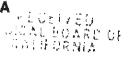


LICENSING PROGRAM
1426 Howe Avenue, Suite 54
Sacramento, CA 95825-3236
(916) 283-2382 FAX (918) 263-2487

www.caidocinfo.ca.gov





INITIAL AND UPDATE APPLICATION FOR PHYSICIAN'S AND SURGEON'S LICENSE OR POSTGRADUATE TRAINING AUTHORIZATION LETTER

Application	n for (please che	eck one): 🖬	Cicense 🗆 Pi	ΓAL - c	or -	☐ Update	i
1. NAME: Last	YEN		First THV			idle CH	MBC Use Only
Other names you have us	ed (include maide	n name):	- the second sec	J.S. Social Sec		The state of the s	- 000 01119
	· ·			arrived Military, " when			
3. Place of Birth	-		4. 1	ate of Birth			~
	-						
5. Gender:	☐ Male	Female					
6. Public/Mailing Address (Please note: this information)	tion is public)	ACA_	ST_SALT	IMORE	=_~1	2120	}
(30 characters maximum per line, including spaces	• ,	I LOUIS CHARLE			*		
BALTI MOR	State/Pr	ovince (1)		ital Code	Country	A	
7. Telephone Numbers: (include area code)	Hom	le	Wor		1	Cell	1
8. California Driver's Lic	ense Number (opt	ional):	10. Have you eve	er filed an App	lication f	or Physician's	* Personal Data
9. E-mail Address (antia-			and Surgeon	's License, or	PTAL, in No	California?	
		17	Previous license				7
MEDICAL EDUCATION							
11. LIST EACH MEDICAL	SCHOOL THAT YO			· · · · · · · · · · · · · · · · · · ·			•
School Nam		City,	State/Province, Co.	intry	Dates	of Attendance	-
St. George's U School of Me	niversity	Gree	inada, We	at India	8/0	1-5/05	12 Transpript
School of Me	dicine						
12. School of Graduat			Degree Awarded	*****	Date	of Graduation	
St. George's	MMY.		M.D.		5	12005	Diploma
EXAMINATIONS 13. LIST ALL OF THE FOLLOWING EXAMINATIONS YOU HAVE TAKEN: USMLE, FLEX, NBME, ECFMG, SPEX.							
13, LIST ALL OF THE FOLI	LOWING EXAMINA	LUOY BROTT	HAVE TAKEN: U	SMLE, FLEX, I	NBME, E	CFMG, SPEX, QME in Canada	1
Examination	n		Date			Result (Pass/Fail)	Exame
WMLE I	,		6/03				
WHLEI			8/04	The state of the s			
WMLE III			5/07				1/
•				00			10 P
Mana	Cashlering Use C	ontv		(581	UD		1A
07A-160 (Rev. 12/06)				School	I COMB	<u> </u>	

A "yes" response to Questions 14 through 38 requires a written explanation on a separate sheet of paper along with any supporting materials.

	ACGME/RCPSC A	CCREDITED	POSTGRAD	UATE TR.	AINING		M Use
nava hatricibs	h ACGME/RCPSC acc ted. You must includ m was completed or o	ê êach intarr	tshir rasida	ining prop ncy and fo	gram in w ellowship	hich you whether or	Posty
Facility Name			Specialty A	rea	Dates o	f Attendance	Tre
Univ. of MD Family Medi	cine Rathmo		Family	Med.	7/05	- present	ر ا
	212	01	<u></u>			·	
							
			<u> </u>				1]
OSTGRADUATE	TRAINING: (Those questions a	ITO to be ninswared by A	(LL applicants)				
	leave of absence or bre			Y	E.S	NO -	٤ ا
Have you ever been terminated, dismissed or expelled from a program?							
	ned from a training pro		. •		ES .	NO	
Vere you ever place		-		Y	ES	NO	
	dined or placed under i	nvestigation?		Y	ES	NO	4
	ports ever filed by instr				ES	No	
Vere any limitations	Or special requirement	e njacad uno:	1 Vou for clinic			. 110	
vironnance, discipil	ne, or for any other rea	son?		YI	ES .	NO	6
enewed or offered for	postgraduate training or a following year?	program cont	ract not be	YI	E8	NO -	1
	ME	DICAL LICE	NSURE '				
5. Please list all m	edical licenses (other	r than trainin	a licenses) t	hat have	ever heen	icened by	
	The state of the state of	ates or Cana	dian provinc	0.			Lice: Dat
Jurisdiction	License Number	- Transfer Dates		Dates of	Practice in t	hat Jurisdiction	
Yanyland	D006660	9/07		10/2	4/07-	-stact.	
						The state of the s	
		andread to the contract of the			No.		
PPLICANT:		***************************************	I MAN		APP a h		
Nguyen,	Thy Bich	•	DAT	E OF BIR	TH:		1E

	ABMS CERTIFICATION	S			MBC Use Only
16. Are you currently certified by	a Member Board of the Amer	ican Board of		cialties?	ABMS
Member Board	Expiration Date		Certificate No	ımber	
		······			ם
				<u>.</u>	
ere en	MALPRACTICE HISTOR		·		Malprootice
 Has a claim or an action ever in a malpractice settlement, ju 	been filed against you for the dgment, or arbitration award	practice of m of \$30,000 or	more?	n resulted	
			YES	NO	7
	TICE IMPAIRMENT OR LIV				Limitations
 Have you been enrolled in, red drug or alcohol recovery program 	quired to enter into, or partici ram or impáired practitioner p	oated in any rogram?	YES	NO	7
19. Have you been treated for or lead addictive disorder?	nad a recurrence of a diagno:	sed	YE8	NÓ .	ø
20. Have you been diagnosed with an emotional, a mental, or behavioral YES NO disorder which impairs your ability to practice medicine safely?			ø		
21. Have you ever been diagnosed with a neurological or other physical YES NO I			ø		
22. Do you have any other conditi your ability to practice medicing	on which in any way impairs e safely?	or limits	YES	NO.	ø
If you do receive ongoing treatment or participate in a monitoring program, 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 not eligible for licensure.					
	CRIMINAL RECORD HISTO	to a staff of Marine	The second of the state of the second of	41 - 4	Criminal
23. Have you ever been convicted of, or pled guilty or nolo contendere to ANY offense in any state in the United States or foreign country?			Record		
This includes a citation, infraction, miedemeanor and/or felony, stc. If "YES" attach a list of each offense by arrest and conviction dates, violation, and court of jurisdiction (name and address). Matters in which you were diverted, deferred, pardoned, pled note contenders, or if the conviction was later expunged from the record of the court or set aside under Penal Code Section 1203.4 MUST be disclosed. If you are awaiting judgment and sentending following entry of a plea or jury verdict, you MUST disclose the conviction; you are entitled to submit evidence that you have been rehabilitated. Serious traffic convictions such as reckless driving, driving under the influence of alcohol and/or drugs, hit and run, evading a peace officer, failure to appear, driving while the license is suspended or revoked MUST be reported. This list is not all-inclusive. If in doubt as to whether a conviction should be disclosed, it is better to disclose the conviction on the application.					
For each conviction disclosed, you must submit with the application certified copies of the arresting agency report, certified copies of the count documents, and a descriptive explanation of the circumstances surrounding the conviction of disciplinary action (i.e., dates and location of incident and all droumstances surrounding the incident). This letter must accompany the application. If documents were purged by arresting agency and/or court, a letter of explanation from these agencies is required.					
Applicants who answer "NO" to the question but have a previous conviction or plea, may have their application deplet or license.				. /	
revoked for knowingly faisitying the application. YES NO					7
NGUYEN, THY	BICH	DATE OF BI	RTH:		1C
07A-100 (Rev. 12/05)		·			

	CRI. NAL RECORD HISTORY (cont'd)		Addition to the second
24.	Is any criminal action pending against you?	YES	NO
25.	Are you required to register as a Sex Offender?	YES	NO
	DISCIPLINARY HISTORY		
	These questions refer to discipline by any U.S. military or public health or other governmental agency of any U.S. state, territory, Canadian I	h service, sta province, or	ate board country.
26.	Have you ever been denied a license to practice medicine?	YES	NO
27.	is any denial pending against you?	YES	No
28.	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?	YES	NO
29,	Have you ever had any license to practice medicine revoked, suspended, or placed on probation?	YES	No
	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
31.	Have you ever had any license to practice medicine subjected to any other disciplinary action?	YE\$	NO.
2.	Is any disciplinary action pending against any of your licenses to practice medicine?	YFS	NO
3.	Have you ever had staff privileges in a hospital terminated, denied, suspended, limited, revoked, or not renewed?	YES	NO
4.	Have you ever resigned from a medical staff in lieu of disciplinary or administrative action?	YES	МО
35.	Is any disciplinary action pending against your hospital staff privileges?	YES	NO
	Have you ever surrendered a license to practice medicine?	YES	NO.
7. 1	Have your DEA privileges ever been denied, suspended, restricted, or terminated?	YES	NO.
88. H	lave you ever entered into any arrangement or plea or agreement in ieu of a federal prosecution for a drug violation regulated by the DEA?	YES	NO
	LICANT: DATE OF BIRTH	l u	
	NGUYEN, THY BICH	1;	



Notice: All items in this application, except #8 and #9, 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 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 law enforcement agencies. You have the right to review your application subject to the provisions of the Information Practices Act. The Chief of the

	missioning Frogram is the custodish of records.
and evidence or other credentials submitted here of Medicine as prescribed by this application, that examination, and that it, together with all the credentiatake of which I am aware and that I am the law organizations, my references, personal physicians associates (past, present, and future), and all governorm of California or its successors any information records of psychiatric treatment and treatment for connection with this application; or any further or from the competence, professional conduct, or physical or authorize the Medical Board of California or its successors and information which is material to this application.	characteristic productions of the supplications of the Information contained herein with are true and correct; that I am the lawful holder of the degree of Doctor the same was procured in the regular course of instruction and entials submitted, were procured without fraud or misrepresentation or any viul holder thereof. Further, I hereby authorize all hospitals, institutions or a, employers (past, present and future), business and professional ermment agencies (local, state, federal, or foreign) to release to the Medical on, files or records, including medical records, educational records, and drug and/or alcohol abuse or dependency, requested by that Board in uture investigation by that Board necessary to determine any medical mental ability to safely engage in the practice of medicine. I further excessors to release to the organizations, individuals or groups listed above in or any subsequent licensure. **MISREPRESENTATION OF ANY ITEM OR RESPONSE ON THIS RETO IS A SUFFICIENT BASIS FOR DENYING OR REVOKING A
SIGNATURE OF APPLICANT:	Mrs May
State of MARY/AND	(Please sign full name)
County of BACTURE	· · · · · · · · · · · · · · · · · · ·
Subscribed and sworn to (or affirmed) before me o	on
this Ob day of Get	20 0 7
by DAUS F. Allew	
personally known to me or proved to me on the bas	sis of satisfactory evidence to be the person(s) who appeared before me.
DAVID F. ALLEN Notary Public State of Maryland Baltimore County	GNATURE OF NOTARY PUBLIC
7A-100 (Rev. 12/05)	

Gallers of Cambraia Bagastiment of 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



ELIGIBILITY FOR REDUCED INITIAL LICENSE FEE

(If you are enrolled in an ACGME/RCPSC postgraduate training program at the time of licensure, you are entitled to a reduced initial license fee. This form is used to certify current participation in a training program.)

This is to certify that THY NGOVE					
4	to occur account in the control of t				
(Date of Birth -MM/DD/YYYY)	ACGME/RCPSC postgraduate training position that				
commenced on OT 01 2005	Year and is expected to be completed on				
07/01/2008 in Fax	my Medicine Residency OF (Type of Training) 29 5. Paca Street ss of Facility)				
at University of Manland	(Type of Training)				
at University of Maryland Uname and Addre	ss of Facility)				
	lower Level Baltimore MD.				
	2/201				
ATTENTION DIDECTORS OF APPROAL COUNTY					
ATTENTION DIRECTORS OF MEDICAL EDUCATION: THE PERSON WHO SIGNS TO MARRIAGE, OR ADOPTION.	HIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD,				
Only the Director of Medical Education may sign this form, it that signature delegation must be attached to this torm may be a photocopy.)	authority is being delegated to another person, evidence of that				
delegation must be attached to this form (may be a photocopy). Such delicat 12 months.	egalion must be an official letternead and must be dated within the				
hereby declare under penalty of position and	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	er the laws of the State of California that the				
nceso to offer the type and level of training	g completed by the applicant and that the				
applicant is being trained in an approved	ACGME or RCPSC program position.				
Allibon M. Andres					
(Type of print name of Director of Medical Education)					
(Signature of Director of Medical Education)					
2/x8/08	410.328,1151				
(Date)	(Telephone Number)				
	1				
	·				
	OFFICIAL HOSPITAL SEAL, OR				
	NOTARY SEAL (WITH DATE AND				
	NOTARY'S SIGNATURE) MUST BE				
	AFFIXED IN THE BOX AT THE LEFT.				
.	· I				

NOTE: Do not use this form in lieu of Form L3A, "Certificate of Completion of ACGME/RCPSC Postgraduate Training."



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



6/15/05

05 JUN 17 PM 3: 16

OFFICIAL BREAKDOWN OF UNDERGRADUATE CLINICAL CLERKSHIPS (The completion of this form is required only of international medical school graduates.

	Please complete this form in the Eng	glish language.)	•		
Name of Applicant (type or p		U.S. Social Security Number:			
THY BICH NGUYEN		Pate of Birth-MM/DD/YYYY;			
Only undergraduate clinical clerks PATIENTS IN A CLINICAL SETT criteria should NOT be	ships in which the applicant participated in DIRE FING should be reported on this form. Any clinic reported on this form as they will NOT satisfy	CT, HANDS-ON DIAGNOSIS OR TREATM cal clerkships completed that do not meet the California's clinical training requirements.	MENT OF he above		
(Please list ALL clinical traini reverse of this form. List trai	UNDERGRADUATE CLINICAL Cling completed prior to issuance of your ning in date/chronological order, comme		d on the aining.)		
CLINICAL SUBJECT AREA	FACILITY NAME AND ADDRES	DATES OF ATTENDANCE FROM - TO (Month/Day/Year)	WEEKS OR WEEKLY HOUR OF OREDIT		
Medicine	Highland Hospital 1471 5.318+ St. Oakland, CA 94402	9/8/03-11/28/03	.12		
Surgery	Jamaica Hospital 8900 Van Wyck Expury Jamaica, NY 11418	12/1/03-1/9/04	, [2		
Pediatrics	Jamaica Hospital	2/23/04-4/2/04	6		
Psychiatry	St. Anno Hospital, Poole 109 Haven Road Canford Cliffs Rock BH13:	4/5/04-5/14/04	6		
Ob-Gyn.	Poole General Hospital Longfleet Road Poole Dorset BH15 2JB	5/17/04-4/25/04	6		
Emergency Medicine	Jamaica Hospital	10/28/04 - 7/23/04	4		
	n. If that signature authority is being delegated to anoth gation must be on official interhecid and must be dated in any interpretable in the delegated and must be dated in a part of Enrollment Planning University Registrar FULL NAME of Dean or Real		iched to		
dec that resp	lare under penalty of perjury, that I am/was the have carefully read this form and that the sta	·	pove and ary		

OFFICIAL BREAKDOWN OF UNDERGRADUATE CLINICAL CLERKSHIPS

(Continued from the front of this form. If additional space is needed, you may photocopy this side of the form; however, original signatures and seals (below) will be required on all photocopies submitted.)

Name of Applicant (type or print FULL name):		U.S. Social Secu	ırlty Number:		
Thy Bich	Nguyen	Date of Birth-MN	Mbpww.		
	INDERGRADUATE CL	INICAL CLERKSH	IIPS		
CLINICAL SUBJECT AREA	FACILITY NAME A	ND ADDRESS	DATES OF ATTENDANCE FROM -TO (Month/Day/Year)	WEEKS OR WEEKLY HOURS OF CREDIT	
Family Practice	Brooklyn Ho	spital center	8/23/04-9/10/04 9/13/04-9/10/04	4	
Medicine / sus	Highland Gener	c A	9/20/04	4	
Medicine Radiology		s above	11/12/04	4	
Surgery Opthal nology	University of C	CA	11/26/04	2	
Mediane - 219	oakland C	eral Hospital	12/30/04	4	
Pediatrics-suo	inhildrens Has	F 20 1	1/28/05	4	
Medicine Tatections	es University.	medicine A	2/25/05	4	
Surgery / Urology	some as	above	2/28/05	. 4.	
Pediatrics/Oncology	Children's Hosp County Oran		4/4/05	4	
00		O .		1,	
ATTENTION DEANS OR REGISTRARS: THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE, OR ADOPTION.					
Oxly the Dean or Registrar may sign this form. If that eigneture 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 deted within the leaf 2 months. A. Lambert					
MEDICAL SCHOOL SEAL Dean of Enrollment Planning University Registrar					
FULL NAME of Deep or Registrary Please TYPE OR PRINT) declare under penalty of perfuty, that I am/was the Deep or Registrar for the student named above and that I have carefully read this form and that the statements preparently are strictly true in every respect.					
	Signature of Dean or Registrar	A KAMA AMMA	6/15/05 Date	1.5B	

Consumer Affairs

MEDICAL BOARD OF CALIFORNIA LICENSING PROGRAM

LICENSING PROGRAM
1426 Howe Avenue, Suite 54
Secramento, CA 95825-3236
(916) 263-2362 FAX (916) 263-2487

www.medbd.ca.gov



CERTIFICATE OF CLINICAL TRAINING

[The completion of this form is required only of informational medical school graduates, SUT may be omitted if all clinical training was done in the primary teaching hospital of the medical acheol and such hospital is located in the same country as the medical acheol and such hospital is located in the same country as the medical acheol and such hospital is located in the same country as the medical acheol and such hospital is located in the same country as the medical acheol and such hospital is located in the primary teaching form, Form LEARS.] Please complete title form in the English language.

Complete ONE certificate for EACH clerkship, s	gnad by the facility program director or instructor.
Only undergraduate clinical clerkships in which the applicant participated in DIRECT, H. be reported on this form. Any clinical clerkships completed that do not meat the above of training requirements.	ANDS-ON DIAGNOSIS OR TREATMENT OF PATIENTS IN A CLINICAL SETTING Phank
This is to certify that THY NGUYEN STUDENTS NAME	
STUCENT'S NAME	U.S. BOCIAL BEQURITY NO.;
WASE OF BIRTHAMMIODAYYYY a student of St. G	eorge's University School of Medicine,
Completed a clerkship offered by Alameda County Medica	ıl Center - Highland Campus
1411 East 31st Street, Cakland, Califo	MENER ADD GENERALITY
From D9 OB 2003 through 11 of Medicine DAY COre YEAR GENERALAREA	28 2003 in the clinical area
This facility A is affiliated with a U.S. or international school	This facility Excess have an ACGME-accredited residency program
☐ is NOT stillated with a U.S. or international achool	in the areas of: Medicine, Surgery, EM
Name of U.S. or international medical school, if affiliated;	does not have an ACGME-accredited residency program,
UCSF, UC Davis, St. George's University	
ATTENTION FACILITY PROGRAM DIRECTORS OR INSTRUCTORS: THE PERSON W MARRIAGE, OR ADOPTION,	HO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD,
Only the Facility Program Director or instructor may ston this form. If that signature authoritions (may be a photocopy). Such delegation must be on official latter(lead and must be de	y is being delegated to snother person, evidence of that delegation must be effected to this ted within the last 12 months.
i, Theodore G. Rose, M.D., F.A.C.P swear or af student named above during the clerkship indicated and that I have care are strictly true in every respect.	inn that I am/was the individual facility program director or instructor for the fully read and completed this form and that the statements made herein
Thoodona C. Poco	To M. Th. Till A. O. Th.
Theodore G. Rose,	Jr., M.J., F.A.U.P.
TYPE OR PRINT NAME OF FACILITY PROGRAM DIR 1411 East 31st Str G ADDRESS: NUMBER AND STREET TO Oakland	
ADDRESS: NUMBER AND STREET	
ត្នី Oakland	California 94602
O ORY	STATE
510/437-4268 TELEPHONE NUMBER	SIGNATURE OF FACILITY PROGRAM DIRECTOR OR INSTRUCTOR
MOTE IN ARCENOS OF AN OPPION TO THE PROPERTY OF THE PROPERTY O	
IN THE PRESENCE OF AN OFFICIAL HOSPITAL SEAL, THE FACILI' IN THE PRESENCE OF A NOTARY PUBLIC WHO AFFIXES HIS/HER	TY PROGRAM DIRECTOR OF INSTRUCTOR MUST SIGN THIS FORM
Signed and sworn to before me this day of	Month Year
	MO-151
į	,
NOTARY PUBLIC	The state of the s
ADDRESS	
S es	
My Commissio	ns Expires:



LICENSING PROGRAM
1426 Howe Avenue, Suite 64
Sacramento, CA 95826-3236
(918) 263-2382 FAX (918) 263-2487
www.medbd.ca.goy



Ø

CERTIFICATE OF CLINICAL TRAINING

[The completion of this form is required only of international medical school graduates, BUT may be omitted if all clinical training was done in the primary teaching hospital of the medical school and such hospital is located in the same country as the medical school AND the medical school completes and certifies the "Official Breakdown of Undergraduate Olinical Clerkships form, Form L&A/B.] Please complete this form in the English language.

Only undergraduate clinical clerkships in which the applicant participated in DIRECT, HANDS-ON DIAGNOSIS OR TREATMENT OF PATIENTS IN A CLINICAL se reported on this form. Any clinical clerkships completed that do not meet the above criteria should NOT be reported on this form as they will NOT satisfy Californ training requirements.	ETTING should his's clinical
This is to certify that	co, NY 11410
of DAY YEAR MONTH DAY YEAR IN THE Clinical area	
This facility	
ATTENTION FACILITY PROGRAM DIRECTORS OR INSTRUCTORS: THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLC Only the Facility Program Director or instructor may sign this form. If that signature authority is being delegated to another person, evidence of that delegation must be attack form (may be a photocopy). Such delegation must be on official letterhead and must be dated within the last 12 months. If the facility Program Director or instruction may sign this form. If that signature authority is being delegated to another person, evidence of that delegation must be attack form (may be a photocopy). Such delegation must be on official letterhead and must be dated within the last 12 months. If the facility Program Director or instruction are strictly true in every respect. If the person with the statement of the program Director or instruction are strictly true in every respect. If the person with the person with the statement of the person with the	tructor for the ade herein
NOTE: IN ABSENCE OF AN OFFICIAL HOSPITAL SEAL, THE FACILITY PROGRAM DIRECTOR OR INSTRUCTOR MUST SIGN T IN THE PRESENCE OF A NOTARY PUBLIC WHO AFFIXES HIS/HER OFFICIAL NOTARY SEAL. Signed and sworn to before me this dey of	HIS FORM
NOTARY PUBLIC ADDRESS My Commissions Expires:	16



LICENSING PROGRAM
1426 Howe Avenue, Suite 54
Sacramento, CA 95825-3236
(918) 263-2382 FAX (916) 263-2487
www.medbd.ca.gov



CERTIFICATE OF CLINICAL TRAINING

[The completion of this form is required <u>only.</u>of international medical school graduates, BUT may be omitted if all clinical training was done in the primary teaching hospital of the medical school and such hospital is located in the same country as the medical school AND the medical school completes and certifies the "Official Breakdown of Undergraduate Clinical Clarkships form, Form L5A/B.] Please complete this form in the English language.

Complete ONE certificate for EACH clerkship, signed by the facility program director or instructor,
Only undergraduate clinical clerkehips in which the applicant participated in DIRECT, HANDS-ON DIAGNOSIS OR TREATMENT OF PATIENTS IN A CLINICAL SETTING should be reported on this form, Any clinical clerkships completed that do not meet the above criteria should NOT be reported on this form as they will NOT satisfy California's clinical training requirements.
This is to certify that THY NavyEM
STUDENT'S NAME U.S. SOCIAL SEGURITYNO.;
DATE OF BIKIN-MINDDAYYY a student of St Crear als Wessity
Completed a clerkship offered by Jamaica Hospital 8900 Van Wyck 500.
Jamaica NY 11418 NAME AND ADDRESS OF FACILITY
From Feb. 23 2004 through Apr. 2, 2004 In the clinical area of Padartics YEAR MONTH DAY YEAR
This facility
Is NOT affiliated with a U.S. of International school in the areas of: Fed S - Flus Shing Hoster
Name of U.S. or international medical school. If effiliated:
St. (reage's (INIV: School S), Nedicine
ATTENTION FACILITY PROGRAM DIRECTORS OR INSTRUCTORS: THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD,
Only the Facility Program Director or instructor may sign this form. If that signature authority is being delagated 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.
I, <u>len Morie Kins (as Mori</u> swear or affirm that I am/was the Individual facility program director or instructor for the student named above during the clerkship indicated and that I have carefully read and completed this form and that the statements made herein are strictly true in every respect.
S TYPE OR PRINT NAME OF FACILITY PROGRAM DIRECTOR OR INSTRUCTOR
TYPE OR PRINT NAME OF FACILITY PROGRAM DIRECTOR OR INSTRUCTOR STATE ADDRESS MUMBER AND STREET STATE OUT OUT OUT OUT OUT OUT OUT O
ADDRESS NUMBER AND STREET
1 James 11418
TELEPHONE NUMBER TELEPHONE NUMBER SIGNATURE OF FACILITY PROGRAM DIRECTOR OF INSTRUCTOR
NOTE: IN ABSENCE OF AN OFFICIAL HOSPITAL SEAL, THE FACILITY PROGRAM DIRECTOR OR INSTRUCTOR MUST SIGN THIS FORM IN THE PRESENCE OF A NOTARY PUBLIC WHO AFFIXES HIS/HER OFFICIAL NOTARY SEAL.
Signed and sworn to before me this day of
Month Year
Z NOTARY PUBLIC
ADDRESS
My Commissions Expires:

LICENSING PROGRAM

1426 Howe Avenue, Suite 54 Sacramento, CA 95825-3236 (916) 263-2382 FAX (916) 263-2487 www.medbd.ca.gov



CERTIFICATE OF CLINICAL TRAINING

[The completion of this form is required only of international medical author) graduates, BUT may be omitted if all clinical training was done in the primary teaching hospital of the medical school and such hospital is located in the same country as the medical school AND the medical school completes and certifies the "Official Breakdown of Undergraduate Olinical Clerkships form, Form L5A/B.] Please complete this form in the English language.

Complete ONE certificate for EACH clerkship, sig	ined by the facility program director or instructor.
Only undergraduate clinical clerkships in which the applicant participated in DIRECT, HAI be reported on this form. Any clinical clerkships completed that do not meet the above or training requirements.	NOS-ON DIAGNOSIS OR TREATMENT OF PATIENTS IN A CLINICAL SETTING SECUL
This is to certify that THY B. Narry EN	
STUDENT'S NAME	U.S. SOCIAL SECURITY NO.:
d Student of St	Greatge's University
DATE OF SIRTH-MANIDONYYYY	MEDICAL SCHOOL
Completed a clerkship offered by Ann's Hospital	69 Haven Rd Pook, Dorset
ME 481-13 7LM.	AND ADDRESS OF FACILITY
From April 5, 2004 through May	14, 2004 In the clinical area
of_ MONTH PSYCHIATOUYEAR MONTH	DAY YEAR III THE CHINGS SIE
GLINICAL AREA	
This facility is affiliated with a U.S. of International school	This facility . 7 does have an ACGME-accredited residency program
is NOT affiliated with a U.S. or International school	in the areas of:
Namo of U.S. or International medical school, if affiliated:	Gloes not have an ACGME-accredited residency program.
ST GEORGES UNIVERSITY SCHOOL OF MEDICINE	
ATTENTION FACILITY PROGRAM DIRECTORS OR INSTRUCTORS: THE PERSON WHO MARRIAGE, OR ADOPTION.	SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD.
l I	I :
Only the Facility Program Director or Instructor may sign this form. If that signature authority in form (may be a photocopy). Such delegation must be on official letterhead and must be dated.	s being delegated to another person, evidence of that delegation must be attached to this within the last 12 months.
1) M AUMAN RN	
student named above during the clarkable indicated and that I have been or affin	m that I am/was the individual facility program director or instructor for the
are strictly true in every respect.	lly read and completed this form and that the statements made herein
ST ANNI HOUTTAL	,
ST ANNI HOSPITAL:	Dr N. CHOUDRY
TYPE OR PRINT NAME OF FACILITY PROGRAM DIRECT	TOR OR INSTRUCTOR
S ADDRESS: NUMBER AND STREET	VFORD CLIPPS POOLE
ADDRESS: NUMBER AND STREET	1. BuisaLN
S COTY 12-22 1/2-2-14	STATE ZIP CODE
TELEPHONE NUMBER	
	SIGNATURE OF FACILITY PROGRAM DIRECTOR OR INSTRUCTOR
NOTE: IN ABSENCE OF AN OFFICIAL HOSPITAL SEAL, THE FACILITY IN THE PRESENCE OF A NOTARY PUBLIC WHO AFFIXES HIS HER OF	PROGRAM DIRECTOR OR INSTRUCTOR MUST SIGN THIS FORM
THE	FICIAL NOTARY SEAL
Signed and sworn to before me this day of	MAY Month 2004 Your
**************************************	1001
	_
NOTARY PUBLIC	
NOTARY PUBLIC ADDRESS ADDRESS	
My Commissions	Expires;
· : :	The state of the s



LICENSING PROGRAM
1426 Howe Avenue, Suite 54
Sacramento, CA 95825-3236
(916) 253-2382 FAX (916) 263-2487
www.medbd.ca.gov



CERTIFICATE OF CLINICAL TRAINING [The completion of this form is required only of international medical school graduates, 80° may be omitted if all clinical training was done in the primary teaching hospital of the

redical school and such hospital is located in the same country as the medical school AND the medical school completes and certifies the "Official Brackdown of Undergraduate

Clinical Clerkships form, Form L5A/H.] Please complete this form in the English language. Complete ONE certificate for EACH clerkship, signed by the facility program director or instructor. Only undergraduate clinical derivation in which the applicant participated in DIRECT, HANDS-ON DIAGNOSIS OR TREATMENT OF PATIENTS IN A CLINICAL SETTING should be reported on this form. Any clinical cierkships completed that do not meet the above criteria should NOT be reported on this form as they will NOT satisfy California's clinical training requirements. NGUYEN This is to certify that School of Medicin through in the clinical area In alfillated with a U.S. or International school This facility This facility I does have an ACGME-accredited residency program \square is NOT affillated with a U.S. or international school Gos not have an ACGME-accredited residency program, St. Greoral's University School ATTENTION FACILITY PROGRAM DIRECTORS OR INSTRUCTORS: THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE, OR ADOPTION. Only the Facility Program Director or instructor may sign this form. If that signature authority is being selegated to another person, avidence 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. Henry swear or affirm that I am/was the individual facility program director or instructor for the student named above during the cuerkship indicated and that I have carefully read and completed this form and that the statements made harein are strictly true in every respect. LONGFLET ROA NOTE: IN ABSENCE OF AN OFFICIAL HOSPITAL SEAL, THE FACILITY PROGRAM DIRECTOR OR INSTRUCTOR MUST SIGN THIS FORM IN THE PRESENCE OF A NOTARY PUBLIC WHO AFFIXES HIS/HER OFFICIAL NOTARY SEAL, Signed and sworn to before me this NOTARY PUBLIC ADDRESS My Commissions Expires:_



LICENSING PROGRAM
1426 Howe Avenue, Suite 54
Sacramento, CA 95825-3236
(916) 263-2382 FAX (916) 263-2487
www.medbd ca.goy



CERTIFICATE OF CLINICAL TRAINING

[The completion of this form is required only of international medical school graduates, BUT may be emitted if all clinical training was done in the primary teaching hospital of the medical school and such hospital is located in the same country as the medical school AND the medical school completes and certifies the "Official Breakdown of Undergraduate Clinical Clurkships form, Form LSA/8.] Please complete this form in the English language.

Complete ONE certificate for EACH clerkship, sig	ned by the facility program director or instructor.
Only undergraduate clinical clerkships in which the applicant participated in DIRECT, HAI be reported on this form. Any clinical clerkships completed that do not meet the above criterining requirements.	APPAR AND MILE AND
Completed a clerkship offered by Januar August Hospital San Van Wyck Express way Name From June 28 2004 through Month of Emergency Madicine OLINICAL AREA This facility X is affiliated with a U.S. or International school	U.S. SOCIAL SECURITY NO.: GEORGE'S SCHOOL MEDICAL SCHOOL AND ADDRESS OF FACILITY Y 1418 DAY VEAR This facility Close have an ACGME-accredited residency program In the areas of:
Is NOT affillated with a U.S. or International school	In the areas of: 0/3
Name of U.S. or International medical school, if effiliated:	does not have an ACGME-accredited residency program.
St. (Florges University School of Medic	ine in the second of the secon
ATTENTION FACILITY PROGRAM DIRECTORS OR INSTRUCTORS: THE PERSON WHO MARRIAGE, OR ADOPTION. Only the Facility Program Director or instructor may sign this form. If that signature authority is form (may be a photogopy). Such delegation must be on official letterhead and must be dated.	being delegated to another person, evidence of that delegation must be attached to this within the last 12 months. In that I arm/was the individual facility program director or instructor for the fly read and completed this form and that the statements made herein OR OR INSTRUCTOR CLE CLESS CLAY SIGNATURE OF FACILITY PROGRAM DIRECTOR OR INSTRUCTOR
Signed and sworn to before me this day of	MonthYear
NOTARY PUBLIC	The second secon
ADDRESS	Thy may refer to the second of
9	7.794
My Commissions E	Expires:

Consumer Affairs



LICENSING PROGRAM
1426 Howe Avenue, Suite 64
Sacramento, CA 95825-3236
(916) 263-2382 FAX (916) 263-2487
www.medbd.cs.gov



CERTIFICATE OF CLINICAL TRAINING

[The completion of this form is required only of internations] medical school graduates, BUT may be omitted if all clinical training was done in the primary teaching hospital of the medical school and such hospital is located in the same country as the medical school AND the medical school completes and sertifies the "Official Breakdown of Undergraduate Clinical Clarkships form, Form L6A/B.] Please complete this form in the English language.

Complete ONE certificate for EACH clerkship, signed by the facility program director or instructor,
Only undergraduate clinical clerkships in which the applicant participated in DIRECT, HANDS ON DIAGNOSIS OR TREATMENT OF PATIENTS IN A CLINICAL SETTING should be reported on this form. Any clinical clerkships completed that do not meet the above criteria should NOT be reported on this form as they will NOT salisfy California's clinical training requirements.
This is to certify that TO NOUTEN STUDINGS NAME OF ST. GOVOES IN VEVS HY Completed a glerkship offered by TWO BYOO KIUN HOSOITE CENTER.
From S - 4 through - 1204 in the clinical area of CUNCAL AREA
This facility Exts affiliated with a U.S. or international school This facility Exts affiliated with a U.S. or international school In the areas of: Introduct In the areas of: In the areas of
ATTENTION PACILITY PROGRAM DIRECTORS OR INSTRUCTORS: THE PERSON WHO SIGHS THIS FORM MAY NOT BE. RELATED TO THE APPLICANT BY BLOOD, MARRIAGE, OR ADOPTION. Only the Facility Program Director or Instructor 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.
I. LOCOTTA A TEXTERNOVA M.O. swear or affirm that I am/was the Individual facility program director or instructor for the student named above during the clerkship indicated and that I have carefully read and completed this form and that the statements made herein are strictly true in every respect.
LOROTTA A TERRANOVA MAD TYPE OR PRINT NAME OF FACILITY PROGRAM DIRECTOR OR INSTRUCTOR THE BROWN HAYN HOS P CHR. ADDRESS: NUMBER AND STREET BROWN N THE PHONE NUMBER TELEPHONE NUMBER
NOTE: IN ABSENCE OF AN OFFICIAL HOSPITAL SEAL, THE FACILITY PROGRAM DIRECTOR OR INSTRUCTOR MUST SIGN THIS FORM IN THE PRESENCE OF A NOTARY PUBLIC WHO AFFIXES HIS/HER OFFICIAL NOTARY SEAL.
Signed and sworn to before me this day of
NOTARY PUBLIC ADDRESS My Commissions Expires:

LICENSING PROGRAM 1426 Howe Avenue, Suite 54 Sacramento, CA 96825-3238 (916) 263-2382 FAX (916) 263-2487 www.medbd.ca.gov



CERTIFICATE OF CLINICAL TRAINING

[The completion of this form is required gally of international medical school graduates, BUT may be omitted if all clinical fraining was done in the primary teaching hospital of the medical school and such hospital is located in the same country as the medical school AND the medical school completes and cartifies the "Official Breakdown of Undergraduate Olinical Clerkships form, Form L6A/B.] Please complete this form in the English language.

X	Complete Our north, roth Local Please complete this form in the English language.
	Complete ONE certificate for EACH clerkship, signed by the facility program director or instructor. Only undergraduate clinical clerkships in which the applicant participated in DIRECT, HANDS-ON DIAGNOSIS OR TREATMENT OF PATIENTS IN A CLINICAL SETTING should training requirements.
	This is to certify that TAN NGUYEN
T.	GTUDENT'S NAME
ı	U.E. SOCIAL SECURITY NO.:
	DATE OF BRITH-MANDEN AND A Student of St. George's University School of Medicine Med
Ç	The state of the s
***	- Date Bereet, Oaktand, Call Tother and September 1
F	rom Sep. 22, 2004 through Dort 10 20011
0	OLINICAL AREA OLINICAL AREA OLINICAL AREA OLINICAL AREA
7.	his facility
L	☐ is NCT affiliated with a U.S. or International school in the areas or Medit of the Course of the second of the areas or Medit of the areas of th
, N	does not have an ACGME, contailing the state of rectal and the second state of rectal and the
Ľ	CSF, UC Davis, St. George's University
	ATTENTION FACULTY DOGGO.
	ATTENTION FACILITY PROGRAM DIRECTORS OR INSTRUCTORS: THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE, OR ADOPTION.
ŀ	Only the Facility Program Director or Instructor may sign this form. If this signature outback to be a second or instructor may sign this form.
L	Only the Facility Program Director or Instructor may sign this form. If that signature authority is being delegated to another person, evidence of that delegation must be attached to this The Od own C. The
sla are	Theodore G. Rose, M.D., F.A.C.Pewear or affirm that I am/was the individual facility program director or instructor for the e strictly true in every respect.
10"	
	Theodore G. Rose, Jr., M.D., F.A.C.P.
l¦	TYPE OR PRINT NAME OF FACILITY PROGRAM DIRECTOR OR INSTRUCTOR 1411 East 31st Street ADDRESS: NUMBER AND STREET Oakland Colifornia Colifornia Colifornia
	图 1411 East 31st Street
i	ADDRESS: NUMBER AND STREET
	Oakland California 94602
L_	510/437-4268 STATE 94602 STATE 2/F CODE
	TELEPHONE NUMBER SIGNATURE OF PACILITY PROGRAM DIRECTOR OR INSTRUCTOR
NC	DTE: N ABSENCE OF AN OFFICIAL LOCALITY
lN	THE PRESENCE OF A NOTARY PUBLIC WHO AFFIXES HIS/HER OFFICIAL NOTARY SEAL.
Sig	aned and sworn to before me this day of
,	Month Year
i I	
ĺ	NOTARY PUBLIC
]]	
!	NOTARY PUBLIC ADDRESS
) • • • •	My Commissions Expires:
	.6



LICENSING PROGRAM 1426 Howe Avenue, Suite 64 Sacramento, CA 95825-3236 (916) 263-2382 FAX (916) 263-2487 www.medbd.ca.gov



CERTIFICATE OF CLINICAL TRAINING

[The completion of this form is required only of international medical school graduates, BUT may be omitted if all aliminal training was done in the primary teaching hespital of the medical school and such hospital is located in the same country as the medical school AND the medical school completes and certifies the "Official Breakdown of Undergraduate Clinical Clerkships form, Form LSA/B.] Please complete this form in the English language.

Complete QNE certificate for EACH clerkship, si	gned by the facility program director or instructor.
Only undergraduate clinical clerkships in which the applicant participated in DIRECT, His be reported on this form. Any clinical clerkships completed that do not meet the above of training requirements.	STISS BY THE TROITTY PROGRAM director or instructor. ANDS-ON DIAGNOSIS OR TREATMENT OF PATIENTS IN A CLINICAL SETTING should riteria should NOT be reported on this form as they will NOT satisfy California's clinical
This is to certify that Thy Nguyen	u.e. soom. becurity no.:
DATE OF DIRTHAMNODATTY a student of St. Ge	eorge's University School of Medicine
Completed a clerkship offered by Alameda County Medica	Madical school of Medicine
- Jac Screet, Cakland, Californ	5-40 ADD SESSON COLUTY
of RADIOLOGY VEAR HOUGH MONTH	12 2004 in the clinical area
This facility Is affiliated with a U.S. or international school	This facility (3) does have an ACGME-procedure reality
☐ is NOT affiliated with a U.S. or International actual	in the areas of: Medicine Surgery EM
Name of U.S. or International machinel sphool, if affiliated; UCSF, UC Davis, St. Communications	☐ does not have an AGGME-accredited residency program.
UCSF, UC Davis, St. George's University	
ATTENTION PACILITY PROGRAM DIRECTORS OR INSTRUCTORS: THE PERSON WHO MARRIAGE, OR ADOPTION.	D SIGNS THIS FORM MAY NOT BE HELATED TO THE ARRIVED TO
Only the Facility Program Director or instructor may sign this form. If thet signature authorities	Shahadda a da a sa a sa a sa a sa a sa a
Only the Facility Program Director or instructor may sign this form. If that signature authority is form (may be a photocopy). Such delegation must be an official letterhead and must be delegation.	s being delegated to another person, evidence of that delegation must be attached to this within the last 12 months.
student named above during the clerkship indicated and that I have careful are strictly true in every respect.	illy read and completed this form and that the statements made herein
· · · · · · · · · · · · · · · · · · ·	
Theodore G. Rose, Jr	TORON M.D., F.A.C.P.
TYPE OR PRINT NAME OF FACILITY PROGRAM DIRECT 1411 East 31st Stree ADDRESS: NUMBER AND STREET Oakland	et
ADDRESS; NUMBER AND STREET	
Oakland Ony	California 94602
510/437-4268	STATE ZEP CODE
	SIGNATURE OF FACILITY PROGRAM DIRECTOR OR INSTRUCTOR
NOTE: IN ABSENCE OF AN OFFICIAL HOSPITAL SEAL, THE FACILITY IN THE PRESENCE OF A NOTARY PUBLIC WHO AFFIXES HIS/HER OF	PROGRAM DIRECTOR OR INSTRUCTOR MUST SIGN THIS FORM
Signed and sworn to before me this day of	FICIAL NOTARY SEAL,
- N N	Month Year
NOTARY PUBLIC ADDRESS	- Address
ADDRESS ADDRESS	
My Commissions E	Expires:
	6



MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM
1426 Howe Avenue, Suite 64
Sacramento, CA 98825-3236
(916) 263-2382 FAX (918) 263-2487
www.coldocinis.ga.gov



CERTIFICATE OF CLINICAL TRAINING

The completion of this form in required goly of international market) seriori graduates, BUT was be united if all clinical validity was done in the primary teaching hospital of the medical seriori completes and certains the 'Official Broakdown of Undergraduate

Complete ONE certificate for SACH clerkohio about it is form in the Briglish language.
Complete ONE certificate for EACH clerkship, aloned by the facility program director or instructor. Only undergraduate plinked blackships in which the applicant periodopted in DIRECT, HANDS ON CHACKNOSKS OR TREATMENT OF PATIENTS IN A CLINICAL SETTING and the reported on this form. Any clinical clerkships completed that do not meet the above citizals should NOT be reported on this form as they will NOT satisfy California's
This is to certify that Thy B. Nguyen
STLOGNTS NAME
carries surremented a student of St. Georga's University School of Medicine
Completed a clerishly offered by University of California, Irvine College of Medicine
118 Mad Survey T Pitte Cip
118 Med Surge I Bidg. 810. Irvine, CA 92697-4375
From 11/15/2004 through 11/26/2004 in the clinical area
of Ophthalmology
DLINGALAREA
This facility I does have an ACGME-according methods.
is NOT affiliated with a U.S. or (nearnational action)
VAIDS OF LIST OF INTERPROPERTY AND ADDRESS OF ACCOUNT AND ADDRESS OF
University of California, Irvine
ATTENTION SACE DY SUAGRAM CONTAINS
ATTENTION FACILITY PROBRAM DIRECTORS OR INSTRUCTORS: THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD,
Only the Facility Program Director or instructor may eign trile form, if that signature authority is being getsigned to are the person, evidence of that delegation must be on obtain letternessed and must be delegated within the last 18 months. If in die C. be a research of the control of t
swear or diffirm that I am/was the individual facility program director or instructor for the trade in every respect. swear or diffirm that I am/was the individual facility program director or instructor for the estrictly true in every respect.
Linds S.M. Lipps, MD THE OR PRINT NAME OF FACILITY PROGRAM DIRECTOR OR PRSYRACTOR 118 Med Surge T. Bldg. 810 Trvine CA 92697-4375
1 St.
ADDRESS HOMER AND STREET Bldg. 810
Trvine
CA 92697-4375 (949) 824-3004
WAS TOWN AND THE PARTY OF THE P
THE PRESENCE OF AN OFFICIAL HOSPITAL SEAL, THE PACILITY PROGRAM DIRECTOR OR INSTRUCTOR THE PRESENCE OF A NOTARY PUBLIC WHO AFFIXES HIS/HER OFFICIAL NOTARY SEAL.
aned end sworn to before me thisday of
tay of
Z WOTARY PUBLIC
De la contract cabrilla
NOTARY PUBLIC ADDRESS
My Commission Expires:
Б в в в в в в в в в в в в в в в в в в в



LICENSING PROGRAM
1426 Howe Avenue, Suite 54
Sacramento, CA 95525-3236
(916) 263-2382 FAX (916) 263-2487
www.medbd.ca.gov



CERTIFICATE OF CLINICAL TRAINING

[The completion of this form is required only of international medical school graduates, BUT may be emitted if all clinical training was done in the primary teaching hospital of the medical school and such hospital is located in the same country as the medical school AND the medical school completes and certifies the "Official Breakdown of Undergraduate Clinical Cierkships form, Form LEA/B.) Please complete this form in the English language.

Complete ONE certificate for EACH clerkship, signed by the facility program director or instructor.
Only undergraduate clinical clerkships in which the applicant participated in DIRECT, HANDS-ON DIAGNOSIS OR TREATMENT OF PATIENTS IN A CLINICAL SETTING should be reported on this form. Any clinical derkships completed that do not meet the above criteria should NOT be reported on this form as they will NOT satisfy California's clinical training requirements.
This is to certify that Thy B. Nauven
DATE OF BETTH MANDDAYYYY a student of St, George's University School of Medicine
Completed a clerkship offered by Alameda County Medical Center - Highland Campus
1411 East 31st Street, Oakland, California 74602 1400
From 12 05 2004 through 12 30 2004 in the clinical area of Medicine Subinternship MONTH DAY YEAR
This facility
in the areas of: Medicine, Surgery, EM
Name of U.S. or International medical achool. If affiliated: UCSF, UC Davis, St. George's University
deorge's university
ATTENTION FACILITY PROGRAM DIRECTORS OR INSTRUCTORS: THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD, Only the Facility Program Director or instructor may sign this form. If that signature authority is being delegated to another porson, evidence of that delegation must be attached to this form (may be a photocopy). Such delegation must be on official latterhead and must be dated within the last 12 months.
I. Theodore G. Rose, M.D., F.A.C.P swear or affirm that I am/was the individual facility program director or instructor for the student named above during the clerkship indicated and that I have carefully read and completed this form and that the statements made herein
Theodore G. Rose, Jr., M.D., F.A.C.P. TYPE OF PRINT NAME OF FACILITY PROGRAM DIRECTOR OR INSTRUCTOR
TYPE OF PRINT NAME OF FACILITY PROGRAM DIRECTOR OR INSTRUCTOR 1411 East 31st Street ADDRESS: NUMBER AND STREET Oakland California 94602
T 1471 past Sist Street
S ADDRESS: NUMBER AND STREET California 94602
© OITY STATE /
510/437-4268
TELEPHONE NUMBER SIGNATURE OF FACILITY PROGRAM DIRECTOR OR INSTRUCTOR
NOTE: IN ABSENCE OF AN OFFICIAL HOSPITAL SEAL, THE FACILITY PROGRAM DIRECTOR OR INSTRUCTOR MUST SIGN THIS FORM IN THE PRESENCE OF A NOTARY PUBLIC WHO AFFIXES HIS/HER OFFICIAL NOTARY SEAL,
Signed and sworn to before me this day of MonthYear
F
≥ NÖTARY PÜBLIC
otan
ADDRESS
My Commissions Expires:



LICENSING PROGRAM 1426 Howe Avenue, Suite 54 Sacramento, CA 95825-3236 (916) 263-2382 FAX (916) 263-2487 www.medbd.ca.gov



CERTIFICATE OF CLINICAL TRAINING

[The completion of this form is required only of international medical school graduates, BUT may be omitted if all clinical training was done in the primary teaching hospital of the medical achool and such hospital is located in the same country as the medical school AND the medical school completes and certifies the "Official Breakdown of Undergraduate Chnical Clerkships form, Form LSA/B.] Please complete this form in the English language. Complete ONE certificate for EACH clerkship, signed by the facility program director or instructor. Only undergraduals clinical clerkships in which the applicant perticipated in DIRECT, HANDS-ON DIAGNOSIS OR TREATMENT OF PATIENTS IN A CLINICAL SETTING should be reported on this form. Any clinical derikships completed that do not meet the above criteria should NOT be reported on this form as they will NOT satisfy California's clinical The Nauven This is to certify that

This is to certify that IT IS TACKED	
THIDE IT'S NAME	
	U.S. SODIAL SECURITY NO.:
DATE OF BIRTH-MANUDDAYYYY a student of	t. George's University
Completed a clerkship offered by Children's Hospital	median school
	all of Orange County
455 S. Main Street	MINAND ANDRESS OF FACILITY OF COLOR
From 1/3/05	91 MINE, CA - 42808
Massell	128/95
of reduatric Sub-Internship MONTH	DAY YEAR In the clinical area
OCHNICAL AREA	
This facility Is affiliated with a U.S. or international school	
The North Assistance of the Marienal School	This facility does have an ACGME-accredited models
ls NOT affiliated with a U.S. or international school	This facility does have an ACGME accredited residency program in the areas of:
Name of U.S. or International medical school, if affiliated:	does not have an ACOME
	. does not have ah ACGME-accredited residency program.
LST. George's University	
ATTENTION FACILITY PROGRAM DIRECTORS OR INSTRUCTORS: THE PERSON WIND MARRIAGE, OR ADOPTION. Only the Facility Program Directors.	
WELLIAMOR! OF ADDITION,	IO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD
Only the Facility Program Director or Institution come along the Automatic	, and a bridge,
Only like Facility Program Director or Instrictor may sign this form. If that signature authority form (may be a photocopy). Such designation must be on official letterfield and must be date.	is being delegated to another person, evidence of the table and
delegation of the state of the	id within the last 12 months.

ppy). Such detegation must be on official letterflead and must be dated within the last 12 months. <u>Den lamin</u>

Silverman, MD swear or animit max i arrives the moving the clerkship indicated and that I have carefully read and completed this form and that the statements made herein are strictly true in every respect. swear or affirm that I am/was the individual facility program director or instructor for the

BENEMIN SILVERMAN, MD
YPE OR PRINT NAME OF FACILITY PROGRAM DIRECTOR OR INSTRUCTOR S. Main Street ZIP CODE

NOTE: IN ABSENCE OF AN OFFICIAL HOSPITAL SEAL, THE FACILITY PROGRAM DIRECTOR OR INSTRUCTOR MUST SIGN THIS FORM IN THE PRESENCE OF A NOTARY PUBLIC WHO AFFIXES HIS/HER OFFICIAL NOTARY SEAL.

Signed and sworn to before me this

day of

JANETTE RODRIGUEZ Commission # 1396462 Notary Public - California Los Angeles County My Comm. Explies Jan 27, 2007

My Commissions Expires:

L6



LICENSING PROGRAM 1425 Howe Avenue, Suite 54 Sacramento, CA 95825-3236 (916) 263-2382 FAX (916) 263-2487 www.caidocinfo.ca.gov



CERTIFICATE OF CLINICAL TRAINING

[The completion of this form is required only of international medical school graduates, BUT may be omitted if all clinical training was done in the primary teaching hospital of the ris digal school and such hospital is located in the same country as the medical school AND the medical school completes and certifies the "Official Breakdown of Undergraduate Cilnical Clerkships form, Form LEA/B.] Please complete this form in the English language.

Complete ONE certificate for EACH clerkship, signed by the facility program director or instructor.
Only undergraduate clinical clerkships in which the applicant participated in DIRECT, HANDS-ON DIAGNOSIS OR TREATMENT OF PATIENTS IN A CLINICAL SETTING should be reported on this form. Any clinical clerkships completed that do not meet the above criteria should NOT be reported on this form as they will NOT satisfy California's
This is to certify that THY Navyew
8YUDENT'S NAME
DATE OF SHITHMANDOTTYYY a student of St. Georges University MEDICAL SCHOOL MEDICAL SCHOOL
Campleted a clerkship offered by University of California Trine College of Medicine
17 January Drives. Bldg 53 Rm 215 Orange CA 92697
Fruin Jan 31 2005 In the clinical area
of Infectious Diseases
This facility is similated with a U.S. or international school. This facility (3)
Is NOT affiliated with a U.S. or international school This facility does have an ACGME-accredited residency program in the areas of:
Nenre of U.S. or International medical school, if attiliated:
University of California, Trying
ATTENTION FACILITY PROGRAM DIRECTORS OR INSTRUCTORS: THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD,
() hity the Facility Program Director or Instructor may sign this form. If that signature authority is being delegated to another person, evidence of that delegation must be attached to this
swear or affirm that I amiwas the individual facility program director or instructor for the all strictly true in every respect.
TYPE OR PRINT NAME OF FACILITY PROGRAM DIRECTOR OR INSTRUCTOR
T T T T T T T T T T T T T T T T T T T
TYPE OR PRINT NAME OF FACILITY PROGRAM DIRECTOR OR INSTRUCTOR LOI THE CITY Drive S. Bldg. 53 ADDREGS: NUMBER AND STREET
6 CA 92697
714-456-7612 STATE AND XIP CODE
NOTE: IN ABSENCE OF AN OFFICIAL HOSPITAL SEAL, THE FACILITY PROGRAM DIRECTOR OR INSTRUCTOR OF INSTRUCTOR MUST SIGN THIS FORM SIGNATURE OF FACILITY PROGRAM DIRECTOR OR INSTRUCTOR MUST SIGN THIS FORM SIGNATURE OF FACILITY PROGRAM DIRECTOR OR INSTRUCTOR MUST SIGN THIS FORM SIGNATURE OF FACILITY PROGRAM DIRECTOR OR INSTRUCTOR MUST SIGN THIS FORM
Signed and sworn to before me this day of
Month Year
NOTARY PUBLIC
ADDRESS
My Commission Expires:



LICENSING PROGRAM 1426 Howe Avenue, Suite 54 Sacramento, CA 95825-3236 (916) 263-2382 FAX (916) 263-2487 www.csldocinfo.ca.gov



CERTIFICATE OF CLINICAL TRAINING

[The completion of this form is required only of international medical school graduates, BUT may be omitted if all clinical training was done in the primary teaching hospital of the medical school and such hospital is located in the same country as the medical school AND the medical school completes and certifies the "Official Breakdown of Undergraduate Clinical Clarkehips form, Form L5A/B.] Please complete this form in the English language.

Complete ONE certificate for EACH clerkship, algred by the facility program director or instructor.
should be reported on this form. Any clinical clerkships completed that do not meet the above criteria should NOT be reported on this form as they will NOT satisfy California's
This is to certify that THY B. NOUVEN STUDENT'S NAME U.S. SOCIAL SECURITY NO.:
Completed a clerkship offered by Univ. on California, Traine Bldg. 26 Blink 204
Completed a clerkship offered by Muiv. on California Trvine Bldg. 26 Blik 204
For Feb 28
From Feb. 28 2005 through March 25 2005 in the clinical area of Urology
This faults.
This facility Is affiliated with a U.S. or international school In the areas of: Legislated with a U.S. or international school We not affiliated with a U.S. or international school
realize of o.c.s. or international medical school, if efficiency program
Unit of CA, Irvine School of Medicine
ATTENTION FACILITY PROGRAM DISCOVERS OF THE STATE OF THE
ATTENTION FACILITY PROGRAM DIRECTORS OR INSTRUCTORS: THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD,
Only the Facility Program Director or Instructor may sign this form. If that signature authority is being delogated to another person, evidence of that delegation must be attached to this
student natified above during the elerkship indicated and that I have carefully read and completed this form and that the statements made herein
are strictly true in every respect.
\mathcal{P}_{2}
C ON PRINT, AGME OF FACILITY PROGRAM DIRECTOR INSTRUCTOR
TYPE OR PRINCHAME OF FACILITY PROGRAM DIAGROTOFOR INSTRUCTOR TO THE CITY Drive Bldg. 26 Suite 204 Orange CA 928000 C
Orange CA 92868 ZIP CODE ZIP CODE
774-456- 6719 (STATE ZIP CODE
INUTE: IN ARSENCE OF AN AFECOAL AND AFEOAL AND AFECOAL AND AFEOAL AND
IN THE PRESENCE OF AN OFFICIAL HOSPITAL SEAL, THE FACILITY PROGRAM DIRECTOR OR INSTRUCTOR MUST SIGN THIS FORM Signed and sworn to before me thisday of
2 MATABURING
NOTARY PUBLIC
ADDRESS
My Commission Expires:



LICENSING PROGRAM 1426 Howe Avenue, Suite 54 Sacramento, CA 95825-3236 (916) 263-2382 FAX (916) 263-2487 www.medbd.ce.gov



CERTIFICATE OF CLINICAL TRAINING

[The completion of this form is required only of international medical school graduates, BUT may be omitted if all clinical training was done in the primary teaching hospital of the medical school and such hospital is toosted in the same country as the medical school AND the medical school completes and certifies the "Official Breakdown of Undergraduate Clinical Clerkships form, Form L5A/8.] Please complete this form in the English language.

Complete ONE certificate for EACH clerkship, signed by the facility program director or instructor.
Only undergraduate clinical clerkships in which the applicant participated in DIRECT, HANDS-ON DIAGNOSIS OR TREATMENT OF PATIENTS IN A CLINICAL SETTING should be reported on this form. Any clinical clerkships completed that do not meet the above criteria should NOT be reported on this form as they will NOT satisfy California's clinical training requirements.
This is to certify that Thy B. Naugen STUDENT'S NAME U.S. SOCIAL SECURITY NO.:
Completed a clerkship offered by Children's Hospital of Orange County 455 S. Main Sharefald Appress of Frigurity
From 4/04/05 Main STREET, Orange, CA 92868 of MONTH DAY YEAR In the clinical area OLINICAL AREA OS LA
This facility It is affiliated with a U.S. or International school Is NOT affiliated with a U.S. or International school Name of U.S. or International medical school. It affiliated: This facility Iddoes have an ACGME-accredited residency program in the areas of: XXIVITYCES Obes not have an ACGME-accredited residency program.
ST GEORGES UNIVERSITY ATTENTION FACILITY PROGRAM DIRECTORS OR INSTRUCTORS: THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD,
Only the Facility Program Director or instructor may sign this form. If that signature authority is being delegated to enother person, evidence of that delegation must be attached to this DOPNOS. NAME AND ADDRESS OF THE PROPERTY OF THE PR
student named above during the clerkship haddated and that I have carefully read and completed this form and that the statements made herein
Daphne Wong, MD TYPE DRIPHINT NAME OF FACILITY PROGRAM DIRECTOR OR INSTRUCTOR 455 S. Main Street Address: Number and street Ovalore Ov
ADDRESS: NUMBER AND STREET Orange CA 92868
NOTE: IN ABSENCE OF AN OFFICIAL HOSPITAL SEAL, THE FACILITY PROGRAM DIRECTOR OR INSTRUCTOR MUST SIGN THIS FORM IN THE PRESENCE OF A NOTARY PUBLIC WHO AFFIXES HIS/HER OFFICIAL NOTARY SEAL
IN THE PRESENCE OF A NOTARY PUBLIC WHO AFFIXES HIS/HER OFFICIAL NOTARY SEAL. Signed and sworn to before me this day of Month 2005 Year.
JANETTE RODRIGUEZ Commission # 1396462 Notary Public - California Los Angeles County My Comm. Expless Jan 27, 2007 8 ADDRESS A
My Comm. Expires Jan 27, 2007 My Commissions Expires: /27/07

STATE DEPARTMENT OF CONSUMER AFFAIRS INTERNET CASHIERING SYSTEM MEDICAL BOARD OF CALIFORNIA SUPPLEMENTAL INFORMATION REPORT From Date: 07/17/2013 To Date: 07/17/2013

ATRISUPPINF

21-JUN-16 08:18:50

Person Id :	Name :	Nguyen,Thy	
Question		Answer	
	Expiration I art Of The R		YES
		Pain Management And End-Of-Life Care	NO
	Physicians \ east 20% O	Radiologist Or Pathologist. Who Have 25% Of Their Patient Population Aged 65 of The Required Ome in Gerlatric Medicine Or The	NO
		r Immediate Family Hold Financial Interest. Type	NONE
I Certify Under Penalty Of Perjury Under Contained In This Application is True A	r The Laws o	Of The State Of California That The Information	YES
I Have Read My Profile On The Medica	Board Web	Site At Www.Mbc.Ca.Gov And Acknowledge The	YES
	Have You I Have You B	Had Any License Disciplined By A Government Been Convicted Of Any Crime In Any State, The U.S	NO

Total Questions Asked For Person:

LICENSEE NAME		's Initial Renewal	EXPIR	ATION ATE	AMOUN DUE NO		AMOUNT STMARKI OCTOBER	ED AFT
NGUYEN, THY B	Ā	A104638	09/	30/15	\$820.0	0	\$898	.00
LICENSEE MUST CHECK CORRECT H" Completed Continuing Education E" Change of Address (fill in reverse side Conviction Disclosure – Yes		statements, a	er penalty of penswers, and repreto, are true, con	esentations o	e laws of the S n this form, in	state of Ca	lifornia th	at all
"J" Conviction Disclosure – No		Signature (Lows			Date	6/16/	22/5
F' Family Physician Training Program (\$	25)	Lucianian and and		N W ALTERNATION AS ASSESSED.	AN AN ALL THE REAL PROPERTY AND THE PROPER		As 20, 49 At 30 UA 20	. No. 100 Mar No. 100
"G" Financial Interest Statement-Read ins	tructions above	E	NTER YOUR	HONE NUI	VIBER FOR F ——	CEFERES	NOE:	
CHANGE OF MAILING ADDR	RĘSS	ĭ	NGUYEN, TI	HY B	ı		A	10463
			NGUYEN, TI		ı		Ā	A10463
seseoie 20001931 200100	₩ %			нү в		then beco		
seseoie sooologi sooloo	₩ %			нү в		then beco		
66256612 20001631 560168	₩ %			нү в		then beco		
Street Address (this address is public information of the control	₩ %			нү в		then beco		
Street Address (this address is public information of the control	₩ %			dress of recor	d; this address	then beco		
Street Address (this address is public information)	ation except whe	n a PO Box is used f		dress of recor	d; this address	then beco		
CHANGE OF MAILING ADDRESS CHANGE OF MAILING	ation except whe	n a PO Box is used f		dress of recor	d; this address	then beco		