STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY 01036 EDMUND G. BROWN JR., *Governor*

DEPARTMENT OF Consumer Affairs

BOARD OF MEDICAL QUALITY ASSURANCE
1430 HOWE AVENUE, SACRAMENTO, CA 95825
TELEPHONE:
Applications and Examinations (916) 920-6411

RECEIVED
SACRAMENTO
BOARD OF MEDICAL
QUALITY ASSURANCE

MAR 22 4 52 PM '83

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

150204
$218.50

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

1. NAME: Last WEIGEN First Christine Middle Pamela Maiden — 2. Telephone No.

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

4. Address: Street and No./Rural Route PO Box 1611 City SALINAS State CA Zip Code 93902

5. Name you wish on License: Christine P. Weigen Birthdate: (Month - Day - Year)

6. Premedical Education—Name of College or University: Stanford University Location: Stanford CA
Period of attendance: From: 72 To: 76
Check premed courses successfully completed: ☒ Chemistry ☒ Physics ☒ Biology or Zoology

7. Medical School:

Year	Name of Institution	Location	From	To
1st	University California, San Francisco	SF	1977	78
2nd			78	79
3rd			79	80
4th			80	81
5th				
6th				

8. Doctor of Medicine Degree granted by: U. of CA Sch. of Med. Date 6/81 For office use only School Code: CA-002

9. 1st Year Postgraduate Training (Internship):

Location	Type of Service	From	To
Natividad Med Center Salinas CA	Family Practice	7/81	6/82

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: N A

State	Date	Charge	Disposition

12. Have you ever been denied a license to practice medicine in any State or Country?
If Yes, indicate below: N. A

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 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?

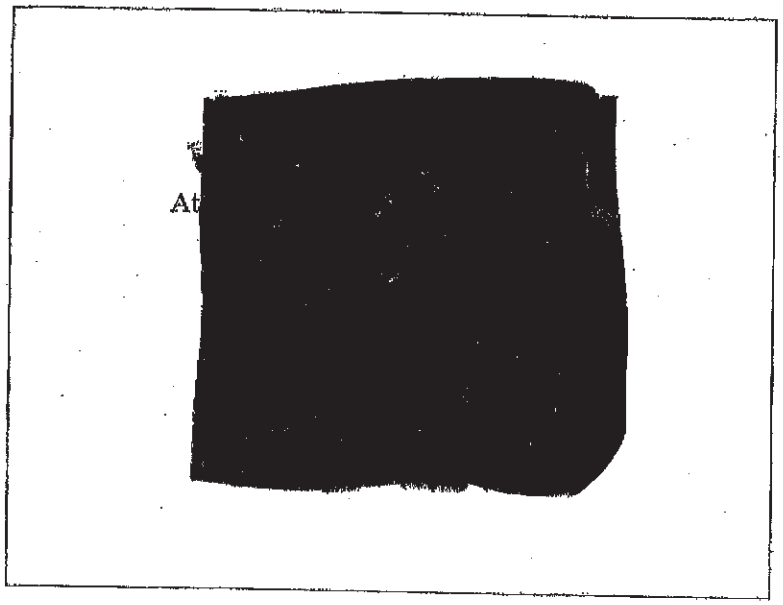
15. Have you ever been convicted of, or pled nolo contendere to any offense, misdemeanor or felony in any state? (Except violations of traffic laws resulting in fines of $50.00 or less.)

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

Violation and Location	Date	Penalty/Disposition

17. Have you ever had staff privileges in a hospital suspended or revoked? If "Yes", please explain on another sheet of paper.

18. Have you ever voluntarily surrendered your license to practice in another state?



Applicant: Please complete the following:

Height: _ Ft. _ In. Weight: _ Lbs.

Hair color: _ Eye color: _

Identifying marks:

NOTE: The information on 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, under the laws of the State of California, 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 Christine Pruzzo M.D.

Date 22 February 1983

Subscribed and sworn to before me this 22nd day of February 19 83.

OFFICIAL SEAL
DOROTHY PARKER
NOTARY PUBLIC - CALIFORNIA
PRINCIPAL OFFICE IN
MONTEREY COUNTY
My Commission Expires August 6, 1983

Signature of Notary Dorothy Parker

Address 1433 N. Main Street
Salinas, CA 93906

My commission expires: Aug. 6, 1983

STATE OF CALIFORNIA--STATE AND CONSUMER SERVICES AGENCY — EDMUND G. BROWN JR., *Governor*

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BOARD OF MEDICAL QUALITY ASSURANCE
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(916) 920-6411

PLEASE FORWARD TO YOUR MEDICAL SCHOOL
CERTIFICATE OF EDUCATION

This Certifies That Christine P. Weigen
(Full name of applicant)

enrolled in University of California San Francisco
(Name of medical school (college))

on the 22 day of September (Month) 19 77 (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 Stanford University (Please indicate school), and that he attended while at this medical school (college) 14.5 (Specify number) courses of lectures of 12 (Specify number of weeks) weeks each, completing at least 4000 (Total hours) hours in the subjects below listed, and that he/she:

☑ was granted the degree ~~Bachelor~~ Doctor of Medicine.

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

_____

_____

on the 28 day of June (Month) 19 81 (Year).

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

A SEPARATE COURSE IN EACH OF THE SUBJECTS LISTED IS NOT REQUIRED. HOWEVER, THE COURSE OF STUDY COMPLETED BY THE CANDIDATE SHALL HAVE PROVIDED ADEQUATE INSTRUCTION IN ALL THE AREAS LISTED.

☐ Pathology, bacteriology and immunology	☐ Urology	☐ Psychiatry	☐ Child Abuse detection and treatment
	☐ Ophthalmology	☐ Neurology	
	☐ Pharmacology	☐ Anesthesia	

[AFFIX SEAL HERE]

Signed and the College seal affixed this 25 day of February 25 (Month) 19 83 (Year).

By H. Hamm Seeley, M.D.
(President, Secretary, Dean)

Associate Dean

07A-32 (REV. 3/80)

STATE DEPARTMENT OF CONSUMER AFFAIRS
INTERNET CASHIERING SYSTEM
MEDICAL BOARD OF CALIFORNIA
SUPPLEMENTAL INFORMATION REPORT
From Date: 11/05/2012 **To Date:** 11/05/2012

ATRISUPPINF

10-AUG-16 09:44:22

Person Id : **Name :** Weigen,Christine

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:	WEIGEN, CHRISTINE PAMELA
Transaction Date:	11/18/2014 00:08
Application Number:	
Complaint Number:	
License Type:	8002
License Number:	50842
Payment Description:	Physician's and Surgeon's Renewal
Fee Paid: (US $)	845.00
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:	**50842**
File Number:	
Application:	**Physician's and Surgeon's Renewal**
Application Number:	
Application Date:	**11/18/2014 (mm/dd/yyyy)**

Personal Detail

First Name:	**CHRISTINE**
Middle Name:	**PAMELA**
Last Name:	**WEIGEN**
Birthdate:	****/**/******
Gender:	**Female**

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**
Amount - $25.00 Minimum:	**25**

Attachments

Physician Survey

Are you retired?	**No**
Activities in Medicine	**Administration - 1-9 Hours** **Other - 1-9 Hours** **Patient Care - 10-19 Hours** **Research - None** **Teaching - None** **Telemedicine - None**
Patient Care Practice Location	**Zip: 95060 County: SANTA CRUZ**
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	**Family Medicine - Primary** **Family Medicine - Secondary**
Board Certifications	**American Board of Family Medicine - Family Medicine**
Postgraduate Training Years	**3 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**
Family Physician Training Fee	**$25.00**
Total Amount Due:	**$845.00**

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: