STATE OF CALIFORNIA — STATE AND CONSUMER SERVICES AGENCY

GRAY DAVIS, Governor

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State of California Department of Consumer Affairs

MEDICAL BOARD OF CALIFORNIA

1426 Howe Avenue, Suite 54, Sacramento, CA 95825-3236

TEL: (916) 263-2499/FAX: (916) 263-2487 Internet: www.medbd.ca.gov

505 8/22/01

MEDICAL BOARD OF CALIFORNIA 01 AUG 21 PM 1:05

RECEIVED BOARD OF CALIFORNIA AUG 22 PM 2:5 LICENSING PROGRAM

APPLICATION FOR PHYSICIAN'S AND SURGEON'S LICENSE

Please READ all instructions prior to completing this application. ALL questions on this application must be answered, and all supporting documents must be submitted as per instructions. Please type or print neatly. When space provided is insufficient, attach additional sheets of paper. All attachments are considered part of the application.

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.

MBC USE ONLY

1. NAME: Last: Wolfe First: Michelle Middle: Gdalia

2. Other names you have used (include maiden name): Michelle Gdalia Brand (maiden name)

3. U.S. Social Security Number*:

4A. (PUBLIC ADDRESS; will be released by the Board to the public): Number and Street/P.O. Box/Rural Route/Apartment Number, if any. 1692 Dublin Rd.

City: Penfield State: NY Zip Code: 14526 Country: USA

4B. (CONFIDENTIAL ADDRESS): Number and Street/Rural Route/Apartment Number, if any. [Applicants must provide a confidential street address if a P. O. Box is used as the Public Address in #4A above.]

Same as above

City State Zip Code Country

5. Telephone Number:
Home: ( )
Work: ( )

6. California Driver's License Number (optional): NUMBER EXPIRATION

7. Date of Birth (Month/Day/Year) and Place of Birth:

8. Sex: ☐ Male ☒ Female

9. Are you a U.S. citizen? ☒ Yes ☐ No

10. Have you ever filed an application for Physician's and Surgeon's examination or licensure in California? ☐ Yes ☒ No

IF YES, PLEASE GIVE DATE PREVIOUS APPLICATION WAS SUBMITTED:

11. List the names and locations of all colleges or universities attended where pre-professional, postsecondary instruction was received. Please submit official transcripts with the school seal affixed for each school attended. Transcripts will not be returned.

Name	City, State, Country	Dates of Attendance
University of California-San Diego	La Jolla, CA, USA	9/89 - 6/90
University of California-Santa Cruz	Santa Cruz, CA, USA	9/90 - 6/93

12. List the names and locations of all schools where professional medical instruction was received, and, where applicable, the degree awarded.

PLEASE SUBMIT: 1) an original Certificate of Medical Education (Form L2) and official transcripts with the signature of the dean or registrar and the school seal affixed from each school attended; and,
2) an original medical diploma and a 8 1/2" x 11" photocopy (original diploma will be returned).

School Name	City, State, Country	Dates of Attendance	Degree Awarded
St George's University	Grenada, West Indies	8/29/94 - 6/19/98	MD

DOCTOR OF MEDICINE DEGREE, as referenced above

Name of Medical School	Address of Medical School	Exact Date of Issuance
St. George's University	Medical School Services, Ltd. One East Main St. Bayshore, NY 11706-8399	6/19/98

MBC USE ONLY: Personal Data, Pre-Medical Education, Medical Education, L2 Trans

*** MANDATORY DISCLOSURE OF U.S. SOCIAL SECURITY NUMBERS**

Disclosure of your U.S. social security number is mandatory. Section 30 of the Business and Professions Code and Public Law 94-455 (42 USCA 405(b)(2)(C)) authorize collection of your social security number. Your social security number will be used exclusively for tax enforcement purposes, for purposes of compliance with any judgment or order for family support in accordance with Section 17520 of the Family Code, or for verification of licensure or examination status by a licensing or examination entity which utilizes a national examination and where licensure is reciprocal with the requesting state. If you fail to disclose your social security number your application for initial licensure will not be processed AND you will be reported to the Franchise Tax Board, which may assess a $100 penalty against you.

MBC USE ONLY: GRN 01 School Code

L1A

07A-100 (Rev. 9/01)

MBC USE ONLY

13. Have you taken any of the following written examinations: National Boards, other state boards, USMLE, SPEX, FLEX, ECFMG or LMCC? *Written Examination*

☒ Yes ☐ No

IF YES, LIST NAME, LOCATION, DATE AND RESULT OF EACH EXAMINATION; FAILURES MUST ALSO BE DISCLOSED. EACH EXAMINATION AGENCY MUST SUBMIT AN ORIGINAL OFFICIAL EXAMINATION HISTORY REPORT DIRECTLY TO THE MEDICAL BOARD OF CALIFORNIA. THESE REPORTS WILL NOT BE RETURNED.

Examination	Date	Result (Pass/Fail)
USMLE 1, San Francisco, CA	8/1/96	
USMLE 2, San Francisco, CA	8/27/97	
USMLE 3, Oakland, CA	4/3/01	

14. Have you ever been licensed to practice medicine in any state, territory, province, country, or U.S. federal jurisdiction? *License Data*

☒ Yes ☐ No

IF YES, LIST THE JURISDICTION, LICENSE NUMBER, DATE ISSUED AND DATES OF PRACTICE IN THAT JURISDICTION. PLEASE INCLUDE PERMANENT, TEMPORARY, TRAINING, PROVISIONAL, LIMITED LICENSE, OR PERMIT. AN ORIGINAL OFFICIAL LETTER OF GOOD STANDING (LGS), OR COMPARABLE LICENSE HISTORY CERTIFICATION, IS REQUIRED FOR EACH PERMANENT, TEMPORARY, TRAINING, PROVISIONAL, LIMITED LICENSE, OR PERMIT OBTAINED IN ANY U.S. STATE, U.S. OR CANADIAN TERRITORY, CANADIAN PROVINCE, OR U.S. FEDERAL JURISDICTION. EACH LGS, OR COMPARABLE CERTIFICATION, SHOULD BE MAILED BY THE ISSUING AUTHORITY DIRECTLY TO THE MEDICAL BOARD OF CALIFORNIA. *LGS*

Jurisdiction	License Number	Date of Issuance	Dates of Practice in that Jurisdiction
New York State	221403-1	6/12/01	7/1/01 – current

15. Do you hold any other professional license in any state, territory, province, country, or U.S. federal jurisdiction? *Other Professional Licenses*

☐ Yes ☒ No

IF YES: PROFESSION: _____ LICENSE NO.: _____ JURISDICTION: _____

HAS THIS LICENSE EVER BEEN REVOKED, OR SUBJECT TO DISCIPLINE? IF YES, PLEASE PROVIDE ALL OFFICIAL DOCUMENTATION REGARDING THE MATTER IN ADDITION TO A WRITTEN EXPLANATION. YOU ARE ALSO REQUIRED TO REPORT ANY MATTER THAT IS PENDING OR IN WHICH CHARGES HAVE BEEN DROPPED OR EXPUNGED.

☐ Yes ☐ No

16A. Are you currently, or have you ever been, a participant in a postgraduate training program in a facility in the U.S. or Canada? (You must include every residency, internship, and fellowship, whether or not completed.) *Postgraduate Training*

☒ Yes ☐ No

IF YES, LIST NAMES AND ADDRESSES OF ALL FACILITIES. SUBMIT AN ORIGINAL CERTIFICATE OF COMPLETION OF ACGME/RCPSC POSTGRADUATE TRAINING (FORM L3A) FROM EACH FACILITY. (DO NOT COMPLETE FORM L3A TO DOCUMENT TRAINING RECEIVED IN RESEARCH FELLOWSHIP PROGRAMS.) ALL TRAINING MUST BE LISTED, REGARDLESS OF WHETHER IT WAS SATISFACTORILY COMPLETED OR WILL BE USED TO MEET LICENSING REQUIREMENTS.

Facility Name	Address	Categorial Specialty Area	Dates of Attendance
University of Rochester/ Highland Hospital	985 South Ave Rochester, NY 14620	Family Medicine	6/22/98 – 6/30/01
University of Rochester/ Highland Hospital	985 South Ave Rochester, NY 14620	Family Medicine	7/1/01 – 6/30/02

QUESTIONS 16B through 23

If you answer YES to any of the following questions, please provide ALL official documentation regarding the matter in addition to your written personal explanations. An applicant must provide official hearing/court documents and original letters of explanation from medical schools or training program directors. If these documents are not provided with the application, they will be requested before review of the application can proceed. APPLICANTS ARE REQUIRED TO REPORT ANY MATTER THAT IS PENDING OR IN WHICH CHARGES HAVE BEEN DROPPED OR EXPUNGED.

16B. Have you ever withdrawn from, or been suspended, dismissed or expelled from a medical school or postgraduate training program OR have you ever taken a leave of absence from such a school or program?

IF YOU ANSWERED YES, BOTH APPLICANT AND SCHOOL/PROGRAM MUST PROVIDE DETAILS ON A SEPARATE ATTACHMENT. Yes No

NAME OF APPLICANT: Michelle Gdalia Wolfe

DATE OF BIRTH:

L1B

MBC USE ONLY

License Data

For all of the below, also include any disciplinary actions by the U.S. Military, U.S. Public Health Service, or other U.S. federal governmental entity.

17A. 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?

17B. Has any disciplinary action ever been filed or taken, including but not limited to, informal or confidential discipline, consent orders, or letters of warning, regarding any healing arts license which you now hold or have ever held?

17C. Is any such action as described above pending?

IF YOU ANSWERED YES TO 17A, 17B OR 17C, PROVIDE DETAILS ON A SEPARATE ATTACHMENT.

17(A)	Yes	No	☒
17(B)	Yes	No	☒
17(C)	Yes	No	☒

18. Has a claim or action for damages ever been filed against you in the course of the practice of medicine or any other healing art which resulted in a malpractice settlement, judgement, or arbitration award of over $30,000.00?

IF YOU ANSWERED YES, PROVIDE DETAILS ON A SEPARATE ATTACHMENT.

Yes No ☒

19. Have you ever been denied a license, permission to practice medicine or any other healing art, or denied permission to take an examination in any state, territory, country, or U.S. federal jurisdiction, or is any such action pending?

IF YOU ANSWERED YES, PROVIDE DETAILS ON A SEPARATE ATTACHMENT.

Yes No ☒

20. Have you ever voluntarily surrendered a license to practice medicine or any other healing arts in this or any other state, or voluntarily surrendered your narcotic (controlled substance) permit (state or federal) to any licensing board or any other agency, or is any such action pending?

IF YOU ANSWERED YES, PROVIDE DETAILS ON A SEPARATE ATTACHMENT.

Yes No ☒

21. Have you ever had staff privileges in a hospital denied, suspended, limited, revoked, or not renewed for medical disciplinary cause, or resigned from a medical staff in lieu of disciplinary or administrative action, or is any such action pending?

YOU MUST DISCLOSE ANY INFORMAL OR CONFIDENTIAL DISCIPLINARY ACTION.

Yes No ☒

22. Do you have any condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety, including but not limited to, any of the following?

IF YES, PLEASE CHECK THE APPROPRIATE BOX(ES) BELOW:

Yes No ☒

- ☐ A condition which required admission to an inpatient psychiatric treatment facility.
- ☐ Alcohol or chemical substance dependency or addiction.
- ☐ Emotional, mental or behavioral disorder.
- ☐ Other (explain): _____

FOR ANY OF THE BOXES CHECKED ABOVE, PLEASE SUBMIT COMPLETE OFFICIAL INPATIENT AND OUTPATIENT TREATMENT RECORDS, EVIDENCE OF ONGOING REHABILITATION TREATMENT, AND A PERSONAL WRITTEN EXPLANATION.

FOR ALL OF THE BELOW, YOU ARE REQUIRED TO LIST ANY CONVICTION THAT HAS BEEN SET ASIDE AND DISMISSED OR EXPUNGED, OR WHERE A STAY OF EXECUTION HAS BEEN ISSUED.

23A. Have you ever been convicted of, or pled nolo contendere to, ANY violation (include every misdemeanor or felony) of any local, state, or federal law of any state, territory, country, or U.S. federal jurisdiction?

23B. Is any criminal action related to the above pending?

IF YOU ANSWERED YES TO 23A OR 23B, PROVIDE DETAILS ON A SEPARATE ATTACHMENT.

23 (A)	Yes	No	☐
23 (B)	Yes	No	☒

NAME OF APPLICANT: Michelle Gdalia Wolfe

DATE OF BIRTH:

L1C

STATE OF CALIFORNIA — STATE AND CONSUMER SERVICES AGENCY

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MEDICAL BOARD OF CALIFORNIA
1426 Howe Avenue, Suite 54, Sacramento, CA 95825-3236
(916) 263-2499/FAX (916) 263-2487
Internet: www.medbd.ca.gov

CERTIFICATE OF MEDICAL EDUCATION

MEDICAL SCHOOL: PLEASE COMPLETE THIS FORM IN THE ENGLISH LANGUAGE.

This certifies that Michelle Edalia Wolfe (previously Michelle Edalia Brandy) FULL NAME OF APPLICANT; SOCIAL SECURITY NO.; DATE OF BIRTH MM/DD/YYYY

enrolled in St George's School of Medicine (NAME OF MEDICAL SCHOOL) Grenada, West Indies (LOCATION)

on the 29th day of August (MONTH), 1994 (YEAR) and was granted the following credits on enrollment:

Advanced Credits: *Credits previously obtained at an approved medical, dental, or osteopathic school.**

MEDICAL SCHOOL | TOTAL CREDITS | DATES

The undersigned further certifies that the records of this institution show that the applicant attended in this institution 9 TERMS OF 12-18 WEEKS + 2 TERMS OF 6 WEEKS EACH (NUMBER OF YEARS) ~~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 the applicant:

☒ was granted the degree Bachelor/Doctor of Medicine by OR ☐ withdrew from

the above mentioned medical school on the 19th day of June (MONTH), 1998 (YEAR).

Anatomy
Otolaryngology
Obstetrics and Gynecology
Radiology, including Radiation Safety
Tropical Medicine
Physiology
Biochemistry
Pathology, Bacteriology and Immunology
Ophthalmology
Dermatology

Embryology
Histology
Human Sexuality as defined in Section 2090
Medicine
Surgery, including Orthopedic Surgery
Urology
Psychiatry
Neurology
Alcoholism and Chemical Dependency
Preventive medicine, including Nutrition

Physical Medicine
Therapeutics
Neuroanatomy
Child Abuse Detection and Treatment
Geriatric Medicine
Pediatrics
Pharmacology
Anesthesia
Spousal or Partner Abuse Detection & Treatment**
Family Medicine***
Pain Management and End-of-Life Care****

* Each school where professional medical instruction was received MUST complete one of these forms. If more than one school was attended, photocopies of this blank form may be made and used.
** 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.

MEDICAL SCHOOL SEAL MUST BE IMPRINTED BELOW.

ATTENTION MEDICAL SCHOOL: The person who signs this form MAY NOT be related to the applicant by blood, marriage or adoption.

Only the President, Dean, or Registrar 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.

Signed and the school seal affixed this 18th day of July (MONTH), 2001 (YEAR).

BY [signature] Margaret A. Lambert / Dean of Enrolment Planning / Registrar
PRESIDENT, DEAN, OR REGISTRAR

L2

07A-100-L2 (Rev. 3/01)

STATE OF CALIFORNIA — STATE AND CONSUMER SERVICES AGENCY

GRAY DAVIS, Governor

Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
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(916) 263-2490/FAX (916) 263-2487 Internet: www.medbd.ca.gov

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.

ATTENTION PROGRAM DIRECTORS AND DIRECTORS OF MEDICAL EDUCATION: THE PERSON WHO SIGNS THIS FORM MAY NOT BE REMOVED TO THE APPROPRIATE BY BIRTH, MARRIAGE, OR ADOPTION. Only the Program Director and the Director of Medical Education may sign this form. If that signature is 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.

PART 1: To be completed by the APPLICANT

LAST NAME of Applicant: Wolfe
First Name: Michelle
Middle Initial: G
U.S. Social Security Number:
Date of Birth: MM/DD/YYYY
Telephone Number:
Home: ( )
Current Address: 1692 Dublin Rd.
City: Penfield
State: NY
Zip Code: 14526

PART 2: To be completed by the PROGRAM DIRECTOR

ATTENTION PROGRAM DIRECTOR: Do not sign and date this form before the last day of any postgraduate training year which will be used by the applicant to qualify for licensure. Completion of this form will certify that the individual named in PART 1 above completed a period of accredited postgraduate training at this facility. If a period of training WAS NOT completed in a satisfactory manner, please provide a separate detailed narrative explanation. The following information is provided to certify "satisfactory" completion. PLEASE SEE THE REVERSE FOR A DEFINITION OF "SATISFACTORY."

Name of Facility: Univ. Rochester / Highland Hosp.
Address of Facility: 885 South Avenue
Name of Program Director: Jeffrey J Harp
Telephone Number: (716) 442-7470
Signature of Program Director:
Date Signed: 7-13-01
List Categorical Specialty Area of Training Completed by Trainee: Family Practice
Date Training Commenced: 6/30/98
Date Training Completed: 6/30/00

If the training was rotating or transitional, list the specific rotations and the number of weeks spent in each (SEE THE REVERSE FOR INFORMATION ON SATISFYING THE GENERAL MEDICINE TRAINING REQUIREMENT):

PART 3: To be completed by the DIRECTOR OF MEDICAL EDUCATION and affixed with the official facility seal

Name of the Director of Medical Education: Jeffrey J Harp
Name of Facility: Univ. Rochester / Highland
Address of Facility: 885 South Ave
City: Rochester
State: New York
Zip Code: 14620
Telephone Number: (716) 442-7470

PART 4: Signature of DIRECTOR OF MEDICAL EDUCATION certifying satisfactory completion of training

Attention: Director of Medical Education! *Do not sign and date this form before the last day of any postgraduate training year which will be used by the applicant to qualify for licensure. This form may be signed by the current Director of Medical Education; it does not need to be signed by the person who was the Director of Medical Education at the time of the training listed above.*

Notice to Applicant: If this form is used to verify postgraduate training beyond that which is required for licensure, this form can be signed by the Director of Medical Education and the Program Director before the final day of training. However, if you are licensed after the date upon which training was completed AND if the form was signed before the final day of the training year, a new form must be completed and submitted to the Medical Board of California.

HOSPITAL OR NOTARY SEAL

CHRISTINE BAIR
NOTARY PUBLIC - STATE OF NEW YORK
NO. 01BA6048113
QUALIFIED IN MONROE COUNTY
MY COMMISSION EXPIRES 09-18-20

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

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 RCPSC to offer the type and level of training completed by the applicant and that the applicant was trained in an approved ACGME or RCPSC program position.

Signature of Director of Medical Education:
Date Signed: 7-13-01

L3A

STATE OF CALIFORNIA — STATE AND CONSUMER SERVICES AGENCY

GRAY DAVIS, Governor

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ELIGIBILITY FOR REDUCED INITIAL LICENSE FEE

(If you are enrolled in an ACGME/RCPSC postgraduate training program at the time of licensure, you are entitled to a reduced initial license fee. This form is used to certify current participation in a training program.)

This is to certify that Michelle Wolfe (Name of Applicant) _____ (U.S. Social Security Number)

_____ (Date of Birth -MM/DD/YYYY) is in an approved ACGME/RCPSC postgraduate training position that commenced on 6 (Month) 22 (Day) 98 (Year) and is expected to be completed on 6 (Month) 22 (Day) 02 (Year) in OB Family Practice (Type of Training)

at Wm. Beaumont Memorial Hospital (Name and Address of Facility)
Family Medicine

ATTENTION DIRECTORS OF MEDICAL EDUCATION: THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE, OR ADOPTION.

Only the Director of Medical Education 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.

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

Jeffrey T Kark, MD
(Type or print name of Director of Medical Education)

(Signature of Director of Medical Education)

7-10-01
(Date)

716-442-7400
(Telephone Number)

CHRISTINE BAIR
NOTARY PUBLIC - STATE OF NEW YORK
NO. 01BA6048113
QUALIFIED IN MONROE COUNTY
MY COMMISSION EXPIRES 09-18-20 02

OFFICIAL HOSPITAL SEAL, OR NOTARY SEAL (WITH DATE AND NOTARY'S SIGNATURE) MUST BE AFFIXED IN THE BOX AT THE LEFT.

NOTE: Do not use this form in lieu of Form L3A, "Certificate of Completion of ACGME/RCPSC Postgraduate Training."

L4

07A-107-L4 (3/01)

STATE OF CALIFORNIA — STATE AND CONSUMER SERVICES AGENCY GRAY DAVIS, Governor

State of California Department of Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
1426 Howe Avenue, Suite 54, Sacramento, CA 95825-3236
(916) 263-2499/FAX (916) 263-2487
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OFFICIAL BREAKDOWN OF UNDERGRADUATE CLINICAL CLERKSHIPS

(The completion of this form is required only of international medical school graduates. Please complete this form in the English language.)

Name of Applicant (type or print FULL name):	U.S. Social Security Number:
Michelle Gdalia Wolfe (previously Michelle Gdalia Brand)	Date of Birth-MM/DD/YYYY:

Only undergraduate clinical clerkships in which the applicant participated in DIRECT, HANDS-ON DIAGNOSIS OR TREATMENT OF PATIENTS IN A CLINICAL SETTING should be reported on this form. Any clinical clerkships completed that do not meet the above criteria should NOT be reported on this form as they will NOT satisfy California's clinical training requirements.

UNDERGRADUATE CLINICAL CLERKSHIPS

(Please list ALL clinical training completed prior to issuance of your medical degree in the area below and on the reverse of this form. List training in date/chronological order, commencing with the first clinical year of training.)

CLINICAL SUBJECT AREA	✓	FACILITY NAME AND ADDRESS	DATES OF ATTENDANCE FROM -- TO (Month/Day/Year)	WEEKS ON WEEKLY HOURS OF CREDIT
Medicine I	✓	Alameda County Med. Center 1411 E. 31st St., Oakland, CA 94602	9/2/96 - 9/27/96	4 ✓
psychiatry	✓	Napa State Hospital 2100 Napa Valley Highway Napa, CA 94558	9/30/96 - 11/8/96	6 ✓
Medicine II	✓	Alameda County Med. Center 1411 E. 31st St., Oakland, CA 94602	11/11/96 - 1/31/97	12 ✓
Surgery	✓	Chelsea & Westminster Hospital 369 Fulham Rd. Chelsea, London SW10 9NH	2/10/97 - 5/2/97	12 ✓
OB/gyn	✓	University College London Med School 86-96 Chenies Mews London WC1E 6HX	5/5/97 - 6/13/97	6 ✓
pediatrics	✓	Children's Hospital of Orange County 541 S. Main St. Orange, CA 92688	7/14/97 - 8/1/97	3 ✓

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

Only the Dean or Registrar 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.

MEDICAL SCHOOL SEAL

I, Margaret A. Lambert, Dean of Enrolment Planning/Registrar
FULL NAME of Dean or Registrar (Please TYPE OR PRINT)

declare under penalty of perjury that I am/was the Dean or Registrar for the student named above and that I have carefully read this form and that the statements made herein are strictly true in every respect.

Signature of Dean or Registrar: Margaret A. Lambert — Date: 7/18/2001

L5A

OFFICIAL BR (DOWN OF UNDERGRADUATE CLINIC CLERKSHIPS
(Continued from the front of this form. If additional space is needed, you may photocopy this side of the form; however, original signatures and seals (below) will be required on all photocopies submitted.)

Name of Applicant (type or print FULL name):	U.S. Social Security Number:
Michelle Gdalia Wolfe (previously Michelle Gdalia Brand)	Date of Birth-MM/DD/YYYY:

UNDERGRADUATE CLINICAL CLERKSHIPS

CLINICAL SUBJECT AREA	FACILITY NAME AND ADDRESS	DATES OF ATTENDANCE FROM -- TO (Month/Day/Year)	Wks	WEEKS OR WEEKLY HOURS OF CREDIT
Pediatrics	Children's Hospital of Orange County 541 S. Main St. Orange, CA 92688	9/1/97 - 9/19/97	✓	3 ✓
Medicine Subinternship	Alameda County Medical Center 1411 E. 31st St. HIGHLAND CAMPUS Oakland, CA 94602	9/22/97 - 11/14/97	✓	8 ✓
Cardiology	Alameda County Medical Center 1411 E. 31st St. Oakland, CA 94602	11/17/97 - 12/5/97	✓	3 FE ✓
Primary Care Medicine	Alameda County Medical Center 1411 E. 31st St. HIGHLAND CAMPUS Oakland, CA 94602	12/15/97 - 1/16/98	✓	5 FE ✓
Hematology / Oncology	St. Joseph's Hospital & Med. Center 703 Main St. Patterson, NJ 07503	2/2/98 - 2/27/98	✓	4 ✓
Pediatric subinternship	St. Joseph's Hospital & Med. Center 703 Main St. Patterson, NJ 07503	3/2/98 - 3/27/98	✓	4 ✓
Family Practice	St. Joseph's Hospital & Med. Center 703 Main St. Patterson, NJ 07503	3/30/98 - 4/24/98	✓	4 ✓
Radiology	Alameda County Medical Center 1411 E. 31st St. Oakland, CA 94602	4/27/98 - 5/15/98	✓	3 FE ✓
Infectious Disease	St. Joseph's Hospital & Med. Center 703 Main St. Patterson, NJ 07503	5/18/98 - 6/5/98	✓	3 ✓

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

Only the Dean or Registrar 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.

MEDICAL SCHOOL SEAL

Margaret A. Lambert
Dean of Enrolment Planning / Registrar

I, _____
FULL NAME of Dean or Registrar (Please TYPE OR PRINT)

declare under penalty of perjury that I am/was the Dean or Registrar for the student named above and that I have carefully read this form and that the statements made herein are strictly true in every respect.

Signature of Dean or Registrar

7/18/2001
Date

L5B

STATE OF CALIFORNIA — STATE AND CONSUMER SERVICES AGENCY

PETE WILSON, Governor

State of California Department of Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM
1426 Howe Avenue
Sacramento, CA 95825-3236
(916) 263-2499

CERTIFICATE OF CLINICAL TRAINING

(The completion of this form is required only of international medical school graduates.)

NOTE: THIS FORM MAY BE OMITTED IF ALL CLINICAL TRAINING WAS DONE IN THE PRIMARY TEACHING HOSPITAL OF THE MEDICAL SCHOOL AND SUCH HOSPITAL IS LOCATED IN THE SAME COUNTRY AS THE MEDICAL SCHOOL AND THE MEDICAL SCHOOL COMPLETES AND CERTIFIES THE OFFICIAL BREAKDOWN OF UNDERGRADUATE CLINICAL CLERKSHIPS FORMS, FORMS L3A/B.

Complete ONE certificate for EACH clerkship, signed by the instructor or facility program director.

ONLY UNDERGRADUATE CLINICAL CLERKSHIPS IN WHICH THE APPLICANT PARTICIPATED IN DIRECT, HANDS-ON DIAGNOSIS OR TREATMENT OF PATIENTS IN A CLINICAL SETTING SHOULD BE REPORTED ON THIS FORM. ANY CLINICAL CLERKSHIPS COMPLETED THAT DO NOT MEET THE ABOVE CRITERIA SHOULD NOT BE REPORTED ON THIS FORM AS THEY WILL NOT SATISFY CALIFORNIA'S CLINICAL TRAINING REQUIREMENTS.

This is to certify that Michael Brand (STUDENT'S NAME), a student of St George's University School of Medicine (MEDICAL SCHOOL), completed a clerkship offered by Children's Hospital of Orange County 455 S. Main St. Orange, CA 92868 (NAME AND ADDRESS OF FACILITY)

from 7/14/97 (DATE), 19__ through 8/11/97 (DATE) (2 weeks), 19__ in the clinical area of Pediatric Care Studies (CLINICAL AREA).

James O. Kerr being duly sworn, says he was the individual instructor or program director for the student named above during the clerkship indicated and that he has carefully read and completed this form and that the statements made herein are strictly true in every respect.

Pd 0/2 03 PC 07-01

This facility ☑ is affiliated with a U.S. or international school
☐ is not
Name of U.S. or International medical school, if affiliated:
St. Georges University School of Medicine

This facility ☑ does have an ACGME-accredited residency program in the areas of: Pediatrics
☐ does not have an ACGME-accredited residency program.

James O. Kerr, MD
TYPE OR PRINT NAME OF INSTRUCTOR OR FACILITY PROGRAM DIRECTOR

455 S. Main St.
ADDRESS: NUMBER AND STREET

Orange, CA 92868
CITY STATE ZIP CODE

(714) 532-8338
TELEPHONE NUMBER

SIGNATURE OF INSTRUCTOR/FACILITY PROGRAM DIRECTOR

Official Hospital Seal

SASH SANDFORD
Comm. # 1205417
NOTARY PUBLIC - CALIFORNIA
Orange County
My Comm. Expires Dec. 19, 2002

NOTE: IN ABSENCE OF AN OFFICIAL HOSPITAL SEAL, THE INSTRUCTOR OR PROGRAM DIRECTOR MUST SIGN THIS FORM IN THE PRESENCE OF A NOTARY PUBLIC WHO AFFIXES HIS/HER OFFICIAL NOTARY SEAL.

Signed and sworn to before me this 1st day of August 1997

SASH SANDFORD
Comm. # 1205417
NOTARY PUBLIC - CALIFORNIA
Orange County
My Comm. Expires Dec. 19, 2002

Notary Seal

NOTARY PUBLIC
455 S. Main St. Orange Ca
ADDRESS

My Commission Expires 12/19/2002

07A-100-1.6 (Rev. 2/97)

L6

STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY

PETE WILSON, Governor

MEDICAL BOARD OF CALIFORNIA
1426 HOWE AVENUE, SUITE 54, SACRAMENTO, CALIFORNIA 95825-3236
(916) 920-6411

CERTIFICATE OF CLINICAL TRAINING

Complete one certificate for each clerkship, signed by the instructor or facility program director.

ONLY ROTATIONS IN WHICH THE APPLICANT PARTICIPATED IN DIRECT, HANDS-ON DIAGNOSIS OR TREATMENT OF PATIENTS, IN A CLINICAL SETTING MAY BE REPORTED ON THIS FORM. IF ROTATIONS WERE COMPLETED DURING THE JUNIOR OR SENIOR YEAR OF MEDICAL SCHOOL BUT DO NOT SATISFY THIS REQUIREMENT, THEY SHOULD NOT BE REPORTED ON THIS FORM BECAUSE THEY DO NOT SATISFY CLINICAL TRAINING REQUIREMENTS.

This is to certify that Michelle Brand (STUDENT'S NAME), a student of St. George's University School of Medicine (MEDICAL SCHOOL), participated in a clerkship offered by Alameda County Medical Center-Highland (NAME AND ADDRESS OF FACILITY) 1411 E. 31st St. Oakland, CA 94602 from 9/3 (DATE) 19 96 thru 9/27 (DATE) 19 96 in the clinical area of Medicine I (CLINICAL AREA). That the above named student successfully completed this clerkship on 9/27 (DATE) 19 96

IM Okay PG 928 Oct. 97

_____ being duly sworn, says he is/was the individual instructor or program director for the student named above during the clerkship indicated and that he has carefully read and completed this form and that the statements made herein are strictly true in every respect.

This facility [X] is [ ] is not affiliated with a U.S. or foreign medical school.

Name of U.S. or foreign medical school if affiliated: UCSF, UC-Davis, St. George's

This facility [X] does have an ACGME-accredited residency program in the areas of: ~~Medicine, Surgery, ER~~
[ ] does not have an ACGME-accredited residency program.

OFFICIAL HOSPITAL SEAL

Theodore G. Rose, M.D. FACP
TYPE OR PRINT, NAME OF INSTRUCTOR OR FACILITY PROGRAM DIRECTOR

1411 E. 31st St. Dept. of Medicine
Address Number and Street

Oakland, CA 94602
City State ZIP Code

PHONE NUMBER (510)437-4268

SIGNATURE OF INSTRUCTOR/FACILITY PROGRAM DIRECTOR

NOTE: IN ABSENCE OF OFFICIAL HOSPITAL SEAL, THE INSTRUCTOR OR PROGRAM DIRECTOR MUST SIGN THE FORM IN THE PRESENCE OF A NOTARY PUBLIC WHO AFFIXES HIS OFFICIAL NOTARY SEAL.

Signed and sworn to before me this _____ day of _____, 19____

NOTARY SEAL

NOTARY PUBLIC

ADDRESS

My commission expires _____

NOTE: This form may be omitted if all clinical training was done in the primary teaching hospital of the medical school and such hospital is located in the same country as the medical school and the medical school completes and certifies the Junior and Senior Year Clinical Rotations forms.

07A-100-16 (REV. 7/91)

L6

STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY

PETE WILSON, Governor

Consumer Affairs

MEDICAL BOARD OF CALIFORNIA

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

CERTIFICATE OF CLINICAL TRAINING

Complete one certificate for each clerkship, signed by the instructor or facility program director.

ONLY ROTATIONS IN WHICH THE APPLICANT PARTICIPATED IN DIRECT, HANDS-ON DIAGNOSIS OR TREATMENT OF PATIENTS, IN A CLINICAL SETTING MAY BE REPORTED ON THIS FORM. IF ROTATIONS WERE COMPLETED DURING THE JUNIOR OR SENIOR YEAR OF MEDICAL SCHOOL BUT DO NOT SATISFY THIS REQUIREMENT, THEY SHOULD NOT BE REPORTED ON THIS FORM BECAUSE THEY DO NOT SATISFY CLINICAL TRAINING REQUIREMENTS.

This is to certify that Michelle Brand (STUDENT'S NAME), a student of St. George's University School of Medicine (MEDICAL SCHOOL), participated in a clerkship offered by Napa State Hospital (NAME AND ADDRESS OF FACILITY) 2100 Napa-Vallejo Highway; Napa, CA 94558 from September 30 (DATE) 19 96 thru November 8 (DATE) 19 96 in the clinical area of Psychiatry (CLINICAL AREA). That the above named student successfully completed this clerkship on November 8 (DATE) 19 96.

P OKAY 8/26 8/26-97

GEORGE POWSMAREFF, MD being duly sworn, says he is/was the individual instructor or program director for the student named above during the clerkship indicated and that he has carefully read and completed this form and that the statements made herein are strictly true in every respect.

This facility ☑ is ☐ is not affiliated with a U.S. or foreign medical school.

Name of U.S. or foreign medical school if affiliated: U. C. DAVIS

This facility ☑ does have an ACGME-accredited residency program in the area of: PSYCHIATRY

☐ does not have an ACGME-accredited residency program.

OFFICIAL HOSPITAL SEAL

GEORGE POWSMAREFF, MD
TYPE OR PRINT NAME OF INSTRUCTOR OR FACILITY PROGRAM DIRECTOR

2100 - NAPA VALLEJO HWY
Address, Number and Street

NAPA CA 94558
City State Zip Code

PHONE NUMBER 707-253-5991

SIGNATURE OF INSTRUCTOR OR FACILITY PROGRAM DIRECTOR

NOTE: IN ABSENCE OF OFFICIAL HOSPITAL SEAL, THE INSTRUCTOR OR PROGRAM DIRECTOR MUST SIGN THE FORM IN THE PRESENCE OF A NOTARY PUBLIC WHO AFFIXES HIS OFFICIAL NOTARY SEAL.

Signed and sworn to before me this 5th day of May, 19 98

Pamela S. Healer
Comm. #1061421
NOTARY PUBLIC - CALIFORNIA
SONOMA COUNTY
Comm. Exp. June 13, 1999

Pamela S Healer
NOTARY PUBLIC

NAPA, CA.
ADDRESS

My commission expires 6/13/99

NOTE: This form may be omitted if all clinical training was done in the primary teaching hospital of the medical school and such hospital is located in the same country as the medical school and the medical school completes and certifies the Junior and Senior Year Clinical Rotations forms.

07A-10046 (REV. 7/91)

L6

STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY

PETE WILSON, Governor

Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
1426 HOWE AVENUE, SUITE 54, SACRAMENTO, CALIFORNIA 95825-3236
(916) 920-6411

CERTIFICATE OF CLINICAL TRAINING

Complete one certificate for each clerkship, signed by the instructor or facility program director.

ONLY ROTATIONS IN WHICH THE APPLICANT PARTICIPATED IN DIRECT, HANDS-ON DIAGNOSIS OR TREATMENT OF PATIENTS, IN A CLINICAL SETTING MAY BE REPORTED ON THIS FORM. IF ROTATIONS WERE COMPLETED DURING THE JUNIOR OR SENIOR YEAR OF MEDICAL SCHOOL BUT DO NOT SATISFY THIS REQUIREMENT, THEY SHOULD NOT BE REPORTED ON THIS FORM BECAUSE THEY DO NOT SATISFY CLINICAL TRAINING REQUIREMENTS.

This is to certify that Michelle Brand (STUDENT'S NAME), a student of St. George's University School of Medicine (MEDICAL SCHOOL), participated in a clerkship offered by Alameda County Medical Center-Highland (NAME AND ADDRESS OF FACILITY) 1411 E. 31st St. Oakland, CA 94602 from 11/11 (DATE) 19 96 thru 1/31 (DATE) 19 97 in the clinical area of Medicine 2 (CLINICAL AREA). That the above named student successfully completed this clerkship on 1/31 (DATE) 19 97.

OKAY

_____ being duly sworn, says he is/was the individual instructor or program director for the student named above during the clerkship indicated and that he has carefully read and completed this form and that the statements made herein are strictly true in every respect.

This facility [X] is [ ] is not affiliated with a U.S. or foreign medical school.

Name of U.S. or foreign medical school if affiliated: UCSF, UC-Davis, St. George's

This facility [X] does have an ACGME-accredited residency program in the areas of: Medicine, Surgery, ER
[ ] does not have an ACGME-accredited residency program.

[OFFICIAL HOSPITAL SEAL]

Theodore G. Rose, M.D. FACP
TYPE OR PRINT NAME OF INSTRUCTOR OR FACILITY PROGRAM DIRECTOR

1411 E. 31st St. Dept. of Medicine
Address: Number and Street

Oakland, CA 94602
City State Zip Code

PHONE NUMBER (510)437-4268

SIGNATURE OF INSTRUCTOR/FACILITY PROGRAM DIRECTOR

NOTE: IN ABSENCE OF OFFICIAL HOSPITAL SEAL, THE INSTRUCTOR OR PROGRAM DIRECTOR MUST SIGN THE FORM IN THE PRESENCE OF A NOTARY PUBLIC WHO AFFIXES HIS OFFICIAL NOTARY SEAL.

Signed and sworn to before me this _____ day of _____, 19____

[NOTARY SEAL]

_____
NOTARY PUBLIC

ADDRESS

My commission expires _____

NOTE: This form may be omitted if all clinical training was done in the primary teaching hospital of the medical school and such hospital is located in the same country as the medical school and the medical school completes and certifies the Junior and Senior Year Clinical Rotations forms.

97A-100-16 (REV. 7/91)

L6

STATE OF CALIFORNIA STATE AND CONSUMER SERVICES AGENCY

PETE WILSON, Governor

State Consumer Department of Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
1426 HOWE AVENUE, SUITE 54, SACRAMENTO, CALIFORNIA 95825-3236
(916) 920-6411

CERTIFICATE OF CLINICAL TRAINING

Complete one certificate for each clerkship, signed by the instructor or facility program director.

ONLY ROTATIONS IN WHICH THE APPLICANT PARTICIPATED IN DIRECT, HANDS-ON DIAGNOSIS OR TREATMENT OF PATIENTS, IN A CLINICAL SETTING MAY BE REPORTED ON THIS FORM. IF ROTATIONS WERE COMPLETED DURING THE JUNIOR OR SENIOR YEAR OF MEDICAL SCHOOL BUT DO NOT SATISFY THIS REQUIREMENT, THEY SHOULD NOT BE REPORTED ON THIS FORM BECAUSE THEY DO NOT SATISFY CLINICAL TRAINING REQUIREMENTS.

This is to certify that Michelle Brand (APPLICANT'S NAME), a student of St George's University School of Medicine (MEDICAL SCHOOL), participated in a clerkship offered by Chelsea & Westminster Hospital (NAME AND ADDRESS OF FACILITY) 369 Fulham Road, Chelsea, London SW10 9NH from 10 February (DATE) 19 97 thru 2 May (DATE) 19 97 in the clinical area of Surgery (CLINICAL AREA). That the above named student successfully completed this clerkship on 2 May (DATE) 19 97

OK 2/4

Dr R J Summerfield ~~being duly sworn~~, says he is/was the ~~individual instructor~~ or program director for the student named above during the clerkship indicated and that he has carefully read and completed this form and that the statements made herein are strictly true in every respect.

See binder

This facility ☐ is ☐ is not affiliated with a U.S. or foreign medical school.
(U.S. or foreign medical school if affiliated:)

This facility ☐ does have an ACGME-accredited residency program in the areas of: ☐ does not have an ACGME-accredited residency program.

OFFICIAL HOSPITAL SEAL

Dr R J Summerfield
(TYPE OR PRINT NAME OF INSTRUCTOR OR FACILITY PROGRAM DIRECTOR)

St George's University School of Medicine
(Address: Number and Street)

33 Lynch Hill Park, Whitchurch, Hampshire RG28 7NF
(City, State, Zip)

PHONE NUMBER 01256 892975

(SIGNATURE OF INSTRUCTOR OR FACILITY PROGRAM DIRECTOR)

NOTE: IN ABSENCE OF OFFICIAL HOSPITAL SEAL, THE INSTRUCTOR OR PROGRAM DIRECTOR MUST SIGN THE FORM IN THE PRESENCE OF A NOTARY PUBLIC WHO AFFIXES HIS OFFICIAL NOTARY SEAL.

Signed and ~~sworn to before me~~ this 27 day of June, 19 97

NOTARY SEAL

(NOTARY PUBLIC)

ADDRESS

My commission expires

(OR) This form may be completed if all clinical training was done in the primary teaching hospital of the medical school and such hospital is located in the same country as the medical school and the medical school completes and certifies the Junior and Senior Year Clinical Rotation forms

(01/97 7/90)

L6

STATE OF CALIFORNIA - STATE AND CONSUMER SERVICES AGENCY

PETE WILSON, Governor

State of California Department of Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
1426 HOWE AVENUE, SUITE 54, SACRAMENTO, CALIFORNIA 95825-3236
(916) 920-6411

CERTIFICATE OF CLINICAL TRAINING

Complete one certificate for each clerkship, signed by the instructor or facility program director.

ONLY ROTATIONS IN WHICH THE APPLICANT PARTICIPATED IN DIRECT, HANDS-ON DIAGNOSIS OR TREATMENT OF PATIENTS, IN A CLINICAL SETTING MAY BE REPORTED ON THIS FORM. IF ROTATIONS WERE COMPLETED DURING THE JUNIOR OR SENIOR YEAR OF MEDICAL SCHOOL BUT DO NOT SATISFY THIS REQUIREMENT, THEY SHOULD NOT BE REPORTED ON THIS FORM BECAUSE THEY DO NOT SATISFY CLINICAL TRAINING REQUIREMENTS.

This is to certify that Michelle Brand (STUDENT'S NAME), a student of St George's University School of Medicine (MEDICAL SCHOOL), participated in a clerkship offered by University College London Medical School (NAME AND ADDRESS OF FACILITY) 86-96 Chenies Mews, London WC1E 6HX

from 5 May (DATE) 19 97 thru 13 June (DATE) 19 97 in the clinical area of Obstetrics & Gynaecology (CLINICAL AREA). That the above named student successfully completed this clerkship on 13 June (DATE) 19 97.

OK and see binder

Dr R J Summerfield ~~being duly sworn~~ says he is/was the ~~individual instructor or~~ program director for the student named above during the clerkship indicated and that he has carefully read and completed this form and that the statements made herein are strictly true in every respect.

Facility ☑ is ☐ is not affiliated with a U.S. or foreign medical school.

This facility ☐ does have an ACGME-accredited residency program in the areas of: _____
☐ does not have an ACGME-accredited residency program.

OFFICIAL HOSPITAL SEAL

Dr R J Summerfield
TYPE OR PRINT NAME OF ~~INSTRUCTOR OR~~ FACILITY PROGRAM DIRECTOR

St George's University School of Medicine
Address, Hospital and Street

33 Lynch Hill Park, Whitchurch, Hampshire RG28 7NF
City State or Country

PHONE: TELEPHONE 01256 892975

R Summerfield
SIGNATURE OF ~~INSTRUCTOR OR~~ FACILITY PROGRAM DIRECTOR

NOTE: IN ABSENCE OF OFFICIAL HOSPITAL SEAL, THE INSTRUCTOR OR PROGRAM DIRECTOR MUST SIGN THE FORM IN THE PRESENCE OF A NOTARY PUBLIC WHO AFFIXES HIS OFFICIAL NOTARY SEAL.

Signed and ~~sworn to before me~~ this 27 day of June, 19 97

NOTARY SEAL

ADDRESS

NOTARY PUBLIC

My commission expires

NOTE: This form may be omitted if all clinical training was done at the primary teaching hospital of the medical school and such hospital is located in the same country as the medical school and the medical school has filed complete and certified the Junior and Senior Year Clinical Rotations forms.

L6

DEV 1/91

STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY

PETE WILSON, Governor

Consumer Affairs

MEDICAL BOARD OF CALIFORNIA

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

(916) 920-6411

CERTIFICATE OF CLINICAL TRAINING

Complete one certificate for each clerkship, signed by the instructor or facility program director.

ONLY ROTATIONS IN WHICH THE APPLICANT PARTICIPATED IN DIRECT, HANDS-ON DIAGNOSIS OR TREATMENT OF PATIENTS, IN A CLINICAL SETTING MAY BE REPORTED ON THIS FORM. IF ROTATIONS WERE COMPLETED DURING THE JUNIOR OR SENIOR YEAR OF MEDICAL SCHOOL BUT DO NOT SATISFY THIS REQUIREMENT, THEY SHOULD NOT BE REPORTED ON THIS FORM BECAUSE THEY DO NOT SATISFY CLINICAL TRAINING REQUIREMENTS.

This is to certify that Michelle Brand (STUDENT'S NAME), a student of St. George's University School of Medicine (MEDICAL SCHOOL), participated in a clerkship offered by Alameda County Medical Center-Highland (NAME AND ADDRESS OF FACILITY) 1411 E. 31st St. Oakland, CA 94602 from 9/22/97 (DATE) 19 97 thru 11/14 (DATE) 19 97 in the clinical area of medicine subinternship (CLINICAL AREA). That the above named student successfully completed this clerkship on 11/14 (DATE) 19 97.

OKAY

_____ being duly sworn, says he is/was the individual instructor or program director for the student named above during the clerkship indicated and that he has carefully read and completed this form and that the statements made herein are strictly true in every respect.

This facility [X] is [ ] is not affiliated with a U.S. or foreign medical school.

Name of U.S. or foreign medical school if affiliated: UCSF, UC-Davis, St. George's

This facility [X] does have an ACGME-accredited residency program in the areas of: Medicine, Surgery, ER [ ] does not have an ACGME-accredited residency program.

OFFICIAL HOSPITAL SEAL

Theodore G. Rose, M.D. FACP
TYPE OR PRINT NAME OF INSTRUCTOR OR FACILITY PROGRAM DIRECTOR

1411 E. 31st St. Dept. of Medicine
Address: Number and Street

Oakland, CA 94602
City State Zip Code

PHONE NUMBER (510)437-4268

SIGNATURE OF INSTRUCTOR/FACILITY PROGRAM DIRECTOR

NOTE: IN ABSENCE OF OFFICIAL HOSPITAL SEAL, THE INSTRUCTOR OR PROGRAM DIRECTOR MUST SIGN THE FORM IN THE PRESENCE OF A NOTARY PUBLIC WHO AFFIXES HIS OFFICIAL NOTARY SEAL.

Signed and sworn to before me this _____ day of _____, 19____

NOTARY SEAL

NOTARY PUBLIC

ADDRESS

My commission expires _____

NOTE: This form may be omitted if all clinical training was done in the primary teaching hospital of the medical school and such hospital is located in the same country as the medical school and the medical school completes and certifies the Junior and Senior Year Clinical Rotations forms.

07A-100-L6 (REV. 7/91)

L6

State of California Department of Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
1426 HOWE AVENUE, SUITE 54, SACRAMENTO, CALIFORNIA 95825-3236
(916) 920-6411

CERTIFICATE OF CLINICAL TRAINING

Complete one certificate for each clerkship, signed by the instructor or facility program director.

ONLY ROTATIONS IN WHICH THE APPLICANT PARTICIPATED IN DIRECT, HANDS-ON DIAGNOSIS OR TREATMENT OF PATIENTS, IN A CLINICAL SETTING MAY BE REPORTED ON THIS FORM. IF ROTATIONS WERE COMPLETED DURING THE JUNIOR OR SENIOR YEAR OF MEDICAL SCHOOL BUT DO NOT SATISFY THIS REQUIREMENT, THEY SHOULD NOT BE REPORTED ON THIS FORM BECAUSE THEY DO NOT SATISFY CLINICAL TRAINING REQUIREMENTS.

This is to certify that Michelle Brand (STUDENT'S NAME), a student of St. George's University School of Medicine (MEDICAL SCHOOL), participated in a clerkship offered by Alameda County Medical Center-Highland (NAME AND ADDRESS OF FACILITY) 1411 E. 31st St. Oakland, CA 94602 from November 17 (DATE) 19 97 thru December 5, (DATE) 19 97 in the clinical area of Cardiology (CLINICAL AREA). That the above named student successfully completed this clerkship on December 5 (DATE) 19 97.

FE

Theodore G. Rose, Jr., M.D. being duly sworn, says X he is/was the individual instructor or program director for the student named above during the clerkship indicated and that X he has carefully read and completed this form and that the statements made herein are strictly true in every respect.

This facility XXX is ☐ is not affiliated with a U.S. or foreign medical school.

Name of U.S. or foreign medical school if affiliated: UCSF, UC-Davis, St. George's

This facility XX does have an ACGME-accredited residency program in the areas of Medicine, Surgery, ER ☐ does not have an ACGME-accredited residency program.

OFFICIAL HOSPITAL SEAL

Theodore G. Rose, M.D. FACP
TYPE OR PRINT NAME OF INSTRUCTOR OR FACILITY PROGRAM DIRECTOR

1411 E. 31st St. Dept. of Medicine
Address Number and Street

Oakland, CA 94602
City State Zip Code

PHONE NUMBER (510)437-4268

SIGNATURE OF INSTRUCTOR/FACILITY PROGRAM DIRECTOR

NOTE: IN ABSENCE OF OFFICIAL HOSPITAL SEAL, THE INSTRUCTOR OR PROGRAM DIRECTOR MUST SIGN THE FORM IN THE PRESENCE OF A NOTARY PUBLIC WHO AFFIXES HIS OFFICIAL NOTARY SEAL.

Signed and sworn to before me this _____ day of _____, 19____

NOTARY SEAL

NOTARY PUBLIC

ADDRESS

My commission expires

NOTE: This form may be omitted if all clinical training was done in the primary teaching hospital of the medical school and such hospital is located in the same country as the medical school and the medical school completes and certifies the Junior and Senior Year Clinical Rotations forms.

L6

STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY

PETE WILSON, Governor

MEDICAL BOARD OF CALIFORNIA
1426 HOWE AVENUE, SUITE 54, SACRAMENTO, CALIFORNIA 95825-3236
(916) 920-6411

CERTIFICATE OF CLINICAL TRAINING

Complete one certificate for each clerkship, signed by the instructor or facility program director.

ONLY ROTATIONS IN WHICH THE APPLICANT PARTICIPATED IN DIRECT, HANDS-ON DIAGNOSIS OR TREATMENT OF PATIENTS, IN A CLINICAL SETTING MAY BE REPORTED ON THIS FORM. IF ROTATIONS WERE COMPLETED DURING THE JUNIOR OR SENIOR YEAR OF MEDICAL SCHOOL BUT DO NOT SATISFY THIS REQUIREMENT, THEY SHOULD NOT BE REPORTED ON THIS FORM BECAUSE THEY DO NOT SATISFY CLINICAL TRAINING REQUIREMENTS.

This is to certify that Michelle Brand (STUDENT'S NAME), a student of St. George's University School of Medicine (MEDICAL SCHOOL), participated in a clerkship offered by Alameda County Medical Center-Highland (NAME AND ADDRESS OF FACILITY) 1411 E. 31st St. Oakland, CA 94602 from December 15, (DATE) 1997 thru January 16 (DATE) 1998 in the clinical area of Primary Care Medicine (CLINICAL AREA). That the above named student successfully completed this clerkship on January 16, (DATE) 1998.

Theodore G. Rose, Jr., M.D. being duly sworn, says X he is/was the individual instructor or program director for the student named above during the clerkship indicated and that X he has carefully read and completed this form and that the statements made herein are strictly true in every respect.

This facility XXX is / ☐ is not affiliated with a U.S. or foreign medical school.

Name of U.S. or foreign medical school if affiliated: UCSF, UC-Davis, St. George's

This facility XX does have an ACGME-accredited residency program in the areas of: Medicine, Surgery, ER ☐ does not have an ACGME-accredited residency program.

OFFICIAL HOSPITAL SEAL

Theodore G. Rose, M.D. FACP
TYPE OR PRINT NAME OF INSTRUCTOR OR FACILITY PROGRAM DIRECTOR

1411 E. 31st St., Dept. of Medicine
Address, Number and Street

Oakland, CA 94602
City State Zip Code

PHONE NUMBER (510)437-4268

SIGNATURE OF INSTRUCTOR/FACILITY PROGRAM DIRECTOR

NOTE: IN ABSENCE OF OFFICIAL HOSPITAL SEAL, THE INSTRUCTOR OR PROGRAM DIRECTOR MUST SIGN THE FORM IN THE PRESENCE OF A NOTARY PUBLIC WHO AFFIXES HIS OFFICIAL NOTARY SEAL.

Signed and sworn to before me this _____ day of _____, 19____

NOTARY SEAL

NOTARY PUBLIC

ADDRESS

My commission expires _____

NOTE: This form may be omitted if all clinical training was done in the primary teaching hospital of the medical school and such hospital is located in the same country as the medical school and the medical school completes and certifies the Junior and Senior Year Clinical Rotations forms.

07A-100-L6 (REV. 7/91)

L6

STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY

PETE WILSON, Governor

Consumer Affairs

MEDICAL BOARD OF CALIFORNIA

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

CERTIFICATE OF CLINICAL TRAINING

Complete one certificate for each clerkship, signed by the instructor or facility program director.

ONLY ROTATIONS IN WHICH THE APPLICANT PARTICIPATED IN DIRECT, HANDS-ON DIAGNOSIS OR TREATMENT OF PATIENTS, IN A CLINICAL SETTING MAY BE REPORTED ON THIS FORM. IF ROTATIONS WERE COMPLETED DURING THE JUNIOR OR SENIOR YEAR OF MEDICAL SCHOOL BUT DO NOT SATISFY THIS REQUIREMENT, THEY SHOULD NOT BE REPORTED ON THIS FORM BECAUSE THEY DO NOT SATISFY CLINICAL TRAINING REQUIREMENTS.

This is to certify that Michelle Brand (STUDENT'S NAME), a student of St. George's University School of Medicine (MEDICAL SCHOOL) participated in a clerkship offered by St. Joseph's Hospital Medical Center (NAME AND ADDRESS OF FACILITY) 703 Main St., Paterson, NJ 07503 from February 2 (DATE) 19 98 thru February 27 (DATE) 19 98 in the clinical area of Hematology-Oncology (CLINICAL AREA). That the above named student successfully completed this clerkship on February 27 (DATE) 19 98

Edmund O Rothschild MD being duly sworn, says he is/was the individual instructor or program director for the student named above during the clerkship indicated and that he has carefully read and completed this form and that the statements made herein are strictly true in every respect.

OKAY FP 97-98

This facility ☑ is ☐ is not affiliated with a U.S. or foreign medical school.

Name of U.S. or foreign medical school if affiliated: SGUSOM

This facility ☑ does have an ACGME-accredited residency program in the areas of: Hem/Onc

☐ does not have an ACGME-accredited residency program.

OFFICIAL HOSPITAL SEAL

Edmund O Rothschild MD (PRINT OR TYPE NAME OF INSTRUCTOR OR FACILITY PROGRAM DIRECTOR)

703 Main Street (Address Number and Street)

Paterson NJ 07503 (City, State, ZIP Code)

973 247 2765 (PHONE NUMBER)

(SIGNATURE OF INSTRUCTOR/FACILITY PROGRAM DIRECTOR)

NOTE: IN ABSENCE OF OFFICIAL HOSPITAL SEAL, THE INSTRUCTOR OR PROGRAM DIRECTOR MUST SIGN THE FORM IN THE PRESENCE OF A NOTARY PUBLIC WHO AFFIXES HIS OFFICIAL NOTARY SEAL.

Signed and sworn to before me this _____ day of _____, 19____

NOTARY SEAL

NOTARY PUBLIC

ADDRESS

My commission expires _____

NOTE: This form may be omitted if all clinical training was done in the primary teaching hospital of the medical school and such hospital is located in the same country as the medical school and the medical school completes and certifies the Junior and Senior Year Clinical Rotations form.

L6

07A-100-16 (REV. 7/91)

STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY

PETE WILSON, Governor

Consumer Affairs

MEDICAL BOARD OF CALIFORNIA

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

CERTIFICATE OF CLINICAL TRAINING

Complete one certificate for each clerkship, signed by the instructor or facility program director.

ONLY ROTATIONS IN WHICH THE APPLICANT PARTICIPATED IN DIRECT, HANDS-ON DIAGNOSIS OR TREATMENT OF PATIENTS, IN A CLINICAL SETTING MAY BE REPORTED ON THIS FORM. IF ROTATIONS WERE COMPLETED DURING THE JUNIOR OR SENIOR YEAR OF MEDICAL SCHOOL BUT DO NOT SATISFY THIS REQUIREMENT, THEY SHOULD NOT BE REPORTED ON THIS FORM BECAUSE THEY DO NOT SATISFY CLINICAL TRAINING REQUIREMENTS.

This is to certify that Michelle Brand (STUDENT'S NAME), a student of St. George's University School of Medicine (MEDICAL SCHOOL), participated in a clerkship offered by St. Joseph's Hospital Medical Center (NAME AND ADDRESS OF FACILITY) 703 Main St, Paterson, N.J. 07503 from March 2 (DATE) 19 98 thru March 27 (DATE) 19 98 in the clinical area of pediatric subinternship (CLINICAL AREA). That the above named student successfully completed this clerkship on March 27 (DATE) 19 98

Edmund O Rothschild MD being duly sworn, says he is/was the individual instructor or program director for the student named above during the clerkship indicated and that he has carefully read and completed this form and that the statements made herein are strictly true in every respect.

This facility [x] is [ ] is not affiliated with a U.S. or foreign medical school.

Name of U.S. or foreign medical school if affiliated: Mount Sinai, Sinai

This facility [x] does have an ACGME-accredited residency program in the areas of: Peds [ ] does not have an ACGME-accredited residency program.

OFFICIAL HOSPITAL SEAL

Edmund O Rothschild MD
TYPE OR PRINT NAME OF INSTRUCTOR OR FACILITY PROGRAM DIRECTOR

703 Main St.
Address (Number and Street)

Paterson NJ 07503
City State Zip Code

PHONE NUMBER 973 754 2765

SIGNATURE OF INSTRUCTOR/FACILITY PROGRAM DIRECTOR

NOTE: IN ABSENCE OF OFFICIAL HOSPITAL SEAL, THE INSTRUCTOR OR PROGRAM DIRECTOR MUST SIGN THE FORM IN THE PRESENCE OF A NOTARY PUBLIC WHO AFFIXES HIS OFFICIAL NOTARY SEAL.

Signed and sworn to before me this _____ day of _____, 19____

NOTARY SEAL

NOTARY PUBLIC

ADDRESS

My commission expires _____

NOTE: This form may be omitted if all clinical training was done in the primary teaching hospital of the medical school and such hospital is located in the same country as the medical school and the medical school completes and certifies the Junior and Senior Year Clinical Rotations form.

07A-100-L6 (REV. 7/91)

L6

STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY

PETE WILSON, Governor

State of California Department of Consumer Affairs

MEDICAL BOARD OF CALIFORNIA

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

CERTIFICATE OF CLINICAL TRAINING

Complete one certificate for each clerkship, signed by the instructor or facility program director.

ONLY ROTATIONS IN WHICH THE APPLICANT PARTICIPATED IN DIRECT, HANDS-ON DIAGNOSIS OR TREATMENT OF PATIENTS, IN A CLINICAL SETTING MAY BE REPORTED ON THIS FORM. IF ROTATIONS WERE COMPLETED DURING THE JUNIOR OR SENIOR YEAR OF MEDICAL SCHOOL BUT DO NOT SATISFY THIS REQUIREMENT, THEY SHOULD NOT BE REPORTED ON THIS FORM BECAUSE THEY DO NOT SATISFY CLINICAL TRAINING REQUIREMENTS.

This is to certify that Michelle Brand (STUDENT'S NAME), a student of St. George's University School of Medicine (MEDICAL SCHOOL), participated in a clerkship offered by St. Joseph's Hospital Medical Center (NAME AND ADDRESS OF FACILITY) 703 Main St., Paterson, N.J. 07503

from March 30 (DATE) 19 98 thru April 24 (DATE) 19 98 in the clinical area of Family Practice (CLINICAL AREA). That the above named student successfully completed this clerkship on April 24 (DATE) 19 98.

RAFAEL R. LUCILA being duly sworn, says he is/was the individual instructor or program director for the student named above during the clerkship indicated and that he has carefully read and completed this form and that the statements made herein are strictly true in every respect.

OKay!

This facility ☒ is ☐ is not affiliated with a U.S. or foreign medical school.

Name of U.S. or foreign medical school if affiliated: UMDNJ + Mt. Sinai School of Medicine

This facility ☒ does have an ACGME-accredited residency program in the areas of: _____

☐ does not have an ACGME-accredited residency program.

[OFFICIAL HOSPITAL SEAL]

RAFAEL R. LUCILA MD (TYPE OR PRINT NAME OF INSTRUCTOR OR FACILITY PROGRAM DIRECTOR)

716 BROAD ST. (Address, Number and Street)

CLIFTON N.J. 07013 (City, State, Zip Code)

WORK PHONE 973-754-4100

(SIGNATURE OF INSTRUCTOR/FACILITY PROGRAM DIRECTOR)

NOTE: IN ABSENCE OF OFFICIAL HOSPITAL SEAL, THE INSTRUCTOR OR PROGRAM DIRECTOR MUST SIGN THE FORM IN THE PRESENCE OF A NOTARY PUBLIC WHO AFFIXES HIS OFFICIAL NOTARY SEAL.

Signed and sworn to before me this 24th day of April, 1998

[NOTARY SEAL]

Shirley Kurdock (NOTARY PUBLIC)

SHIRLEY KURDOCK (NOTARY PUBLIC)

NOTARY PUBLIC OF NEW JERSEY

(ADDRESS)

My Commission Expires Mar. 18, 2002

My commission expires _____

NOTE: This form may be omitted if all clinical training was done in the primary teaching hospital of the medical school and such hospital is located in the same country as the medical school and the medical school completes and certifies the Junior and Senior Year Clinical Rotations forms.

07A-100-L6 (REV. 7/91)

L6

STATE OF CALIFORNIA — STATE AND CONSUMER SERVICES AGENCY

PETE WILSON, Governor

State of California Department of Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM
1426 Howe Avenue
Sacramento, CA 95825-3236
(916) 263-2499

CERTIFICATE OF CLINICAL TRAINING

(The completion of this form is required only of international medical school graduates.)

NOTE: THIS FORM MAY BE OMITTED IF ALL CLINICAL TRAINING WAS DONE IN THE PRIMARY TEACHING HOSPITAL OF THE MEDICAL SCHOOL AND SUCH HOSPITAL IS LOCATED IN THE SAME COUNTRY AS THE MEDICAL SCHOOL AND THE MEDICAL SCHOOL COMPLETES AND CERTIFIES THE OFFICIAL BREAKDOWN OF UNDERGRADUATE CLINICAL CLERKSHIPS FORMS, FORMS L5A/B.

Complete ONE certificate for EACH clerkship, signed by the instructor or facility program director.

ONLY UNDERGRADUATE CLINICAL CLERKSHIPS IN WHICH THE APPLICANT PARTICIPATED IN DIRECT, HANDS-ON DIAGNOSIS OR TREATMENT OF PATIENTS IN A CLINICAL SETTING SHOULD BE REPORTED ON THIS FORM. ANY CLINICAL CLERKSHIPS COMPLETED THAT DO NOT MEET THE ABOVE CRITERIA SHOULD NOT BE REPORTED ON THIS FORM AS THEY WILL NOT SATISFY CALIFORNIA'S CLINICAL TRAINING REQUIREMENTS.

This is to certify that MICHALE BRAND (STUDENT'S NAME), a student of St. George's University School of Medicine (MEDICAL SCHOOL), completed a clerkship offered by Alameda County Medical Center--Highland Hospital Campus (NAME AND ADDRESS OF FACILITY) 1411 E. 31st Street, Oakland, CA 94602 from 4/07 (DATE), 1998 through 5/15 (DATE), 1998 in the clinical area of RADIOLOGY (CLINICAL AREA).

FE

Theodore G. Rose, Jr., M.D., FACP *being duly sworn, says* X *he is/was the individual instructor or program director for the student named above during the clerkship indicated and that* X *he has carefully read and completed this form and that the statements made herein are strictly true in every respect.*

This facility ☒ is ☐ is not affiliated with a U.S. or International school

Name of U.S. or International medical school, if affiliated: UCSF, UC Davis, St. George's University

This facility ☒ does have an ACGME-accredited residency program in the areas of: Medicine, Surgery, ER
☐ does not have an ACGME-accredited residency program.

Official Hospital Seal

Theodore G. Rose, Jr., M.D., FACP
TYPE OR PRINT NAME OF INSTRUCTOR OR FACILITY PROGRAM DIRECTOR

Dept. of Medicine, Ala. County Med. Center, Highland Campus
ADDRESS: NUMBER AND STREET 1411 E. 31st Street

Oakland — CA — 94602
CITY — STATE — ZIP CODE

(510) 437-4268
TELEPHONE NUMBER

SIGNATURE OF INSTRUCTOR/FACILITY PROGRAM DIRECTOR

NOTE: IN ABSENCE OF AN OFFICIAL HOSPITAL SEAL, THE INSTRUCTOR OR PROGRAM DIRECTOR MUST SIGN THIS FORM IN THE PRESENCE OF A NOTARY PUBLIC WHO AFFIXES HIS/HER OFFICIAL NOTARY SEAL.

Signed and sworn to before me this _____ day of _____, 19 ____

Notary Seal

NOTARY PUBLIC

ADDRESS

My Commission Expires

07A-1100-L6(Rev. 2/97)

L6

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

State of California Department of Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM
1426 Howe Avenue
Sacramento, CA 95825-3236
(916) 263-2499

CERTIFICATE OF CLINICAL TRAINING

(The completion of this form is required only of international medical school graduates.)

NOTE: THIS FORM MAY BE OMITTED IF ALL CLINICAL TRAINING WAS DONE IN THE PRIMARY TEACHING HOSPITAL OF THE MEDICAL SCHOOL AND SUCH HOSPITAL IS LOCATED IN THE SAME COUN AS THE MEDICAL SCHOOL AND THE MEDICAL SCHOOL COMPLETES AND CERTIFIES THE OFFICIAL BREAKDOWN OF UNDERGRADUATE CLINICAL CLERKSHIPS FORMS, FORMS L6A/B.

Complete ONE certificate for EACH clerkship, signed by the instructor or facility program director.

ONLY UNDERGRADUATE CLINICAL CLERKSHIPS IN WHICH THE APPLICANT PARTICIPATED IN DIRECT, HANDS-ON DIAGNOSIS OR TREATMENT OF PATIENTS IN A CLINICAL SETTING SHOULD BE REPORTED ON THIS FORM. ANY CLINICAL CLERKSHIPS COMPLETED THAT DO NOT MEET THE ABOVE CRITERIA SHOULD NOT BE REPORTED ON THIS FORM AS THEY WILL NOT SATISFY CALIFORNIA'S CLINICAL TRAINING REQUIREMENTS.

This is to certify that Michelle Brand (STUDENT'S NAME), a student of St. George's University School of Medicine (MEDICAL SCHOOL), completed a clerkship offered by St. Joseph's Hospital Medical Center (NAME AND ADDRESS OF FACILITY) 703 Main St., Paterson, NJ. 07503 from May 18 (DATE), 19 98 through June 5 (DATE), 19 98 in the clinical area of Infectious Disease (CLINICAL AREA).

Edmund O Rothschild MD *being duly sworn, says he is/was the individual instructor or program director for the student named above during the clerkship indicated and that he has carefully read and completed this form and that the statements made herein are strictly true in every respect.*

This facility ☒ is affiliated with a U.S. or International school
☐ is not
Name of U.S. or International medical school, if affiliated: Mount Sinai

This facility ☒ does have an ACGME-accredited residency program in the areas of: medicine
☐ does not have an ACGME-accredited residency program.

Official Hospital Seal

Edmund O Rothschild MD
TYPE OR PRINT NAME OF INSTRUCTOR OR FACILITY PROGRAM DIRECTOR

703 Main Street
ADDRESS: NUMBER AND STREET

Paterson NJ 07503
CITY STATE ZIP CODE

973-754-2765
TELEPHONE NUMBER

SIGNATURE OF INSTRUCTOR/FACILITY PROGRAM DIRECTOR

NOTE: IN ABSENCE OF AN OFFICIAL HOSPITAL SEAL, THE INSTRUCTOR OR PROGRAM DIRECTOR MUST SIGN THIS FORM IN THE PRESENCE OF A NOTARY PUBLIC WHO AFFIXES HIS/HER OFFICIAL NOTARY SEAL.

Signed and sworn to before me this _____ day of _____, 19 ____.

Notary Seal

NOTARY PUBLIC

ADDRESS

My Commission Expires _____

07A-100-L6 (Rev. 2/97)

L6

STATE OF CALIFORNIA

DEPARTMENT OF CONSUMER AFFAIRS

Department of Consumer Affairs

RECEIPT

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

Name:	WOLFE, MICHELLE GDALIA
Transaction Date:	12/25/2013 13:32
Application Number:	
Complaint Number:	
License Type:	8002
License Number:	77816
Payment Description:	Physician's and Surgeon's Renewal
Fee Paid: (US $)	808.00
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:	**77816**
File Number:	
Application:	**Physician's and Surgeon's Renewal**
Application Number:	
Application Date:	**12/25/2013 (mm/dd/yyyy)**

Personal Detail

First Name:	**MICHELLE**
Middle Name:	**GDALIA**
Last Name:	**WOLFE**
Birthdate:	
Gender:	**Female**

Addresses

License Related Addresses

Confidential Address (Optional)

Name:

Address:

License Specific Public/Mailing Address (Required)

Name:	**WOLFE, MICHELLE GDALIA**
Address:	**UCSF SFGH FMLY PRAC RESIDENCY** **1001 POTRERO AVE BLDG 80-83** **SAN FRANCISCO, CA** **94110**
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:	**No**

Attachments

Physician Survey

Are you retired?	**No**
Activities in Medicine	**Administration - 20-29 Hours**
	Other - None
	Patient Care - 10-19 Hours
	Research - None
	Teaching - 1-9 Hours
	Telemedicine - None
Patient Care Practice Location	**Zip: 94592 County: SOLANO**
Telemedicine Practice Location	**Zip: County:**
Patient Care Secondary Practice Location	**Zip: County:**
Telemedicine Secondary Practice Location	**Zip: County:**
Current Training Status	**Not in Training**
Areas of Practice	**Family Medicine - Primary**
Board Certifications	**American Board of Family Medicine - Family Medicine**
Postgraduate Training Years	**4 Years**
Cultural Background	**Decline to State**
Foreign Language Proficiency	**None**
Web Site Profile	**Cultural Background - No**
	Foreign Language Proficiency - No
	Gender - No

E-mail:

Fees

Biennial Renewal Fee	**$783.00**
Steven M. Thompson Physician Corps Loan Repayment Program	**$25.00**
Total Amount Due:	**$808.00**

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

DEPARTMENT OF CONSUMER AFFAIRS

Department of Consumer Affairs

RECEIPT

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

Name:	WOLFE, MICHELLE GDALIA
Transaction Date:	11/12/2015 18:16
Application Number:	
Complaint Number:	
License Type:	8002
License Number:	77816
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:	**77816**
File Number:	
Application:	**Physician's and Surgeon's Renewal**
Application Number:	
Application Date:	**11/12/2015 (mm/dd/yyyy)**

Application Questions

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

Personal Detail

First Name:	**MICHELLE**
Middle Name:	**GDALIA**
Last Name:	**WOLFE**
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 - 10-19 Hours**
	Patient Care - 1-9 Hours
	Research - 1-9 Hours
	Teaching - 1-9 Hours
	Telemedicine - None
Patient Care Practice Location	**Zip: 94530 County: CONTRA COSTA**
Telemedicine Practice Location	**Zip: County:**
Patient Care Secondary Practice Location	**Zip: County:**
Telemedicine Secondary Practice Location	**Zip: County:**
Current Training Status	**Not in Training**
Areas of Practice	**Family Medicine - Primary**
Board Certifications	**American Board of Family Medicine - Family Medicine**
Postgraduate Training Years	**4 Years**
Cultural Background	**White**
Web Site Profile	**Cultural Background - No**
	Foreign Language Proficiency - No
	Gender - No

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: