

Date Approved: 7-10-90  
License No.: 055016  
Approved by: pd

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATION  
BOARD OF MEDICINE  
P.O. BOX 30192  
LANSING, MICHIGAN 48909  
(517) 373-0680

LIC. & REG.  
REC'D. \$ 20.00

JUN 4 1990

LMD-040 (2/90)

This form is required by P.A. 368 of 1978 in order for you to be licensed in Michigan.

## APPLICATION FOR MEDICAL AND CONTROLLED SUBSTANCE LICENSES

I am applying for the following:

- ☒ License by examination (National Boards or FLEX) \$90.00  
☐ License by endorsement (Must be currently licensed in another state) \$90.00  
☐ Controlled Substance License \$60.00

### MEDICAL LICENSE APPLICATION

I am applying on the basis of the following examination:

- ☒ FLEX ☐ NATIONAL BOARDS ☐ OTHER

NAME OF APPLICANT (last, first, middle)

TORBATI KAMRAN

LIST PREVIOUS NAME(S) USED:

—

ADDRESS (no., street, city, state, ZIP)

DATE OF BIRTH

SOCIAL SECURITY NUMBER

CHECK THE APPROPRIATE ANSWER TO EACH OF THE FOLLOWING QUESTIONS. ATTACH DETAILED EXPLANATION FOR ANY YES ANSWER YOU CHECK.

Have you ever been convicted of a crime? ☐ YES ☒ NO

Have you ever been under treatment for addiction or insobriety? ☐ YES ☒ NO

Have you ever been warned, censured, or requested to withdraw from a health care facility's staff or had your health care facility staff privileges modified? ☐ YES ☒ NO

Are you now or have you ever been a defendant in a medical malpractice civil suit? ☐ YES ☒ NO

Have you ever been refused a license to practice professionally for any reason by any state or federal agency? ☐ YES ☒ NO

Have you ever been denied the privilege of taking an examination by any state medical board? ☐ YES ☒ NO

Have you ever had your medical or controlled substance license, certificate, registration or approval revoked or suspended, or have you ever been otherwise disciplined by a medical board or a board responsible for regulating controlled substances? ☐ YES ☒ NO

Do you currently have any charges or complaints pending against you before a medical board or a board responsible for regulating controlled substance? ☐ YES ☒ NO

Have you ever held a restricted state or federal license, certificate, registration, or approval? ☐ YES ☒ NO

Do you hold or have you ever held a medical license in this or any other state? If yes, list each state below and the date such license was issued and cause certification of license in good standing to be submitted directly from all other states: ☐ YES ☐ NO

Provide a complete chronological record of all your educational preparation and work experience to the present date. Attach additional sheets if necessary.

NAME AND ADDRESS OF INSTITUTION	DATES OF ATTENDANCE		DEGREE OBTAINED
	From	To	
Sinai Hospital - Detroit, MI	7.89	6.90	Internship OB-GYN
LAC - U.S.C Medical Center Los Angeles, C.A.	7.88	6.89	Internship Medicine
Backler School of Medicine TEL-AVIV Univ. , Israel	10.81	7.86	M.D. Diploma
TEHRAN Univ. School of Medicine <sup>Tehran</sup>	10.76	6.80	-
ALBORS High School, <sup>TEHRAN</sup> Iran	9.70	6.76	High school diploma in Science
BEHESHT Primary School, TEHRAN, IRAN	9.64	6.70	-

I understand that it is the policy of the Department of Licensing and Regulation to secure conviction criminal history information as part of their pre-licensure screening process, and I authorize the department to use the information provided in this application to obtain a conviction criminal history file search from the Central Records Division of the Michigan Department of State Police. I hereby certify that the information in this application is true and correct and I hereby make application for medical licensure in Michigan.

Signature K. R. [Signature] MD Date 6.1.90  
 Subscribed and sworn to before me this 1st day of June, 19 90  
 Signature of Notary Public René Maltese  
 County of Wayne My commission expires Sept. 26, 1992

#### CONTROLLED SUBSTANCE LICENSE APPLICATION

A controlled substance license is required for every person who prescribes, manufactures, distributes, or dispenses any controlled substance in Michigan as described in Article 7 of Public Act 368 of 1978, as amended. A separate controlled substance license is required for each business location from which you manufacture, distribute, prescribe, or dispense controlled substances. If you will practice at an additional location or in a methadone program, please request in writing an Application for Additional Location from the Michigan Board of Pharmacy, P.O. Box 30018, Lansing, Michigan 48909.

Information on obtaining a Federal controlled substance license may be obtained by contacting the Regional Branch, Drug Enforcement Administration, 357 Federal Building, 231 Lafayette, Detroit, Michigan 48226 (Telephone 313-226-7290).

I hereby make application for a Michigan controlled substance license.

Signature \_\_\_\_\_ Date: \_\_\_\_\_

KAMRAN TORBAIZ M.D.



RECEIVED  
JUN 28 1990  
DEPT. OF LIC. & REG.

RECEIVED

State of Michigan  
BOARD OF MEDICINE JUN 28 1990  
LANSING, MI. DEPT. OF LIC. & REG.  
BOARD OF MEDICINE

Dear Madam/Sir

In answer To The last question in my application for permanent License in Medicine, I should add That at This Time I do not carry and have never carried a medical License in The United States. I appreciate your Cooperation in This matter.

Sincerely yours

K. Torbaiz M.D.

6.26.90

(Do Not Detach)

**Quick Processing Card**

**APPLICANT**

To help us process your application more quickly, please complete the following information about the application and your fee payment.

Applicant's Name <i>TORBATI KAMRAN</i>	Social Security Number [REDACTED]	Date of Application <i>6.1.90</i>
---	--------------------------------------	--------------------------------------

Check the type of license you are seeking – and be sure to enclose your payment!

- ☒ (43-01-01) License by Examination, Fee: \$90.00  
☐ (43-01-09) License by Endorsement, Fee: \$90.00  
☐ (43-01-37) Controlled Substance License, Fee: \$60.00

Your check or money order must accompany this application. Make it payable, in U.S. currency, to the STATE OF MICHIGAN. DO NOT SEND CASH. Fees are earned upon receipt and can only be refunded under refund rules promulgated by the department.

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JUN 25 1990

DEPT. OF LIC. &amp; REG.

State of Michigan  
Department of Licensing and Regulation  
**BOARD OF MEDICINE**  
P.O. Box 30192  
Lansing, Michigan 48909

This form is required by P.A. 368 of  
1976 in order for you to be licensed  
in Michigan.

# CERTIFICATION OF POSTGRADUATE TRAINING

JUN 25 1990

## APPLICANT INSTRUCTIONS

Type or print your name in Section I exactly as it appears on your application. Send this form to be completed and mailed directly to the board by the director of medical education where you completed your postgraduate training.

### SECTION I: APPLICANT INFORMATION

NAME OF APPLICANT (last, first, middle)

TORBATI KAMRAN

ADDRESS (no. street city state ZIP)

SOCIAL SECURITY NUMBER

DATE OF BIRTH

### SECTION II: APPLICANT INFORMATION

HOSPITAL NAME

Los Angeles County/U.S.C. Medical Center

HOSPITAL'S COMPLETE ADDRESS

1200 North State Street, Los Angeles, CA, 90033

I certify that Kamran Torbati, M.D. a graduate of the  
Tel-Aviv University Tel-Aviv Israel medical school, has successfully completed postgraduate  
clinical training offered by the hospital named above from June 24 19 88 through June 24  
19 89 in the clinical area of Internal Medicine.

June 14, 1990

Date

Signature of Director of Medical Education

Ralph C. Jung, M.D.

Type or Print Name of Director of Medical Education

(SEAL)

Is this training program accredited by ACGME or by the national  
joint committee on accreditation of preregistration physician  
training programs of the Canadian medical association?

☒ YES ☐ NO

If hospital has no seal, please so indicate.

NOTE: Certification of postgraduate training will not be accepted if certified more than 15 days prior to actual completion.

State of Michigan  
Department of Licensing and Regulation  
**BOARD OF MEDICINE**  
P.O. Box 30192  
Lansing, Michigan 48909

This form is required by P.A. 368 of 1978 in order for you to be licensed in Michigan.

## CERTIFICATION OF POSTGRADUATE TRAINING

JUL 10 1990

### APPLICANT INSTRUCTIONS

Type or print your name in Section I exactly as it appears on your application. Send this form to be completed and mailed directly to the board by the director of medical education where you completed your postgraduate training.

#### SECTION I: APPLICANT INFORMATION

NAME OF APPLICANT (last, first, middle)

TORBATI, KAMRAN, M.D.

ADDRESS (no., street, city, state, ZIP)

SOCIAL SECURITY NUMBER

DATE OF BIRTH

RECEIVED  
JUL 09 1990  
DEPT. OF LIC. & REG.

#### SECTION II: APPLICANT INFORMATION

HOSPITAL NAME

Sinai Hospital

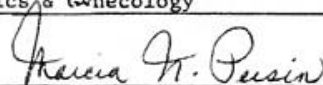
HOSPITAL'S COMPLETE ADDRESS

6'67 West Outer Drive, Detroit, MI 48235

I certify that Kamran Torbati, M.D. a graduate of the  
Sackler University School of Medicine medical school, has successfully completed postgraduate  
clinical training offered by the hospital named above from July 1, 19 89 through June 30,  
19 90 in the clinical area of Obstetrics & Gynecology.

June 30, 1990

Date



Signature of Director of Medical Education

Marcia N. Persin, Associate Administrator, Clinical/Support Services  
Type or Print Name of Director of Medical Education

(SEAL)

Is this training program accredited by ACGME or by the national  
joint committee on accreditation of preregistration physician  
training programs of the Canadian medical association?

☒ YES ☐ NO

If hospital has no seal, please so indicate.

NOTE: Certification of postgraduate training will not be accepted if certified more than 15 days prior to actual completion.

The Federation of State Medical Boards

of the United States

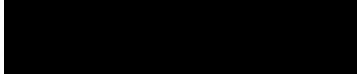
INCORPORATED

2630 WEST FREEWAY, SUITE #138  
FORT WORTH, TEXAS 76107-7199  
(817) 335-1141

To: Michigan Board of Medicine.

Subject: FLEX/SPEX Scores

KAMRAN TORBATI



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JUN 11 1990

DEPT. OF LIC. & REG.

It is certified that the named physician took the Federation Licensing and/or Special Purpose Examination on the date(s) entered below for the State Medical Licensing Board(s) listed and obtained the following scores:

FIN: 580326009

Date of Certification: 06/05/90

DATE OF EXAM	STATE TAKEN FOR	STATE ID #	COMP 1	COMP 2
06/87	PENNSYLVANIA			

COMPONENT 1 of FLEX is designed to evaluate measurable aspects of the knowledge and understanding of basic and clinical sciences, with specific emphasis on principles and mechanisms underlying disease and modes of therapy.

COMPONENT 2 of FLEX is designed to assess the additional cognitive abilities required of physicians who will ultimately assume independent responsibilities for the general health care of patients.

Furthermore:

\*\*\*\*\*  
A search of the Federation's Board Action Data Bank reveals no reported disciplinary information on the above named physician.

ddl



EDUCATIONAL COMMISSION  
for  
FOREIGN MEDICAL GRADUATES

RECEIVED  
JUN 23 1989  
DEPT. OF LIC. & REG.  
BOARD OF MEDICINE

CERTIFIES THAT

KAMRAN TORBATI

HAS SATISFIED ALL THE REQUIREMENTS OF THE COMMISSION,  
SUCCESSFULLY PASSED ITS EXAMINATIONS  
AND HAS BEEN AWARDED THIS CERTIFICATE.

CERTIFICATE NUMBER 403-816-2  
MEDICAL EXAMINATION  
BASIC SCIENCE JULY 21, 1987  
CLINICAL SCIENCE JULY 23, 1986  
ENGLISH EXAMINATION JULY 23, 1986  
VA ID THROUGH JULY, 1988



*Stanley S. Berger Jr. M.D.*  
CHAIRMAN, BOARD OF TRUSTEES  
*Philip R. Stiles M.D.*  
PRESIDENT, CHIEF EXECUTIVE OFFICER  
*Ray L. Conner M.D.*  
VICE PRESIDENT, CHIEF OPERATING OFFICER

DATE ISSUED

APR 04 1988

Subscribed and sworn before me, this 21st  
day of June, 1988, a Notary Public  
in and for Wayne County,  
Michigan.  
*Gene Maltese*  
Notary Public, Wayne County, MI  
My Commission Expires Sept. 26, 1992



State of Michigan  
Department of Licensing and Regulation  
BOARD OF MEDICINE  
P.O. Box 30018  
Lansing, Michigan 48909

CERTIFICATION OF MEDICAL EDUCATION FOR FOREIGN MEDICAL SCHOOL GRADUATES

APPLICANT INSTRUCTIONS

Complete Section I. Type or print your name exactly as it appears on your application. Send this form to the dean of the medical school you attended for completion of Section II. This certification must be submitted directly to the Michigan Board of Medicine by the medical school.

SECTION I: APPLICANT INFORMATION

NAME OF APPLICANT (last, first, middle)	
TORBATI KAMRAN	
ADDRESS (no., street, city, state, zip)	
[REDACTED]	
DATE OF BIRTH	SOCIAL SECURITY
[REDACTED]	[REDACTED]
DATE OF ADMISSION	DATE OF GRADUATION
10.81	10.30.1985

SECTION II: CERTIFICATION OF MEDICAL EDUCATION

NAME OF MEDICAL SCHOOL
Sackler sch. of Med., Tel-Aviv Univ.
FULL ADDRESS OF MEDICAL SCHOOL
School of Medicine, Tel-Aviv University, RAMAT-AVIV, Israel

I certify that KAMRAN TORBATI attended the medical school named above from OCT, 1981 through Sept, 1985 and was granted the degree of M.D. Diploma on 7.1.1985

I also certify that the medical educational program from which the applicant named above has graduated was not less than 130 weeks and does not award credit for any courses taken by correspondence. I further certify that this medical educational program included basic science courses in anatomy; physiology; biochemistry; pathology; and pharmacology and therapeutics; and clinical clerkships in the sciences completed at the hospitals or institutions as listed below:

CLINICAL SCIENCES	NAME AND ADDRESS OF HOSPITAL	TEACHING HOSPITAL
Internal Medicine	Shiba Med. Ctr., Ramat-Gan, Israel.	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
General Surgery	Golda Med. Ctr., Petah-Tikva, Israel.	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
Pediatrics	Golda Med. Ctr., Petah-Tikva, Israel.	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
Obstetrics and Gynecology	Golda Med. Ctr., Petah-Tikva, Israel.	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
Psychiatry	Shalvata Hosp., HOD-HA SHARON, Israel.	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

May 11, 1986  
(Date)



Signature of Dean or Registrar  
Soume SEGAL  
Type or Print Name of Dean or Registrar

\* Teaching hospital means that the hospital or institution offers a postgraduate clinical training program in the same content area of the clerkship.

RECEIVED  
MAY 19 1989  
DEPT. OF LIC. & REG.  
BOARD OF MEDICINE

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MAY 20 1989  
DEPT. OF LIC. & REG.  
BOARD OF MEDICINE

REC'D  
MAY 1989  
REC'D \$ 80.00

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATION  
BOARD OF MEDICINE  
P.O. BOX 30018  
LANSING, MICHIGAN 48909  
(517) 373-0680

LMD-851 (2/86)

This form is required by P.A.  
368 of 1978 in order for you to  
be licensed in Michigan.

MAY 1989 1989

### APPLICATION FOR LIMITED MEDICAL AND CONTROLLED SUBSTANCE LICENSES

I am applying for the following license(s):

☒ Limited Educational  
Fee: \$30.00

☐ Limited Clinical Academic  
Fee: \$30.00

☒ Controlled Substance  
Fee: \$50.00

#### APPLICANT INFORMATION

This application will not be accepted unless properly signed and sworn to by the applicant before a notary public. Your fee should accompany this application and should be in the form of a check or money order. No responsibility will be assumed for fees sent in any other manner.

NAME OF APPLICANT (last, first, middle)

TORBATI KAMRAN

ADDRESS (no., street, city, state, zip)

DATE OF BIRTH

SOCIAL SECURITY NUMBER

CHECK THE APPROPRIATE ANSWER TO EACH OF THE FOLLOWING QUESTIONS. ATTACH DETAILED EXPLANATION FOR ANY YES ANSWER YOU CHECK.

Have you ever been convicted of a crime? ☐ YES ☒ NO

Have you ever been under treatment for addiction or insobriety? ☐ YES ☒ NO

Are you now or have you ever been a defendant in a medical malpractice civil suit? ☐ YES ☒ NO

Have you ever been refused a license to practice professionally for any reason by any state or federal agency? ☐ YES ☒ NO

Have you ever been denied the privilege of taking an examination by any state medical board? ☐ YES ☒ NO

Have you ever had a medical or controlled substance license, certificate, registration or approval revoked or suspended, or have you ever been otherwise disciplined by a medical board or a board responsible for regulating controlled substances? ☐ YES ☒ NO

Do you currently have any charges or complaints pending against you before a medical board or a board responsible for regulating controlled substance? ☐ YES ☒ NO

Have you ever held a restricted state or federal license, certificate, registration or approval? *I have been certified to commence my internship in state of California in July 88* ☒ YES ☒ NO

Do you hold or have you ever held a medical license in another state? If yes, list each state and the date such license was issued: ☐ YES ☒ NO

[illegible]

Signature *R. Leon* Date 4-11-89  
Subscribed and sworn to before me this 11th day of APRIL, 1989  
Signature of Notary Public *R. Leon*  
County of LOS ANGELES My commission expires 11-11-91

A controlled substance license is required for every person who prescribes, manufactures, distributes, or dispenses any controlled substance in Michigan as described in Article 7 of Public Act 368 of 1978, as amended. Information on obtaining a Federal controlled substance license may be obtained by contacting the Regional Branch, Drug Enforcement Administration, 357 Federal Building, 231 Lafayette, Detroit, Michigan 48226 (Telephone 313-226-7290).

Signature *H. C. T. Liati* Date 2-11-89

State of Michigan  
 Department of Licensing and Regulation  
**BOARD OF MEDICINE**  
 P.O. Box 30018  
 Lansing, Michigan 48909

# **CERTIFICATION OF APPOINTMENT TO MICHIGAN TRAINING HOSPITAL**

This certifies that Kamran Torbati  
(name of applicant)

has been duly appointed to a training program in the clinical area of \_\_\_\_\_

Obstetrics & Gynecology

beginning July 1, 1989 and ending June 30, 1990

in the Sinai Hospital of Detroit  
(name of training hospital)

6767 W. Outer Drive  
 Detroit, MI 48235

(Address of hospital - this address will be printed on license)

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 MAY 9 5 1989  
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 BOARD OF MEDICINE

Marcia N. Persin, Assoc. Administrator for Clinical/Support Services

Type or print name of Director of Medical Education

*Marcia N. Persin*

Signature of Director of Medical Education

4/25/89

Date

(SEAL)

Is program accredited by ACGME?

YES	NO
<input checked="" type="checkbox"/>	<input type="checkbox"/>

Is hospital or institution  
 accredited by JCAH?

<input checked="" type="checkbox"/>	<input type="checkbox"/>
-------------------------------------	--------------------------

If hospital has no seal, please indicate.

NOTE: This certification must be mailed directly to the Michigan Board of Medicine from the training hospital or institution.

State of Michigan  
Department of Licensing and Regulation  
BOARD OF MEDICINE  
P.O. Box 30018  
Lansing, Michigan 48909

CERTIFICATION OF MEDICAL EDUCATION FOR FOREIGN MEDICAL SCHOOL GRADUATES

APPLICANT INSTRUCTIONS

Complete Section I. Type or print your name exactly as it appears on your application. Send this form to the dean of the medical school you attended for completion of Section II. This certification must be submitted directly to the Michigan Board of Medicine by the medical school.

SECTION I: APPLICANT INFORMATION

NAME OF APPLICANT (last, first, middle) <u>Torbati, Kamran</u>	
ADDRESS (no. / street, city, state, zip) [REDACTED]	
DATE OF BIRTH [REDACTED]	SOCIAL SECURITY NUMBER [REDACTED]
DATE OF ADMISSION <u>10/81</u>	DATE OF GRADUATION <u>7/86</u>

SECTION II: CERTIFICATION OF MEDICAL EDUCATION

NAME OF MEDICAL SCHOOL <u>Sackler School of Medicine</u>
FULL ADDRESS OF MEDICAL SCHOOL <u>Tel Aviv University; University Street</u> <u>Tel Aviv Israel</u>

I certify that \_\_\_\_\_ attended the medical school  
named above from \_\_\_\_\_, 19\_\_\_\_ through \_\_\_\_\_, 19\_\_\_\_ and was  
granted the degree of \_\_\_\_\_ on \_\_\_\_\_, 19\_\_\_\_.

I also certify that the medical educational program from which the applicant named  
above has graduated was not less than 110 weeks and does not award credit for any  
courses taken by correspondence. I further certify that this medical educational  
program included basic science courses in anatomy; physiology; biochemistry; microbiology;  
pathology; and pharmacology and therapeutics; and clinical clerkships in the clinical  
sciences completed at the hospitals or institutions as listed below:

CLINICAL SCIENCES	NAME AND ADDRESS OF HOSPITAL	TEACHING HOSPITAL
Internal Medicine	_____	YES <input type="checkbox"/> NO <input type="checkbox"/>
General Surgery	_____	YES <input type="checkbox"/> NO <input type="checkbox"/>
Pediatrics	_____	YES <input type="checkbox"/> NO <input type="checkbox"/>
Obstetrics and Gynecology	_____	YES <input type="checkbox"/> NO <input type="checkbox"/>
Psychiatry	_____	YES <input type="checkbox"/> NO <input type="checkbox"/>

(Date) \_\_\_\_\_

( S E A L )

Signature of Dean or Registrar \_\_\_\_\_

Type or Print Name of Dean or Registrar \_\_\_\_\_

\* Teaching hospital means that the hospital or institution offers a  
postgraduate clinical training program in the same content area of  
the clerkship.



Date: April, 12, 1989

Kamran Torbati, M.D.

Department of Licensing and Regulation  
Board of Medicine  
P.O. Box 30018  
Lansing, Michigan, 48909

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MAY 05 1989

DEPT. OF LIC. & REG.  
BOARD OF MEDICINE

Dear Madam/Sir;

The purpose of this letter is to clarify my medical education background. I am a graduate of Sackler School of medicine in Tel-Aviv University, Israel. At this moment I am an intern in the preliminary Medicine program in LAC/USC medical Center in Los Angeles. I am supposed to start my residency in Ob/Gyn in Sinai Hospital of Detroit beginning July 1989.

I have recieved almost all of my medical school education in the above mentioned university except a few courses. Being a fourth grade student (out of 6) in Tehran University School of Medicine (1976-80), the officials in Sackler gave me credit for Anatomy, Microbiology, Biochemistry and Physiology after passing a special written examination covering those fields. Unfortunately, due to the political situation in Iran, the officials are not allowed to issue any kind of certification regarding medical education of Tehran University students and graduates.

Copy No. 1 has been issued in response to the request by the board of medical quality assurance in Sacramento, California and they carry the original.

I have also enclosed Copy No. 2 (I have the original) that was obtained in 1980 and is an official witness to my education in Tehran Univ.

I have also enclosed a copy of "Postgraduate Training authorization" issued by the state of California after evaluating my records, which aknowledges my eligibility to be licensed in that state.

You should soon receive the certification from Sackler. Please let me know if any further clarification is required.

Sincerely Yours;



THE ISLAMIC REPUBLIC OF IRAN

Copy No. 1



The Medical Sciences  
University of Tehran  
Faculty of Medicine

TO WHOM IT MAY CONCERN:

July 25th, 1987

Re: the request of Dr. Kamran Torbati

This is to advise that on instructions received from the authorities concerned, we no longer issue certificates of medical education to physicians who have graduated from this institution.

M. H. Bastan Hagh, M.D.

Chancellor, the Medical Sciences University of Tehran



**RECEIVED**

MAY 05 1989

DEPT. OF LIC. & REG.  
BOARD OF MEDICINE



COPY No. 2



University of Tehran  
Faculty of Medicine

Poor Original

TO WHOM IT MAY CONCERN: /

May 27, 1980

This is to certify that Kamran Torbati is a bonafide student of good standing of the Faculty of Medicine, University of Tehran attending the fourth year of 6-year medical course in the academic year 1979-1980.

Sincerely,

*Saadatnadeh*

A. H. Saadatnadeh, M.D.  
Vice-Dean Education & Research



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MAY 05 1980

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BOARD OF MEDICINE



## BOARD OF MEDICAL QUALITY ASSURANCE

1430 HOWE AVENUE, SACRAMENTO, CALIFORNIA 95825

(916) 920-6411



DATE: March 30, 1988

KAMRAN TORBATI

POSTGRADUATE TRAINING  
AUTHORIZATION

Dear Applicant:

Having received and evaluated your application under the provisions of Section 2101, 2102, or 2103 of the Business and Professions Code, you have been determined eligible to participate in postgraduate training in California should you be offered a position.

Acceptance in a postgraduate training program is not assured by this authorization. All requirements for participation imposed by the program must be met and independently verified by the program director. It is possible that you will not qualify, or be selected, for a program in this state.

To obtain licensure in this state, your training must be in an approved program listed in the American Medical Association's Directory of Residency Training Programs. Clinical service may be in a categorical or flexible training program; it must include a minimum of four (4) months of training in general medicine. This requirement may be met by participation in ACGME programs in family practice, internal medicine, surgery, Ob/Gyn, and pediatrics.

Successful completion of postgraduate training does not guarantee licensure in this state. Once you have been accepted into a postgraduate program, you must have the enclosed Certificate of Commencement of ACGME Postgraduate Training form completed and returned to the Board. If you have not notified the Board of your acceptance into a postgraduate training position within one year, your file will be closed and returned to your last address of record.

Since licensing laws may change over time, it is your responsibility to remain aware of any changes and to provide proof of satisfying all licensing requirements.

Sincerely,

Pacita Resuello  
Licensing Technician  
Division of Licensing

Enclosure: PG Commencement Form

**RECEIVED**

MAY 05 1988

DEPT. OF LIC. & REG.  
BOARD OF MEDICINE