STATE OF CALIFORNIA
BOARD OF MEDICAL QUALITY ASSURANCE

Fictitious Name Permit

COMMUNITY INDUSTRIAL MEDICAL GROUP, INC.

43 N. GARFIELD AVENUE, #203, ALAMEDA, CA 94501

having shown to the satisfaction of the Division of Licensing of the Board of Medical Quality Assurance that it complies with the provisions of Section 2415 of the Business and Professions Code is hereby issued this permit authorizing the use of the above designated name in connection with its practice.

Signed and sealed at Sacramento, California

this 6 day of FEBRUARY 1985

EXPIRES ON FEBRUARY 28, 1986

Secretary-Treasurer
Division of Licensing
APPLICATION FOR A FICTITIOUS NAME PERMIT
(SECTION 2415 OF THE BUSINESS AND PROFESSIONS CODE)

PLEASE READ THE BACK OF THIS APPLICATION BEFORE SIGNING

1. NAME WHICH THE APPLICANT(s) WILL USE IN THIS PRACTICE: (See Sec. 2415(b)(1)(3) reverse side)
   Community Industrial Medical Group, Inc.

2. THE APPLICANT(s) WILL BE: (Check appropriate box)
   [ ] AN INDIVIDUAL  [ ] GROUP OF INDIVIDUALS  [X] CORPORATION

   If a corporation, state corporate name:

3. NAME(s) AND LICENSE NUMBER(s) OF APPLICANT(s), SHAREHOLDING, AND PROFESSIONAL EMPLOYEES ENGAGED IN PRACTICE:

<table>
<thead>
<tr>
<th>PRINT NAME</th>
<th>LICENSE NUMBER</th>
<th>REFERENCE NO.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bonnie Rogers-Neufeld, M.D.</td>
<td>G46068</td>
<td>KL1099101</td>
</tr>
<tr>
<td>Beverly Ann Sansone, M.D.</td>
<td>G53820</td>
<td>KB1322559</td>
</tr>
<tr>
<td>Kathleen E. Willard, M.D.</td>
<td>G51079</td>
<td>KL118272</td>
</tr>
<tr>
<td>Alice Polce, M.D.</td>
<td>G044292</td>
<td>K610650</td>
</tr>
<tr>
<td>Robert J. Haines, M.D.</td>
<td>C27750</td>
<td>KX041151</td>
</tr>
</tbody>
</table>

4. ADDRESS(es) OF PLACE(s) OR ESTABLISHMENT(s) WHERE APPLICANT(s) WILL PRACTICE:
   43 N. Garfield Avenue, Suite 203
   Alhambra, CA 91801

5. THE PLACE OR ESTABLISHMENT, OR PORTION THEREOF, WHICH WILL BE USED IN THIS PRACTICE IS [ ] OWNED OR [X] LEASED BY APPLICANT(s).

   If leased, state terms of the lease and give name and address of lessor:

   Termination date: December 31, 1991
   Mr. Larry Lee

6. THE MEDICAL PRACTICE AT THE ABOVE LOCATION [X] IS / [ ] IS NOT WHOLLY OWNED AND ENTIRELY CONTROLLED BY THE APPLICANT(s).

   If it is not, explain why:

I have read the foregoing application and all attachments thereto and I declare under penalty of perjury, under the laws of the State of California, that the foregoing is true and correct.

Bonnie Rogers-Neufeld, M.D.

43 N. Garfield Avenue, Suite 306
Alhambra, CA 91801

PLEASE SUBMIT DATA CARD TO BE COMPLETED IN NAME OF THE GROUP OR CLINIC. THANK YOU.

40A-214 (1/94) IMPORTANT – SEE REVERSE SIDE
4. NAME AND LICENSE NUMBER OF ALL PERSONS RENDERING PROFESSIONAL SERVICES FOR THE ORGANIZATION:

<table>
<thead>
<tr>
<th>NAME</th>
<th>LICENSE NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beverly Sansone, M.D.</td>
<td>G53820</td>
</tr>
<tr>
<td>Alice Police, M.D.</td>
<td>G0442920</td>
</tr>
</tbody>
</table>

5. IS THE PLACE OR ESTABLISHMENT, OR THE PORTION THEREOF IN WHICH YOU ENGAGE IN PRACTICE, OWNED OR LEASED BY YOU?

Leased  

(STATE WHETHER OWNED OR LEASED)

IN THE EVENT THE PLACE OR ESTABLISHMENT IS LEASED BY YOU, GIVE TERMS OF THE LEASE AND FROM WHOM LEASED:

10 year lease entered in 1980

6. IS THE MEDICAL PRACTICE WHOLLY OWNED AND CONTROLLED BY THE APPLICANT?

YES  x  NO ______

IF ANSWER IS "NO", GIVE EXPLANATION:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
1986 - 87 RENEWAL FEE $20.00

Your permit expires February 23, 1986. Please complete this form and submit it with your $20.00 fee. Failure to renew by March 30, 1986 requires payment of $30.00 ($20.00 Renewal fee plus a $10.00 delinquent fee).

STATEMENT OF APPLICANT

I have read the following application in its entirety and know the contents thereof. I hereby declare under penalty of perjury under the laws of the State of California that all statements made therein are true and correct. (To be signed by a licensed physician and surgeon only or the application cannot be accepted.)

EXECUTED AT Alhambra, CA
SIGNATURE
DATE 3/30/86  CA. LIC # 00627750

1. FICTITIOUS NAME WHICH THE APPLICANT OR APPLICANTS USE IN PRACTICE:

Community Industrial Medical Group, Inc.

2. PRACTICE ADDRESS: (Complete only if there has been an address change from the one shown above).

No change
(Street and Number)
(City)  (State)  (Zip Code)

3. THIS PRACTICE IS: ☐INDIVIDUAL  ☐PARTNERSHIP  ☐CORPORATION  ☑GROUP

THIS FORM MUST BE RETURNED WITH YOUR RENEWAL FEE.