STATE OF CALIFORNIA – STATE AND CONSUMER SERVICES AGENCY — ARNOLD SCHWARZENEGGER, *Governor*

Consumer Affairs

# MEDICAL BOARD OF CALIFORNIA

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

RECEIVED MEDICAL BOARD OF CALIFORNIA 07 OCT 11 AM 9:24

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

**Application for** (please check one): ☑ License ☐ PTAL - or - ☐ Update

| 1. NAME: Last | First | Middle | MBC Use Only |
|---|---|---|---|
| NGUYEN | THY | BICH | |

| Other names you have used (include maiden name): | 2. U.S. Social Security Number |
|---|---|
| | |
| **3. Place of Birth** | **4. Date of Birth** |
| | |

**5. Gender:** ☐ Male ☑ Female

**6. Public/Mailing Address:** 29 S. PACA ST BALTIMORE, MD 21201
(Please note: this information is public)
(30 characters maximum per line, including spaces)

| City | State/Province | Zip/Postal Code | Country |
|---|---|---|---|
| BALTIMORE | MD | 21201 | USA |

| 7. Telephone Numbers: (Include area code) | Home | Work | Cell |
|---|---|---|---|
| | | | |

**8. California Driver's License Number (optional):**

**9. E-mail Address (optional):** [redacted]

**10. Have you ever filed an Application for Physician's and Surgeon's License, or PTAL, in California?**
☐ Yes ☑ No
Previous license number, if any: _____

Personal Data ☑

## MEDICAL EDUCATION

**11. LIST EACH MEDICAL SCHOOL THAT YOU HAVE ATTENDED.**

| School Name | City, State/Province, Country | Dates of Attendance | L2 Transcript |
|---|---|---|---|
| St. George's University School of Medicine | Grenada, West Indies | 8/01 - 5/05 | ☑ ☐ |
| | | | ☐ ☐ |
| | | | ☐ ☐ |

| 12. School of Graduation | Degree Awarded | Date of Graduation | Diploma |
|---|---|---|---|
| St. George's Univ. | M.D. | 5/2005 | ☐ |

## EXAMINATIONS

**13. LIST ALL OF THE FOLLOWING EXAMINATIONS YOU HAVE TAKEN: USMLE, FLEX, NBME, ECFMG, SPEX, STATE BOARDS and/or QME in Canada**

| Examination | Date | Result (Pass/Fail) | Exams |
|---|---|---|---|
| USMLE I | 6/03 | | ☑ |
| USMLE II | 8/04 | | ☐ |
| USMLE III | 5/07 | | ☑ |

Cashiering Use Only — GEN01 School Code — **L1A**

07A-100 (Rev. 12/06)

**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 ACCREDITED POSTGRADUATE TRAINING

MBC Use Only

**14. Please list each ACGME/RCPSC accredited postgraduate training program in which you have participated. You must include each internship, residency and fellowship, whether or not the program was completed or credit granted.**

| Facility Name | Address | Specialty Area | Dates of Attendance | Postgraduate Training |
|---|---|---|---|---|
| Univ. of MD Family Medicine | 29 S. Paca St Baltimore, MD 21201 | Family Med. | 7/05 - present | ☑ 4 |
| | | | | ☐ |
| | | | | ☐ |
| | | | | ☐ |
| | | | | ☐ |

**POSTGRADUATE TRAINING:** (These questions are to be answered by ALL applicants)

| | | | |
|---|---|---|---|
| Did you ever take a leave of absence or break from your training? | YES | NO | ☑ |
| Have you ever been terminated, dismissed or expelled from a program? | YES | NO | ☑ |
| Have you ever resigned from a training program? | YES | NO | ☑ |
| Were you ever placed on probation? | YES | NO | ☑ |
| Were you ever disciplined or placed under investigation? | YES | NO | ☐ |
| Were any incident reports ever filed by instructors? | YES | NO | ☑ |
| Were any limitations or special requirements placed upon you for clinical performance, discipline, or for any other reason? | YES | NO | ☐ |
| Have you ever had a postgraduate training program contract not be renewed or offered for a following year? | YES | NO | ☐ |

## MEDICAL LICENSURE

**15. Please list all medical licenses (other than training licenses) that have ever been issued by any state or territory in the United States or Canadian province.**

| Jurisdiction | License Number | Date of Issuance | Dates of Practice in that Jurisdiction | License Date |
|---|---|---|---|---|
| Maryland | D0066660 | 9/07 | 10/21/07 - start. | ☐ |
| | | | | ☐ |
| | | | | ☐ |
| | | | | ☐ |
| | | | | ☐ |

**APPLICANT:** Nguyen, Thy Bich

**DATE OF BIRTH:**

L1B

## ABMS CERTIFICATIONS

MBC Use Only

16. Are you currently certified by a Member Board of the American Board of Medical Specialties? YES ☐ NO ☑

ABMS ☑

| Member Board | Expiration Date | Certificate Number | |
|---|---|---|---|
| | | | ☐ |
| | | | ☐ |

## MALPRACTICE HISTORY

Malpractice

17. Has a claim or an action ever been filed against you for the practice of medicine which resulted in a malpractice settlement, judgment, or arbitration award of $30,000 or more? YES NO ☑

## PRACTICE IMPAIRMENT OR LIMITATIONS

Limitations

18. Have you been enrolled in, required to enter into, or participated in any drug or alcohol recovery program or impaired practitioner program? YES NO ☑

19. Have you been treated for or had a recurrence of a diagnosed addictive disorder? YES NO ☑

20. Have you been diagnosed with an emotional, a mental, or behavioral disorder which impairs your ability to practice medicine safely? YES NO ☑

21. Have you ever been diagnosed with a neurological or other physical condition that would impair your ability to practice medicine safely? YES NO ☑

22. Do you have any other condition which in any way impairs or limits your ability to practice medicine safely? YES NO ☑

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 HISTORY

Criminal Record

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?

**This includes a citation, infraction, misdemeanor and/or felony, etc.** 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 nolo contendere, 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 sentencing 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 court documents, and a descriptive explanation of the circumstances surrounding the conviction of disciplinary action (i.e., dates and location of incident and all circumstances 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 denied or license revoked for knowingly falsifying the application.** YES NO ☑

**APPLICANT:** NGUYEN, THY BICH

**DATE OF BIRTH:**

L1C

## CRIMINAL RECORD HISTORY (cont'd)

MBC Use Only
Criminal Record

| | | | |
|---|---|---|---|
| 24. Is any criminal action pending against you? | YES | NO | ☐ |
| 25. Are you required to register as a Sex Offender? | YES | NO | ☐ |

## DISCIPLINARY HISTORY

Discipline

These questions refer to discipline by any U.S. military or public health service, state board or other governmental agency of any U.S. state, territory, Canadian province, or 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 | ☐ |
| 30. 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? | YES | NO | ☐ |
| 32. Is any disciplinary action pending against any of your licenses to practice medicine? | YES | NO | ☐ |
| 33. Have you ever had staff privileges in a hospital terminated, denied, suspended, limited, revoked, or not renewed? | YES | NO | ☐ |
| 34. Have you ever resigned from a medical staff in lieu of disciplinary or administrative action? | YES | NO | ☐ |
| 35. Is any disciplinary action pending against your hospital staff privileges? | YES | NO | ☐ |
| 36. Have you ever surrendered a license to practice medicine? | YES | NO | ☐ |
| 37. Have your DEA privileges ever been denied, suspended, restricted, or terminated? | YES | NO | ☐ |
| 38. Have you ever entered into any arrangement or plea or agreement in lieu of a federal prosecution for a drug violation regulated by the DEA? | YES | NO | ☐ |

**APPLICANT:** NGUYEN, THY BICH

**DATE OF BIRTH:**

L1D

**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 Licensing Program is the custodian of records.**

The applicant, THY BICH NGUYEN (PLEASE PRINT FULL NAME) _____ (DATE OF BIRTH) being first duly sworn upon his/her oath deposes and says: that I am the person herein named subscribing to this application; that I have read the complete application, know the full content thereof, and declare under penalty of perjury, that all of the information contained herein and evidence or other credentials submitted herewith are true and correct; that I am the lawful holder of the degree of Doctor of Medicine as prescribed by this application, that the same was procured in the regular course of instruction and examination, and that it, together with all the credentials submitted, were procured without fraud or misrepresentation or any mistake of which I am aware and that I am the lawful holder thereof. Further, I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past, present and future), 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 any medical competence, professional conduct, or physical or mental ability to safely engage in the practice of medicine. I further authorize the Medical Board of California or its successors to release to the organizations, individuals or groups listed above any information which is material to this application or any subsequent licensure.

**I UNDERSTAND THAT 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.** TN. **(PLEASE INITIAL BOX)**

**SIGNATURE OF APPLICANT:** _____ (Please sign full name)

State of Maryland

County of Baltimore

Subscribed and sworn to (or affirmed) before me on

this 06 day of Oct, 20 07,

by DAVID F. ALLEN

personally known to me or proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.

NOTARY SEAL
DAVID F. ALLEN
Notary Public
State of Maryland
Baltimore County
My commission exp. April 9, 2011

_____
SIGNATURE OF NOTARY PUBLIC

L1E

State of California Department 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 NGUYEN (Name of Applicant) _____ (U.S. Social Security Number)

_____ (Date of Birth -MM/DD/YYYY) is in an approved ACGME/RCPSC postgraduate training position that commenced on 07 / 01 / 2005 (Month / Day / Year) and is expected to be completed on 07 / 01 / 2008 (Month / Day / Year) in Family Medicine Residency (Type of Training) OK

at University of Maryland 29 S. Paca Street (Name and Address of Facility)
Lower Level Baltimore, MD. 21201

*ATTENTION DIRECTORS OF MEDICAL EDUCATION: THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE, OR ADOPTION.*

*Only the Director of Medical Education 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 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 RCPSC to offer the type and level of training completed by the applicant and that the applicant is being trained in an approved ACGME or RCPSC program position.

Allison M. Andrus
(Type or print name of Director of Medical Education)

Allison M. Andrus
(Signature of Director of Medical Education)

2/28/08
(Date)

410.328.1151
(Telephone Number)

*OFFICIAL HOSPITAL SEAL, OR NOTARY SEAL (WITH DATE AND NOTARY'S SIGNATURE) MUST BE AFFIXED IN THE BOX AT THE LEFT.*

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

**L4**

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
05 JUN 17 PM 3:16
LICENSING PROGRAM

# 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 English language.)**

| Name of Applicant (type or print FULL name): | U.S. Social Security Number: |
|---|---|
| THY BICH NGUYEN | Date of Birth-MM/DD/YYYY: |

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.

## UNDERGRADUATE CLINICAL CLERKSHIPS

(Please list ALL clinical training completed prior to issuance of your medical degree in the area below and on the reverse of this form. List training in date/chronological order, commencing with the first clinical year of training.)

| CLINICAL SUBJECT AREA | FACILITY NAME AND ADDRESS | DATES OF ATTENDANCE FROM – TO (Month/Day/Year) | WEEKS OR WEEKLY HOURS OF CREDIT |
|---|---|---|---|
| Medicine | Highland Hospital<br>1411 E. 31st St<br>Oakland, CA 94602 | 9/8/03 – 11/28/03 | 12 |
| Surgery | Jamaica Hospital<br>8900 Van Wyck Expwy<br>Jamaica, NY 11418 | 12/1/03 – 1/18/04<br>1/12/04 – 2/20/04 | 12 |
| Pediatrics | Jamaica Hospital | 2/23/04 – 4/2/04 | 6 |
| Psychiatry | St. Ann's Hospital, Poole<br>69 Haven Road<br>Canford Cliffs Poole BH13 7LN | 4/5/04 – 5/14/04 | 6 |
| Ob-Gyn. | Poole General Hospital<br>Longfleet Road<br>Poole Dorset BH15 2JB | 5/17/04 – 6/25/04 | 6 |
| Emergency Medicine | Jamaica Hospital | 6/28/04 – 7/23/04 | 4 |

*ATTENTION DEANS OR REGISTRARS: THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE, OR ADOPTION.*

*Only the Dean or Registrar 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.*

MEDICAL SCHOOL SEAL

I, Margaret A. Lambert
Dean of Enrollment Planning
University Registrar
FULL NAME of Dean or Registrar (Please TYPE OR PRINT)

declare under penalty of perjury, that I am/was the Dean or Registrar for the student named above and that I have carefully read this form and that the statements made herein are strictly true in every respect.

[signature] 6/15/05

LSA

## 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 Security Number: |
|---|---|
| Thy Bich Nguyen | ___ ___ ___ |
| | Date of Birth-MM/DD/YYYY: |

### UNDERGRADUATE CLINICAL CLERKSHIPS

| CLINICAL SUBJECT AREA | FACILITY NAME AND ADDRESS | DATES OF ATTENDANCE FROM –TO (Month/Day/Year) | WEEKS OR WEEKLY HOURS OF CREDIT |
|---|---|---|---|
| Family Practice | Brooklyn Hospital center Brooklyn NY | 8/23/04 – 9/10/04<br>9/13/04 – 9/17/04 | 4 |
| Medicine / sub | Highland General Hospt. Oakland CA | 9/20/04<br>10/15/04 | 4 |
| Medicine/Radiology | Same as above | 10/18/04<br>11/2/04 | 4 |
| Surgery/Opthalmology | University of California – Medical center Orange CA | 11/15/04<br>11/26/04 | 2 |
| Medicine - sub | Highland General Hospital Oakland CA | 11/05/04<br>12/30/04 | 4 |
| Pediatrics - sub | Children's Hospital of Orange County Orange CA | 1/3/05<br>1/28/05 | 4 |
| Medicine/Infectious Diseases | University of California college of medicine Irvine CA | 1/31/05<br>2/25/05 | 4 |
| Surgery/Urology | Same as above | 2/28/05<br>3/25/05 | 4 |
| Pediatrics/Oncology | Childrens Hospital of Orange County Orange CA | 4/4/05<br>4/29/05 | 4 |
| | | | |

*ATTENTION DEANS OR REGISTRARS: THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE, OR ADOPTION.*

Only the Dean or Registrar 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.

MEDICAL SCHOOL SEAL

I, Margaret A. Lambert
Dean of Enrollment Planning
University Registrar
(FULL NAME of Dean or Registrar-Please TYPE OR PRINT)

declare under penalty of perjury, that I am/was the Dean or Registrar for the student named above and that I have carefully read this form and that the statements made hereon are strictly true in every respect.

Signature of Dean or Registrar

6/15/05
Date

L5B

STATE OF CALIFORNIA -- STATE AND CONSUMER SERVICES AGENCY — ARNOLD SCHWARZENEGGER, Governor

Consumer Affairs

# MEDICAL BOARD OF CALIFORNIA

LICENSING PROGRAM
1426 Howe Avenue, Suite 54
Sacramento, CA 95825-3236
(916) 263-2382 FAX (916) 263-2467
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 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 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 satisfy California's clinical training requirements.

This is to certify that THY NGUYEN (STUDENT'S NAME) ; _____ (U.S. SOCIAL SECURITY NO.)

_____ (DATE OF BIRTH-MM/DD/YYYY) a student of St. George's University School of Medicine (MEDICAL SCHOOL)

Completed a clerkship offered by Alameda County Medical Center - Highland Campus

1411 East 31st Street, Oakland, California 94602 (NAME AND ADDRESS OF FACILITY)

From 09 (MONTH) 08 (DAY) 2003 (YEAR) through 11 (MONTH) 28 (DAY) 2003 (YEAR) in the clinical area of Medicine Core (CLINICAL AREA)

This facility ☒ 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, if affiliated:* UCSF, UC Davis, St. George's University

This facility ☒ does have an ACGME-accredited residency program in the areas of: Medicine, Surgery, EM ☐ does not have an ACGME-accredited residency program.

***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 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, 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 are strictly true in every respect.

Official Hospital Seal

Theodore G. Rose, Jr., M.D., F.A.C.P.
TYPE OR PRINT NAME OF FACILITY PROGRAM DIRECTOR OR INSTRUCTOR

1411 East 31st Street
ADDRESS: NUMBER AND STREET

Oakland (CITY) California (STATE) 94602 (ZIP CODE)

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 _____ Month _____ Year

Notary Seal

_____
NOTARY PUBLIC

_____
ADDRESS

My Commissions Expires: _____

L6

STATE OF CALIFORNIA – STATE AND CONSUMER SERVICES AGENCY — ARNOLD SCHWARZENEGGER, Governor

Consumer Affairs

# MEDICAL BOARD OF CALIFORNIA

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 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 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 satisfy California's clinical training requirements.

This is to certify that THY NGUYEN (STUDENT'S NAME) _____ (U.S. SOCIAL SECURITY NO.)

_____ (DATE OF BIRTH-MM/DD/YYYY) a student of St. George's University (MEDICAL SCHOOL)

Completed a clerkship offered by Jamaica Hospital 8900 Van Wyck Exp. Jamaica, NY 11418 (NAME AND ADDRESS OF FACILITY)

From Dec. 1, 2003 (MONTH, DAY, YEAR) through Feb. 20, 2004 (MONTH, DAY, YEAR) in the clinical area of Surgery (CLINICAL AREA)

This facility ☑ 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 affiliated: St. George's Univ. School of Medicine

This facility ☑ does have an ACGME-accredited residency program in the areas of: Surgery (Gen'l) ☐ does not have an ACGME-accredited residency program.

***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 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, Ellen Marie Kinsley MPH 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.

Official Hospital Seal

Ellen Marie Kinsley, MPH (TYPE OR PRINT NAME OF FACILITY PROGRAM DIRECTOR OR INSTRUCTOR)

8900 Van Wyck Expressway (ADDRESS NUMBER AND STREET)

Jamaica (CITY) NY (STATE) 11418 (ZIP CODE)

718 206-8037 (TELEPHONE NUMBER)

Ellen Marie Kinsley MPH (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 _____ (Month) _____ (Year)

Notary Seal

NOTARY PUBLIC

ADDRESS

My Commissions Expires: _____

L6

STATE OF CALIFORNIA – STATE AND CONSUMER SERVICES AGENCY — ARNOLD SCHWARZENEGGER, Governor

Consumer Affairs

# MEDICAL BOARD OF CALIFORNIA

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 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 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 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 NGUYEN (STUDENT'S NAME) ___ (U.S. SOCIAL SECURITY NO.)

___ (DATE OF BIRTH-MM/DD/YYYY) ___ a student of St. George's University (MEDICAL SCHOOL)

Completed a clerkship offered by Jamaica Hospital 8900 Van Wyck Exp. Jamaica, NY 11418 (NAME AND ADDRESS OF FACILITY)

From Feb. (MONTH) 23 (DAY), 2004 (YEAR) through Apr. (MONTH) 2 (DAY), 2004 (YEAR) in the clinical area of Pediatrics (CLINICAL AREA)

This facility ☑ 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, if affiliated:* St. George's Univ. School of Medicine

This facility ☑ does have an ACGME-accredited residency program, in the areas of: Peds - Flushing Hosp. ☐ does not have an ACGME-accredited residency program.

***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 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, Ellen Marie Kinsler MPH 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.

Official Hospital Seal

Ellen Marie Kinsler MPH (TYPE OR PRINT NAME OF FACILITY PROGRAM DIRECTOR OR INSTRUCTOR)

8900 Van Wyck Expressway (ADDRESS, NUMBER AND STREET)

Jamaica (CITY) NY (STATE) 11418 (ZIP CODE)

718 206-8037 (TELEPHONE NUMBER)

Ellen Marie Kinsler MPH (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 ___ (Month) ___ (Year)

Notary Seal

NOTARY PUBLIC

ADDRESS

My Commissions Expires: ___

L6

STATE OF CALIFORNIA -- STATE AND CONSUMER SERVICES AGENCY — ARNOLD SCHWARZENEGGER, Governor

Consumer Affairs

# MEDICAL BOARD OF CALIFORNIA

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 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 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 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. NGUYEN (STUDENT'S NAME) ____ (U.S. SOCIAL SECURITY NO.:)

____ (DATE OF BIRTH-MM/DD/YYYY) a student of St. George's University (MEDICAL SCHOOL)

Completed a clerkship offered by St. Ann's Hospital 69 Haven Rd Poole, Dorset UK BH13 7LN. (NAME AND ADDRESS OF FACILITY)

From April (MONTH) 5 (DAY), 2004 (YEAR) through May (MONTH) 14 (DAY), 2004 (YEAR) in the clinical area

of Psychiatry (CLINICAL AREA)

This facility ☑ 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, if affiliated:* ST GEORGES UNIVERSITY SCHOOL OF MEDICINE

This facility ☐ does have an ACGME-accredited residency program in the areas of: ____ ☑ does not have an ACGME-accredited residency program.

*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 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, Dr N. CHOUDRY 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.

St Ann's Hospital Canford Cliffs POOLE Dorset (Official Hospital Seal)

St Anns Hospital: Dr N. CHOUDRY
TYPE OR PRINT NAME OF FACILITY PROGRAM DIRECTOR OR INSTRUCTOR

Haven Rd Canford Cliffs, Poole
ADDRESS: NUMBER AND STREET

Poole UK. BH13 7LN
CITY STATE ZIP CODE

#1202-492054
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 18 day of MAY Month 2004 Year

Notary Seal

NOTARY PUBLIC

ADDRESS

My Commissions Expires: ____

L6

07A-100-L6 (Revised 11-26-03)

STATE OF CALIFORNIA – STATE AND CONSUMER SERVICES AGENCY — ARNOLD SCHWARZENEGGER, Governor

Consumer Affairs

# MEDICAL BOARD OF CALIFORNIA

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 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 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 satisfy California's clinical training requirements.

This is to certify that THY B. NGUYEN (STUDENT'S NAME) ; _____ (U.S. SOCIAL SECURITY NO.:)

_____ (DATE OF BIRTH-MM/DD/YYYY) a student of St. George's University School of Medicine (MEDICAL SCHOOL)

Completed a clerkship offered by Poole Hospital NHS Trust (NAME AND ADDRESS OF FACILITY) Longfleet Road Poole, Dorset BH15 2JB

From 05 (MONTH) / 17 (DAY) / 2004 (YEAR) through 06 (MONTH) / 25 (DAY) / 2004 (YEAR) in the clinical area of Obstetrics and Gynaecology (CLINICAL AREA)

This facility ☑ 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, if affiliated:* St. George's University School of Medicine

This facility ☐ does have an ACGME-accredited residency program in the areas of: _____ ☑ does not have an ACGME-accredited residency program.

***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 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, Dr. R. Henry 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.

Official Hospital Seal

POOLE HOSPITAL NHS TRUST
LONGFLEET ROAD
POOLE BH15 2JB

Richard Henry (TYPE OR PRINT NAME OF FACILITY PROGRAM DIRECTOR OR INSTRUCTOR)

Longfleet Road (ADDRESS/NUMBER AND STREET)

Poole, Dorset UK BH15 2JB (CITY / STATE / ZIP CODE)

01202 442600 (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 _____ (Month) _____ (Year)

Notary Seal

_____ (NOTARY PUBLIC)

_____ (ADDRESS)

My Commissions Expires: _____

L6

07A-100-L6 (Revised 03-01)

STATE OF CALIFORNIA -- STATE AND CONSUMER SERVICES AGENCY — ARNOLD SCHWARZENEGGER, Governor

Consumer Affairs

# MEDICAL BOARD OF CALIFORNIA

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 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 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 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. NGUYEN
STUDENT'S NAME — U.S. SOCIAL SECURITY NO.:

DATE OF BIRTH-MM/DD/YYYY — a student of St. George's School of Medicine
MEDICAL SCHOOL

Completed a clerkship offered by Jamaica Hospital
8900 Van Wyck Expressway Jamaica, NY 11418
NAME AND ADDRESS OF FACILITY

From June 28, 2004 through July 23, 2004 in the clinical area
MONTH DAY YEAR — MONTH DAY YEAR

of Emergency Medicine
CLINICAL AREA

This facility [X] 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, if affiliated:*
St. George's University School of Medicine

This facility [X] does have an ACGME-accredited residency program in the areas of: 013
[ ] does not have an ACGME-accredited residency program.

***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 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, Ellen Marie Kinsler MPH 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.

Official Hospital Seal

Ellen Marie Kinsler MPH
TYPE OR PRINT NAME OF FACILITY PROGRAM DIRECTOR OR INSTRUCTOR

8900 Van Wyck Expressway
ADDRESS: NUMBER AND STREET

Jamaica NY 11418
CITY STATE ZIP CODE

718 206 - 8037
TELEPHONE NUMBER

Ellen Marie Kinsler MPH
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 _____ Month _____ Year

Notary Seal

NOTARY PUBLIC

ADDRESS

My Commissions Expires: _____

L6

07A-100-L6 (Revised 03-01)

STATE OF CALIFORNIA -- STATE AND CONSUMER SERVICES AGENCY — ARNOLD SCHWARZENEGGER, Governor

Consumer Affairs

# MEDICAL BOARD OF CALIFORNIA

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 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 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 satisfy California's clinical training requirements.

This is to certify that Thy Nguyen (STUDENT'S NAME); U.S. SOCIAL SECURITY NO.: ; (DATE OF BIRTH-MM/DD/YYYY) a student of St. George's University (MEDICAL SCHOOL)

Completed a clerkship offered by The Brooklyn Hospital Center (NAME AND ADDRESS OF FACILITY) 121 DeKalb Avenue Bklyn NY 11201

From 8 (MONTH) - 23 (DAY) - 04 (YEAR) through 9 (MONTH) - 17 (DAY) - 04 (YEAR) in the clinical area of Family Practice (CLINICAL AREA)

This facility
- [X] 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, if affiliated:* CORNELL UNIVERSITY

This facility
- [X] does have an ACGME-accredited residency program in the areas of: FAMILY PRACTICE
- [ ] does not have an ACGME-accredited residency program.

***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 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, LORETTA A TERRANOVA M.D. 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.

Official Hospital Seal

LORETTA A TERRANOVA, MD
TYPE OR PRINT NAME OF FACILITY PROGRAM DIRECTOR OR INSTRUCTOR
THE BROOKLYN HOSP CTR
121 DEKALB AVE
ADDRESS: NUMBER AND STREET
BROOKLYN NY 11201
CITY STATE ZIP CODE
718 250-8817
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 _____ Month _____ Year

Notary Seal

NOTARY PUBLIC

ADDRESS

My Commissions Expires: _____

L6

STATE OF CALIFORNIA -- STATE AND CONSUMER SERVICES AGENCY — ARNOLD SCHWARZENEGGER, Governor

Consumer Affairs

# MEDICAL BOARD OF CALIFORNIA

LICENSING PROGRAM
1426 Howe Avenue, Suite 54
Sacramento, CA 95825-3238
(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 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 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 satisfy California's clinical training requirements.

This is to certify that TAN NGUYEN
STUDENT'S NAME — U.S. SOCIAL SECURITY NO.:

DATE OF BIRTH-MM/DD/YYYY — a student of St. George's University School of Medicine
MEDICAL SCHOOL

Completed a clerkship offered by Alameda County Medical Center - Highland Campus
1411 East 31st Street, Oakland, California 94602
NAME AND ADDRESS OF FACILITY

From Sep. (MONTH) 22, (DAY) 2004 (YEAR) through Oct. (MONTH) 15, (DAY) 2004 (YEAR) in the clinical area of Medicine Sub-Internship
CLINICAL AREA

This facility ☒ 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, if affiliated:* UCSF, UC Davis, St. George's University

This facility ☒ does have an ACGME-accredited residency program in the areas of: Medicine, Surgery, EM ☐ does not have an ACGME-accredited residency program.

***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 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, 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 are strictly true in every respect.

Official Hospital Seal

Theodore G. Rose, Jr., M.D., F.A.C.P.
TYPE OR PRINT NAME OF FACILITY PROGRAM DIRECTOR OR INSTRUCTOR

1411 East 31st Street
ADDRESS: NUMBER AND STREET

Oakland — California — 94602
CITY — STATE — ZIP CODE

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 _____ Month _____ Year

Notary Seal

NOTARY PUBLIC

ADDRESS

My Commissions Expires: _____

L6

07A-100-L6 (Revised 03-01)

STATE OF CALIFORNIA -- STATE AND CONSUMER SERVICES AGENCY

ARNOLD SCHWARZENEGGER, Governor

Consumer Affairs

# MEDICAL BOARD OF CALIFORNIA

LICENSING PROGRAM
1426 Howe Avenue, Suite 54
Sacramento, CA 95825-3236
(916) 263-2382 FAX (916) 263-2467
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 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 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 satisfy California's clinical training requirements.

This is to certify that Thy Nguyen (STUDENT'S NAME) ; (U.S. SOCIAL SECURITY NO.:)

(DATE OF BIRTH-MM/DD/YYYY) a student of St. George's University School of Medicine (MEDICAL SCHOOL)

Completed a clerkship offered by Alameda County Medical Center - Highland Campus

1411 East 31st Street, Oakland, California 94602 (NAME AND ADDRESS OF FACILITY)

From 10 (MONTH) 18 (DAY) 2004 (YEAR) through 11 (MONTH) 12 (DAY) 2004 (YEAR) in the clinical area of RADIOLOGY (CLINICAL AREA)

This facility
- [x] 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, if affiliated:*
UCSF, UC Davis, St. George's University

This facility
- [x] does have an ACGME-accredited residency program in the areas of: Medicine, Surgery, EM
- [ ] does not have an ACGME-accredited residency program.

***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 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, 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 are strictly true in every respect.

Official Hospital Seal

Theodore G. Rose, Jr., M.D., F.A.C.P.
TYPE OR PRINT NAME OF FACILITY PROGRAM DIRECTOR OR INSTRUCTOR

1411 East 31st Street
ADDRESS: NUMBER AND STREET

Oakland — California — 94602
CITY — STATE — ZIP CODE

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 _____ Month _____ Year

Notary Seal

NOTARY PUBLIC

ADDRESS

My Commissions Expires: _____

L6

STATE OF CALIFORNIA -- STATE AND CONSUMER SERVICES AGENCY ARNOLD SCHWARZENEGGER, Governor

Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM
1426 Howe Avenue, Suite 54
Sacramento, CA 95825-3236
(916) 263-2382 FAX (916) 263-2387
www.caldocinfo.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 completed and certifies the "Official Breakdown of Undergraduate Clinical Clerkships 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 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. Nguyen (STUDENT'S NAME) _____ (U.S. SOCIAL SECURITY NO.:) _____ (DATE OF BIRTH-MM/DD/YYYY) a student of St. George's University School of Medicine (MEDICAL SCHOOL)

Completed a clerkship offered by University of California, Irvine College of Medicine (NAME AND ADDRESS OF FACILITY)
118 Med Surge I Bldg. 810, Irvine, CA 92697-4375

From 11/15/2004 (MONTH DAY YEAR) through 11/26/2004 (MONTH DAY YEAR) in the clinical area of Ophthalmology (CLINICAL AREA)

This facility ☒ 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, if affiliated:*
University of California, Irvine

This facility ☒ does have an ACGME-accredited residency program in the areas of: ophthalmology
☐ does not have an ACGME-accredited residency program.

***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 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, Linda S.M. Lippa, MD 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.

Official Hospital Seal

Linda S.M. Lippa, MD (TYPE OR PRINT NAME OF FACILITY PROGRAM DIRECTOR OR INSTRUCTOR) Linda S.M. Lippa

118 Med Surge I, Bldg. 810 (ADDRESS, NUMBER AND STREET)
Irvine (CITY) CA (STATE) 92697-4375 (ZIP CODE)
(949) 824-3004 (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 _____ (Month) _____ (Year)

Notary Seal

NOTARY PUBLIC _____

ADDRESS _____

My Commission Expires: _____

L6

STATE OF CALIFORNIA -- STATE AND CONSUMER SERVICES AGENCY — ARNOLD SCHWARZENEGGER, Governor

Consumer Affairs

# MEDICAL BOARD OF CALIFORNIA

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 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 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 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. Nguyen (STUDENT'S NAME) ; U.S. SOCIAL SECURITY NO.:

___ (DATE OF BIRTH-MM/DD/YYYY) _____ a student of St. George's University School of Medicine (MEDICAL SCHOOL)

Completed a clerkship offered by Alameda County Medical Center - Highland Campus
1411 East 31st Street, Oakland, California 94602 (NAME AND ADDRESS OF FACILITY)

From 12 (MONTH) 05 (DAY) 2004 (YEAR) through 12 (MONTH) 30 (DAY) 2004 (YEAR) in the clinical area of Medicine Subinternship (CLINICAL AREA)

This facility ☑ 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, if affiliated:* UCSF, UC Davis, St. George's University

This facility ☑ does have an ACGME-accredited residency program in the areas of: Medicine, Surgery, EM ☐ does not have an ACGME-accredited residency program.

***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 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, 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 are strictly true in every respect.

Official Hospital Seal

Theodore G. Rose, Jr., M.D., F.A.C.P.
TYPE OR PRINT NAME OF FACILITY PROGRAM DIRECTOR OR INSTRUCTOR

1411 East 31st Street
ADDRESS: NUMBER AND STREET

Oakland — California — 94602
CITY — STATE — ZIP CODE

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 _____ Month _____ Year

Notary Seal

NOTARY PUBLIC

ADDRESS

My Commissions Expires: _____

L6

07A-100-L6 (Revised 03-01)

STATE OF CALIFORNIA -- STATE AND CONSUMER SERVICES AGENCY

ARNOLD SCHWARZENEGGER, Governor

Consumer Affairs

# MEDICAL BOARD OF CALIFORNIA

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 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 L3A/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 clinical training requirements.

This is to certify that Thy Nguyen (STUDENT'S NAME) _____ (U.S. SOCIAL SECURITY NO.)

_____ (DATE OF BIRTH-MM/DD/YYYY) a student of St. George's University (MEDICAL SCHOOL)

Completed a clerkship offered by Children's Hospital of Orange County (NAME AND ADDRESS OF FACILITY) 455 S. Main Street, Orange, CA 92868

From 1/3/05 (MONTH DAY YEAR) through 1/28/05 (MONTH DAY YEAR) of Pediatric Sub-Internship (CLINICAL AREA) in the clinical area

This facility ☑ 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, if affiliated:* St. George's University

This facility ☑ does have an ACGME-accredited residency program in the areas of: Pediatrics ☐ does not have an ACGME-accredited residency program.

***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 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, Benjamin Silverman, MD 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.

Official Hospital Seal

Benjamin Silverman, MD
TYPE OR PRINT NAME OF FACILITY PROGRAM DIRECTOR OR INSTRUCTOR

455 S. Main Street
ADDRESS: NUMBER AND STREET

Orange CA 92868
CITY STATE ZIP CODE

714-532-8338
TELEPHONE NUMBER

Benjamin Silverman MD
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 24 day of January (Month) 2005 (Year)

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

Notary Seal

Janette Rodriguez
NOTARY PUBLIC

2875 S. La Cienega Blvd, Westchester, CA 90045
ADDRESS

My Commissions Expires: 1/27/07

L6

07A-100-L6 (Revised 03-01)

STATE OF CALIFORNIA -- STATE AND CONSUMER SERVICES AGENCY

ARNOLD SCHWARZENEGGER, Governor

Consumer Affairs

# MEDICAL BOARD OF CALIFORNIA

LICENSING PROGRAM
1426 Howe Avenue, Suite 54
Sacramento, CA 95825-3236
(916) 263-2382 FAX (916) 263-2487
www.caldocinfo.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 Clerkships 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 satisfy California's clinical training requirements.

This is to certify that THY NGUYEN (STUDENT'S NAME) _____ (U.S. SOCIAL SECURITY NO.)

_____ (DATE OF BIRTH-MM/DD/YY) a student of St. George's University (MEDICAL SCHOOL)

Completed a clerkship offered by University of California, Irvine College of Medicine (NAME AND ADDRESS OF FACILITY)

101 The City Drive S. Bldg. 53 Rm 215 Orange, CA 92697

From Jan. 31, 2005 (MONTH, DAY, YEAR) through Feb. 25, 2005 (MONTH, DAY, YEAR) in the clinical area

of Infectious Diseases. (CLINICAL AREA)

This facility [X] 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, if affiliated:*
University of California, Irvine

This facility [X] does have an ACGME-accredited residency program in the areas of: Infectious Diseases
[ ] does not have an ACGME-accredited residency program.

***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 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, Donald Forthal 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.

Official Hospital Seal

Donald Forthal
TYPE OR PRINT NAME OF FACILITY PROGRAM DIRECTOR OR INSTRUCTOR

101 The City Drive S. Bldg. 53
ADDRESS: NUMBER AND STREET

Orange CA 92697,
CITY STATE ZIP CODE

714-456-7612
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 _____ Month _____ Year

Notary Seal

NOTARY PUBLIC

ADDRESS

My Commission Expires: _____

L6

(7A-10-L6 (Revised 03-01)

STATE OF CALIFORNIA -- STATE AND CONSUMER SERVICES AGENCY

ARNOLD SCHWARZENEGGER, Governor

Consumer Affairs

# MEDICAL BOARD OF CALIFORNIA

LICENSING PROGRAM
1426 Howe Avenue, Suite 54
Sacramento, CA 95825-3236
(916) 263-2382 FAX (916) 263-2487
www.caldocinfo.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 Clerkships 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 satisfy California's clinical training requirements.

This is to certify that THY B. NGUYEN (STUDENT'S NAME); U.S. SOCIAL SECURITY NO.: ____

____ (DATE OF BIRTH-MM/DD/YYYY) a student of St. George's University School of Medicine (MEDICAL SCHOOL)

Completed a clerkship offered by Univ. of California, Irvine Bldg. 26 Suite 204 (NAME AND ADDRESS OF FACILITY)
101 The City Drive Orange, CA 92868

From Feb. 28 (MONTH DAY) , 2005 (YEAR) through March 25 (MONTH DAY) , 2005 (YEAR) in the clinical area

of Urology (CLINICAL AREA)

This facility [X] 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, if affiliated:*
Univ. of CA, Irvine School of Medicine

This facility [X] does have an ACGME-accredited residency program in the areas of: Urology
[ ] does not have an ACGME-accredited residency program.

***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 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, Regina Hovey M.D. 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.

Official Hospital Seal

Regina Hovey, M.D.
TYPE OR PRINT NAME OF FACILITY PROGRAM DIRECTOR OR INSTRUCTOR

101 The City Drive Bldg. 26 Suite 204
ADDRESS: NUMBER AND STREET

Orange , CA 92868
CITY STATE ZIP CODE

714-456-6779
TELEPHONE NUMBER

Regina Hovey
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 ____ Month ____ Year

Notary Seal

NOTARY PUBLIC

ADDRESS

My Commission Expires: ____

L6

STATE OF CALIFORNIA -- STATE AND CONSUMER SERVICES AGENCY — ARNOLD SCHWARZENEGGER, Governor

Consumer Affairs

# MEDICAL BOARD OF CALIFORNIA

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 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 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 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 Try B. Nguyen (STUDENT'S NAME) _____ (U.S. SOCIAL SECURITY NO.)

_____ (DATE OF BIRTH-MM/DD/YYYY) a student of St. George's University (MEDICAL SCHOOL)

Completed a clerkship offered by Children's Hospital of Orange County (NAME AND ADDRESS OF FACILITY) 455 S. Main Street, Orange, CA 92868

From 4/04/05 (MONTH DAY YEAR) through 4/29/05 (MONTH DAY YEAR) in the clinical area of Pediatric Oncology (CLINICAL AREA)

This facility ☑ 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, if affiliated:* St. George's University

This facility ☑ does have an ACGME-accredited residency program in the areas of: Pediatrics ☐ does not have an ACGME-accredited residency program.

***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 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, Daphne Wong, MD 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.

Official Hospital Seal

Daphne Wong, MD
TYPE OR PRINT NAME OF FACILITY PROGRAM DIRECTOR OR INSTRUCTOR

455 S. Main Street
ADDRESS: NUMBER AND STREET

Orange CA 92868
CITY STATE ZIP CODE

714-532-8338
TELEPHONE NUMBER

Daphne Wong
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 4 day of May (Month) 2005 (Year)

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

Notary Seal

Janette Rodriguez
NOTARY PUBLIC

7237 S. La Cienega Blvd Westchester, CA 90045
ADDRESS

My Commissions Expires: 1/27/07

L6

07A-100-L6 (Revised 03-01)

**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 |
|---|---|
| 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

(DO NOT DETACH)

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

| LICENSEE NAME | LICENSE NO. | EXPIRATION DATE | AMOUNT DUE NOW | AMOUNT DUE IF POSTMARKED AFTER OCTOBER 30, 2015 |
|---|---|---|---|---|
| **NGUYEN, THY B** | **A104638** | **09/30/15** | **$820.00** | **$898.00** |

**LICENSEE MUST CHECK CORRECT BOXES**

- "H" [X] Completed Continuing Education
- "E" [ ] Change of Address (fill in reverse side)
- "I" [ ] Conviction Disclosure – Yes
- "J" [X] Conviction Disclosure – No
- "F" [ ] Family Physician Training Program ($25)
- "G" [X] Financial Interest Statement-**Read instructions above**

"D" **SIGNATURE REQUIRED**

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

Signature _____ Date 6/16/2015

**ENTER YOUR PHONE NUMBER FOR REFERENCE:**

( ) - -

630101000001000020010463820109301500082000000089800

**CHANGE OF MAILING ADDRESS** **NGUYEN, THY B** **A104638**

06252015 20001931 20010020

Street Address (this address is public information **except** when a PO Box is used for the public address of record; this address then becomes confidential)

City State Zip

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

City State Zip