STATE OF CALIFORNIA — STATE AND CONSUMER SERVICES AGENCY

PETE WILSON, Gover

State of California Department of Consumer Affairs

RECEIVED MEDICAL BOARD OF CALIFORNIA
99 OCT -1 AM 8:15
LICENSING PROGRAM

MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM
1426 Howe Avenue
Sacramento, CA 95825-3236
(916) 263-2499

RECEIVED SACRAMENTO MEDICAL BOARD OF CALIFORNIA
99 OCT 25 12:15 PM

CERTIFICATE OF MEDICAL EDUCATION

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

This certifies that Jessica M. Kingston (FULL NAME OF APPLICANT) of 435 Whitney Ave (ADDRESS WHEN ENROLLED) enrolled in UT Southwestern Med School (NAME OF MEDICAL SCHOOL) Dallas TX (LOCATION) on the 22 day of AUGUST (MONTH) 19 94 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).*

UT Austin (EDUCATIONAL INSTITUTION) 9/89-5/93 (DATES)

Advanced Credits: *Credits previously obtained at an approved medical, dental, or osteopathic school.♦*

(MEDICAL SCHOOL) (TOTAL CREDITS) (DATES)

The undersigned further certifies that the records of this institution show that he attended in this institution (SPECIFY NUMBER) years of resident instruction of 1 year (NUMBER OF WEEKS) 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:

☐ he was granted the degree Bachelor/Doctor of Medicine by **OR** ☒ he withdrew from Graduated

the above mentioned medical school on the 26 day of May (MONTH), 19 95

Anatomy
Otolaryngology
Obstetrics and Gynecology
Radiology, including Radiation Safety
Tropical Medicine
Physiology
Biochemistry
Pathology, Bacteriology and Immunology
Ophthalmology

Dermatology
Embryology
Histology
Human Sexuality as defined in Section 2090
Medicine
Surgery, including Orthopedic Surgery
Urology
Psychiatry
Neurology
Alcoholism and Chemical Dependency

Preventive medicine, including Nutrition
Physical Medicine
Therapeutics
Neuroanatomy
Child Abuse Detection and Treatment
Geriatric Medicine
Pediatrics
Pharmacology
Anesthesia
Family Medicine♦♦
Spousal or Partner Abuse Detection & Treatment♦♦♦

♦ 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.

♦♦ 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 September 1, 1994.

TRANSCRIPTS FOR ALL ADVANCED CREDITS AND MEDICAL SCHOOL CREDITS MUST BE SUPPLIED WITH THIS CERTIFICATE

Medical School Seal MUST be Imprinted Partially on the Photograph.

Signed and the school seal affixed this 22 day of October, 19 99

BY Mary Armstrong

MARY ARMSTRONG, ASSISTANT TO REGISTRAR (PRESIDENT, SECRETARY, DEAN)

L2

07A-100-L2 (Rev. 3/97)

STATE OF CALIFORNIA — STATE AND CONSUMER SERVICES AGENCY

PETE WILSON, Governor

RECEIVED
MEDICAL BOARD OF CALIFORNIA
Consumer Affairs
99 NOV -9 AM 8:57
LICENSING PROGRAM

MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM
1426 Howe Avenue
Sacramento, CA 95825-3236
(916) 263-2499

RECEIVED
MEDICAL BOARD OF CALIFORNIA
99 NOV -8 AM 10:52

CERTIFICATE OF MEDICAL EDUCATION

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

This certifies that Jessica Mary Kingston (FULL NAME OF APPLICANT) of New Haven, CT (ADDRESS WHEN ENROLLED) enrolled in Yale University School of Medicine (NAME OF MEDICAL SCHOOL) New Haven, CT (LOCATION) on the 1st day of September (MONTH) 1995 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, dental, or osteopathic school.*•

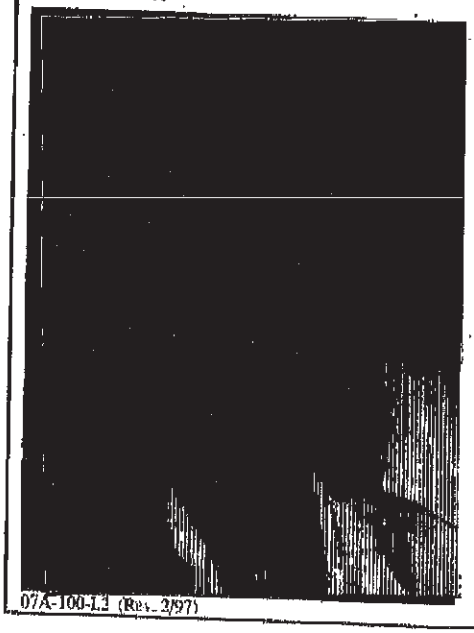
Yale University School of Medicine (MEDICAL SCHOOL) _____ (TOTAL CREDITS) 9/1/95 - 5/25/98 (DATES)

The undersigned further certifies that the records of this institution show that he attended in this institution _____ (SPECIFY NUMBER) years of resident instruction of _____ (NUMBER OF WEEKS) 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:

☒ he was granted the degree Bachelor/Doctor of Medicine by OR ☐ he withdrew from the above mentioned medical school on the 25th day of May (MONTH) 19 98

*** It is the policy of Yale School of Medicine for the faculty to carefully evaluate and report on the performance of our students. Grades, numerical standings and credits are not determined.

Anatomy
Otolaryngology
Obstetrics and Gynecology
Radiology, including Radiation Safety
Tropical Medicine
Physiology
Biochemistry
Pathology, Bacteriology and Immunology
Ophthalmology
Dermatology
Embryology
Histology
Human Sexuality as defined in Section 2090
Medicine
Surgery, including Orthopedic Surgery
Urology
Psychiatry
Neurology
Alcoholism and Chemical Dependency.
Preventive medicine, including Nutrition
Physical Medicine
Therapeutics
Neuroanatomy
Child Abuse Detection and Treatment
Geriatric Medicine
Pediatrics
Pharmacology
Anesthesia
Family Medicine••
Spousal or Partner Abuse Detection & Treatment•••



• 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.

•• 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 September 1, 1994.

TRANSCRIPTS FOR ALL ADVANCED CREDITS AND MEDICAL SCHOOL CREDITS MUST BE SUPPLIED WITH THIS CERTIFICATE

Medical School Seal MUST be Imprinted Partially on the Photograph.

Signed and the school seal affixed this 1st day of November, 19 99.

BY Ann Senick, MSW - Registrar Ann Senick
PRESIDENT, SECRETARY, DEAN

L2

07A-100-L3 (Rev. 2/97)

STATE OF CALIFORNIA — STATE AND CONSUMER SERVICES AGENCY

PETE WILSON, Governor

Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM

1426 Howe Avenue, Sacramento, CA 95825-3236
(916) 263-2499

CERTIFICATE OF COMPLETION OF ACGME/CCME POSTGRADUATE TRAINING

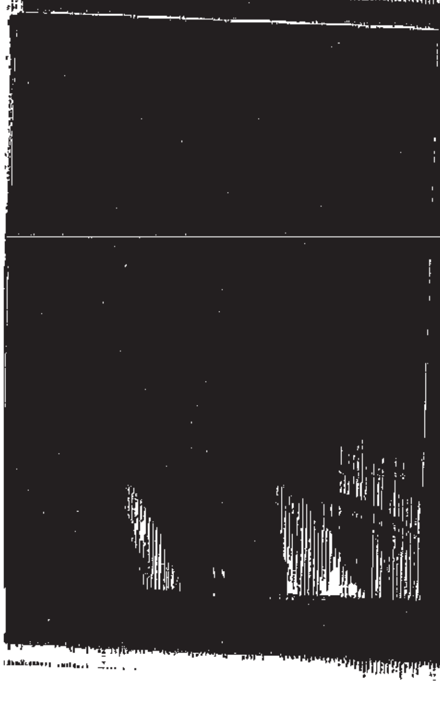
To be completed by the facility for a U.S. medical school graduate completing postgraduate training in the United States or Canada.

Last Name of Trainee: KINGSTON	First Name: JESSICA		Middle Initial: M
Current Address: 628 TORRANCE ST, APT B			Social Security Number:
City: SAN DIEGO	State: CA	Zip Code: 92103	Telephone Number:

Name of Facility: Univ California San Diego	Address of Facility: 200 W Arbor Drive San Diego CA 92103-8434	
Name of Program Director: Charles Nager, MD		Telephone Number: (619) 543-6922
Signature of Program Director: X Charles Nager MD		Date Signed: 9-8-99
List Categorical Specialty Area of Training Completed by Trainee: OB-Gyn	Date Training Commenced: 6-24-98	Date Training Completed: 6-27-99

If the training was rotating or transitional, list the specific rotations and the number of weeks spent in each (SEE THE REVERSE FOR INFORMATION ON SATISFYING THE GENERAL MEDICINE TRAINING REQUIREMENT):

Name of the Director of Medical Education: CECILIA M. SMITH, DO		Facility Name: UCSD MEDICAL CENTER	
Facility Address: 200 W. ARBOR DRIVE			
City: SAN DIEGO	State: CA	Zip Code: 92103	Telephone Number: (619) 543-3614



PART 4 Signature of Director of Medical Education confirming satisfactory completion of training.

ATTENTION PROGRAM DIRECTOR:
IF TRAINEE IS IN HIS/HER FIRST YEAR OF POSTGRADUATE TRAINING, DO NOT SIGN OR DATE THIS AFFIDAVIT UNTIL AFTER THE COMPLETION OF THE TRAINEE'S LAST DAY OF TRAINING.

I hereby declare under penalty of perjury under the laws of the State of California that the above statements are true and correct and that the training program 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/CCME program position.

Signature of Director of Medical Education: [signature] Date Signed: 9-9-99

OFFICIAL HOSPITAL SEAL OR STAMP BELOW SIGNATURE MUST BE AFFIXED TO CERTIFY TRAINING.

L3A

Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM
1426 Howe Avenue
Sacramento, CA 95825-3236
(916) 263-2499

CERTIFICATION STATEMENT

This is to certify that Jessica M. Kingston, MD
(Name of Physician)

is in an approved ACGME/CCME postgraduate training position that commenced on 24 June, 1998 and is expected to be completed on 30 June 2002 in Obstetrics-Gynecology
Month Day Year (Type of Training)

at University of California, San Diego
(Name and Address of Facility)
200 West Arbor Drive, San Diego, CA 92103

UCSD MEDICAL CENTER

AFFIX OFFICIAL HOSPITAL SEAL OR NOTARY SEAL IN THE BOX AT THE LEFT.

"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."

CECILIA M. SMITH, DO, DIRECTOR, GRADUATE MEDICAL EDUCATION
(Type or print name of Director of Medical Education)

Cecilia M Smith
(Signature of Director of Medical Education)

9/9/99
(Date)

(619) 543-3684
(Telephone Number)

NOTE: Do not use this form in lieu of Form L3A, "Certificate of Completion of ACGME/CCME Postgraduate Training."

07A-107-L4(2/97)

L4 (formerly Form L9)

STATE OF CALIFORNIA — STATE AND CONSUMER SERVICES AGENCY

PETE WILSON, *Governor*

State of California Department of Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM
1426 Howe Avenue, Sacramento, CA 95825-3236
(916) 263-2499

004779
$808.00
10/25/99

APPLICATION FOR PHYSICIAN AND SURGEON'S EXAMINATION OR LICENSURE

99 OCT 27 PM 3:15
LICENSING PROGRAM
MEDICAL BOARD OF CALIFORNIA

Please 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 as per instructions.
Please type or print neatly. When space provided is insufficient, attach additional sheets of paper.

MBC USE ONLY

1. Name: Last: KINGSTON | First: JESSICA | Middle: MARY

2. Other names you have used (include maiden name): JESSICA MARY MISLINSKI

3. Social Security Number◆

4. Address: Number and Street/Rural Route (include apartment number, if any) ~~420 TORRANCE ST, APT B~~ 200 W. Arbor Dr. #8434

5. Sex: ☒ Female ☐ Male

City: SAN DIEGO | State: CA | Zip Code: 92103 | Country: USA

6. Telephone Number: Home: (Work:

7. Date of Birth: Mo/Day/Yr

Place of Birth:

8. California Driver's License Number, if applicable: NUMBER EXPIRATION

9. Are you a U.S. citizen? ☒ Yes ☐ No
If you are an international medical school graduate, you must provide an original full and unrestricted license to practice medicine in another state or country, OR official documentation of U.S. citizenship, OR an official Declaration of Intent to become a U.S. citizen.

10. Have you ever filed an application for physician and surgeon examination or licensure in California? ☐ Yes ☒ No
IF YES, PLEASE GIVE DATE PREVIOUS APPLICATION WAS SUBMITTED AND ATTACH ANY APPLICATION MATERIALS YOU MAY HAVE RETAINED.

99 OCT 27 PM 3:15 LICENSING PROGRAM MEDICAL BOARD OF CALIFORNIA

11. List the names and addresses of all colleges or universities attended where pre-professional, postsecondary instruction was received. Please submit official transcripts with the school seal affixed for each school attended.

Name	Address	Dates of Attendance
UNIV OF TEXAS AT AUSTIN	P.O. Box 7758, UT Station, Austin, TX 78713	8/89 - 5/93

11. Check whether the following premedical courses were successfully completed and show where completed:

Course	Yes	No	Name of College or University
Chemistry	✓		UNIV OF TEXAS AT AUSTIN
Physics	✓		UNIV OF TEXAS AT AUSTIN
Biology or Zoology	✓		UNIV OF TEXAS AT AUSTIN

12. List the names and addresses of all schools where professional medical instruction was received, and, where applicable, the degree awarded. **PLEASE SUBMIT: 1)** an original Certificate of Medical Education (Form L2) and official transcripts with the signature of the dean or registrar and the school seal affixed from each school attended; **and 2)** an original medical diploma and a photocopy.

School Name	Address	Place of Instruction	Dates of Attendance	Degree Awarded
U. of TX Southwestern	5323 Harry Hines Blvd, Dallas, TX 75235		8/94 - 5/95	NONE
Yale University	School of Medicine 367 Cedar St., New Haven, CT 06510		8/30/95 - 5/30/98	M.D.

DOCTOR OF MEDICINE DEGREE, as referenced above. (Note: A U.S. graduate may, in lieu of the original, submit an official certified photocopy that has the school seal affixed and the signature of the registrar certifying authenticity.)

Name of Medical School	Address of Medical School	Exact Date of Issuance
Yale University School of Medicine	367 Cedar St., New Haven, CT 06510	5/25/98

◆ MANDATORY DISCLOSURE OF SOCIAL SECURITY NUMBERS
Disclosure of your social security number (or federal employer identification number (FEIN), if you are a partnership) is mandatory. Section 30 of the Business and Professions Code and Public Law 94-455 (42 USCA 405(c)(2)(C)) authorize collection of your social security number. Your social security number or FEIN will be used exclusively for tax enforcement purposes, for purposes of compliance with any judgment or order for family support in accordance with Section 11350.6 of the Welfare and Institutions Code, or for verification of licensure or examination status by a licensing or examination entity which utilizes a national examination and where licensure is reciprocal with the requesting state. If you fail to disclose your social security number or your FEIN, your application for initial licensure will not be processed AND you will be reported to the Franchise Tax Board, which may assess a $100 penalty against you.

CT 001
School Code

L1A

07A-100 (Rev. 9/97)

MBC USE ONLY

13. Have you taken any of the following written examinations: National Boards, other state boards, USMLE, SPEX, FLEX, or LMCC? ☒ Yes ☐ No

IF YES, LIST NAME, LOCATION, DATE AND RESULT OF EXAMINATION. SUBMIT AN ORIGINAL OFFICIAL EXAMINATION HISTORY REPORT FROM EACH EXAMINATION AGENCY. APPLICANTS WHO HOLD CERTIFICATION THROUGH THE EDUCATIONAL COMMISSION FOR FOREIGN MEDICAL GRADUATES (ECFMG) WILL NEED TO SUBMIT AN ORIGINAL VALID ECFMG CERTIFICATE PRIOR TO WRITTEN EXAMINATION AND LICENSURE.

Examination	Location	Date	Result
USMLE Step 1	Yale Univ., New Haven, CT	June 1996	
USMLE Step 2	Yale Univ., New Haven, CT	August 1997	
USMLE Step 3	Pomona, CA	May 1999	

14. Have you ever 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 EACH ISSUING AGENCY'S JURISDICTION. SUBMIT A LETTER OF GOOD STANDING FROM EACH STATE IN WHICH YOU ARE OR HAVE BEEN LICENSED. PLEASE INCLUDE TEMPORARY, TRAINING, OR PROVISIONAL LICENSES.

State or Country	License Number	Date of Issuance	Dates of Practice in that Jurisdiction

15A. Are you currently, or have you ever been, a participant in a postgraduate training program in a facility in the U.S. or Canada? ☒ Yes ☐ No

IF YES, LIST NAMES AND ADDRESSES OF ALL FACILITIES. SUBMIT AN ORIGINAL CERTIFICATE OF COMPLETION OF ACGME/CCME POSTGRADUATE TRAINING (FORM L3A) FROM EACH FACILITY. (DO NOT COMPLETE FORM L3A/BS TO DOCUMENT TRAINING RECEIVED IN RESEARCH FELLOWSHIP PROGRAMS.) **ALL TRAINING MUST BE LISTED, REGARDLESS OF WHETHER IT WAS SATISFACTORILY COMPLETED OR WILL BE USED TO MEET LICENSING REQUIREMENTS.**

Facility Name	Address	Type of Service	Dates of Attendance
UCSD Medical Center	200 W. Arbor Dr. #8434 San Diego CA	OB/GYN resident	6/98 - currently

QUESTIONS 15B through 21: For any positive response to the following questions, please provide ALL official documentation regarding the matter in addition to written explanations. If applicable, an applicant should also provide official hearing/court documents and original letters of explanation from medical school or training program directors or other appropriate authorities. APPLICANTS ARE ALSO REQUIRED TO REPORT ANY MATTER THAT IS PENDING OR IN WHICH CHARGES HAVE BEEN DROPPED OR EXPUNGED.

15B. Have you ever withdrawn from, or been suspended, dismissed or expelled from a medical school or postgraduate training program? Yes No

16. 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 or has any disciplinary action ever been filed or taken regarding any healing arts license which you now hold or have ever held, or is any such action pending? Include any disciplinary actions by the U.S. Military, U.S. Public Health Service or other U.S. federal governmental entity. IF YES, GIVE DETAILS BELOW. Yes No

State	Date	Charge	Disposition

MBC USE ONLY

License Data

17. Has a claim or action for damages ever been filed against you in the course of the practice of medicine or any other healing art which resulted in a malpractice settlement, judgement or arbitration award of over $30,000.00? Yes No

IF YES, GIVE DETAILS BELOW.

Name of Claimant	Location of Court	Brief Description of the Facts

18. Have you ever been denied a license, permission to practice medicine or any other healing art, or denied permission to take an examination in any state, country, or U.S. federal jurisdiction, or is any such action pending? Yes No

IF YES, GIVE DETAILS BELOW.

State or Country	Date of Denial	Reason for Denial

19. Have you ever voluntarily surrendered a license to practice in the healing arts in this or any other state, or voluntarily surrendered your narcotic (controlled substance) permit (state or federal) to any licensing board or any other agency, or is any such action pending? Yes No

20. Have you ever had staff privileges in a hospital denied, suspended, limited, revoked or not renewed for medical disciplinary cause, or resigned from a medical staff in lieu of disciplinary or administrative action, or is any such action pending? Yes No

21. Do you have any condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety, including but not limited to, any of the following? Yes No

IF YES, PLEASE CHECK THE APPROPRIATE BOX(ES) BELOW:

- ☐ A condition which required admission to an inpatient psychiatric treatment facility.
- ☐ Alcohol or chemical substance dependency or addiction.
- ☐ Emotional, mental or behavioral disorder.
- ☐ Other (explain): _____

FOR ANY OF THE BOXES CHECKED ABOVE, PLEASE SUBMIT COMPLETE OFFICIAL INPATIENT AND OUTPATIENT TREATMENT RECORDS, EVIDENCE OF ONGOING REHABILITATION TREATMENT, AND A PERSONAL WRITTEN EXPLANATION.

QUESTION 22: For any positive response to the following question, please provide ALL official documentation regarding the matter in addition to written explanations. If applicable, an applicant should also provide official hearing/court documents and original letters of explanation from appropriate authorities.

22. Have you ever been convicted of or pled nolo contendere to any violation (including misdemeanors and felonies) of any federal, state or local law of any state, the United States, or a foreign country or any violation relating to the possession, use, illegal sale, transportation, manufacture, distribution or dispensing of controlled substances, or is any such action pending? *(Exclude violations of traffic laws, including speeding, which resulted in fines of $300.00 or less.)* If YES, give details below. Yes No

YOU ARE REQUIRED TO LIST ANY CONVICTION THAT HAS BEEN SET ASIDE AND DISMISSED OR EXPUNGED, OR WHERE A STAY OF EXECUTION HAS BEEN ISSUED.

Violation and Location	Date	Penalty or Disposition

TOP OF PHOTO

BOTTOM OF PHOTO

PHOTO DECLARATION

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;

my color of hair ____;

my color of eyes ____;

my height ____ ft. ____ in.;

my weight ____ lbs.;

and identifying marks are ____

Signature of Applicant

Notice: All items in this application are mandatory; none are voluntary. Failure to provide any of the requested information will delay the processing of your application. This 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 or law enforcement agencies. You have the right to review your application subject to the provisions of the Information Practices Act. The Program Manager of the Licensing Program is the custodian of records.

STATE OF California

COUNTY OF San Diego

Applicant Declaration/Signature and NOTARY

The applicant, Jessica M. Kingston, being first duly sworn upon his/her oath deposes and says: that he/she is the person herein named subscribing to this application; that he/she has read the complete application, knows the full content thereof, and declares that all of the information contained herein and evidence or other credentials submitted herewith are true and correct; that he/she is 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 the applicant is aware and that the applicant is 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 my 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 further acknowledge that falsification or misrepresentation of any item or response on this application is adequate to deny the same or to hold a hearing to revoke the same, if issued.

PRINT FULL NAME OF APPLICANT

SIGNATURE OF APPLICANT: Jessica M. Kingston

(PLEASE WRITE FULL NAME, NOT INITIALS)

Signed and sworn to before me this 13th day of October 1999.

JASON L. FRISBY
Commission # 1190504
Notary Public - California
San Diego County
My Comm. Expires Jul 19, 2002

NOTARY SEAL

SIGNATURE OF NOTARY PUBLIC

3707 5th Ave, S.D. CA, 92103-4221
ADDRESS

My commission expires 07-19-02

07A-100 (Rev. 9/97)

L1D

STATE DEPARTMENT OF CONSUMER AFFAIRS
INTERNET CASHIERING SYSTEM
MEDICAL BOARD OF CALIFORNIA
SUPPLEMENTAL INFORMATION REPORT
From Date: 06/10/2013 **To Date:** 06/10/2013

ATRISUPPINF
19-MAY-16 15:59:59

Person Id : **Name :** Kingston,Jessica

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?	NO

Total Questions Asked For Person : 8

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:	KINGSTON, JESSICA MARY
Transaction Date:	05/14/2015 22:52
Application Number:	
Complaint Number:	
License Type:	8002
License Number:	70367
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:	**70367**
File Number:	
Application:	**Physician's and Surgeon's Renewal**
Application Number:	
Application Date:	**05/14/2015 (mm/dd/yyyy)**

Personal Detail

First Name:	**JESSICA**
Middle Name:	**MARY**
Last Name:	**KINGSTON**
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 - 10-19 Hours**
	Other - 1-9 Hours
	Patient Care - 40+ Hours
	Research - 1-9 Hours
	Teaching - 20-29 Hours
	Telemedicine - None
Patient Care Practice Location	**Zip: 92037 County: SAN DIEGO**
Telemedicine Practice Location	**Zip: County:**
Patient Care Secondary Practice Location	**Zip: 92103 County: SAN DIEGO**
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	**4 Years**
Cultural Background	**Decline to State**
Foreign Language Proficiency	**Decline to state**
Web Site Profile	**Cultural Background - No**
	Foreign Language Proficiency - No
	Gender - Yes
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: