



**BOARD OF MEDICAL QUALITY ASSURANCE**  
 1430 HOWE AVENUE  
 SACRAMENTO, CA 95825  
 (916) 920-4411

RECEIVED  
 SACRAMENTO  
 BOARD OF MEDICAL  
 QUALITY ASSURANCE



16 FEB 80 14 33

**APPLICATION FOR PHYSICIAN AND SURGEON'S  
 EXAMINATION AND LICENSURE**

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.

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 30630  
 11000/5 8  
 009722  
 BACK USE ONLY

1. Name: Last First Middle <b>OGBURN JOSEPH ANTHONY</b>				PERSONAL DATA
2. Other names you have used:				
3. Address: Member and Street/Rural Route (include apartment number, if any) [Redacted] City State ZIP Code County				
4. Telephone Numbers Home Work		5. Date of Birth Mo/Day/Yr		NON-MEDICAL EDUCATION
[Redacted]		[Redacted]		
6. Sex: <input type="checkbox"/> Female <input checked="" type="checkbox"/> Male		7. Are you a U.S. citizen? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <small>Submit a verified copy of birth certificate, Certificate of Naturalization, Declaration of Intention to become U.S. Citizen (INS Form #1300), VISA document, or license to practice medicine.</small>		
8. Have you ever filed an application in California? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <small>If YES, the date of previous application:</small>				
9. List name and address of all colleges or universities attended other than schools where professional medical instruction was received. Submit an official transcript from each school attended.				
Name	Address	Period of Attendance From (Mo/Yr) To (Mo/Yr)		
<b>FLORIDA JUNIOR COLLEGE</b>	<b>SOUTH CAMPUS, JAX FLA</b>	<b>6/75</b>	<b>6/76</b>	<input checked="" type="checkbox"/>
<b>UNIV. OF FLORIDA</b>	<b>TIGERT HALL, GAINESVILLE FLA</b>	<b>9/76</b>	<b>12/80</b>	<input checked="" type="checkbox"/>
10. Check whether the following premedical courses were successfully completed and show where completed:				
Course	Yes	No	Name of College or University	
Chemistry	<input checked="" type="checkbox"/>	<input type="checkbox"/>	UNIVERSITY OF FLORIDA	
Physics	<input checked="" type="checkbox"/>	<input type="checkbox"/>	UNIVERSITY OF FLORIDA	
Biology	<input checked="" type="checkbox"/>	<input type="checkbox"/>	UNIVERSITY OF FLORIDA	
Zoology	<input checked="" type="checkbox"/>	<input type="checkbox"/>	UNIVERSITY OF FLORIDA	



**L1A**

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

Name	Address	Place Where Instruction Received	Period of Attendance	
			From (Mo/Yr)	To (Mo/Yr)
UNIV. OF FLORIDA		GAINESVILLE	8/82	5/86

EDUCATION  
 CME  
 TRANS

12. Doctor of Medicine Degree granted by: (submit original medical diploma and a photocopy)  
 Name of Medical School: UNIVERSITY OF FLORIDA SCHOOL OF MEDICINE  
 Address of Medical School: Box J-210, JHMHC, GAINESVILLE, FL 32610  
 Date of Issuance: 5/31/86

603  
 School Code

13. Have you taken any of the following written examinations: National Boards, ECFMG, FMGEMS, ILEX, MSKP, MCAT, other relative of medical competency examinations?  
 If YES, list name, location, date and result of examination. Submit certification of scores from each examination agency.

Name	Location	Date	Result
NATIONAL Bd. PT 1	UNIV. OF FLA GAINESVILLE, FL	6/85	570 (84)
NATIONAL Bd. PT 2	UNIV. OF FLA GAINESVILLE, FL	4/85	600 (86)
NATIONAL Bd. PT 3	UCFA - HARBOUR RIDGE SANTA FE, CALIFORNIA CA	5/82	430 (79.6)

EXAMINATION

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 ACCME Postgraduate Training from each facility.

Name	Address	Type of Service	Period of Attendance	
			From (Mo/Yr)	To (Mo/Yr)
UNIV. CAL - IRVINE	ORANGE, CA 92697	CATEGORICAL INTERNSHIP	7/1/86	6/31/87

POSTGRADUATE TRAINING

15. Have you been licensed to practice medicine in any state or country?  Yes  No  
 If YES, list state or country, license number, date issued and dates of practice in issuing agency's jurisdiction for each. Submit a letter of Good Standing from each state in which you are licensed or have been licensed.

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

L1B

BMCA USE ONLY

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.

Yes  No If yes, give details below:

State	Date	Charge	Disposition

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

Yes  No If yes, give details below:

State or Country	Date of Denial	Reason for Denial

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

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

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

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

20. Are you now, or were you in the past, addicted to controlled substances, such as narcotics or alcohol?

Yes  No

21. Have you ever been convicted of, or pled not guilty to a violation of any federal, state or local law relating to the manufacture, distribution or dispensing of controlled substances, or to drug addiction?

Yes  No If yes, give details below:

Violation and Location	Date	Penalty or Disposition

22. Have you ever been convicted of, or pled not guilty 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.)

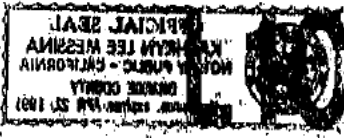
Yes  No If yes, give details below:

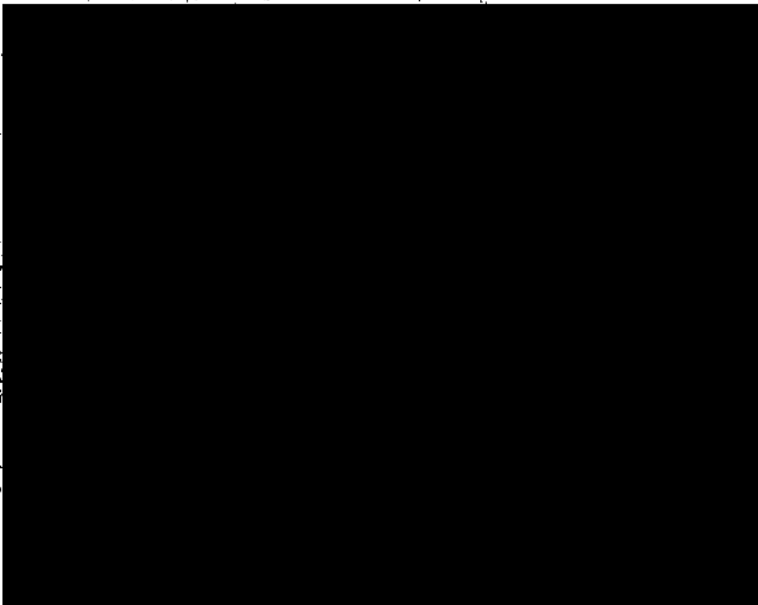
Violation and Location	Date	Penalty or Disposition

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.

LICENSE DATA (continued)

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

on or about [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. 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 ORANGE

JOSEPH ANTHONY OGBURN 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.

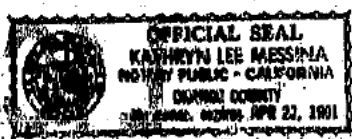
Joseph Anthony Ogburn  
Signature of applicant in FULL (Do not use INITALS ONLY)

Signed and sworn to before me this 21 day of JANUARY, 1988

Signature of Notary Public Kathryn Lee Messina

Address 150 Town Center Drive Costa Mesa

(SEAL)



My commission expires April 22, 1991

**L1D**



BOARD OF MEDICAL QUALITY ASSURANCE  
1430 HOWE AVENUE, SACRAMENTO, CALIFORNIA 95827  
(916) 920-6411

SACRAMENTO  
BOARD OF MEDICAL  
QUALITY ASSURANCE



CERTIFICATE OF MEDICAL EDUCATION

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

This certifies that Joseph Anthony Ogburn FULL NAME OF APPLICANT  
of [REDACTED] ADDRESS WHEN ENROLLED enrolled in University of Florida NAME OF MEDICAL SCHOOL  
Gainesville, Florida LOCATION on the 23 day of August 1982 MONTH YEAR

and was granted the following credits on enrollment:  
Premedical Education. Two years of preprofessional postsecondary education, including five subjects of physics, chemistry, and biology (Business and Professions Code Section 2088);  
University of Florida 1976-80  
EDUCATIONAL INSTITUTION DATES

Advanced Credits. Credit previously obtained at an approved medical school,  
MEDICAL SCHOOL TOTAL CREDITS DATES

He underwent further certifies that the records of this institution show that he attended in this institution 30 CREDITS COURSES of  
resident instruction of 2-10 weeks each, completing at least 4,000 hours, of which at least 90 percent actual attendance is re-  
quired, in the subjects set forth hereunder (Business and Professions Code Section 2089), and that  
 he was granted the degree Doctor of Medicine by  
 he withdrew from  
the above mentioned medical school on the 31 day of MAY 1986 MONTH YEAR

- Anatomy
- Otolaryngology
- Obstetrics and Gynecology
- Radiology, including Radiation Safety
- Tropical Medicine
- Physiology
- Biophysics
- Pathology, Bacteriology and Immunology
- Ophthalmology

- Dermatology
- Embryology
- Histology
- Physical Sexuality as defined in Section 2090
- Medicine
- Surgery, including Orthopedic Surgery
- Urology
- Psychiatry
- Neurology

- Preventive medicine, including Nutrition
- Physical Medicine
- Neurophysiology
- Neuroanatomy
- Child Abuse Detection and Treatment
- Geriatric Medicine
- Pediatrics
- Pharmacology
- Anesthesia

Signed and the college sealed this 25 day of March 1988

BY Rebecca B. Leacock  
Rebecca B. Leacock, Asst. Registrar FOR MEDICINE

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

\* For a school where postsecondary study of instruction was received ALL courses and all these courses, if  
more than one school was attended, for transcripts all the blank space may be made and used. Make that  
photograph and all return to the form must be signed.

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BOARD OF MEDICAL QUALITY ASSURANCE

1400 HOWE AVENUE, SACRAMENTO, CALIFORNIA 95825  
(916) 920-4111



CERTIFICATE OF MEDICAL EDUCATION

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

This certifies that JOSEPH ANTHONY OGBURN

NET NAME OF APPLICANT

of [REDACTED] called in UNIVERSITY OF FLORIDA

NAME OF MEDICAL SCHOOL

GAINESVILLE, FLA on the 31<sup>st</sup> day of MAY 1986

LOCATION

DATE

MONTH

YEAR

and was granted the following credits on enrollment:

**Premedical Education:** Two years of preprofessional postsecondary education, including the subjects of physical, chemistry, and biology (Business and Professions Code Section 2088).

University of Florida College of Medicine 1976-1980

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 <u>he</u> attended in this institution <u>30</u> courses of		
residential instruction of <u>2-10</u> weeks each, comprising at least 4,000 hours, of which at least 80 percent actual attendance is re-		
quired, in the subjects set forth hereunder (Business and Professions Code Section 2089), and that		
<input checked="" type="checkbox"/> <u>he</u> was granted the degree Bachelor/Doctor of Medicine by		
<input type="checkbox"/> <u>he</u> withdrew from		
the above mentioned medical school on the <u>31</u> day of <u>May</u> <u>1986</u> .		

- Anatomy
- Otolaryngology
- Obstetrics and Gynecology
- Nephrology/Including Radiation Safety
- Tropical Medicine
- Pathology
- Microbiology
- Immunology and Immunology
- Ophthalmology

- Dermatology
- Embryology
- Histology
- Human Sexuality as defined in Section 2090
- Medicine
- Surgery, including Orthopedic Surgery
- Urology
- Psychiatry
- Neurology

- Preventive medicine, including Nutrition
- Physical Medicine
- Therapeutics
- Neuroanatomy
- Child Abuse Detection and Treatment
- Geriatric Medicine
- Pediatrics
- Pharmacology
- Anesthesia

**APPLICANT:**

Attach a 2 1/2" x 3" BLACK and WHITE finished photograph of passport quality of your head and shoulders only. Photo must have been taken within the last 60 days and be signed in ink across the lower portion of the front side.

Proof photos, negatives, polaroid-type photos are not acceptable.

Signed and the college seal affixed this 8<sup>th</sup> day of December, 19 87

BY Rebecca D. Leglock PRESIDENT, SECRETARY, DEAN  
Deputy Registrar College of Medicine

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

\* 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 name printed in the top right be aligned.

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



CERTIFICATE OF COMPLETION OF ACGME POSTGRADUATE TRAINING

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

This is to certify that JOSEPH ANTHONY OGBURN  
NAME OF APPLICANT

is graduate of UNIVERSITY OF FLORIDA  
NAME OF MEDICAL SCHOOL

at UC IRVINE MEDICAL CENTER  
101 THE CITY DRIVE, D-OB/GYN  
ORANGE, CA 92668  
NAME AND ADDRESS OF FACILITY

on JULY 1, 1986 and completed such training

on JUNE 30, 1987. 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:

(All rotations completed. If service was not rotating, indicate type of straight rotating 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 residents in family practice, internal medicine, surgery, pediatrics and ob/gyn would normally satisfy this requirement.)

ROTATION	LENGTH OF ROTATION
OB/GYN	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 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 THOMAS L. NELSON, M.D., ASSOCIATE DEAN  
DIRECTOR OF MEDICAL EDUCATION  
UC IRVINE MEDICAL CENTER  
101 THE CITY DRIVE - HOSPITAL AFFAIRS  
ADDRESS ORANGE, CA 92668

AT THE SEAL OF HOSPITAL OR NOTARY PUBLIC

PHONE NUMBER [REDACTED]

DATE January 7, 1988

SIGNATURE [Signature]

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BOARD OF MEDICAL QUALITY ASSURANCE

1430 HOWE AVENUE, SACRAMENTO, CALIFORNIA 95825

(916) 920-6411



CERTIFICATION STATEMENT

This is to certify that JOSEPH ANTHONY OGBURN, M.D. is in an  
(Name of Physician)

ACGME/CCME postgraduate training position that commenced on

JULY 1, 19 86 and is expected to be completed on

JUNE 30, 19 90 in OBSTETRICS AND GYNECOLOGY  
(Type of Training)

at UC IRVINE MEDICAL CENTER  
(Name and Address of Facility)  
101 THE CITY DRIVE, D-OB/GYN  
ORANGE, CA 92668

(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.

THOMAS L. NELSON, M.D.  
ASSOCIATE DEAN, HOSPITAL AFFAIRS

TYPE OR PRINT NAME OF DIRECTOR OF MEDICAL EDUCATION

*Thomas L. Nelson*  
SIGNATURE OF DIRECTOR OF MEDICAL EDUCATION

January 7, 1988  
DATE [REDACTED]  
PHONE NUMBER