

DEPARTMENT OF CONSUMER AFFAIRS  
**BOARD OF MEDICAL EXAMINERS**  
 OF THE STATE OF CALIFORNIA  
**NATIONAL BOARD APPLICATION — CLASS G**

Application Fee 2/104/31  
 Initial License Fee 3.48 PM 72-104/33  
 Certificate Fee 1/104/32

Print or Type

1. Name: Last MORRIS First MICHAEL Middle JAMES Maiden \_\_\_\_\_ 2. Social Security No. \_\_\_\_\_

3. Address: Street and Number/Rural Route S. King #1306 City Chicago State Illinois Zip Code No. 60816  
2901 S. Mt. King Jr. Drive

4. Birth date: (Month) (Day) (Year)  Male  Female Color Eyes \_\_\_\_\_ Color Hair \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ U.S. Citizen?  Yes  No If U.S. Citizen, by  Birth  Naturalization

5. Preliminary Education (4-Year High School or Equivalent)  
 Name of High School Oakwood School Location Doughkeepsie, N.Y. Period of Attendance From 1958 To 1962

6. Premedical Education—College or University  
 Name of College CORNELL UNIVERSITY Location ITHACA, N.Y. Period of Attendance From 1962 To 1966

Required Premed Courses	College	Location	Period of Attendance From	To
Chemistry	CORNELL UNIVERSITY	ITHACA, N.Y.	1962	1966
Physics				
Biology				

7. Medical School Course (Year) Medical College Location Period of Attendance From To

1st } CORNELL UNIVERSITY MEDICAL COLLEGE ITHACA, N.Y. 1966 1970

2nd } 300 York Ave New York, N.Y.

3rd } 300 York Ave New York, N.Y.

4th } 300 York Ave New York, N.Y.

5th } 300 York Ave New York, N.Y.

6th } 300 York Ave New York, N.Y.

8. Doctor of Medicine degree granted by: N.Y. 20  
 Name of Institution CORNELL UNIVERSITY MEDICAL COLLEGE Location New York, N.Y. Exact Date of Issuance June 2, 1970

Attach proof of degree and, if attended more than one school, proof of attendance at other school.

9. Post Graduate Education  
 Name of Institution \_\_\_\_\_ Location \_\_\_\_\_ Period of Attendance From \_\_\_\_\_ To \_\_\_\_\_

10. Internship  
 Name of Hospital Mary Hitchcock Memorial Hospital Location Hanover, N.H. Period of Attendance From 6/1970 To 6/1971

11. Have you been licensed to practice medicine in any state or country?  Yes  No

State or Country	Year License Issued	Current Status of License			
		Active	Inactive	Suspended	Revoked
<u>Illinois</u>	<u>1971</u>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Vermont</u>	<u>1971</u>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If previous license ever suspended or revoked: none  
 License Issued by \_\_\_\_\_ Date of Suspension or Revocation \_\_\_\_\_ Charge \_\_\_\_\_

12. Have you been denied a license to practice medicine by any state or country?  Yes  No

State or Country	Date of Denial	Reason for Denial
_____	_____	_____

HAVE YOU EVER FAILED A WRITTEN OR ORAL EXAMINATION GIVEN BY THIS BOARD?  Yes  No

07A-161 (REV. 6-71) (Over)

13. Are you now or have you ever been addicted to narcotic drugs? Yes No

14. Have you ever been charged with drug addiction? Yes No

If yes:	Charge	Date	Disposition

Have you ever made an offer in compromise in connection with the Harrison Narcotic Law? Yes No

15. Have you ever been convicted of or pled guilty or nolo contendere to any violation of any law of any state, the United States, or a foreign country? Yes No

If yes:	Violation	Date	Penalty or Disposition

16. Are you suffering from any ailment communicable to others? Yes No



State of Illinois  
County of Cook ss.

applicant, being duly sworn says he is the person whose photo is attached, that he is the person named in and lawful holder of each diploma submitted herewith and that said diplomas were procured in the regular resident course of instruction and examination without fraud or misrepresentation; that he has read and understands all the requirements relating to this application and that all statements made herein are true.

APPLICANT WILL LEGIBLY COPY in the space immediately below, the "DIPLOMATE" CERTIFICATE ON which he applies.

NATIONAL BOARD OF MEDICAL EXAMINERS  
OF THE  
UNITED STATES OF AMERICA

Michael James Morris, M.D.

having satisfied all the requirements and having successfully passed the examinations is hereby declared a Diplomate of the National Board of Medical Examiners.

Attest: J. D. MYERS  
Chairman of the Board

SEAL

JOHN P. HUBBARD  
President of the Board

Philadelphia, Pa.  
July 1, 1971

Cert. # 109065

*John and Educational  
Illinois  
Gov. Governor  
H. Michael S. Morris, M.D.  
SB-44501  
encl  
mean  
provisions of the laws  
must and be fulfilled  
eng in all of its  
part*

*Copy Attached*

*COPY ATTACHED*

I hereby apply for a physician's and surgeon's certificate in the State of California and submit the following credentials as required in Section 2194 of the Business and Professions Code and by the rules of the Board of Medical Examiners of the State of California.

*Michael J. Morris M.D.*  
Signature of applicant in full—use no initials

Subscribed and sworn to before me this 21 day of SEP 1972 19

[SEAL]

*Adriety Burke*  
Signature of notary

My commission expires 11-72

*2113 So Mission*  
Address

(NOTE—This affidavit and the endorsement required at the top of the next page must be dated within 60 days of the filing date of this application. After you have completed all data required on pages No. 1 and No. 2, affix your affidavit, THEN send this blank to the Secretary of the National Board of Medical Examiners, who will endorse at top of next page.)

**Certification of the National Board of Medical Examiners**

(Note.—This endorsement SHOULD NOT BE EXECUTED unless the applicant has affixed the affidavit at the bottom of the preceding page (2))

**NATIONAL BOARD OF MEDICAL EXAMINERS**

I, John P. Hubbard, M.D., President of the National Board of Medical Examiners and official custodian of the records of said Board, certify that the foregoing Diplomate Certificate No. 109065 was issued to Michael James Morris, M.D., on the 1st day of July, 1971, and has been delivered to him; (2) that prior thereto said applicant filed with the National Board, his Medical Diploma; (3) that said applicant has passed examinations given by the National Board as follows:

1st part	<u>New York, N.Y.</u>	from	<u>June 18</u>	to	<u>June 19</u>	<u>19 68</u>	Enter percentage
	<small>Location of examination</small>		<small>Month Day</small>		<small>Month Day</small>		
2d part	<u>New York, N.Y.</u>	from	<u>April 14</u>	to	<u>April 15</u>	<u>19 70</u>	Enter percentage
	<small>Location of examination</small>		<small>Month Day</small>		<small>Month Day</small>		
3d part	<u>Hanover, N.H.</u>	from	<del>XXXX</del> <u>March 10</u>	to		<u>19 71</u>	Enter percentage
	<small>Location of examination</small>		<small>Month Day</small>		<small>Month Day</small>		

(4) that the complete record of said applicant's credentials and examination will be forwarded for inspection to the California Board on request; (5) that the "Diplomate" Certificate on the preceding page bears the original date of issue (if a Duplicate please add an explanatory note).

In testimony whereof witness my hand and seal

John P. Hubbard, M.D.  
Signature of executive officer

[SEAL]

Official title President

dated at Philadelphia, Pennsylvania  
this 27th day of September 1972

Address 3930 Chestnut Street  
Philadelphia,  
Pennsylvania, 19104

It is hereby certified that MICHAEL JAMES MORRIS entered the Freshman class in the CORNELL UNIVERSITY MEDICAL COLLEGE the 9th day of September 1966

1. That as evidence of PRELIMINARY EDUCATION (high school) he presented Graduation from the Oakwood School, Poughkeepsie, New York, June 1962.

2. That as evidence of PRÆMEDICAL EDUCATION (college) he presented An A.B. degree from Cornell University, June 1966.

3. That prior to commencing the Freshman the study of medicine he completed a one-year course of college grade in each of the subjects of Physics, Chemistry and Biology as shown on the accompanying certification.

Every application based on a certificate issued after January 1, 1919, must show that prior to commencing the last half of the second year in the study of medicine, he has completed one year of college grade in the subjects of Physics, Chemistry and Biology. After January 1, 1924, said course must have preceded the study of medicine. After September 21, 1951, an applicant must show the completion of a two-year college course, including the subjects of Physics, Chemistry and Biology prior to commencing the study of medicine and an applicant matriculating in a medical school after January 1, 1954, must show the completion of a three-year college course, including the subjects of Physics, Chemistry and Biology.

4. Strike out number 3 if course not of record in your institution, i.e., filed as matriculation requirement.

4. That he attended 4 courses of lectures given by this institution completed during a period of 4 and was issued the degree Doctor of Medicine on the 2nd day of June 1970

Signed Charles A. Santos Buck, M.D.  
Associate Dean  
of Cornell University Medical College

{ SEAL OF SCHOOL }

this 26th day of September 1972

Graduates after August 10, 1913, must show the completion of 4 terms of 32 weeks, totaling 128 weeks, and a minimum of 4000 hours in the subjects set forth in the Medical Practice Act of California.

# CERTIFICATE OF MORAL CHARACTER

Preferably Signed by Two Licensed Physicians and Surgeons in the State Where Applicant Last Practiced and Who Have Known Applicant for at Least One Year

(No practitioner is expected to sign this recommendation who is not personally acquainted with the applicant and who is not willing to furnish information concerning his or her character, education and standing, on request of the Board.)

This certifies that I have been personally acquainted with Michael S. Morris, M.D., for 2 years and that I know him to be of good moral character and hereby recommend him to the Board of Medical Examiners of the State of California as most worthy to be licensed to practice as a "physician and surgeon" in the State of California.

Name Barbara Blustein M.D. Address 2201 S. King St.  
Graduated from Jefferson Medical College Date 6/8 1970 Licensed in IL No. 36-44675  
State

This certifies that I have been personally acquainted with Michael J. Morris, M.D., for 1 1/2 years and that I know him to be of good moral character and hereby recommend him to the Board of Medical Examiners of the State of California as most worthy to be licensed to practice as a "physician and surgeon" in the State of California.

Name Robert S. Weinschein Address 2934 Ellis Ave, Chicago, Ill. 60611  
Graduated from Univ. of Ill Med School Date 6/12/70 1970 Licensed in ILL No. 36-4524  
State

## INFORMATION

### DEAR DOCTOR:

Answering your recent inquiry, we submit the following information regulating the issuance of a certificate to practice in California under the provisions of Section 2194 of the Business and Professions Code, with the suggestion that you carefully supply all the data required on this application blank.

National Board reciprocity applications are acted on at credential committee meeting held approximately once a week. Final action requires the affirmative vote of seven members of the Board.

**NOT TO BE USED FOR RECIPROCITY BASED ON ANOTHER STATE'S LICENSE—WRITE FOR APPROPRIATE APPLICATION.**

No TEMPORARY CERTIFICATES or SPECIAL PERMITS to practice are issued. The filing of an application does not grant applicant any special privileges, nor is any method of treating the sick or afflicted permitted in California without the lawful possession of a certificate issued by this Board and then only after said certificate has been recorded in the county wherein such practice is conducted. See sections 2141 to 2143 of the Business and Professions Code. Applicants must not establish offices nor circulate professional printed matter before a California certificate has been issued.

APPLICATION FEE of \$10.00 (foreign exchange to be added) preferably in any form other than a personal check (which must be held 2 weeks to clear bank) must accompany this application and be deposited in the office of the Board, 1020 N. Street, Sacramento, California 95814, two weeks before any date shown on the accompanying dates for meetings for the current year. An additional \$100.00 to be paid if certificate is issued, together with the current initial fee as provided by law and the Board rules and regulations.

### PARTIALLY COMPLETED APPLICATIONS NOT ACCEPTABLE.

All preliminary, premedical and professional training must have been "resident" courses in a school approved by the Board.

THE BUSINESS AND PROFESSIONS CODE PROVIDES ADDITIONAL REQUIREMENTS THAT MUST BE COMPLETED BY GRADUATES OF FOREIGN MEDICAL SCHOOLS. APPLICANTS WHO ARE GRADUATES OF FOREIGN MEDICAL SCHOOLS SHOULD REQUEST INFORMATION REGARDING THE ADDITIONAL REQUIREMENTS PRIOR TO COMPLETING THIS APPLICATION.

Section 2194 of the Business and Professions Code. An applicant, whose application is based on a diplomate certificate issued by the National Board of Medical Examiners of the United States, shall pay the fee provided by this chapter and, in addition to all other requirements provided for a physician's and surgeon's certificate, he shall file testimonials of good moral character satisfactory to the board and shall satisfy the board that the standard of the National Board of Medical Examiners on the date that the diplomate certificate was issued was in no degree or particular less than that which was required for a physician's and surgeon's certificate under this chapter on the same date.

He shall also satisfy the board that the diplomate certificate was procured without fraud or misrepresentation and that at no time has any certificate or license issued by any state of the United States or issued by a foreign country been revoked or annulled for unprofessional conduct.

The board may, in its discretion, with or without an oral examination, issue a certificate to an applicant who has complied with the requirements provided for a diplomate certificate.

OCT 2 1 10 PM '72

Responding to your request dated

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?  
 \_\_\_ YES OR X NO

SUMMARY OF RENEWAL FEES OWED		FINANCIAL INTEREST STATEMENT	
		Health Facility Name	Address
2013 Renewal Fee	808.00		
Delinquent Fee			
Penalty Fee			
<b>TOTAL FEES:</b>	<b>\$808.00</b>		

MEDICAL BOARD OF CALIFORNIA LICENSE RENEWAL PHYSICIAN AND SURGEON APPLICATION

F. \_\_\_\_\_ YES I WISH TO CONTRIBUTE \$25 FOR THE FAMILY PHYSICIAN TRAINING PROGRAM.  
 H. \_\_\_\_\_ YES I WISH TO CONTRIBUTE \$50 FOR THE S.M. THOMPSON LOAN REPAYMENT 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 SECOND PAGE 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 *Michael James Morris* 0032847

LICENSE NO. **G 23554** EXPIRES **2/28/13**

TOTAL ENCLOSED

FEE OWED \$ _____	DELINQ FEE IF POSTMARKED AFTER _____ \$ _____ \$ _____ \$ _____
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E. FOR ADDRESS CHANGE ONLY IF YOUR ADDRESS SHOWN IS INCORRECT, CORRECT IT BELOW.  
 STREET \_\_\_\_\_  
 CITY \_\_\_\_\_ STATE \_\_\_\_\_  
 ZIP \_\_\_\_\_  
 PHONE NUMBER (\_\_\_\_) \_\_\_\_\_

**Dr. MICHAEL JAMES MORRIS**  
**198 B ARROWHEAD AVE STE 6**  
**SAN BERNARDINO, CA 92408**

G. FINANCIAL INTEREST STATEMENT  
 I CERTIFY UNDER PENALTY OF PERJURY THAT I HAVE DISCLOSED ON THIS RENEWAL APPLICATION FORM 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 required *Michael James Morris*



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Department of Consumer Affairs

RECEIPT

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

Name:	MORRIS, MICHAEL JAMES
Transaction Date:	03/11/2015 13:34
Application Number:	
Complaint Number:	
License Type:	8002
License Number:	23554
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.

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## Application Summary

3/11/15 1:16 PM

Page 1 of 3

License Type: **Physician and Surgeon G**  
License Number: **23554**  
File Number:  
Application: **Physician's and Surgeon's Renewal**  
Application Number:  
Application Date: **03/11/2015 (mm/dd/yyyy)**

### Personal Detail

First Name: **MICHAEL**  
Middle Name: **JAMES**  
Last Name: **MORRIS**  
Birthdate: **\*\*/\*\*/\*\*\*\***  
Gender: **Male**

### 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?

**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 - None**

**Other - None**

**Patient Care - 1-9 Hours**

**Research - None**

**Teaching - None**

**Telemedicine - None**

Patient Care Practice Location **Zip: 92408 County: SAN BERNARDINO**

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 **General Practice - Primary**

Board Certifications **None**

Postgraduate Training Years **2 Years**

Cultural Background **White**

Foreign Language Proficiency **None**

Web Site Profile **Cultural Background - No**

**Foreign Language Proficiency - No**

**Gender - No**

E-mail:

**Fees**

Biennial Renewal Fee **\$783.00**

DUE TO CURES FUND **\$12.00**





Steven M. Thompson Physician Corps Loan                   **\$25.00**  
Repayment Program

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: