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

MEDICAL BOARD OF CALIFORNIA
Licensing Program

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	MBC Use Only
Altshuler	Anna	Lea	
Other names you have used (include maiden name):	2. U.S. Social Security Number		
3. Place of Birth	4. Date of Birth		
5. Gender: ☐ Male ☑ Female			
6. Public/Mailing Address: (Please note: this information is public) (30 characters maximum per line, including spaces)			
City	State/Province	Zip/Postal Code / Country: USA	
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 PTAL, in California? ☐ Yes ☑ No		☐
9. E-mail Address (optional):	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
University of California, Irvine School of Medicine	Irvine, CA USA	06/2004-06/2009	☑ ☑
			☐ ☐
			☐ ☐

12. School of Graduation	Degree Awarded	Date of Graduation	Diploma
University of California, Irvine School of Medicine	MD	06-13-2009	☑

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	Exams
USMLE Step 1	06/17/2006		☑
USMLE Step 2 CS and CK	6/5/07 and 6/27/07		☑
USMLE Step 3	2/17/11		☑

Cashiering Use Only — CA 015 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.**

Postgraduate Training

Facility Name	Address	Specialty Area	Dates of Attendance	
University of Washington	1959 NE Pacific Street, Seattle, WA 98195	Obstetrics/Gynecology	6/2009-6/2013	☑
				☐
				☑ 14
				☐
				☐

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.**

License Data

Jurisdiction	License Number	Date of Issuance	Dates of Practice in that Jurisdiction	
Washington State	ML60093363	09-17-2009	9/17/2009-7/31/2013	☑
				☐
				☐
				☐
				☐

APPLICANT: Anna Lea Altshuler

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 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: Anna Lea Altshuler

DATE OF BIRTH:

L1C

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

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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

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Criminal Record

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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.

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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: Anna Altshuler

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, Anna Lea Altshuler, [redacted], 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. ALA **(PLEASE INITIAL BOX)**

SIGNATURE OF APPLICANT: Anna Altshuler
(Please sign full name – in presence of notary)

State of Washington

County of King

Subscribed and sworn to (or affirmed) before me on this 28 day of November, 20 12, by

~~Patricia~~ PA: Anna Lea Altshuler
(Notary to print name of applicant.)

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

Signature Patricia Maritza Cavazos (seal)

PATRICIA MARITZA CAVAZOS
NOTARY PUBLIC
STATE OF WASHINGTON
COMMISSION EXPIRES SEPT. 30, 2015

L1E

EA6

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

MEDICAL BOARD OF CALIFORNIA

Licensing Program

2012 NOV 16 PM

CERTIFICATE OF MEDICAL EDUCATION

Check one: ☑ **U.S. or Canadian Medical School Graduate** ☐ **International Medical School Graduate**

Type or Print Legibly

APPLICANT INFORMATION

NAME: Last	First	Middle
ALTSHULER	ANNA	LEA

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Medical School of Graduation
	XXX - XX - ____	As below

MEDICAL SCHOOL: PLEASE COMPLETE THIS FORM IN THE ENGLISH LANGUAGE

Name of Medical School	University of California, Irvine School of Medicine
State/Province/Country	California/USA
Did the applicant complete an English Language program?	☑ Yes ☐ No

The undersigned further certifies that the records of this institution show that the applicant attended in this institution four *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). **The standard duration of the curriculum at this institution is** four **years.**

- Anatomy
- Otolaryngology
- Obstetrics and Gynecology
- Radiology, including Radiation Safety
- Tropical Medicine
- Physiology
- Biochemistry
- Pathology, Bacteriology, and Immunology
- Ophthalmology
- Dermatology
- Embryology
- Histology
- Human Sexuality
- Medicine
- Surgery, including Orthopedic Surgery
- Urology
- Psychiatry
- Neurology
- Alcoholism and Chemical Dependency
- Preventative Medicine, including Nutrition
- Physical Medicine
- Therapeutics
- Neuroanatomy
- Child Abuse Detection and Treatment
- Geriatric Medicine
- Pediatrics
- Pharmacology
- Anesthesia
- Spousal Partner Abuse Detection & Treatment*
- 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 graduated from medical school on or after June 30, 1998
*** ONLY applicable to medical students who enrolled in medical school on or after June 1, 2000

Date the applicant enrolled in medical school:	06/24/2004
Date the applicant was issued the diploma of Bachelor/Doctor of Medicine:	06/13/2009
Date the applicant withdrew from medical school (if applicable):	__/__/____

UNUSUAL CIRCUMSTANCES DURING MEDICAL SCHOOL

Any "Yes" response below requires a signed and dated letter of explanation by school official.

1. Did this applicant ever take a leave of absence from his/her medical education?	Yes	No
2. Was this applicant ever placed on probation?	Yes	No
3. Was this applicant ever disciplined or placed under investigation?	Yes	No
4. Were any negative reports regarding this applicant ever filed by instructors?	Yes	No
5. Were any limitations or special requirements imposed on this applicant because of questions of academic or disciplinary problems, or for any other reason?	Yes	No

MEDICAL SCHOOL OFFICIAL CERTIFICATION

AFFIX MEDICAL SCHOOL SEAL

I certify that I am the President, Dean, or Registrar and hereby declare under penalty of perjury under the laws of the State of California that the above statements are true and correct.

Barbara R. Lutz
PRINTED NAME OF SCHOOL OFFICIAL

Registrar
TITLE OF SCHOOL OFFICIAL

Barbara R Lutz
SIGNATURE OF SCHOOL OFFICIAL

11/14/12
DATE

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 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.

MBC Use Only

Part of School Information

Original Attendance

Graduation

Signature & Seal

L2

NOTE: The completed form must be mailed directly from the medical school to the Board to be acceptable.

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

MEDICAL BOARD OF CALIFORNIA
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
Altshuler	Anna	Lea

U.S. Social Security Number	Date of Birth	Telephone Number
		Home (Work (

Public/Mailing Address: 1423 Boylston Ave #233

City	State/Province	Zip/Postal Code
Seattle	WA	98122

Medical School of Graduation: University of California, Irvine School of Medicine

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)
University of Washington	2205421301
Address of Facility	**Telephone #**
1959 NE Pacific St.	206-543-3891

Categorical Specialty Area of Training	Start Date of Training	End Date (or anticipated completion date) of Training
OB/GYN	06/25/2009	06/23/2013

UNUSUAL CIRCUMSTANCES:

Did the trainee ever take a leave of absence or break from his/her 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

07A-100-L3 (Rev. 03/11)

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 RESPONSIBILTY 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 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.

SEINE CHIANG

PRINT NAME OF PROGRAM DIRECTOR

SIGNATURE OF PROGRAM DIRECTOR
Signature Stamp is Not Acceptable

11/1/2012

DATE SIGNED

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

SIGNATURE OF PROGRAM DIRECTOR: _____

(Please sign full name – in presence of notary)

State of _____

County of _____

Subscribed and sworn to (or affirmed) before me on this _____ day of _____, 20_____, by

_____

(Notary to print director's name.)

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

Signature_____(seal)

L3B

07A-100-L3 (Rev, 03/11)

MEDICAL BOARD OF CALIFORNIA
Licensing Program

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	First	Middle
Altshuler	Anna	Lea

U.S. Social Security Number	Date of Birth	Medical School of Graduation
		University of California, Irvine School of Medicine

This is to certify that the above applicant is actively participating in an ACGME or RCPSC accredited postgraduate training position that started on 06/25/2009 (Month / Day / Year) **and is expected to be completed on** 06/23/2013 (Month / Day / Year) **in** Obstetrics/Gynecology (Categorical Specialty Area of Training) **at** University of Washington Medical Center (Name of Facility) **located at** 1959 NE Pacific Street, Box 356460; Health Sciences Building, BB667; Seattle, WA 98195 (Address of Facility)

The 10 digit ACGME Program # : 2205421301 (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.

Seine Chiang
PRINT NAME OF PROGRAM DIRECTOR

SIGNATURE OF PROGRAM DIRECTOR – Signature Stamp Is Not Acceptable

11/1/2012
DATE

(206) 543-9626
TELEPHONE NUMBER

Hospital Seal

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.

SIGNATURE OF PROGRAM DIRECTOR: _____
(Please sign full name – in presence of notary)

State of _____

County of _____

Subscribed and sworn to (or affirmed) before me on this _____ day of _____, 20_____, by

_____
(Notary to print director's name.)

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

Signature _____ (seal)

L4

2005 Evergreen Street, Suite 1200, Sacramento, CA 95815-3831 (916) 263-2382 (800) 633-2322 FAX: (916) 263-2944 www.mbc.ca.gov

STATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS

dca BREEZE

Department of Consumer Affairs

RECEIPT

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

Name:	ALTSHULER, ANNA LEA
Transaction Date:	11/24/2014 22:31
Application Number:	
Complaint Number:	
License Type:	8002
License Number:	124503
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.

Application Summary

License Type:	**Physician and Surgeon A**
License Number:	**124503**
File Number:	
Application:	**Physician's and Surgeon's Renewal**
Application Number:	
Application Date:	**11/24/2014 (mm/dd/yyyy)**

Personal Detail

First Name:	**ANNA**
Middle Name:	**LEA**
Last Name:	**ALTSHULER**
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?	**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** **Other - None** **Patient Care - 10-19 Hours** **Research - 20-29 Hours** **Teaching - 1-9 Hours** **Telemedicine - None**
Patient Care Practice Location	**Zip: 94305 County: SAN MATEO**
Telemedicine Practice Location	**Zip: County:**
Patient Care Secondary Practice Location	**Zip: 95128 County: SANTA CLARA**
Telemedicine Secondary Practice Location	**Zip: County:**
Current Training Status	**Fellow**
Areas of Practice	**Obstetrics and Gynecology - Primary**
Board Certifications	**None**
Postgraduate Training Years	**1 Year**
Cultural Background	**White**
Foreign Language Proficiency	**Russian** **Spanish**
Web Site Profile	**Cultural Background - No** **Foreign Language Proficiency - Yes** **Gender - Yes**

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: