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

DEPARTMENT OF Consumer Affairs

BOARD OF MEDICAL QUALITY ASSURANCE
1430 HOWE AVENUE
SACRAMENTO, CA 95825
(916) 920-6411

007523

APPLICATION FOR PHYSICIAN AND SURGEON'S EXAMINATION OR LICENSURE

003307

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

002039

BMQA USE ONLY

1. Name

2. Other names you have used

3. Social Security Number

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

City | State | Zip Code | Country

5. Telephone Number: Home | Work

6. Date of Birth Mo/Day/Yr

7. Sex: ☐ Female ☑ Male

8. Are you a U.S. citizen? ☐ Yes ☑ No

Submit a certified copy of birth certificate, Certificate of Naturalization, Declaration of Intention to become U.S. citizen (INS Form I-508), Visa, document or license to practice medicine.

9. Have you ever filed an application for examination or licensure in California? ☑ Yes ☐ No

10. List name and address of all colleges or universities attended other than schools where professional medical instruction was received. Submit an official transcript from each school attended.

Name	Address	Period of Attendance From (Mo/Yr)	To (Mo/Yr)
Ateneo de Manila Univ	Loyola Heights, Quezon City, Philippines	[illegible]	[illegible]

NON-MEDICAL EDUCATION

11. List name and address of all schools where professional medical instruction was received. Submit an original Certificate of Medical Education and official transcripts from each school attended.

Name	Address	Place Where Instruction Received	Period of Attendance From (Mo/Yr)	To (Mo/Yr)
[illegible]	Quezon City, Philippines	Quezon City, Philippines	[illegible]	[illegible]

MEDICAL EDUCATION

CMB TRANS.

12. Doctor of Medicine Degree granted by: (submit original medical diploma and a photocopy)

Name of Medical School | Address of Medical School | Exact Date of Issuance
[illegible] Medical Center | Quezon City, Philippines | [illegible]

School Code

L1A

07A-100

BOARD USE ONLY

13. Have you taken any of the following written examinations: National Boards, ECFMG, FMGEMS, FLEX, MSKP, MCAT, other related medical competency examinations? ☑ Yes ☐ No

If YES, list name, location, date and result of examination. Submit certification of scores from each examination agency.

WRITTEN EXAMINATION

Name	Location	Date	Result
[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]

14. Have you received qualifying postgraduate training in U.S. or Canadian facilities? ☑ Yes ☐ No

If YES, list name and address of all facilities. Submit an original Certificate of Completion of ACGME Postgraduate Training (Form 13) from each facility.

POSTGRADUATE TRAINING

Name	Address	Type of Service	Period of Attendance From (Mo/Yr)	Period of Attendance To (Mo/Yr)
[illegible]	Newark, New Jersey	[illegible]	[illegible]	[illegible]
[illegible]	New York, New York	[illegible]	[illegible]	[illegible]

15. Have you been licensed to practice medicine in any state or country? ☑ Yes ☐ No

If YES, list state or country, license number, date issued and dates of practice in issuing agency's jurisdiction for each. Submit a Letter of Good Standing from each state in which you are licensed or have been licensed.

LICENSE DATA

LGS CE

State or Country	License Number	Date of Issuance	Dates of Practice in Issuing Agency's Jurisdiction From (Mo/Yr)	To (Mo/Yr)
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Washington	[illegible]	[illegible]	[illegible]	[illegible]
New York	[illegible]	[illegible]	[illegible]	Present

16. Has any disciplinary action ever been taken regarding any healing arts license which you now hold or have ever held? (Include any disciplinary action by the U.S. Military, U.S. Public Health Service or other U.S. federal governmental entity.)

Yes No If yes, give details below

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State	Date	Charge	Disposition

008036

008255

L1B

BPA-100

17. Have you ever been denied a license, permission to practice medicine or [illegible] healing arts, or permission to take an examination in any state, country, or U.S. federal jurisdiction?

If yes, give details below:

State or Country	Date of Denial	Reason for Denial

18. Have you been charged with unprofessional conduct or any other unlawful activity by any healing arts licensing authority or by the U.S. military and are awaiting final disposition by that body?

If yes, please explain on a separate sheet of paper.

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

If yes, please explain on a separate sheet of paper.

20. Have you ever had [illegible] denied, suspended or revoked, or resigned from a medical staff in lieu of [illegible] action?

If yes, please explain on a separate sheet of paper.

21. Are you now, [illegible] addicted to or treated for addiction to controlled substances such as narcotics or alcohol?

If yes, please explain on a separate sheet of paper.

22. Have you ever been convicted of, or pled nolo contendere to a violation of any federal, state or local law relating to the manufacture, distribution or dispensing of controlled substances, or to their addiction?

If yes, give details below:

Violation or [illegible]	Date	Penalty or Disposition

23. Have you ever been convicted of, or pled nolo contendere to any offense, misdemeanor or felony of any state, the United States, or a foreign country? (except violations of traffic laws resulting in fines of $[illegible] or less.)

If yes, give details below

Violation or [illegible]	Date	Penalty or Disposition

You [illegible] Penal Code or under any other provision [illegible]

Disclosure [illegible] mandatory. Section 30 of the Business and Professions Code and Pub. L. 94-455 (42 U.S.C. [illegible]) [illegible] your social security number. [illegible] security number will be used exclusively for [illegible]. If you fail to disclose your social security number, you will be reported to the Franchise Tax Board, which may assess a $100 penalty against you.

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I hereby declare under penalty of perjury under the laws of the State of California, that the photo of myself attached hereto, was taken

on or about ________ 19__

my age then being ____ years

color of hair ________

color of eyes ________

height ____ ft. ____ in.

weight ____ lbs.

identifying marks ________

NOTE: All items in this application are mandatory; none are voluntary. Failure to provide any of the requested information will result in the application being rejected as incomplete. The information provided will be used to determine qualification for licensure per Section 2000 of the Business and Professions Code which authorizes the collection of this information. Information regarding the issuance or denial of a license by the Board may be transmitted to any other medical licensing authority or the Federation of State Medical Boards. Applicants have the right to review their application subject to the provisions of the Information Practices Act. The Program Manager of the Division of Licensing is the custodian of records.

STATE OF New York }

COUNTY OF Orange }

________________ being duly sworn, says ...he is the person referred to in the foregoing application for a physician and surgeon's certificate in California and that ...he has carefully read and thoroughly understood all the requirements therein and that the statements made herein and all attachments are true and correct under penalty of perjury under the laws of the State of California.

He requests that the Division of Licensing, Board of Medical Quality Assurance, initiate a review of the records to determine their eligibility for examination, postgraduate training or licensure in California. In making this request, ...he authorizes the release of any information or records held by any individual or agency, relative to their training and qualifications as a physician and surgeon, upon request by the Board for use in evaluating their file.

[signature] MD
Signature of applicant in FULL (Do not use INITIALS ONLY)

Signed and sworn to before me this 18th day of JANUARY 19 90

Signature of Notary Public [signature]

SEAL Address Middletown, N.Y. 10940

JUDITH ANN WOLKOFF
Notary Public, State of New York
Sullivan County Clerk's #3138
My commission expires ________ Commission Expires April 30, 1990

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

DEPARTMENT OF CONSUMER AFFAIRS

BOARD OF MEDICAL QUALITY ASSURANCE

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

CERTIFICATE OF MEDICAL EDUCATION

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

This certifies that REYNALDO L. MANABAT [illegible]
of [illegible] Calocan City [illegible] enrolled in University of the East-Ramon Magsaysay Memorial Medical Center
Aurora Blvd., Quezon City, Phil. on the [illegible] day of June 19[illegible]
and was given the following credits on enrollment:

Premedical Education: Two years of preprofessional postsecondary education including the subjects of physics, chemistry and biology (Business and Professions Code Section 2089).

[illegible] De Manila University — 1970 – 1974

Advanced Credits: Credit previously obtained at an approved medical school.

[illegible] (MEDICAL SCHOOL) — (TOTAL CREDIT)

The undersigned further certifies that the records of this institution show that he attended in this institution [illegible] courses of [illegible] weeks each, completing at least 4,000 hours of which at least 80 percent [illegible] in the subjects set forth hereunder (Business and Professions Code Section 2089), and that [illegible] the degree Bachelor/Doctor of Medicine by [illegible] medical school on the [illegible] day of April 19[illegible]

[illegible] clerkship in the [illegible]

[illegible]

Surgery including Orthopedic Surgery – 389

Pediatrics – 114

Psychiatry – 156

Ophthalmology – 204

Obstetrics – 216

[illegible] Included in Surgery [illegible] Included in Pediatrics

Signed and the official seal affixed this [illegible] day of January 19 92

By [illegible]

Medical School Seal MUST be imprinted partially on the Photograph.

TRANSCRIPTS OF PREMEDICAL EDUCATION, ADVANCED CREDITS, AND MEDICAL SCHOOL CREDITS MUST BE SUPPLIED WITH THIS CERTIFICATE.

[illegible]

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

DEPARTMENT OF CONSUMER AFFAIRS

BOARD OF MEDICAL QUALITY ASSURANCE

1430 HOWE AVENUE, SACRAMENTO, CALIFORNIA [illegible]
(916) [illegible]

CERTIFICATE OF MEDICAL EDUCATION

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

This certifies that [illegible]
of [illegible] enrolled in University of the [illegible] [illegible]
Aurora Blvd., Quezon City, [illegible] on the 2nd day of June 19 72

[illegible] the following credits on enrollment:

Premedical Education: Two years of preprofessional postsecondary education, including the subjects of physics, chemistry, and biology (Business and Professions Code Section 2089).

[illegible] University — 1970 – 1974

Advanced Credit: Credit previously obtained at an approved medical school.

The undersigned further certifies that the records of this institution show that [illegible] he attended in this institution [illegible] of resident instruction of [illegible] 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

[illegible] was granted the degree [illegible] Doctor of Medicine by

[illegible] withdrew from

the above mentioned medical school on the [illegible] day of [illegible] 19 72.

[illegible]

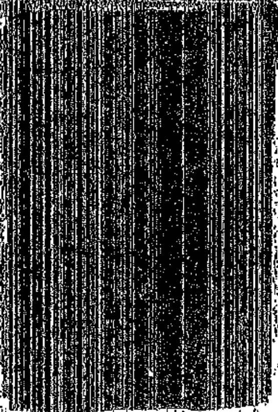
[illegible]

**Included in Surgery [illegible]

Signed and the college seal affixed this [illegible] day of January, 19 92

by [illegible] MAGDALENO [illegible]

Medical School Seal MUST be Imprinted Partially On the Photograph.



TRANSCRIPTS OF PREMEDICAL EDUCATION, ADVANCED CREDITS, AND MEDICAL SCHOOL CREDITS MUST BE SUPPLIED WITH THIS CERTIFICATE

[illegible]

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

BOARD OF MEDICAL QUALITY ASSURANCE

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

CERTIFICATE OF COMPLETION OF ACGME POSTGRADUATE TRAINING

To be completed by the facility for every medical school graduate completing postgraduate training in the United States or Canada. Do not complete if photograph of applicant is not attached below. Please type or print.

This is to certify that [illegible] Reynaldo Makabali
(Name of applicant)

a graduate of UERM Memorial Medical Center, Quezon City, Philippines
(Name of medical school)

(has) commenced an approved postgraduate training program at UMDNJ-New Jersey Medical School
185 S. Orange Ave., Newark, NJ 07103 in Pediatrics
(Field)

on [illegible] 19[illegible] and completed [illegible] on June 30 19[illegible] [illegible] [illegible] months of [illegible] clinical [illegible] approved by the Accreditation Council for Graduate Medical Education (ACGME) or the Coordinating Council of Medical Education of the Canadian Medical Association (CCME) in the following rotations:

[illegible]

ROTATION: Pediatrics
LENGTH OF ROTATION: [illegible] 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 CCME to offer the type and level of training completed by the applicant and that the applicant was trained in an approved ACGME or CCME program position.

NAME: Dennis P. Quinlan, M.D.
DIRECTOR OF MEDICAL EDUCATION
(HOSPITAL SEAL) UMDNJ - NJMS
ADDRESS: 185 So. Orange Ave., B-646
Newark, New Jersey 07103

PHONE NUMBER: 201/456-6049

DATE: March 5, 1993

SIGNATURE: [signature]

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STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY

BOARD OF MEDICAL QUALITY ASSURANCE

CERTIFICATE OF COMPLETION OF ACGME POSTGRADUATE TRAINING

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

This is to certify [illegible] Reynaldo [illegible]

Graduate of University of the East – Ramon Magsaysay Medical Center

[illegible] Bronx Lebanon Hospital Center [illegible]

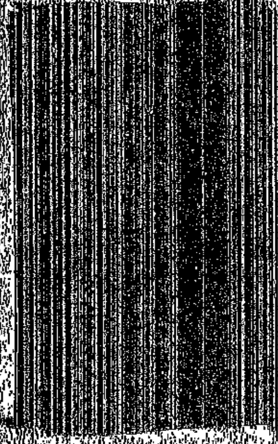
[illegible] [illegible] July [illegible] June 30 [illegible]

[illegible] Pediatrics

[illegible]

ROTATION | LENGTH OF ROTATION

[illegible]



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

NAME Milton A. Gumbs, M.D.

Director of Medical Education

ADDRESS 1276 Fulton Avenue

Bronx, New York 10456

PHONE NUMBER (212) [illegible]

DATE January [illegible]

SIGNATURE [signature]

13

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

1. Medicine	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible] M.D.
2. Surgery	[illegible]	[illegible]	[illegible]	36	[illegible]	[illegible] M.D.
3. Obstetrics and Gynecology	[illegible]	[illegible]	3/17/78	[illegible]	[illegible]	[illegible] M.D.
4. Pediatrics	[illegible]	[illegible]	[illegible]	36	[illegible]	[illegible] M.D.
5. E.E.N.T.	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible] M.D.
6. Psychiatry	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible] M.D.
7. Neurology	[illegible]	[illegible]	[illegible]	[illegible]	[illegible] M.D.	[illegible]
8.						

1Eh100, 000000

REPORT FOR SENIOR YEAR CLINICAL ROTATIONS

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

LICENSEE NAME	LICENSE NO.	EXPIRATION DATE	AMOUNT DUE NOW	AMOUNT DUE IF POSTMARKED AFTER OCTOBER 30, 2014
MAKABALI, REYNALDO L	A51157	09/30/14	$820.00	$898.00

LICENSEE MUST CHECK CORRECT BOXES

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

"D" **SIGNATURE REQUIRED**

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

Signature ______________ Date 6/20/15

ENTER YOUR PHONE NUMBER FOR REFERENCE:

630101000001000020005115760109301400082000000089800

CHANGE OF MAILING ADDRESS **MAKABALI, REYNALDO L** **A51157**

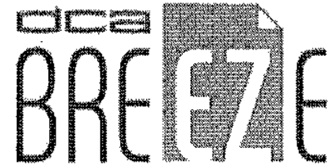
06242014 20001741 20010018

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

City State Zip

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

City State Zip



Department of Consumer Affairs

RECEIPT

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

Name:	MAKABALI, REYNALDO LIMPIN
Transaction Date:	08/23/2016 01:53
Application Number:	
Complaint Number:	
License Type:	8002
License Number:	51157
Payment Description:	Physician's and Surgeon's Renewal
Fee Paid: (US $)	845.00
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:	**51157**
File Number:	
Application:	**Physician's and Surgeon's Renewal**
Application Number:	
Application Date:	**08/23/2016 (mm/dd/yyyy)**

Application Questions

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

Personal Detail

First Name:	**REYNALDO**
Middle Name:	**LIMPIN**
Last Name:	**MAKABALI**
Birthdate:	****/**/******
Gender:	**Male**

Addresses

License Related Addresses

Address of Record (Required)

Warning: **In order to protect your privacy and identity, address will not be displayed.**

Confidential Address

Warning: **In order to protect your privacy and identity, address will not be displayed.**

Financial Interest Disclosure Summary

Health-Related Facility Name:	**reynaldo makabali md inc**
Address:	**2400 w 7th st los angeles ca 90057**

Questions

Since you last renewed your license, have you had any license disciplined by a government agency or other disciplinary body, or, have you been convicted of any crime in any state, the U.S.A. and its territories, military court or a foreign country?	**No**

Have you successfully completed, and can document, the mandatory courses and hours of CME within the last two years, or you meet the conditions which would exempt you from all or part of the CME requirements, or you hold a permanent CME waiver?	**Yes**
I certify under penalty of perjury, under the laws of California, that I have disclosed the names of those health-related facilities in which I or my family have a financial interest OR I declare under penalty of perjury I have no financial interests to disclose.	**Yes**

Family Physician Training Program Voluntary Fee

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

Attachments

Physician Survey

Are you retired?	**No**
Activities in Medicine	**Administration - None**
	Other - 20-29 Hours
	Patient Care - 40+ Hours
	Research - None
	Teaching - None
	Telemedicine - None
Patient Care Practice Location	**Zip: 90057 County: LOS ANGELES**
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	**General Practice - Secondary**
	Other - Not Listed - Secondary
	Pediatrics - Primary
Board Certifications	**American Board of Pediatrics - Pediatrics**
Postgraduate Training Years	**3 Years**
Cultural Background	**Filipino**
Foreign Language Proficiency	**African Languages**

1471942415695

German

Spanish

Tagalog

Web Site Profile

Cultural Background - No

Foreign Language Proficiency - No

Gender - Yes

E-mail:

Fees

Biennial Renewal Fee	**$783.00**
DUE TO CURES FUND	**$12.00**
Steven M. Thompson Physician Corps Loan Repayment Program	**$25.00**
Family Physician Training Fee	**$25.00**
Total Amount Due:	**$845.00**

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: