STATE OF CALIFORNIA — STATE AND CONSUMER SERVICES #11962 GRAY DAVIS, Governor

State of California Department of Consumer Affairs

RECEIVED IN CASHIERS 01 MAR 13 PM 1:40

MEDICAL BOARD OF CALIFORNIA

LICENSING PROGRAM

1426 Howe Avenue, Sacramento, CA 95825-3236

(916) 263-2499

APPLICATION FOR PHYSICIAN AND SURGEON'S LICENSURE

Please **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 as per instructions.

Please type or print neatly. When space provided is insufficient, attach additional sheets of paper.

MBC USE ONLY

1. Name: Last REEVES First MATTHEW Middle FONTAINE

2. Other names you have used (include maiden name): n/a

3. Social Security Number◆

4. Address: Number and Street/Rural Route (include apartment number, if any) 505 Parnassus Avenue, M-1483, Box 0132

City San Francisco State CA Zip Code 94144 Country USA

5. Sex: ☐ Female ☒ Male

6. Telephone Number:
Home:
Work:

7. Date of Birth: Mo/Day/Yr

Place of Birth:

8. California Driver's License Number, if applicable:
NUMBER EXPIRATION

9. Are you a U.S. citizen? ☒ Yes ☐ No

If you are an international medical school graduate, you must provide an original full and unrestricted license to practice medicine in another state or country, OR official documentation of U.S. citizenship, OR an official Declaration of Intent to become a U.S. citizen.

10. Have you ever filed an application for physician and surgeon examination or licensure in California? ☐ Yes ☒ No

IF YES, PLEASE GIVE DATE PREVIOUS APPLICATION WAS SUBMITTED AND ATTACH ANY APPLICATION MATERIALS YOU MAY HAVE RETAINED.

11A. List the names and addresses 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.

Name	Address	Dates of Attendance
University of Pennsylvania	Office of the Registrar, Franklin Bldg. 3451 Walnut St., Philadelphia, PA 19104	9/89-5/93, 9/93-5/95

11B. Check whether the following premedical courses were successfully completed and show where completed:

Course	Yes	No	Name of College or University
Chemistry	X		Univ. of Pennsylvania
Physics	X		Univ. of Pennsylvania
Biology or Zoology	X		Univ. of Pennsylvania

12. List the names and addresses 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 photocopy.

School Name	Address	Place of Instruction	Dates of Attendance	Degree Awarded
Harvard Medical School	25 Shattuck St.	Boston, MA 02115	8/95 - 6/99	M.D.

DOCTOR OF MEDICINE DEGREE, as referenced above. (Note: A U.S. graduate may, in lieu of the original, submit an official certified photocopy that has the school seal affixed and the signature of the registrar certifying authenticity.)

Name of Medical School	Address of Medical School	Exact Date of Issuance
Harvard Medical School	25 Shattuck St. Boston, MA 02115	June 10, 1999

◆ MANDATORY DISCLOSURE OF SOCIAL SECURITY NUMBERS

Disclosure of your social security number (or federal employer identification number (FEIN), if you are a partnership) is mandatory. Section 30 of the Business and Professions Code and Public Law 94-455 (42 USCA 405(c)(2)(C)) authorize collection of your social security number. Your social security number or FEIN will be used exclusively for tax enforcement purposes, for purposes of compliance with any judgment or order for family support in accordance with Section 11350.6 of the Welfare and Institutions 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 or your FEIN, 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.

School Code

L1A

07A-100 (Rev. 12/99)

MBC USE ONLY

13. Have you taken any of the following written examinations: National Boards, other state boards, USMLE, SPEX, FLEX, ECFMG or LMCC? ☒ Yes ☐ No

IF YES, LIST NAME, LOCATION, DATE AND RESULT OF EXAMINATION. SUBMIT AN ORIGINAL OFFICIAL EXAMINATION HISTORY REPORT FROM EACH EXAMINATION AGENCY. APPLICANTS WHO HOLD CERTIFICATION THROUGH THE EDUCATIONAL COMMISSION FOR FOREIGN MEDICAL GRADUATES (ECFMG) WILL NEED TO SUBMIT AN ORIGINAL VALID ECFMG CERTIFICATE PRIOR TO LICENSURE.

Examination	Location	Date	Result
USMLE Step 1	Harvard, Boston, MA	6/10 - 6/11/1997	
USMLE Step 2	Harvard, Boston, MA	3/25 - 3/26/1998	
USMLE Step 3	Sylvan Testing Center, San Francisco, CA	12/20/1999	

14. Have you ever 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 EACH ISSUING AGENCY'S JURISDICTION. SUBMIT A LETTER OF GOOD STANDING FROM EACH STATE IN WHICH YOU ARE OR HAVE BEEN LICENSED. PLEASE INCLUDE TEMPORARY, TRAINING, OR PROVISIONAL LICENSES.

State or Country	License Number	Date of Issuance	Dates of Practice in that Jurisdiction

15A. Are you currently, or have you ever been, a participant in a postgraduate training program in a facility in the U.S. or Canada? ☒ Yes ☐ No

IF YES, LIST NAMES AND ADDRESSES OF ALL FACILITIES. SUBMIT AN ORIGINAL CERTIFICATE OF COMPLETION OF ACGME/CCME POSTGRADUATE TRAINING (FORM L3A) FROM EACH FACILITY. (DO NOT COMPLETE FORM L3As 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	Type of Service	Dates of Attendance
Univ. of Calif., San Francisco Dept of Ob/Gyn + Reproductive Sci.	1483 Moffitt, Box 0132 505 Parnassus, SF, CA 94143	Internship	6/21/99 - 6/20/00
Univ of Calif., San Francisco Dept of Ob/Gyn + Reproductive Sci.	1483 Moffitt, Box 0132 505 Parnassus, SF, CA 94143	Residency	6/24/00 - 6/20/03

QUESTIONS 15B through 21: For any positive response to the following questions, please provide ALL official documentation regarding the matter in addition to written explanations. If applicable, applicants should also provide official hearing/court documents and original letters of explanation from medical school or training program directors or other appropriate authorities. APPLICANTS ARE ALSO REQUIRED TO REPORT ANY MATTER THAT IS PENDING OR IN WHICH CHARGES HAVE BEEN DROPPED OR EXPUNGED.

15B. 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? Yes No

16. 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 or has any disciplinary action ever been filed or taken regarding any healing arts license which you now hold or have ever held, or is any such action pending? Include any disciplinary actions by the U.S. Military, U.S. Public Health Service or other U.S. federal governmental entity. IF YES, GIVE DETAILS BELOW. Yes No

State	Date	Charge	Disposition

MBC USE ONLY

17. 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? Yes No

IF YES, GIVE DETAILS BELOW.

Name of Claimant	Location of Court	Brief Description of the Facts

18. 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, country, or U.S. federal jurisdiction, or is any such action pending? Yes No

IF YES, GIVE DETAILS BELOW.

State or Country	Date of Denial	Reason for Denial

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

20. 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? Yes No

21. 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? Yes No

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

- ☐ 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.

QUESTION 22: For any positive response to the following question, please provide ALL official documentation regarding the matter in addition to written explanations. If applicable, an applicant should also provide official hearing/court documents and original letters of explanation from appropriate authorities.

22. Have you ever been convicted of or pled nolo contendere to any violation (including misdemeanors and felonies) of any federal, state or local law of any state, the United States, OR a foreign country or any violation relating to the possession, use, illegal sale, transportation, manufacture, distribution or dispensing of controlled substances, or is any such action pending? *(Exclude violations of traffic laws, including speeding, which resulted in fines of $300.00 or less.)* If YES, give details below. Yes No

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.

Violation and Location	Date	Penalty or Disposition

TOP OF PHOTO

[redacted]

BOTTOM OF PHOTO

PHOTO DECLARATION

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

MONTH DAY YEAR

my age then being ______ years;

my color of hair ______;

my color of eyes ______;

my height ______ ft. ______ in.;

my weight ______ lbs.;

... identifying marks are

______

______

Signature of Applicant

Notice: All items in this application are mandatory; none are voluntary. Failure to provide any of the requested information will delay the processing of your application. The information provided will be used to determine your qualifications for licensure per Section 2050 of the California Business and Professions Code, which authorizes the collection of this information. The information on your application may be transferred to other medical licensing authorities, the Federation of State Medical Boards, or other governmental or law enforcement agencies. You have the right to review your application subject to the provisions of the Information Practices Act. The Program Manager of the Licensing Program is the custodian of records.

STATE OF California

COUNTY OF San Francisco

(Applicant Declaration before NOTARY)

The applicant, MATTHEW FONTAINE REEVES, being first duly sworn upon his/her
PRINT FULL NAME OF APPLICANT
oath deposes and says: that he/she is the person herein named subscribing to this application; that he/she has read the complete application, knows the full content thereof, and declares that all of the information contained herein and evidence or other credentials submitted herewith are true and correct; that he/she is the lawful holder of the degree of Doctor of Medicine as prescribed by this application, that the same was procured in the regular course of instruction and examination, and that it, together with all the credentials submitted, were procured without fraud or misrepresentation or any mistake of which the applicant is aware and that the applicant is the lawful holder thereof. Further, I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past, present and future), business and professional associates (past, present and future), and all government agencies (local, state, federal or foreign) to release to the Medical Board of California or its successors any information, files or records, including medical records, educational records, and records of psychiatric treatment and treatment for drug and/or alcohol abuse or dependency, requested by that Board in connection with this application; or any further or future investigation by that Board necessary to determine my medical competence, professional conduct or physical or mental ability to safely engage in the practice of medicine. I further authorize the Medical Board of California or its successors to release to the organizations, individuals or groups listed above any information which is material to this application or any subsequent licensure. I FURTHER ACKNOWLEDGE THAT FALSIFICATION OR MISREPRESENTATION OF ANY ITEM OR RESPONSE ON THIS APPLICATION IS ADEQUATE TO DENY THE SAME OR TO HOLD A HEARING TO REVOKE THE SAME, IF ISSUED.

SIGNATURE OF APPLICANT: [signature]
(PLEASE WRITE FULL NAME, NOT INITIALS)

Signed and sworn to before me this 3rd day of March 2001
MONTH YEAR

JOHN DOWNEY
Commission # 1220624
Notary Public - California
San Francisco County
My Comm. Expires May 22, 2003

NOTARY SEAL

John Downey
SIGNATURE OF NOTARY PUBLIC

584 Castro St San Francisco
ADDRESS

My commission expires May 22 2003

07A-100 (Rev. 12/99)

L1D

STATE OF CALIFORNIA — STATE AND CONSUMER SERVICES AGE

GRAY DAVIS, Governor

Consumer Affairs

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

RECEIVED
MEDICAL BOARD OF
CALIFORNIA

01 MAR 14 PM 3:45

LICENSING PROGRAM

CERTIFICATE OF COMPLETION OF ACGME/CCME POSTGRADUATE TRAINING

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

PART 1. To be completed by the applicant/trainee.

Last Name of Trainee	First Name	Middle Initial
REEVES	MATTHEW	F

Current Address:	Social Security Number
Box 0132, M-1483, 505 Parnassus Avenue	

City	State	Zip Code	Telephone Number:
San Francisco	CA	94143-0132	

PART 2. To be completed by the facility. Completion of this form will certify that the individual named in PART 1 above and whose photograph is attached to this form, formally completed an accredited postgraduate training program at this facility. The following information is provided to certify "satisfactory" completion. PLEASE SEE THE REVERSE FOR A DEFINITION OF "SATISFACTORY."

Name of Facility	Address of Facility
University of California, San Francisco	505 Parnassus Ave., Box 0132, San Francisco, CA 9414

Name of Program Director:	Telephone Number:
Lee A. Learman, M.D., Ph.D.	(415) 476-5192
Signature of Program Director: Lee A. Learman	**Date Signed:** 2/22/01 ✓

List Categorical Specialty Area of Training Completed by Trainee:	Date Training Commenced:	Date Training Completed:
OB/GYN ✓	6/21/99	6/20/00

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):

Straight training in OB/GYN

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:	Facility Name:
Susan D. Wall, M.D.	University of California, San Francisco

Facility Address:			
500 Parnassus Ave., Box 0140			
City	**State**	**Zip Code**	**Telephone Number:**
San Francisco	CA	94143	(415) 476-4561

PART 4. Signature of Director of Medical Education certifying satisfactory completion of training.

ATTENTION PROGRAM DIRECTOR!
IF TRAINEE IS IN HIS/HER FIRST YEAR OF POSTGRADUATE TRAINING, DO NOT SIGN OR DATE THE STATEMENT BELOW UNTIL AFTER THE COMPLETION OF THE TRAINEE'S LAST DAY OF 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 CCME to offer the type and level of training completed by the applicant and that the applicant was trained in an approved ACGME or CCME program position.

Signature of Director of Medical Education:	Date Signed:
Susan D. Wall MD	2/28/01 ✓

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

✓

L3A

07A-100.1.1 (Rev. 1/99)

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

State of California Department of Consumer Affairs

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

RECEIVED
SACRAMENTO
MEDICAL BOARD
OF CALIFORNIA

01 JAN 29 AM 11:09

CERTIFICATE OF MEDICAL EDUCATION

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

This certifies that MATTHEW FONTAINE [redacted] of 4422 Osage Ave, Philadelphia, PA enrolled in
FULL NAME OF APPLICANT — ADDRESS WHEN ENROLLED

HARVARD MEDICAL SCHOOL — 25 Shattuck St, Boston, MA
NAME OF MEDICAL SCHOOL — LOCATION

on the 5 day of SEPTEMBER 19 95 and was granted the following credits on enrollment:
MONTH

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

University of Pennsylvania — 9/1989 - 5/1993, 9/1993 - 5/1995
EDUCATIONAL INSTITUTION — DATES

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

none
MEDICAL SCHOOL — TOTAL CREDITS — DATES

The undersigned further certifies that the records of this institution show that he attended in this institution 4 years
SPECIFY NUMBER

of resident instruction of 36 weeks each, completing at least 4,000 hours, of which at least 80 percent actual
NUMBER OF WEEKS

attendance is required, in the subjects set forth hereunder (Business and Professions Code Section 2089), and that:

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

the above mentioned medical school on the 10th day of June, 19 99.
MONTH

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
Family Medicine**
Spousal or Partner Abuse Detection & Treatment***

* 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. Note that photograph and all entries to the form must be original.

** 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 September 1, 1994.

TRANSCRIPTS FOR ALL ADVANCED CREDITS AND MEDICAL SCHOOL CREDITS MUST BE SUPPLIED WITH THIS CERTIFICATE

Medical School Seal MUST be Imprinted Partially on the Photograph

Signed and the school seal affixed this 23rd day of JANUARY, 19 01.

BY [signature]
CARL A. DUFFEY, Registrar
PRESIDENT, SECRETARY, DEAN

L2

State of California Department of Consumer Affairs

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

CERTIFICATION STATEMENT

This is to certify that Matthew Fontaine Reeves
(Name of Physician)

is in an approved ACGME/CCME postgraduate training position that commenced on June 21, 19 99 and is expected to be completed on June (Month) 20 (Day) 2003 (Year) ✓ in Obstetrics and Gynecology (Type of Training)

at University of California, San Francisco
(Name and Address of Facility)

505 Parnassus Ave., Box 0132, San Francisco, CA 94143

✓

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

"I hereby declare under penalty of perjury under the laws of the State of California that the above statements are true and correct and the facility is approved by the ACGME or the CCME to offer the type and level of training completed by the applicant and that the applicant is being trained in an approved ACGME or CCME program position."

Susan D. Wall, M.D., Associate Dean for Graduate Medical Education
(Type or print name of Director of Medical Education)

Susan D. Wall ✓
(Signature of Director of Medical Education)

2/28/01
(Date)

(415) 476-4561
(Telephone Number)

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

07A-107-L4 (3/99)

L4

A 75550

State of California Department of Consumer Affairs

AUG 15 2003

nms

MEDICAL BOARD OF CALIFORNIA

LICENSING PROGRAM
1426 Howe Avenue, Suite 54
Sacramento, CA 95825-3236
(916) 263-2382
www.medbd.ca.gov

IMPORTANT ADDRESS CHANGE INFORMATION

You must report all address changes to the board within 30 days. Please allow only 32 characters per line for your new address. Return to the address indicated above. If the address reported is a post office box, you must also provide a confidential street address.

MUST INCLUDE PHYSICIAN'S SIGNATURE

07A-107 (Rev. 9/2001)

License #: A75550 Name: Matthew F. Reeves

New Address: Dept of Radiology, Box 0628
505 Parnassus Ave.

City: San Francisco State: CA Zip: 94143

Confidential Street Address if PO Box is used:

City: State: Zip:

Signature: [signature] Date: 8/3/03

Telephone Number: