STATE OF CALIFORNIA -- STATE AND CONSUMER SERVICES AGENCY

Consumer Affairs

ARNOLD SCHWARZENEGGER, Governor

MEDICAL BOARD OF CALIFORNIA

LICENSING PROGRAM
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815
(800) 633-2322 (916) 263-2382 FAX (916) 263-2487
www.mbc.ca.gov

RECEIVED MEDICAL BOARD OF CALIFORNIA 2010 FEB -1 AM 9: 10

INITIAL AND UPDATE APPLICATION FOR PHYSICIAN'S AND SURGEON'S LICENSE *OR* POSTGRADUATE TRAINING AUTHORIZATION LETTER

Application for (please check one): ☒ License ☐ PTAL - or - ☐ Update

1. NAME: Last: DIEDRICH First: JUSTIN Middle: THOMAS

Other names you have used (include maiden name):

2. U.S. Social Security Number

3. Place of Birth

4. Date of Birth

5. Gender: ☒ Male ☐ Female

6. Public/Mailing Address: 101 CITY DRIVE, BLDG 56, #800
(Please note: this information is public) ~~LONG~~ ORANGE, CA 92868
(30 characters maximum per line, including spaces)

City: ORANGE State/Province: CA Zip/Postal Code: 92868 Country: usa

7. Telephone Numbers: (include area code) Home: (Work: Cell:

8. California Driver's License Number (optional):

9.

10. Have you ever filed an Application for Physician's and Surgeon's License, or PTAL, in California? ☐ Yes ☒ No
Previous license number, if any: ____________

MBC Use Only — Personal Data

MEDICAL EDUCATION

11. LIST EACH MEDICAL SCHOOL THAT YOU HAVE ATTENDED.

School Name	City, State/Province, Country	Dates of Attendance
CASE S.O.M.	CLEVELAND, OH USA	7/03 - 1/08

L2 Transcripts ☑ ☑ ☐ ☐ ☐ ☐

12. School of Graduation: CASE S.O.M. Degree Awarded: MD Date of Graduation: 1/2008

Diploma ☑ 1/18/2008

EXAMINATIONS

13. LIST ALL OF THE FOLLOWING EXAMINATIONS YOU HAVE TAKEN: USMLE, FLEX, NBME, ECFMG, SPEX, STATE BOARDS and/or QME in Canada

Examination	Date	Result (Pass/Fail)
STEP 1	~~8/2006~~ 8/2005	
STEP 2CK	~~12/2006~~ 12/2006	
STEP 2CS	1/2007 + 5/2007	

Exams ☑ ☑ ☑

0002075 $493 1/27/10 EG
Cashiering Use Only

OH 044
School Code

07A-100 (Rev. 04/2008)

L1A

A "yes" response to Questions 14 through 38 requires a written explanation on a separate sheet of paper along with any supporting materials.

ACGME/RCPSC ACCREDITED POSTGRADUATE TRAINING

MBC Use Only

Postgraduate Training

14. **Please list each ACGME/RCPSC accredited postgraduate training program in which you have participated. You must include each internship, residency and fellowship, whether or not the program was completed or credit granted.**

Facility Name	Address	Specialty Area	Dates of Attendance
UCI-MC	200 S. MANCHESTER ORANGE, CA 92868	OBGYN	7/2009 – Current

POSTGRADUATE TRAINING: (These questions are to be answered by ALL applicants)

Did you ever take a leave of absence or break from your training?	YES	NO
Have you ever been terminated, dismissed or expelled from a program?	YES	NO
Have you ever resigned from a training program?	YES	NO
Were you ever placed on probation?	YES	NO
Were you ever disciplined or placed under investigation?	YES	NO
Were any incident reports ever filed by instructors?	YES	NO
Were any limitations or special requirements placed upon you for clinical performance, discipline, or for any other reason?	YES	NO
Have you ever had a postgraduate training program contract not be renewed or offered for a following year?	YES	NO

MEDICAL LICENSURE

License Data

15. **Please list all medical licenses (other than training licenses) that have ever been issued by any state or territory in the United States or Canadian province.**

Jurisdiction	License Number	Date of Issuance	Dates of Practice in that Jurisdiction

APPLICANT: JUSTIN DIEDRICH

DATE OF BIRTH:

ABMS CERTIFICATIONS

16. Are you currently certified by a Member Board of the American Board of Medical Specialties? YES ☐ NO ☒

Member Board	Expiration Date	Certificate Number

MBC Use Only ABMS

MALPRACTICE HISTORY

17. Has a claim or an action ever been filed against you for the practice of medicine which resulted in a malpractice settlement, judgment, or arbitration award of $30,000 or more? YES NO

Malpractice

PRACTICE IMPAIRMENT OR LIMITATIONS

18. Have you been enrolled in, required to enter into, or participated in any drug or alcohol recovery program or impaired practitioner program? YES NO

19. Have you been treated for or had a recurrence of a diagnosed addictive disorder? YES NO

20. Have you been diagnosed with an emotional, a mental, or behavioral disorder which impairs your ability to practice medicine safely? YES NO

21. Have you ever been diagnosed with a neurological or other physical condition that would impair your ability to practice medicine safely? YES NO

22. Do you have any other condition which in any way impairs or limits your ability to practice medicine safely? YES NO

Limitations

If you do receive ongoing treatment or participate in a monitoring program, the Board will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure.

CRIMINAL RECORD HISTORY

23. Have you ever been convicted of, or pled guilty or nolo contendere to ANY offense in any state in the United States or foreign country?

This includes a citation, infraction, misdemeanor and/or felony, etc. If "YES" attach a list of each offense by arrest and conviction dates, violation, and court of jurisdiction (name and address). Matters in which you were diverted, deferred, pardoned, pled nolo contendere, or if the conviction was later expunged from the record of the court or set aside under Penal Code Section 1203.4 MUST be disclosed. If you are awaiting judgment and sentencing following entry of a plea or jury verdict, you MUST disclose the conviction; you are entitled to submit evidence that you have been rehabilitated. Serious traffic convictions such as reckless driving, driving under the influence of alcohol and/or drugs, hit and run, evading a peace officer, failure to appear, driving while the license is suspended or revoked MUST be reported. This list is not all-inclusive. If in doubt as to whether a conviction should be disclosed, it is better to disclose the conviction on the application.

For each conviction disclosed, you must submit with the application certified copies of the arresting agency report, certified copies of the court documents, and a descriptive explanation of the circumstances surrounding the conviction of disciplinary action (i.e., dates and location of incident and all circumstances surrounding the incident). This letter must accompany the application. If documents were purged by arresting agency and/or court, a letter of explanation from these agencies is required.

Applicants who answer "NO" to the question but have a previous conviction or plea, may have their application denied or license revoked for knowingly falsifying the application.

Criminal Record

APPLICANT: JUSTIN DIEDRICH

DATE OF BIRTH:

L1C

CRIMINAL RECORD HISTORY (cont'd)

MBC Use Only
Criminal Record

24. Is any criminal action pending against you? YES NO

25. Are you required to register as a Sex Offender? YES NO

DISCIPLINARY HISTORY

Discipline

These questions refer to discipline by any U.S. military or public health service, state board or other governmental agency of any U.S. state, territory, Canadian province, or country.

26. Have you ever been denied a license to practice medicine? YES NO

27. Is any denial pending against you? YES NO

28. 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? YES NO

29. Have you ever had any license to practice medicine revoked, suspended, or placed on probation? YES NO

30. Have you ever had any license to practice medicine subjected to any action including but not limited to informal or confidential discipline, consent orders, letters of warning, letters of reprimand, or citation? YES NO

31. Have you ever had any license to practice medicine subjected to any other disciplinary action? YES NO

32. Is any disciplinary action pending against any of your licenses to practice medicine? YES NO

33. Have you ever had staff privileges in a hospital terminated, denied, suspended, limited, revoked, or not renewed? YES NO

34. Have you ever resigned from a medical staff in lieu of disciplinary or administrative action? YES NO

35. Is any disciplinary action pending against your hospital staff privileges? YES NO

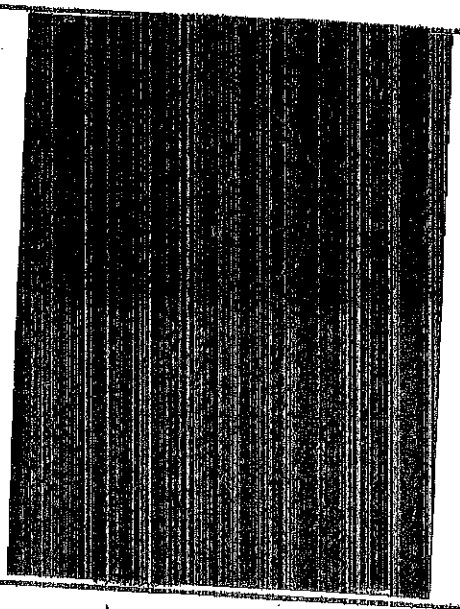
36. Have you ever surrendered a license to practice medicine? YES NO

37. Have your DEA privileges ever been denied, suspended, restricted, or terminated? YES NO

38. Have you ever entered into any arrangement or plea or agreement in lieu of a federal prosecution for a drug violation regulated by the DEA? YES NO

APPLICANT: JUSTIN DIEDRICH

DATE OF BIRTH:



Notice: All items in this application, except #8 and #9, are mandatory. 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 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.

The applicant, JUSTIN THOMAS DIEDRICH (PLEASE PRINT FULL NAME) _____ (DATE OF BIRTH) being first duly sworn upon his/her oath deposes and says: that I am the person herein named subscribing to this application; that I have read the complete application, know the full content thereof, and declare under penalty of perjury, that all of the information contained herein and evidence or other credentials submitted herewith are true and correct; that I am the lawful holder of the degree of Doctor of Medicine as prescribed by this application, that the same was procured in the regular course of instruction and examination, and that it, together with all the credentials submitted, were procured without fraud or misrepresentation or any mistake of which I am aware and that I am the lawful holder thereof. Further, I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past, present and future), business and professional associates (past, present, and future), and all government agencies (local, state, federal, or foreign) to release to the Medical Board of California or its successors any information, files or records, including medical records, educational records, and records of psychiatric treatment and treatment for drug and/or alcohol abuse or dependency, requested by that Board in connection with this application; or any further or future investigation by that Board necessary to determine any medical competence, professional conduct, or physical or mental ability to safely engage in the practice of medicine. I further authorize the Medical Board of California or its successors to release to the organizations, individuals or groups listed above any information which is material to this application or any subsequent licensure.

I UNDERSTAND THAT FALSIFICATION OR MISREPRESENTATION OF ANY ITEM OR RESPONSE ON THIS APPLICATION OR ANY ATTACHMENT HERETO IS A SUFFICIENT BASIS FOR DENYING OR REVOKING A LICENSE. J.D. **(PLEASE INITIAL BOX)**

SIGNATURE OF APPLICANT: Justin Diedrich (Please sign full name)

State of California

County of Orange

Subscribed and sworn to (or affirmed) before me on this 25th day of September, 20 09, by: (applicant's name to be printed here) JUSTIN DIEDRICH proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.

NOTARY PUBLIC
Commission # 1698879
Notary Public - California
Orange County
My Comm. Expires Sep 24, 2010

SIGNATURE OF NOTARY PUBLIC

LiE

NS
Misc

STATE OF CALIFORNIA -- STATE AND CONSUMER SERVICES AGENCY ARNOLD SCHWARZENEGGER, Governor

Consumer Affairs

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2009 NOV 12 PM 3:59

LICENSING PROGRAM

CERTIFICATE OF MEDICAL EDUCATION

MEDICAL SCHOOL: PLEASE COMPLETE THIS FORM IN THE ENGLISH LANGUAGE

This certifies that JUSTIN THOMAS DIEDRICH
Full Name of Applicant — U.S. Social Security Number

Date of Birth enrolled in Case Western Res
Name of Medical School

located in Cleveland, OH
State/Province Country on 08/07/2002.
Enrollment Date

The undersigned further certifies that the records of this institution show that the applicant attended in this institution 4 years of resident instruction, 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 Sections 2089,2089.5, 2089.7,2090, 2091.1,2091.2) and that the applicant

Anatomy
Otolaryngology
Obstetrics and Gynecology
Radiology, including Radiation Safety
Tropical Medicine
Physiology
Biochemistry
Pathology, Bacteriology, and Immunology
Ophthalmology
Dermatology
Embryology
Histology
Human Sexuality
Medicine
Surgery, including Orthopedic Surgery
Urology
Psychiatry
Neurology
Alcoholism and Chemical Dependency
Preventative Medicine, including Nutrition
Physical Medicine
Therapeutics
Neuroanatomy
Child Abuse Detection and Treatment
Geriatric Medicine
Pediatrics
Pharmacology
Anesthesia
Spousal Partner Abuse Detection & Treatment*
Family Medicine**
Pain Management and End-of-Life-Care***

* ONLY applicable to medical students who enrolled in medical school on or after September 1, 1994.
** ONLY applicable to medical students who graduate from medical school on or after May 1, 1998.
*** ONLY applicable to medical students who enrolled in medical school on or after June 1, 2000.

☑ was granted the degree of Bachelor/Doctor of Medicine on the 1 day of January, 2008.

☐ withdrew from medical school on ____ day of ____, ____.

Unusual Circumstances

	Responses	
Did this individual ever take a leave of absence from their medical education?	Yes	No
Was this individual ever placed on probation?	Yes	No
Was this individual ever disciplined or under investigation?	Yes	No
Were any incident reports regarding this individual ever filed by instructors?	Yes	No
Were any limitations or special requirements imposed on this individual because of questions of academic or disciplinary problems, or for any other reason?	Yes	No

A "Yes" response to ANY of the above questions requires the medical school to provide a written explanation on a separate attachment.

Medical School Seal Must Be Imprinted Below

Attention Medical School: Only the President, Dean, or Registrar may sign this form. If the signature is being delegated to another person, evidence of that delegation must be attached to this form (may be a photocopy). Such delegation must be on official letterhead and must be dated within the last 12 months.

Signed and the school seal affixed this 9th day of Nov., 2009.

By: Joseph Corrao MEd
Registrar

Signature: Joseph J. Corrao MEd

07A-100-L2 (Rev. 12/06)

L2

252065 DR

STATE OF CALIFORNIA – STATE AND CONSUMER SERVICES AGENCY ARNOLD SCHWARZENEGGER, Governor

Consumer Affairs

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RECEIVED MEDICAL BOARD OF CALIFORNIA 2010 NOV 18 PM LICENSING PROGRAM

CERTIFICATE OF COMPLETION OF ACGME/RCPSC POSTGRADUATE TRAINING

To be completed by the facility for every medical school graduate completing postgraduate training in the United States or Canada.

PART 1: TO BE COMPLETED BY THE APPLICANT

NAME: Last: Diedrich First: Justin Middle: Thomas

U.S. Social Security Number:
Date of Birth:
Telephone Number: Home: Work:

Public/Mailing Address: 101 The City Drive, Building 56, Suite 800

City: Orange State/Province: CA Zip/Postal Code: 92868

Medical School of Graduation: Case Western Reserve University School of Medicine

PART 2: TO BE COMPLETED BY THE PROGRAM DIRECTOR

ATTENTION PROGRAM DIRECTOR: [illegible] this form before the last day of [illegible] training year [illegible] Completion of this form will certify that the individual named in [illegible] completed a period of [illegible] postgraduate training at this facility and that [illegible] the skill and qualifications necessary to safely [illegible] unrestricted practice of medicine in this state.

Name of Facility: University of California, Irvine
ACGME 10-digit Program number (www.acgme.org): 2200521031

Address of Facility: 101 The City Drive, Orange, CA 92868
Telephone #: 714 456-6707

Categorical Specialty Area of Training: OB/Gyn
Start Date of Training: 06/23/2009
End Date (or anticipated completion date) of Training: 06/21/2013

UNUSUAL CIRCUMSTANCES

Did the trainee ever take a leave of absence or break from his/her training?	YES	NO
Was the trainee ever terminated, dismissed or expelled?	YES	NO
Did the trainee ever resign?	YES	NO
Was the trainee ever placed on probation?	YES	NO
Was the trainee ever disciplined or placed under investigation?	YES	NO
Were any incident reports regarding this trainee ever filed by instructors?	YES	NO
Were any limitations or special requirements placed upon the trainee for clinical incompetence, disciplinary problems or for any other reason?	YES	NO
Did the program decline to renew or offer the trainee a postgraduate training program contract for a following year?	YES	NO

A "Yes" response to ANY of the above questions requires the program director to provide a written explanation on a seperate attachment.

L3A

07A-100-L3 (Rev. 12/09)

DEFINITION OF "SATISFACTORY" COMPLETION OF TRAINING

The program director signing this form is formally certifying and documenting under penalty of perjury that the trainee received instruction appropriate for the particular postgraduate level and that he/she satisfactorily completed periods of training in accordance with the accepted standards and the criteria defined as equating to "satisfactory" performance as described below. The program director will personally be attesting to the fact that the trainee has acquired the skill and qualifications necessary to safely assume the unrestricted practice of medicine in this state.

"SATISFACTORY" IS DEFINED AS: THE TRAINEE PERFORMED AT AN ADEQUATE LEVEL BASED ON EVIDENCE OF SATISFACTORY PROGRESSIVE GROWTH INCLUDING DEMONSTRATED ABILITY TO ASSUME GRADED AND INCREASING RESPONSIBILITY FOR PATIENT CARE.

GENERAL MEDICINE TRAINING REQUIREMENT

To qualify for licensure in California, applicants who are graduates of an international medical school must complete at least four months of postgraduate training in GENERAL MEDICINE as part of the requirement. Applicants who are graduates of a U.S. or Canadian medical school, who have not completed postgraduate training required for licensure by July 1, 1990, must also complete four months of training in GENERAL MEDICINE prior to 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.

I hereby certify as the program director, that the individual named in Part 1
☑ **has completed** ☐ **has not completed**
a minimum of four months of general medicine as part of this postgraduate training program accredited by the ACGME or the RCPSC.

Carol A. Major
SIGNATURE OF PROGRAM DIRECTOR

ATTENTION PROGRAM DIRECTOR: THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE, OR ADOPTION. If that signature authority is being delegated to another person, evidence of that delegation must be attached to this form (may be a photocopy). Each delegation must be on official letterhead and must be dated within the last 12 months.

HOSPITAL SEAL

OFFICIAL HOSPITAL SEAL MUST BE AFFIXED IN THE BOX TO THE LEFT TO CERTIFY TRAINING

The training program is accredited by the ACGME or the RCPSC to offer the type and level of training completed by the applicant, and the applicant was trained in an accredited ACGME or RCPSC program position. I hereby declare under penalty of perjury under the laws of the State of California that the statements are true and correct.

Carol A. Major, MD
PRINT NAME OF PROGRAM DIRECTOR

Carol A. Major
SIGNATURE OF PROGRAM DIRECTOR
Signature Stamp is Not Acceptable

10/22/10
DATE SIGNED

If a hospital seal is not available, the program director shall sign this form in the presence of a notary public.

SIGNATURE OF PROGRAM DIRECTOR: _____
(Please sign full name – in presence of notary)

State of _____

County of _____

Subscribed and sworn to (or affirmed) before me on this _____ day of _____, 20_____, by

_____
(Notary to print director's name.)

proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.

Signature _____(seal)

L3B

STATE OF CALIFORNIA -- STATE AND CONSUMER SERVICES AGENCY ARNOLD SCHWARZENEGGER, Governor

Consumer Affairs

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MEDICAL BOARD OF CALIFORNIA
2010 NOV 18 PM 3:

LICENSING PROGRAM

CERTIFICATE OF CURRENT POSTGRADUATE TRAINING ENROLLMENT

At the time of licensure, you may be entitled to a reduced initial license fee if you are actively participating in a slotted position in an ACGME/RCPSC accredited postgraduate training program.

NOTE: This form may not be used in lieu of the Form L3A-8, "Certificate of Completion of ACGME/RCPSC Postgraduate Training."

NAME: Last	First	Middle
Diedrich	Justin	Thomas

U.S. Social Security Number	Date of Birth	Medical School of Graduation
		Case Western Reserve University School of Medicine

This is to certify that the above applicant is actively participating in an ACGME or RCPSC accredited postgraduate training position that started on 06 (Month) 23 (Day) 2009 (Year) and is expected to be completed on 06 (Month) 21 (Day) 2013 (Year) in OB/Gyn (Categorical Specialty Area of Training)

at University of California, Irvine (Name of Facility)

located at 101 The City Drive, Bldg. 56, Suite 600 Orange, CA 92868 (Address of Facility)

The 10 digit ACGME Program #: 2200521031 (Refer to http://www.acgme.org/adspublic)

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 above program is accredited by the ACGME or the RCPSC to offer the type and level of training completed by the applicant and that the applicant is being trained in an accredited ACGME or RCPSC postgraduate training position.

PRINT NAME OF PROGRAM DIRECTOR: Carol A. Major, MD

SIGNATURE OF PROGRAM DIRECTOR - Signature Stamp is Not Acceptable: Carol A. Major

DATE: 10/22/10

TELEPHONE NUMBER: 714 456-6707

Hospital Seal ✓

ATTENTION PROGRAM DIRECTOR: THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE, OR ADOPTION.

Only the Program Director may sign this form. If that signature authority is being delegated to another person, evidence of that delegation must be attached to this form (may be a photocopy). Such delegation must be on official letterhead and must be dated within the last 12 months.

If a hospital seal is not available, the program director shall sign this form in the presence of a notary public.

SIGNATURE OF PROGRAM DIRECTOR: _____ (Please sign full name – in presence of notary)

State of _____

County of _____

Subscribed and sworn to (or affirmed) before me on this _____ day of _____, 20_____, by

_____ (Notary to print director's name.)

proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.

Signature _____ (seal)

L4

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

Department of Consumer Affairs

RECEIPT

Thank you for using the BreEZe System to submit your application.

Name:	DIEDRICH, JUSTIN THOMAS
Transaction Date:	09/22/2014 14:21
Application Number:	
Complaint Number:	
License Type:	8002
License Number:	114859
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:	**114859**
File Number:	
Application:	**Physician's and Surgeon's Renewal**
Application Number:	
Application Date:	**09/22/2014 (mm/dd/yyyy)**

Personal Detail

First Name:	**JUSTIN**
Middle Name:	**THOMAS**
Last Name:	**DIEDRICH**
Birthdate:	****/**/******
Gender:	**Male**

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**

Family Physician Training Program Voluntary Fee

Voluntary Fee:	**No**

Attachments

Physician Survey

Are you retired?	**No**
Activities in Medicine	**Administration - 10-19 Hours**
	Other - None
	Patient Care - 20-29 Hours
	Research - 20-29 Hours
	Teaching - 10-19 Hours
	Telemedicine - None
Patient Care Practice Location	**Zip: 63110 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	**Fellow**
Areas of Practice	**Obstetrics and Gynecology - Secondary**
Board Certifications	**None**
Postgraduate Training Years	**5 Years**
Cultural Background	**White**
Foreign Language Proficiency	**Spanish**
Web Site Profile	**Cultural Background - No**
	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**
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:

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:	DIEDRICH, JUSTIN THOMAS
Transaction Date:	07/25/2016 12:14
Application Number:	
Complaint Number:	
License Type:	8002
License Number:	114859
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:	**114859**
File Number:	
Application:	**Physician's and Surgeon's Renewal**
Application Number:	
Application Date:	**07/25/2016 (mm/dd/yyyy)**

Application Questions

Have you served or are you currently serving in the military?	**No**

Personal Detail

First Name:	**JUSTIN**
Middle Name:	**THOMAS**
Last Name:	**DIEDRICH**
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 - 10-19 Hours** **Other - None** **Patient Care - 30-39 Hours** **Research - 10-19 Hours** **Teaching - 20-29 Hours** **Telemedicine - 1-9 Hours**
Patient Care Practice Location	**Zip: 92508 County: RIVERSIDE**
Telemedicine Practice Location	**Zip: County:**
Patient Care Secondary Practice Location	**Zip: 92555 County: RIVERSIDE**
Telemedicine Secondary Practice Location	**Zip: County:**
Areas of Practice	**Obstetrics and Gynecology - Primary** **Other - Not Listed - Secondary**
Board Certifications	**American Board of Obstetrics and Gynecology - Obstetrics and Gynecology**
Postgraduate Training Years	**7 Years**
Cultural Background	**White**
Foreign Language Proficiency	**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**
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: