STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY — PETE WILSON, Governor

Consumer Affairs

MEDICAL BOARD OF CALIFORNIA

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

APPLICATION FOR PHYSICIAN AND SURGEON'S EXAMINATION OR LICENSURE

96 JAN 24 PM 3:45

008566

Read all instructions prior to completing this application. All question on this application must be answered, and all supporting documents must be submitted with the application per instructions. Please type or print neatly. When space provided is insufficient, attach additional sheets of paper.

BMC USE ONLY

1. Name: Last: GOODMAN First: SUZAN Middle: R. — 013402

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

3. Social Security Number:

4. Address: Number and Street/Rural Route (include apartment number, if any): 6441 Regent Street

City: Oakland State: CA ZIP Code: 94618 Country: USA

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)	To (Mo/Yr)
Hampshire College	Box 820 Amherst Mass 01002	9/81	6/85
U.C. Santa Cruz	1156 High Santa Cruz CA 95064	9/84	12/84
Harvard University	124 Mt Auburn Street Cambridge Mass 02138	9/86	9/87

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

Course	Yes	No	Name of College or University
Chemistry	X		Harvard University
Physics	X		Harvard University
Biology or Zoology	X		Harvard University

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)	To (Mo/Yr)
Stanford University	Stanford, CA 94305	Stanford School of Medicine	9/88	6/93

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 | Address of Medical School | Exact Date of Issuance | School Code

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

GEA 100 (REV 7/91)

L1A

0016

AMC USE ONLY
WRITTEN EXAMINATION

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

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

Name	Location	Date	Result
NBME Part I	Stanford University, CA	9/1-10	
USMLE Step II	Portland, OR	9/1-95	
NBME Part II CC Exam	Seattle, WA	3/2/94	

14. Have you satisfactorily completed at least one year of qualifying postgraduate training in U.S. or Canadian facilities?
(Note: Do not complete Item 13 (a) 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 13) from each facility.

Name	Address	Type of Service	Period of Attendance From (Mo/Yr)	To (Mo/Yr)
University of Washington Medical	1959 Pacific, Seattle, WA	GP/Surg. Residency	7/90	6/95

QUESTIONS 14A–22: 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, 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 as 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)
Washington	6256C9-MD00C52957	6-25-93	6-25-93	2-16-96

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

FSA-100 (REV. 7/93)

MBC USE ONLY

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?

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.

19. Have you ever voluntarily surrendered a license to practice in the healing arts in another state?

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?

21. Are you now, or were you in the past, addicted to or treated for addiction to controlled substances, such as narcotics or alcohol?

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?

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 your state, the United States, or a foreign country? (except violations of traffic laws resulting in fines of $75.00 or less)

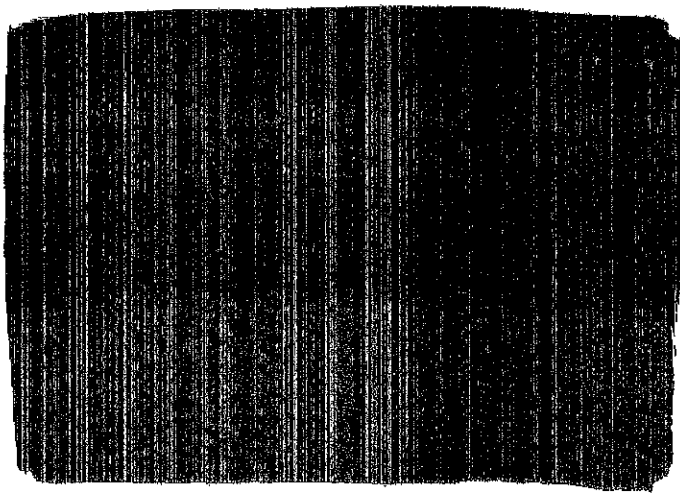
YOU ARE REQUIRED TO LIST ANY CONVICTION THAT HAS BEEN SET ASIDE AND DISMISSED UNDER SECTION 1203.4 OF THE PENAL CODE OR UNDER ANY OTHER PROVISION OF LAW. A SEPARATE LETTER EXPLAINING THE DETAILS OF THE OFFENSE IS ALSO REQUIRED, IN ADDITION TO CERTIFIED COURT DOCUMENTS.

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 Profession 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



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. _____ 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 or incomplete. The information provided will be used to determine qualification for licensure, per Section 2020 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 CALIFORNIA

COUNTY OF CONTRA COSTA

SUSAN R. GOLDMAN
(PRINT FULL NAME OF APPLICANT)
being duly sworn, says She is the person referred to in the foregoing application for a physician and surgeon's certificate in California and that She 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.

She 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, She 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.

Susan R. Goldman
(Signature of Applicant - Affix Full Name, not stamp)

Signed and sworn to before me this 27th day of October, 1995.

Signature of Notary Public Donna M. Bleidel

(NOTARY SEAL)

Address MERRITHEW MEMORIAL HOSPITAL, MARTINEZ, CA. 94553

My commission expires: April 20, 1998

L1D

BPA-100 (REV 7/91)

STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY PETE WILSON, Governor

Consumer Affairs

MEDICAL BOARD OF CALIFORNIA

1430 HOWE AVENUE, SUITE 54, SACRAMENTO, CALIFORNIA 95825-3236
(916) 920-6411

95 OCT 16 AM 11:46

CERTIFICATE OF MEDICAL EDUCATION

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

This certifies that Susan R Gluusman
(FULL NAME OF APPLICANT)

of Los Altos, California enrolled in Stanford University School of Medicine
(ADDRESS WHEN ENROLLED) (NAME OF MEDICAL SCHOOL)

Stanford, California on the 28th day of September 19 88
(LOCATION) (MONTH) (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).

Harvard University Extension 9/86 - 9/87
(INSTITUTION(S) ATTENDED) (DATES)

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

(MEDICAL SCHOOL) (TOTAL CREDITS) received sufficient

The undersigned further certifies that the records of this institution show that S/he attended in this institution hours of medical instruction and units of credit (NUMBER) years of resident instruction of (NUMBER OF WEEKS) weeks 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

☒ S/he was granted the degree Bachelor/Doctor of Medicine by

OR

☐ S/he withdrew from

the above-mentioned medical school on the 13th day of June 19 93
(MONTH)

Anatomy	Dermatology	Preventive Medicine, including Nutrition
Otolaryngology	Embryology	Physical Medicine
Obstetrics and Gynecology	Histology	Therapeutics
Radiology, including Radiation Safety	Human Sexuality as defined in Section 2090	Neuroanatomy
Tropical Medicine	Medicine	Child Abuse Detection and Treatment
Physiology	Surgery, including Orthopedic Surgery	Geriatric Medicine
Biochemistry	Urology	Pediatrics
Pathology, Bacteriology and Immunology	Psychiatry	Pharmacology
Ophthalmology	Neurology	Anesthesia

[redacted]

Signed and the college seal affixed this 10th day of October, 19 95

BY Ellen Weber, M.D., Associate Dean
(PRESIDENT, SECRETARY, DEAN)

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

* [illegible]

L2

STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY

PETE WILSON, Governor

Governor's Office

MEDICAL BOARD OF CALIFORNIA
1426 HOWE AVENUE
SACRAMENTO, CALIFORNIA 95825-3236

95 OCT 30 AM 10:55

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: GOODMAN | First Name: SUSAN | Middle Initial: R

Current Address: 6941 Regent Street | Phone Number:

City: Oakland | State: CA | Zip Code: 94618

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: UNIVERSITY OF WASHINGTON MEDICAL CENTER

Address of Facility: SEATTLE WASH 98195

Name of Program Director: MORTON M. STRICHARTZ MD | Phone Number: (206) 543-3...

Signature of Program Director: [signature] M.D. | Date Signed: 10-5-95

List Categorical Specialty Area of Training Completed by Trainee: General Preventive Surg. | Date Training Commenced: 7-1-93 | Date Training Completed: 6-30-94

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, 1990, 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)

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 A Vontver MD MEd Phone Number: 206 543-3726

Facility Name: University of Washington Medical Center Date Form Completed: 28 Oct 95

Facility Address: Dept Ob-Gyn 35-6460 Seattle Wa

City: Seattle State: Wa Zip Code: 98195

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.

2 years as an approved Ob-Gyn 4 year residency program

Definition of "Satisfactory": The physician performed at an adequate level based on evidence of satisfactory progress in 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: Louis A. Vontver

Date Signed: 28 Oct 1995

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

[redacted]

SUBSCRIBED AND SWORN TO BEFORE ME this 28th day of Oct, 19 95.

Carol Pruzan, Notary Public
State of Washington, King County, Seattle
My commission expires 7/31/98

L3B

07A-1003-3 (Rev 2/92)

STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY

Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
1426 HOWE AVENUE
SACRAMENTO, CA 95825-3236
(916) 263-2498

95 SEP 21 P1:30 BD. OF LICENSING

95 SEP 22 AM 9:26

CERTIFICATION STATEMENT

This is to certify that Susan R. Goodman
(Name of Physician)

is in an approved ACGME/CCME postgraduate training position that commenced on

July 1, 1995 and is expected to be completed

on June 30, 1998 in Family Medicine
(Type of Training)

at Merrithew Memorial Hospital, Contra Costa County Public Health
(Name and Address of Facility)

Donna M. Blundell

AFFIX OFFICIAL HOSPITAL SEAL OR NOTARY SEAL IN THE BOX AT THE LEFT.

Donna Blundell, Notary Public

"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."

J. Rich McNabb
(Type or print name of Director of Medical Education)

J. Rich McNabb MD
(Signature of Director of Medical Education)

09/14/95
(Date)

510 370 5117
(Telephone Number)

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

L9

A79 (Rev. 9 (Rev. 12/93)

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:	GOODMAN, SUZAN R
Transaction Date:	12/22/2013 13:57
Application Number:	
Complaint Number:	
License Type:	8002
License Number:	82282
Payment Description:	Physician's and Surgeon's Renewal
Fee Paid: (US $)	833.00
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:	**82282**
File Number:	
Application:	**Physician's and Surgeon's Renewal**
Application Number:	
Application Date:	**12/22/2013 (mm/dd/yyyy)**

Personal Detail

First Name:	**SUZAN**
Middle Name:	**R**
Last Name:	**GOODMAN**
Birthdate:	
Gender:	**Female**

Addresses

License Related Addresses

Confidential Address (Optional)

Name:

Address:

License Specific Public/Mailing Address (Required)

Name:	**GOODMAN, SUZAN R**
Address:	**1300 BROADWAY STE 1100** **OAKLAND, CA** **94612**
Phone Number:	
E-mail Address:	

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:	**Yes**
Amount - $25.00 Minimum:	**25**

Attachments

Physician Survey

Are you retired?	**No**
Activities in Medicine	**Administration - 1-9 Hours** **Patient Care - 20-29 Hours** **Research - 1-9 Hours** **Teaching - 1-9 Hours** **Telemedicine - None**
Patient Care Practice Location	**Zip: 94520 County: CONTRA COSTA**
Telemedicine Practice Location	**Zip: County:**
Patient Care Secondary Practice Location	**Zip: 94038 County: SAN MATEO**
Telemedicine Secondary Practice Location	**Zip: County:**
Current Training Status	**Not in Training**
Areas of Practice	**Emergency Medicine - Secondary** **Family Medicine - Primary** **Obstetrics and Gynecology - Secondary**
Board Certifications	**American Board of Family Medicine - Family Medicine**
Postgraduate Training Years	**1 Year**
Cultural Background	**White**
Foreign Language Proficiency	**Spanish**
Web Site Profile	**Cultural Background - No**

Foreign Language Proficiency - Yes

Gender - Yes

Fees

Biennial Renewal Fee	**$783.00**
Steven M. Thompson Physician Corps Loan Repayment Program	**$25.00**
Family Physician Training Fee	**$25.00**
Total Amount Due:	**$833.00**

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:	GOODMAN, SUZAN R
Transaction Date:	12/08/2015 11:03
Application Number:	
Complaint Number:	
License Type:	8002
License Number:	82282
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 G**
License Number:	**82282**
File Number:	
Application:	**Physician's and Surgeon's Renewal**
Application Number:	
Application Date:	**12/08/2015 (mm/dd/yyyy)**

Application Questions

Have you served or are you currently serving in the military?	**N**

Personal Detail

First Name:	**SUZAN**
Middle Name:	**R**
Last Name:	**GOODMAN**
Birthdate:	**/**/****
Gender:	**Female**

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 - 1-9 Hours**
	Patient Care - 10-19 Hours
	Research - 1-9 Hours
	Teaching - 1-9 Hours
	Telemedicine - None
Patient Care Practice Location	**Zip: 94612 County: ALAMEDA**
Telemedicine Practice Location	**Zip: County:**
Patient Care Secondary Practice Location	**Zip: 94520 County:**
Telemedicine Secondary Practice Location	**Zip: County:**
Current Training Status	**Not in Training**
Areas of Practice	**Emergency Medicine - Secondary**
	Family Medicine - Secondary
	Obstetrics and Gynecology - Primary
Board Certifications	**American Board of Family Medicine - Family Medicine**
Postgraduate Training Years	**1 Year**
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: