STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY

DEPARTMENT OF CONSUMER AFFAIRS

BOARD OF MEDICAL QUALITY ASSURANCE

1430 Howe Avenue
Sacramento, CA [illegible]
(916) 920-[illegible]

3 091 106

APPLICATION FOR PHYSICIAN AND SURGEON'S EXAMINATION AND LICENSURE

Read instructions before completing this application. All questions on this application must be answered, and all supporting documents must be submitted with this application per instructions. Please type or print neatly. When space provided is insufficient, attach additional sheets of paper.

BMQA USE ONLY

1. Name: Last / First / Middle — [illegible]

PERSONAL DATA

2. Other names you have used: [illegible]

3. Address: [illegible]

4. Telephone Numbers: Home / Work

5. Date of Birth: Mo/Day/Yr

6. Sex: ☐ Female ☒ Male

7. Are you a U.S. citizen? ☒ Yes ☐ No [illegible]

8. Have you ever filed an application in California? If yes, give date of previous application. ☐ Yes ☒ No [illegible] Pennsylvania

9. List name and address of all colleges or universities attended other than schools where professional medical instruction was received. Submit official transcripts from each school attended.

Name	Address	Period of Attendance From Mo/Yr	To Mo/Yr
Univ. of Calif. at Santa Barbara	University of California Santa Barbara, California 93106	Sept. '70	June '74
Univ. of Calif. at Berkeley	University of California Berkeley, California	June '74	Dec. '75

NON-MEDICAL EDUCATION

10. Check whether the following premedical courses were successfully completed and show where completed:

Course	Name of College or University
Chemistry	(Inorganic) Chemistry 1A UC Santa Barbara Chem 1B, 5; (Organic) Chem 8A, 8B UC Berkeley
Physics	UC Berkeley
Biology	UC Berkeley
Zoology	

L1A

MEDICAL EDUCATION

Name			Period of Attendance	
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

POSTGRADUATE TRAINING

Name		Type of Service	Period of Attendance From (Mo/Yr)	To (Mo/Yr)
[illegible] Hospital	[illegible]	Surgery	July 1980	June 1981

Have you been licensed to practice in any state or country?

State or Country	License Number	Date of Issuance		
Maryland	[illegible]	Sept. 20, 1983	[illegible]	[illegible]

L1B

16. Has any disciplinary action ever been taken regarding any healing arts license which you now hold or have ever held? Include any action by the U.S. military, U.S. Public Health Service or other U.S. federal governmental entity.
If yes, give details below.

State	Date	Charge	Disposition

17. Have you ever been denied a license, permit or privilege to practice medicine, or permission to take any examination in any state, country, or U.S. federal jurisdiction?
If yes, give details below.

State or Country	Date of Denial	Reason for Denial

18. Have you ever voluntarily [illegible] license to practice the healing arts in another state?
If yes, [illegible] details [illegible] separate sheet of paper.

19. Have you ever had staff privileges denied, suspended, revoked or resigned from a medical staff in lieu of disciplinary action? ☐ Yes ☒ No If yes, please explain on a separate sheet of paper.

20. Are you now or were you in the past, addicted to controlled substances, such as narcotics, or alcohol?

21. Have you ever been convicted of, or plead nolo contendere to a violation of any federal, state or local law relating to the manufacture, distribution, or dispensing of controlled substances or to drug addiction?
If yes, give details below.

Violation and Location	Date	Penalty or Disposition

22. Have you ever been convicted of, or plead nolo contendere to any offense, misdemeanor or felony of any state, the United States, or a foreign country? (Except minor traffic laws resulting in fines of $75.00 or less)
If yes, give details below.

Violation and Location	Date	Penalty or Disposition

You are required to list any conviction that has been set aside and dismissed under Section 1203.4 Penal Code or under any other provision of law.

For [illegible] Use Only

LICENSE DATA

GENERAL DATA

L1C

I hereby declare under penalty of perjury under the laws of the State of California that the photo of myself attached hereto was taken

on or about [illegible] 19[illegible]

at age then being [illegible]

color of hair [illegible]

color of eyes [illegible]

height [illegible]

weight [illegible]

identifying marks [illegible]

NOTE: All information requested on this application is mandatory. Failure to provide any of the requested information will result in the application being rejected as incomplete. [illegible] Business and Professions Code [illegible] Section 2080 [illegible] Applicants have the right to review their applications [illegible] the Program Manager of the Division of Licensing [illegible] records.

STATE OF California

COUNTY OF San Diego

THOMAS PATRICK MORAN

[illegible] the foregoing application for a physician's and surgeon's certificate in California and that [illegible] has carefully read and thoroughly understands all the requirements therein and that the statements made herein and all attachments are true and correct under penalty of perjury under the laws of the State of California.

[illegible] requests that the Division of Licensing, Board of Medical Quality Assurance, initiate a review of the records to determine their eligibility for examination, postgraduate training or licensure in California. In making this request, [illegible] authorize the release of any information or records held by any individual or agency relative to [illegible] qualifications as a physician and surgeon, upon request by the Board for use in evaluating their file.

Thomas Patrick Moran

(Signature of applicant in full; do not use INITIALS ONLY)

Subscribed and sworn to before me this [illegible] day of October 1986

Signature of Notary Public Julia [illegible]

Address Naval Hospital, San Diego CA 92134

(SEAL)

My commission expires October 20, 1987

L1D

STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY [illegible] GEORGE DEUKMEJIAN, Governor

BOARD OF MEDICAL QUALITY ASSURANCE

[illegible] AVENUE, SACRAMENTO, CALIFORNIA [illegible]

CERTIFICATE OF MEDICAL EDUCATION

MEDICAL SCHOOL: DO NOT COMPLETE IF PHOTOGRAPH OF APPLICANT/STUDENT IS NOT ATTACHED BELOW

This certifies that [illegible]
(Name of Applicant)

of Coronado, California [illegible] enrolled in University of Maryland School of Medicine
(Name of Medical School)

655 West Baltimore Street on the 7 day of September 19 76
(Address) (Month)

and was granted the following credits on enrollment:

Premedical Education: Two years of preprofessional postsecondary education, including the subjects of physics, chemistry, and biology (Business and Professions Code Section 2089)

(Name of Institution) (Dates)

Advanced Standing: Credit previously obtained at an approved medical school [illegible]

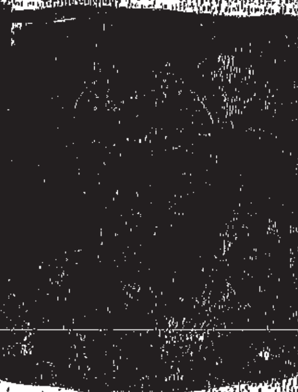
The undersigned further certifies that the records of this institution show that he attended in this institution [illegible] courses of resident instruction of [illegible] each, completing at least 4000 hours, of which at least 80 percent actual attendance is required, in the subjects set forth hereunder (Business and Professions Code Section 2089) and that:

[X] He was granted the degree of Doctor of Medicine by

[ ] He withdrew from

the above mentioned medical school on the 31 day of August 19 80

Anatomy
Obstetrics and Gynecology
Radiology, including Radiation Safety
[illegible]
Pathology
[illegible]
[illegible]
Dermatology
Embryology
Histology
Human Sexuality as defined in Section 2090
Medicine
Surgery, including Orthopedic Surgery
Urology
Psychiatry
Neurology
Preventive Medicine, including Nutrition
Physical Medicine
Therapeutics
Neuroanatomy
Child Abuse Detection and Treatment
Geriatric Medicine
Pediatrics
Pharmacology
[illegible]



Signed and the school seal affixed this 6 day of November 19 85

BY [signature]

Bernice Sigman, M.D.
Associate Dean for Student Affairs

Medical School Seal MUST be imprinted partially on the photograph

TRANSCRIPTS OF PREMEDICAL EDUCATION, ADVANCED CREDITS AND MEDICAL SCHOOL CREDITS MUST BE SUPPLIED WITH THIS CERTIFICATE

[illegible]

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STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY — GEORGE DEUKMEJIAN, Governor

BOARD OF MEDICAL QUALITY ASSURANCE

1430 HOWE AVENUE, SACRAMENTO, CALIFORNIA [illegible]
(916) [illegible]

CERTIFICATE OF COMPLETION OF ACGME POSTGRADUATE TRAINING

To be completed [illegible] for every [illegible] who has completed postgraduate training [illegible] Canada. Do not complete [illegible] of clinical [illegible] described below. Please type or print. [illegible]

This is to certify that [illegible] (Name of Applicant)

a graduate of [illegible] University of Maryland School of Medicine, Baltimore, MD (Name of Medical School)

completed postgraduate training at The Union Memorial Hospital, Baltimore, Maryland 21218 (Name and Address of Facility)

201 E. University Parkway, Baltimore, Maryland 21218

on [illegible] 1980 to [illegible] 1980 and completed such training

on [illegible] 30 [illegible] 19 [illegible]. This training consisted of [illegible] months of actual clinical instruction and is approved by the Accreditation Council for Graduate Medical Education (ACGME) or the Coordinating Council of Medical Education of the Canadian Medical Association (CCME) and consisted of the following rotations:

[illegible]

ROTATION	LENGTH OF ROTATION
[illegible] AND [illegible]OLOGY	18 Months

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

NAME Clifford R. Wheeless, [illegible]

ADDRESS 201 E. University Parkway
Baltimore, Maryland 21218

PHONE NUMBER (301) 554-2671

DATE 12/1/80

SIGNATURE [signature]

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STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY — GEORGE DEUKMEJIAN, Governor

BOARD OF MEDICAL QUALITY ASSURANCE

1430 HOWE AVENUE, SACRAMENTO, CALIFORNIA

CERTIFICATE OF ENDORSEMENT BY STATE LICENSING AGENCY

1. NAME (last) (first) (middle)
Moran, Thomas Patrick

2. ADDRESS (Number and street/rural route/include city)

3. DATE OF BIRTH mo/day/yr

4. SEX

5. STATE LICENSING AGENCY

NOTE: Applicant will sign this statement in presence of notary public.

(Signature of applicant)

Signed and sworn to before me this 18 day of October 1986

Signature of Notary Public

Address

My commission expires

TO BE COMPLETED BY STATE LICENSING AGENCY

(Do not complete if photograph of applicant is not attached above. Please type or print.)

I certify that THOMAS PATRICK MORAN, M.D. (name of applicant) who graduated from UNIVERSITY OF MARYLAND (name of medical school) on 6/80 (date of graduation) was granted license number D27796 on (date license issued) on the basis of NATIONAL BOARDS

NOTE: If the license was issued by written examination, complete the following certification; otherwise do not accept the following certification.

I further certify that this doctor passed the REGULAR WRITTEN EXAMINATION given by this Board on (date) and obtained a general average of per cent in the following subjects:

Subject of Examination	Per Cent	Subject of Examination	Per Cent
ISSUED ON CREDENTIALS			

I certify that this license is valid/current, has never been suspended or revoked, and will expire 9/30/87, and that records in this office indicate that there are not now, nor have there ever been any charges filed against the holder of this license.

NOTE: If any portion of the above certification is deleted or modified, please attach an explanation.

PATRICIA CARRINGTON, EXECUTIVE DIRECTOR
(Name and title of agency official)

MARYLAND BOARD OF MEDICAL EXAMINERS
(Name of state licensing agency)

(Signature of agency official)

201 W. PRESTON STREET
(Address)

BALTIMORE, MD 21201

(301) 225-5900
(Telephone number)

L4

STATE DEPARTMENT OF CONSUMER AFFAIRS
INTERNET CASHIERING SYSTEM
MEDICAL BOARD OF CALIFORNIA
SUPPLEMENTAL INFORMATION REPORT
From Date: 02/24/2012 **To Date:** 02/24/2012

ATRISUPPINF

10-AUG-16 09:29:06

Person Id : **Name :** Moran,Thomas

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

Medical Board of California – Physician's and Surgeon's Initial Renewal

LICENSEE NAME	LICENSE NO.	EXPIRATION DATE	AMOUNT DUE NOW	AMOUNT DUE IF POSTMARKED AFTER JUNE 30, 2014
MORAN, THOMAS P	G59541	05/31/14	$820.00	$898.00

LICENSEE MUST CHECK CORRECT BOXES

- "H" [x] Completed Continuing Education
- "E" [ ] Change of Address (fill in reverse side)
- "I" [ ] Conviction Disclosure – Yes
- "J" [x] Conviction Disclosure – No
- "F" [ ] Family Physician Training Program ($25)
- "G" [x] Financial Interest Statement

"D" **SIGNATURE REQUIRED**

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

Signature Thomas P. Moran MD Date 3/7/2014

ENTER YOUR PHONE NUMBER FOR REFERENCE:

6301070000070000600059541301053114000820000089800

CHANGE OF MAILING ADDRESS **MORAN, THOMAS P** **G59541**

03132014 20001149 20010012

Street Address (this address is public information **except** when a PO Box is used for the public address of record; this address then becomes confidential)

City State Zip –

PO Box (if used, must provide a confidential physical street address, above)

City State Zip –

Department of Consumer Affairs

RECEIPT

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

Name:	MORAN, THOMAS PATRICK
Transaction Date:	03/03/2016 07:29
Application Number:	
Complaint Number:	
License Type:	8002
License Number:	59541
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:	**59541**
File Number:	
Application:	**Physician's and Surgeon's Renewal**
Application Number:	
Application Date:	**03/03/2016 (mm/dd/yyyy)**

Application Questions

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

Personal Detail

First Name:	**THOMAS**
Middle Name:	**PATRICK**
Last Name:	**MORAN**
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.**

License Attributes Selected

Secondary Status	**Military**

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** **Patient Care - 30-39 Hours** **Research - 1-9 Hours** **Teaching - 1-9 Hours** **Telemedicine - None**
Patient Care Practice Location	**Zip: 92101 County: SAN DIEGO**
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 - Secondary**
Board Certifications	**American Board of Obstetrics and Gynecology - Obstetrics and Gynecology**
Postgraduate Training Years	**4 Years**
Cultural Background	**White**
Foreign Language Proficiency	**Decline to state**
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:

1457016892995