STATE OF CALIFORNIA — STATE AND CONSUMER SERVICES AGENCY

MEDICAL BOARD OF CALIFORNIA

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

Consumer Affairs

505
3-01-02
M.

117415

APPLICATION FOR PHYSICIAN'S AND SURGEON'S LICENSE

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

FALSIFICATION OR MISREPRESENTATION OF ANY ITEM OR RESPONSE ON THIS APPLICATION OR ANY ATTACHMENT HERETO IS A SUFFICIENT BASIS FOR DENYING OR REVOKING A LICENSE.

MBC USE ONLY

1. NAME: Last: PAUL | First: MAUREEN | Middle: ELIZABETH

2. Other names you have used (include maiden name): MAUREEN ELIZABETH GROENING

3. U.S. Social Security Number*:

4A. (PUBLIC ADDRESS; will be released by the Board to the public): Number and Street/P.O. Box/Rural Route/Apartment Number, if any. 1055 COMMONWEALTH AVENUE

City: BOSTON | State: MASSACHUSETTS | Zip Code: 02215 | Country: U.S.A.

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

City | State | Zip Code | Country

5. Telephone Number:
Home:
Work: (

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

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

8. Sex: ☐ Male ☑ Female

9. Are you a U.S. citizen? ☑ Yes ☐ No

10. Have you ever filed an application for Physician's and Surgeon's examination or licensure in California? ☐ Yes ☑ No

IF YES, PLEASE GIVE DATE PREVIOUS APPLICATION WAS SUBMITTED.

11. List the names and locations of all colleges or universities attended where pre-professional, postsecondary instruction was received. Please submit official transcripts with the school seal affixed for each school attended. Transcripts will not be returned.

Name	City, State, Country	Dates of Attendance
MICHIGAN STATE UNIV.	E.LANSING, MICHIGAN, U.S.A.	1967 – 1970
UNIV. OF WASHINGTON	SEATTLE, WASHINGTON, U.S.A.	1973 – 1975

12. List the names and locations of all schools where professional medical instruction was received, and, where applicable, the degree awarded.
PLEASE SUBMIT: 1) an original Certificate of Medical Education (Form L2) and official transcripts with the signature of the dean or registrar and the school seal affixed from each school attended; and,
2) an original medical diploma and a 8 1/2" x 11" photocopy (original diploma will be returned).

School Name	City, State, Country	Dates of Attendance	Degree Awarded
TUFTS UNIV. SCHOOL OF MEDICINE	BOSTON, MASSACHUSETTS, U.S.A.	09/01/75 – 06/13/79	M.D.
BOSTON UNIV. SCHOOL OF PUBLIC HEALTH	BOSTON, MASSACHUSETTS, U.S.A.	09/84 – 05/88	M.P.H.

DOCTOR OF MEDICINE DEGREE as referenced above.

Name of Medical School	Address of Medical School	Exact Date of Issuance
TUFTS UNIVERSITY SCHOOL OF MEDICINE	136 HARRISON AVENUE BOSTON, MASSACHUSETTS 02111	06/13/79

*** MANDATORY DISCLOSURE OF U.S. SOCIAL SECURITY NUMBERS**
Disclosure of your U.S. social security number is mandatory. Section 30 of the Business and Professions Code and Public Law 94-466 (42 USCA 405(c)(2)(C)) authorize collection of your social security number. Your social security number will be used exclusively for tax enforcement purposes, for purposes of compliance with any judgment or order for family support in accordance with Section 17520 of the Family Code, or for verification of licensure or examination status by a licensing or examination entity which utilizes a national examination and where licensure is reciprocal with the requesting state. If you fail to disclose your social security number your application for initial licensure will not be processed AND you will be reported to the Franchise Tax Board, which may assess a $100 penalty against you.

MBC USE ONLY
MA007
School Code

L1

07A-100 (Rev. 3/01)

13. Have you taken any of the following written examinations: National Boards, other state boards, USMLE, SPEX, FLEX, ECFMG or LMCC? ☑ Yes ☐ No

IF YES, LIST NAME, LOCATION, DATE AND RESULT OF EACH EXAMINATION; FAILURES MUST ALSO BE DISCLOSED. EACH EXAMINATION AGENCY MUST SUBMIT AN ORIGINAL OFFICIAL EXAMINATION HISTORY REPORT DIRECTLY TO THE MEDICAL BOARD OF CALIFORNIA. THESE REPORTS WILL NOT BE RETURNED.

Examination	Date	Result (Pass/Fail)
National Boards Part I - Boston, MA.	06/77	
National Boards Part II - Boston, MA.	09/78	
National Boards Part III - Seattle, WA	03/80	

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

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

Jurisdiction	License Number	Date of Issuance	Dates of Practice in that Jurisdiction
WASHINGTON	18747	1980	07/79 - 06/81 (residency)
MASSACHUSETTS	48979	1981	07/81 - present
CONNECTICUT	035618	09/30/97	NONE
ARKANSAS	E-3126	12/07/01	2002 (part time)

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

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

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

16A. Are you currently, or have you ever been, a participant in a postgraduate training program in a facility in the U.S. or Canada? (You must include every residency, internship, and fellowship, whether or not completed.) ☑ Yes ☐ No

IF YES, LIST NAMES AND ADDRESSES OF ALL FACILITIES. SUBMIT AN ORIGINAL CERTIFICATE OF COMPLETION OF ACGME/RCPSC POSTGRADUATE TRAINING (FORM L3A) FROM EACH FACILITY. (DO NOT COMPLETE FORM L3As TO DOCUMENT TRAINING RECEIVED IN RESEARCH FELLOWSHIP PROGRAMS.) ALL TRAINING MUST BE LISTED, REGARDLESS OF WHETHER IT WAS SATISFACTORILY COMPLETED OR WILL BE USED TO MEET LICENSING REQUIREMENTS.

Facility Name	Address	Categorial Specialty Area	Dates of Attendance
UNIV. OF WASHINGTON AFFILIATED HOSPITALS	1959 N.E. PACIFIC ST. SEATTLE, WA. 98195	OB-GYN	07/01/79 - 06/30/81
TUFTS UNIV. SCHOOL OF MEDICINE AFFILIATED HOSPITALS	145 HARRISON AV. BOSTON, MA. 02111	OB-GYN	07/01/81 - 06/30/84
UNIV. OF MASSACHUSETTS MEDICAL CENTER	55 LAKE AV. NORTH WORCESTER, MA 01655	OCCUPATIONAL MEDICINE	01/01/87 - 12/31/87

QUESTIONS 16B through 22:
If you answer Yes to any of the following questions, please provide ALL official documentation regarding the matter in addition to your written personal explanations. An applicant must provide official hearing/court documents and original letters of explanation from medical schools or training program directors. If these documents are not provided with the application, they will be requested before review of the application can proceed. APPLICANTS ARE REQUIRED TO REPORT ANY MATTER THAT IS PENDING OR IN WHICH CHARGES HAVE BEEN DROPPED OR EXPUNGED.

16B. Have you ever withdrawn from, or been suspended, dismissed or expelled from a medical school or postgraduate training program OR have you ever taken a leave of absence from such a school or program? ☐ Yes ☑ No

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

NAME OF APPLICANT: MAUREEN ELIZ[redacted]ETH PAUL

DATE OF BIRTH: [redacted]

MBC USE ONLY

Written Examinations ☐ ☐ ☐

License Data

LGS ☐ ☐ ☐ ☐

Other Professional Licenses ☐

Postgraduate Training ☐ ☐ ☐ ☐

1B

MBC USE ONLY

License Data

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

17A. 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?

17B. Has any disciplinary action ever been filed or taken, including but not limited to, informal or confidential discipline, consent orders, or letters of warning, regarding any healing arts license which you now hold or have ever held?

17C. Is any such action as described above pending?

IF YOU ANSWERED YES TO 17A, 17B OR 17C, PROVIDE DETAILS ON A SEPARATE ATTACHMENT.

17(A)	Yes	No ☑
17(B)	Yes	No ☐
17(C)	Yes	No ☐

18. Has a claim or action for damages ever been filed against you in the course of the practice of medicine or any other healing art which resulted in a malpractice settlement, judgement, or arbitration award of over $30,000.00?

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

Yes No ☑

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

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

Yes No ☑

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

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

Yes No ☑

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

YOU MUST DISCLOSE ANY INFORMAL OR CONFIDENTIAL DISCIPLINARY ACTION.

Yes No ☐

22. Do you have any condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety, including but not limited to, any of the following?

IF YES, PLEASE CHECK THE APPROPRIATE BOX(ES) BELOW:

Yes No ☐

- ☐ A condition which required admission to an inpatient psychiatric treatment facility.
- ☐ Alcohol or chemical substance dependency or addiction.
- ☐ Emotional, mental or behavioral disorder.
- ☐ Other (explain): _____

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

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

23A. Have you ever been convicted of, or pled nolo contendere to, ANY violation (include every misdemeanor or felony) of any local, state, or federal law of any state, territory, country, or U.S. federal jurisdiction?

23B. Is any criminal action related to the above pending?

IF YOU ANSWERED YES TO 23A OR 23B, PROVIDE DETAILS ON A SEPARATE ATTACHMENT.

23 (A)	Yes	NO ☑
23 (B)	Yes	No ☐

NAME OF APPLICANT: MAUREEN ELIZABETH PAUL

DATE OF BIRTH:

L1C

STATE OF CALIFORNIA — STATE AND CONSUMER SERVICES AGENCY

GRAY DAVIS, Governor

Consumer Affairs

RECEIVED
SACRAMENTO
MEDICAL BOARD
OF CALIFORNIA

02 FEB 14 PM 4:38

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
02 FEB 15 AM 9:30
LICENSING PROG.

CERTIFICATE OF MEDICAL EDUCATION

MEDICAL SCHOOL: PLEASE COMPLETE THIS FORM IN THE ENGLISH LANGUAGE.

This certifies that MAUREEN ELIZABETH PAUL ; _____ ; _____
FULL NAME OF APPLICANT — U.S. SOCIAL SECURITY NO — DATE OF BIRTH-MM/DD/YYYY

enrolled in Tufts Univ. School of Medicine Boston, MA.
NAME OF MEDICAL SCHOOL — LOCATION

on the 8 day of SEPTEMBER 1975 and was granted the following credits on enrollment:
MONTH — YEAR

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

_____ _____ _____
MEDICAL SCHOOL — TOTAL CREDITS — DATES

The undersigned further certifies that the records of this institution show that the applicant attended in this institution 4 NUMBER OF YEARS

years of resident instruction of 32-46 NUMBER OF WEEKS weeks each, completing at least 4,000 hours, of which at least 80 percent actual attendance is required, in the subjects set forth hereunder (Business and Professions Code Section 2089), and that the applicant:

☑ was granted the degree Bachelor/Doctor of Medicine by OR ☐ withdrew from

the above mentioned medical school on the 20 day of MAY MONTH 1979 YEAR

Anatomy
Otolaryngology
Obstetrics and Gynecology
Radiology, including Radiation Safety
Tropical Medicine
Physiology
Biochemistry
Pathology, Bacteriology and Immunology
Ophthalmology
Dermatology
Embryology
Histology
Human Sexuality as defined in Section 2090
Medicine
Surgery, including Orthopedic Surgery
Urology
Psychiatry
Neurology
Alcoholism and Chemical Dependency
Preventive medicine, including Nutrition
Physical Medicine
Therapeutics
Neuroanatomy
Child Abuse Detection and Treatment
Geriatric Medicine
Pediatrics
Pharmacology
Anesthesia
Spousal or Partner Abuse Detection & Treatment**
Family Medicine***
Pain Management and End-of-Life Care****

* Each school where professional medical instruction was received MUST complete one of these forms. If more than one school was attended, photocopies of this blank form may be made and used.
** ONLY applicable to medical students who enrolled in medical school on or after September 1, 1994.
*** ONLY applicable to medical students who graduate from medical school on or after May 1, 1998
**** Only applicable to medical students who enrolled in medical school on or after June 1, 2000.

MEDICAL SCHOOL SEAL MUST BE IMPRINTED BELOW.

ATTENTION MEDICAL SCHOOL: The person who signs this form MAY NOT be related to the applicant by blood, marriage or adoption.

Only the President, 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.

Signed and the school seal affixed this 11 day of FEBRUARY 2002
MONTH — YEAR

BY Kathleen A. Kiedrowski
PRESIDENT, DEAN, OR REGISTRAR

L2

07A-100-L2 (Rev. 3/01)

STATE OF CALIFORNIA — STATE AND CONSUMER SERVICES

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 SACRAMENTO MEDICAL BOARD OF CALIFORNIA

CERTIFICATE OF COMPLETION OF ACGME/RCPSC POSTGRADUATE TRAINING

To be completed by the facility for every medical school graduate completing postgraduate training in the United States or Canada.

ATTENTION PROGRAM DIRECTORS AND DIRECTORS OF MEDICAL EDUCATION: THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE, OR ADOPTION. Only the Program Director and the Director of Medical Education may sign this form. If that signature authority is being delegated to another person, evidence of that delegation must be attached to this form (may be a memorandum from the Director of Medical Education). Such delegation must be on official letterhead and must be dated within the last 12 months.

PART 1: To be completed by the APPLICANT.

LAST NAME of Applicant: PAUL
First Name: MAUREEN
Middle Initial: E
U.S. Social Security Number:
Date of Birth: MM/DD/YYYY
Telephone Number: Home: Work:
Current Address: 1055 COMMONWEALTH AVENUE
City: BOSTON State: MASSACHUSETTS Zip Code: 02215

PART 2: To be completed by the PROGRAM DIRECTOR.

ATTENTION PROGRAM DIRECTOR: Do not sign and date this form before the last day of any postgraduate training year which will be used by the applicant to qualify for licensure. Completion of this form will certify that the individual named in PART 1 above completed a period of accredited postgraduate training at this facility. If a period of training WAS NOT completed in a satisfactory manner, please provide a separate detailed narrative explanation. The following information is provided to certify "satisfactory" completion. PLEASE SEE THE REVERSE FOR A DEFINITION OF "SATISFACTORY."

Name of Facility: University of Washington
Address of Facility: Box 356460 Seattle, WA 98195
Name of Program Director: Jane Brown, MD
Telephone Number: (206) 543-3891
Signature of Program Director:
Date Signed: 2/25/02
List Categorical Specialty Area of Training Completed by Trainee: OB/GYN
Date Training Commenced: July 1979
Date Training Completed: June 1981

If the training was rotating or transitional, list the specific rotations and the number of weeks spent in each (SEE THE REVERSE FOR INFORMATION ON SATISFYING THE GENERAL MEDICINE TRAINING REQUIREMENT):

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

Name of the Director of Medical Education: Lewis A Venter
Name of Facility: Dept Ob-Gyn U of Wash
Address of Facility: Box 356460 Seattle Wa 98195
City: Seattle State: Wa Zip Code: 98195
Telephone Number: (206) 543 3891

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

Attention: Director of Medical Education! *Do not sign and date this form before the last day of any postgraduate training year which will be used by the applicant to qualify for licensure. This form may be signed by the current Director of Medical Education; it does not need to be signed by the person who was the Director of Medical Education at the time the training listed above.*

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

OFFICIAL HOSPITAL SEAL OR NOTARY SEAL, DATE AND SIGNATURE MUST BE AFFIXED IN THE BOX TO THE LEFT TO CERTIFY TRAINING.

HOSPITAL OR NOTARY SEAL

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

Signature of Director of Medical Education: Lewis A. Venter
Date Signed: 25 Feb 02

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

L3A

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

STATE OF CALIFORNIA — STATE AND CONSUMER SERVICES AG

3-1-02

GRAY DAVIS, Governor

Consumer Affairs

DEPARTMENT OF MEDICAL BOARD OF CALIFORNIA

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

02 MAR 2 PM 4:16

CERTIFICATE OF COMPLETION OF ACGME/RCPSC POSTGRADUATE TRAINING

To be completed by the facility for every medical school graduate completing postgraduate training in the United States or Canada.

ATTENTION PROGRAM DIRECTORS AND DIRECTORS OF MEDICAL EDUCATION: THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE, OR ADOPTION. Only the Program Director and the Director of Medical Education may sign this form. If that signature authority is being delegated to another person, evidence of such delegation must be attached to this form (may be a photocopy). Such delegation must be on official letterhead and must be dated within the last 12 months.

PART 1: To be completed by the APPLICANT.

LAST NAME of Applicant	First Name	Middle Initial
PAUL	MAUREEN	E.

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

Current Address: 1055 COMMONWEALTH AVENUE

City	State	Zip Code
BOSTON	MASSACHUSETTS	02215

PART 2: To be completed by the PROGRAM DIRECTOR.

ATTENTION PROGRAM DIRECTOR: Do not sign and date this form before the last day of any postgraduate training year which will be used by the applicant to qualify for licensure. Completion of this form will certify that the individual named in PART 1 above completed a period of accredited postgraduate training at this facility. If period of training WAS NOT completed in a satisfactory manner, please provide a separate detailed narrative explanation. The following information is provided to certify "satisfactory" completion. PLEASE SEE THE REVERSE FOR A DEFINITION OF "SATISFACTORY."

Name of Facility:	Address of Facility:
New England Medical Center	Boston, MA 02111 750 Washington Street, Box 32

Name of Program Director:	Telephone Number:
Robert D. Kennison, MD	(617) 636-0265

Signature of Program Director:	Date Signed:
Robert D. Kennison, MD DK	2-27-02

List Categorical Specialty Area of Training Completed by Trainee:	Date Training Commenced:	Date Training Completed:
obstetrics & Gynecology	7-1-81	6-30-84

If the training was rotating or transitional, list the specific rotations and the number of weeks spent in each (SEE THE REVERSE FOR INFORMATION ON SATISFYING THE GENERAL MEDICINE TRAINING REQUIREMENT):

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

Name of the Director of Medical Education:	Name of Facility:
See attached letter	#

Address of Facility:

City	State	Zip Code	Telephone Number:
			( )

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

Attention: Director of Medical Education! *Do not sign and date this form before the last day of any postgraduate training year which will be used by the applicant to qualify for licensure. This form may be signed by the current Director of Medical Education; it does not need to be signed by the person who was the Director of Medical Education at the time of the training listed above.*

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HOSPITAL OR NOTARY SEAL

OFFICIAL HOSPITAL SEAL OR NOTARY SEAL, DATE AND SIGNATURE MUST BE AFFIXED IN THE BOX TO THE LEFT TO CERTIFY TRAINING.

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

Signature of ~~Director of Medical Education~~: Notary Public	Date Signed:
Sheila Lambert Pollack	3-12-02

L3A

STATE OF CALIFORNIA — STATE AND CONSUMER SERVICES AGENCY

3-1-02

GRAY DAVIS, Governor

Consumer Affairs

DEPARTMENT OF CONSUMER AFFAIRS
MEDICAL BOARD OF CALIFORNIA

MEDICAL BOARD OF CALIFORNIA
1426 Howe Avenue, Suite 54, Sacramento, CA 95825-3236
(916) 263-2499/FAX (916) 263-2467 Internet: www.medbd.ca.gov

02 APR -5 PM 9:31

CERTIFICATE OF COMPLETION OF ACGME/RCPSC POSTGRADUATE TRAINING

To be completed by the facility for every medical school graduate completing postgraduate training in the United States or Canada.

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

PART 1: To be completed by the APPLICANT.

LAST NAME of Applicant	First Name	Middle Initial
PAUL	MAUREEN	E.

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

Current Address: 1055 COMMONWEALTH AVENUE

City	State	Zip Code
BOSTON	MASSACHUSETTS	02215

PART 2: To be completed by the PROGRAM DIRECTOR.

ATTENTION PROGRAM DIRECTOR: Do not sign and date this form before the last day of any postgraduate training year which will be used by the applicant to qualify for licensure. Completion of this form will certify that the individual named in PART 1 above completed a period of accredited postgraduate training at this facility. If a period of training WAS NOT completed in a satisfactory manner, please provide a separate detailed narrative explanation. The following information is provided to certify "satisfactory" completion. PLEASE SEE THE REVERSE FOR A DEFINITION OF "SATISFACTORY."

Name of Facility:	Address of Facility:
Univ. of Massachusetts	55 Lake Ave N. Worcester MA

Name of Program Director:	Telephone Number:
Jay Himmelstein	(508) 856-3957
Signature of Program Director:	Date Signed: 2/27/02

List Categorical Specialty Area of Training Completed by Trainee:	Date Training Commenced:	Date Training Completed:
Preventive Med / Occupational Health	Jan 1 1987	Dec 31st 1987

If the training was rotating or transitional, list the specific rotations and the number of weeks spent in each (SEE THE REVERSE FOR INFORMATION ON SATISFYING THE GENERAL MEDICINE TRAINING REQUIREMENT):

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

Name of the Director of Medical Education:	Name of Facility:
Marilyn P. Leeds	

Address of Facility:	City	Zip Code	Telephone Number:
Admin. Dir., Grad Med Ed UMass Medical School 55 Lake Ave. No., Room S2-332	Worcester, MA 01655		( )

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

Attention: Director of Medical Education: *Do not sign and date this form before the last day of any postgraduate training year which will be used by the applicant to qualify for licensure. This form may be signed by the current Director of Medical Education; it does not need to be signed by the person who was the Director of Medical Education at the time of the training listed above.*

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

Signature of Director of Medical Education:	Date Signed:
Marilyn P. Leeds	3/26/02

L3A