



BOARD OF MEDICAL QUALITY ASSURANCE

1430 HOWE AVENUE, SACRAMENTO, CALIFORNIA 95825
APPLICATIONS AND EXAMINATIONS (916) 920-6411

RECEIVED
GEORGE DEUKER, Governor
SACRAMENTO
BOARD OF MEDICAL
QUALITY ASSURANCE
11 SEP 04 12 10

APPLICATION FOR PHYSICIAN'S AND SURGEON'S CERTIFICATE

BASED ON NATIONAL BOARD CREDENTIALS

CLASS G

31550
004607

PLEASE TYPE OR PRINT NEATLY, WHEN SPACE PROVIDED IS INSUFFICIENT, ATTACH ADDITIONAL SHEETS.

1. NAME: LAST FIRST MIDDLE MAIDEN 2. TELEPHONE NO.
SAWSONE Beverly ANN [REDACTED]

3. LIST OTHER NAMES, IF ANY, YOU HAVE USED:

4. ADDRESS: STREET AND NO. /RURAL ROUTE, CITY STATE ZIP CODE
[REDACTED]

5. NAME YOU WISH ON LICENSE: Beverly A. SAWSONE BIRTHDATE: MONTH, DAY, YEAR [REDACTED]

6. PREMEDICAL EDUCATION: NAME OF COLLEGE OR UNIVERSITY LOCATION
University of Michigan Ann Arbor, MI

PERIOD OF ATTENDANCE: FROM: 9/73 TO: 6/77 CHECK PREMED COURSES SUCCESSFULLY COMPLETED:
 CHEMISTRY PHYSICS BIOLOGY OR ZOOLOGY

7. MEDICAL SCHOOL: University of Michigan

YEAR	NAME OF INSTITUTION	LOCATION	FROM	TO
1	University of Michigan	Ann Arbor, MI	9/79	6/83
2				
3				
4				
5				
6				

8. DOCTOR OF MEDICINE DEGREE GRANTED BY: University of Michigan DATE: 6/3/83 FOR OFFICE USE ONLY SCHOOL CODE: ME001

9. 1ST YEAR POSTGRADUATE TRAINING/INTERNSHIP: University of Southern Calif - Los Angeles Ca. Internal Medicine FROM: 6/83 TO: 6/84

10. LIST ALL STATES IN WHICH YOU HAVE BEEN LICENSED TO PRACTICE MEDICINE:

11. HAS ANY DISCIPLINARY ACTION EVER BEEN TAKEN REGARDING ANY LICENSE WHICH YOU NOW HOLD OR HAVE EVER HELD? YES NO
IF YES INDICATE BELOW

STATE	DATE	CHARGE	DISPOSITION

12. HAVE YOU EVER BEEN DENIED A LICENSE TO PRACTICE MEDICINE IN ANY STATE OR COUNTRY? YES NO
IF YES INDICATE BELOW

STATE OR COUNTRY	DATE OF DENIAL	REASON FOR DENIAL

13. ARE YOU NOW OR HAVE YOU EVER BEEN ADDICTED TO NARCOTIC DRUGS? YES NO

14. 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/NARCOTICS, OR TO DRUG ADDICTION? YES NO

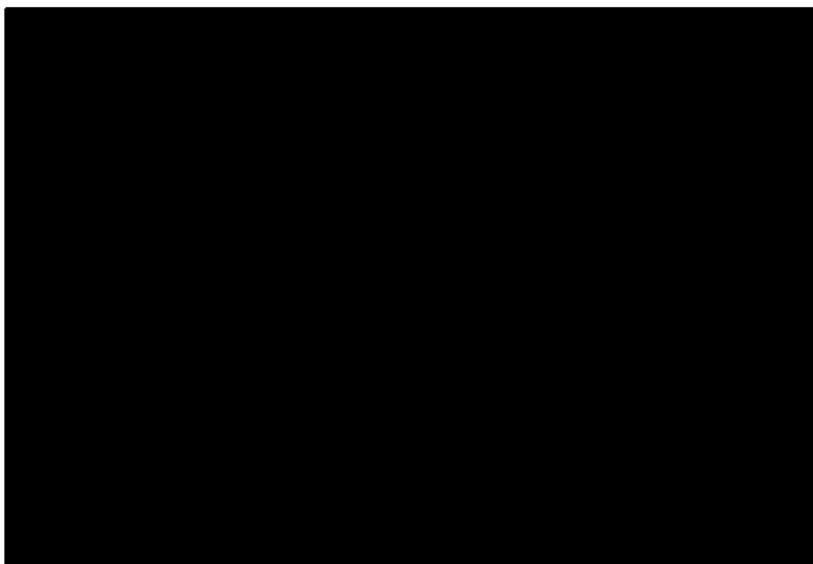
15. HAVE YOU EVER BEEN CONVICTED OF, OR PLED NOLO CONTENDERE TO ANY OFFENSE, MISDEMEANOR OR FELONY IN ANY STATE? (EXCEPT VIOLATIONS OF TRAFFIC LAWS RESULTING IN FINES OF \$50.00 OR LESS.) YES NO

16. IF YOU ANSWERED "YES" TO EITHER NO. 14 OR 15 ABOVE, PLEASE PROVIDE THE FOLLOWING INFORMATION:

VIOLATION AND LOCATION	DATE	PENALTY/DISPOSITION

17. HAVE YOU EVER HAD STAFF PRIVILEGES IN A HOSPITAL SUSPENDED OR REVOKED? YES NO
IF "YES" PLEASE EXPLAIN ON ANOTHER SHEET OF PAPER.

18. HAVE YOU EVER VOLUNTARILY SURRENDERED YOUR LICENSE TO PRACTICE IN ANOTHER STATE? YES NO



APPLICANT: PLEASE COMPLETE THE FOLLOWING:

HEIGHT: FT IN WEIGHT: LBS

HAIR COLOR: EYE COLOR:

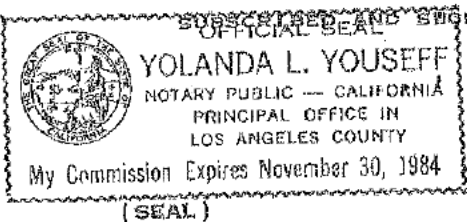
IDENTIFYING MARKS:

IS REQUIRED AND MAINTAINED PURSUANT TO SECTION 26100 OF THE BUSINESS AND PROFESSIONS CODE. 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. APPLICANTS HAVE THE RIGHT TO REVIEW THEIR APPLICATIONS SUBJECT TO THE PROVISIONS OF THE CALIFORNIA INFORMATION PRACTICES ACT.

NOTE: APPLICANT WILL SIGN THIS STATEMENT IN PRESENCE OF NOTARY PUBLIC.

"I HEREBY CERTIFY (OR DECLARE), UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA, THAT THE FOREGOING INFORMATION CONTAINED IN THIS APPLICATION AND ANY ATTACHMENTS IS TRUE AND CORRECT, AND THAT THE ATTACHED PHOTO AND DUPLICATE COPY ARE A TRUE LIKENESS OF MYSELF, THE APPLICANT IDENTIFIED HEREIN."

SIGNATURE OF APPLICANT Beverly L. Sansone
DATE 9/4/84



SIGNATURE OF NOTARY Yolanda L. Youseff
ADDRESS Los Angeles County USC Medical Center
1200 North State Street
LOS ANGELES, CALIFORNIA 90033

MY COMMISSION EXPIRES November 30, 1984



BOARD OF MEDICAL QUALITY ASSURANCE
1430 HOWE AVENUE, SACRAMENTO, CALIFORNIA 95825

RECEIVED
SACRAMENTO
BOARD OF MEDICAL
QUALITY ASSURANCE



AUG 27 2 11 PM '84

PLEASE FORWARD TO YOUR MEDICAL SCHOOL

CERTIFICATE OF MEDICAL EDUCATION

THIS CERTIFIES THAT Beverly Ann Sansone FULL NAME OF APPLICANT
OF [REDACTED] ENROLLED IN University of Michigan NAME OF MEDICAL SCHOOL
ADDRESS WHEN ENROLLED
Ann Arbor - Michigan ON THE 4 DAY OF September 19 79
LOCATION MONTH YEAR
September 79

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 Michigan - Ann Arbor EDUCATIONAL INSTITUTION
B.S. Degree 4/77 9/73 - 4/77 DATES
"With Distinction"

ADVANCED CREDITS. CREDITS PREVIOUSLY OBTAINED AT AN APPROVED MEDICAL SCHOOL.*

MEDICAL SCHOOL	TOTAL CREDITS	DATES
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TRANSCRIPTS OF PREMEDICAL EDUCATION, ADVANCED CREDITS, AND MEDICAL SCHOOL CREDITS MUST BE SUPPLIED WITH THIS CERTIFICATE

THE UNDERSIGNED FURTHER CERTIFIES THAT THE RECORDS OF THIS INSTITUTION SHOW THAT SHE ATTENDED IN THIS INSTITUTION 4 year COURSES OF RESIDENT INSTRUCTION OF 8 1/2 months SPECIFY NUMBER NUMBER OF 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 SHE WAS GRANTED THE DEGREE BACHELOR (DOCTOR OF MEDICINE) BY THE ABOVE MENTIONED MEDICAL SCHOOL ON THE 27 DAY OF May 19 83 MONTH

- | | | |
|--|---|--|
| X ANATOMY | X DERMATOLOGY | PREVENTIVE MEDICINE, INCLUDING NUTRITION |
| X OTOLARYNGOLOGY | X EMBRYOLOGY | X PHYSICAL MEDICINE |
| X OBSTETRICS AND GYNECOLOGY | X HISTOLOGY | THERAPEUTICS |
| RADIOLOGY, INCLUDING RADIATION SAFETY | X HUMAN SEXUALITY AS AS DEFINED IN SECTION 2090 | NEUROANATOMY |
| TROPICAL MEDICINE | X MEDICINE | CHILD ABUSE DETECTION AND TREATMENT X OB/GYN; Oncology |
| X PHYSIOLOGY | X SURGERY, INCLUDING ORTHOPEDIC SURGERY | GERIATRIC MEDICINE X Internal Medicine |
| X BIOCHEMISTRY | X UROLOGY | X PEDIATRICS X Medicine; Endocrinology & Metabolism |
| X PATHOLOGY, BACTERIOLOGY AND IMMUNOLOGY | X PSYCHIATRY | X PHARMACOLOGY X Medicine; Infectious Diseases |
| OPHTHALMOLOGY | X NEUROLOGY | X ANESTHESIA X Medicine; Cardiology 2 |
| | | X Medicine; Gastroen |

SIGNED AND THE COLLEGE SEAL AFFIXED THIS 9 DAY OF August 19 84

[AFFIX SEAL HERE]

BY [Signature] PRESIDENT, SECRETARY, DEAN
James A. Taren, M.D.
Associate Dean for Education and Student Affairs

*EACH MEDICAL SCHOOL ATTENDED MUST COMPLETE ONE OF THESE FORMS COVERING PERIOD OF ATTENDANCE.

(DO NOT DETACH)

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

LICENSEE NAME
SANSONE, BEVERLY A

LICENSE NO.
G53820

EXPIRATION
DATE
02/28/18

AMOUNT
DUE NOW
\$820.00

AMOUNT DUE IF
POSTMARKED AFTER
MARCH 30, 2018
\$898.00

LICENSEE MUST CHECK CORRECT BOXES

"H" Completed Continuing Education (See Question 1)

"E" Change of Address (fill in reverse side)

"I" Conviction

"J" Conviction

"F" Family Physician Training Program

"G" Financial Interest Statement

"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 Beverly A. Sansone MD Date 11/21/17

ENTER YOUR PHONE NUMBER FOR REFERENCE:
[REDACTED]

63010700000700006000538207010228180008200000089800

CHANGE OF ADDRESS (Only if different from address above)
ADDRESS OF RECORD (Required)

SANSONE, BEVERLY A

G53820

Address Line 2

Address Line 3

City State Zip

CONFIDENTIAL STREET ADDRESS (Required if PO Box used above for Address of Record)

Address Line 1

Address Line 2

Address Line 3

City State Zip

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

LICENSEE NAME
SANSONE, BEVERLY A

LICENSE NO.
G53820

EXPIRATION DATE
02/29/16

AMOUNT DUE NOW
\$820.00

AMOUNT DUE IF POSTMARKED AFTER MARCH 30, 2016
\$898.00

LICENSEE MUST CHECK CORRECT BOXES

"H" Completed Continuing Education

"E" Change of Address (fill in reverse side)

"T" Conviction Disclosure

"J" Conviction Disclosure

"F" Family Physician Training Program (\$25)

"C" 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 Beverly A Sansone MD Date 11/19/15

ENTER YOUR PHONE NUMBER FOR REFERENCE:

[Redacted phone number]

63010700000700006000538207010229160008200000089800

CHANGE OF MAILING ADDRESS

SANSONE, BEVERLY A

G53820

02082016 20002155 20010022

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)

[Street Address grid]

[Street Address grid]

City

[City grid]

State

[State grid]

Zip

[Zip grid]

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

[PO Box grid]

City

[City grid]

State

[State grid]

Zip

[Zip grid]

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

LICENSEE NAME
SANSONE, BEVERLY A

LICENSE NO.
G53820

EXPIRATION DATE
02/28/14

AMOUNT DUE NOW
\$808.00

LICENSEE MUST CHECK CORRECT BOXES

"H" Completed Continuing Education

"E" Change of Address (fill in reverse side)

"I" Conviction Disclosure

"J" Conviction Disclosure

"F" Family Physician Training Program (\$25)

"G" Financial Interest Statement

"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: Beverly A Sansone MD Date: 11/20/13

ENTER YOUR PHONE NUMBER FOR REFERENCE:



63010700000700006000538207010228140008080000127750

CHANGE OF MAILING ADDRESS

SANSONE, BEVERLY A

G53820

12182813 20080877 20010007

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: _____