STATE OF CALIFORNIA -- STATE AND CONSUMER SERVICES AGENCY

ARNOLD SCHWARZENEGGER, Governor

Consumer Affairs

MEDICAL BOARD OF CALIFORNIA

LICENSING PROGRAM
1426 Howe Avenue, Suite 54
Sacramento, CA 95825-3236
(916) 263-2382 FAX (916) 263-2487
www.caldocinfo.ca.gov

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2008 APR -3 PM 1:47

INITIAL AND UPDATE APPLICATION FOR PHYSICIAN'S AND SURGEON'S LICENSE OR POSTGRADUATE TRAINING AUTHORIZATION LETTER

Application for (please check one): ☒ License ☐ PTAL - or - ☐ Update

Recd running record

1. NAME: Last	First	Middle	MBC Use Only
ZAPATA	M/A	R.	

Other names you have used (include maiden name):	2. U.S. Social Security Number

3. Place of Birth	4. Date of Birth
INGLEWOOD, CA, USA.	

5. Gender: ☐ Male ☒ Female

6. Public/Mailing Address.
(Please note: this information is public)
(30 characters maximum per line, including spaces)

City	State/Province	Zip/Postal Code	Country
Los Angeles	CA	90095	USA

7. Telephone Numbers: (include area code)	Home	Work	Cell

8. California Driver's License Number (optional):	10. Have you ever filed an Application for Physician's and Surgeon's License, or PTAL, in California? ☐ Yes ☒ No
9. E-mail Address (optional):	Previous license number, if any:

MEDICAL EDUCATION

11. LIST EACH MEDICAL SCHOOL THAT YOU HAVE ATTENDED.

School Name	City, State/Province, Country	Dates of Attendance
Univ of Chicago, Pritzker School of Medicine	Chicago, IL, USA	9/02 - 6/06

12. School of Graduation	Degree Awarded	Date of Graduation
Univ of Chicago, Pritzker School of Medicine	MD	6/2006

EXAMINATIONS

13. LIST ALL OF THE FOLLOWING EXAMINATIONS YOU HAVE TAKEN: USMLE, FLEX, NBME, ECFMG, SPEX, STATE BOARDS and/or QME in Canada

Examination	Date	Result (Pass/Fail)
USMLE Step 3	6/8/07	
USMLE Step 2 CK/CS	7/05, 9/05	
USMLE Step 1	6/04	

Exams

Web 3-28-08 90650 — Cashiering Use Only

IL01A — School Code

L1A

07A-100 (Rev. 12/05)

A "yes" response to Questions 14 through 38 requires a written explanation on a separate sheet of paper along with any supporting materials.

ACGME/RCPSC ACCREDITED POSTGRADUATE TRAINING

14. Please list each ACGME/RCPSC accredited postgraduate training program in which you have participated. You must include each internship, residency and fellowship, whether or not the program was completed or credit granted.

Facility Name	Address	Specialty Area	Dates of Attendance
UCLA	10833 LeConte Ave Los Angeles, CA 90095	OB/GYN	6/2006 - current

POSTGRADUATE TRAINING: (These questions are to be answered by ALL applicants)

Did you ever take a leave of absence or break from your training?	YES	NO
Have you ever been terminated, dismissed or expelled from a program?	YES	NO
Have you ever resigned from a training program?	YES	NO
Were you ever placed on probation?	YES	NO
Were you ever disciplined or placed under investigation?	YES	NO
Were any incident reports ever filed by instructors?	YES	NO
Were any limitations or special requirements placed upon you for clinical performance, discipline, or for any other reason?	YES	NO
Have you ever had a postgraduate training program contract not be renewed or offered for a following year?	YES	NO

MEDICAL LICENSURE

15. Please list all medical licenses (other than training licenses) that have ever been issued by any state or territory in the United States or Canadian province.

Jurisdiction	License Number	Date of Issuance	Dates of Practice in that Jurisdiction

APPLICANT: ZAPATA, MYA R.

DATE OF BIRTH:

L1B

ABMS CERTIFICATIONS

16. Are you currently certified by a Member Board of the American Board of Medical Specialties? YES ☐ NO ☒

Member Board	Expiration Date	Certificate Number

MALPRACTICE HISTORY

17. Has a claim or an action ever been filed against you for the practice of medicine which resulted in a malpractice settlement, judgment, or arbitration award of $30,000 or more? YES NO

PRACTICE IMPAIRMENT OR LIMITATIONS

18. Have you been enrolled in, required to enter into, or participated in any drug or alcohol recovery program or impaired practitioner program? YES NO

19. Have you been treated for or had a recurrence of a diagnosed addictive disorder? YES NO

20. Have you been diagnosed with an emotional, a mental, or behavioral disorder which impairs your ability to practice medicine safely? YES NO

21. Have you ever been diagnosed with a neurological or other physical condition that would impair your ability to practice medicine safely? YES NO

22. Do you have any other condition which in any way impairs or limits your ability to practice medicine safely? YES NO

If you do receive ongoing treatment or participate in a monitoring program, the Board will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure.

CRIMINAL RECORD HISTORY

23. Have you ever been convicted of, or pled guilty or nolo contendere to ANY offense in any state in the United States or foreign country?

This includes a citation, infraction, misdemeanor and/or felony, etc. If "YES" attach a list of each offense by arrest and conviction dates, violation, and court of jurisdiction (name and address). Matters in which you were diverted, deferred, pardoned, pled nolo contendere, or if the conviction was later expunged from the record of the court or set aside under Penal Code Section 1203.4 MUST be disclosed. If you are awaiting judgment and sentencing following entry of a plea or jury verdict, you MUST disclose the conviction; you are entitled to submit evidence that you have been rehabilitated. Serious traffic convictions such as reckless driving, driving under the influence of alcohol and/or drugs, hit and run, evading a peace officer, failure to appear, driving while the license is suspended or revoked MUST be reported. This list is not all-inclusive. If in doubt as to whether a conviction should be disclosed, it is better to disclose the conviction on the application.

For each conviction disclosed, you must submit with the application certified copies of the arresting agency report, certified copies of the court documents, and a descriptive explanation of the circumstances surrounding the conviction of disciplinary action (i.e., dates and location of incident and all circumstances surrounding the incident). This letter must accompany the application. If documents were purged by arresting agency and/or court, a letter of explanation from these agencies is required.

Applicants who answer "NO" to the question but have a previous conviction or plea, may have their application denied or license revoked for knowingly falsifying the application. YES NO

APPLICANT: ZAPATA, MYA R.

DATE OF BIRTH:

MBC Use Only: ABMS ☐ Malpractice ☐ Limitations ☐ Criminal Record ☐

L1C

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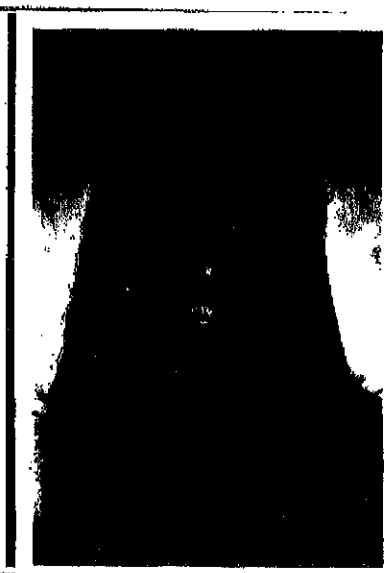
CRIMINAL RECORD HISTORY (cont'd)

24. Is any criminal action pending against you?	YES	NO
25. Are you required to register as a Sex Offender?	YES	NO

DISCIPLINARY HISTORY

These questions refer to discipline by any U.S. military or public health service, state board or other governmental agency of any U.S. state, territory, Canadian province, or country.

26. Have you ever been denied a license to practice medicine?	YES	NO
27. Is any denial pending against you?	YES	NO
28. Have you ever been charged with, or been found to have committed, unprofessional conduct, professional incompetence, gross negligence, or repeated negligent acts or malpractice by any medical licensing board, other agency, or hospital?	YES	NO
29. Have you ever had any license to practice medicine revoked, suspended, or placed on probation?	YES	NO
30. Have you ever had any license to practice medicine subjected to any action including but not limited to informal or confidential discipline, consent orders, letters of warning, letters of reprimand, or citation?	YES	NO
31. Have you ever had any license to practice medicine subjected to any other disciplinary action?	YES	NO
32. Is any disciplinary action pending against any of your licenses to practice medicine?	YES	NO
33. Have you ever had staff privileges in a hospital terminated, denied, suspended, limited, revoked, or not renewed?	YES	NO
34. Have you ever resigned from a medical staff in lieu of disciplinary or administrative action?	YES	NO
35. Is any disciplinary action pending against your hospital staff privileges?	YES	NO
36. Have you ever surrendered a license to practice medicine?	YES	NO
37. Have your DEA privileges ever been denied, suspended, restricted, or terminated?	YES	NO
38. Have you ever entered into any arrangement or plea or agreement in lieu of a federal prosecution for a drug violation regulated by the DEA?	YES	NO



Notice: All items in this application, except #8 and #9, are mandatory. Failure to provide any of the requested information will delay the processing of your application. The information provided will be used to determine your qualifications for licensure per Section 2080 of the California Business and Professions Code, which authorizes the collection of this information. The information on your application may be transferred to other medical licensing authorities, the Federation of State Medical Boards, or other governmental law enforcement agencies. You have the right to review your application subject to the provisions of the Information Practices Act. The Chief of the Licensing Program is the custodian of records.

The applicant, MYA ROSE ZAPATA, ___ being first duly sworn upon his/her
(PLEASE PRINT FULL NAME) (DATE OF BIRTH)

oath deposes and says: that I am the person herein named subscribing to this application; that I have read the complete application, know the full content thereof, and declare under penalty of perjury, that all of the information contained herein and evidence or other credentials submitted herewith are true and correct; that I am the lawful holder of the degree of Doctor of Medicine as prescribed by this application, that the same was procured in the regular course of instruction and examination, and that it, together with all the credentials submitted, were procured without fraud or misrepresentation or any mistake of which I am aware and that I am the lawful holder thereof. Further, I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past, present and future), business and professional associates (past, present, and future), and all government agencies (local, state, federal, or foreign) to release to the Medical Board of California or its successors any information, files or records, including medical records, educational records, and records of psychiatric treatment and treatment for drug and/or alcohol abuse or dependency, requested by that Board in connection with this application; or any further or future investigation by that Board necessary to determine any medical competence, professional conduct, or physical or mental ability to safely engage in the practice of medicine. I further authorize the Medical Board of California or its successors to release to the organizations, individuals or groups listed above any information which is material to this application or any subsequent licensure.

I UNDERSTAND THAT FALSIFICATION OR MISREPRESENTATION OF ANY ITEM OR RESPONSE ON THIS APPLICATION OR ANY ATTACHMENT HERETO IS A SUFFICIENT BASIS FOR DENYING OR REVOKING A LICENSE. MZ **(PLEASE INITIAL BOX)**

SIGNATURE OF APPLICANT: Mzapata
(Please sign full name)

State of California

County of Los Angeles

Subscribed and sworn to (or affirmed) before me on

this 9th day of January, 2008,

by Mya Zapata

personally known to me or proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.

ROSE M. ZIFF
NOTARY SEAL
Commission # 1487468
Notary Public - California
Los Angeles County
My Comm. Expires May 3, 2008

Rose M Ziff
SIGNATURE OF NOTARY PUBLIC

L1E

07A-100 (Rev. 12/05)

STATE OF CALIFORNIA -- STATE AND CONSUMER SERVICES AGENCY — ARNOLD SCHWARZENEGGER, Governor

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08 JAN 24 AM 9:45

LICENSING PROGRAM

CERTIFICATE OF MEDICAL EDUCATION

MEDICAL SCHOOL: PLEASE COMPLETE THIS FORM IN THE ENGLISH LANGUAGE

This certifies that MYA ROSE ZAPATA ; _____
Full Name of Applicant — U.S. Social Security Number

_____ enrolled in University of Chicago, Pritzker School of Medicine
Date of Birth — Name of Medical School

located in Chicago, IL, USA on 09/30/2002.
State/Province Country — Enrollment Date

The undersigned further certifies that the records of this institution show that the applicant attended in this institution _____ years of resident instruction, completing at least 4,000 hours, of which at least 80 percent actual attendance is required in the subjects set forth hereunder (Business and Professions Code Sections 2089,2089.5, 2089.7,2090, 2091.1,2091.2) and that the applicant

Anatomy	Embryology	Physical Medicine
Otolaryngology	Histology	Therapeutics
Obstetrics and Gynecology	Human Sexuality	Neuroanatomy
Radiology, including Radiation Safety	Medicine	Child Abuse Detection and Treatment
Tropical Medicine	Surgery, including Orthopedic Surgery	Geriatric Medicine
Physiology	Urology	Pediatrics
Biochemistry	Psychiatry	Pharmacology
Pathology, Bacteriology, and Immunology	Neurology	Anesthesia
Ophthalmology	Alcoholism and Chemical Dependency	Spousal Partner Abuse Detection & Treatment*
Dermatology	Preventative Medicine, Including Nutrition	Family Medicine**
		Pain Management and End-of-Life-Care***

* ONLY applicable to medical students who enrolled in medical school on or after September 1, 1994.
** ONLY applicable to medical students who graduate from medical school on or after May 1, 1998.
*** ONLY applicable to medical students who enrolled in medical school on or after June 1, 2000.

☒ was granted the degree of Bachelor/Doctor of Medicine on the 9th day of JUNE, 2006.

☐ withdrew from medical school on ____ day of _____, _____.

Unusual Circumstances

	Responses	
Did this individual ever take a leave of absence from their medical education?	Yes	No
Was this individual ever placed on probation?	Yes	No
Was this individual ever disciplined or under investigation?	Yes	No
Were any incident reports regarding this individual ever filed by instructors?	Yes	No
Were any limitations or special requirements imposed on this individual because of questions of academic or disciplinary problems, or for any other reason?	Yes	No

A "Yes" response to ANY of the above questions requires the medical school to provide a written explanation on a separate attachment.

Medical School Seal Must Be Imprinted Below	Attention Medical School: Only the President, Dean, or Registrar may sign this form. If the signature is being delegated to another person, evidence of that delegation must be attached to this form (may be a photocopy). Such delegation must be on official letterhead and must be dated within the last 12 months.
	Signed and the school seal affixed this 16th day of JAN, 2007.
	By: Lori Dea Director, Med. Schl. Educ. (Printed Name and Title of School Official)
	Signature: _____

L2

07A-100-L2 (Rev. 12/06)

STATE OF CALIFORNIA – STATE AND CONSUMER SERVICES AGENCY ARNOLD SCHWARZENEGGER, Governor

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LICENSING PROGRAM

OK

CERTIFICATE OF COMPLETION OF ACGME/RCPSC POSTGRADUATE TRAINING

To be completed by the facility for every medical school graduate completing postgraduate training in the United States or Canada.

PART 1: TO BE COMPLETED BY THE APPLICANT

NAME: Last	First	Middle
ZAPATA	MYA	ROSE

U.S. Social Security Number	Date of Birth	Telephone Number
		Home / Work

Public/Mailing Address: 3234 Sawtelle Blvd, #307

City	State/Province	Zip/Postal Code
Los Angeles	CA	90066

Medical School of Graduation: University of Chicago, Pritzker School of Medicine.

PART 2: TO BE COMPLETED BY THE PROGRAM DIRECTOR

ATTENTION PROGRAM DIRECTOR: Do not sign and date this form before the last day of any postgraduate training year which will be used by the applicant to qualify for licensure. Completion of this form will certify that the individual named in PART 1 above satisfactorily completed a period of accredited postgraduate training at this facility and that the trainee has acquired the skill and qualifications necessary to safely assume the unrestricted practice of medicine in this state.

Name of Facility:	ACGME 10 digit Program number: (www.acgme.org)
UCLA Dept. of Obstetrics and Gynecology	2 2 0 0 5 3 1 0 3 8

Address of Facility:	Telephone #:
10833 Le Conte Avenue, Los Angeles, CA	(310) 825-9945

Categorical Specialty Area of Training	Start Date of Training	End Date (or anticipated completion date) of Training
Obstetrics and Gynecology	06, 24, 2006	06, 23, 2010

UNUSUAL CIRCUMSTANCES:

Did the trainee ever take a leave of absence or break from their training?	YES	NO
Was the trainee ever terminated, dismissed or expelled?	YES	NO
Did the trainee ever resign?	YES	NO
Was the trainee ever placed on probation?	YES	NO
Was the trainee ever disciplined or placed under investigation?	YES	NO
Were any incident reports regarding this trainee ever filed by instructors?	YES	NO
Were any limitations or special requirements placed upon the trainee for clinical incompetence, disciplinary problems or for any other reason?	YES	NO
Did the program decline to renew or offer the trainee a postgraduate training program contract for a following year?	YES	NO

A "Yes" response to ANY of the above questions requires the program director to provide a written explanation on a separate attachment.

L3A

DEFINITION OF "SATISFACTORY" COMPLETION OF TRAINING

The program director signing this form is formally certifying and documenting under penalty of perjury that the trainee received instruction appropriate for the particular postgraduate level and that he/she satisfactorily completed periods of training in accordance with the accepted standards and the criteria defined as equating to "satisfactory" performance as described below. The program director will personally be attesting to the fact that the trainee has acquired the skill and qualifications necessary to safely assume the unrestricted practice of medicine in this state.

"SATISFACTORY" IS DEFINED AS: THE TRAINEE PERFORMED AT AN ADEQUATE LEVEL BASED ON EVIDENCE OF SATISFACTORY PROGRESSIVE GROWTH INCLUDING DEMONSTRATED ABILITY TO ASSUME GRADED AND INCREASING RESPONSIBILTY FOR PATIENT CARE.

GENERAL MEDICINE TRAINING REQUIREMENT

To qualify for licensure in California, applicants who are graduates of an international medical school must complete **at least four months** of postgraduate training in GENERAL MEDICINE as part of the requirement. Applicants who are graduates of a U.S. or Canadian medical school, who have not completed postgraduate training required for licensure by July 1, 1990, must also complete four months of training in GENERAL MEDICINE prior to licensure. The GENERAL MEDICINE requirement may be satisfied by actual clinical practice where the applicant has direct patient care responsibilities in any particular specialty or sub-specialty area for at least four months.

I hereby certify as the program director, that the individual named in Part 1
☑ **has completed** ☐ **has not completed**
a minimum of four months of general medicine as part of this postgraduate training program accredited by the ACGME or the RCPSC.

SIGNATURE OF PROGRAM DIRECTOR

ATTENTION PROGRAM DIRECTOR: THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE, OR ADOPTION. If that signature authority is being delegated to another person, evidence of that delegation must be attached to this form (may be a photocopy). Each delegation must be on official letterhead and must be dated within the last 12 months.

HOSPITAL SEAL

UCLA MEDICAL CENTER UNIVERSITY OF CALIFORNIA 1868 LOS ANGELES

OFFICIAL HOSPITAL SEAL MUST BE AFFIXED IN THE BOX TO THE LEFT TO CERTIFY TRAINING

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

Gautam Chaudhuri, M.D., Ph.D.
PRINT NAME OF PROGRAM DIRECTOR

SIGNATURE OF PROGRAM DIRECTOR
Signature Stamp is Not Acceptable

1/24/08
DATE SIGNED

If a hospital seal is not available, the program director shall sign this form in the presence of a notary public.

State of _____

County of _____

Subscribed and sworn to (or affirmed) before me on

this _____ day of _____, 20_____,

by _____

personally known to me or proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.

NOTARY SEAL

_____
SIGNATURE OF NOTARY PUBLIC

L3B

6/23/10 in CA

STATE OF CALIFORNIA -- STATE AND CONSUMER SERVICES AGENCY ARNOLD SCHWARZENEGGER, Governor

Consumer Affairs

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MEDICAL BOARD CALIFORNIA
2008 APR 14 AM 9:18
LICENSING PROGRAM

CERTIFICATE OF CURRENT POSTGRADUATE TRAINING ENROLLMENT

At the time of licensure, you may be entitled to a reduced initial license fee if you are actively participating in a slotted position in an ACGME/RCPSC accredited postgraduate training program.

NOTE: This form may not be used in lieu of the Form L3A-B, "Certificate of Completion of ACGME/RCPSC Postgraduate Training."

NAME: Last	First	Middle
Zapata	Mya	Rose

U.S. Social Security Number	Date of Birth	Medical School of Graduation:
___-___-___	___/___/___	PRITZKER - univ. of Chicago

This is to certify that the above applicant is actively participating in an ACGME or RCPSC accredited postgraduate training position that started on June 24, 2006 (Month / Day / Year) **and is expected to be completed on** June 23, 2010 (Month / Day / Year) **in** Obstetrics and Gynecology (Categorical Specialty Area of Training)

at UCLA Medical Center (Name of Facility)

located at 10833 Le Conte Avenue, Los Angeles, CA 90095 (Address of Facility)

The 10 digit ACGME Program # : 2 2 0 0 5 3 1 0 3 8 (Refer to http://www.acgme.org/adspublic)

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 above program is accredited by the ACGME or the RCPSC to offer the type and level of training completed by the applicant and that the applicant is being trained in an accredited ACGME or RCPSC postgraduate training position.

Gautam Chaudhuri, M.D., Ph.D.
PRINT NAME OF PROGRAM DIRECTOR

SIGNATURE OF PROGRAM DIRECTOR – Signature Stamp Is Not Acceptable

03/27/08
DATE

(310) 206-6575
TELEPHONE NUMBER

ATTENTION PROGRAM DIRECTOR: THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE, OR ADOPTION.

Only the Program Director may sign this form. If that signature authority is being delegated to another person, evidence of that delegation must be attached to this form (may be a photocopy). Such delegation must be on official letterhead and must be dated within the last 12 months.

If a hospital seal is not available, the program director shall sign this form in the presence of a notary public.

State of _____

County of _____

Subscribed and sworn to (or affirmed) before me on

this _____ day of _____, 20_____,

by _____

personally known to me or proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.

Official Hospital Seal

SIGNATURE OF NOTARY PUBLIC

OFFICIAL HOSPITAL SEAL OR NOTARY SEAL (WITH JURAT COMPLETED ABOVE) MUST BE AFFIXED IN THE BOX AT THE LEFT

L4

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

Department of Consumer Affairs

RECEIPT

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

Name:	ZAPATA, MYA R
Transaction Date:	03/16/2016 14:04
Application Number:	
Complaint Number:	
License Type:	8002
License Number:	104318
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 A**
License Number:	**104318**
File Number:	
Application:	**Physician's and Surgeon's Renewal**
Application Number:	
Application Date:	**03/16/2016 (mm/dd/yyyy)**

Application Questions

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

Personal Detail

First Name:	**MYA**
Middle Name:	**R**
Last Name:	**ZAPATA**
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.**

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 - 40+ Hours** **Research - 1-9 Hours** **Teaching - 10-19 Hours** **Telemedicine - None**
Patient Care Practice Location	**Zip: 90095 County: LOS ANGELES**
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	**2 Years**
Cultural Background	**Mexican**
Foreign Language Proficiency	**Spanish**
Web Site Profile	**Cultural Background - Yes** **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:

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:	ZAPATA, MYA R
Transaction Date:	03/14/2014 12:24
Application Number:	
Complaint Number:	
License Type:	8002
License Number:	104318
Payment Description:	Physician's and Surgeon's Renewal
Fee Paid: (US $)	833.00
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 A**
License Number:	**104318**
File Number:	
Application:	**Physician's and Surgeon's Renewal**
Application Number:	
Application Date:	**03/14/2014 (mm/dd/yyyy)**

Personal Detail

First Name:	**MYA**
Middle Name:	**R**
Last Name:	**ZAPATA**
Birthdate:	
Gender:	**Female**

Addresses

License Related Addresses

Confidential Address (Optional)

Name:

Address:

Phone Number:

License Specific Public/Mailing Address (Required)

Name:	**ZAPATA, MYA R**
Address:	**U OF M OBGYN LOBBY K LEVEL 3** **PO BOX 531** **ANN ARBOR, MI** **481060531**
Phone Number:	
E-mail Address:	

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 - None** **Patient Care - 40+ Hours** **Research - 1-9 Hours** **Teaching - 10-19 Hours** **Telemedicine - None**
Patient Care Practice Location	**Zip: 90095 County: LOS ANGELES**
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	**3 Years**

Cultural Background	**Mexican**
Foreign Language Proficiency	**Spanish**
Web Site Profile	**Cultural Background - Yes**
	Foreign Language Proficiency - Yes
	Gender - Yes

Fees

Biennial Renewal Fee	**$783.00**
Steven M. Thompson Physician Corps Loan Repayment Program	**$25.00**
Family Physician Training Fee	**$25.00**
Total Amount Due:	**$833.00**

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: