

002955
 EDWARD G. BROWN JR., Governor



BOARD OF MEDICAL EXAMINERS

1030 H STREET, SACRAMENTO, CALIFORNIA 95811
 TELEPHONE:

Applications and Examinations (916) 322-5040

RECEIVED SACRAMENTO
 BOARD OF MEDICAL
 QUALITY ASSURANCE



JUN 8 3 32 PM '77

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

00014

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

1. NAME: Last First Middle Maiden					2. Social Security No.	
ROITMAN NORTON A.						
3. List other names, if any, you have used:						
4. Address: Street and No./Rural Route				City	State	Zip Code
2152 PINE ST.				SAN DIEGO	CALIF	92103
5. Name you wish on license:					Birthdate: (Month - Day - Year)	
NORTON A. ROITMAN						
6. 1. UNIVERSITY OF WISCONSIN, MADISON, WISCONSIN					Location	
CHICAGO, ILLINOIS						
Period of attendance:			Check printed courses successfully completed:			
From: 1972 To: 1976			<input type="checkbox"/> Chemistry <input type="checkbox"/> Physics <input type="checkbox"/> Biology or Zoology			
7. Medical Schools:						
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:					Date	For office use only
UNIVERSITY OF ILLINOIS, ABRAHAM LINCOLN					JUNE 1976	School Code: ILL 11
SCHOOL OF MEDICINE College of Med.						
9. 1st Year Postgraduate Training (Internship):						
Location		Type of Service	From	To		
UNIVERSITY OF CALIFORNIA - SAN DIEGO		PSYCHIATRIC INTERN	JUN 1976	JUN 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?						

14. Have you ever been convicted or 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 or pled guilty or nolo contendere to any offense, misdemeanor or felony in any state? (Except violations of traffic laws resulting in fines of \$500.00 or less.)

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

Offense and Location	Date	Penalty/Disposition



Applicant: Please complete the following:

Height: _____ Ft. _____ In. Weight: _____ Lbs.

Hair color: _____ Eye color: _____

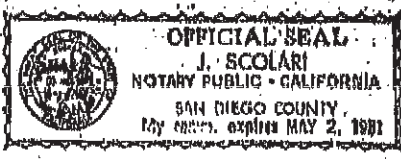
Identifying marks: _____

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: *Robert D. [Signature]*
 Date: 7/6/77

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



Signature of Notary: *J. Scolari*
 Address: 3160 Selman La Jolla, Cal.
92037

My commission expires: 5-2-81



BOARD OF MEDICAL EXAMINERS
 1020 N STREET, SACRAMENTO, CALIFORNIA 95814
 TELEPHONE: (916) 322-3040



THIS CERTIFIES That Norman Reisman Full name of applicant
 of Chicago, Illinois Address where matriculated matriculated in University of Illinois Medical Center Name of medical school (college)
Chicago, Illinois Location on the 25th day of September Month 10 Year 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 courses of lectures of Twelve weeks each, completing the following schedule totaling at least 4,000 hours in the subjects required by Article 5, Section 2192 of the Business and Professions Code, relating to the practice of medicine, as set forth hereunder, and that he was granted the degree BACHELOR of Medicine Doctor by the above-mentioned Medical (College) on the 4th day of June Month 10 Year 76

- 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 Unit devoted thereto and institution where completed.
 † An applicant matriculating in a medical school before January 1, 1954 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 to a school approved by the Board.

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

License Renewal Application
Physician and Surgeon

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: YES NO

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: Norton A. Roitman DATE: 3/10/13

AMOUNT DUE NOW	DELINQ. FEE IF POSTMARKED AFTER 04/30/13
\$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 DO NOT, UNDER PENALTY OF PERJURY, HAVE A FINANCIAL INTEREST TO DISCLOSE.
Norton A. Roitman
Signature required here

LICENSE NO. 35003 EXPIRES 03/31/13

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

OVER

63010700000700006000350033010331130008080000088600

13712013 10007019 10010031

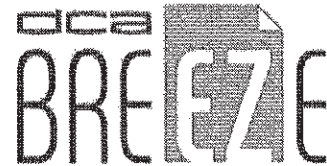
G. Financial Interest Statement

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	

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



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

1/4/15 4:01 PM

Page 1 of 3

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: *****j******
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



1420416119142

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: