STATE OF CALIFORNIA — STATE AND CONSUMER SERVICES AGENCY

GRAY DAVIS, *Governor*

Consumer Affairs

MEDICAL BOARD OF CALIFORNIA

1426 Howe Avenue, Suite 54, Sacramento, CA 95825-3236
TEL: (916) 263-2499 FAX: (916) 263-2387 Internet: www.medbd.ca.gov

APPLICATION UPDATE FOR PHYSICIAN'S AND SURGEON'S LICENSE

Please READ all instructions prior to completing this application. ALL questions on this application must be answered, and all supporting documents must be submitted as per instructions. Please type or print neatly. When space provided is insufficient, attach additional sheets of paper. All attachments are considered part of the application. 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.

1. NAME: Last: GOPAL | First: TIRUN | Middle: A

MBC USE ONLY — Personal Data

2. Other names you have used (include maiden name): ANANTHARAMAN GOPALAKRISHNAN TIRUNILAYI

3. U.S. Social Security Number*:

4A. (PUBLIC ADDRESS; will be released by the Board to the public): Number and Street/P.O. Box/Rural Route/Apartment Number, if any. 1742 CENTRAL PARK

City: OREFIELD | State: PA | Zip Code: 18069 | Country: USA

4B. (CONFIDENTIAL ADDRESS): Number and Street/Rural Route/Apartment Number, if any. [Applicants must provide a confidential street address if a P. O. Box is used as the Public Address in #4A above.]

City | State | Zip Code | Country

5. Telephone Numbers:
Home: (
Work: (

6. California Driver's License Number (optional): PA
NUMBER – EXPIRATION

7. Date of Birth (Month/Day/Year) and Place of Birth:

8. Sex: ☒ Male ☐ Female

9. Have you ever been licensed to practice medicine in any state, territory, province, country, or U.S. federal jurisdiction? ☒ Yes ☐ No

License Data

IF YES, LIST THE JURISDICTION, LICENSE NUMBER, DATE ISSUED AND DATES OF PRACTICE IN THAT JURISDICTION. PLEASE INCLUDE PERMANENT, TEMPORARY, TRAINING, PROVISIONAL, LIMITED LICENSE, OR PERMIT. AN ORIGINAL OFFICIAL LETTER OF GOOD STANDING (LGS), OR COMPARABLE LICENSE HISTORY CERTIFICATION, IS REQUIRED FOR EACH PERMANENT, TEMPORARY, TRAINING, PROVISIONAL, LIMITED LICENSE, OR PERMIT OBTAINED IN ANY U.S. STATE, U.S. OR CANADIAN TERRITORY, CANADIAN PROVINCE, OR U.S. FEDERAL JURISDICTION. EACH LGS, OR COMPARABLE CERTIFICATION, SHOULD BE MAILED, BY THE ISSUING AUTHORITY DIRECTLY TO THE MEDICAL BOARD OF CALIFORNIA.

Jurisdiction	License Number	Date of Issuance	Dates of Practice in that Jurisdiction	LGS
PENNSYLVANIA	MD036354-L	1978	1978 TO PRESENT	☑
				☐
				☐
				☐

10. Do you hold any other professional license in any state, territory, province, country, or U.S. federal jurisdiction? ☐ Yes ☒ No

Other Professional Licenses

IF YES: PROFESSION: _____, LICENSE NO.: _____, JURISDICTION: _____

HAS THIS LICENSE EVER BEEN REVOKED, OR SUBJECT TO DISCIPLINE? IF YES, PLEASE PROVIDE ALL OFFICIAL DOCUMENTATION REGARDING THE MATTER IN ADDITION TO A WRITTEN EXPLANATION. YOU ARE ALSO REQUIRED TO REPORT ANY MATTER THAT IS PENDING OR IN WHICH CHARGES HAVE BEEN DROPPED OR EXPUNGED.

Yes No ☐

11A. Are you currently, or have you ever been, a participant in a postgraduate training program in a facility in the U.S. or Canada? (You must include every residency, internship, and fellowship, whether or not completed.) ☐ Yes ☐ No

Postgraduate Training

IF YES, LIST NAMES AND ADDRESSES OF ALL FACILITIES. SUBMIT AN ORIGINAL CERTIFICATE OF COMPLETION OF ACGME/RCPSC POSTGRADUATE TRAINING (FORM L3A) FROM EACH FACILITY. (DO NOT COMPLETE FORM L3As 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	Categorial Specialty Area	Dates of Attendance	
ELLIS HOSPITAL	SCHENECTADY N.Y.	ROTATING INTERN	JULY 1974 JUNE 1975	☑
THE ALLENTOWN HOSP	17TH & CHEW STS ALLENTOWN, PA	OB-GYN RESIDENCY	JULY-1975 JUNE 1978	☑

QUESTIONS 11B through 12:
If you answer YES to any of the following questions, please provide ALL official documentation regarding the matter in addition to your written personal explanations. An applicant must provide official hearing/court documents and original letters of explanation from medical schools or training program directors. If these documents are not provided with the application, they will be requested before review of the application can proceed. APPLICANTS ARE REQUIRED TO REPORT ANY MATTER THAT IS PENDING OR IN WHICH CHARGES HAVE BEEN DROPPED OR EXPUNGED.

11B. Have you ever withdrawn from, or been suspended, dismissed or expelled from a medical school or postgraduate training program OR have you ever taken a leave of absence from such a school or program?

IF YOU ANSWERED YES, BOTH APPLICANT AND SCHOOL/PROGRAM MUST PROVIDE DETAILS ON A SEPARATE ATTACHMENT.

Yes No ☐

12. 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?

IF YOU ANSWERED YES, PROVIDE DETAILS ON A SEPARATE ATTACHMENT.

Yes No ☐

* MANDATORY DISCLOSURE OF U.S. SOCIAL SECURITY NUMBERS
Disclosure of your U.S. social security number 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 will be used exclusively for tax enforcement purposes, for purposes of compliance with any judgment or order for family support in accordance with Section 17520 of the Family 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 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.

MBC USE ONLY: IWA 01 — School Code

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r all of the below, also include any disciplinary actions by the U.S. Military, U.S. Public Health Service, or other U.S. federal vernmental entity.

MBC USE ONLY
License Date

A. Have you ever been charged with, or been found to have committed, unprofessional conduct, professional incompetence, gross diligence, or repeated negligent acts or malpractice by any medical licensing board, other agency, or hospital?

B. Has any disciplinary action ever been filed or taken, including but not limited to, informal or confidential discipline, consent orders, letters of warning, regarding any healing arts license which you now hold or have ever held?

C. Is any such action as described above pending?

13 (A)	Yes	No	☐
13 (B)	Yes	No	☐
13 (C)	Yes	No	☐

YOU ANSWERED YES TO 13A, 13B OR 13C, PROVIDE DETAILS ON A SEPARATE ATTACHMENT.

. Have you ever been denied a license, permission to practice medicine or any other healing art, or denied permission take an examination in any state, territory, country, or U.S. federal jurisdiction, or is any such action pending?

YOU ANSWERED YES, PROVIDE DETAILS ON A SEPARATE ATTACHMENT.

Yes No ☐

. Have you ever voluntarily surrendered a license to practice medicine or any other healing arts in this or any other state, or voluntarily rrendered your narcotic (controlled substance) permit (state or federal) to any licensing board or any other agency, or is any such tion pending?

YOU ANSWERED YES, PROVIDE DETAILS ON A SEPARATE ATTACHMENT.

Yes No ☐

. Have you ever had staff privileges in a hospital denied, suspended, limited, revoked, or not renewed for medical disciplinary cause, or signed from a medical staff in lieu of disciplinary or administrative action, or is any such action pending?

OU MUST DISCLOSE ANY INFORMAL OR CONFIDENTIAL DISCIPLINARY ACTION.

Yes No ☐

Do you have any condition which in any way impairs or limits your ability to practice medicine with reasonable ll 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): _____

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

I ALL OF THE BELOW, YOU ARE REQUIRED TO LIST ANY CONVICTION THAT HAS BEEN SET ASIDE AND DISMISSED OR EXPUNGED, OR WHERE A STAY OF CUTION HAS BEEN ISSUED.

. Have you ever been convicted of, or pled nolo contendere to, ANY violation (include every misdemeanor or felony) of any local, te, or federal law of any state, territory, country, or U.S. federal jurisdiction?

. Is any criminal action related to the above pending?

18 (A)	Yes	No	☐
18 (B)	Yes	No	☐

YOU ANSWERED YES TO 18A OR 18B, PROVIDE DETAILS ON A SEPARATE ATTACHMENT.

Applicant Declaration/Signature and NOTARY

ATE OF PA

OUNTY OF Lehigh

applicant, _____ _____ being first duly sworn upon his/her oath deposes and
(PLEASE PRINT FULL NAME) (DATE OF BIRTH)

s: 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 er 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 ul 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 mination, and that it, together with all the credentials submitted, were procured without fraud or misrepresentation or any mistake of which I am aware and I am the lawful holder thereof. Further, I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past, ent, and future), business and professional associates (past, present, and future), and all government agencies (local, state, federal, or foreign) to release e Medical Board of California or its successors any information, files or records, including medical records, educational records, and records of psychiatric tment and treatment for drug and/or alcohol abuse or dependency, requested by that Board in connection with this application; or any further or future stigation by that Board necessary to determine my medical competence, professional conduct, or physical or mental ability to safely engage in the practice edicine. I further authorize the Medical Board of California or its successors to release to the organizations, individuals, or groups listed above any rmation which is material to this application or any subsequent licensure. I UNDERSTAND THAT FALSIFICATION OR MISREPRESENTATION OF ANY W OR RESPONSE ON THIS APPLICATION OR ANY ATTACHMENT HERETO IS A SUFFICIENT BASIS FOR DENYING OR REVOKING A LICENSE.

GNATURE OF APPLICANT: _____
(PLEASE SIGN FULL NAME, NOT INITIALS)

ned and sworn to before me this 22nd day of July 2003
MONTH YEAR

Notarial Seal
Yvonne K. Howard, Notary Public
South Whitehall Twp., Lehigh County
My Commission Expires Aug. 18, 2005
Member, Pennsylvania Association of Notaries

NOTARY SEAL

SIGNATURE OF NOTARY PUBLIC

ADDRESS

My commission expires

Notarial Seal
Yvonne K. Howard, Notary Public
South Whitehall Twp., Lehigh County
My Commission Expires Aug. 18, 2005
Member, Pennsylvania Association of Notaries

(Rev. 03/01)

L8B

STATE OF CALIFORNIA — STATE AND CONSUMER SERVICES AGENCY

GRAY DAVIS, Governor

RECEIVED CASHIERS
Consumer Affairs
01 APR 16 AM 11:02

MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM

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

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APPLICATION FOR PHYSICIAN AND SURGEON'S LICENSURE

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: GOPAL | First: FIRUN | Middle: A

2. Other names you have used (include maiden name): (C.T.A. GOPAL) GOPALAKRISHNAN TIRUNILAYI ANANTHARAMAN

3. Social Security Number◆

4. Address: Number and Street/Rural Route (include apartment number, if any): 1742 CENTRAL PARK

5. Sex: ☐ Female ☒ Male

City: OREFIELD | State: PA | Zip Code: 18069 PA | Country: USA.

6. Telephone Number: Home: ( ) Work: ( )

7. Date of Birth: Mo/Day/Yr

Place of Birth:

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.

11A. 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
UNIVERSITY OF BOMBAY	BOMBAY, INDIA.	JULY 1965 – MARCH 66
UNIVERSITY OF BOMBAY	BOMBAY, INDIA	APRIL '66 – APRIL '67

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

Course	Yes	No	Name of College or University
Chemistry	✓		BOMBAY. UNIVERSITY
Physics	✓		BOMBAY UNIVERSITY
Biology or Zoology	✓		BOMBAY UNIVERSITY

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
GRANT MEDICAL COLLEGE	BYCULLA, BOMBAY-8 INDIA	SAME	JULY 1967 – OCTOBER 1971	M.B.B.S

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: UNIVERSITY OF BOMBAY | Address of Medical School: GRANT MEDICAL COLLEGE, BYCULLA, BOMBAY 8. INDIA | Exact Date of Issuance: OCT 13, 1973.

◆ 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.

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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 LICENSURE.

Examination	Location	Date	Result
FLEX	HARRISBURG PA	6/75 – 12/75	
ECFMG	CERT # 157 4219	7/1972	

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
PA	036354-L	2/19/1976	1976 – PRESENT

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
ELLIS HOSPITAL	SCHENECTADY, NY.	ROTATING INTERNSHIP	JULY 1974 – JUNE 75
THE ALLENTOWN (HOSP)	17th & CHEW STS. ALLENTOWN, PA /	RESIDENCY IN OB-GYN	JULY 1975 – JUNE 1978
(NOW - LEHIGH VALLEY HOSPITAL)			

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

ONLY

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.

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. Yes No

Violation and Location	Date	Penalty or Disposition

L1C

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

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. 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 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 Pennsylvania

COUNTY OF Lehigh

Applicant Declaration/Signature and NOTARY

The applicant, TIRUM . A. GOPAL, being first duly sworn upon his/her

PRINT FULL NAME OF APPLICANT

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.

SIGNATURE OF APPLICANT: _____

(PLEASE WRITE FULL NAME, NOT INITIALS)

Signed and sworn to before me this 9th day of March, ~~19~~ 2001.

NOTARY SEAL

Beth A. Martin

SIGNATURE OF NOTARY PUBLIC

Lehigh Valley Hospital

ADDRESS

My commission expires December 31, 2001

07A-100 (Rev. 3/99)

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STATE OF CALIFORNIA — STATE AND CONSUMER SERVICES AGENCY

GRAY DAVIS, Governor

State of California Department of Consumer Affairs

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

CERTIFICATE OF MEDICAL EDUCATION

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

This certifies that TIRUNILAYI ANANTHARAMAN GOPALAKRISHNAN of 1/63 MAGAN VIHAR enrolled in
FULL NAME OF APPLICANT ADDRESS WHEN ENROLLED

GRANT MEDICAL COLLEGE BYCULLA BOMBAY-8.
NAME OF MEDICAL SCHOOL LOCATION

on the _____ day of APRIL 19 67 and was granted the following credits on enrollment:
MONTH

Premedical Education: *Two years of preprofessional postsecondary education, including the subjects of physics, chemistry, and biology (Business and Professions Code Section 2088).*

RAMNARAIN RUIA COLLEGE, UNIVERSITY OF BOMBAY 1965-66 1966-67
EDUCATIONAL INSTITUTION DATES

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

GRANT MEDICAL COLLEGE _____ 1967-1972
MEDICAL SCHOOL TOTAL CREDITS DATES

The undersigned further certifies that the records of this institution show that he attended in this institution 4 1/2 YEARS
SPECIFY NUMBER

years of resident instruction of 42 weeks each, completing at least 4,000 hours, of which at least 80 percent actual
NUMBER OF WEEKS

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 13th day of OCTOBER, 19 73.
MONTH

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 2060
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***

[redacted]

* 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 25th day of January, 2001

KBY Dr. V. R Bhatade Dean
T.J. Hospital, Grant Medical College
PRESIDENT, SECRETARY, DEAN

Grant Medical College Bombay

L2

07A-1002 (REV. [illegible])

STATE OF CALIFORNIA — STATE AND CONSUMER SERVICES AGENCY

GRAY DAVIS, Governor

Consumer Affairs

MEDICAL BOARD OF CALIFORNIA

1426 Howe Avenue, Suite 54, Sacramento, CA 95825-3236
(916) 263-2499/FAX (916) 263-2487 Internet: www.medbd.ca.gov

RECEIVED
BOARD OF
CALIFORNIA

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.

ATTENTION PROGRAM DIRECTORS AND DIRECTORS OF MEDICAL EDUCATION: THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE, OR ADOPTION. Only the Program Director and the Director of Medical Education may sign this form. If that signature authority is being delegated to another person, a written official 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 month[illegible]

PART 1: To be completed by the APPLICANT.

LAST NAME of Applicant	First Name	Middle Initial
GOPALAKRISHNAN.	TIRUNILAYI	ANANTHARAMAN.

U.S. Social Security Number:	Date of Birth: MM/DD/YYYY	Telephone Number: Home: ( ) Work: ( )

Current Address: 1742 CENTRAL PARK, OREFIELD, PA 18069

City | State | Zip Code

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 completed a period of accredited postgraduate training at this facility. If a period of training WAS NOT completed in a satisfactory manner, please provide a separate detailed narrative explanation. The following information is provided to certify "satisfactory" completion. PLEASE SEE THE REVERSE FOR A DEFINITION OF "SATISFACTORY."

Name of Facility:	Address of Facility:
ELLIS HOSPITAL	1101 NOTT ST. SCHENECTADY NY 1230

Name of Program Director:	Telephone Number:
Gary L. Wilson, MD	(518) 243-4179
Signature of Program Director: Gary L. Wilson, MD	**Date Signed:** 11/7/01

List Categorical Specialty Area of Training Completed by Trainee:	Date Training Commenced:	Date Training Completed:
	July 1st 1974	June 30, 1975

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):

Rotating Internship

PART 3: To be completed by the DIRECTOR OF MEDICAL EDUCATION and affixed with the official facility seal.

Name of the Director of Medical Education:	Name of Facility:
Gary L. Wilson, MD	Ellis Hospital

Address of Facility: 1101 Nott Street

City	State	Zip Code	Telephone Number:
Schenectady	NY	12308	(518) 243-4179

PART 4: Signature of DIRECTOR OF MEDICAL EDUCATION certifying satisfactory completion of training.

Attention: Director of Medical Education! *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. This form may be signed by the current Director of Medical Education; it does not need to be signed by the person who was the Director of Medical Education at the time of the training listed above.*

Notice to Applicant: If this form is used to verify postgraduate training beyond that which is required for licensure, this form can be signed by the Director of Medical Education and the Program Director before the final day of training. However, if you are licensed after the date upon which training was completed AND if the form was signed before the final day of the training year, a new form must be completed and submitted to the Medical Board of California.

HOSPITAL OR NOTARY SEAL

OFFICIAL HOSPITAL SEAL OR NOTARY SEAL, DATE AND SIGNATURE MUST BE AFFIXED IN THE BOX TO THE LEFT TO CERTIFY 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 RCPSC to offer the type and level of training completed by the applicant and that the applicant was trained in an approved ACGME or RCPSC program position.

Signature of Director of Medical Education:	Date Signed:
	11/7/01

L3A

07A-100-L3 (Rev. 3/01)

STATE OF CALIFORNIA — STATE AND CONSUMER SERVICES AGENCY

GRAY DAVIS, Governor

Consumer Affairs

MEDICAL BOARD OF CALIFORNIA

1426 Howe Avenue, Suite 54, Sacramento, CA 95825-3236
(916) 263-2499/FAX (916) 263-2487 Internet: www.medbd.ca.gov

RECEIVED
MEDICAL BOARD OF CALIFORNIA
03 JUL 23 PM 1:03

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.

ATTENTION PROGRAM DIRECTORS AND DIRECTORS OF MEDICAL EDUCATION: THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE, OR ADOPTION. Only the Program Director and the Director of Medical Education may sign this form. If that signature authority is being delegated to another physician, a letter outlining this 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.

PART 1: To be completed by the APPLICANT.

LAST NAME of Applicant	First Name	Middle Initial
GOPAL	TIRUV	A

U.S. Social Security Number:	Date of Birth: MM/DD/YYYY	Telephone Number:
		Home: (Work: (

Current Address: 1742 CENTRAL PARK

City: OREFIELD State: PA Zip Code: 18069

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 completed a period of accredited postgraduate training at this facility. If a period of training WAS NOT completed in a satisfactory manner, please provide a separate detailed narrative explanation. The following information is provided to certify "satisfactory" completion. PLEASE SEE THE REVERSE FOR A DEFINITION OF "SATISFACTORY."

Name of Facility:	Address of Facility:
Lehigh Valley Hospital	Allentown, PA

Name of Program Director:	Telephone Number:
Craig J. Sobolewski, MD, FACOG	(610) 402-2890

Signature of Program Director:	Date Signed:

List Categorical Specialty Area of Training Completed byTrainee:	Date Training Commenced:	Date Training Completed:
Obstetrics + Gynecology	1975	1978

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):

PART 3: To be completed by the DIRECTOR OF MEDICAL EDUCATION and affixed with the official facility seal.

Name of the Director of Medical Education:	Name of Facility:
Martyn O. Hotvedt, Ph.D.	Lehigh Valley Hospital

Address of Facility: 17th & Chew Streets, P.O. Box 7017

City	State	Zip Code	Telephone Number:
Allentown	PA	18105-7017	(610) 402-2501

PART 4: Signature of DIRECTOR OF MEDICAL EDUCATION certifying satisfactory completion of training.

Attention: Director of Medical Education! *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. This form may be signed by the current Director of Medical Education; it does not need to be signed by the person who was the Director of Medical Education at the time of the training listed above.*

Notice to Applicant: If this form is used to verify postgraduate training beyond that which is required for licensure, this form can be signed by the Director of Medical Education and the Program Director before the final day of training. However, if you are licensed after the date upon which training was completed AND if the form was signed before the final day of the training year, a new form must be completed and submitted to the Medical Board of California.

HOSPITAL OR NOTARY SEAL

OFFICIAL HOSPITAL SEAL OR NOTARY SEAL, DATE AND SIGNATURE MUST BE AFFIXED IN THE BOX TO THE LEFT TO CERTIFY 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 RCPSC to offer the type and level of training completed by the applicant and that the applicant was trained in an approved ACGME or RCPSC program position.

Signature of Director of Medical Education:	Date Signed:
	10-26-01

L3A

07A-100-L3 (Rev. 3/01)

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

PART II

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 Applicatio
Physician and Surgeon

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

D. **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 _____ MD DATE: 9/26/2012

LICENSE NO.	EXPIRES	AMOUNT DUE NOW	DELINQ FEE IF POSTMARKED AFTER 10/30/12
C 51866	09/30/12	$808.00	$886.00
	VOLUNTARY FEE =	$	$
	TOTAL ENCLOSED =	$ 808.00	$

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.

Signature required here

MD

ACTIVE TIRUN A. GOPAL
1742 CENTRAL PARK
OREFIELD PA 18069

ENTERED OCT 02 2012

OVER

630103000003000040005186620109301200080800000088600

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 o the front of this document at G.

Health-Related Facility Name	Address

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
PO BOX 942520
SACRAMENTO CA 94258-0520

SMBCLS 02/28/05

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:	GOPAL, TIRUN A
Transaction Date:	09/19/2014 15:56
Application Number:	
Complaint Number:	
License Type:	8002
License Number:	51866
Payment Description:	Physician's and Surgeon's Renewal
Fee Paid: (US $)	845.00
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 C**
License Number:	**51866**
File Number:	
Application:	**Physician's and Surgeon's Renewal**
Application Number:	
Application Date:	**09/19/2014 (mm/dd/yyyy)**

Personal Detail

First Name:	**TIRUN**
Middle Name:	**A**
Last Name:	**GOPAL**
Birthdate:	****/**/******
Gender:	**Male**

Addresses

License Related Addresses

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:	**Yes**

Amount - $25.00 Minimum:	**25**

Attachments

Physician Survey

Are you retired?	**No**
Activities in Medicine	**Administration - 10-19 Hours**
	Other - None
	Patient Care - 40+ 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	**Not in Training**
Areas of Practice	**Obstetrics and Gynecology - Secondary**
Board Certifications	**American Board of Obstetrics and Gynecology - Obstetrics and Gynecology**
Cultural Background	**Indian**
Foreign Language Proficiency	**Hindi**
	Other Non-English
Web Site Profile	**Cultural Background - Yes**
	Foreign Language Proficiency - Yes
	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**
Family Physician Training Fee	**$25.00**
Total Amount Due:	**$845.00**

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:

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:	GOPAL, TIRUN A
Transaction Date:	06/11/2016 10:37
Application Number:	
Complaint Number:	
License Type:	8002
License Number:	51866
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 C**
License Number:	**51866**
File Number:	
Application:	**Physician's and Surgeon's Renewal**
Application Number:	
Application Date:	**06/11/2016 (mm/dd/yyyy)**

Application Questions

Have you served or are you currently serving in the military?	**N**

Personal Detail

First Name:	**TIRUN**
Middle Name:	**A**
Last Name:	**GOPAL**
Birthdate:	***/**/****
Gender:	**Male**

Addresses

License Related Addresses

Address of Record (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:	**Yes**

Attachments

Physician Survey

Are you retired?	**No**
Activities in Medicine	**Administration - 20-29 Hours**
	Other - None
	Patient Care - 40+ 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	**Not in Training**
Areas of Practice	**Obstetrics and Gynecology - Primary**
Board Certifications	**American Board of Obstetrics and Gynecology - Obstetrics and Gynecology**
Postgraduate Training Years	**9+ Years**
Cultural Background	**Indian**
Foreign Language Proficiency	**Hindi**
	Other Non-English
Web Site Profile	**Cultural Background - Yes**
	Foreign Language Proficiency - Yes
	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: