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

DEPARTMENT OF Consumer Affairs

BOARD OF MEDICAL QUALITY ASSURANCE

1430 HOWE AVENUE, SACRAMENTO, CALIFORNIA 95825
TELEPHONE:
Applications and Examinations (916) 322-5040

JUL 23 8 51 AM '80

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

000655

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

1. NAME: Last	First	Middle	Maiden	2. Telephone No.
FRIED	YVONNE	SUZANNE		

3. List other names, if any, you have used:
NOT APPLICABLE

4. Address: Street and No./Rural Route	City	State	Zip Code
2216 KELTON AVE.	LOS ANGELES	CALIFORNIA	90064

5. Name you wish on License: YVONNE SUZANNE FRIED — Birthdate (Month - Day - Year):

6. Premedical [redacted] University — Location:
UNIV OF CALIFORNIA AT LOS ANGELES — LOS ANGELES

Period of Attendance: From 9/68 To 6/74

Check premed courses successfully completed: XX Chemistry XX Physics XX Biology or Zoology

7. Medical School:

Year	Name of Institution	Location	From	To
1st	UNIV. OF CALIF. AT DAVIS	DAVIS, CALIFORNIA	9/74	
2nd				
3rd				
4th				
5th				
6th				6/79

8. Doctor of Medicine Degree granted by: UNIV. OF CALIF. AT DAVIS — Date: 6/79 — For office use only School Code: CA016

9. 1st Year Postgraduate Training (Internship):
SANTA CLARA VALLEY MEDICAL CENTER

Location	Type of Service	From	To
SAN JOSE, CALIFORNIA	FLEXIBLE INTERNSHIP	6/25/79	6/25/80

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? Yes No

If Yes, indicate below:

State	Date	Charge	Disposition

12. Have you ever been denied a license to practice medicine in any State or Country? Yes No

If Yes, indicate below:

State or Country	Date of Denial	Reason for Denial

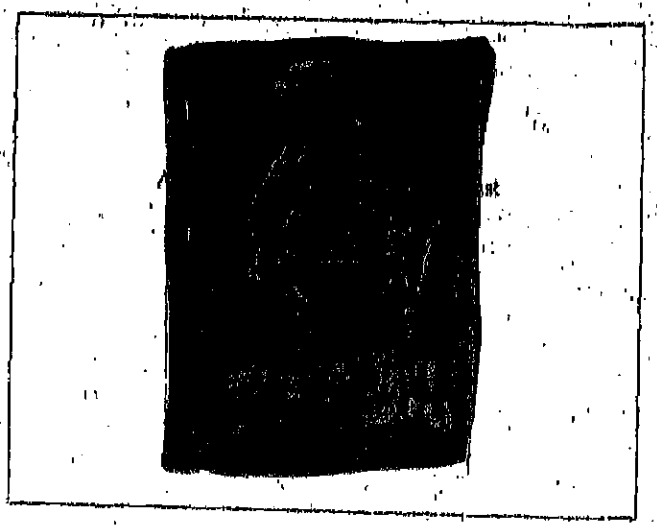
13. Are you now or have you ever been addicted to narcotic drugs? Yes No

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?	Yes	No
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.)	Yes	No

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."	Yes	No



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: Yvonne Fried

Date: 7/15/80

Subscribed and sworn to before me this 18TH day of JULY 1980

OFFICIAL SEAL
VILMA U. SIEBERS
NOTARY PUBLIC — CALIFORNIA
PRINCIPAL OFFICE IN
LOS ANGELES COUNTY
My Commission Expires January 17, 1984

Signature of Notary: Vilma U. Siebers

Address: 10850 W. Pico Blvd.
L.A. 90064

My commission expires: Jan 17 1984

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

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BOARD OF MEDICAL QUALITY ASSURANCE

1430 HOWE AVENUE, SACRAMENTO, CALIFORNIA 95825
Applications and Examinations
920-6411

PLEASE FORWARD TO YOUR MEDICAL SCHOOL

CERTIFICATE OF EDUCATION

This Certifies That YVONNE SUZANNE FRIED
(Full name of applicant)

enrolled in Univ. of CA., Davis School of Medicine Davis, CA. 95616
(Name of medical school [college])

on the 30 day of September 19 74,
(Month) (Year)

☒ as a Freshman.

☐ with advanced standing based on _____
(State 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 Univ. of CA. Los Angeles, and that he attended while at this
(Please indicate school)

medical school (college) 4 courses of lectures of 40 weeks each,
(Specify number) (Specify number of weeks)

completing 4,000 hours in the subjects below listed, and that he/she
(Total hours)

☒ was granted the degree { ~~Doctor~~ Doctor } of Medicine

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

_____

_____

on the 16 day of June 19 78,
(Month) (Year)

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

**********ALL**********

Anatomy	Dermatology	Preventive medicine, including nutrition	Otolaryngology
Embryology	Physical medicine	Radiology, including radiation safety	Obstetrics and gynecology
Histology	Therapeutics	Medicine	Human sexuality as defined in Section 2192.3
Neuroanatomy	Tropical medicine	Pediatrics	Child abuse detection and treatment
Physiology	Surgery, including orthopedic surgery	Psychiatry	
Biochemistry	Urology	Neurology	
Pathology, bacteriology and immunology	Ophthalmology	Anesthesia	
	Pharmacology		

Signed and the College seal affixed this 8 day
of April 19 80,
(Month) (Year)

[Affix Seal Here]

By Gary Henderson
(President, Provost, Dean)
Gary Henderson, Ph.D.
Assist. Dean

BMA-12 (Rev. 3/79)

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:	FRIED, YVONNE SUZANNE
Transaction Date:	12/07/2015 14:41
Application Number:	
Complaint Number:	
License Type:	8002
License Number:	42747
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:	**42747**
File Number:	
Application:	**Physician's and Surgeon's Renewal**
Application Number:	
Application Date:	**11/01/2015 (mm/dd/yyyy)**

Application Questions

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

Personal Detail

First Name:	**YVONNE**
Middle Name:	**SUZANNE**
Last Name:	**FRIED**
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 - 10-19 Hours** **Research - None** **Teaching - None** **Telemedicine - None**
Patient Care Practice Location	**Zip: 97520 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	**Obstetrics and Gynecology - Primary**
Board Certifications	**American Board of Obstetrics and Gynecology - Obstetrics and Gynecology**
Postgraduate Training Years	**4 Years**
Cultural Background	**White**
Foreign Language Proficiency	**Spanish**
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:

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

PART 3

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 Yvonne Fried MD DATE: 11/18/13

LICENSE NO.	EXPIRES	AMOUNT DUE NOW	DELINQ FEE IF POSTMARKED AFTER 01/30/14
G 42747	12/31/13	$808.00	$886.00
	VOLUNTARY FEE =	$	$
	TOTAL ENCLOSED =	$	$

ACTIVE YVONNE SUZANNE FRIED
540 CATALINA DR
ASHLAND OR 97520

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

Yvonne Fried MD
Signature required here

OVER

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11252013 20000583 20010004

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

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	

SMBCLS 02/28/06