001596

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
ALLIED HEALTH PROFESSIONS (916) 322-5043
APPLICATIONS AND EXAMINATIONS (916) 322-5040
COMPLAINTS (916) 322-5030
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VERIFICATIONS OF LICENSES (916) 322-2831

RECEIVED SACRAMENTO BOARD OF MEDICAL QUALITY ASSURANCE APR 18 3 00 PM '78

02552

APPLICATION FOR A WRITTEN EXAMINATION FOR A PHYSICIAN'S-SURGEON'S CERTIFICATE (CLASS A)

AF
00105

ANSWER ALL QUESTIONS

1. Name *(Please print)* — First: Jeffrey — Middle: mark — Last: Waldman

2. Address — No. and Street: 3039 MACOMB ST NW. — City: WASHington D.C. — State — Zip Code: 20008

3. Date of birth Mo/Day/Yr — Age today — Telephone No.

4. Send California certificate, if issued, to: — No. and Street: 3039 MACOMB ST N.W. — City: WASHington D.C. — State — Zip Code: 20008

5. Premedical education—College/University

Name of College	Location	Period of attendance From (mo/yr)	To (mo/yr)
		9/64	6/68

6. Premed courses (required) See Page 4.

	Yes	No	College	Location	From (mo/yr)	To (mo/yr)
Chemistry	✓		Drew University	MADISON, New Jersey	9/64	6/68
Physics	✓		Drew University	MADISON, N.J.		
Biology	✓		Drew University	MADISON, N.J.		

7. Academic Degree of B.A. granted by Drew University on ~~May~~ June 1968

8. Medical education

Course	Medical College	Location	From (mo/yr)	To (mo/yr)
1st	University of Brussels Medical School	Brussels, Belgium	10/68	7/75
2nd				
3rd				
4th				
5th				
6th				

9. Doctor of Medicine Degree granted by: ATTACH PROOF OF MEDICAL DEGREE

Name of institution	Location	Exact date of issuance
University of Brussels Medical School	Brussels Belgium	July 1, 1975

10. Internship: ATTACH PROOF OF INTERNSHIP FROM EACH HOSPITAL

Name of hospital	Location	From (mo/yr)	To (mo/yr)
Georgetown University Hospital	WASHington D.C.	7/75	6/78

BEHS Free Univ of Brussels Fac. of Med.

11. Have you been licensed to practice medicine in any state or country? . . . . . ✓ Yes ___ No
If YES, where?
New York, Washington D.C.

12. Have you ever had a medical license suspended or revoked? . . . . . .
If YES, give details.

13. Have you been denied a license to practice medicine by any state or country? . . . . . .
If YES, give details.

14. Are you now, or have you ever been addicted to narcotic drugs? . . . . . .

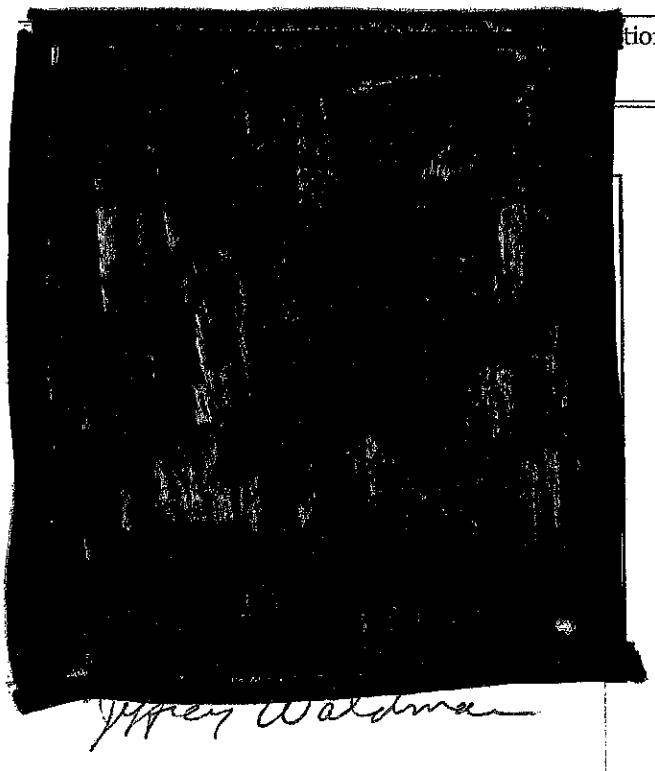
15. Have you ever been charged with drug addiction? . . . . . .
If YES, explain below.

Charge	Date	Disposition

16. Have you ever been charged with a violation of a federal, state or local law relating to the manufacture, distribution, or dispensing of controlled substances (narcotics)? . . . . . .

17. 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? . . . . . .
If YES, attach paper and explain.

tion given by this Board? . . . . . .



Jeffrey Waldman

I hereby declare that the photo of myself, attached hereto, was taken on or about ___ ___, 19___, my age then being ___ years, and my physical description then being as follows:
Native of ___; ___ complexion; color of hair ___; color of eyes ___; height ___; (light / medium / heavy) weight ___ lbs.
marks ___

I certify under penalty or perjury that all statements made are true in every respect, and understand that misstatements or omissions of material fact may be cause for denial of this application or invalidation of any such approval.

District of Columbia,
Personally appeared Jeffrey Waldman
on this the 10th day of April 1978.
Thomas J. Aletta
NOTARY PUBLIC

Jeffrey Waldman
Signature of applicant in full—use no initials

April 7, 1978
Date

A - Prof

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Verifications of Licenses (916) 322-2831

PLEASE FORWARD TO YOUR MEDICAL SCHOOL

CERTIFICATE OF MEDICAL EDUCATION

THIS CERTIFIES That Jeffrey Mark Waldman (Full name of applicant)

of 12 Place Loix (Address when enrolled) enrolled in University of Brussels Medical School (Name of medical school (college))

Brussels, Belgium (Location) on the 1e day of October (Month) 19 68

and was granted the following credits on enrollment:

Advanced credits
(Specify whether entered freshman or with advanced credits)

based upon the following credentials: (College Transcript - Drew University)
(Give a transcript of premedical education or advanced credit either above or on an attached paper)

The undersigned further certifies * that the records of this institution show that ...he attended *in this institution* ‡

25 (Specify number) courses of lectures of 52 (Specify number of weeks) weeks each, completing the following schedule totaling at least 4,000 hours in the subjects required by Article 5, Section 2192 of the Business and Professions Code, relating to the practice of medicine, as set forth hereunder, and that ...he was granted the degree { ~~BACHELOR~~ / DOCTOR } of Medicine §

by the above-mentioned Medical (College) on the 1er day of Juillet (Month) 19 75 (Year)

Anatomy 568h	Medicine 405h
Embryology 30h	Pediatrics 60h
Histology 150h	Psychiatry 60h
Neuroanatomy 40h	Neurology 75h
Physiology 478h	Dermatology 15h
Psychobiology 90h	Physical medicine 15h
Biochemistry 223h	Therapeutics
Pathology, bacteriology and immunology 90h	Tropical medicine 20h
Pharmacology 133h	Surgery, including orthopedic surgery 300h
Preventive medicine / Hygiene and sanitation 165h	Urology 15h
Radiology, including roentgenologic technique and radiation safety 45h	Ophthalmology 25h
Statistics: 30h	Anesthesia
	Otolaryngology 15h
	Obstetrics and gynecology 240h
	Stomatology: 10h

Forensic Medicine: 45h
Stages: 5th, 6th, and 7th year of medicine: 33 month of 120h = 3.960h

AFFIX SEAL HERE — UNIVERSITÉ LIBRE DE BRUXELLES * FACULTÉ DE MÉDECINE ET DE PHARMACIE

Signed and the College seal affixed this 6 day of avril 19 78

By FACULTÉ DE MÉDECINE ET DE PHARMACIE PAR DELEGATION LE RESPONSABLE DU SECRETARIAT ETUDIANT [signature] ~~President~~, Secretary, ~~Dean~~

* If premedical work has been completed state the time devoted thereto and institution where completed.
† An applicant matriculating in a medical school before January 1, 1954, need only present evidence satisfactory to the Board of having completed a TWO-year resident course of college grade including the subjects of physics, chemistry and biology.
‡ Each medical school attended must complete one of these forms covering period of attendance.
§ Strike out the degree NOT CONFERRED.

RETURN THE ENTIRE FORM TO THE RETURN ADDRESS ON THE BACK. MAKE A PHOTOCOPY FOR YOUR RECORDS.

PART 1

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

☐ YES, I WISH TO CONTRIBUTE $25 FOR THE FAMILY PHYSICIAN TRAINING PROGRAM

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: Jeffrey Waldman DATE: 2/17/12

LICENSE NO.	EXPIRES	AMOUNT DUE NOW	DELINQ FEE IF POSTMARKED AFTER 04/30/12
A 32417	03/31/12	$808.00	$886.00
	VOLUNTARY FEE =	$	$
	TOTAL ENCLOSED =	$	$

ACTIVE JEFFREY MARK WALDMAN

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.

Jeffrey Waldman
Signature required here

OVER

6301010000010000200032417801033112000808000008860O

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
NA	

12222012 10003002 10010035

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	LICENSE NO.	EXPIRATION DATE	AMOUNT DUE NOW
WALDMAN, JEFFREY M	**A32417**	**03/31/14**	**$808.00**

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

"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 *Jeffrey Waldman* Date 12/18/13

ENTER YOUR PHONE NUMBER FOR REFERENCE:

___ ___ ___

630101000001000020003241780103311400080800000886 00

CHANGE OF MAILING ADDRESS **WALDMAN, JEFFREY M** **A32417**

12202013 20000349 20010004

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)

City State Zip

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

City State Zip

(DO NOT DETACH)

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

LICENSEE NAME	LICENSE NO.	EXPIRATION DATE	AMOUNT DUE NOW	AMOUNT DUE IF POSTMARKED AFTER APRIL 30, 2016
WALDMAN, JEFFREY M	**A32417**	**03/31/16**	**$820.00**	**$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 Jeffrey Waldman Date 2/1/2016

ENTER YOUR PHONE NUMBER FOR REFERENCE:

( ) - -

630101000001000020003241780103311600082000000089800

CHANGE OF MAILING ADDRESS **WALDMAN, JEFFREY M** **A32417**

02092016 20001453 20010015

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)

8 MORAGA CT

City ORINDA State CA Zip 94563 -

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

City State Zip -