STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY

DEPARTMENT OF CONSUMER AFFAIRS

MEDICAL BOARD OF CALIFORNIA
1426 Howe Avenue, Suite 54, Sacramento, CA 95825-3236
(916) 920-6400

RICHARD DEUKMEJIAN, Governor

APPLICATION FOR PHYSICIAN AND SURGEON'S EXAMINATION OR LICENSURE

00 3 79 8

007267 869-91

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 neatly. When space provided is insufficient, attach additional sheets of paper.

1. Name: Last MALTZER First MARK Middle CHARLES

2. Other names you have used (include maiden name): NONE

3. Social Security Number

4. Address: Number and Street/Rural Route (Include apartment number if any) 505 BEDFORD COURT
City ROSEVILLE State CALIFORNIA Zip Code 95661 Country USA

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
If you are not a U.S. citizen or did not receive your Certificate of Naturalization, Declaration of Intent to become a U.S. citizen or did not receive your restricted license/practice medicine between country.

9. Have you ever filed an application for examination or licensure in California? ☐ Yes ☒ No
If Yes, give date of previous application:

10. Listing 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	
		Month/Year	To (Month/Year)
OBERLIN COLLEGE	OBERLIN, OHIO	9/66	6/70

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

Course	Yes	No	Name of College or University
Chemistry	✓		OBERLIN COLLEGE
Physics	✓		OBERLIN COLLEGE
Biology (Zoology)	✓		OBERLIN COLLEGE

11. List name and address of all schools where professional medical instruction was received. Submit original Certificate of Medical Education (Form L-2) and official transcripts from each school attended.

Name	Address	Place Where Instruction Received	Period of Attendance	
			Month/Year	To (Month/Year)
U. OF MICHIGAN	1301 CATHERINE ANN ARBOR, MI 48109	ANN ARBOR, MI	9/72	6/76

12. Doctor of Medicine Degree received by: (submitting official medical diploma and a photocopy; Note: a U.S. diploma may in lieu of original, submit an officially certified photocopy that has the school seal affixed on the signature of the registrar certifying authority).

Name of Medical School: UNIVERSITY OF MICHIGAN MEDICAL SCHOOL

Address of Medical School: 1301 CATHERINE ANN ARBOR, MI 48109

Date of Diploma: MAY 26, 1976

School Code: 7976

MEDICAL EDUCATION: CME ☐ TRANS ☐

L1A

07A-160 (Rev. 1/89)

13. Have you taken any of the following written examinations: National Boards, other State Boards, FLEX, ECFMG Certification? ☒ Yes ☐ No

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

Name	Location	Date	Result
NATIONAL BOARDS I	ANN ARBOR, MI	06/74	
NATIONAL BOARDS II	ANN ARBOR, MI	09/75	
NATIONAL BOARDS III	NEW HAVEN, CT	03/77	

14. Have you satisfactorily completed at least one year of qualifying postgraduate training in U.S. or Canadian facilities? ☒ Yes ☐ No

If YES, list name and address of facilities. Submit an original Certificate of Completion of ACGME Postgraduate Training Form (3) from each facility.

Name	Address	Type of Service	Dates of Attendance From (Mo/Yr)	To (Mo/Yr)
YALE NEW HAVEN HOSP	20 YORK ST NEW HAVEN, CT 06510	RESIDENCY OB/GYN	7/74	6/80

14A. Have you ever withdrawn from or been suspended, dismissed or expelled from a medical school or postgraduate training program? If yes, please explain on a separate sheet of paper. ☐ Yes ☐ No

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

If YES, list state or country, license number, date issued, dates of practice, licensing agency's jurisdiction for each. Submit copies of Good Standing Forms each state in which you are licensed or have been licensed.

State or Country	License Number	Date of Issuance	Dates of Practice / Licensing Agency's Jurisdiction From (Mo/Year)	To (Mo/Yr)	LGS	CE
CONNECTICUT	26,801	11-26-79	12/80	4/82	☒	☐
MICHIGAN	042011	12-27-80	2/81	3/81	☒	☐
FLORIDA	ME 0037317	12-10-81	4/82	PRESENT	☒	☐

16. Have any disciplinary actions ever been filed or taken regarding any healing arts license which you now hold or have held? Include any disciplinary actions by the U.S. Military, U.S. Public Health Service or other U.S. federal government entity.

If yes, give details below: ☐ Yes ☐ No

State	Date	Charge	Disposition

07A-100

L1B

BDA. USE ONLY

17. Have you ever been denied a license, permission to practice medicine or any other healing arts, or permission to take an examination in any state, country, or U.S. federal jurisdiction? Yes No

If yes, give details below:

State or Country	Date of Denial	Reason for Denial

LICENSE DATA

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 the board? You must also list any pending actions or accusations.

If yes, please explain on a separate sheet of paper. Yes No

19. Have you ever voluntarily surrendered a license to practice in the healing arts in another state? Yes No

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

20. Have you ever had staff privileges in a hospital denied, withdrawn or revoked, or resigned from a medical staff in lieu of disciplinary action?

If yes, please explain on a separate sheet of paper. Yes No

21. Are you now, or were you in the past, addicted to or treated for addiction to controlled substances, such as narcotics or alcohol? Yes No

GENERAL DATA

22. Have you ever been convicted of, or did you plead nolo contendere to a violation of any federal, state or local law relating to the manufacture, distribution or dispensing of controlled substances? Yes No

If yes, give details below:

Violation and Location	Date	Penalty or Disposition

23. Have you ever been convicted of, or did you plead nolo contendere to any felony, misdemeanor or felony of any state, the United States, or a foreign country? (except violations of traffic laws resulting in fines of $75.00 or less.) Yes No

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

If yes, give details below:

Violation and Location	Date	Penalty or Disposition

"Disclosure of your social security number is mandatory. Section 19 of the Business and Professions Code and Pub. L. 94-455 (42 U.S.C.A. 405 (c) (2) (C)) authorizes collection of your social security number. Your social security number will be used exclusively for tax enforcement purposes. If you fail to disclose your social security number, you will be reported to the Franchise Tax Board, which may assess a $100 penalty against you."

L1C

07A-150

TOP

BOTTOM

Black and White

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 ____

my age then being ____ years

color of hair ____

color of eyes ____

height ____ ft. ____ in.

weight ____ lbs.

identifying marks ____

NOTE: All items of 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 2080 of the Business and Professions Code which authorizes the collection of this information. Information regarding the issuance or denial of licenses 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 California

COUNTY OF Sacramento

Donald L. Fisher 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 understands all the requirements therein and that the statements made herein and attachments are true and correct, under penalty of perjury under the laws of the State of California.

He requests that the Division of Licensing, Medical Board of California, initiate a review of the records to determine their eligibility for examination, postgraduate training or licensure in California. In making this request, he authorizes 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.

Donald L. Fisher M.D.

Sign each applicant in FULL (Initials OK)

Signed and sworn to before me this 2ND day of October, 1990

Signature of Notary Public [signature]

(SEAL) Address (Street) Powerline Rd. Sacramento, CA 95826

OFFICIAL SEAL
DONALD L. FISHER
NOTARY PUBLIC-CALIFORNIA
SACRAMENTO COUNTY
My Comm. Expires JUL 1, 1994

My commission expires 7/1/94

L1D

07A-166

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

DEPARTMENT OF Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
1426 HOWE AVENUE, SUITE 54, SACRAMENTO, CALIFORNIA 95825-3236
(916) 920-6441

CERTIFICATE OF MEDICAL EDUCATION

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

This certifies that MARK CHARLES MALTZER (FULL NAME OF APPLICANT)

of HUNTINGTON WOODS, MICHIGAN (ADDRESS WHEN ENROLLED) enrolled in THE UNIVERSITY OF MICHIGAN MEDICAL SCHOOL (NAME OF MEDICAL SCHOOL)

ANN ARBOR, MICHIGAN (LOCATION) on the 28TH day of AUGUST (MONTH) 1972 (DATE)

and was granted the following credit on enrollment:

Premedical Education: Two years of professional pre-secondary education, including the subjects of physics, chemistry, and biology (Business and Professions Code Section 2089).

(EDUCATIONAL INSTITUTION) (DATES)

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

(MEDICAL SCHOOL) (NO. CREDITS) (DATES)

The undersigned hereby certifies that the records of this institution show that he attended this institution A YEAR OF (STUDY NUMBER) course of resident instruction of 33 MONTHS (NUMBER OF WEEKS) weeks each, completing at least 4,000 hours, of which at least 80 percent were actual attendance hours required, in the subjects set forth herein (Business and Professions Code Section 2089), and that

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

☐ he withdrew from

the above mentioned medical school on the 30TH day of MAY (MONTH) 19 76

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 1000
Medicine
Surgery, Including Orthopedic Surgery
Urology
Psychiatry
Neurology

Preventive Medicine, Including Nutrition
Physical Medicine
Therapeutics
Neuromuscular
Child Abuse, Correction and Treatment
Geriatric Medicine
Pediatrics
Pharmacology
Anesthesia

[redacted]

Signed and the official seal affixed this 5TH day of SEPTEMBER, 19 90

BY CAROL A. KAUFFMAN, M.D. (PRESIDENT, DEAN, DEAN)
ASSISTANT DEAN FOR STUDENT AFFAIRS

Medical School Seal MUST Be Impressed Partially Over the Photograph.

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

* Each school where applicant attended must provide a separate SEAL or signature for those years. If more than one school was attended, the completed form must be sent to each, with the photograph and signature on the last month attended.

L2

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

DEPARTMENT OF Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
1426 HOWE AVE., SUITE 54, SACRAMENTO, CALIFORNIA 95825-3236
(916) 924-4111

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. A recent complete photograph of applicant is not attached below. Please type or print.

This is to certify that Mark C. Maltzer, M.D.
(Name of applicant)

a graduate of University of Michigan
(Name of medical school)

formally commenced on a certified postgraduate training program at Yale-New Haven Hospital
(Name and address of facility)

20 York Street, New Haven, Connecticut — Obstetrics/Gynecology
(Specialty)

on July 1, 1976, 19 76, and satisfactorily completed such training on: June 30, 19 80

This training consisted of 48 months of formal clinical instruction and is approved by the Accreditation Council for Graduate Medical Education (ACGME) or the Coordinating Council of Medical Education of the Canadian Medical Association (CCME) and consisted of the following rotations:

(List rotations rotated. If services not rotating, indicate "straight training" or "not". NOTE—To qualify for licensure in California, graduates of foreign medical schools must have completed at least twelve months of postgraduate training in general medicine. Effective July 1, 1990, all applicants who have not completed one year of postgraduate training necessary for licensure will be required to complete at least four months of postgraduate training in general medicine as part of the one year requirement. The general medicine requirement may be satisfied by rotations in clinical practice where the applicant delivers patient care responsibilities in any patient care specialty or subspecialty areas for or at facilities approved by the Board. The general medicine requirement may be satisfied by training in specialties such as pediatrics, family practice, internal medicine, surgery, psychiatry, obstetrics and gynecology. The Program Director may submit a description of the type of training in sufficient detail to allow the Division to determine if it is acceptable.)

ROTATION	LENGTH OF ROTATION
Assistant Resident, Obstetrics/Gynecology	36 Months
Chief Resident, Obstetrics/Gynecology	12 Months

[redacted]

I hereby declare under penalty of perjury under the laws of the State of California that the above statement 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 training on an approved ACGME or CCME program position.

NAME John M. Fanaz M.D., Chief of Staff
(Director of Medical Education)

ADDRESS (Street or Post Office Box) Yale-New Haven Hospital
20 York Street

New Haven, CT 06504

PHONE NUMBER (203) 785-2-359

DATE August 31, 1990

SIGNATURE [signature]

L3

07-4100

STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY

GEORGE DEUKMEJIAN, Governor

DEPARTMENT OF CONSUMER AFFAIRS

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

CERTIFICATE OF ENDORSEMENT BY STATE LICENSING AGENCY

TO BE COMPLETED BY APPLICANT:
(Please type or print legibly)

1. NAME: (last) (first) (middle)
MILLER CHARLES

2. ADDRESS: Number and street/rural route (include apt. no.) (line)
153 BELBOROUGH DRIVE
(City) (State) (ZIP Code) (Country)
BERWYN PA 19312 USA

3. DATE OF BIRTH (Mo. Day Yr.)

4. SEX: ☐ Female ☒ Male

5. STATE LICENSING AGENCY
MICHIGAN

NOTE: Applicant will do this statement in presence of notary public. "I hereby declare under penalty of perjury under the laws of the State of California that the attached photograph is a true likeness of myself and that the information contained in this application and any documents are true and correct."

Mel Charles Miller M.D.
SIGNATURE APPLICANT IN FULL

OFFICIAL SEAL
ELEANOR E. BENNER
NOTARY PUBLIC - CALIFORNIA
SACRAMENTO COUNTY
My Commission Expires Feb 28, 1991

Subscribed and sworn to before me this 1 day of September 1990

Eleanor E. Benner
Notary Public in and for the State of California

TO BE COMPLETED BY STATE LICENSING AGENCY:
(Do not complete if photograph of applicant is not attached above. Please type or print)

I certify that _____ (NAME OF APPLICANT) who graduated from _____ (NAME OF MEDICAL SCHOOL) on _____ (DATE OF GRADUATION) was granted license number _____ on _____ (DATE LICENSE ISSUED) on the basis of _____ (NAME OF STATE LICENSING AGENCY)

NOTE: If the license was issued by reciprocity, complete the following certificate, or if unable to complete the following certificate, the words "unable to do so" should be inserted.

I further certify that at this doctor passed the REGULAR WRITTEN EXAMINATION given by the Board on _____ (DATE) and obtained a general average of _____ per cent in the following subjects:

Subjects of Examination	Per Cent	Subjects of Examination	Per Cent

I certify that this license is valid, that it has never been suspended or revoked, and will expire _____ (DATE) and that records in this office indicate that there are now or have there ever been any charges filed against the holder of this license.

NOTE: If any portion of the above certification is deleted or modified, please attach an explanation.

_____ (TYPE OR PRINT NAME AND TITLE OF AGENCY OFFICIAL) _____ (THIS LICENSING AGENCY STATE) _____ (NAME OF STATE LICENSING AGENCY)

_____ (SIGNATURE OF AGENCY OFFICIAL) _____ (ADDRESS)

_____ (DATE) _____ (PHONE NUMBER)

L4

STATE OF CALIFORNIA—HEALTH AND CONSUMER SERVICES AGENCY

GEORGE DEUKMEJIAN, Governor

DEPARTMENT OF Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
1426 HOWE AVENUE, SUITE 54, SACRAMENTO, CALIFORNIA 95825-3236
(916) 920-6011

CERTIFICATE OF ENDORSEMENT BY STATE LICENSING AGENCY

TO BE COMPLETED BY APPLICANT. (Please type or print neatly.)

[redacted]

1. NAME (First) (Middle) (Initial)
MALTZER MARK CHARLES

2. ADDRESS, Number and street (Include apt., no., if any)
153 BARRINGTON DRIVE
CITY: BRANDON STATE: FL ZIP CODE: 33511 COUNTRY: USA

3. NAME AS GIVEN ON PRIOR LICENSE (Initial W.)

4. SEX: ☐ Female ☒ Male

5. STATE LICENSING AGENCY: CONNECTICUT

NOTE: Applicant will sign this jurat in presence of notary public. "I hereby declare under penalty of perjury under the laws of the State of California that the attached photograph is a true likeness of myself and that the information contained in this document is true and correct."

Mark Charles Maltzer M.D.
SIGNATURE OF APPLICANT IN FULL

Signed and sworn to before me this 27th day of August, 1990.

(SEAL) Signature of Notary Public: Dorothy D. Brannon
Address: [illegible] Hernando, FL 33601-3911
My commission expires: MAY 29, 1992
Dorothy D. Brannon
Notary Public, State of Florida
My Commission Expires May 29, 1992
Bonded Thru Agent's Notary Brokers

TO BE COMPLETED BY STATE LICENSING AGENCY.
(Do not complete if photograph of applicant is not attached above. Please type or print.)

I certify that _____ (NAME OF APPLICANT), who graduated from _____ (NAME OF MEDICAL SCHOOL) on _____ (DATE OF GRADUATION) was granted license number _____ on _____ (DATE LICENSE GRANTED) on the basis of _____ (FEDERAL/NATIONAL BOARD EXAM, LICENSING AGENCY EXAM)

NOTE: If the license was issued by written examination, complete the following certification, otherwise, write across the following certification it records issued on Credentials.

I further certify that this doctor passed the REGULAR WRITTEN EXAMINATION given by this Board on _____ (DATE) and obtained a general average of _____ per cent in the following subjects:

Subjects of Examination	Per Cent	Subjects of Examination	Per Cent

I certify that this license is valid, current, has never been suspended or revoked, and will expire _____ (DATE) and that records in this office indicate that there are now or have ever been any charges filed against the holder of this license.

NOTE: If any portion of the above certification is deleted or modified, please attach an explanation.

_____ (TYPE OR PRINT NAME AND TITLE OF ADMIN. OFFICIAL) (AFFIX SEAL)

STATE OF CONNECTICUT
(NAME OF STATE LICENSING AGENCY)
DEPT. OF HEALTH SERVICES (L.A.)
150 WASHINGTON STREET
HARTFORD, CT 06106
(ADDRESS)
SEE ATTACHED
(PHONE NUMBER)

_____ (SIGNATURE OF ADMIN. OFFICIAL)

_____ (DATE)

L4

STATE OF CALIFORNIA

DEPARTMENT OF CONSUMER AFFAIRS

Department of Consumer Affairs

RECEIPT

746658

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

Name:	MALTZER, MARK C
Transaction Date:	10/07/2014 09:32
Application Number:	14125095
Complaint Number:	
License Type:	8002
License Number:	70633
Payment Description:	Physician's and Surgeon's Renewal
Fee Paid: (US $)	820.00
Remaining Balance: (US $)	0.00

Please print and save this receipt for your records.

This receipt is provided as a record for the above named licensee/applicant.

Illegal use or alteration of this receipt may result in criminal prosecution.

Application Summary

License Type:	**Physician and Surgeon G**
License Number:	**70633**
File Number:	**89991**
Application:	**Physician's and Surgeon's Renewal**
Application Number:	**14125095**
Application Date:	**10/07/2014 (mm/dd/yyyy)**

Personal Detail

First Name:	**MARK**
Middle Name:	**C**
Last Name:	**MALTZER**
Birthdate:	****/**/******
Gender:	**Male**

Addresses

License Related Addresses

Confidential Address (Optional)

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

License Specific Public/Mailing Address (Required)

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

Questions

Since you last renewed your license, have you had any license disciplined by a government agency or other disciplinary body, or, have you been convicted of any crime in any state, the U.S.A. and its territories, military court or a foreign country?	**No**
Have you successfully completed, and can document, the mandatory courses and hours of CME within the last two years, or you meet the conditions which would exempt you from all or part of the CME requirements, or you hold a permanent CME waiver?	**Yes**

I certify under penalty of perjury, under the laws of California, that I have disclosed the names of those health-related facilities in which I or my family have a financial interest OR I declare under penalty of perjury I have no financial interests to disclose.	**Yes**

Family Physician Training Program Voluntary Fee

Voluntary Fee:	**No**

Attachments

Physician Survey

Are you retired?	**No**
Activities in Medicine	**Administration - 1-9 Hours**
	Patient Care - 20-29 Hours
	Research - 1-9 Hours
	Teaching - 1-9 Hours
	Telemedicine - 1-9 Hours
Patient Care Practice Location	**Zip: 95815 County: SACRAMENTO**
Telemedicine Practice Location	**Zip: County:**
Patient Care Secondary Practice Location	**Zip: 95661 County: PLACER**
Telemedicine Secondary Practice Location	**Zip: County:**
Current Training Status	**Not in Training**
Areas of Practice	**Obstetrics and Gynecology - Primary**
Board Certifications	**American Board of Obstetrics and Gynecology - Obstetrics and Gynecology**
Postgraduate Training Years	**4 Years**
Cultural Background	**White**
Foreign Language Proficiency	**Decline to state**
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**
Total Amount Due:	**$820.00**

Applications are not considered submitted for processing until payment is received.

Attestation

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

Signature: Date:

STATE OF CALIFORNIA

DEPARTMENT OF CONSUMER AFFAIRS

Department of Consumer Affairs

RECEIPT

19280951

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

Name:	MALTZER, MARK C
Transaction Date:	09/23/2016 12:41
Application Number:	14341546
Complaint Number:	
License Type:	8002
License Number:	70633
Payment Description:	Physician's and Surgeon's Renewal
Fee Paid: (US $)	820.00
Remaining Balance: (US $)	0.00

Please print and save this receipt for your records.

This receipt is provided as a record for the above named licensee/applicant.

Illegal use or alteration of this receipt may result in criminal prosecution.

Application Summary

License Type:	**Physician and Surgeon G**
License Number:	**70633**
File Number:	**89991**
Application:	**Physician's and Surgeon's Renewal**
Application Number:	**14341546**
Application Date:	**09/23/2016 (mm/dd/yyyy)**

Application Questions

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

Personal Detail

First Name:	**MARK**
Middle Name:	**C**
Last Name:	**MALTZER**
Birthdate:	**/**/****
Gender:	**Male**

Addresses

License Related Addresses

Address of Record (Required)

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

Confidential Address

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

Questions

Since you last renewed your license, have you had any license disciplined by a government agency or other disciplinary body, or, have you been convicted of any crime in any state, the U.S.A. and its territories, military court or a foreign country?	**No**
Have you successfully completed, and can document, the mandatory courses and hours of CME within the last two years, or you meet the conditions which would exempt you from all or part of the CME requirements, or you hold a permanent CME waiver?	**Yes**

I certify under penalty of perjury, under the laws of California, that I have disclosed the names of those health-related facilities in which I or my family have a financial interest OR I declare under penalty of perjury I have no financial interests to disclose.	**Yes**

Family Physician Training Program Voluntary Fee

Voluntary Fee:	**No**

Attachments

Physician Survey

Are you retired?	**No**
Activities in Medicine	**Administration - 1-9 Hours**
	Other - None
	Patient Care - 20-29 Hours
	Research - 1-9 Hours
	Teaching - 1-9 Hours
	Telemedicine - 1-9 Hours
Patient Care Practice Location	**Zip: 95816 County: SACRAMENTO**
Telemedicine Practice Location	**Zip: 95816 County: SACRAMENTO**
Patient Care Secondary Practice Location	**Zip: 95661 County: PLACER**
Telemedicine Secondary Practice Location	**Zip: 95661 County: PLACER**
Current Training Status	**Not in Training**
Areas of Practice	**Obstetrics and Gynecology - Primary**
Board Certifications	**American Board of Obstetrics and Gynecology - Obstetrics and Gynecology**
Postgraduate Training Years	**8 Years**
Cultural Background	**White**
Foreign Language Proficiency	**French**
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**
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: