#3114

STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY

PETE WILSON, Governor

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Consumer Affairs

MEDICAL BOARD OF CALIFORNIA

1426 HOWE AVENUE, SUITE 54, SACRAMENTO, CA 95825-3236

(916) 920-6411 263-2499

96 APR -2 AM 7:27

96 APR -1 PM 7:38

APPLICATION FOR PHYSICIAN AND SURGEON'S EXAMINATION OR LICENSURE

01246050 $ 200.00 4-1-96

Read all instructions prior to 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.**

000547 209 4/96 MBC USE ONLY

1. Name: Last Yousefzadeh First Payman Middle

2. Other names you have used (include maiden name):

3. Social Security Number

4. Address: Number and Street/Rural Route (include apartment number, if any) 214-03 Waters Edge Dr.

City Bayside State NY ZIP Code 11360 Country

5. Telephone Number: Home Work

6. Date of Birth: Mo/Day/Yr Place of Birth:

7. Sex: ☐ Female ☒ Male

8. Are you a U.S. citizen? ☒ Yes ☐ No

If you are a Foreign Medical Graduate, you must provide an original Certificate of Naturalization, Declaration of Intent to become a U.S. citizen, or a full unrestricted license to practice medicine in a state or country.

9. Have you ever filed an application for examination or licensure in California? ☐ Yes ☒ No

If YES, give date previous application was submitted:

10. List name and address of all colleges or universities attended where pre-professional, postsecondary instruction was received. Please submit an official sealed transcript for each school attended.

Name	Address	Period of Attendance From (Mo/Yr)	Period of Attendance To (Mo/Yr)
University of Southern CA	Los Angeles, CA	6/86	6/90

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

Course	Yes	No	Name of College or University
Chemistry	X		University of Southern CA
Physics	X		"
Biology or Zoology	X		"

11. List name and address of all schools where professional medical instruction was received. Submit an original Certificate of Medical Education (Form L2) and official sealed transcripts from each school attended.

Name	Address	Place Where Instruction Received	Period of Attendance From (Mo/Yr)	Period of Attendance To (Mo/Yr)
Wayne State University	Detroit, MI	Detroit, MI	6/90	6/94

12. Doctor of Medicine Degree granted by: (submit original medical diploma and a photocopy; Note, a U.S. graduate may, in lieu of the original, submit an official certified photocopy that has the school seal affixed on the signature of the registrar certifying authenticity.)

Name of Medical School: Wayne State University

Address of Medical School: Detroit, MI

Exact Date of Issuance: June 12, 1994

School Code

NOTE: APPLICANT MUST PROVIDE NAME, ADDRESS AND DATE OF ISSUANCE OF DEGREE.

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L1A

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13. Have you taken any of the following written examinations: National Boards, other State Boards, FLEX, ECFMG Certification?

If YES, list name, location, date and result of examination. Submit certification of scores from each examination agency. Applicants who hold ECFMG certification will need to submit an original valid ECFMG certificate for examination and licensure. ☐ Yes ☒ No

Name	Location	Date	Result

WRITTEN EXAMINATION

14. Have you satisfactorily completed at least one year of qualifying postgraduate training in U.S. or Canadian facilities?
(Note: Do not complete Form L3 (s) to document training received in research or clinical fellowship programs) ☒ Yes ☐ No

If YES, list name and address of all facilities. Submit an original Certificate of Completion of ACGME Postgraduate Training (Form L3) from each facility.

Name	Address	Type of Service	Period of Attendance	
			From (Mo/Yr)	To (Mo/Yr)
Flushing Medical Center	Flushing, NY	OB-GYN	7/94	Present

QUESTIONS 14A–23 For any positive response to these questions, applicant should provide, in addition to written explanations, any documentation regarding the matter.

14A. Have you ever withdrawn from, or been suspended, dismissed or expelled from, a medical school or postgraduate training program? Yes No

15. Have you been licensed to practice medicine in any state or country? ☐ Yes ☒ No

If YES, list state or country, license number, date issued and dates of practice in issuing agency's jurisdiction for each. Submit a Letter of Good Standing from each state in which you are licensed or have been licensed. Please include temporary, limited, or provisional licenses.

State or Country	License Number	Date of Issuance	Dates of Practice in Issuing Agency's Jurisdiction	
			From (Mo/Yr)	To (Mo/Yr)

16. Has any disciplinary action ever been filed or taken regarding any healing arts license which you now hold or have ever held? Include any disciplinary actions by the U.S. Military, U.S. Public Health Service or other U.S. federal governmental entity.

If yes, give details below. Yes No

State	Date	Charge	Disposition

L1B

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17. Have you ever been denied a license, permission to practice medicine or any other healing arts, or permission to take an examination in any state, country, or U.S. federal jurisdiction? Yes No

If yes, give details below.

State or Country	Date of Denial	Reason for Denial

18. Have you been charged with unprofessional conduct or any other unlawful activity by any healing arts licensing authority or by the U.S. military and are awaiting final disposition by that body? You must also list any pending actions or accusations. Yes No

19. Have you ever voluntarily surrendered a license to practice in the healing arts in another state? Yes No

20. Have you ever had staff privileges in a hospital denied, suspended or revoked, or resigned from a medical staff in lieu of disciplinary action? Yes No

21. Are you now, or were you in the past, addicted to or treated for addiction to controlled substances, such as narcotics or alcohol? Yes No

22. 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? Yes No

If yes, give details below.

Violation and Location	Date	Penalty or Disposition

23. Have you ever been convicted of, or pled nolo contendere to any offense, misdemeanor or felony of any state, the United States, or a foreign country? (except violations of traffic laws resulting in fines of $75.00 or less.) Yes | No

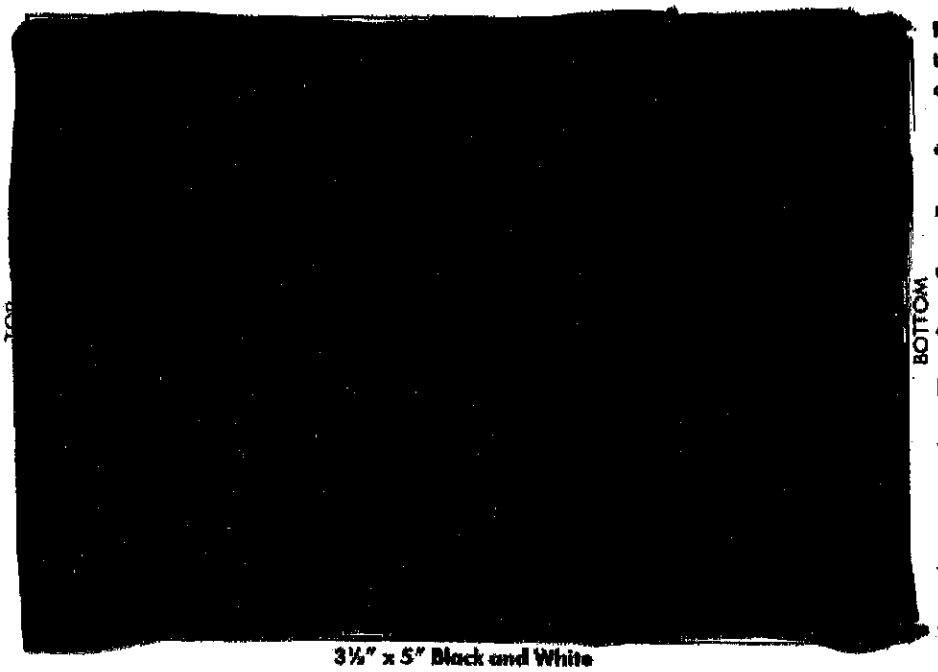
YOU ARE REQUIRED TO LIST ANY CONVICTION THAT HAS BEEN SET ASIDE AND DISMISSED UNDER SECTION 1203.4 OF THE PENAL CODE OR UNDER ANY OTHER PROVISION OF LAW. A SEPARATE LETTER EXPLAINING THE DETAILS OF THE OFFENSE IS ALSO REQUIRED, IN addition TO CERTIFIED COURT DOCUMENTS.

If yes, give details below.

Violation and Location	Date	Penalty or Disposition

"Disclosure of your social security number is mandatory. Section 30 of the Business and Professions Code and Pub. L. 94-455 (42 U.S.C.A. 405 (c) (2) (C)) authorizes collection of your social security number. Your social security number will be used exclusively for tax enforcement purposes. If you fail to disclose your social security number, you will be reported to the Franchise Tax Board, which may assess a $100 penalty against you."

L1C



3½" x 5" Black and White

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 _____, 19____,

my age then being____ years;

color of hair ____ ____;

color of eyes ____ ____;

height____ ____ ft.____ ____ in.;

weight____ ____ lbs.;

identifying marks ____ ____

NOTE: 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, per Section 2080 of the Business and Professions Code which authorizes the collection of this information. Information regarding the issuance or denial of a license by the Board may be transmitted to any other medical licensing authority or the Federation of State Medical Boards. Applicants have the right to review their application subject to the provisions of the Information Practices Act. The Program Manager of the Division of Licensing is the custodian of records.

NOTARIZATION PORTION

STATE OF NEW YORK)

COUNTY OF QUEENS)

PAYMAN YOUSEFZADEH being duly sworn, says he is the person referred to in
PRINT FULL NAME OF APPLICANT

the foregoing application for a physician and surgeon's certificate in California and that he 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.

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

Payman Yousefzadeh
Signature of applicant: (Write FULL name, not initials)

Signed and sworn to before me this 25th day of March, 1996.

Signature of Notary Public Lynn Kittelberger

[NOTARY SEAL]

Address Flushing N.Y.

LYNN KITTELBERGER
Notary Public, State of New York
No. 01KI4963661
Qualified in Queens County
Commission Expires March 19, 1998

My commission expires ____

L1D

07A-100 (REV. 7/91)

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PETE WILSON, Governor

State of California Department of Consumer Affairs

MEDICAL BOARD OF CALIFORNIA

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96 APR -9 PM 12:35

CERTIFICATE OF MEDICAL EDUCATION

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

This certifies that PAYMAN YOUSEFZADEH, M.D.
(FULL NAME OF APPLICANT)

of 1301 Orleans Detroit, MI. (ADDRESS WHEN ENROLLED) enrolled in WAYNE STATE UNIV. SCHOOL OF MEDICINE (NAME OF MEDICAL SCHOOL)

540 East Canfield Avenue Detroit, MI (LOCATION) on the 20th day of AUGUST (MONTH) 19 90 (YEAR) ✓

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 2088).

University of Southern CAlifornia B.S. DEGREE 06/90 1986 - 1990
SANTA MONICA COLLEGE (EDUCATIONAL INSTITUTION) 1984 (DATES) 1989

Advanced Credits. Credits previously obtained at an approved medical school.*

(MEDICAL SCHOOL) (TOTAL CREDITS) (DATES)

The undersigned further certifies that the records of this institution show that ☒ he ☐ she attended in this institution --all-- (SPECIFY NUMBER) years of resident instruction of four years (NUMBER OF) each, 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 Section 2089), and that

OR ☑ he was granted the degree Bachelor/Doctor of Medicine by
☐ he withdrew from

the above-mentioned medical school on the 2nd day of JUNE (MONTH) 19 94. ✓

Anatomy
Otolaryngology
Obstetrics and Gynecology
Radiology, including Radiation Safety
Tropical Medicine
Physiology
Biochemistry
Pathology, Bacteriology and Immunology
Ophthalmology
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
Anesthesia

[redacted]

Signed and the college seal affixed this 2 day of APRIL, 19 96

BY Sandra J. Driscoll
MS. SANDRA J. DRISCOLL/RECORDER

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

* Each school where professional medical instruction was received MUST complete one of these forms. If more than one school was attended, photocopies of this blank form may be made and used. Note that photograph and all entries to the form must be original.

RECEIVED
MAR 2 8 1996
WSU SCHOOL OF MEDICINE

L2

STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY

Consumer Affairs

MEDICAL BOARD OF CALIFORNIA

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SACRAMENTO, CALIFORNIA 95825-3236

4/4 #3114

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96 APR -1 AM 1:50

95 APR -2 AM 8:55

CERTIFICATE OF COMPLETION OF ACGME/CCME POSTGRADUATE TRAINING

To be completed by the facility for every medical school graduate completing postgraduate training in the United States or Canada. Do not complete if photograph of applicant is not attached on the reverse side. Also, please print or type information on the form.

PART 1: *To be completed by applicant/trainee.*

Last Name Of Trainee: Youseftadeh | First Name: Payman | Middle Initial:

Current Address: 214-03 Waters Edge Dr | Phone Number:

City: Bayside | State: NY | Zip Code: 11360

PART 2: *To be completed by facility.*

Completion of this form will certify that the individual named in Part 1 above and whose photograph is attached to this form, formally completed an accredited postgraduate training program at this facility. The following information is provided to certify "satisfactory" completion. See reverse side of Form for definition of "satisfactory".

Name of Facility: Flushing Hospital Medical Center

Address of Facility: 45th Ave. at Parsons Blvd., Flushing, N.Y. 11355

Name of Program Director: Joseph Pennisi, M.D. | Phone Number: (718) 670-5440

Signature of Program Director: Joseph C Pennisi MD | Date Signed: 3-20-96

List Categorical Specialty Area of Training Completed by Trainee: Obstetrics/Gynecology | Date Training Commenced: 7/1/94 | Date Training Completed: is expected to be 6/30/98

If the training was rotating or transitional, list in the space provided below, the specific rotations and the number of weeks spent in each:

Note: To qualify for licensure in California, applicants who are graduates of a foreign medical school must complete at least four months of postgraduate training in general medicine as part of the one-year requirement. Applicants who are graduates of a U.S. or Canadian medical school, who have not completed the one-year of postgraduate training required for licensure by July 1, 1980, must also complete four-months of training in general medicine as part of the one year required for 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. If the general medicine requirement is satisfied by training in a specialty area other than family practice, internal medicine, surgery, pediatrics or obstetrics and gynecology, the Program Director must submit a description of the type of training in sufficient detail to allow the Division of Licensing to make a determination regarding its acceptability.

(OVER)

07A-100-L3 (Rev. 2/92)

L3A

PART 3: *To be completed by the Director of Medical Education and affixed with the official facility seal.*

Name of Director of Medical Education:	Louis J. Delli-Pizzi, M.D.	Phone Number:	(718) 670-5520
Facility Name:	Flushing Hospital Medical Center	Date Form Completed:	March 25, 1996
Facility Address:	45th Avenue at Parsons Boulevard		
City:	Flushing	State: N.Y.	Zip Code: 11355

The individual signing this form is formally certifying and documenting, under penalty of perjury, that the physician received instruction appropriate for the particular postgraduate level and that they satisfactorily completed the training program in accordance with the accepted standards and the criteria defined as equating to "satisfactory" performance as described below. In cases where the Director of Medical Education is certifying the completion of the minimum one-year of training required for licensure, he or she will personally be attesting to the fact that the physician/ trainee has acquired the skill and qualifications necessary to safely assume the unrestricted practice of medicine in this state.

Definition of "Satisfactory": The physician performed at an adequate level based on evidence of satisfactory progressive scholarship and professional growth including demonstrated ability to assume graded and increasing responsibility for patient care.

I hereby declare under penalty of perjury under the laws of the State of California that the above statements are true and correct and that the training program 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.

Signature of Director of Medical Education:

Date Signed: March 25, 1996

OFFICIAL HOSPITAL SEAL OR NOTARY SEAL, DATE AND SIGNATURE MUST BE AFFIXED TO CERTIFY TRAINING.

[redacted]

L3B

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State of California Department of Consumer Affairs

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CERTIFICATION STATEMENT

This is to certify that PAYMAN YOUSEFZADEH (Name of Physician) is in an approved ACGME/CCME postgraduate training position that commenced on July 1, 1994 and is expected to be completed on June 30, 1998 in Obstetrics/Gynecology (Type of Training)

at Flushing Hospital Medical Center (Name and Address of Facility)

45th Avenue at Parsons Blvd., Flushing, N.Y. 11355

(AFFIX OFFICIAL HOSPITAL SEAL OR NOTARY PUBLIC SEAL)

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 is being trained in an approved ACGME or CCME program position.

Louis J. Delli-Pizzi, M.D.
Type or print name of Director of Medical Education

Signature of Director of Medical Education

March 25, 1996
Date

(718) 670-5520
Phone Number

NOTE: Do not use this form in lieu of Form L3 "Certificate of Completion of ACGME Postgraduate Training"

07A 100-L9 (Rev. 12/92)

L9

STATE DEPARTMENT OF CONSUMER AFFAIRS
INTERNET CASHIERING SYSTEM
MEDICAL BOARD OF CALIFORNIA
SUPPLEMENTAL INFORMATION REPORT
From Date: 08/08/2013 **To Date:** 08/08/2013

ATRISUPPINF

09-AUG-16 16:48:07

Person Id : **Name :** Joseph;Payman

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:	JOSEPH, PAYMAN PAUL
Transaction Date:	07/11/2015 10:29
Application Number:	
Complaint Number:	
License Type:	8002
License Number:	60633
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:	**60633**
File Number:	
Application:	**Physician's and Surgeon's Renewal**
Application Number:	
Application Date:	**07/11/2015 (mm/dd/yyyy)**

Personal Detail

First Name:	**PAYMAN**
Middle Name:	**PAUL**
Last Name:	**JOSEPH**
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.**

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 - 30-39 Hours**
	Other - None
	Patient Care - 40+ Hours
	Research - None
	Teaching - None
	Telemedicine - None
Patient Care Practice Location	**Zip: 91405 County: LOS ANGELES**
Telemedicine Practice Location	**Zip: County:**
Patient Care Secondary Practice Location	**Zip: 90019 County: LOS ANGELES**
Telemedicine Secondary Practice Location	**Zip: County:**
Current Training Status	**Not in Training**
Areas of Practice	**Obstetrics and Gynecology - Primary**
Board Certifications	**None**
Postgraduate Training Years	**4 Years**
Cultural Background	**Middle Eastern**
Foreign Language Proficiency	**Persian (Farsi)**
Web Site Profile	**Cultural Background - No**
	Foreign Language Proficiency - No
	Gender - No

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: