

### MEDICAL BOARD OF CALIFORNIA

LICENSING PROGRAM 1426 Howe Avenue, Suite 54 Sacramento, CA 95825-3236 (916) 263-2362 FAX (916) 263-2487



www.medbd.ca.gov

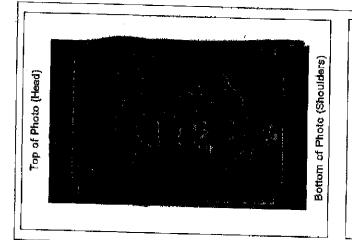
Please READ all instructions prior to completing this application. ALL questions on this application must be answered, and all priority to completing the application.

When space provided is insufficient, attach additional absence of paper. All attachments are considered part of the application.

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MBC USE For all of the below, also Include any disciplinary actions by the U.S. Military, U.S. Public Health Service, or other U.S. tteral governmental License Deta 17A. 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? 17B. Has any disciplinary action ever been filed or taken, including but not limited to, informal or confidential discipline, cosent orders, or letters of warning, regarding any healing arts license which you now hold or have ever held?  $17\underline{C}$ . Is any such action as described above pending? 17(A) No 17(B) IF YOU ANSWERED YES TO 17A, 17B OR 17C, PROVIDE DETAILS ON No A SEPARATE ATTACHMENT. 17(C) No 18. Has a claim or action for damages ever been filed against you in the course of the practice of medicine or any other healteant which resulted in a majoractice settlement, judgement, or arbitration award of over \$30,000.00? Yes IF YOU ANSWERED YES, PROVIDE DETAILS ON A SEPARATE ATTACHMENT. 19. Have you ever been denied a license, permission to practice medicine or any other healing art, or denied permission to take an examination in any state, territory, country, or U.S. federal jurisdiction, or is any such action pending? IF YOU ANSWERED YES, PROVIDE DETAILS ON A SEPARATE ATTACHMENT. 20. Have you ever voluntarily surrendered a license to practice medicine or any other healing arts in this or any other state, or voluntarily surrendered your narcottle (controlled substance) permit (state or federal) to any licensing board or any other agency, or is any such action IF YOU ANSWERED YES, PROVIDE DETAILS ON A SEPARATE ATTACHMENT. Yes No 21. Have you ever hed staff privileges in a hospital denied, suspended, limited, revoked, or not renewed for medical discipling cause, or resigned from a medical staff in lieu of disciplinary or administrative action, or is any such action pending? YOU MUST DISCLOSE ANY INFORMAL OR CONFIDENTIAL DISCIPLINARY ACTION. Yes No 22. Do you have any condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety, including but not limited to, any of the following? Ø IF YES, PLEASE CHECK THE APPROPRIATE BOX(ES) BELOW: No A condition which required admission to an inpatient psychiatric treatment facility. Alcohol or chemical substance dependency or addiction. П Emotional, mental or behavioral disorder. Other (explain): FOR ANY OF THE BOXES CHECKED ABOVE, PLEASE SUBMIT COMPLETE CEPICIAL INPATIENT AND OUTPATIENT TREATMENT RECORDS, EVIDENCE OF ONGOING REHABILITATION TREATMENT, AND A PERSONAL WRITTEN EXPLANATION. FOR ALL OF THE BELOW, YOU ARE REQUIRED TO LIST ANY CONVICTION THAT HAS BEEN SET ASIDE AND DISMISSED OR EXPUNGED, OR WHERE A SYAY OF 23A. Have you ever been convicted of, or pled note contenders to, ANY violation (include every misdemeaner or felony) of any load, state, or federal law of any state, territory, country, or U.S. federal jurisdiction?  $23\underline{R}$ . Is any criminal action related to the above pending? 23 (A) Na IF YOU ANSWERED YES TO 23A OR 23B, PROVIDE DETAILS ON A SEPARATE ATTACHMENT. 23 (B) Ñο NAME OF APPLICANT: DATE OF BIRTH: Ward



Notice: All Items In this application are mandatory; none are voluntary. 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 or 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.

	Appt cant Deciaration/Signature
STATEOF Vermont	and NOTARY
countrof Chitenden	<del></del>
The applicant, Sarah ward Prager	,being first duly sworn
upon his/her oath deposes and says: that I am the person herein named subscribing to this application, know the full content thereof, and declare under penalty of perjury, that is contained herein and evidence or other credentials submitted herewith are true and correct; that I the degree of Doctor of Medicine as prescribed by this application, that the same was procured in instruction and examination, and that it, together with all the credentials submitted, were procured resentation or any mistake of which I am aware and that I am the lawful holder thereof. Further, I hospitals, institutions or organizations, my references, personal physicians, employers (past, present and professional associates (past, present, and future), and all government agencies (local, state, release to the Medical Board of California or its successors any information, files or records, included advantage and records of psychiatric treatment and treatment for drug and/or alochol abort determine my medical connection with this application; or any further or future investigation by medicine. I further authorize the Medical Board of California or its successors to release to the organization or groups ilsted above any information which is material to this application or any subsequent licent THAT FALSIFICATION OR MISREPRESENTATION OF ANY ITEM OR RESPONSE ON THIS A	ration; that I have read all of the information am the lawful holder of the regular course of without fraud or misrephereby authorize all ont, and future), business federal, or foreign) to fing medical records, use or dependency, that Board necessary to gage in the practice of ganizations, individuals, isure. I UNDERSTAND
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"STATE OF CALIFORNIA -- STATE AND CONSUMER SERVICES AGENCY

ARNOLD SCHWARZENEGGER, Governor



MEDICAL BOARD OF CALIFORNIA

1428 Howe Avenue, Suite 54: UE 13 11 G PR O GR Δ 13

Sacremento, CA 98825-3236

(916) 263-2382 FAX (916) 263-2487 www.medbd.ca.gov



## CERTIFICATE OF MEDICAL EDUCATION

MEDICAL SCHOOL	PLEASE COMPLETE THIS FORM IN THE E	NG ISH : ANGHAGE
This certifies that Sarah		
FULL NAM	Ward Prager : U.S. SOCIAL SECURITY	NO. DATE OF BIRTH-MM/DD/YYYY
NAME OF MEI	stas South wasterny Dallas	rexas
on the day of ATU 6 4	MONTH 1990 and was granted the	/ LOCATION
Advanced Credits: Credits pr	MONTH  YEAR  aviously obtained at an approved medical, dental, or osleopathle	following credits on enrollment:
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	L SCHOOL TOTAL CREDITS	DATES
The undersigned further certifies that the	e records of this institution show that the applicant attend	ded in this institution
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attendance is required, in the subjects s	et forth hereunder (Business and Professions Code Sec	tion 2089), and that the annileant
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The above medical school on	the day of u.e.	2000 V
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auon dele	resident, Dean, or Rogistrar may sign this form. If that signature aut person, evidence of that delegation must be attached to this form gation must be on official letterhood and must be dated within the nd the school sign affixed this 14th day of 1600 million of 1600 million with the school sign affixed this 14th day of 1600 million with the school sign affixed this 16th day of 1600 million with the school sign affixed this 16th day of 1600 million with the school sign affixed this 16th day of 16th day o	(MRY De a phatocopy), last 12 months.
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MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM
1426 Howe Avenue, Sulte 54
Sacramento, CA 95825-3236
(916) 263-2382 FAX (916) 263-2467
www.medbd.ca.gov



# CERTIFICATE OF COMPLETION OF ACGME/RCPSC POSTGRADUATE TRAINING

	PS OF MEDICAL EDUCATION. THE PERSON WHO SIGN Medical Education may sign this form. If that signs Not delegation must be on official tells rhead and PPLICANT.	ature gut hori ty i s bel ng del ugal ed to ad I mini ha del ed	THE APPLICANT BY BLOOD, MARK Incliner persons, Byl denca of I hat de	IAGE, OR ADOPTION I egation must be
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