STATE OF CALIFORNIA — STATE AND CONSUMER SERVICES AGENCY

PETE WILSON, Governor

MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM

1426 Howe Avenue, Sacramento, CA 95825-3236
(916) 263-2499

99 JUL 12 PM 2:30
DIVISION OF LICENSING

APPLICATION FOR PHYSICIAN AND SURGEON'S EXAMINATION OR LICENSURE

98 JUL 13 PM 12:08

Please **READ** all instructions prior to completing this application. ALL questions on this application must be answered, and all supporting documents must be submitted with this application as per instructions.
Please type or print neatly. When space provided is insufficient, attach additional sheets of paper.

MBC USE ONLY

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

3. Social Security Number◆ [redacted]

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

5. Sex: ☒ Female ☐ Male

City [redacted] State [redacted] Zip Code [redacted] Country [redacted]

6. Telephone Number:
Home: [redacted]
Work: [redacted]

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

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

9. Are you a U.S. citizen? [redacted] Yes [redacted] No
If you are an international medical school graduate, you must provide an original full and unrestricted license to practice medicine in another state or country, **OR** official documentation of U.S. citzenship, **OR** an official Declaration of Intent to become a U.S. citizen.

10. Have you ever filed an application for physician and surgeon examination or licensure in California? ☐ Yes ☒ No
IF YES, PLEASE GIVE DATE PREVIOUS APPLICATION WAS SUBMITTED AND ATTACH ANY APPLICATION MATERIALS YOU MAY HAVE RETAINED.

11A. List the names and addresses of all colleges or universities attended where pre-professional, postsecondary instruction was received. Please submit official transcripts with the school seal affixed for each school attended.

Name	Address	Dates of Attendance
Oberlin	Oberlin, Ohio	9/83-5/88

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

Course	Yes	No	Name of College or University
Chemistry	X		San Francisco State
Physics	X		San Francisco State
Biology or Zoology	X		San Francisco State

12. List the names and addresses of all schools where professional medical instruction was received, and, where applicable, the degree awarded. **PLEASE SUBMIT:** 1) an original Certificate of Medical Education (Form L2) and official transcripts with the signature of the dean or registrar and the school seal affixed from each school attended; and 2) an original medical diploma and a photocopy.

School Name	Address	Place of Instruction	Dates of Attendance	Degree Awarded
Medical College of Pennsylvania	2900 Queen Lane	Phila, PA	8/93-5/97	MD

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

Name of Medical School	Address of Medical School	Exact Date of Issuance
Medical College of Pennsylvania	2900 Queen Lane, Phila, PA	5/23/97

◆ MANDATORY DISCLOSURE OF SOCIAL SECURITY NUMBERS
Disclosure of your social security number (or federal employer identification number [FEIN], if you are a partnership) is mandatory. Section 30 of the Business and Professions Code and Public Law 94-455 (42 USCA 405(c)(2)(C)) authorize collection of your social security number. Your social security number or FEIN will be used exclusively for tax enforcement purposes, for purposes of compliance with any judgment or order for family support in accordance with Section 11350.6 of the Welfare and Institutions Code, or for verification of licensure or examination status by a licensing or examination entity which utilizes a national examination and where licensure is reciprocal with the requesting state. If you fail to disclose your social security number or your FEIN, your application for initial licensure will not be processed AND you will be reported to the Franchise Tax Board, which may assess a $100 penalty against you.

School Code: 0907

L1A

07A-100 (Rev. 9/97)

MBC USE ONLY

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

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

Examination	Location	Date	Result
USMLE 1	Philadelphia, PA	June 95	PASSED
USMLE 2	Philadelphia, PA	May 1997	Passed
USMLE 3	San Mateo, CA	May 1998	Pending

14. Have you ever been licensed to practice medicine in any state or country? ☐ Yes ☒ No

IF YES, LIST STATE OR COUNTRY, LICENSE NUMBER, DATE ISSUED AND DATES OF PRACTICE IN EACH ISSUING AGENCY'S JURISDICTION. SUBMIT A LETTER OF GOOD STANDING FROM EACH STATE IN WHICH YOU ARE OR HAVE BEEN LICENSED. PLEASE INCLUDE TEMPORARY, TRAINING, OR PROVISIONAL LICENSES.

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

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

IF YES, LIST NAMES AND ADDRESSES OF ALL FACILITIES. SUBMIT AN ORIGINAL CERTIFICATE OF COMPLETION OF ACGME/CCME POSTGRADUATE TRAINING (FORM L3A/B) FROM EACH FACILITY. (DO NOT COMPLETE FORM L3A/BS TO DOCUMENT TRAINING RECEIVED IN RESEARCH FELLOWSHIP PROGRAMS.) **ALL TRAINING MUST BE LISTED, REGARDLESS OF WHETHER IT WAS SATISFACTORILY COMPLETED OR WILL BE USED TO MEET LICENSING REQUIREMENTS.**

Facility Name	Address	Type of Service	Dates of Attendance
Sutter Medical Center of Santa Rosa	3324 Chanate Road Santa Rosa, CA	Family Practice	07/01/97-06/30/98

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

15B. Have you ever withdrawn from, or been suspended, dismissed or expelled from a medical school or postgraduate training program? [redacted] Yes [redacted] No

16. Have you ever been charged with, or been found to have committed, unprofessional conduct, professional incompetence, gross negligence or repeated negligent acts or malpractice by any medical licensing board, other agency, or hospital or has any disciplinary action ever been filed or taken regarding any healing arts license which you now hold or have ever held, or is any such action pending? Include any disciplinary actions by the U.S. Military, U.S. Public Health Service or other U.S. federal governmental entity. IF YES, GIVE DETAILS BELOW. [redacted] Yes [redacted] No

State	Date	Charge	Disposition

L1B

MBC USE ONLY

17. Has a claim or action for damages ever been filed against you in the course of the practice of medicine or any other healing art which resulted in a malpractice settlement, judgement or arbitration award of over $30,000.00? [redacted] Yes [redacted] No

IF YES, GIVE DETAILS BELOW.

Name of Claimant	Location of Court	Brief Description of the Facts

18. Have you ever been denied a license, permission to practice medicine or any other healing art, or denied permission to take an examination in any state, country, or U.S. federal jurisdiction, or is any such action pending? [redacted] Yes [redacted] No

IF YES, GIVE DETAILS BELOW.

State or Country	Date of Denial	Reason for Denial

19. Have you ever voluntarily surrendered a license to practice in the healing arts in this or any other state, or voluntarily surrendered your narcotic (controlled substance) permit (state or federal) to any licensing board or any other agency, or is any such action pending? [redacted] Yes [redacted] No

20. Have you ever had staff privileges in a hospital denied, suspended, limited, revoked or not renewed for medical disciplinary cause, or resigned from a medical staff in lieu of disciplinary or administrative action, or is any such action pending? [redacted] Yes [redacted] No

21. Do you have any condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety, including but not limited to, any of the following? [redacted] Yes [redacted] No

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

- ☐ A condition which required admission to an inpatient psychiatric treatment facility.
- ☐ Alcohol or chemical substance dependency or addiction.
- ☐ Emotional, mental or behavioral disorder.
- ☐ Other (explain): ______________________

FOR ANY OF THE BOXES CHECKED ABOVE, PLEASE SUBMIT COMPLETE OFFICIAL INPATIENT AND OUTPATIENT TREATMENT RECORDS, EVIDENCE OF ONGOING REHABILITATION TREATMENT, AND A PERSONAL WRITTEN EXPLANATION.

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

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

YOU ARE REQUIRED TO LIST ANY CONVICTION THAT HAS BEEN SET ASIDE AND DISMISSED OR EXPUNGED, OR WHERE A STAY OF EXECUTION HAS BEEN ISSUED.

Violation and Location	Date	Penalty or Disposition

PHOTO DECLARATION

I hereby declare under penalty of perjury under the laws of the State of California, that the photo of myself attached hereto, taken on or about ________, 19__

my age then being ____ years;

my color of hair ________;

my color of eyes ________;

my height ____ ft. ____ in.;

my weight ________ lbs.;

and identifying marks are

____

Signature of Applicant: Kelly S Pfeifer

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 Program Manager of the Licensing Program is the custodian of records.

STATE OF California)

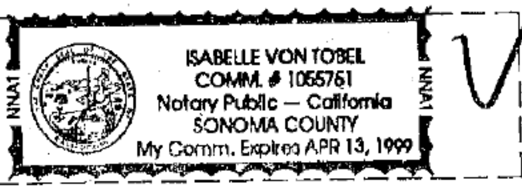
COUNTY OF Sonoma)

The applicant, Kelly Sue Pfeifer, being first duly sworn upon his/her
PRINT FULL NAME OF APPLICANT

oath deposes and says: that he/she is the person herein named subscribing to this application; that he/she has read the complete application, knows the full content thereof, and declares that all of the information contained herein and evidence or other credentials submitted herewith are true and correct; that he/she is the lawful holder of the degree of Doctor of Medicine as prescribed by this application, that the same was procured in the regular course of instruction and examination, and that it, together with all the credentials submitted, were procured without fraud or misrepresentation or any mistake of which the applicant is aware and that the applicant is the lawful holder thereof. Further, I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past, present and future), business and professional associates (past, present and future), and all government agencies (local, state, federal or foreign) to release to the Medical Board of California or its successors any information, files or records, including medical records, educational records, and records of psychiatric treatment and treatment for drug and/or alcohol abuse or dependency, requested by that Board in connection with this application; or any further or future investigation by that Board necessary to determine my medical competence, professional conduct or physical or mental ability to safely engage in the practice of medicine. I further authorize the Medical Board of California or its successors to release to the organizations, individuals or groups listed above any information which is material to this application or any subsequent licensure. I further acknowledge that falsification or misrepresentation of any item or response on this application is adequate to deny the same or to hold a hearing to revoke the same, if issued.

SIGNATURE OF APPLICANT: Kelly Sue Pfeifer
(PLEASE WRITE FULL NAME NOT INITIALS)

Signed and sworn to before me this 7th day of July, 19 98



NOTARY SEAL

Isabelle von Tobel
SIGNATURE OF NOTARY PUBLIC

3324 Chanate Rd
Santa Rosa CA 95404
ADDRESS

My commission expires 4/13/99

L1D

07A-100 (Rev. 9/97)

STATE OF CALIFORNIA — STATE AND CONSUMER SERVICES AGENCY PETE WILSON, Governor

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

RECEIVED BOARD OF MEDICAL QUALITY ASSURANCE
98 JUL 15 PM 3:17
DIVISION OF LICENSING

RECEIVED SACRAMENTO MEDICAL BOARD OF CALIFORNIA
98 JUL 13 PM 3:42

CERTIFICATE OF MEDICAL EDUCATION

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

This certifies that Kelley Sue Pfeifer (FULL NAME OF APPLICANT) of [redacted] (ADDRESS WHEN ENROLLED) enrolled in Medical College of Pennsylvania (NAME OF MEDICAL SCHOOL) Philadelphia, PA (LOCATION) on the 1st day of August (MONTH) 19 93 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).*

Oberlin College (EDUCATIONAL INSTITUTION) 9/83-5/88 (DATES)

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 she attended in this institution 4 (SPECIFY NUMBER) years of resident instruction of approx. 40 (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:

[X] she was granted the degree Bachelor/Doctor of Medicine by OR [ ] he withdrew from the above mentioned medical school on the 23rd day of May (MONTH), 19 97.

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

• Each school where professional medical instruction was received MUST complete one of these forms. If more than one school was attended, photocopies of this blank form may be made and used. Note that photograph and all entries to the form must be **original.**

•• ONLY applicable to medical students who graduate from medical school on or after May 1, 1998

••• ONLY applicable to medical students who enrolled in medical school on or after September 1, 1994.

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

Signed and the school seal affixed this ____ day of July, 1998.

BY Jerri A. Simmons, Director, Registrar's Office
PRESIDENT, SECRETARY, DEAN

L2

STATE OF CALIFORNIA — STATE AND CONSUMER SERVICES AGENCY

PETE WILSON, Governor

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

CERTIFICATE OF COMPLETION OF ACGME/CCME POSTGRADUATE TRAINING

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

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

Last Name of Trainee	First Name	Middle Initial
Pfeifer	Kelly	S.

Current Address:	Social Security Number
[redacted]	[redacted]

City	State	Zip Code	Telephone Number
[redacted]	[redacted]	[redacted]	[redacted]

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

Name of Facility	Address of Facility
Sutter Medical Center of Santa Rosa	3324 Chanate Road Santa Rosa, CA 95404

Name of Program Director:	Telephone Number
Marshall Kubota, MD	[redacted]

Signature of Program Director	Date Signed:
[signature]	July 7, 1998

List Categorical Specialty Area of Training Completed by Trainee:	Date Training Commenced:	Date Training Completed:
Family Medicine	07/01/97	07/01/98

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):

Adult Medicine 12 weeks	Musc/Skel 4 weeks	Gyn 4 weeks
OB 12 weeks	Peds 8 weeks	Vac/Ed 4 weeks
Surgery 4 weeks	ER 4 weeks	

PART 3: To be completed by the Director of Medical Education and affixed with the official facility seal.

Name of the Director of Medical Education:	Facility Name:
Marshall Kubota, MD	Sutter Medical Center of Santa Rosa

Facility Address:
3324 Chanate Road

City	State	Zip Code	Telephone Number:
Santa Rosa	CA	95404	[redacted]

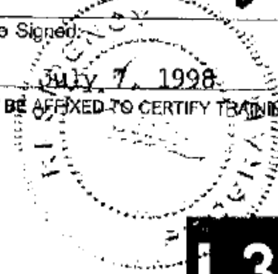
PART 4: Signature of Director of Medical Education certifying satisfactory completion of training.

ATTENTION PROGRAM DIRECTOR!
IF TRAINEE IS IN HIS/HER FIRST YEAR OF POSTGRADUATE TRAINING, DO NOT SIGN OR DATE THE STATEMENT BELOW UNTIL AFTER THE COMPLETION OF THE TRAINEE'S LAST DAY OF TRAINING.

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

Signature of Director of Medical Education	Date Signed:
[signature]	July 7, 1998

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



07A-100-L3 (Rev. 2/97)

L3A

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

CERTIFICATION STATEMENT

This is to certify that Kelly Sue Pfeifer MD
(Name of Physician)

is in an approved ACGME/CCME postgraduate training position that commenced on

July 1, 19 97 and is expected to be completed

on June 30 2000 in Family Medicine
Month Day Year (Type of Training)

at Sutter Medical Center of Santa Rosa
(Name and Address of Facility)

3324 Chanate Road Santa Rosa, CA 95404

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

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

Marshall Kubota, MD
(Type or print name of Director of Medical Education)

(Signature of Director of Medical Education)

July 2, 1998
(Date)

(Telephone Number)

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

07A-107-L4 (2/97)

L4
(formerly Form L9)

Collegii Medicinae Pennsylvaniensis

ad Instruendum in Arte Medica Instituti

Omnibus et Singulis has literas lecturis Salutem.

Notum sit quod nos

Hac membrana **Kelly S. Pfeifer** omnibus studiis ad gradum Doctoris Medicinae rite et legitime spectantibus apud nos incubuisse Testamur, cumque coram professoribus examinatione comprobatum **Doctorem in Arte Medendi** creavimus et constituimus, eique omnia jura, immunitates et privilegia ad illum gradum hic aut ubique gentium pertinentia dedimus et concessimus. In cujus rei majorem fidem hoc diploma communi nostro sigillo munitum et chirographis nostris subscriptum, sit testimonio.

Datum Philadelphiae Die XXIII. Mensis Maii, Annoque Domini 1997.

[signature] Praeses

[signature] Praepositus

Certified as a true copy of the M.D. diploma
of Kelly S. Pfeifer.

Jerri A. Simmons, Director, Registrar's Office

The Medical College of Pennsylvania, now known as
MCP-Hahnemann School of Medicine of Allegheny University of the Health Sciences
6/11/97

BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY - *Department of Consumer Affairs* EDMUND G. BROWN JR., *Governor*

MEDICAL BOARD OF CALIFORNIA

Licensing Program

CHANGE OF ADDRESS FORM

Please fax to (916) 263-2944 or mail to
Medical Board of California, at the below address.
PLEASE PRINT ALL INFORMATION CLEARLY.

7/9/14

LICENSE/REGISTRATION NUMBER: A66577

NAME:	Pfeifer	Kelly	Sue
	LAST	FIRST	(FULL) MIDDLE

PREVIOUS ADDRESS OF RECORD:

201 3rd street, 7th floor

San Francisco	CA	94103	US
CITY	STATE	ZIP	COUNTRY

Please allow only 30 characters per line for your Address of Record.

PLEASE CHANGE MY ADDRESS OF RECORD TO:

Note: Pursuant to Business and Professions Code Section 2021(a)(b), the Address of Record is public information and will be posted in the licensee's profile on the Medical Board's Web site.

1438 Webster Street, Suite 400

Oakland	CA	94612	US
CITY	STATE	ZIP	COUNTRY

IF THE ADDRESS OF RECORD IS A POST OFFICE BOX, A CONFIDENTIAL STREET ADDRESS MUST ALSO BE REPORTED:

NOTE: The street address of a private mail box service may not be used as a confidential street address.

CITY	STATE	ZIP	COUNTRY

Providing your telephone number and email address is for the Medical Board's internal use only for contacting licensees and registrants. This information will not be released to the public nor will it be displayed online.

TELEPHONE NUMBER: (PLEASE INCLUDE AREA CODE)

E-MAIL ADDRESS:

SIGNATURE & DATE

07A-06 Revised 11/2013

12/16/14

Medical Board of California

2005 Evergreen Street, Suite 1200

Sacramento, California

RE: Kelly Pfeifer, MD A66577 (expires 3/31/1016) ***address change***

Dear Medical Board,

Would you update my new work address in your system, and send me a revised pocket card?

Kelly Pfeifer, MD

California HealthCare Foundation

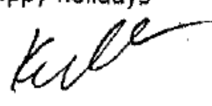
1438 Webster Street, Suite 400

Oakland, CA 94612

Work email:

Personal email:

Thank you, and happy holidays

Kelly Pfeifer, MD 

SAN FRANCISCO HEALTH PLAN

Here for you

201 Third Street, 7th Floor • San Francisco, CA 94103
(415) 547-7800 • FAX (415) 547-7821 • www.sfhp.org

1/25/2010 JR

Previously changed

Medical Board of California
Consumer Information Unit
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815

January 13, 2010

To Whom It May Concern:

Please change the address of record on www.mbc.ca.gov. My license is A66577 and my new address is:

201 Third Street, Floor 7
San Francisco, CA 94103

If you need further information, or for confirmation of this change, please call me at [redacted] or email me at [redacted]

Sincerely,

Kelly Pfeifer, MD

MEDICAL BOARD OF CALIFORNIA LICENSE RENEWAL APPLICATION PHYSICIAN AND SURGEON

SSN= *****9328

D. Continuing Medical Education (CME) Certification Statement: I CERTIFY UNDER PENALTY OF PERJURY UNDER THE LAWS OF CALIFORNIA TO THE FOLLOWING STATEMENT: I CERTIFY THAT I DO MEET EACH OF THE CONTINUING MEDICAL EDUCATION REQUIREMENTS LISTED ON THE BACK OF THIS FORM OR THAT I MEET THE CONDITIONS WHICH WOULD EXEMPT ME FROM ALL OR PART OF THE REQUIREMENTS OR I HOLD A PERMANENT CME WAIVER.

SIGNATURE REQUIRED HERE: ____________ DATE 12/15/05

F YES, I WISH TO CONTRIBUTE $25 FOR THE FAMILY PHYSICIAN TRAINING PROGRAM

H YES, I WISH TO CONTRIBUTE $50 FOR THE S.M. THOMPSON LOAN REPAYMENT PROGRAM

LICENSE NO.	EXPIRES	AMOUNT DUE NOW	DELINQ FEE IF POSTMARKED AFTER 04/30/06
A 66577	03/31/06	$790.00	$869.00
	VOLUNTARY FEE =	$	$
	TOTAL ENCLOSED =	$	$

E. FOR ADDRESS CHANGE ONLY

IF YOUR ADDRESS SHOWN IS INCORRECT, CORRECT IT BELOW:

STREET ____________

CITY ____________ STATE ______ ZIP ______

PHONE NUMBER ( )

G. FINANCIAL INTEREST STATEMENT

I CERTIFY UNDER PENALTY OF PERJURY THAT I HAVE DISCLOSED ON THIS RENEWAL APPLICATION FORM (SEE REVERSE FOR SPACE) THE NAMES OF THOSE HEALTH-RELATED FACILITIES IN WHICH I OR MY FAMILY HAVE A FINANCIAL INTEREST OR I CERTIFY UNDER PENALTY OF PERJURY I HAVE NO FINANCIAL INTEREST TO DISCLOSE.

____
Signature required here

ACTIVE KELLY SUE PFEIFER
1301 SOUTHPOINT BL
PETALUMA CA 94954

630101000001000020006657780103310600079000008690

(DO NOT DETACH)

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

17261

LICENSEE NAME	LICENSE NO.	EXPIRATION DATE	AMOUNT DUE NOW
PFEIFER, KELLY S	**A66577**	**03/31/14**	**$808.00**

LICENSEE MUST CHECK CORRECT BOXES

- "H" Completed Continuing Education
- "E" Change of Address (fill in reverse side)
- "I" Conviction Disclosure – Yes
- "J" Conviction Disclosure – No
- "F" Family Physician Training Program ($25)
- "G" Financial Interest Statement

"D" **SIGNATURE REQUIRED** refund 18.00

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 12/17/13

ENTER YOUR PHONE NUMBER FOR REFERENCE:

600165

6301010000010000200066577801033114000808000008860 0

CHANGE OF MAILING ADDRESS **PFEIFER, KELLY S** **A66577**

Street Address (this address is public information **except** when a PO Box is used for the public address of record; this address then becomes confidential)

City State Zip –

PO Box (if used, must provide a confidential physical street address, above)

City State Zip –

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

LICENSEE NAME	LICENSE NO.	EXPIRATION DATE	AMOUNT DUE NOW	AMOUNT DUE IF POSTMARKED AFTER APRIL 30, 2016
PFEIFER, KELLY S	A66577	03/31/16	$820.00	$898.00

LICENSEE MUST CHECK CORRECT BOXES

- "H" [redacted] Completed Continuing Education
- "E" [redacted] Change of Address (fill in reverse side)
- "I" [redacted] Conviction Disclosure – Yes
- "J" [redacted] Conviction Disclosure – No
- "F" [redacted] Family Physician Training Program ($25)
- "G" [redacted] Financial Interest Statement-**Read instructions above**

"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 [signed] Date 1-16-16

ENTER YOUR PHONE NUMBER FOR REFERENCE: [redacted]

6301010000010000200066577801033116000820000000089800

CHANGE OF MAILING ADDRESS **PFEIFER, KELLY S** **A66577**

01252016 20062297 E0010023

Street Address (this address is public information **except** when a PO Box is used for the public address of record; this address then becomes confidential)

City State Zip –

PO Box (if used, must provide a confidential physical street address, above)

City State Zip –

Application Summary

License Type:	**Physician and Surgeon A**
License Number:	**66577**
File Number:	**68560**
Application:	**Physician's and Surgeon's Renewal**
Application Number:	**14482060**
Application Date:	**02/04/2018 (mm/dd/yyyy)**

Application Questions

Have you served or are you currently serving in the military?

Personal Detail

First Name:	**KELLY**
Middle Name:	**SUE**
Last Name:	**PFEIFER**
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.**

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?

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?

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.

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Family Physician Training Program Voluntary Fee

Would you like to contribute?	
Amount:	

Attachments

Physician Survey

Are you retired?	**No**
Activities in Medicine	**Administration - 40+ Hours**
	Other - None
	Patient Care - 1-9 Hours
	Research - None
	Teaching - 1-9 Hours
	Telemedicine - None
Patient Care Practice Location	**Zip: 66212 County: OUT OF STATE**
Telemedicine Practice Location	**Zip: County:**
Patient Care Secondary Practice Location	**Zip: 94954 County: SONOMA**
Telemedicine Secondary Practice Location	**Zip: County:**
Current Training Status	**Not in Training**
Areas of Practice	**Family Medicine - Primary**
Board Certifications	**American Board of Family Medicine - Family Medicine**
Postgraduate Training Years	**3 Years**
Cultural Background	
Foreign Language Proficiency	**Spanish**
Web Site Profile	**Cultural Background - No**
	Foreign Language Proficiency - Yes
	Gender - Yes
E-mail:	

Fees

Biennial Renewal Fee	**$783.00**
DUE TO CURES FUND	**$12.00**
StephenM.ThompsonLRP	**$25.00**
Vol.Funds	**$100.00**
Total Amount Due:	**$920.00**

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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: