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

MEDICAL BOARD OF CALIFORNIA
Licensing Program

2012 NOV 27 AM 8:50

APPLICATION

(Please Check All That Apply)
- [X] Physician's and Surgeon's License
- [ ] Postgraduate Training Authorization Letter (PTAL)
- [ ] Update Application: ATS #_____
- [ ] Limited Practice License

(Please Check One)
- [X] U.S. or Canadian Medical School Graduate
- [ ] International Medical School Graduate

PROGRAM

Type or Print Legibly

PERSONAL INFORMATION

MBC Use Only

1. Legal Name	Last: French	First: Valerie	Middle: Anne
2. Other Names/Alias			
3. United States Social Security Number		4. Gender: ☐ Male ☒ Female	
5. Date of Birth (mm/dd/yyyy)		6. Place of Birth (City, State/Country)	
7. Public/Mailing Address. If you are using a P.O. Box please include a confidential street address on a separate sheet of paper. The address of record will be posted on the Medical Board's Web site once you have obtained a license.	Mailing Address (30 characters maximum per line, including spaces): 983255 Nebraska Medical Center		
	Mailing Address continued (30 characters maximum per line, including spaces):		
	City: Omaha	State/Province: NE	Zip/Postal Code: 68198
	Country: USA		
8. Telephone Numbers	Home #: ( )	Work #: ( )	Cell #:
9. E-mail Address			

Personal Information

10. Have you ever filed an application for a Physician's and Surgeon's License or a PTAL in California that has been withdrawn, abandoned, or denied? ☐ Yes ☒ No

11. Have you previously held a Physician's and Surgeon's License in California? ☐ Yes ☒ No
If yes, please provide license number: _____ Expired: _____

Prev. License

EXAMINATIONS

Exams

12. Have you ever been found to have engaged in irregular behavior during an examination? ☐ Yes ☒ No

13. Have you ever been subject to an investigation by an examination entity? ☐ Yes ☒ No

14. Are you certified by the Educational Commission for Foreign Medical Graduates? ☐ Yes ☒ No
If yes, please provide the Certificate Issue Date: _____

15. List all of the following examinations you have taken: **USMLE, FLEX, NBME, LMCC and/or STATE BOARDS**
(Use the *Addendum to Question #15 Form* if additional space is needed)

Examination	Date (mm/yyyy)	Result (Pass/Fail)
USMLE Step 3	12/2009	
USMLE Step 2 CS	09/2008	
USMLE Step 2 CK	06/2008	
USMLE Step 1	05/2007	

907.50 0002020 BS 11/28/12 MO 003
Cashiering Use Only School Code

L1A

07A-100 (Rev. 10/2012)

MEDICAL EDUCATION

NOTE: To be eligible for a PTAL or License, all schools attended must be on the Board's list of recognized or approved medical schools. If you did not attend or graduate from a recognized or approved medical school you may be eligible for licensure pursuant to Section 2136.7 of the Business and Professions Code (effective 1/2014). To view the Board's list, please refer to our Web site at: http://www.mbc.ca.gov/applicant/schools_recognized.html.

16. List each medical school that you have attended.

Medical School Name	Mailing Address	Attendance Dates (mm/dd/yyyy)	
University of Missouri School of Medicine	One Hospital Dr. MA204 DC018.00 Columbia MO 65212	Start	08/08/2005
		End	05/16/2009
		Start	
		End	
		Start	
		End	

17. School of Graduation	Title of Degree Awarded	Issue Date of Degree (mm/dd/yyyy)
University of Missouri School of Medicine	MD	05/16/2009

UNUSUAL CIRCUMSTANCES DURING MEDICAL SCHOOL

18. Did you ever take a leave of absence during medical school?	Yes	No
19. Were you ever placed on probation?	Yes	No
20. Were you ever disciplined or placed under investigation?	Yes	No
21. Were any negative reports ever filed by your instructors?	Yes	No
22. Were any limitations or special requirements imposed on you because of questions of academic or disciplinary problems, or for any other reason?	Yes	No

ACGME/RCPSC ACCREDITED POSTGRADUATE TRAINING

23. Have you participated in any ACGME-accredited postgraduate training in the United States or RCPSC-accredited postgraduate training in Canada? ***List every program in which you have participated or are currently participating, regardless of whether the program was completed or any credit was granted.*** (Use the *Addendum to Question #23 Form* if additional space is needed)

(If NO please skip to question # 33) ☒ Yes ☐ No

Facility Name	City, State/Province	Specialty	Training Dates (mm/dd/yyyy)	
University of Nebraska Medical Center	Omaha NE	OB/GYN	Start	07/01/09
			End	06/30/13
			Start	
			End	
			Start	
			End	
			Start	
			End	

APPLICANT (Print Name): Valerie Anne French DATE OF BIRTH (mm/dd/yyyy): [illegible]

A "yes" response to questions 18-22 requires a signed and dated written explanation.

MBC Use Only

Le Trans

School Code

Diploma

Unusual Circumstances

Postgraduate Training

L4

L1B

UNUSUAL CIRCUMSTANCES DURING POSTGRADUATE TRAINING

MEC Use Only

24. Have you ever received partial or no credit for a postgraduate training program?	
25. Have you ever taken a leave of absence or break from your training?	
26. Have you ever been terminated, dismissed or expelled from a program?	
27. Have you ever resigned from a program?	
28. Were you ever placed on probation for any reason?	
29. Were you ever disciplined or placed under investigation?	
30. Were any incident reports ever filed by instructors?	
31. Were any limitations or special requirements placed upon you for clinical performance, professionalism, medical knowledge, discipline, or for any other reason?	—
32. Have you ever had a postgraduate training program contract not be renewed or offered for a following year?	—

MEDICAL LICENSE

33. Have you ever held, or do you currently hold a medical license in any U.S. state, U.S. territory or Canadian province? ***List medical license information below. It is not necessary to list temporary, training, or provisional licenses.***
(Use the *Addendum to Question #33 Form* if additional space is needed) ☒ Yes ☐ No

State/Province	License Number	Issue Date (mm/dd/yyyy)	Expiration Date (mm/dd/yyyy)	Dates of Practice (mm/yyyy to mm/yyyy)
NE	26134	10/01/2012	10/01/2014	03/2011-present

ABMS CERTIFICATION

34. Are you currently certified by a Member Board of the American Board of Medical Specialties? ☐ Yes ☒ No

Member Board	Certificate Number	Expiration Date (mm/yyyy)

35. Has your certification ever been suspended or revoked?	
36. Is there any action currently pending against you?	

APPLICANT: (Print Name) Valerie Anne French DATE OF BIRTH: (mm/dd/yyyy)

L1C

A "yes" response to questions 24-32 and 35-36 requires a signed and dated written explanation.

DEA CERTIFICATION

37. Are you currently registered with the Drug Enforcement Agency (DEA)?		☒ Yes ☐ No
DEA Number	**State of Issue**	**Expiration Date** (mm/dd/yyyy)
FF1489093	NE	09/30/2015

38. Have your DEA privileges ever been denied, suspended, restricted, or terminated?	Yes	No
39. Have you ever entered into any arrangement, agreement or plea in lieu of federal prosecution with the DEA to resolve an alleged violation of a federal or state drug statute or regulation?	Yes	No

MALPRACTICE HISTORY

40. Has a claim or an action ever been filed against you for the practice of medicine that resulted in a malpractice settlement?	Yes	No
41. Has a judgment or arbitration ever been awarded in the amount of $30,000 or more?	Yes	No

DISCIPLINARY HISTORY

These questions refer to discipline by any hospital, Military or Public Health Service, State Board, or other Governmental Agency of any U.S. state or territory, Canadian province, or foreign country.

42. Have you ever withdrawn an application for medical licensure in lieu of denial, disciplinary action, or for any other similar reason?	Yes	No
43. Have you ever been denied a license to practice medicine?	Yes	No
44. Is any denial pending against you?	Yes	No
45. Have you ever had any license to practice medicine subjected to any disciplinary action?	Yes	No
46. Is any disciplinary action pending against any of your licenses to practice medicine?	Yes	No
47. Have you ever surrendered a license to practice medicine?	Yes	No
48. Have you ever had any license to practice medicine revoked, suspended, or placed on probation?	Yes	No
49. 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
50. Have you ever been charged with, or been found to have committed unprofessional conduct, professional incompetence, gross negligence, or repeated negligent acts by any medical licensing board or hospital?	Yes	No
51. Have you ever resigned from a medical staff in lieu of disciplinary or administrative action?	Yes	No
52. Is any disciplinary action pending against your hospital or staff privileges?	Yes	No
53. Have you ever had staff privileges in a hospital terminated, denied, suspended, limited, revoked, or not renewed?	Yes	No
54. Have you ever had any healing arts license or certificate disciplined by another state or federal territory?	Yes	No

APPLICANT: (Print Name) Valerie Ann French **DATE OF BIRTH:** (mm/dd/yyyy)

A "yes" response to questions 38-54 requires a signed and dated written explanation.

MBC Use Only
DEA
Malpractice History
Disciplinary History
L1D

CRIMINAL RECORD HISTORY

Applicants who answer "NO" to the questions below, but have a previous conviction or plea, may have their application denied for knowingly falsifying the application. If in doubt as to whether a conviction should be disclosed, it is best to disclose the conviction on the application.

For each conviction disclosed, you must submit certified copies of the arresting agency report, certified copies of the court documents, including a plea form and court docket, and a signed and dated descriptive explanation of the circumstances surrounding the conviction or disciplinary action (i.e., dates and location of the incident and all circumstances surrounding the incident). If the documents were purged by the arresting agency and/or court, a letter of explanation from these agencies is required. In addition, you may submit evidence of rehabilitation.

55. Have you ever been convicted of, or pled guilty or nolo contendere to **ANY** offense in the United States, its territories, or a foreign country? ***This includes every citation, infraction, misdemeanor and/or felony, including traffic violations. Convictions that were adjudicated in the juvenile court or convictions under California Health and Safety Code sections 11357(b), (c), (d), (e), or section 11360(b) which are two years or older should NOT be reported. Convictions that were later expunged from the record of the court or set aside pursuant to section 1203.4 of the California Penal Code or equivalent non-California law MUST be disclosed.***	
56. Exclusive of juvenile court adjudications and criminal charges dismissed under section 1000.3 of the California Penal Code or equivalent non-California laws, or convictions under California Health and Safety Code section 11357(b), (c), (d), (e), or section 11360(b) which are two years or older, have you had a charge or conviction that was set aside or later expunged from the record of the court?	
57. Is any criminal action pending against you, or are you currently awaiting judgment and sentencing following entry of a plea or jury verdict?	
58. Are you a registered sex offender?	

PRACTICE IMPAIRMENT OR LIMITATIONS

If you give an affirmative answer to any of the questions below, 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 eligible for licensure. Please note that a Limited Practice License may be available. Please refer to the *Application Information for a Limited Practice License* for further information.

59. Have you ever been enrolled in, required to enter into, or participated in any drug, alcohol, or substance abuse recovery program or impaired practitioner program?	Yes	No
60. Have you ever been treated for or had a recurrence of a diagnosed addictive disorder?	Yes	No
61. Have you ever been diagnosed with an emotional, mental, or behavioral disorder that may impair your ability to practice medicine safely?	Yes	No
62. Have you ever been diagnosed with a neurological or other physical condition that may impair your ability to practice medicine safely?	Yes	No
63. Do you have any other condition that may in any way impair or limit your ability to practice medicine safely?	Yes	No
64. Do you suffer from a progressive disorder or a health condition that will likely result in a general decline in health or function that may impair or limit your ability to practice medicine safely?	Yes	No

APPLICANT: (Print Name) Valerie Ann French **DATE OF BIRTH:** (mm/dd/yyyy)

A "yes" response to questions 55-64 requires a signed and dated written explanation.

MBC Use Only

Criminal History

Limitations

L1E

PHOTOGRAPH

Notice: All items in this application 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 licensing 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.

MBC Use Only

Photograph

DECLARATION

The applicant, Valerie Anne French, (Please print full name (First, Middle, Last)) - (Date of Birth (mm/dd/yyyy))

being first duly sworn upon his/her 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), or 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, alcohol and/or substance 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, in any investigation or proceeding, to the organizations, individuals or groups listed above any information which is material to this application or any subsequent licensure.

Applicant Name & DOB

I UNDERSTAND THAT ANY OMISSION, 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.

SIGNATURE: [signature] **DATE:** 11/14/12

Applicant Signature & Date

NOTARY SECTION

SIGNATURE OF APPLICANT: [signature]
(DO NOT SIGN EXCEPT IN THE PRESENCE OF NOTARY – Please sign full name)

Applicant Signature

State of Nebraska

County of Douglas

Subscribed and sworn to (or affirmed) before me on this 14 day of November 20 12

Applicant Name & Notary Date

by, Valerie Anne French proved to me on the basis of satisfactory evidence
(Print applicant's name)

to be the person who appeared before me.

Alison A. Harmon
SIGNATURE OF NOTARY PUBLIC

NOTARY SEAL

GENERAL NOTARY - State of Nebraska
ALISON A HARMON
My Comm. Exp. Oct. 8, 2016

Notary Signature Seal

L1F

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

MEDICAL BOARD OF CALIFORNIA

Licensing Program

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
French	Valerie	Anne

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

MEDICAL SCHOOL: PLEASE COMPLETE THIS FORM IN THE ENGLISH LANGUAGE

Name of Medical School	University of Missouri - School of Medicine
State/Province/Country	Missouri - 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 4 *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 4 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, 1999
*** ONLY applicable to medical students who enrolled in medical school on or after June 1, 2000

Date the applicant enrolled in medical school:	08/01/2005
Date the applicant was issued the diploma of Bachelor/Doctor of Medicine:	05/15/2009
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?	
2. Was this applicant ever placed on probation?	
3. Was this applicant ever disciplined or placed under investigation?	
4. Were any negative reports regarding this applicant ever filed by instructors?	
5. Were any limitations or special requirements imposed on this applicant because of questions of academic or disciplinary problems, or for any other reason?	

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.

Rachel M.A. Brown, M.D.
PRINTED NAME OF SCHOOL OFFICIAL

ASSOCIATE DEAN, STUDENT PROGRAMS
TITLE OF SCHOOL OFFICIAL

SIGNATURE OF SCHOOL OFFICIAL

11-12-12
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
Medical School Information
Dates of Attendance
Unusual Circumstances
Signature & Seal

L2

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

07A-100 (Rev. 10/2012)

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.

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

Type or Print Legibly

APPLICANT INFORMATION

NAME: Last	First	Middle
French	Valerie	Anne

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Medical School of Graduation
- -	XXX - XX - ___ ___ ___	University of Missouri - Columbia

MBC Use Only: Personal Data ☑

PROGRAM DIRECTOR TO COMPLETE ACGME OR RCPSC TRAINING INFORMATION

ATTENTION PROGRAM DIRECTOR: Do not sign and date this form prior to 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 applicant referenced above has satisfactorily completed a period of accredited postgraduate training at this facility and that the applicant has acquired the skill and qualifications necessary to safely assume the unrestricted practice of medicine in this state. *The completed form must be mailed directly from the program to the Board.*

MBC Use Only: Training Information

Facility Name	University of Nebraska Medical Center		☑
Facility Address	983255 Nebraska Medical Center Omaha NE 68198-3255		☑
Specialty	OB/Gyn	ACGME 10-digit Program # (http://www.acgme.org/adspublic) 2203021161	☑ ☑
Dates of Training (mm/dd/yyyy)	Start Date: 07/01/2009	End Date (or anticipated completion date): 06/30/2013	☑ ☑

UNUSUAL CIRCUMSTANCES

			MBC Use Only
1. Did the applicant receive partial or no credit for any postgraduate training year?	Yes	No	☐
2. Did the applicant ever take a leave of absence or break from his/her training?	Yes	No	☐
3. Was the applicant ever terminated, dismissed or expelled?	Yes	No	☐
4. Did the applicant ever resign?	Yes	No	☐
5. Was the applicant ever placed on probation?	Yes	No	☐
6. Was the applicant ever disciplined or placed under investigation?	Yes	No	☐
7. Were any incident reports regarding this applicant ever filed by instructors?	Yes	No	☐
8. Were any limitations or special requirements placed upon the applicant for clinical performance, professionalism, medical knowledge, discipline, or for any other reason?	Yes	No	☐
9. Did the program decline to renew or offer the applicant postgraduate training program contract for a following year?	Yes	No	☐

Program Director: **Please provide a signed and dated letter of explanation for any "yes" response to questions # 1-9. The explanation must be provided on program letterhead and mailed directly to the Board with the Form L3A-L3B.**

L3A

07A-100 (Rev. 10/2012)

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, 1980, 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 had direct patient care responsibilities for at least four months in any particular specialty or sub-specialty area.

10. Did the applicant named on the L3A form complete a minimum of four months of general medicine as part of this postgraduate training program accredited by the ACGME or the RCPSC? ☒ Yes ☐ No

PROGRAM DIRECTOR OFFICIAL CERTIFICATION

NOTE: The completed Form L3A-L3B must be mailed directly from the program to the Board to be acceptable.

The program director signing this form is formally certifying and documenting under penalty of perjury that the applicant 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. The program director is attesting to the fact that the applicant has acquired the skill and qualifications necessary to safely assume the unrestricted practice of medicine in this state.

I hereby declare under penalty of perjury under the laws of the State of California that all of the information contained on these forms is true and correct. I further certify that the training program is accredited by the ACGME or the RCPSC to offer the type and level of training completed by the applicant named on the Form L3A, and the applicant was trained in an ACGME or RCPSC slotted program position.

Jennifer L. Griffin, M.D., M.P.H.
PRINTED NAME OF PROGRAM DIRECTOR

jgriffin@unmc.edu
Email Address

Jennifer Griffin Miller M.D. 1/9/13
SIGNATURE OF PROGRAM DIRECTOR (Signature Stamp Is Not Acceptable) **DATE**

402-559-6160
Phone Number

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.

NOTE: If a hospital seal is not available, the program director shall also sign in the section below 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, _____ proved to me on the basis of satisfactory evidence
(Print program director's name)

to be the person who appeared before me.

_____
SIGNATURE OF NOTARY PUBLIC

HOSPITAL or NOTARY SEAL

MBC Use Only

General Medicine ☑

Program Director's Signature & Date ☑

Program Director's Signature ☐

Notary Signature & Seal ☐

Hospital Seal ☑

L3B

NOTE: The completed form must be mailed directly from the program 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

2012 NOV 19 AM 9:51

CURRENT POSTGRADUATE TRAINING ENROLLMENT

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

Type or Print Legibly

APPLICANT INFORMATION

NAME: Last	First	Middle
French	Valerie	Anne

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Medical School of Graduation
[redacted]	XXX - XX -	University of Missouri-Columbia

PROGRAM DIRECTOR TO COMPLETE ACGME OR RCPSC TRAINING INFORMATION

Facility Name	University of Nebraska Medical Center		
Facility Address	983255 Nebraska Medical Center, 68198325		
Specialty Area	Ob/Gyn	ACGME 10-digit Program # http://www.abpmb.org/adapublic	2203021161
Dates of Training (mm/dd/yyyy)	Start Date: 07/01/2009	Anticipated Completion Date:	06/30/2013

PROGRAM DIRECTOR OFFICIAL CERTIFICATION

NOTE: The completed Form L4 must be mailed directly from the program to the Board to be acceptable.

I hereby declare under penalty of perjury under the laws of the State of California that the information contained on this form is true and correct. I further certify that the training program is accredited by the ACGME or the RCPSC to offer the type and level of training to the above named applicant and that the applicant is actively participating in a slotted position in an accredited ACGME or RCPSC postgraduate training program.

Jennifer L. Griffin Miller MD MPH — jgriffin@unmc.edu

PRINT NAME OF PROGRAM DIRECTOR — Email Address

Jennifer L. Griffin Miller MD — 11/11/12 — (402) 559-6160

SIGNATURE OF PROGRAM DIRECTOR (Signature Stamp Is Not Acceptable) — DATE — Phone Number

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.

NOTE: If a hospital seal is not available, the program director shall also sign in the section below 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, _____ (Print program director's name) proved to me on the basis of satisfactory evidence

to be the person who appeared before me.

HOSPITAL or NOTARY SEAL

_____
SIGNATURE OF NOTARY PUBLIC

MBC Use Only
Personal Data ☐
Program Verified ☐
Program Director's Signature & Date ☐
Program Director's Signature ☐
Notary Signature & Seal ☐
Hospital Seal ☐

L4

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

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 JUNE 30, 2016
FRENCH, VALERIE A	**A124836**	**05/31/16**	**$820.00**	**$898.00**

LICENSEE MUST CHECK CORRECT BOXES

- "H" [X] Completed Continuing Education
- "E" [ ] Change of Address (fill in reverse side)
- "I" [ ] Conviction Disclosure – Yes
- "J" [X] Conviction Disclosure – No
- "F" [ ] Family Physician Training Program ($25)
- "G" [X] 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 _____ Date 3/4/16

ENTER YOUR PHONE NUMBER FOR REFERENCE:

630101000001000020012483680105311600082000000089800

CHANGE OF MAILING ADDRESS **FRENCH, VALERIE A** **A124836**

03142016 20001161 20010012

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 –

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

dca BREEZE

Department of Consumer Affairs

RECEIPT

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

Name:	FRENCH, VALERIE ANNE
Transaction Date:	04/07/2014 20:55
Application Number:	
Complaint Number:	
License Type:	8002
License Number:	124836
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:	**124836**
File Number:	
Application:	**Physician's and Surgeon's Renewal**
Application Number:	
Application Date:	**04/07/2014 (mm/dd/yyyy)**

Personal Detail

First Name:	**VALERIE**
Middle Name:	**ANNE**
Last Name:	**FRENCH**
Birthdate:	
Gender:	**Female**

Addresses

License Related Addresses

License Specific Public/Mailing Address (Required)

Name:	**FRENCH, VALERIE ANNE**
Address:	**1001 Potrero Ave # Ward6D** **SAN FRANCISCO, CA** **94110-3518** **US**
Phone Number:	
E-mail Address:	

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?	**No**

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 - 20-29 Hours
	Research - 1-9 Hours
	Teaching - 1-9 Hours
	Telemedicine - None
Patient Care Practice Location	**Zip: 94110 County: SAN FRANCISCO**
Telemedicine Practice Location	**Zip: County:**
Patient Care Secondary Practice Location	**Zip: County:**
Telemedicine Secondary Practice Location	**Zip: County:**
Current Training Status	**Fellow**
Areas of Practice	**Obstetrics and Gynecology - Primary**
Board Certifications	**None**
Postgraduate Training Years	**4 Years**
Cultural Background	**European**
Web Site Profile	**Cultural Background - No**
	Foreign Language Proficiency - No
	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: