STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY — GEORGE DEUKMEJIAN, Governor

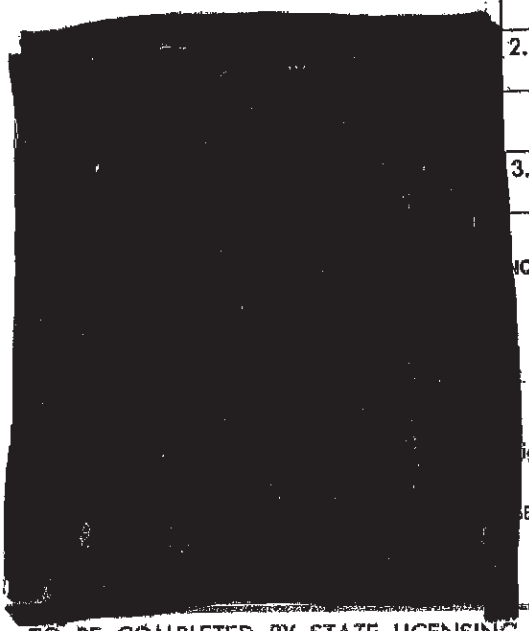
DEPARTMENT OF Consumer Affairs

BOARD OF MEDICAL QUALITY ASSURANCE

1430 HOWE AVENUE, SACRAMENTO, CALIFORNIA 95825
(916) 920-6411

RECEIVED
MAY 16 1989

CERTIFICATE OF ENDORSEMENT BY STATE LICENSING AGENCY



1. NAME: (last) Webster (first) Karen (middle) Michele CSU

2. ADDRESS: Number and street/rural route (include apt. no., if any) 421 G St NE
CITY: Washington STATE: DC ZIP CODE: 20002 COUNTRY:

3. DATE OF BIRTH: mo/day/yr

4. SEX: ☑ Female ☐ Male

5. STATE LICENSING AGENCY: New York State

NOTE: Applicant will sign this statement in presence of notary public. "I hereby declare under penalty of perjury under the laws of the State of California that the attached photograph is a true likeness of myself and that the information contained in this document and any attachments are true and correct."

Karen Michele Webster
SIGNATURE OF APPLICANT IN FULL

Signed and sworn to before me this 11 day of May 1989.

[SEAL]

Signature of Notary Public Theresa C. Cicchiano
Address Prov. Hos. 1150 Varnum St. N.E. Wash. D.C. 20017
My commission expires My Commission Expires April 30, 1992

TO BE COMPLETED BY STATE LICENSING AGENCY:
(Do not complete if photograph of applicant is not attached above. Please type or print.)

I certify that _____ (NAME OF APPLICANT) who graduated from _____ (NAME OF MEDICAL SCHOOL) on _____ (DATE OF GRADUATION) was granted license number _____ on _____ (DATE LICENSE ISSUED) on the basis of _____ (FLEX, NATIONAL BOARD EXAM, LICENSING AGENCY EXAM)

NOTE: If the license was issued by written examination, complete the following certification, otherwise write across the following certification the words: Issued on Credentials.

I further certify that this doctor passed the REGULAR WRITTEN EXAMINATION given by this Board on _____ (DATE)

and obtained a general average of _____ per cent in the following subjects:

Subjects of Examination	Per Cent	Subjects of Examination	Per Cent

I certify that this license is valid, current, has never been suspended or revoked, and will expire _____ (DATE) and that records in this office indicate that there are not now nor have there ever been any charges filed against the holder of this license.

NOTE: If any portion of the above certification is deleted or modified, please attach an explanation.

_____ (TYPE OR PRINT NAME AND TITLE OF AGENCY OFFICIAL) (AFFIX LICENSING AGENCY SEAL) _____ (NAME OF STATE LICENSING AGENCY)

_____ (SIGNATURE OF AGENCY OFFICIAL) _____ (ADDRESS)

_____ (DATE) _____ (PHONE NUMBER)

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(916) 920-6411

CERTIFICATE OF COMPLETION OF ACGME POSTGRADUATE TRAINING

To be completed by the facility for every medical school graduate completing postgraduate training in the United States or Canada. Do not complete if photograph of applicant is not attached below. Please type or print.

This is to certify that Karen M. Webster (NAME OF APPLICANT)

a graduate of Johns Hopkins School of Medicine (NAME OF MEDICAL SCHOOL)

formally commenced an accredited postgraduate training program at Georgetown University / Providence Hospital (NAME AND ADDRESS OF FACILITY) O.K.

3001 Bladensburg Rd, NE, Wash 20018 in Family Practice (SPECIALTY)

on July 1, 19 86, and completed such training on June 30, 19 89.
This training consisted of 36 months of actual clinical instruction and is approved by the Accreditation Council for Graduate Medical Education (ACGME) or the Coordinating Council of Medical Education of the Canadian Medical Association (CCME) and consisted of the following rotations:

(List rotations completed. If service was not rotating, indicate type of straight training performed. NOTE—To qualify for licensure in California, graduates of foreign medical schools must have completed at least four months of postgraduate training in general medicine. ACGME or CCME residencies in family practice, internal medicine, surgery, pediatrics, and ob/gyn would normally satisfy this requirement.)

ROTATION	LENGTH OF ROTATION

[redacted]

I hereby declare under penalty of perjury under the laws of the State of California that the above statements are true and correct and the facility is approved by the ACGME or the CCME to offer the type and level of training completed by the applicant and that the applicant was trained in an approved ACGME or CCME program position.

NAME David C. Lanier, MD (DIRECTOR OF MEDICAL EDUCATION)

(AFFIX SEAL OF HOSPITAL OR NOTARY PUBLIC)

ADDRESS 3001 Bladensburg RD, NE
Washington, DC 20018

PHONE NUMBER (202) 529-5407

DATE 5/4/89

SIGNATURE David C. Lanier, MD

Subscribed and sworn to before me this 4th day of May, 1989 in the District of Columbia

Notary Public

L3

STATE OF CALIFORNIA—STATE AND CONSUMER SERV[redacted] AGENCY — GEORGE DEUKMEJIAN, *Governor*

DEPARTMENT OF Consumer Affairs

BOARD OF MEDICAL QUALITY ASSURANCE

1430 HOWE AVENUE, SACRAMENTO, CALIFORNIA 95825
(916) 920-6411

CERTIFICATE OF MEDICAL EDUCATION

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

This certifies that Karen Michele Webster
FULL NAME OF APPLICANT

of 544 A N. Bond St. enrolled in Johns Hopkins School of Medicine
ADDRESS WHEN ENROLLED — NAME OF MEDICAL SCHOOL

Baltimore, Maryland on the 30 10th day of ~~August~~ September 1981
LOCATION — MONTH — YEAR

and was granted the following credits on enrollment:

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

Brandeis University — 9/77 - 6/81
EDUCATIONAL INSTITUTION — DATES

Advanced Credits. Credits previously obtained at an approved medical school.*

MEDICAL SCHOOL — TOTAL CREDITS — DATES

The undersigned further certifies that the records of this institution show that she attended in this institution 4 (SPECIFY NUMBER) courses of resident instruction of 36 (NUMBER OF WEEKS) weeks each, completing at least 4,000 hours, of which at least 80 percent actual attendance is required, in the subjects set forth hereunder (Business and Professions Code Section 2089), and that

☒ she was granted the degree Bachelor/Doctor of Medicine by
☐ she withdrew from

the above mentioned medical school on the 31st day of May (MONTH) 1985

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

[redacted]

Signed and the college seal affixed this 17th day of May, 1989.

BY Mary E. Foy, Assistant Dean/Registrar
PRESIDENT, SECRETARY, DEAN

Medical School Seal MUST Be Imprinted Partially on the Photograph.

TRANSCRIPTS OF PREMEDICAL EDUCATION, ADVANCED CREDITS, AND MEDICAL SCHOOL CREDITS MUST BE SUPPLIED WITH THIS CERTIFICATE

* 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.

L2

07A-100

STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY — GEORGE DEUKMEJIAN, Governor

DEPARTMENT OF Consumer Affairs

BOARD OF MEDICAL QUALITY ASSURANCE

1430 HOWE AVENUE
SACRAMENTO, CA 95825
(916) 920-6411

013711 127.50 6/82

RECEIVED SACRAMENTO BOARD OF MEDICAL QUALITY ASSURANCE

MAY 15 1 34 PM '89

APPLICATION FOR PHYSICIAN AND SURGEON'S EXAMINATION OR LICENSURE

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

011956 335.00 5/89

BMQA USE ONLY

PERSONAL DATA

1. Name: Last: Webster First: Karen Middle: Michele

2. Other names you have used:

3. Social Security Number — See disclosure statement on L1C

4. Address: Number and Street/Rural Route (include apartment number, if any): 421 G St NE
City: Washington State: DC ZIP Code: 20002 Country:

5. Telephone Number: Home Work

6. Date of Birth: Mo/Day/Yr

7. Sex: ☑ Female ☐ Male

8. Are you a U.S. citizen? ☑ Yes ☐ No
Submit a certified copy of birth certificate, Certificate of Naturalization, Declaration of Intention to become U.S. citizen (INS Form N300), VISA documents, or license to practice medicine.

9. Have you ever filed an application for examination or licensure in California? ☐ Yes ☑ No
If YES, give date of previous application:

NON-MEDICAL EDUCATION

10. List name and address of all colleges or universities attended other than schools where professional medical instruction was received. Submit an official transcript from each school attended.

Name	Address	Period of Attendance From (Mo/Yr)	Period of Attendance To (Mo/Yr)
Brandeis University	Waltham, Mass 02254	9/77	6/81
Johns Hopkins School of Public Health	Baltimore, Md 21205	6/85	5/86

MEDICAL EDUCATION

11. List name and address of all schools where professional medical instruction was received. Submit an original Certificate of Medical Education and official transcripts from each school attended.

Name	Address	Place Where Instruction Received	Period of Attendance From (Mo/Yr)	Period of Attendance To (Mo/Yr)
Johns Hopkins School of Medicine	720 Rutland Ave Balt, Md 21205	Balt, Md	9/81	5/85

CME TRANS:

MD207
School Code

12. Doctor of Medicine Degree granted by: (submit original medical diploma and a photocopy)

Name of Medical School	Address of Medical School	Exact Date of Issuance
Johns Hopkins School of Medicine	720 Rutland Ave Balt, Md 21205	5-31-85

L1A

07A-100 88 86184

BMQA USE ONLY

13. Have you taken any of the following written examinations: National Boards, ECFMG, FMGEMS, FLEX, MSKP, MCAT, other related medical competency examinations? ☑ Yes ☐ No

If YES, list name, location, date and result of examination. Submit certification of scores from each examination agency.

WRITTEN EXAMINATION

Name	Location	Date	Result
FLEX	New York, NY	June 1985	

14. Have you received qualifying postgraduate training in U.S. or Canadian facilities? ☑ Yes ☐ No

If YES, list name and address of all facilities. Submit an original Certificate of Completion of ACGME Postgraduate Training (Form L3) from each facility.

POSTGRADUATE TRAINING

Name	Address	Type of Service	Period of Attendance	
			From (Mo/Yr)	To (Mo/Yr)
Georgetown University	3001 Blackenburg	Family Practice	6/86	6/89
Providence Hospital	Rd NE, Wash DC	Residency training		
Family Practice	20018			
Residency Program				

15. Have you 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 issuing agency's jurisdiction for each. Submit a Letter of Good Standing from each state in which you are licensed or have been licensed.

LICENSE DATA

State or Country	License Number	Date of Issuance	Dates of Practice in Issuing Agency's Jurisdiction		LGS	CE
			From (Mo/Yr)	To (Mo/Yr)		
New York, NY	160436	September 13, 1985	NA	NA	☐	☐
Washington, DC	17187	April 6, 1988	6/86	7/89	☐	☐
					☐	☐
					☐	☐

16. Has any disciplinary action ever been taken regarding any healing arts license which you now hold or have ever held? Include any disciplinary actions by the U.S. Military, U.S. Public Health Service or other U.S. federal governmental entity.

Yes No If yes, give details below:

State	Date	Charge	Disposition

L1E

My Commission Expires May 30, 1993

BMQA USE ONLY

17. Have you ever been denied a license, permission to practice medicine or any other healing arts, or permission to take an examination in any state, country, or U.S. federal jurisdiction? Yes No

If yes, give details below:

State or Country	Date of Denial	Reason for Denial

18. Have you been charged with unprofessional conduct or any other unlawful activity by any healing arts licensing authority or by the U.S. military and are awaiting final disposition by that body?

Yes No If yes, please explain on a separate sheet of paper.

19. Have you ever voluntarily surrendered a license to practice in the healing arts in another state?

Yes No If yes, please explain on a separate sheet of paper.

20. Have you ever had staff privileges in a hospital denied, suspended or revoked, or resigned from a medical staff in lieu of disciplinary action? Yes No If yes, please explain on a separate sheet of paper.

21. Are you now, or were you in the past, addicted to or treated for addiction to controlled substances, such as narcotics or alcohol? Yes No If yes, please explain on a separate sheet of paper.

22. Have you ever been convicted of, or pled nolo contendere to a violation of any federal, state or local law relating to the manufacture, distribution or dispensing of controlled substances, or to drug addiction? Yes No

If yes, give details below:

Violation and Location	Date	Penalty or Disposition

23. Have you ever been convicted of, or pled nolo contendere to any offense, misdemeanor or felony of any state, the United States, or a foreign country? (except violations of traffic laws resulting in fines of $75.00 or less.)

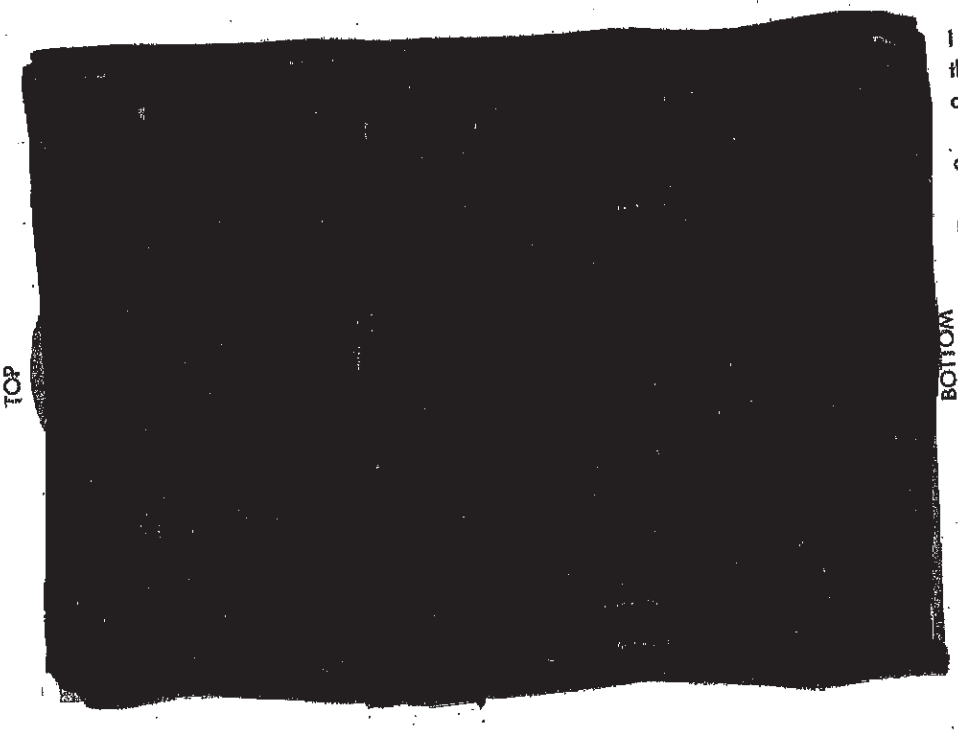
Yes No If yes, give details below:

Violation and Location	Date	Penalty or Disposition

You are required to list any conviction that has been set aside and dismissed under Section 1203.4 Penal Code or under any other provision of law.

"Disclosure of your social security number is mandatory. Section 30 of the Business and Professions Code and Pub. L. 94-455 (42 U.S.C.A. 405 (c) (2) (C)) authorizes collection of your social security number. Your social security number will be used exclusively for tax enforcement purposes. If you fail to disclose your social security number, you will be reported to the Franchise Tax Board, which may assess a $100 penalty against you."

L1C



TOP

BOTTOM

I hereby declare under penalty of perjury under the laws of the State of California, that the photo of myself attached hereto, was taken

on or about ____, 19__

my age then being ____ years;

color of hair ____;

color of eyes ____;

height ____ ft. ____ in.;

weight ____ lbs.;

identifying marks ____

NOTE: All items in this application are mandatory; none are voluntary. Failure to provide any of the requested information will result in the application being rejected as incomplete. The information provided will be used to determine qualification for licensure, per Section 2080 of the Business and Professions Code which authorizes the collection of this information. Information regarding the issuance or denial of a license by the Board may be transmitted to any other medical licensing authority or the Federation of State Medical Boards. Applicants have the right to review their application subject to the provisions of the Information Practices Act. The Program Manager of the Division of Licensing is the custodian of records.

STATE OF District of Columbia)
)
COUNTY OF ____)

Karen Michele Webster being duly sworn, says She is the person referred to in the foregoing application for a physician and surgeon's certificate in California and that She has carefully read and thoroughly understands all the requirements therein and that the statements made herein and all attachments are true and correct under penalty of perjury under the laws of the State of California.

She requests that the Division of Licensing, Board of Medical Quality Assurance, initiate a review of the records to determine their eligibility for examination, postgraduate training or licensure in California. In making this request, she authorizes the release of any information or records held by any individual or agency, relative to their training and qualifications as a physician and surgeon, upon request by the Board for use in evaluating their file.

Karen Michele Webster
Signature of applicant in FULL (Do not use INITIALS ONLY)

Signed and sworn to before me this 11 day of May, 19 89

Signature of Notary Public Theresa C. Cullinane

Address Providence Hospital, 1150 Varnum St. N.E. Wash DC 20017

[SEAL]

My commission expires My Commission Expires April 30, 1993

LIC

STATE DEPARTMENT OF CONSUMER AFFAIRS
INTERNET CASHIERING SYSTEM
MEDICAL BOARD OF CALIFORNIA
SUPPLEMENTAL INFORMATION REPORT
From Date: 01/12/2013 **To Date:** 01/12/2013

ATRISUPPINF
17-JUN-16 08:15:27

Person Id : **Name :** Webster,Karen

Question	Answer
I Have Completed Cme And Can Document Not Less Than 50 Hours Of Approved Cme For The Two-Year Period Immediately Preceding The Expiration Date Of My License. Or I Meet The Conditions Which Would Exempt Me From All Or Part Of The Requirements.	YES
I Have Completed 12 Hours Of Pain Management And End-Of-Life Care.	YES
I Am Exempt From The Completion Of 12 Hours Of Pain Management And End-Of-Life Care Continuing Education Requirement Because I Am A Radiologist Or Pathologist.	NO
Only For General Internists And Family Physicians Who Have 25% Of Their Patient Population Aged 65 Years Or Older: I Have Completed At Least 20% Of The Required Cme In Geriatric Medicine Or The Care Of Older Patients. Click No If Not Applicable.	NO
Enter Name/Address Of Facility Where You Or Your Immediate Family Hold Financial Interest. Type "None", If None Held.	NONE
I Certify Under Penalty Of Perjury Under The Laws Of The State Of California That The Information Contained In This Application Is True And Correct.	YES
I Have Read My Profile On The Medical Board Web Site At Www.Mbc.Ca.Gov And Acknowledge The Information Contained Therein As Current And Accurate.	YES
Since You Last Renewed Your License, Have You Had Any License Disciplined By A Government Agency Or Other Disciplinary Body; Or, Have You Been Convicted Of Any Crime In Any State, The U S A And Its Territories, Military Court Or A Foreign Country?	NO

Total Questions Asked For Person : 8

STATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS

dca BREEZE

Department of Consumer Affairs

RECEIPT

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

Name:	WEBSTER, KAREN MICHELE
Transaction Date:	12/16/2014 13:27
Application Number:	
Complaint Number:	
License Type:	8002
License Number:	46274
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:	**46274**
File Number:	
Application:	**Physician's and Surgeon's Renewal**
Application Number:	
Application Date:	**12/16/2014 (mm/dd/yyyy)**

Personal Detail

First Name:	**KAREN**
Middle Name:	**MICHELE**
Last Name:	**WEBSTER**
Birthdate:	****/**/******
Gender:	**Female**

Addresses

License Related Addresses

Address of Record (Required)

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

Confidential Address

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

Questions

Since you last renewed your license, have you had any license disciplined by a government agency or other disciplinary body, or, have you been convicted of any crime in any state, the U.S.A. and its territories, military court or a foreign country?	**No**
Have you successfully completed, and can document, the mandatory courses and hours of CME within the last two years, or you meet the conditions which would exempt you from all or part of the CME requirements, or you hold a permanent CME waiver?	**Yes**

I certify under penalty of perjury, under the laws of California, that I have disclosed the names of those health-related facilities in which I or my family have a financial interest OR I declare under penalty of perjury I have no financial interests to disclose.	**Yes**

Family Physician Training Program Voluntary Fee

Voluntary Fee:	**No**

Attachments

Physician Survey

Are you retired?	**No**
Activities in Medicine	**Administration - 1-9 Hours** **Other - None** **Patient Care - 30-39 Hours** **Research - None** **Teaching - 1-9 Hours** **Telemedicine - None**
Patient Care Practice Location	**Zip: County:**
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	**Family Medicine - Secondary**
Postgraduate Training Years	**6 Years**
Cultural Background	**African American**
Web Site Profile	**Cultural Background - Yes** **Foreign Language Proficiency - No** **Gender - Yes**

E-mail:

Fees

Biennial Renewal Fee	**$783.00**
DUE TO CURES FUND	**$12.00**
Steven M. Thompson Physician Corps Loan Repayment Program	**$25.00**
Total Amount Due:	**$820.00**

Applications are not considered submitted for processing until payment is received.

Attestation

I declare under penalty of perjury under the laws of the State of California that all statements, answers, and representations provided, including supplementary attached hereto, are true, complete and accurate.

Signature: Date: