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

RECEIVED SACRAMENTO BOARD OF MEDICAL QUALITY ASSURANCE
16 FEB 00 14 33

APPLICATION FOR PHYSICIAN AND SURGEON'S EXAMINATION AND LICENSURE

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11000/5
127 A 18

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.

009722 BMQA USE ONLY

1. Name: Last OGBURN First JOSEPH Middle ANTHONY

2. Other names you have used:

3. Address: Number and Street/Rural Route (include apartment number, if any) [redacted]
City State ZIP Code County [redacted]

4. Telephone Number: Home Work [redacted]

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

6. Sex: ☐ Female ☒ Male

7. 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.

8. Have you ever filed an application in California? ☐ Yes ☒ No
If YES, give date of previous application:

PERSONAL DATA

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)
FLORIDA JUNIOR COLLEGE	SOUTH CAMPUS, JAX FLA	6/75	6/76
UNIV. OF FLORIDA	TIGERT HALL, GAINESVILLE FLA	9/76	12/80

NON-MEDICAL EDUCATION

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

Course	Yes	No	Name of College or University
Chemistry	✓		UNIVERSITY OF FLORIDA
Physics	✓		UNIVERSITY OF FLORIDA
Biology	✓		UNIVERSITY OF FLORIDA
Zoology	✓		UNIVERSITY OF FLORIDA

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AMA USE ONLY

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)	Period of Attendance To (Mo/Yr)
UNIV. OF FLORIDA		GAINESVILLE	8/82	5/86

EDUCATION

CME ☑ TRAINS ☑

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
UNIVERSITY OF FLORIDA SCHOOL OF MEDICINE	BOX J-210, JHMHC GAINESVILLE, FL 32610	5/31/86

FL 003
School Code

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.

EXAMINATION

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	UCLA - HARBOR VIEW CNTR/TORRANCE CA	5/87	430 (79.6)

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 from each facility.

POSTGRADUATE TRAINING

Name	Address	Type of Service	Period of Attendance From (Mo/Yr)	Period of Attendance To (Mo/Yr)
UNIV. CAL - IRVINE	ORANGE/VA MEDICAL CTR 101 THE CITY DRIVE	SURGICAL INTERN	7/1/86	6/30/87

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.

LICENSURE DATA

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

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LICENSE DATA (continued)

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

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 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.

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? [redacted] Yes [redacted] 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?

[redacted] Yes [redacted] No

21. 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

22. 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.

OFFICIAL SEAL
[redacted]
NOTARY PUBLIC - CALIFORNIA
ORANGE COUNTY
My Comm. Expires [redacted]

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 Profession 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)

Robert 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.

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

Signed and sworn to before me this 21 day of January 1988

Signature of Notary Public Kathryn Lee Messina

(SEAL)

Address 650 Town Center Drive, Costa Mesa

OFFICIAL SEAL
KATHRYN LEE MESSINA
NOTARY PUBLIC - CALIFORNIA
ORANGE COUNTY
My comm. expires APR 22, 1991

My commission expires April 22, 1991

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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

RECEIVED
SACRAMENTO
BOARD OF MEDICAL
QUALITY ASSURANCE

6 Dec 88 1301

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] enrolled in University of Florida
(ADDRESS WHEN ENROLLED) (NAME OF MEDICAL SCHOOL)

Gainesville, Florida on the 23 day of August 19 82
(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 2089).

University of Florida 1976-80
(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 30 (WEEKS/YEARS) courses of resident instruction of 2-10 (YEARS OR 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 31 day of May (MONTH), 19 86

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

[redacted]

Signed and the college seal affixed this 25 day of March, 19 88

BY Rebecca C. Leacock
Rebecca C. 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

* Each school which premedical credit of instruction were received MUST complete one of these forms. If more than one school was attended, photocopies of the blank form may be made and used. Note that photocopied seals will indicate the seal must be original.

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(916) 920-6411

CERTIFICATE OF MEDICAL EDUCATION

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

This certifies that Joseph Anthony Oeburn
(FULL NAME OF APPLICANT)

of [redacted] matriculated in University of Florida
(NAME OF MEDICAL SCHOOL)

Gainesville Fla (LOCATION) on the 31st 23rd day of May August (MONTH) 1986 82

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 2088).

University of Florida College of Medicine (EDUCATIONAL INSTITUTION) 1976-1980 (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 30 (SPECIFY NUMBER) courses of resident instruction of 2 to 10 (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 31 day of May (MONTH) 19 86.

Anatomy
Otolaryngology
Obstetrics and Gynecology
Radiology, including Radiation Safety
Tropical Medicine
Physiology
Biochemistry
Bacteriology, Microbiology 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
Neuromotology
Child Abuse Detection and Treatment
Geriatric Medicine
Pediatrics
Pharmacology
Anesthesia

APPLICANT:

Attach a 2½" 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 8th day of December, 19 87

BY Rebecca D. Lemock
(PRESIDENT, SECRETARY, DEAN)
Rebecca D. Lemock, 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 all entries to the form must be original.

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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)

a graduate of UNIVERSITY OF FLORIDA
(NAME OF MEDICAL SCHOOL)

commenced postgraduate training in UC IRVINE MEDICAL CENTER
101 THE CITY DRIVE, D-OB/GYN
ORANGE, CA 92668
(NAME AND ADDRESS OF FACILITY)

on JULY 1, 19 86, and completed such training

on JUNE 30, 19 87. 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
OB/GYN	12 MONTHS

[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 THOMAS L. NELSON, M.D., ASSOCIATE DEAN
(DIRECTOR OF MEDICAL EDUCATION)

AFFIX SEAL OF HOSPITAL OR NOTARY PUBLIC

ADDRESS UC IRVINE MEDICAL CENTER
101 THE CITY DRIVE - HOSPITAL AFFAIRS
ORANGE, CA 92668

PHONE NUMBER [redacted]

DATE January 7, 1988

SIGNATURE Thos. L. Nelson, Jr.

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(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

Thos. L. Nelson M.D.
SIGNATURE OF DIRECTOR OF MEDICAL EDUCATION

January 7, 1988
DATE

[redacted]
PHONE NUMBER

OTM-71 (3-87)

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