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STATE OF CALIFORNIA—AGRICULTURE AND SERVICES AGENCY — EDMUND G. BROWN JR., Governor

DEPARTMENT OF Consumer Affairs

BOARD OF MEDICAL QUALITY ASSURANCE

1430 HOWE AVENUE, SACRAMENTO, CALIFORNIA 95825
TELEPHONE: Applications and Examinations (916) 322-5040

1430 HOWE AVENUE SACRAMENTO
BOARD OF MEDICAL QUALITY ASSURANCE

Nov 13 5 43 PM '78

APPLICATION FOR PHYSICIAN'S AND SURGEON'S CERTIFICATE
BASED ON NATIONAL BOARD CREDENTIALS
CLASS G

001954

PC 1880

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

1. NAME: Last MARTIN, First MALVERSE, Middle, Maiden — 2. Telephone No.

3. List other names, if any, you have used:

4. Address: Street and No./Rural Route: 2221 PALMER AVENUE APT 3A — City: NEW ROCHELLE — State: NEW YORK — Zip Code: 10801

5. Name you wish on License: MALVERSE MARTIN, M.D. — Birthdate: (Month - Day - Year)

6. Premedical Education—Name of College or University: ~~ALBERT EINSTEIN COLLEGE OF MEDICINE~~ NEW YORK CITY — Location: BRONX, NEW YORK, N.Y.

Period of attendance: From: ~~Aug. 2, 1971~~ To: ~~June 4, 1974~~ Sept, 1962 to JUNE, 1971

Check premed courses successfully completed: ☒ Chemistry ☒ Physics ☒ Biology or Zoology

7. Medical School:

Year	Name of Institution	Location	From	To
1st	ALBERT EINSTEIN COLLEGE	1300 MORRIS PARK AVE.	Aug 2, 1971	June 4, 1974
2nd	OF MEDICINE	BRONX, N.Y. 10461		
3rd				
4th				
5th				
6th				

8. Doctor of Medicine Degree granted by: ALBERT EINSTEIN COLLEGE of MEDICINE — Date: JUNE 4, 1974 — For office use only School Code: NY 46

9. 1st Year Postgraduate Training (Internship): Albert Einstein College of Medicine / Bronx Municipal Hospital Center

Location	Type of Service	From	To
BRONX, NEW YORK	OBSTETRICS/GYNECOLOGY - MEDICINE	JULY 1, 1974	JUNE 30, 1975

10. List all States in which you have been licensed to practice medicine: NEW YORK STATE — License # 125760

11. Has any disciplinary action ever been taken regarding any license which you now hold or ever held? Yes No

If Yes, indicate below:

State	Date	Charge	Disposition

12. Have you ever been denied a license to practice medicine in any State or Country? Yes No

If Yes, indicate below:

State or Country	Date of Denial	Reason for Denial

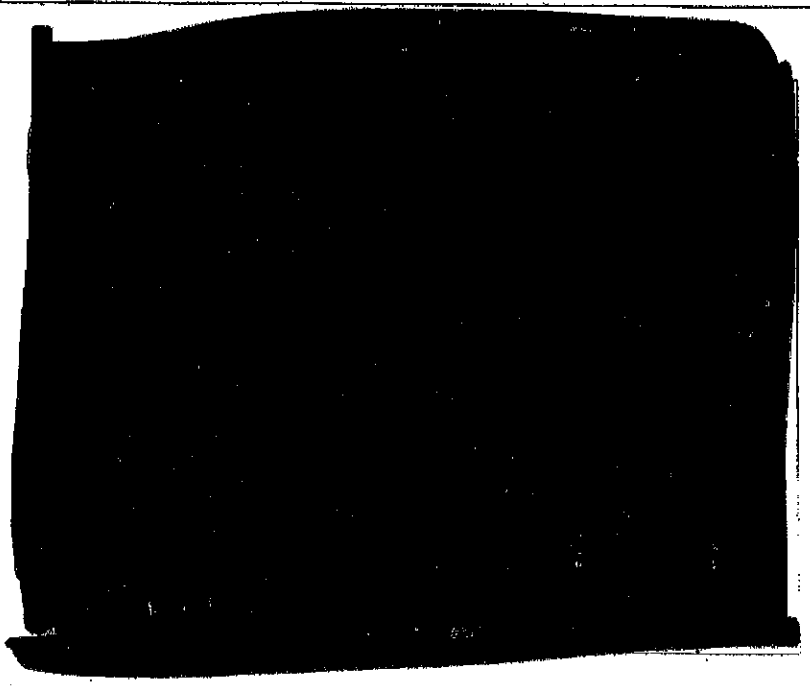
13. Are you now or have you ever been addicted to narcotic drugs? Yes No

14.	Have you ever been convicted of, pled guilty or nolo contendere to a violation of any Federal, State or Local law relating to the manufacture, distribution or dispensing of controlled substances/narcotics, or to drug addiction?	Yes	No
15.	Have you ever been convicted of, pled guilty or nolo contendere to any offense, misdemeanor or felony in any state? (Except violations of traffic laws resulting in fines of $50.00 or less.)	Yes	No

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

Violation and Location	Date	Penalty/Disposition

17.	Have you ever had staff privileges in a hospital suspended or revoked? If yes, please explain on another sheet of paper.	Yes	No



Applicant: Please complete the following:

Height: ___Ft. ___In. Weight: ___ Lbs.

Hair color: ___ Eye color ___

Identifying marks: ___

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

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

Signature of Applicant Malvene Martin

Date Nov. 8, 1978

Subscribed and sworn to before me this 8th day of November 19 78

Signature of Notary Ina L Dalrymple

SEAL

Address 3424 Kossuth Ave
Bronx N.Y 10467

My commission expires: 11/1/79

INA L. DALRYMPLE
Commissioner of Deeds
City of New York #2-392
Certificate filed in New York County
Commission Expires 11/1/1979

DEPARTMENT OF Consumer Affairs

BOARD OF MEDICAL QUALITY ASSURANCE

1430 HOWE AVENUE, SACRAMENTO, CALIFORNIA 95825
ALLIED HEALTH PROFESSIONS (916) 322-5043
APPLICATIONS AND EXAMINATIONS (916) 322-5040

PLEASE FORWARD TO YOUR MEDICAL SCHOOL

CERTIFICATE OF EDUCATION

This Certifies That Malverse Martin, M.D.
Full name of applicant

enrolled in Albert Einstein College of Medicine
Name of medical school (college)

on the 2nd day of August 19 71
Month Year

☒ as a Freshman.

☐ with advanced standing based on _____
Please specify

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

☒ PHYSICS ☒ CHEMISTRY ☒ BIOLOGY (or) ZOOLOGY (Check course(s) completed)

at City College of New York - B.S. -1971 and that he attended while at this
Please indicate school

medical school (college) All 3 yrs. courses of lectures of 33 weeks each,
Specify number Specify number of weeks

completing 3 yrs hours in the subjects below listed, and that he/~~she~~: Malverse Martin, M.D.
Total hours

☒ was granted the degree { ~~Bachelor~~ / Doctor } of Medicine — Has met the requirements for our three-year program

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

_____

_____

on the 4 day of June 19 74.
Month Year

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

____Anatomy	____Preventive medicine	____Medicine
____Embryology	____Hygiene and sanitation	____Pediatrics
____Histology	____Radiology, including roentgenologic technique and radiation safety	____Psychiatry
____Neuroanatomy	____Urology	____Neurology
____Physiology	____Ophthalmology	____Dermatology
____Psychobiology	____Anesthesia	____Physical medicine
____Biochemistry	____Otolaryngology	____Therapeutics
____Pathology, bacteriology and immunology	____Obstetrics and gynecology	____Tropical medicine
____Pharmacology		____Surgery, including orthopedic surgery

Signed and the College seal affixed this 5th day

of October 19 78
Month Year

[Affix Seal Here]

By Dr. Stephen H. Lazar - Asst. Dean
~~President, Secretary, Dean~~

STATE DEPARTMENT OF CONSUMER AFFAIRS
INTERNET CASHIERING SYSTEM
MEDICAL BOARD OF CALIFORNIA
SUPPLEMENTAL INFORMATION REPORT
From Date: 10/17/2012 **To Date:** 10/17/2012

ATRISUPPINF

03-JUN-16 08:53:23

Person Id : **Name :** Martin,Malverse

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:	MARTIN, MALVERSE
Transaction Date:	09/24/2014 16:26
Application Number:	
Complaint Number:	
License Type:	8002
License Number:	38477
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 G**
License Number:	**38477**
File Number:	
Application:	**Physician's and Surgeon's Renewal**
Application Number:	
Application Date:	**09/24/2014 (mm/dd/yyyy)**

Personal Detail

First Name:	**MALVERSE**
Last Name:	**MARTIN**
Birthdate:	****/**/******
Gender:	**Male**

Addresses

License Related Addresses

Confidential Address (Optional)

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

License Specific Public/Mailing Address (Required)

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 - 40+ Hours
	Research - None
	Teaching - None
	Telemedicine - None
Patient Care Practice Location	**Zip: 91304 County: LOS ANGELES**
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	**Obstetrics and Gynecology - Primary**
Board Certifications	**None**
Postgraduate Training Years	**4 Years**
Cultural Background	**Decline to State**
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 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: