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

DEPARTMENT OF Consumer Affairs

BOARD OF MEDICAL EXAMINERS

1020 N STREET, SACRAMENTO, CALIFORNIA 95814
TELEPHONE:
Applications and Examinations (916) 322-5040

RECEIVED SACRAMENTO BOARD OF MEDICAL QUALITY ASSURANCE
JUL 8 3 32 PM '77

APPLICATION FOR PHYSICIAN'S AND SURGEON'S CERTIFICATE BASED ON NATIONAL BOARD CREDENTIALS CLASS G

00014

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

1. NAME: Last ROITMAN First NORTON Middle A. Maiden -
2. Social Security No.:
3. List other names, if any, you have used:
4. Address: Street and No./Rural Route 2152 PINE ST. City SAN DIEGO State CALIF Zip Code 92103
5. Name you wish on License: NORTON A. ROITMAN Birthdate: (Month - Day - Year)
6. P[re-medical school]: UNIVERSITY OF WISCONSIN, MADISON, WISCONSIN Location CHICAGO, ILLINOIS
Period of attendance: From: 1972 To: 1976 Check premed courses successfully completed: ☒ Chemistry ☒ Physics ☒ Biology or Zoology
7. Medical School:

Year	Name of Institution	Location	From	To
1st	UNIVERSITY OF ILLINOIS	1737 W. POLK	1972	
2nd	ABRAHAM LINCOLN	CHICAGO,		
3rd	SCHOOL OF	ILLINOIS		
4th	MEDICINE	60680		1976
5th				
6th				

8. Doctor of Medicine Degree granted by: UNIVERSITY OF ILLINOIS ~~ABRAHAM LINCOLN SCHOOL OF MEDICINE~~ College of Med. Date JUNE 1976 For office use only School Code: IL 11
9. 1st Year Postgraduate Training (Internship):

Location	Type of Service	From	To
UNIVERSITY OF CALIFORNIA/SAN DIEGO	PSYCHIATRIC INTERN	JULY 1976	JUNE 1977

10. List all States in which you have been licensed to practice medicine: NONE
11. 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

12. 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

13. Are you now or have you ever been addicted to narcotic drugs?

FORM 07A-101 (REV. 9-75) (Over)

14. Have you ever been convicted of, pled guilty or 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?	
15. Have you ever been convicted of, pled guilty or nolo contendere to any offense, misdemeanor or felony in any state? (Except violations of traffic laws resulting in fines of $50.00 or less.)	

16. If you answered "Yes" to either No. 14 or No. 15 above, please provide the following information:

Violation and Location	Date	Penalty/Disposition

[redacted]

Applicant: Please complete the following:

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

Hair color: ________ Eye color: ________

Identifying marks: ________

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 ________

Date 7/6/77

Subscribed and sworn to before me this 6th day of July 1977.

OFFICIAL SEAL
J. SCOLARI
NOTARY PUBLIC - CALIFORNIA
SAN DIEGO COUNTY
My comm. expires MAY 2, 1981

Signature of Notary J. Scolari

Address 3166 Gilman La Jolla, Cal 92037

My commission expires: 5-2-81

STATE OF CALIFORNIA—AGRICULTURE AND SERVICES AGENCY — RONALD REAGAN, Governor

DEPARTMENT OF Consumer Affairs

BOARD OF MEDICAL EXAMINERS

1020 N STREET, SACRAMENTO, CALIFORNIA 95814

TELEPHONE: (916) 322-3040

THIS CERTIFIES That Norton Roitman
(Full name of applicant)

of Chicago, Illinois (Address when matriculated) matriculated in University of Illinois Medical Center (Name of medical school (college))

Chicago, Illinois (Location) on the 25th day of September (Month) 19 72

and was granted the following credits on matriculation:

Entered as a Freshman
(Specify whether entered freshman or with advanced credits)

based upon the following credentials: Please see Attached Transcript.
(Give a transcript of premedical education or advanced credit either above or on an attached paper)

The undersigned further certifies * that the records of this institution show that PRIOR TO COMMENCING THE STUDY OF MEDICINE the applicant herein referred to has completed a three-year † course of College grade including the subjects of PHYSICS, CHEMISTRY and BIOLOGY and that he attended *in this institution* ‡ Four (Specify number) courses of lectures of Twelve (Specify number of weeks) weeks each, completing the following schedule totaling at least 4,000 hours in the subjects required by Article 5, Section 2102 of the Business and Professions Code, relating to the practice of medicine, as set forth hereunder, and that he was granted the degree { BACHELOR / DOCTOR } of Medicine §

by the above-mentioned Medical (College) on the 4th day of June (Month) 19 76 (Year)

Anatomy
- Embryology
- Histology
- Neuroanatomy

Physiology
Psychobiology
Biochemistry
Pathology, bacteriology and immunology
Pharmacology
Preventive medicine
- Hygiene and sanitation

Radiology, including roentgenologic technique and radiation safety

Medicine
- Pediatrics
- Psychiatry
- Neurology
- Dermatology
- Physical medicine
- Therapeutics
- Tropical medicine

Surgery, including orthopedic surgery
- Urology
- Ophthalmology
- Anesthesia
- Otolaryngology
- Obstetrics and gynecology

Signed and the College seal affixed this 30th day of June 19 77

[AFFIX SEAL HERE]

By Gerald L. Schmidt, M.D.
(President, Secretary, Dean)

Gerald L. Schmidt Ed.D.
Associate Director of Records

* If premedical work has been completed *state the time* devoted thereto and institution where completed.

† An applicant matriculating in a medical school before January 1, 1951 need only present evidence satisfactory to the board of having completed a TWO Year resident course of college grade including the subjects of physics, chemistry and biology.

‡ Each medical school attended must complete one of these forms covering period of attendance.

§ State out the degree NOT CONFERRED.

The law requires 4 terms of 32 weeks each totaling 4,000 hours medical education completed in a school approved by the Board.

07A-32 (REV. 6-75)

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

PART 1

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: 3/10/13

LICENSE NO.	EXPIRES	AMOUNT DUE NOW	DELINQ. FEE IF POSTMARKED AFTER 04/30/13
G 35003	03/31/13	$808.00	$886.00
	VOLUNTARY FEE =	$	$
	TOTAL ENCLOSED =	$ 808.00	$

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

STREET _____

CITY _____ STATE _____ ZIP _____

PHONE NUMBER ( )

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. I CERTIFY UNDER PENALTY OF PERJURY THAT I HAVE NO FINANCIAL INTEREST TO DISCLOSE.

[signature]
Signature required here

ACTIVE NORTON A. ROITMAN
SUITE D307
2340 PASEO DEL PRADO
LAS VEGAS NV 89102

OVER

6301070000070000600035003301033113000808000008860O

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
NONE	

13212013 10003019 10010031

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

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:	ROITMAN, NORTON A
Transaction Date:	01/04/2015 16:03
Application Number:	
Complaint Number:	
License Type:	8002
License Number:	35003
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:	**35003**
File Number:	
Application:	**Physician's and Surgeon's Renewal**
Application Number:	
Application Date:	**01/04/2015 (mm/dd/yyyy)**

Personal Detail

First Name:	**NORTON**
Middle Name:	**A**
Last Name:	**ROITMAN**
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:	**No**

Attachments

Physician Survey

Are you retired?	**No**
Activities in Medicine	**Administration - 1-9 Hours** **Other - None** **Patient Care - 20-29 Hours** **Research - None** **Teaching - 1-9 Hours** **Telemedicine - None**
Patient Care Practice Location	**Zip: 89102 County: OUT OF STATE**
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	**Psychiatry - Primary**
Board Certifications	**American Board of Psychiatry and Neurology - Child and Adolescent Psychiatry** **American Board of Psychiatry and Neurology - Psychiatry**
Postgraduate Training Years	**5 Years**
Cultural Background	**White**
Foreign Language Proficiency	**None**
Web Site Profile	**Cultural Background - No** **Foreign Language Proficiency - Yes** **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: