NOTE TO APPLICANT:

Forward the completed application form to the State board or agency which issued the license used as the basis for this application. The agency will complete the statement provided below and authenticate it as required, and return it to the APPLICANT.

TO BE COMPLETED BY THE STATE LICENSE ISSUING AGENCY:

(Do not make this endorsement unless the applicant has affixed his photograph on the preceding page and made the required Affidavit.)

I, Bert C. Brennan, Exec. Director, Secretary of the Michigan Medical Practice Board
(Name of Board or Department)

certify that License No. 39013 to practice as a Physician and Surgeon was issued to

David Michael Priver (Name of Licensee) on 6/17/71 (Date)

based on * FLEX Exam. (By written/oral examination or on credentials) that the applicant BEFORE ADMISSION TO THE

EXAMINATION presented to this Board a diploma issued by Wayne State Univ. (Name of Medical School)

on 6/15/70 (Date); that no charge against this Doctor has ever been filed with this Board or any other Board

so far as our records show, nor has his License been revoked or suspended.

I further certify that the License indicated above is currently valid and will expire 12/31/72 (Date)

(NOTE – If the License was issued by written examination, the Secretary will complete the following certification, otherwise write ACROSS the page below this line the words: ISSUED ON CREDENTIALS.)

I further certify that this Doctor passed the REGULAR WRITTEN EXAMINATION given by this Board on June 16-18, 1970 (Date), and obtained a general average of 76.9 per cent in the following subjects:

SUBJECTS OF EXAMINATION	PER CENT	SUBJECTS OF EXAMINATION	PER CENT
Anatomy		Medicine	
Biochemistry		Ob/Gyn	
Microbiology		Pediatrics	
Pathology		Prev. Med. & Pub. Health	
Pharmacology		Psychiatry	
Physiology		Surgery	

BASIC SCIENCES AV. CLINICAL SCIENCES AV. 5.0

I hereby certify that the above License is in good standing; that the above applicant's record is clear and that from the records now on file in this office, I believe the above applicant to be a fit and proper person to receive a California Reciprocity Certificate.

In testimony whereof witness my hand and seal.

[SEAL]

Bert C. Brennan
(Signature)
(Secretary of the Michigan Med. Practice Board (State Board of Examiners))
(General Exec. Director)

dated at Lansing, Michigan

this 22nd day of February 19 71 Address 905 Southland, Lansing, MI 48909

(*)An oral examination shall not be deemed of equal merit with a written examination and no certificate shall be issued in the case where the applicant was given an oral examination in another State and the California law required a written examination on the same data.

172.50 000660

STATE OF CALIFORNIA—AGRICULTURE AND SERVICES AGENCY

DEPARTMENT OF Consumer Affairs

BOARD OF MEDICAL QUALITY ASSURANCE
1430 HOWE AVENUE, SACRAMENTO, CALIFORNIA 95825
ALLIED HEALTH PROFESSIONS (916) 322-3043
APPLICATIONS AND EXAMINATIONS (916) 322-5405

MAR 7 4 29 PM '72

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

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

00067

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

1. NAME: Last: PRIVER First: DAVID Middle: MICHAEL — 2. Telephone Number:

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

4. Address: Street and No. / Rural Route: 4496 CHAMBERLAIN City: BIRMINGHAM State: MICHIGAN Zip Code: 48010

5. Name you wish on License: DAVID M. PRIVER, [redacted] Birthdate: (Month - Day - Year)

6. Premedical Education: Name of College or University: 1) KALAMAZOO COLLEGE 2) WAYNE STATE UNIVERSITY Location: 1) KALAMAZOO, MICH. 2) DETROIT, MICH.

Period of attendance: 1) From: 9/61 To: 9/65 2) 1965 6/66

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

7. Medical School:

Year	NAME OF INSTITUTION	LOCATION	FROM	TO
1st	WAYNE STATE UNIVERSITY	DETROIT, MICH.	9/66	
2nd	"	"	"	
3rd	"	"	"	
4th	"	"	"	6/70
5th				
6th				

8. Doctor of Medicine Degree granted by: WAYNE STATE UNIVERSITY School of Date: 6/1970 — For Office Use Only — School Code: MD 7

9. 1st Year Postgraduate Training (Internship): Medicine

LOCATION	TYPE OF SERVICE	FROM	TO
STATE HOSPITAL OF DETROIT	ROTATING	7/1/70	6/30/71

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

MICHIGAN MEDICAL LICENSE

Name of Board Issuing License or Certificate: MICHIGAN BOARD OF MEDICAL EXAMINERS — Exact Date of Issue: 6/17/71

070-30 (Rev. 2-71)

(continue on reverse side)

11. Have you ever filed an application in California?

12. Have you ever failed in a written or oral examination in California?

(If yes, give details) _____

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

Michigan

14. Has any disciplinary action ever been taken regarding any license which you now hold or ever held?

If Yes, indicate below:

STATE	DATE	CHARGE	DISPOSITION

15. Have you ever been denied a license to practice medicine in any State or Country?

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?

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?

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.)

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: 6 ft. Weight: 180 lbs.

Hair Color: Brown Eye Color: Brown

Identifying marks: None

NOTE: The collection of 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 David Price

Date 2/2/78

Subscribed and sworn to before me this 2nd day of February 19 78

Signature of Notary Virginia L. Herrema

[SEAL]

Address Detroit

VIRGINIA L. HERREMA
Notary Public, Wayne County, Mich.
My commission expires: My Comm. Expires July 23, 1978

STATE OF CALIFORNIA—AGRICULTURE AND SERVICES AGENCY

DEPARTMENT OF Consumer Affairs

BOARD OF MEDICAL EXAMINERS

1020 N STREET, SACRAMENTO, CALIFORNIA 95814
TELEPHONE: (916) 322-3040

PLEASE FORWARD TO YOUR MEDICAL SCHOOL

CERTIFICATE OF EDUCATION

This Certifies That DAVID MICHAEL PRIVER
Full name of applicant

enrolled in WAYNE STATE UNIVERSITY SCHOOL OF MEDICINE
Name of medical school (college)

on the 22 day of September 19 66
Month Year

☒ 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:

☒ PHYSICS ☒ CHEMISTRY ☒ BIOLOGY (or) ZOOLOGY (Check course(s) completed)

at WAYNE STATE UNIVERSITY, and that he attended while at this
Please indicate school

medical school (college) All courses of lectures of 4 years weeks each,
Specify number Specify number of weeks

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

☒ was granted the degree { Bachelor / Doctor } of Medicine.

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

_____

_____

on the 16 day of May 19 70
Month Year

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

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

Signed and the College seal affixed this 20 day
of February 19 78
Month Year

[Affix Seal Here]

By Sandra J. Driscoll
President, Secretary, Etc.

Sandra J. Driscoll, Recorder

07A-33 (REV. 8-78)

STATE DEPARTMENT OF CONSUMER AFFAIRS
INTERNET CASHIERING SYSTEM
MEDICAL BOARD OF CALIFORNIA
SUPPLEMENTAL INFORMATION REPORT
From Date: 08/27/2013 **To Date:** 08/27/2013

ATRISUPPINF

10-AUG-16 09:31:59

Person Id : **Name :** Priver,David

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

Total Questions Asked For Person : 8

STATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS

dca BREEZE

Department of Consumer Affairs

RECEIPT

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

Name:	PRIVER, DAVID MICHAEL
Transaction Date:	09/27/2015 15:36
Application Number:	
Complaint Number:	
License Type:	8002
License Number:	38171
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 C**
License Number:	**38171**
File Number:	
Application:	**Physician's and Surgeon's Renewal**
Application Number:	
Application Date:	**09/27/2015 (mm/dd/yyyy)**

Application Questions

Have you served or are you currently serving in the military?	**N**

Personal Detail

First Name:	**DAVID**
Middle Name:	**MICHAEL**
Last Name:	**PRIVER**
Birthdate:	**/**/****
Gender:	**Male**

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:	**Yes**

Attachments

Physician Survey

Are you retired?	**No**
Activities in Medicine	**Administration - None**
	Other - None
	Patient Care - 1-9 Hours
	Research - None
	Teaching - 1-9 Hours
	Telemedicine - None
Patient Care Practice Location	**Zip: 92101 County: SAN DIEGO**
Telemedicine Practice Location	**Zip: 92101 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	**White**
Web Site Profile	**Cultural Background - No**
	Foreign Language Proficiency - No
	Gender - Yes
E-mail:	

Fees

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

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

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

Attestation

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

Signature: Date: