STATE OF CALIFORNIA—AGRICULTURE AND SERVICES AGENCY

EDMUND G. BROWN JR., Governor

DEPARTMENT OF Consumer Affairs

BOARD OF MEDICAL QUALITY ASSURANCE
1430 HOWE AVENUE, SACRAMENTO, CALIFORNIA 95825
ALLIED HEALTH PROFESSIONS (916) 322-5043
APPLICATIONS AND EXAMINATIONS (916) 322-5040

RECEIVED
SEP 5 1979
LICENSING

APPLICATION FOR PHYSICIAN'S AND SURGEON'S CERTIFICATE
RECIPROCITY - CLASS C

$182.00
003684

INSTRUCTIONS: Applicant must refer to accompanying instructions prior to completing this application. In addition to this form, other essential application requirements must be accomplished.

(Please type or print neatly. When space provided is insufficient, attach additional sheet.)

1. NAME: Last: Zipkin First: Barbara Middle: Ellen

2. Telephone Number:

3. List other names, if any, you have used: —

4. Address: Street and No. / Rural Route: 30 Sycamore Terrace City: Springfield State: N.J. Zip Code: 07081

5. Name you wish on License: Barbara Ellen Zipkin Birthdate: (Month - Day - Year)

6. Premedical Education: Name of College or University: Northwestern University Location: Evanston, Ill.

Period of attendance: From: 9/70 To: 6/72

Check premed courses successfully completed: [X] Chemistry [X] Physics [X] Biology or Zoology

7. Medical School:

Year	NAME OF INSTITUTION	LOCATION	FROM	TO
1st.	Northwestern Univ Medical School	Chicago, Ill	9/72	12/75
2nd				
3rd				
4th				
5th				
6th				

8. Doctor of Medicine Degree granted by: Northwestern Univ. Med. Sch. Date: 6/76

For Office Use Only School Code:

9. 1st Year Postgraduate Training (Internship): St. Barnabas Medical Center

LOCATION	TYPE OF SERVICE	FROM	TO
Livingston, N.J.	Straight medical intern	1/76	6/76

10. Upon what license or certificate do you base this application? X Written Exam by .... Oral Exam

Name of Board Issuing License or Certificate: University of State Education Dept. Exact Date of Issue: 6/24/77

07A-30 (Rev. 2-77)

(continue on reverse side)

11. Have you ever filed an application in California? Yes No

12. Have you ever failed in a written or oral examination in California? Yes No

(If yes, give details)

13. List all States in which you have been licensed to practice medicine:

New York

14. Has any disciplinary action ever been taken regarding any license which you now hold or ever held? Yes No

If Yes, indicate below:

STATE	DATE	CHARGE	DISPOSITION

15. Have you ever been denied a license to practice medicine in any State or Country? Yes No

If Yes, indicate below:

STATE OR COUNTRY	DATE OF DENIAL	REASON FOR DENIAL

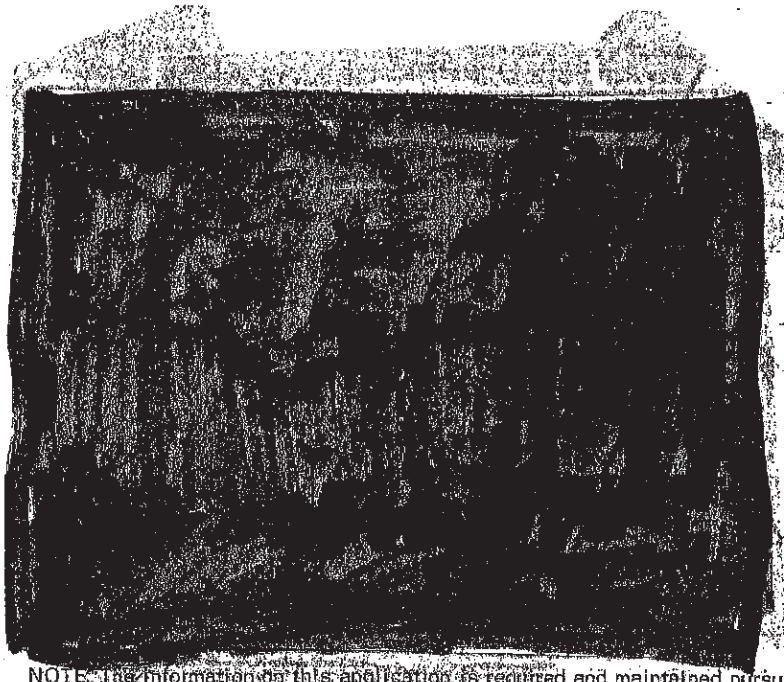
16. Are you now or have you ever been addicted to narcotic drugs? Yes No

17. Have you ever been convicted of, or pled nolo contendere to a violation of any Federal, State or Local law relating to the manufacture, distribution or dispensing of controlled substances/narcotics, or to drug addiction? Yes No

18. Have you ever been convicted of, or pled nolo contendere to any offense, misdemeanor or felony in any State? (Except violations of traffic laws resulting in fines of $50.00 or less.) Yes No

19. If you answered "Yes" to either No. 17 or No. 18 above please provide the following information:

VIOLATION AND LOCATION	DATE	PENALTY OR DISPOSITION



Applicant: Please complete the following:

Height: __ Ft. __ In. Weight: ____ Lbs.

Hair Color: _____ Eye Color: __

Identifying marks: _____

NOTE: The information on this application is required and maintained pursuant to Section 2312 of the Business and Professions Code. All items in this application are mandatory, none are voluntary. Failure to provide any of the requested information will result in the application being rejected as incomplete. The information provided will be used to determine qualification for licensure. Applicants have the right to review their applications subject to the provisions of the California Public Records Act.

NOTE – APPLICANT WILL SIGN THIS STATEMENT IN PRESENCE OF NOTARY PUBLIC.

"I hereby certify (or declare), under penalty of perjury, that the foregoing information contained in this application and any attachments is true and correct, and that the attached photo and duplicate copy are a true likeness of myself, the applicant identified herein."

Signature of Applicant [signature]

Date 8/29/79

Subscribed and sworn to before me this 29 day of August 19 79

Signature of Notary Patricia A. Tolan

[SEAL]

Address 10 Mott Hill Road
Port Washington, N.Y. 11050

PATRICIA A. TOLAN
NOTARY PUBLIC, State of New York
No. 30-4675847
Qualified in Nassau County
Commission Expires March 30, 1980

My commission expires: March 1980

STATE OF CALIFORNIA—AGRICULTURE AND SERVICES AGENCY — EDMUND G. BROWN JR., Governor

DEPARTMENT OF Consumer Affairs

BOARD OF MEDICAL QUALITY ASSURANCE

1430 HOWE AVENUE, SACRAMENTO, CALIFORNIA 95825
ALLIED HEALTH PROFESSIONS (916) 322-5043
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PLEASE FORWARD TO YOUR MEDICAL SCHOOL

CERTIFICATE OF EDUCATION

This Certifies That Barbara Ellen Zipkin
Full name of applicant

enrolled in Northwestern University Medical School
Name of medical school (college)

on the 2 day of October 19 72.
Month Year

[X] as a Freshman.

[ ] with advanced standing based on _____.
Please specify

The undersigned further certifies that official transcripts on file show that prior to completing the study of medicine the applicant herein referred to completed at least a two-year resident course of college grade including:

[X] PHYSICS [X] CHEMISTRY [X] BIOLOGY (or) ZOOLOGY (Check course(s) completed)

at Northwestern University, and that he attended while at this
Please indicate school

medical school (college) 31 courses of lectures of 12 weeks each,
Specify number Specify number of weeks

completing _____ hours in the subjects below listed, and that he/she:
Total hours

[X] was granted the degree { ~~Bachelor~~ / Doctor } of Medicine

[ ] left the above mentioned medical school (college) for the following reason(s):

_____

_____

on the 19 day of Dec. 19 75.
Month Year

Please indicate which of the following courses of study were successfully undertaken by the applicant:

X Anatomy	X Preventive medicine	X Medicine
Embryology	Hygiene and sanitation	X Pediatrics
X Histology	Radiology, including roentgenologic technique and radiation safety	X Psychiatry
X Neuroanatomy	Urology	X Neurology
X Physiology	Ophthalmology	Dermatology
Psychobiology	X Anesthesia	Physical medicine
X Biochemistry	Otolaryngology	Therapeutics
X Pathology, bacteriology and immunology	X Obstetrics and gynecology	Tropical medicine
X Pharmacology		X Surgery, including orthopedic surgery

Signed and the College seal affixed this 26 day

[AFFIX SEAL HERE]

of Oct. 19 78.
Month Year

By Ann Hedde, Registrar
President, Secretary, Dean

07A-32 (REV. 5-77)

51452 -656 5-77 8M ⓘ◊OMP

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

PART 2

Since you last renewed your license, have you had any license disciplined by a government agency or other disciplinary body; or, have you been convicted of any crime in any state, the U S A and its territories, military court or a foreign country? PLEASE READ INSTRUCTIONS BEFORE ANSWERING I. ☐ YES J. ☒ NO

License Renewal Application
Physician and Surgeon

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

D. Continuing Medical Education (CME) Certification Statement: I CERTIFY UNDER PENALTY OF PERJURY UNDER THE LAWS OF CALIFORNIA TO THE FOLLOWING STATEMENT: I CERTIFY THAT I DO MEET EACH OF THE CONTINUING MEDICAL EDUCATION REQUIREMENTS LISTED ON THE BACK OF THIS FORM OR THAT I MEET THE CONDITIONS WHICH WOULD EXEMPT ME FROM ALL OR PART OF THE REQUIREMENTS OR I HOLD A PERMANENT CME WAIVER.

SIGNATURE REQUIRED HERE: [signature] DATE: 2/6/13

LICENSE NO.	EXPIRES	AMOUNT DUE NOW	DELINQ FEE IF POSTMARKED AFTER 05/30/13
41246	04/30/13	$808.00	$886.00
	VOLUNTARY FEE =	$	$
	TOTAL ENCLOSED =	$ 808.00	$

ACTIVE BARBARA ELLEN ZIPKIN
4900 SUNSET BLVD
LOS ANGELES CA 90027

E. FOR ADDRESS CHANGE ONLY
IF YOUR ADDRESS SHOWN IS INCORRECT, CORRECT IT BELOW.

STREET 10200 Sepulveda Blvd.
CITY Mission Hills STATE CA ZIP 91345
PHONE NUMBER (818)

G. FINANCIAL INTEREST STATEMENT
I CERTIFY UNDER PENALTY OF PERJURY THAT I HAVE DISCLOSED ON THIS RENEWAL APPLICATION FORM (SEE REVERSE FOR SPACE) THE NAMES OF THOSE HEALTH-RELATED FACILITIES IN WHICH I OR MY FAMILY HAVE A FINANCIAL INTEREST OR I CERTIFY UNDER PENALTY OF PERJURY I HAVE NO FINANCIAL INTEREST TO DISCLOSE.

[signature] Signature required here

OVER

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02152013 10001587 10010016

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

G. Financial Interest Statement

Please print or type the name(s) and address(es) of each health-related facility in which you or your immediate family have a financial interest. If more space is needed, please attach additional listings. If you have no interests to declare, please write "none" in the area below and sign your name on the front of this document at G.

Health-Related Facility Name	Address

SMBCLS 02/28/05

STATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS

dca BREEZE

Department of Consumer Affairs

RECEIPT

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

Name:	ZIPKIN, BARBARA ELLEN
Transaction Date:	04/05/2015 13:54
Application Number:	
Complaint Number:	
License Type:	8002
License Number:	41246
Payment Description:	Physician's and Surgeon's Renewal
Fee Paid: (US $)	820.00
Remaining Balance: (US $)	0.00

Please print and save this receipt for your records.

This receipt is provided as a record for the above named licensee/applicant.

Illegal use or alteration of this receipt may result in criminal prosecution.

Application Summary

License Type:	**Physician and Surgeon G**
License Number:	**41246**
File Number:	
Application:	**Physician's and Surgeon's Renewal**
Application Number:	
Application Date:	**04/05/2015 (mm/dd/yyyy)**

Personal Detail

First Name:	**BARBARA**
Middle Name:	**ELLEN**
Last Name:	**ZIPKIN**
Birthdate:	****/**/******
Gender:	**Female**

Addresses

License Related Addresses

Address of Record (Required)

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

Confidential Address

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

Questions

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

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

Family Physician Training Program Voluntary Fee

Voluntary Fee:	**No**

Attachments

Physician Survey

Are you retired?	**No**
Activities in Medicine	**Administration - 1-9 Hours** **Other - None** **Patient Care - 30-39 Hours** **Research - None** **Teaching - 1-9 Hours** **Telemedicine - None**
Patient Care Practice Location	**Zip: 91011 County: LOS ANGELES**
Telemedicine Practice Location	**Zip: County:**
Patient Care Secondary Practice Location	**Zip: County:**
Telemedicine Secondary Practice Location	**Zip: County:**
Current Training Status	**Not in Training**
Areas of Practice	**Obstetrics and Gynecology - Primary**
Board Certifications	**American Board of Obstetrics and Gynecology - Obstetrics and Gynecology**
Postgraduate Training Years	**4 Years**
Cultural Background	**Decline to State**
Foreign Language Proficiency	**Decline to state**
Web Site Profile	**Cultural Background - No** **Foreign Language Proficiency - No** **Gender - No**
E-mail:	

Fees

Biennial Renewal Fee	**$783.00**
DUE TO CURES FUND	**$12.00**

Steven M. Thompson Physician Corps Loan Repayment Program	**$25.00**
Total Amount Due:	**$820.00**

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

Attestation

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

Signature: Date: