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STATE OF CALIFORNIA—AGRICULTURE 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

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

CLASS G

(Please type or print neatly. When space provided is insufficient, attach additional sheets.) 1977 00402

1. NAME: Last: Seletz First: Josepha Middle: Inez Maiden:
2. Telephone No.
3. List other names, if any, you have used:
4. Address (Street and No./Rural Route): 4401 Dundee Drive City: Los Angeles State: Calif. Zip Code: 90027
5. Name you wish on License: Josepha I. Seletz Birthdate (Month - Day - Year)
6. Premedical Education: Name of College or University: University of California Location: Los Angeles
Period of attendance: From: 9-1967 To: 6-1972 Check premed courses successfully completed: [x] Chemistry [x] Physics [x] Biology or Zoology
7. Medical School:

Year	Name of Institution	Location	From	To
1st	Temple University	Philadelphia, PA	9-1972	5-1976
2nd				
3rd				
4th				
5th				
6th				

8. Doctor of Medicine Degree granted by: Temple University ~~Medical School~~ School of Med. Date: May 1976 For office use only School Code: PA 13
9. 1st Year Postgraduate Training (Internship):

Location	Type of Service	From	To
San Francisco General Hospital	Rotating	June 1976	June 1977

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:

State	Date	Charge	Disposition

12. Have you ever been denied a license to practice medicine in any State or Country?
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?

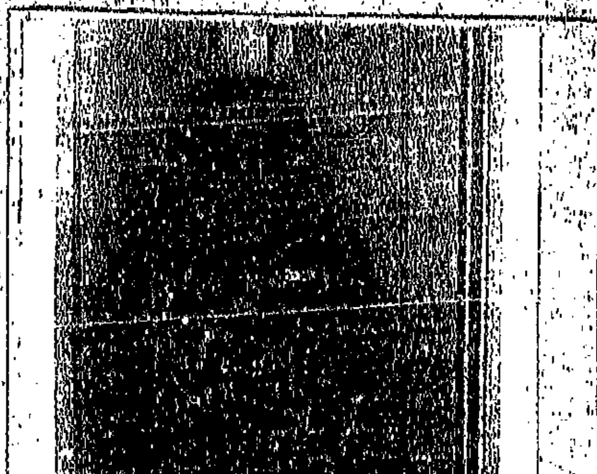
07A-101 (REV. 4/78)

(Over)

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?	
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 fine 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.	



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: Josephia I. Seletz

Date: Aug 8, 1977

Subscribed and sworn to before me this 8th day of August 1977

OFFICIAL SEAL
ADRIENNE R. WINAKUR
NOTARY PUBLIC - CALIFORNIA
PRINCIPAL OFFICE IN
LOS ANGELES COUNTY
My Commission Expires April 2, 1978

Signature of Notary: Adrienne R. Winakur

Address: 4867 Sunset Blvd.
Los Angeles 90027

My commission expires: April 2, 1978

STATE OF CALIFORNIA—AGRICULTURE AND SERVICES AGENCY

DEPARTMENT OF Consumer Affairs

BOARD OF MEDICAL EXAMINERS

1020 N STREET, SACRAMENTO, CALIFORNIA 95814
TELEPHONE (916) 322-5049

PLEASE FORWARD TO YOUR MEDICAL SCHOOL

CERTIFICATE OF EDUCATION

This Certifies That Josepha Inez Saltz
Full name of applicant

enrolled in Temple University Medical
Name of medical school (college)

on the 11 day of September 19 72
Month Year

☒ as a Freshman

☐ with advanced standing based on _____
Please specify

This 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 University of California, and that he attended while at this
Please indicate school

medical school (college) four courses of lectures of 33 weeks each,
Specify number Specify number of weeks

completing n/a hours in the subjects below listed, and that he/she
Total hours

☒ was granted the degree { Bachelor / Doctor } of Medicine

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

_____

_____

on the 27 day of May 19 76
Month Year

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

*see attached sheet

____Anatomy	____Preventive medicine	____Medicine
____Embryology	____Hygiene and sanitation	____Pediatrics
____Histology	____Radiology, including Roentgenologic technique and radiation safety	____Psychiatry
____Neuroanatomy		____Neurology
____Physiology	____Urology	____Dermatology
____Psychobiology	____Ophthalmology	____Physical medicine
____Biochemistry	____Anesthesia	____Therapeutics
____Pathology, bacteriology and immunology	____Otolaryngology	____Tropical medicine
____Pharmacology	____Obstetrics and gynecology	____Surgery, including orthopedic surgery

Signed and the College seal affixed this 22 day
of June 19 76
Month Year

[AFFIX SEAL HERE]

By Mrs. Donald M. Jones, Registrar
President, Secretary, Dean

DTA-32 (REV. 8-73)

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:	SELETZ, JOSEPHA INEZ
Transaction Date:	09/08/2014 11:32
Application Number:	
Complaint Number:	
License Type:	8002
License Number:	35414
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:	**35414**
File Number:	
Application:	**Physician's and Surgeon's Renewal**
Application Number:	
Application Date:	**09/08/2014 (mm/dd/yyyy)**

Personal Detail

First Name:	**JOSEPHA**
Middle Name:	**INEZ**
Last Name:	**SELETZ**
Birthdate:	**/**/****
Gender:	**Female**

Addresses

License Related Addresses

Confidential Address (Optional)

Warning: **In order to protect your privacy and identity, address will not be displayed.**

License Specific Public/Mailing Address (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**

Financial Interest Disclosure Summary

Health-Related Facility Name:	**Sinai Surgical Center**
Address:	**99 N La Cienega #303 Beverly Hills CA 90211**

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**
	Patient Care - 30-39 Hours
	Research - None
	Teaching - 1-9 Hours
	Telemedicine - 1-9 Hours
Patient Care Practice Location	**Zip: 90211 County: LOS ANGELES**
Telemedicine Practice Location	**Zip: 90211 County: LOS ANGELES**
Patient Care Secondary Practice Location	**Zip: County:**
Telemedicine Secondary Practice Location	**Zip: County:**
Current Training Status	**Not in Training**
Areas of Practice	**Neonatal-Perinatal Medicine - Secondary**
	Obstetrics and Gynecology - Primary
Board Certifications	**American Board of Obstetrics and Gynecology - Obstetrics and Gynecology**
Postgraduate Training Years	**5 Years**
Cultural Background	**White**
Foreign Language Proficiency	**Italian**
	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**
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: