STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY — GEORGE DEUKMEJIAN, Governor

DEPARTMENT OF Consumer Affairs

BOARD OF MEDICAL QUALITY ASSURANCE

1430 HOWE AVENUE, SACRAMENTO, CALIFORNIA 95825
APPLICATIONS AND EXAMINATIONS (916) 920-6611

RECEIVED DEPARTMENT OF BOARD OF MEDICAL ASSURANCE

26 NOV 84 16 46 0058 23

APPLICATION FOR PHYSICIAN'S AND SURGEON'S CERTIFICATE

BASED ON NATIONAL BOARD CREDENTIALS

CLASS C

PLEASE TYPE OR PRINT CLEARLY. WHEN SPACE PROVIDED IS INSUFFICIENT, ATTACH ADDITIONAL SHEETS.

1. NAME: LAST ZUMWALT FIRST THERESA MIDDLE ANN MAIDEN SCHAR TELEPHONE NO.

2. LIST OTHER NAMES, IF ANY, YOU HAVE USED: TERRY

3. ADDRESS: STREET AND NO. / RURAL ROUTE 4008 DECATUR CITY LONGWALT STATE OHIO ZIP CODE 43240

4. NAME YOU WISH ON LICENSE: THERESA ZUMWALT M.D. BIRTHDATE: MONTH, DAY, YEAR

5. PRE-MEDICAL EDUCATION: NAME OF COLLEGE OR UNIVERSITY UNIVERSITY OF ILLINOIS LOCATION URBANA, ILLINOIS

PERIOD OF ATTENDANCE: FROM SEPT. 1962 TO JUNE 1967

CHECK PREMED COURSES SUCCESSFULLY COMPLETED: ☒ CHEMISTRY ☒ PHYSICS ☒ BIOLOGY OR ZOOLOGY

6. MEDICAL SCHOOL:

YEAR	NAME AND INSTITUTION	LOCATION	FROM	TO
1.	UNIVERSITY OF ILLINOIS	CHICAGO, ILLINOIS	SEPT 1967	JUNE 1971
2.	COLLEGE OF MEDICINE	Box 6998	INCLUSIVE	
3.	OF CHICAGO	CHICAGO 60680		
4.		ILLINOIS		

7. DOCTOR OF MEDICINE DEGREE GRANTED BY: UNIVERSITY OF ILLINOIS COLLEGE OF MED. AT CHICAGO DATE 11 JUNE 1971 FOR OFFICE USE ONLY SCHOOL CODE L 011

8. 1ST YEAR POSTGRADUATE TRAINING (INTERNSHIP): LOCATION MARY BASSETT HOSPITAL COOPERSTOWN N.Y. TYPE OF SERVICE ROTATING - O FROM JUNE 1971 TO JUNE 1972

10. LIST ALL STATES IN WHICH YOU HAVE BEEN LICENSED TO PRACTICE MEDICINE: NEW YORK STATE INACTIVE TEXAS E5297 OHIO 42600

11. HAS ANY DISCIPLINARY ACTION EVER BEEN TAKEN REGARDING ANY LICENSE WHICH YOU NOW HOLD OR HAVE 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:

NAME OF AUTHORITY	DATE OF DENIAL	REASON FOR DENIAL

13. HAVE YOU EVER BEEN ADDICTED TO NARCOTIC DRUGS?

14. HAVE YOU EVER BEEN CONVICTED OF, OR PLED NOLO CONTENDERE TO A VIOLATION OF ANY FEDERAL, STATE OR FOREIGN LAW RELATING TO THE MANUFACTURE, DISTRIBUTION OR DISPENSING OF CONTROLLED SUBSTANCES/NARCOTICS, OR TO DRUG ADDITION?

15. HAVE YOU EVER BEEN CONVICTED OF, OR PLED NOLO CONTENDERE TO ANY DEFENSE, MISDEMEANOR OR FELONY IN ANY STATE? (EXCEPT VIOLATIONS OF TRAFFIC LAWS RESULTING IN FINES OF $100.00 OR LESS.)

16. IF YOU ANSWERED "YES" TO EITHER NO. 14 OR 15 ABOVE, PLEASE PROVIDE THE FOLLOWING INFORMATION:

CHARGE AND LOCATION	DATE	PENALTY/DISPOSITION

17. HAVE YOU EVER HAD STATE PRIVILEGES IN A HOSPITAL SUSPENDED OR REVOKED? IF YES, PLEASE EXPLAIN ON ANOTHER SHEET OF PAPER.

18. HAVE YOU EVER VOLUNTARILY SURRENDERED YOUR LICENSE TO PRACTICE IN ANOTHER STATE?

(APPLICANT) PLEASE COMPLETE THE FOLLOWING:

HEIGHT: ___ FT. ___ IN. WEIGHT: ___ LBS.

HAIR COLOR: ___ EYE COLOR: ___

IDENTIFYING MARKS: ___

NOTE: THE INFORMATION ON THIS APPLICATION IS REQUIRED AND MAINTAINED PURSUANT TO SECTION [illegible] OF THE BUSINESS AND PROFESSIONS CODE. 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. APPLICANTS HAVE THE RIGHT TO REVIEW THEIR APPLICATIONS PURSUANT TO THE PROVISIONS OF THE CALIFORNIA INFORMATION PRACTICES ACT.

NOTE: APPLICANT WILL SIGN THIS STATEMENT IN PRESENCE OF NOTARY PUBLIC.

I HEREBY CERTIFY (OR DECLARE), UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA, 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: [illegible]

DATE: [illegible]

SUBSCRIBED AND SWORN TO BEFORE ME THIS 8 DAY OF [illegible] 19[illegible]

SIGNATURE OF NOTARY: [illegible]

ADDRESS: [illegible]

(SEAL)

MY COMMISSION EXPIRES: [illegible]

STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY — GEORGE DEUKMEJIAN, GOVERNOR

DEPARTMENT OF CONSUMER AFFAIRS

BOARD OF MEDICAL QUALITY ASSURANCE
1426 HOWE AVENUE, SACRAMENTO, CALIFORNIA 95825

PLEASE FORWARD TO YOUR MEDICAL SCHOOL

CERTIFICATE OF MEDICAL EDUCATION

THIS CERTIFIES THAT THERESA ANN (SCHAR) ZUMWALT
500 BROADWAY/LIBERTYVILLE
OF (ADDRESS AND NUMBER) (CITY) (STATE) ENROLLED IN UNIVERSITY OF ILLINOIS HLTH SCI. CTR.
CHICAGO, ILL.
(LOCATION) ON THE 25 DAY OF SEPTEMBER 67
(MONTH) (YEAR)

AND HAS EARNED THE FOLLOWING CREDITS OR ENROLLMENT:

PREMEDICAL EDUCATION: TWO YEARS OF PREPROFESSIONAL POSTSECONDARY EDUCATION, INCLUDING THE SUBJECTS OF MEDICAL SUMMARY, AND BIOLOGY (BUSINESS AND PROFESSIONS CODE SECTION 2064).

(SECONDARY INSTITUTION) (DATE)

ADVANCED CREDITS: CREDITS PREVIOUSLY OBTAINED AT AN APPROVED MEDICAL SCHOOL.*

(MEDICAL SCHOOL) (TOTAL CREDITS) (DATES)

THE MONTHS OF PRIOR EDUCATION, ADVANCED CREDITS, AND
SCHOLAR ADVANCED CREDITS MUST BE SUPPLIED WITH THIS CERTIFICATE

THE UNDERSIGNED FURTHER CERTIFIES THAT THE RECORDS OF THIS INSTITUTION SHOW THAT HE ATTENDED IN THIS INSTITUTION FOURTEEN (4) COURSES OF RESIDENT INSTRUCTION OF (MONTHS OR WEEKS) 36 WEEKS EACH, COMPLETING AT LEAST 1,100 HOURS, OR UNION AT LEAST 80 PERCENT ACTUAL ATTENDANCE IS REQUIRED, IN THE SUBJECTS OF DENTAL MEDICINE (BUSINESS AND PROFESSIONS CODE SECTION 2000), AND THAT HE WAS GRANTED THE DEGREE BACHELOR/DOCTOR OF MEDICINE BY THE ABOVE MENTIONED MEDICAL SCHOOL ON THE 11 DAY OF June (MONTH) 19 71

ANATOMY	DERMATOLOGY	PREVENTIVE MEDICINE, INCLUDING NUTRITION
OTOLARYNGOLOGY	GERIATRICS	PHYSICAL MEDICINE
OBSTETRICS AND GYNECOLOGY	HISTOLOGY	THERAPEUTICS
RADIOLOGY, INCLUDING RADIATION SAFETY	MEDICAL SPECIALTY AS MAY BE DEFINED IN BOARD RULES	NEUROSURGERY
TROPICAL MEDICINE	MEDICINE	CHILD ABUSE DETECTION AND TREATMENT
PHYSIOLOGY	NEUROLOGY, INCLUDING CEREBROVASCULAR DISEASE	GERIATRIC MEDICINE
BIOCHEMISTRY	VIROLOGY	PEDIATRICS
PATHOLOGY, BACTERIOLOGY AND IMMUNOLOGY	PSYCHIATRY	PHARMACOLOGY
OPHTHALMOLOGY	NEUROLOGY	ANESTHESIA

[AFFIX SEAL HERE]

SIGNED AND THE COLLEGE SEAL AFFIXED THIS 31 DAY OF October 1984
BY Lisa Levely, Associate Director
(SECRETARY, BOARD OF MEDICAL EDUCATION)
OCT 31 1984

*EACH MEDICAL SCHOOL ATTENDED MUST COMPLETE ONE OF THESE FORMS COVERING PERIOD OF ATTENDANCE.

MA-35 (REV. 6/83)

Medical Board of California – Physician's and Surgeon's Initial Renewal

LICENSEE NAME	LICENSE NO.	EXPIRATION DATE	AMOUNT DUE NOW	AMOUNT DUE IF POSTMARKED AFTER DECEMBER 30, 2014
ZUMWALT, THERESA A	**G54501**	**11/30/14**	**$37.00**	**$37.00**

LICENSEE MUST CHECK CORRECT BOXES

- "H" [X] Completed Continuing Education
- "E" [ ] Change of Address (fill in reverse side)
- "I" [ ] Conviction Disclosure – Yes
- "J" [X] Conviction Disclosure – No
- "F" [ ] Family Physician Training Program ($25)
- "G" [X] Financial Interest Statement

"D" **SIGNATURE REQUIRED**

I declare under penalty of perjury under the laws of the State of California that all statements, answers, and representations on this form, including supplementary attached hereto, are true, complete and accurate.

Signature Thera Zumwalt MD Date 22 Aug 2014

ENTER YOUR PHONE NUMBER FOR REFERENCE:

630107000007000060005450120111301400003700000003700

CHANGE OF MAILING ADDRESS **ZUMWALT, THERESA A** **G54501**

CORRECT AS PRINTED

08302014 20003507 20020016

Street Address (this address is public information **except** when a PO Box is used for the public address of record; this address then becomes confidential)

City State Zip

PO Box (if used, must provide a confidential physical street address, above)

City State Zip

Medical Board of California – Physician's and Surgeon's Initial Renewal

LICENSEE NAME	LICENSE NO.	EXPIRATION DATE	AMOUNT DUE NOW	AMOUNT DUE IF POSTMARKED AFTER DECEMBER 30, 2016
ZUMWALT, THERESA A	G54501	11/30/16	$37.00	$37.00

LICENSEE MUST CHECK CORRECT BOXES

- "H" [X] Completed Continuing Education (See Question 1)
- "E" [ ] Change of Address (fill in reverse side) current
- "I" [ ] Conviction – Yes (See Question 3) none
- "J" [X] Conviction – No (See Question 3)
- "F" [ ] Family Physician Training Program ($25 See Question 4) no
- "G" [X] Financial Interest Statement (See Question 5)

"D" **SIGNATURE REQUIRED**

I declare under penalty of perjury under the laws of the State of California that all statements, answers, and representations on this form, including supplementary attached hereto, are true, complete and accurate.

Signature Zumwalt MD. Date 14 Aug 2016

ENTER YOUR PHONE NUMBER FOR REFERENCE:

630107000007000060005450120111301600003700000003700

CHANGE OF ADDRESS (Only if different from address above) ZUMWALT, THERESA A G54501

ADDRESS OF RECORD (Required) (NONE)

Address Line 1

Address Line 2

Address Line 3

City State Zip

CONFIDENTIAL STREET ADDRESS (Required if PO Box used above for Address of Record)

Address Line 1

Address Line 2

Address Line 3

City State Zip