STATE OF CALIFORNIA – STATE AND CONSUMER SERVICES AGENCY

ARNOLD SCHWARZENEGGER, Governor

Consumer Affairs

MEDICAL BOARD OF CALIFORNIA

LICENSING PROGRAM
1426 Howe Avenue, Suite 54
Sacramento, CA 95825-3236
(916) 263-2382 FAX (916) 263-2467
www.medbd.ca.gov

805.00
8/2/05
000698

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 Wallace First Robin Middle Reed

2. Other names you have used (include 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.
3320 Chanate Road

City Santa Rosa State CA Zip Code 95404 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.]

City State Zip Code Country USA

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?
IF YES, PLEASE GIVE DATE PREVIOUS APPLICATION WAS SUBMITTED. ☐ Yes ☑ No

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 signature of the registrar of each school attended. Transcripts will not be returned.

Name	City, State, Country	Dates of Attendance
Univ. of Virginia	Charlottesville, VA USA	8/1996 – 12/1999
Univ. of North Carolina	Chapel Hill, NC USA	5/1998 – 8/1998

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
U. of N. Carolina	Chapel Hill, NC USA	8/2000 – 5/2004	MD

DOCTOR OF MEDICINE DEGREE, as referenced above

Name of Medical School	Address of Medical School	*Exact Date of Issuance
Univ. of North Carolina at Chapel Hill	121 MacNider Bldg, CB#9500 Chapel Hill, NC 27599-9500	5/9/04

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(c)(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
School Code

L1A

07A-100 Web (Revised 11/03)

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 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 - Step 1, Charlotte, NC	06/17/02	
USMLE - Step 2, Raleigh, NC	07/31/03	
USMLE - Step 3, Santa Rosa, CA	04/13/05	

Written Examination

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

Jurisdiction	License Number	Date of Issuance	Dates of Practice in that Jurisdiction

License Date

LGS

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

Other Professional Licenses

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.) ☑ 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 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	Categorical Specialty Area	Dates of Attendance
Sutter Medical Center	3320 Chanate Rd. Santa Rosa, CA 95404	Family Practice	7/2004 - present

Postgraduate Training

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: Robin R. Wallace

DATE OF BIRTH:

L1B

MBC USE ONLY

Licensee 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 plead 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: Robin R Wallace

DATE OF BIRTH:

L1C

[redacted]

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 2080 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 Chief of the Licensing Program is the custodian of records.

Applicant Declaration/Signature and NOTARY

STATE OF California

COUNTY OF Sonoma

The applicant, Robin Reed Wallace (PLEASE PRINT FULL NAME) (DATE OF BIRTH) being first duly sworn upon his/her oath deposes and says: that I am the person herein named subscribing to this application; that I have read the complete application, know the full content thereof, and declare under penalty of perjury, that all of the information contained herein and evidence or other credentials submitted herewith are true and correct; that I am 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 I am aware and that I am 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 UNDERSTAND THAT 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.**

SIGNATURE OF APPLICANT: Robin Reed Wallace (PLEASE SIGN FULL NAME, NOT INITIALS)

Signed and sworn to before me this 28 day of July (MONTH) 2005 (YEAR)

KELLY MANCINS
Commission # 1479191
Notary Public - California
Sonoma County
My Comm. Expires Mar 27, 2008

NOTARY SEAL

SIGNATURE OF NOTARY PUBLIC

3324 Orencia Rd Santa Rosa
ADDRESS

My commission expires 3/27/08

07A-100 Web (Revised 11/03)

L1D

STATE OF CALIFORNIA – STATE AND CONSUMER SERVICES AGENCY

ARNOLD SCHWARZENEGGER, Governor

Consumer Affairs

MEDICAL BOARD OF CALIFORNIA

1426 Howe Avenue, Suite 54
Sacramento, CA 95825-3236
(916) 263-2382 FAX (916) 263-2487
www.caldoptofa.ca.gov

CERTIFICATE OF MEDICAL EDUCATION

MEDICAL SCHOOL: PLEASE COMPLETE THIS FORM IN THE ENGLISH LANGUAGE

This certifies that Robin Reed Wallace (FULL NAME OF APPLICANT) _____ (U.S. SOCIAL SECURITY NO.) _____ (DATE OF BIRTH-MM/DD/YYYY)

enrolled in Univ. of North Carolina (NAME OF MEDICAL SCHOOL) Chapel Hill, NC (LOCATION)

on the 9 day of May (MONTH) 2004 (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 4 (NUMBER OF YEARS) years of resident instruction of 147 total (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 9th day of May (MONTH) 2004 (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 2nd day of August (MONTH) 2005 (YEAR)

BY: _____

Forrest H. [illegible] PERSONNEL SEAL REPRESENTATIVE Registrar

L2

07A-100-L2 (Rev. 02-01)

8/8/2005

Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
1426 Howe Avenue, Suite 54
Sacramento, CA 95825-3236
(916) 263-2382 FAX (916) 263-2487
www.caldocinfo.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 RELATED TO THE APPLICANT BY BLOOD, MARRIAGE, OR ADOPTION. Only the Program Director and 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.

PART 1: To be completed by the APPLICANT

LAST NAME of Applicant: Wallace | First Name: Robin | Middle Initial: R

U.S. Social Security Number: | Date of Birth: MM/DD/YYYY | Telephone Number: Home: (Work: (

Current Address: 3320 Chanate Rd

City: Santa Rosa | State: CA | Zip Code: 95404

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: SUTTER MEDICAL CENTER OF SANTA ROSA | Address of Facility: 3324 CHANATE RD. SANTA ROSA, CA 95404

Name of Program Director: MARSHALL KUBOTA, MD | Telephone Number: (707) 576-4075

Signature of Program Director: MK #12005 11 005 | Date Signed: 6/30/05

List Categorical Specialty Area of Training Completed by Trainee: FAMILY PRACTICE | Date Training Commenced: 7/1/2004 | Date Training Completed: 6/30/2005

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):
12 WKS. MED 10 WKS. OB 8 WKS. PEDS 10 WKS. SURG.
7 WKS. ER 4 WKS. BEH. SCI. 4 WKS. IAC/EDU

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: MARSHALL KUBOTA, MD | Name of Facility: SUTTER MEDICAL CENTER

Address of Facility: 3324 CHANATE RD.

City: SANTA ROSA | State: CA | Zip Code: 95404 | Telephone Number: (707) 576-4070

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

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: 6/30/05

L3A

STATE OF CALIFORNIA – STATE AND CONSUMER SERVICES AGENCY

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Consumer Affairs

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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 Robin R Wallace (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 7/1/2004 (MONTH / DAY / YEAR) and is expected to be completed on

6/30/2007 (MONTH / DAY / YEAR) in FAMILY PRACTICE (Type of Training)

at SUTTER MEDICAL CENTER, 3324 CHANATE RD., SANTA ROSA, CA 95404 (Name and Address of Facility)

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.

MARSHALL KUBOTA, MD
(Type or print name of Director of Medical Education)

(Signature of Director of Medical Education)

6/30/05
(Date)

707.576.4070
(Telephone Number)

OFFICIAL HOSTPITAL 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-100-L4 (Revised 03/01)

STATE OF CALIFORNIA

DEPARTMENT OF CONSUMER AFFAIRS

Department of Consumer Affairs

RECEIPT

915126

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

Name:	WALLACE, ROBIN REED
Transaction Date:	12/29/2014 18:46
Application Number:	14143316
Complaint Number:	
License Type:	8002
License Number:	93140
Payment Description:	Physician's and Surgeon's Renewal
Fee Paid: (US $)	62.00
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:	**93140**
File Number:	**100312**
Application:	**Physician's and Surgeon's Renewal**
Application Number:	**14143316**
Application Date:	**12/29/2014 (mm/dd/yyyy)**

Personal Detail

First Name:	**ROBIN**
Middle Name:	**REED**
Last Name:	**WALLACE**
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:	**Yes**
Amount - $25.00 Minimum:	**25**

Attachments

Physician Survey

Are you retired?	**No**
Activities in Medicine	**Administration - 1-9 Hours**
	Other - None
	Patient Care - 20-29 Hours
	Research - None
	Teaching - 1-9 Hours
	Telemedicine - None
Patient Care Practice Location	**Zip: 75243 County:**
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**
	Other - Not Listed - Secondary
Board Certifications	**American Board of Family Medicine - Family Medicine**
Postgraduate Training Years	**5 Years**
Cultural Background	**White**
Foreign Language Proficiency	**Spanish**
Web Site Profile	**Cultural Background - No**
	Foreign Language Proficiency - Yes
	Gender - Yes

Fees

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:	**$62.00**

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:

(DO NOT DETACH)

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

LICENSEE NAME	LICENSE NO.	EXPIRATION DATE	AMOUNT DUE NOW	AMOUNT DUE IF POSTMARKED AFTER MAY 29, 2017
WALLACE, ROBIN R	**A93140**	**02/28/17**	**$37.00**	**$37.00**

LICENSEE MUST CHECK CORRECT BOXES

- "H" [✓] Completed Continuing Education (See Question 1)
- "E" [ ] Change of Address (fill in reverse side)
- "I" [ ] Conviction – Yes (See Question 3)
- "J" [✓] Conviction – No (See Question 3)
- "F" [ ] Family Physician Training Program ($25 See Question 4)
- "G" [✓] Financial Interest Statement (See Question 5)

"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 5/16/17

ENTER YOUR PHONE NUMBER FOR REFERENCE:

_____ ___ ___

_____ ___ ___

630101000001000020009314020102281700003700000003700

CHANGE OF ADDRESS (Only if different from address above) **WALLACE, ROBIN R** **A93140**

ADDRESS OF RECORD (Required)

Address Line 1

Address Line 2

Address Line 3

City State Zip

CONFIDENTIAL STREET ADDRESS (Required if PO Box used above for Address of Record)

Address Line 1

Address Line 2

Address Line 3

City State Zip