes \_\_\_\_\_

height \_\_\_\_\_ ft. \_\_\_\_\_ in.

weight \_\_\_\_\_ lbs.

identifying marks \_\_\_\_\_

TOP

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**NOTE:** All items in this application are mandatory; none are voluntary. Failure to provide any of the requested information will result in the application being rejected as incomplete. The information provided will be used to determine qualification for licensure, per Section 2080 of the Business and Professions Code which authorizes the collection of this information. Information regarding the issuance or denial of a license by the Board may be transmitted to any other medical licensing authority or the Federation of State Medical Boards. Applicants have the right to review their application subject to the provisions of the Information Practices Act. The Program Manager of the Division of Licensing is the custodian of records.

STATE OF Texas  
COUNTY OF Nueces

Diego Mendez

\_\_\_\_\_ being duly sworn, says he is the person referred to in the foregoing application for a physician and surgeon's certificate in California and that he has carefully read and thoroughly understands all the requirements therein and that the statements made herein and all attachments are true and correct under penalty of perjury under the laws of the State of California.

He requests that the Division of Licensing, Board of Medical Quality Assurance, initiate a review of the records to determine their eligibility for examination, postgraduate training or licensure in California. In making this request, he authorizes the release of any information or records held by any individual or agency, relative to their training and qualifications as a physician and surgeon, upon request by the Board for use in evaluating their file.

Signature of applicant in FULL (Do not use INITIALS ONLY)

Signed and sworn to before me this 23rd day of May, 1989

Signature of Notary Public Eva E. Estrate

Address 3533 So. Alameda, Corpus Christi TX

My commission expires 8-10-92

**L1D**



DEPARTMENT OF CONSUMER AFFAIRS  
**BOARD OF MEDICAL QUALITY ASSURANCE**  
 RE: Diego Mendez, M.D. 1430 HOWE AVENUE, SACRAMENTO, CALIFORNIA 95825  
 (916) 920-6411

UAG Credential No. 633336

**REPORT OF JUNIOR YEAR CLINICAL ROTATIONS**



Clinical Area	Type*	Facility Name and Address	Dates of Attendance From—To	Weeks of Credit	Instructor or Supervisor	Program Director
Cardiology	R	Hospital Angel Leano	1-12-81	4wks/3days	Dr. Salvador Verduzco B.	Chairman
		Guadalajara, Jalisco, Mexico	2-13-81			
Pneumology	R	Hospital Angel Leano	2-16-81	4wks/4days	Dr. Manuel Urbina A.	Acting Chairman
		Guadalajara, Jalisco, Mexico	3-20-81			
Ophthalmology	R	Hospital Angel Leano	3-23-81	2wks	Dr. Jorge Perales C.	Chairman
		Guadalajara, Jalisco, Mexico	4-7-81			
Otorhinolaryngology	R	Hospital Angel Leano	4-8-81	2wks/1days	Dr. Mario Flores	Chairman
		Guadalajara, Jalisco, Mexico	5-2-81			
Gastroenterology	R	Hospital Angel Leano	7-27-81	4wks/2days	Dr. Victoriano Salas F.	Chairman
		Guadalajara, Jalisco, Mexico	8-25-81			
Traumatology	R	Hospital Angel Leano	11-6-81	4wks/4days	Dr. Gustavo Valladares G.	Chairman
		Guadalajara, Jalisco, Mexico	12-11-81			
Dermatology	R	Hospital Angel Leano	10-1-81	5wks/2days	Dr. Raul Aceves	Chairman
		Guadalajara, Jalisco, Mexico	11-5-81			
Forensic Medicine	R	Hospital Angel Leano	10-2-81	5wks/1days	Dr. Jesus F. Zumuano V.	Chairman
		Guadalajara, Jalisco, Mexico	11-5-81			
Emergency Room 9. Radiology	E	Scripps Memorial Hospital	5-5-81	4wks/4days	Peter H.B. McCreight, M.	Director, Medical Ed.
		LaJolla, CA	6-5-81			
Family Medicine 10. Medicine	E	Scripps Memorial Hospital	8-27-81	5wks	Peter H.B. McCreight, M.	Director Medical Educati
		La Jolla, CA	9-30-81			

\*Enter "E" for elective or "R" for required. Eighteen (18) weeks maximum allowable elective rotations.

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

"I hereby declare under penalty of perjury under the laws of the State of California that the foregoing information contained in this document and any attachments are true and correct."

Signed and sworn to before me this 12 day of September 1981

[SEAL]

Signature of Notary Public

Address Desert Hospital / P.O. Box 6530 / Corpus Christi, TX 78406 My commission expires 7/6/93

**L5A**



DEPARTMENT OF RE: Diego Mendez, M.D. BOARD OF MEDICAL QUALITY ASSURANCE  
 UAG Credential #633336 1430-HOWE AVENUE, SACRAMENTO, CALIFORNIA 95825  
 (916) 920-6411



L5B

REPORT OF SENIOR YEAR CLINICAL ROTATIONS

Clinical Area	Type*	Facility Name and Address	Dates of Attendance From—To	Weeks of Credit	Instructor or Supervisor	Program Director
Psychiatry/ Neurology	R	Scripps Memorial Hospital	1-11-82		Peter H.B. McCreight, M.D. Director, Medical Educat:	
		La Jolla, CA	2-26-82	7wks		
Medicine	R	Scripps Memorial Hospital	3-1-82	7wks/4days	Peter H.B. McCreight, M.D. Director, Med. Education	
		La Jolla, CA	4-23-82			
Radiology	R	Scripps Memorial Hospital	4-26-82	1wk	Peter H.B. McCreight, M.D. Director, Medical Educat:	
		La Jolla, CA	4-30-82			
Urology	R	Hospital Angel Leano	9-22-82	4wks/4days	Dr. Angel Orozco Chairman	
		Guadalajara, Jalisco, Mexico	10-25-82			
Pediatrics	R	Hospital Angel Leano	10-26-82	7wks	Dr. Jose Antonio Orana Chairman	
		Guadalajara, Jalisco, Mexico	12-10-82			
OB/GYN	R	Hospital Angel Leano	7-26-82	6wks	Dr. Manuel O. Gomez B. Chairman	
		Guadalajara, Jalisco, Mexico	9-6-82			
7.						
8.						
9.						
10.						

\*Enter "E" for elective or "R" for required. Eighteen (18) weeks maximum allowable elective rotations.

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

"I hereby declare under penalty of perjury under the laws of the State of California that the foregoing information contained in this document and any attachments are true and correct."

*Diego Mendez, M.D., MPH.*  
 SIGNATURE OF APPLICANT IN FULL

Signed and sworn to before me this 1st day of SEPTEMBER 19 89

[SEAL]

Signature of Notary Public

*Alfred K...*

Address Preson Hospital, P.O. Box 6530, Corpus Christi, TX 78466

My commission expires 7/16/93



BOARD OF MEDICAL QUALITY ASSURANCE

1430 HOWE AVENUE, SACRAMENTO, CALIFORNIA 95825

(916) 920-6411



LSB

INTERNADO  
REPORT OF SENIOR/YEAR/CLINICAL ROTATIONS

RE: DIEGO MENDEZ, M.D.  
UAG CRED: 633336

Clinical Area	Type*	Facility Name and Address	Dates of Attendance From--To	Weeks of Credit	Instructor or Supervisor	Program Director
OBSTETRICS/ GYNECOLOGY		Hospital Ramon Garibay	7/1/83 -	3 months	Dr. Jesus Castillo Pacheco	General Director
		Guadalajara, Jalisco Mexico	9/30/83			
PEDIATRICS		same	10/1/83-	3 months	"	"
			12/31/83			
INTERNAL MEDICINE		Hospital del Carmen	1/1/84-	3 months	Dr. Francisco Diaz Martinez	Director
		Tijuana, Baja California	3/31/84			
Surgery		same	4/1/84 -	3 months	"	"
			6/26/84			
5.						
6.						
7.						
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10.						

Alejandro Acevedo, LAE  
Dean of Foreign Students

\*Enter "E" for elective or "R" for required. Eighteen (18) weeks maximum allowable elective rotations.

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

"I hereby declare under penalty of perjury under the laws of the State of California that the foregoing information contained in this document and any attachments are true and correct."

Diego Mendez MD, MPH  
SIGNATURE OF APPLICANT IN FULL

Signed and sworn to before me this 23rd day of October 1989.

[SEAL] Signature of Notary Public Eva E. Muste

Address 3533 So. Alameda, Corpus Christi My commission expires 8-10-92  
Jesus



BOARD OF MEDICAL QUALITY ASSURANCE

1430 HOWE AVENUE, SACRAMENTO, CALIFORNIA 95825  
(916) 920-6411



LSB

INTERNADO

REPORT OF SENIOR/YEAR/CLINICAL ROTATIONS

RE: DIEGO MENDEZ, M.D.  
UAG CRED: 63336

Clinical Area	Type*	Facility Name and Address	Dates of Attendance From—To	Weeks of Credit	Instructor or Supervisor	Program Director
OBSTETRICS/ GYNECOLOGY		Hospital Ramon Garibay	7/1/83 -	3 months	Dr. Jesus Castillo Pacheco	General Director
		Guadalajara, Jalisco Mexico	9/30/83			
PEDIATRICS	2.	same	10/1/83-	3 months	"	"
			12/31/83			
INTERNAL MEDICINE	3.	Hospital del Carmen	1/1/84-	3 months	Dr. Francisco Diaz Martinez	Director
		Tijuana, Baja California	3/31/84			
Surgery	4.	same	4/1/84 -	3 months	"	"
			6/26/84			
	5.					
	6.					
	7.					
	8.					
	9.					
	10.					

*[Handwritten Signature]*  
Alejandro Acevedo, M.D.  
Dean of Foreign Students

\*Enter "E" for elective or "R" for required. Eighteen (18) weeks maximum allowable elective rotations.

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

"I hereby declare under penalty of perjury under the laws of the State of California that the foregoing information contained in this document and any attachments are true and correct."

Signed and sworn to before me this 23<sup>rd</sup> day of October 19 87  
 Signature of Applicant: Diego Mendez, M.D. MPH  
SIGNATURE OF APPLICANT IN FULL

(SEAL) Signature of Notary Public: Eva C. Urste  
 Address: 3533 Sr. Alameda, Corpus Christi, TX My commission expires 8-10-92

This is a copy of the original document.





**BOARD OF MEDICAL QUALITY ASSURANCE**

1430 HOWE AVENUE, SACRAMENTO, CALIFORNIA 95825  
(916) 920-6411



**CERTIFICATE OF MEDICAL EDUCATION**

MEDICAL SCHOOL: DO NOT COMPLETE IF PHOTOGRAPH OF APPLICANT/STUDENT IS NOT ATTACHED BELOW.

This certifies that Diego Mendez Bautista

FULL NAME OF APPLICANT

of Corpus Christi, TX

ADDRESS WHEN ENROLLED

enrolled in Universidad Autonoma de Guadalajara

NAME OF MEDICAL SCHOOL

Guadalajara, Jalisco, Mexico

LOCATION

on the 8th day of January

MONTH

19 79  
YEAR

and was granted the following credits on enrollment:

Premedical Education. Two years of preprofessional postsecondary education, including the subjects of physics, chemistry, and biology (Business and Professions Code Section 2088).

EDUCATIONAL INSTITUTION

DATES

Advanced Credits. Credits previously obtained at an approved medical school.\*

MEDICAL SCHOOL

TOTAL CREDITS

DATES

The undersigned further certifies that the records of this institution show that he attended in this institution 44 courses of resident instruction of various weeks each, completing at least 4,000 hours, of which at least 80 percent actual attendance is required, in the subjects set forth hereunder (Business and Professions Code Section 2089), and that

SPECIFY NUMBER

NUMBER OF WEEKS

he was granted the degree Bachelor of Medicine by Physician-Surgeon

he withdrew from

the above mentioned medical school on the 20th day of December, 1982

MONTH

- Anatomy 200
- Otolaryngology 60
- \* Obstetrics and Gynecology 300
- \* Radiology, including Radiation Safety
- Tropical Medicine 160
- Physiology 200
- Biochemistry 200
- Pathology, Bacteriology and Immunology 414
- Ophthalmology 60

- Dermatology 60
- Embryology 72
- \* Histology 136
- \* Human Sexuality as defined in Section 2090
- Medicine 2116
- Surgery, including Orthopedic Surgery 408
- Urology 60
- Psychiatry 208
- Neurology 160

- \* Preventive medicine, including Nutrition 962
- \* Physical Medicine
- \* Therapeutics
- \* Neuroanatomy
- \* Child Abuse Detection and Treatment
- \* Geriatric Medicine
- Pediatrics 360
- \* Pharmacology 198
- \* Anesthesia

Signed and the college seal affixed this 4th day of August, 1989

BY Alejandro Geves, Dean of Foreign Students

PRESIDENT, SECRETARY, DEAN

Medical School Seal MUST Be Imprinted Partially on the Photograph.

TRANSCRIPTS OF PREMEDICAL EDUCATION, ADVANCED CREDITS, AND MEDICAL SCHOOL CREDITS MUST BE SUPPLIED WITH THIS CERTIFICATE

\* Each school where professional medical instruction was received MUST complete one of these forms. If more than one school was attended, photocopies of this blank form may be made and used. Note that photograph and all entries to the form must be original.



BOARD OF MEDICAL QUALITY ASSURANCE

1430 HOWE AVENUE, SACRAMENTO, CALIFORNIA 95825  
(916) 920-6411



CERTIFICATE OF COMPLETION OF ACGME POSTGRADUATE TRAINING

To be completed by the facility for every medical school graduate completing postgraduate training in the United States or Canada. Do not complete if photograph of applicant is not attached below. Please type or print.

This is to certify that Diego Mendez NAME OF APPLICANT

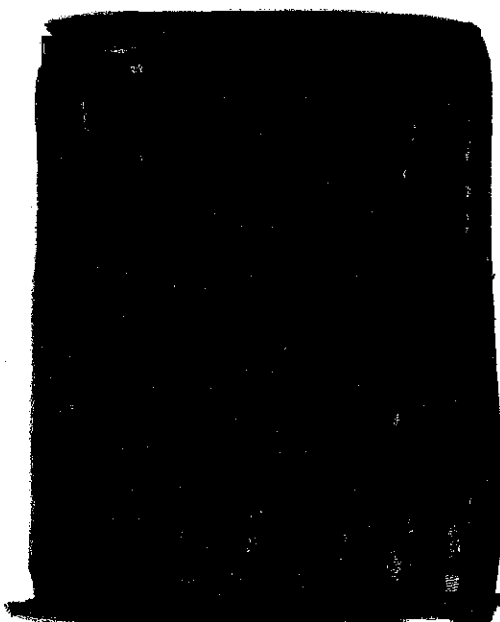
a graduate of Universidad Autonoma de Guadalajara NAME OF MEDICAL SCHOOL

formally commenced an accredited postgraduate training program at Driscoll Foundation Children's Hospital, NAME AND ADDRESS OF FACILITY  
3533 So. Alameda, Corpus Christi, TX in Pediatrics SPECIALTY

on July 1, 1987, and completed such training on June, 1989.  
This training consisted of \_\_\_\_\_ months of actual clinical instruction and is approved by the Accreditation Council for Graduate Medical Education (ACGME) or the Coordinating Council of Medical Education of the Canadian Medical Association (CCME) and consisted of the following rotations:

(List rotations completed. If service was not rotating, indicate type of straight training performed. NOTE—To qualify for licensure in California, graduates of foreign medical schools must have completed at least four months of postgraduate training in general medicine. ACGME or CCME residencies in family practice, internal medicine, surgery, pediatrics, and ob/gyn would normally satisfy this requirement.)

ROTATION	LENGTH OF ROTATION



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

NAME Patrick Brosnan Patrick Brosnan, M.D. DIRECTOR OF MEDICAL EDUCATION

AFFIX SEAL OF HOSPITAL OR NOTARY PUBLIC )

ADDRESS 3533 So. Alameda  
Corpus Christi, TX 78411

PHONE NUMBER (512) 850-5465

DATE June 5, 1989

SIGNATURE Patrick Brosnan

L3



BOARD OF MEDICAL QUALITY ASSURANCE

1430 HOWE AVENUE, SACRAMENTO, CALIFORNIA 95825

(916) 920-6411



CERTIFICATION STATEMENT

This is to certify that Diego Mendez is in an  
(Name of Physician)

ACGME/CCME postgraduate training position that commenced on

July 1, 1987 and is expected to be completed on

June 30, 1990 in Pediatrics  
(Type of Training)

at Driscoll Foundation Children's Hospital  
(Name and Address of Facility)

3533 So. Alameda, Corpus Christi, TX 78411

(AFFIX SEAL OF)  
(HOSPITAL OR )  
(NOTARY PUBLIC)

I hereby declare under penalty of perjury under the laws of the State of California that the above statements are true and correct and the facility is approved by the ACGME or the CCME to offer the type and level of training completed by the applicant and that the applicant is being trained in an approved ACGME or CCME program position.

Patrick Brosnan, M.D.  
TYPE OR PRINT NAME OF DIRECTOR OF MEDICAL EDUCATION

Patrick Brosnan, M.D.  
SIGNATURE OF DIRECTOR OF MEDICAL EDUCATION

7/12/89  
DATE

(512) 850-5465  
PHONE NUMBER

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 I  YES J  NO

**License Renewal Application  
Physician and Surgeon**

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

**D. Continuing Medical Education (CME) Certification Statement:** I CERTIFY UNDER PENALTY OF PERJURY UNDER THE LAWS OF CALIFORNIA TO THE FOLLOWING STATEMENT: I CERTIFY THAT I DO MEET EACH OF THE CONTINUING MEDICAL EDUCATION REQUIREMENTS LISTED ON THE BACK OF THIS FORM OR THAT I MEET THE CONDITIONS WHICH WOULD EXEMPT ME FROM ALL OR PART OF THE REQUIREMENTS OR I HOLD A PERMANENT CME WAIVER.  
SIGNATURE REQUIRED HERE [Signature] DATE: 090813

AMOUNT DUE NOW	DELINQ FEE IF POSTMARKED AFTER 12/30/13
\$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 ( ) \_\_\_\_\_

**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.  
[Signature]

LICENSE NO. **A 47906** EXPIRES **11/30/13**  
VOLUNTARY FEE = \$  
TOTAL ENCLOSED = \$ 808.00  
**ACTIVE DIEGO MENDEZ**  
**PO BOX 22129**  
**SAN DIEGO CA 92192**

*check # 6917*  
**PAID**

OVER

63010100000100002000479063011130130008080000088600

**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

(DO NOT DETACH)

Medical Board of California - Physician's and Surgeon's Initial Renewal

LICENSEE NAME  
MENDEZ, DIEGO



**PAID**

check # 7368

LICENSE NO.  
A47906

EXPIRATION DATE  
11/30/15

AMOUNT DUE NOW  
\$820.00

AMOUNT DUE IF POSTMARKED AFTER DECEMBER 30, 2015  
\$898.00

**LICENSEE MUST CHECK CORRECT BOXES**

"H"  Completed Continuing Education

"E"  Change of Address (fill in reverse side)

"I"  Conviction Disclosure - Yes

"J"  Conviction Disclosure - No

"F"  Family Physician Training Program (\$25)

"G"  Financial Interest Statement-Read instructions above

**"D" SIGNATURE REQUIRED**

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

Signature *Diego Mendez* Date 09/08/15

ENTER YOUR PHONE NUMBER FOR REFERENCE:

63010100000100002000479063011130150008200000089800

CHANGE OF MAILING ADDRESS

MENDEZ, DIEGO

A47906

09162015 20001163 20010012

Street Address (this address is public information except when a PO Box is used for the public address of record; this address then becomes confidential)

2917 NILES ST

City: Bakersfield State: CA Zip: 93306

PO Box (if used, must provide a confidential physical street address, above)

PO Box 2169

City: Bakersfield State: CA Zip: 93306