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

SEP 23 12 49 PM '88

APPLICATION FOR PHYSICIAN AND SURGEON'S EXAMINATION OR LICENSURE

005175
11589
0034ES 33589

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.

BMQA USE ONLY

1. Name: (Last) CREININ (First) MITCHELL (Middle) DAVID

PERSONAL DATA

2. Other names you have used:

3. Social Security Number [redacted]

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

City State ZIP Code Country [redacted]

5. Telephone Number: Home Work [redacted]

6. Date of Birth: Mo/Day/Yr [redacted]

7. Sex ☐ Female ☒ Male

8. Are you a U.S. citizen? [redacted] Yes [redacted] No

Submit a certified copy of birth certificate, Certificate of Naturalization, Declaration of Intention to become U.S. citizen (INS Form N300), VISA documents, or license to practice medicine.

☑

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

☐

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.

NON-MEDICAL EDUCATION

Name	Address	Period of Attendance From (Mo/Yr)	Period of Attendance To (Mo/Yr)
NORTHWESTERN UNIV	633 E. CLARK - EVANSTON, IL	9/82	6/84

☑ ☐ ☐

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.

MEDICAL EDUCATION

Name	Address	Place Where Instruction Received	Period of Attendance From (Mo/Yr)	Period of Attendance To (Mo/Yr)
NORTH WESTERN	303 E. CHICAGO AVE	CHICAGO, IL	9/84	6/88

CME ☑ 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
NORTHWESTERN UNIV.	303 E. CHICAGO AVE CHICAGO, IL 60611	06/03/88

1006 School Code

L1A

07A-100 (REV. 2/88)

BMQA USE ONLY

13. Have you taken any of the following written examinations: National Boards, ECFMG, FMGEMS, FLEX, MSKP, MCAT, other related medical competency examinations? [redacted] Yes [redacted] 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
NBME I	CHICAGO, IL.	6/86	PASS
NBME II	CHICAGO, IL	4/88	PASS
NBME III	SAN FRAN., CA	3/89	PASS

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)	To (Mo/Yr)

15. Have you been licensed to practice medicine in any state or country? [redacted] Yes [redacted] 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

State or Country	License Number	Date of Issuance	Dates of Practice in Issuing Agency's Jurisdiction		LGS	CE
			From (Mo/Yr)	To (Mo/Yr)		
					☐	☐
					☐	☐
					☐	☐
					☐	☐

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

[redacted] Yes [redacted] No If yes, give details below:

State	Date	Charge	Disposition

L1B

07A-100

BMQA 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? [redacted] Yes [redacted] No

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?

☐ Yes ☒ No 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?

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

20. Have you ever had staff privileges in a hospital denied, suspended or revoked, or resigned from a medical staff in lieu of disciplinary action? [redacted] Yes [redacted] No If yes, please explain on a separate sheet of paper.

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

If yes, give details below:

Violation and Location	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 $75.00 or less.)

[redacted] Yes [redacted] No If yes, give details below:

Violation and Location	Date	Penalty or Disposition

You are required to list any conviction that has been set aside and dismissed under Section 1203.4 Penal Code or under any other provision of law.

"Disclosure of your social security number is mandatory. Section 30 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."

LICENSE DATA (continued)

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GENERAL DATA

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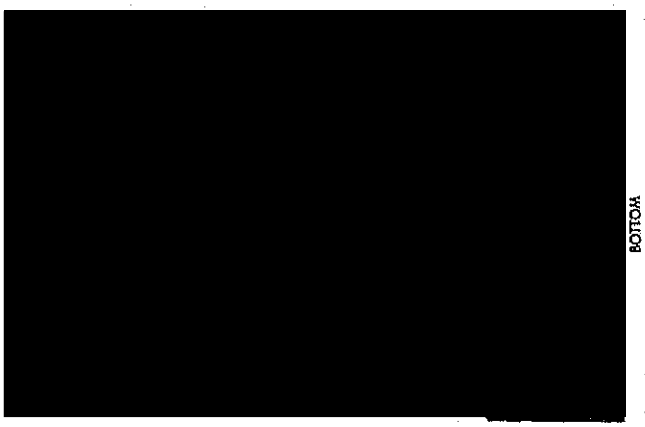
07A-100



TOP

BOTTOM

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 [redacted], 19[redacted]

my age then being [redacted] years;

color of hair [redacted];

color of eyes [redacted];

height [redacted] ft. [redacted] in.;

weight [redacted] lbs.;

identifying marks [redacted]

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 2080 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 CALIFORNIA)

COUNTY OF SAN FRANCISCO)

MITCHELL DAVID CREININ 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 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.

Mitchell David Creinin

Signature of applicant in FULL (Do not use INITIALS ONLY)

Signed and sworn to before me this 19th day of September, 1989.

Signature of Notary Public Tony Travers

(SEAL) OFFICIAL SEAL TONY TRAVERS NOTARY PUBLIC-CALIFORNIA City and County of SAN FRANCISCO My Commission Expires Oct. 2, 1992

Address UCSF, Box 0132 SF, Ca 94143

My commission expires 10-2-92

L1D

07A-100

RECEIVED
SACRAMENTO
BOARD OF MEDICAL
QUALITY ASSURANCE
JUL 26 AM 10:45
DIVISION OF LICENSING

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

JUL 28 12 13 PM

CERTIFICATE OF MEDICAL EDUCATION

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

This certifies that MITCHELL DAVID CREININ
(FULL NAME OF APPLICANT)

of [redacted] enrolled in NORTHWESTERN UNIVERSITY
(ADDRESS WHEN ENROLLED) (NAME OF MEDICAL SCHOOL)

CHICAGO, IL on the 24 day of September 1984
(LOCATION) (MONTH) (YEAR)

and was granted 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 2085).

NORTHWESTERN UNIVERSITY 9/82 - 6/84
(EDUCATIONAL INSTITUTION) (DATES)

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

(MEDICAL SCHOOL) (TOTAL CREDITS) (DATES)

The undersigned further certifies that the records of this institution show that ___he attended in this institution 12 qtr courses of resident instruction of 3 Months (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

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

the above mentioned medical school on the 3rd day of June (MONTH) 1988

Anatomy	Dermatology	Preventive medicine, including Nutrition
Otolaryngology	Embryology	Physical Medicine
Obstetrics and Gynecology	Histology	Therapeutics
Radiology, including Radiation Safety	Human Sexuality as defined in Section 2090	Neuroanatomy
Tropical Medicine	Medicine	Child Abuse Detection and Treatment
Physiology	Surgery, including Orthopedic Surgery	Geriatric Medicine
Biochemistry	Urology	Pediatrics
Pathology, Bacteriology and Immunology	Psychiatry	Pharmacology
Ophthalmology	Neurology	Anesthesia

[redacted]

Signed and the college seal affixed this 21 day of July, 1989.

BY [signature]
PRESIDENT SECRETARY DEAN

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]

L2

Northwestern University

ON RECOMMENDATION OF THE FACULTY OF THE

SCHOOL OF MEDICINE

NORTHWESTERN UNIVERSITY HAS CONFERRED THE DEGREE OF

DOCTOR OF MEDICINE

UPON

MITCHELL DAVID CREININ

WHO HAS HONORABLY FULFILLED ALL THE REQUIREMENTS PRESCRIBED BY THE UNIVERSITY FOR THAT DEGREE

DONE AT EVANSTON ILLINOIS THIS THIRD DAY OF JUNE IN THE YEAR ONE THOUSAND NINE HUNDRED AND EIGHTY-EIGHT A.D.

Howard J. Trueman
CHAIRMAN OF THE BOARD OF TRUSTEES

Thomas Reid
SECRETARY OF THE BOARD OF TRUSTEES

NORTHWESTERN UNIVERSITY
LUX IN TENEBRIS LUCET
1851

Arnold R. Weber
PRESIDENT OF THE UNIVERSITY

Harry M. Beaty, M.D.
DEAN

DEPARTMENT OF CONSUMER AFFAIRS

BOARD OF MEDICAL QUALITY ASSURANCE
1426 HOWE AVENUE, SACRAMENTO, CALIFORNIA 95825
(916) 920-6371

RECEIVED
SACRAMENTO
BOARD OF MEDICAL
QUALITY ASSURANCE
Nov 3 10 54 AM '89

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 MITCHELL CREININ
NAME OF APPLICANT

a graduate of NORTHWESTERN UNIVERSITY
NAME OF MEDICAL SCHOOL

commenced postgraduate training in UNIVERSITY OF CALIFORNIA & SAN FRANCISCO, 505 PARNASSUS AVE, S.F., CA
NAME AND ADDRESS OF FACILITY

on JUNE ~~1~~ 22, 19 86, and completed such training

on June 31 19 89. This training consisted of 12 months of actual 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 completed. If service was not rotating, indicate type of straight training performed. NOTE—To qualify for licensure in California, graduates of foreign medical schools must have completed at least four months of postgraduate training in general medicine. ACGME or CCME residencies in family practice, internal medicine, surgery, pediatrics, and ob/gyn would normally satisfy this requirement.)

ROTATION	LENGTH OF ROTATION
OBSTETRICS	4.5 MONTHS
GYNECOLOGY	4 MONTHS
MEDICINE	1.5 MONTHS
EMERGENCY ROOM	1 MONTH
VACATION	1 MONTH

[redacted]

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 William Hamilton, M.D.
DIRECTOR OF MEDICAL EDUCATION

AFFIX SEAL OF HOSPITAL OR NOTARY PUBLIC

ADDRESS Box 0410, 505 PARNASSUS
SAN FRANCISCO, CA 94143

PHONE NUMBER [redacted]

DATE 10-27-89

SIGNATURE William K Hamilton MD

L3

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

CERTIFICATION STATEMENT

This is to certify that MITCHELL D. CREININ (Name of Physician) is in an ACGME/CCME postgraduate training position that commenced on 6/21/, 1988 and is expected to be completed on 6/30/, 1992 in OBSTETRICS AND GYNECOLOGY (Type of Training)

at UNIVERSITY OF CALIFORNIA - SAN FRANCISCO (Name and Address of Facility)
505 PARNASSUS AVE., S.F., CA

(AFFIX SEAL OF)
(HOSPITAL OR)
(NOTARY PUBLIC)

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.

WILLIAM HAMILTON, M.D.
TYPE OR PRINT NAME OF DIRECTOR OF MEDICAL EDUCATION

William K. Hamilton MD
SIGNATURE OF DIRECTOR OF MEDICAL EDUCATION

Aug 12, 1989
DATE

[redacted]
PHONE NUMBER

L9

07M-71 (3-87)

STATE OF CALIFORNIA -- STATE AND CONSUMER SERVICES AGENCY — ARNOLD SCHWARZENEGGER, *Governor*

Consumer Affairs

MEDICAL BOARD OF CALIFORNIA

LICENSING PROGRAM
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815
(800) 633-2322 (916) 263-2382 FAX (916) 263-2487
www.mbc.ca.gov

INITIAL AND UPDATE APPLICATION FOR PHYSICIAN'S AND SURGEON'S LICENSE *OR* POSTGRADUATE TRAINING AUTHORIZATION LETTER

Application for (please check one): ☑ License ☐ PTAL - or - ☐ Update

MBC Use Only

1. NAME: Last	First	Middle
Creinin	Mitchell	David

Other names you have used (include maiden name):

2. U.S. Social Security Number: [redacted]

3. Place of Birth: [redacted]

4. Date of Birth: [redacted]

5. Gender: ☑ Male ☐ Female

6. Public/Mailing Address: 217 Virginia Manor Drive
(Please note: this information is public)
(30 characters maximum per line, including spaces)

City	State/Province	Zip/Postal Code	Country
Pittsburgh	PA	15215	

7. Telephone Numbers: (include area code) Home [redacted] Work [redacted] Cell [redacted]

8. California Driver's License Number (optional):

9. E-mail Address (optional): [redacted]

10. Have you ever filed an Application for Physician's and Surgeon's License, or PTAL, in California?
[redacted] Yes [redacted] No
Previous license number, if any: _____

Personal Data ☑

MEDICAL EDUCATION

11. LIST EACH MEDICAL SCHOOL THAT YOU HAVE ATTENDED.

School Name	City, State/Province, Country	Dates of Attendance
Northwestern University	Chicago, IL, USA	8/1984-6/1988

L2 Transcript ☑ ☑ ☐ ☐ ☐ ☐

12. School of Graduation	Degree Awarded	Date of Graduation
Northwestern University	MD	06-03-1988

Diploma ☑

EXAMINATIONS

13. LIST ALL OF THE FOLLOWING EXAMINATIONS YOU HAVE TAKEN: USMLE, FLEX, NBME, ECFMG, SPEX, STATE BOARDS and/or QME in Canada

Examination	Date	Result (Pass/Fail)
NBME	07-01-1989	pass

Exams ☑ ☐ ☐

1301.00 — 0012425 Cashiering Use Only — NOV 0 2 2010 — IL006 School Code

L1A

07A-100 (Rev. 04/2008)

A "yes" response to Questions 14 through 38 requires a written explanation on a separate sheet of paper along with any supporting materials.

ACGME/RCPSC ACCREDITED POSTGRADUATE TRAINING

MBC Use Only

Postgraduate Training

14. **Please list each ACGME/RCPSC accredited postgraduate training program in which you have participated. You must include each internship, residency and fellowship, whether or not the program was completed or credit granted.**

Facility Name	Address	Specialty Area	Dates of Attendance
University of California, San Fran	500 Parnassus Ave, SF, CA	Obstetrics and Gynecology	6/1988-6/1989
University of California, San Fran	500 Parnassus Ave, SF, CA	Obstetrics and Gynecology	7/1989-6/1992

POSTGRADUATE TRAINING: (These questions are to be answered by ALL applicants)

Did you ever take a leave of absence or break from your training?	YES [redacted]	NO [redacted]
Have you ever been terminated, dismissed or expelled from a program?	YES [redacted]	NO [redacted]
Have you ever resigned from a training program?	YES [redacted]	NO [redacted]
Were you ever placed on probation?	YES [redacted]	NO [redacted]
Were you ever disciplined or placed under investigation?	YES [redacted]	NO [redacted]
Were any incident reports ever filed by instructors?	YES [redacted]	NO [redacted]
Were any limitations or special requirements placed upon you for clinical performance, discipline, or for any other reason?	YES [redacted]	NO [redacted]
Have you ever had a postgraduate training program contract not be renewed or offered for a following year?	YES [redacted]	NO [redacted]

MEDICAL LICENSURE

License Data

15. **Please list all medical licenses (other than training licenses) that have ever been issued by any state or territory in the United States or Canadian province.**

Jurisdiction	License Number	Date of Issuance	Dates of Practice in that Jurisdiction
California	G67491	11-13-1989	1989-1994
Hawaii	MD-7257	09-04-1990	1990
Pennsylvania	MD052717L	06-29-1994	1994-present

APPLICANT: Mitchell David Creinin

DATE OF BIRTH: [redacted]

L1B

ABMS CERTIFICATIONS

MBC Use Only

ABMS ☐

16. Are you currently certified by a Member Board of the American Board of Medical Specialties? YES [redacted] NO [redacted]

Member Board	Expiration Date	Certificate Number
American Board of Obstetrics and Gynecology	12/31/2010	928552

☐

☐

MALPRACTICE HISTORY

Malpractice

17. Has a claim or an action ever been filed against you for the practice of medicine which resulted in a malpractice settlement, judgment, or arbitration award of $30,000 or more? YES [redacted] NO [redacted]

☐

PRACTICE IMPAIRMENT OR LIMITATIONS

Limitations

18. Have you been enrolled in, required to enter into, or participated in any drug or alcohol recovery program or impaired practitioner program? YES [redacted] NO [redacted]

☐

19. Have you been treated for or had a recurrence of a diagnosed addictive disorder? YES [redacted] NO [redacted]

☑

20. Have you been diagnosed with an emotional, a mental, or behavioral disorder which impairs your ability to practice medicine safely? YES [redacted] NO [redacted]

☐

21. Have you ever been diagnosed with a neurological or other physical condition that would impair your ability to practice medicine safely? YES [redacted] NO [redacted]

☐

22. Do you have any other condition which in any way impairs or limits your ability to practice medicine safely? YES [redacted] NO [redacted]

☐

If you do receive ongoing treatment or participate in a monitoring program, the Board will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure.

CRIMINAL RECORD HISTORY

Criminal Record

23. Have you ever been convicted of, or pled guilty or nolo contendere to ANY offense in any state in the United States or foreign country?

This includes a citation, infraction, misdemeanor and/or felony, etc. If "YES" attach a list of each offense by arrest and conviction dates, violation, and court of jurisdiction (name and address). Matters in which you were diverted, deferred, pardoned, pled nolo contendere, or if the conviction was later expunged from the record of the court or set aside under Penal Code Section 1203.4 MUST be disclosed. If you are awaiting judgment and sentencing following entry of a plea or jury verdict, you MUST disclose the conviction; you are entitled to submit evidence that you have been rehabilitated. Serious traffic convictions such as reckless driving, driving under the influence of alcohol and/or drugs, hit and run, evading a peace officer, failure to appear, driving while the license is suspended or revoked MUST be reported. This list is not all-inclusive. If in doubt as to whether a conviction should be disclosed, it is better to disclose the conviction on the application.

For each conviction disclosed, you must submit with the application certified copies of the arresting agency report, certified copies of the court documents, and a descriptive explanation of the circumstances surrounding the conviction of disciplinary action (i.e., dates and location of incident and all circumstances surrounding the incident). This letter must accompany the application. If documents were purged by arresting agency and/or court, a letter of explanation from these agencies is required.

Applicants who answer "NO" to the question but have a previous conviction or plea, may have their application denied or license revoked for knowingly falsifying the application. YES [redacted] NO [redacted]

☐

APPLICANT:			DATE OF BIRTH:
Mitchell	David	Creinin	[redacted]

L1C

66678) MW

CRIMINAL RECORD HISTORY (cont'd)

MBC Use Only
Criminal Record

24. Is any criminal action pending against you? YES [redacted] NO [redacted]

25. Are you required to register as a Sex Offender? YES [redacted] NO [redacted]

DISCIPLINARY HISTORY

Discipline

These questions refer to discipline by any U.S. military or public health service, state board or other governmental agency of any U.S. state, territory, Canadian province, or country.

26. Have you ever been denied a license to practice medicine? YES [redacted] NO [redacted]

27. Is any denial pending against you? YES [redacted] NO [redacted]

28. 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? YES [redacted] NO [redacted]

29. Have you ever had any license to practice medicine revoked, suspended, or placed on probation? YES [redacted] NO [redacted]

30. Have you ever had any license to practice medicine subjected to any action including but not limited to informal or confidential discipline, consent orders, letters of warning, letters of reprimand, or citation? YES [redacted] NO [redacted]

31. Have you ever had any license to practice medicine subjected to any other disciplinary action? YES [redacted] NO [redacted]

32. Is any disciplinary action pending against any of your licenses to practice medicine? YES [redacted] NO [redacted]

33. Have you ever had staff privileges in a hospital terminated, denied, suspended, limited, revoked, or not renewed? YES [redacted] NO [redacted]

34. Have you ever resigned from a medical staff in lieu of disciplinary or administrative action? YES [redacted] NO [redacted]

35. Is any disciplinary action pending against your hospital staff privileges? YES [redacted] NO [redacted]

36. Have you ever surrendered a license to practice medicine? YES [redacted] NO [redacted]

37. Have your DEA privileges ever been denied, suspended, restricted, or terminated? YES [redacted] NO [redacted]

38. Have you ever entered into any arrangement or plea or agreement in lieu of a federal prosecution for a drug violation regulated by the DEA? YES [redacted] NO [redacted]

APPLICANT:

Mitchell David Crelnin

DATE OF BIRTH: [redacted]

L1D

7

MEDICAL BOARD OF CALIFORNIA

Licensing Program

ADDENDUM TO THE INITIAL AND UPDATE APPLICATION FOR PHYSICIAN'S AND SURGEON'S LICENSE OR POSTGRADUATE TRAINING AUTHORIZATION LETTER FOR FORM L1-D

The applicant, Mitchell David Greinin, [redacted] being first duly sworn
(PLEASE PRINT FULL NAME) (DATE OF BIRTH)

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.

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. MG **(PLEASE INITIAL BOX)**

SIGNATURE OF APPLICANT Mitchell D Greinin
(Please sign full name)

State of Pennsylvania

County of Allegheny

Subscribed and sworn to (or affirmed) before me on

This 16th day of December, 2010

by: (applicant's name to be printed here) Mitchell DAVID Greinin
proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.

NOTARIAL SEAL
DALE A DALEY
Notary Public
PITTSBURGH CITY, ALLEGHENY COUNTY
My Commission Expires Mar 21, 2013

Dale A Daley
SIGNATURE OF NOTARY PUBLIC

CRIMINAL RECORD HISTORY (cont'd)

MBC Use Only
Criminal Record

24. Is any criminal action pending against you? YES [redacted] NO [redacted] ☐

25. Are you required to register as a Sex Offender? YES [redacted] NO [redacted] ☐

DISCIPLINARY HISTORY

Discipline

These questions refer to discipline by any U.S. military or public health service, state board or other governmental agency of any U.S. state, territory, Canadian province, or country.

26. Have you ever been denied a license to practice medicine? YES [redacted] NO [redacted] ☐

27. Is any denial pending against you? YES [redacted] NO [redacted] ☐

28. 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? YES [redacted] NO [redacted] ☐

29. Have you ever had any license to practice medicine revoked, suspended, or placed on probation? YES [redacted] NO [redacted] ☐

30. Have you ever had any license to practice medicine subjected to any action including but not limited to informal or confidential discipline, consent orders, letters of warning, letters of reprimand, or citation? YES [redacted] NO [redacted] ☐

31. Have you ever had any license to practice medicine subjected to any other disciplinary action? YES [redacted] NO [redacted] ☐

32. Is any disciplinary action pending against any of your licenses to practice medicine? YES [redacted] NO [redacted] ☐

33. Have you ever had staff privileges in a hospital terminated, denied, suspended, limited, revoked, or not renewed? YES [redacted] NO [redacted] ☐

34. Have you ever resigned from a medical staff in lieu of disciplinary or administrative action? YES [redacted] NO [redacted] ☐

35. Is any disciplinary action pending against your hospital staff privileges? YES [redacted] NO [redacted] ☐

36. Have you ever surrendered a license to practice medicine? YES [redacted] NO [redacted] ☐

37. Have your DEA privileges ever been denied, suspended, restricted, or terminated? YES [redacted] NO [redacted] ☐

38. Have you ever entered into any arrangement or plea or agreement in lieu of a federal prosecution for a drug violation regulated by the DEA? YES [redacted] NO [redacted] ☐

[redacted]

Notice: All items in this application, except #8 and #9, are mandatory. 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 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.

The applicant, Mitchell David Creinin, [redacted] being first duly sworn upon his/her
(PLEASE PRINT FULL NAME) (DATE OF BIRTH)

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 any 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. MC **(PLEASE INITIAL BOX)**

SIGNATURE OF APPLICANT: Mitchell David Creinin
(Please sign full name – in presence of notary)

State of Pennsylvania

County of Allegheny

Subscribed and sworn to (or affirmed) before me on this 22 day of October, 2010, by

Mitchell DAVID CREININ
(Notary to print name of applicant.)

proved to me on the basis of satisfactory evidence to be the person who appeared before me.

Signature Dale A. Daley

NOTARIAL SEAL
DALE A DALEY
Notary Public
PITTSBURGH CITY, ALLEGHENY COUNTY
My Commission Expires Mar 21, 2013

L1E

10/18

STATE OF CALIFORNIA -- STATE AND CONSUMER SERVICES AGENCY — ARNOLD SCHWARZENEGGER, Governor

Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815
(800) 633-2322 (916) 263-2382 Fax (916) 263-2487
www.mbc.ca.gov

2010 OCT 28 PM 2:24

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11/2/10
MJW

CERTIFICATE OF MEDICAL EDUCATION

MEDICAL SCHOOL: PLEASE COMPLETE THIS FORM IN THE ENGLISH LANGUAGE

This certifies that Mitchell David Creinin ; [redacted] ;
Full Name of Applicant — U.S. Social Security Number

[redacted] ; enrolled in Northwestern University Feinberg School of Medicine
Date of Birth — Name of Medical School

located in Chicago, IL Cook on 09/24/1984.
State/Province Country — Enrollment Date

The undersigned further certifies that the records of this institution show that the applicant attended in this institution 4 years of resident instruction, 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 Sections 2089,2089.5, 2089.7,2090, 2091.1,2091.2) and that the applicant

- Anatomy
- Biochemistry
- Dermatology
- Embryology
- Histology
- Human Sexuality
- Medicine
- Neurology
- Obstetrics and Gynecology
- Ophthalmology
- Otolaryngology
- Pathology, Bacteriology, and Immunology
- Pharmacology
- Physiology
- Psychiatry
- Radiology, including Radiation Safety
- Surgery, including Orthopedic Surgery
- Tropical Medicine
- Urology
- Alcoholism and Chemical Dependency
- Anesthesia
- Child Abuse Detection and Treatment
- Family Medicine**
- Geriatric Medicine
- Pain Management and End-of-Life-Care***
- Pediatrics
- Physical Medicine
- Preventative Medicine, including Nutrition
- Spousal Partner Abuse Detection & Treatment*
- Therapeutics

* 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.

OK

☐ was granted the degree of Bachelor/Doctor of Medicine on the 03 day of JUNE , 1988 .

☐ withdrew from medical school on ____ day of _____ , _____ .

Unusual Circumstances

	Responses
Did this individual ever take a leave of absence from their medical education?	Yes [redacted] No
Was this individual ever placed on probation?	Yes [redacted] No
Was this individual ever disciplined or under investigation?	Yes [redacted] No
Were any incident reports regarding this individual ever filed by instructors?	Yes [redacted] No
Were any limitations or special requirements imposed on this individual because of questions of academic or disciplinary problems, or for any other reason?	Yes [redacted] No

A "Yes" response to ANY of the above questions requires the medical school to provide a written explanation on a separate attachment.

Medical School Seal Must Be Imprinted Below

Attention Medical School: Only the President, Dean, or Registrar may sign this form. If the signature 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 22 day of October , 2010 .

Printed Name and Title of School Official: Barbara M. Reiffman, MBA, Medical School Registrar

Signature: Barbara M. Reiffman

L2

26718 MW 11/2

Northwestern University

ON RECOMMENDATION OF THE FACULTY OF THE

SCHOOL OF MEDICINE

NORTHWESTERN UNIVERSITY HAS CONFERRED THE DEGREE OF

DOCTOR OF MEDICINE

UPON

MITCHELL DAVID CREININ

WHO HAS HONORABLY FULFILLED ALL THE REQUIREMENTS PRESCRIBED BY THE UNIVERSITY FOR THAT DEGREE

DONE AT EVANSTON ILLINOIS THIS THIRD DAY OF JUNE IN THE YEAR ONE THOUSAND NINE HUNDRED AND EIGHTY-EIGHT A.D.

Howard J. Trienens
CHAIRMAN OF THE BOARD OF TRUSTEES

Thomas Reid
SECRETARY OF THE BOARD OF TRUSTEES

NORTHWESTERN UNIVERSITY · QUAECUMQUE SUNT VERA · 1851

Arnold R. Weber
PRESIDENT OF THE UNIVERSITY

Harry N. Beaty, M.D.
DEAN

23

06270 MW

STATE OF CALIFORNIA -- STATE AND CONSUMER SERVICES AGENCY

ARNOLD SCHWARZENEGGER, Governor

Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815
(800) 633-2322 (916) 263-2382 Fax (916) 263-2487
www.mbc.ca.gov

LICENSING PROGRAM

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.

PART 1: TO BE COMPLETED BY THE APPLICANT

NAME: Last	First	Middle
Creinin	Mitchell	David

U.S. Social Security Number	Date of Birth	Telephone Number
[redacted]	[redacted]	Home [redacted] Work [redacted]

Public/Mailing Address [redacted]

City	State/Province	Zip/Postal Code
[redacted]	[redacted]	[redacted]

Medical School of Graduation
Northwestern University

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 satisfactorily completed a period of accredited postgraduate training at this facility and that the trainee has acquired the skill and qualifications necessary to safely assume the unrestricted practice of medicine in this state.

Name of Facility	ACGME 10-digit Program number (www.acgme.org)
University of California, San Francisco	2200521047
Address of Facility	**Telephone #**
505 Parnassus Avenue, SF, CA 94143	[redacted]
Categorical Specialty Area of Training	**Start Date of Training**	**End Date (or anticipated completion date) of Training**
OB/GYN	06/22/1988	06/30/1992

UNUSUAL CIRCUMSTANCES:

Did the trainee ever take a leave of absence or break from his/her training?	YES [redacted]	NO [redacted]
Was the trainee ever terminated, dismissed or expelled?	YES	NO
Did the trainee ever resign?	YES	NO
Was the trainee ever placed on probation?	YES	NO
Was the trainee ever disciplined or placed under investigation?	YES	NO
Were any incident reports regarding this trainee ever filed by instructors?	YES	NO
Were any limitations or special requirements placed upon the trainee for clinical incompetence, disciplinary problems or for any other reason?	YES	NO
Did the program decline to renew or offer the trainee a postgraduate training program contract for a following year?	YES	NO

A "Yes" response to ANY of the above questions requires the program director to provide a written explanation on a separate attachment.

L3A

DEFINITION OF "SATISFACTORY" COMPLETION OF TRAINING

The program director signing this form is formally certifying and documenting under penalty of perjury that the trainee received instruction appropriate for the particular postgraduate level and that he/she satisfactorily completed periods of training in accordance with the accepted standards and the criteria defined as equating to "satisfactory" performance as described below. The program director will personally be attesting to the fact that the trainee has acquired the skill and qualifications necessary to safely assume the unrestricted practice of medicine in this state.

"SATISFACTORY" IS DEFINED AS: THE TRAINEE PERFORMED AT AN ADEQUATE LEVEL BASED ON EVIDENCE OF SATISFACTORY PROGRESSIVE GROWTH INCLUDING DEMONSTRATED ABILITY TO ASSUME GRADED AND INCREASING RESPONSIBILTY FOR PATIENT CARE.

GENERAL MEDICINE TRAINING REQUIREMENT

To qualify for licensure in California, applicants who are graduates of an international medical school must complete at least four months of postgraduate training in GENERAL MEDICINE as part of the requirement. Applicants who are graduates of a U.S. or Canadian medical school, who have not completed postgraduate training required for licensure by July 1, 1990, must also complete four months of training in GENERAL MEDICINE prior to licensure. The GENERAL MEDICINE requirement may be satisfied by actual clinical practice where the applicant has direct patient care responsibilities in any particular specialty or sub-specialty area for at least four months.

I hereby certify as the program director, that the individual named in Part 1

☒ has completed ☐ has not completed

a minimum of four months of general medicine as part of this postgraduate training program accredited by the ACGME or the RCPSC.

SIGNATURE OF PROGRAM DIRECTOR

ATTENTION PROGRAM DIRECTOR: THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE, OR ADOPTION. If that signature authority is being delegated to another person, evidence of that delegation must be attached to this form (may be a photocopy). Each delegation must be on official letterhead and must be dated within the last 12 months.

HOSPITAL SEAL

OFFICIAL HOSPITAL SEAL MUST BE AFFIXED IN THE BOX TO THE LEFT TO CERTIFY TRAINING

The training program is accredited by the ACGME or the RCPSC to offer the type and level of training completed by the applicant, and the applicant was trained in an accredited ACGME or RCPSC program position. I hereby declare under penalty of perjury under the laws of the State of California that the statements are true and correct.

Amy (Meg) Autry M.D.
PRINT NAME OF PROGRAM DIRECTOR

SIGNATURE OF PROGRAM DIRECTOR
Signature Stamp Is Not Acceptable

1/11/11
DATE SIGNED

If a hospital seal is not available, the program director shall sign this form in the presence of a notary public.

SIGNATURE OF PROGRAM DIRECTOR: _____
(Please sign full name – in presence of notary)

State of _____

County of _____

Subscribed and sworn to (or affirmed) before me on this _____ day of _____, 20_____, by

_____
(Notary to print director's name.)

proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.

Signature_____(seal)

L3B

0 MW
2 h2780

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS
P. O. Box 2649
Harrisburg, PA 17105-2649
www.dos.state.pa.us

2011 FEB 10 PM 3:45

LICENSING
PROGRAM

February 3, 2011

CERTIFICATION OF LICENSE

This is to certify that the individual or business named below is licensed by the Department of State, Bureau of Professional and Occupational Affairs:

NAME:	MITCHELL DAVID CREININ
LICENSE TYPE:	Medical Physician and Surgeon
LICENSE NUMBER:	MD052717L
ORIGINAL LICENSURE DATE:	06/29/1994
EXPIRATION DATE:	12/31/2012
STATUS:	Active

The license is in good standing and the records indicate no derogatory information.

SEAL

Deputy Commissioner
Bureau of Professional and Occupational Affairs

STATE OF HAWAII
DEPARTMENT OF COMMERCE AND CONSUMER AFFAIRS
PROFESSIONAL AND VOCATIONAL LICENSING DIVISION
P.O. BOX 3469
HONOLULU, HAWAII 96801

12/21/10

MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM
2005 EVERGREEN ST STE 1200
SACRAMENTO CA 95815

RE: VERIFICATION OF LICENSE/EXAM SCORES DATED 12/21/10 FOR
MITCHELL DAVID CREININ

BOARD/COMMISSION:	HAWAII MEDICAL BOARD
LICENSE TYPE:	PHYSICIAN
LICENSE IDENTIFICATION:	MD 7257
METHOD OF LICENSURE:	
DATE LICENSED:	09/04/90
LICENSE STATUS:	TERMINATED; NEEDS TO REAPPLY
LICENSE EXPIRATION DATE:	01/31/92
DISCIPLINARY ACTION:	NONE

ACCORDING TO OUR COMPLAINT RECORDS WHICH DATE BACK TO 1985:

✓ NO DEROGATORY INFORMATION IS ON FILE.

__ THE ATTACHED INFORMATION IS ON FILE CONCERNING THIS LICENSEE.

CERTIFIED BY:

Constance Cabral

CONSTANCE CABRAL
EXECUTIVE OFFICER

Application Summary

License Type:	**Physician and Surgeon G**
License Number:	**67491**
File Number:	**217804**
Application:	**Physician's and Surgeon's Renewal**
Application Number:	**14331868**
Application Date:	**08/16/2016 (mm/dd/yyyy)**

Application Questions

Have you served or are you currently serving in the military? [redacted]

Personal Detail

First Name:	**MITCHELL**
Middle Name:	**DAVID**
Last Name:	**CREININ**
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? [redacted]

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? [redacted]

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. [redacted]

Family Physician Training Program Voluntary Fee

Voluntary Fee: [redacted]

Attachments

Physician Survey

Are you retired?	**No**
Activities in Medicine	**Administration - 10-19 Hours**
	Other - 1-9 Hours
	Patient Care - 10-19 Hours
	Research - 10-19 Hours
	Teaching - 10-19 Hours
	Telemedicine - 1-9 Hours
Patient Care Practice Location	**Zip: 95817 County: SACRAMENTO**
Telemedicine Practice Location	**Zip: 95817 County: SACRAMENTO**
Patient Care Secondary Practice Location	**Zip: County:**
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	**5 Years**
Cultural Background	**White**
Web Site Profile	**Cultural Background - No**
	Foreign Language Proficiency - No
	Gender - Yes
E-mail:	[redacted]

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
dca
DEPARTMENT OF CONSUMER AFFAIRS

dca BREEZE

Department of Consumer Affairs

RECEIPT

19123937

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

Name:	CREININ, MITCHELL DAVID
Transaction Date:	08/16/2016 17:16
Application Number:	14331868
Complaint Number:	
License Type:	8002
License Number:	67491
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:	**67491**
File Number:	**217804**
Application:	**Physician's and Surgeon's Renewal**
Application Number:	**14118150**
Application Date:	**08/23/2014 (mm/dd/yyyy)**

Personal Detail

First Name:	**MITCHELL**
Middle Name:	**DAVID**
Last Name:	**CREININ**
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? [redacted]

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? [redacted]

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. [redacted]

Family Physician Training Program Voluntary Fee

Voluntary Fee: [redacted]

Attachments

Physician Survey

Are you retired?	**No**
Activities in Medicine	**Administration - 10-19 Hours**
	Patient Care - 10-19 Hours
	Research - 20-29 Hours
	Teaching - 1-9 Hours
	Telemedicine - None
Patient Care Practice Location	**Zip: 95817 County: SACRAMENTO**
Telemedicine Practice Location	**Zip: County:**
Patient Care Secondary Practice Location	**Zip: 95817 County: SACRAMENTO**
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	**None**
Web Site Profile	**Cultural Background - Yes**
	Foreign Language Proficiency - Yes
	Gender - Yes
E-mail:	[redacted]

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**

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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
dca
DEPARTMENT OF CONSUMER AFFAIRS

dca BREEZE

Department of Consumer Affairs

RECEIPT

647499

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

Name:	CREININ, MITCHELL DAVID
Transaction Date:	08/23/2014 09:13
Application Number:	14118150
Complaint Number:	
License Type:	8002
License Number:	67491
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.