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 95825-3236 (916) 920-6421

90 APR 12 AM 7:20 RECEIVED BY CASHIERS

90 APR 11 PM 1:00

APPLICATION FOR PHYSICIAN AND SURGEON'S EXAMINATION OR LICENSURE

515
010597
4/90

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.

BMQA USE ONLY

PERSONAL DATA

1. Name: Last ROSS First SHERYL Middle ANN

2. Other names you have used:

3. Social Security Number [redacted]
See disclosure statement on LIC

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

City [redacted] State Zip Code Country

5. Telephone Number(s): Home [redacted] Work

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

7. Sex: ☑ Female ☐ Male

8. 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 N200), VISA documents, or license to practice medicine.

9. Have you ever filed an application for examination or licensure in California? ☐ Yes ☑ No
If YES, give date of previous application:

10. 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.

NON-MEDICAL EDUCATION

Name	Address	Period of Attendance From (Mo/Yr)	To (Mo/Yr)	
University of California, Santa Barbara	GOLETA, CALIF.	9/80	6/84	☑
				☐
				☐

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.

MEDICAL EDUCATION

Name	Address	Place Where Instruction Received	Period of Attendance From (Mo/Yr)	To (Mo/Yr)	CME	TRANS
SACKLER SCHOOL OF MEDICINE	RAMAT AVIV, ISRAEL		7/84	6/86	☑	☑
NEW YORK MEDICAL COLLEGE	VALHALLA, N.Y.		6/86	6/88	☑	☑
					☐	☐
					☑	

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
NEW YORK MEDICAL COLLEGE	SUNSHINE COTTAGE VALHALLA, NEW YORK 10595	6/6/88

NY069
School Code

L1A

07A-100 (6) (Rev)

13. Have you taken any of the following written examinations: National Boards, ECFMG, FMGEMS, FLEX, MSKP, MCAT, other related medical competency examinations? ☒ Yes ☐ No

If YES, list name, location, date and result of examination. Submit certification of scores from each examination agency.

Name	Location	Date	Result
NATIONAL BOARDS	PT 1 L.A.	9/87	[redacted]
" "	PT 2 N.Y.	4/88	
" "	PT 3 L.A.	5/89	

AMCA USE ONLY
WRITTEN 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 ACGME Postgraduate Training (Form 10) from each facility.

Name	Address	Type of Service	Period of Attendance	
			From (Mo/Yr)	To (Mo/Yr)
Lac L3-L9	LAC/USC	OB/Gyn	89	92

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)

LICENSE DATA

LGS	CE
☐	☐
☐	☐
☐	☐
☐	☐

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

☑
☐
☐
☐

07A-100

L1B

BMQA USE ONLY

LICENSE DATA (continued)

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 been charged with unprofessional conduct or any other unlawful activity by any healing arts licensing authority or by the U.S. military and are awaiting final disposition by that body?

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

19. 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.

20. 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.

GENERAL DATA

21. Are you now, or were you in the past, addicted to or treated for addiction to controlled substances, such as narcotics or alcohol? [redacted] Yes [redacted] No If yes, please explain on a separate sheet of paper.

22. 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

23. 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:

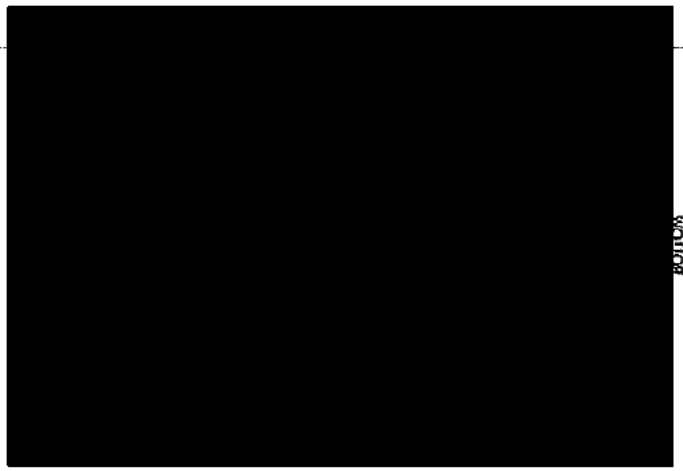
Violation and Location	Date	Penalty or Disposition

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.

"Disclosure of your social security number is mandatory. Section 30 of the Business and Professions Code and Pub. L. 94-455 (42 U.S.C.A. 405 (c) (2) (C)) authorizes collection of your social security number. Your social security number will be used exclusively for tax enforcement purposes. If you fail to disclose your social security number, you will be reported to the Franchise Tax Board, which may assess a $100 penalty against you."

97A-100

L1C



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 _____

_____

_____

BOTTOM

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. Information regarding the issuance or denial of a license by the Board may be transmitted to any other medical licensing authority or the Federation of State Medical Boards. 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 Los Angeles

Sheryl Ann Ross, M.D being duly sworn, says she is the person referred to in the foregoing application for a physician and surgeon's certificate in California and that she 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.

She 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, she 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.

Sheryl Ann Ross
Signature of applicant in FULL (Do not use INITIALS ONLY)

Signed and sworn to before me this 9th day of April, 19[redacted]

Signature of Notary Public George E. Hunt

[SEAL]

OFFICIAL SEAL
George E. Hunt
NOTARY PUBLIC-CALIFORNIA
PRINCIPAL OFFICE IN
LOS ANGELES COUNTY
My Commission Expires Mar. 25, 1992

Address 2245 Westlake Blvd., Bentley Hills, CA 90210

My commission expires March 25, 1992

07A-100

L1D

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

CERTIFICATE OF MEDICAL EDUCATION

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

This certifies that Sheryl Ann Ross
(FULL NAME OF APPLICANT)

of [redacted] (ADDRESS WHEN ENROLLED) enrolled in Sackler School of Medicine (NAME OF MEDICAL SCHOOL)

Tel Aviv, Israel (LOCATION) on the ____ day of JULY (MONTH) 19 84 (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 2068).

University of California, Santa Barbara (EDUCATIONAL INSTITUTION) 1980 - 1984 (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 She attended in this institution 15 (NUMBER) courses of resident instruction of 2-32 (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

☑ She withdrew from → transferred

the above mentioned medical school on the ____ day of June (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 2099
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 Feb., 1990

BY [signature] Registrar
(PRESIDENT, SECRETARY, DEAN)

Medical School Seal MUST Be Imprinted Partially on the Photograph.

TRANSCRIPTS OF PREMEDICAL EDUCATION, ADVANCED CREDITS, AND MEDICAL SCHOOL CREDITS MUST BE SUBMITTED WITH THIS CERTIFICATE

* Each school where premedical credits were received MUST complete one of these forms. If more than one school was attended, photocopies of this form may be made and used. Note that you must request each school to forward transcripts as well.

L2

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

CERTIFICATE OF MEDICAL EDUCATION

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

This certifies that SHERYL ANN ROSS (FULL NAME OF APPLICANT)

of [redacted] (ADDRESS WITH STREET) enrolled in NEW YORK MEDICAL COLLEGE (NAME OF MEDICAL SCHOOL)

Valhalla New York (LOCATION) on the ____ day of JULY (MONTH) 19 86 (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 California, Santa Barbara (EDUCATIONAL INSTITUTION) — 1980 - 1984 (DATES)

Advanced Credits. Credits previously obtained at an approved medical school.*

Sackler School of Medicine (MEDICAL SCHOOL) — NEW YORK MEDICAL COLLEGE 82 (TOTAL CREDITS) — 1984-1986 (DATES)

The undersigned further certifies that the records of this institution show that S he attended in this institution 4 (SPECIFY NUMBER) courses of resident instruction of lecturus of 10 months each (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

☒ S he was granted the degree ~~Bachelor~~/Doctor of Medicine by NEW YORK MEDICAL COLLEGE

☐ he withdrew from

the above mentioned medical school on the 6th day of June (MONTH) 19 88

Anatomy
Otolaryngology
Obstetrics and Gynecology
Radiology, including Radiation Safety
Tropical Medicine
Physiology
Biochemistry
Pathology, Bacteriology and Immunology
Dermatology
Embryology
Histology
Human Sexuality as defined in Section 2099
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 2 day of March, 19 90

BY Barbara Weiss Registrar (PRESIDENT, SECRETARY, DEAN)

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 credit hours are granted MUST complete one of these forms. If more than one school was attended, photocopies of this blank form may be made and used. Also, the photograph and seal must be the same as that originally affixed.

L2

I certify that this is a true and exact copy of the original document that I have personally examined.

Registrar/New York Medical College
3/2/90

The Trustees and Faculty
of

New York Medical College

A Medical University

Be it Known to all persons that

Sheryl Ann Ross

Having satisfied in full the requirements for the Degree of

Doctor of Medicine

has accordingly been admitted to that degree with all the rights, privileges and responsibilities pertaining thereto.
In witness whereof the Seal of the University and the signatures authorized by the Board of Trustees are affixed below.
Given in Valhalla, New York on the sixth day of June
in the year of our Lord, one thousand nine hundred and eighty-eight.

Chairman of the Board of Trustees

President

Dean

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

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 SHERYL ANN ROSS
(NAME OF APPLICANT)

a graduate of NEW YORK MEDICAL COLLEGE
(NAME OF MEDICAL SCHOOL)

formally commenced an accredited postgraduate training program at LAC+USC MEDICAL CENTER
(NAME AND ADDRESS OF FACILITY)

1200 North State Street, Los Angeles, CA in Obstetrics-Gynecology
(SPECIALTY)

on June 24, 1988, and completed such training on June 23, 1989.

This training consisted of 11 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
	there are 13 four-week rotations

16 weeks Obstetrics, 4 weeks Newborn, 4 weeks Medical Intensive Care, 16 weeks High Risk, 4 weeks vacation, 8 weeks Gynecology.

[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 Ralph C. Juno, M.D.
(DIRECTOR OF MEDICAL EDUCATION)

(AFFIX SEAL OF HOSPITAL OR NOTARY PUBLIC)

ADDRESS LAC+USC Medical Center
1200 North State Street, Box 540
Los Angeles, CA 90033

PHONE NUMBER [redacted]

DATE February 16, 1990

SIGNATURE [signature]

L3

07A100

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

CERTIFICATION STATEMENT

This is to certify that Sheryl Ann Ross (Name of Physician) is in an ACGME/CCME postgraduate training position that commenced on July, 19 88 and is expected to be completed on June, 19 92 in Obstetrics and Gynecology (Type of Training)

at LAC+USC MEDICAL CENTER
(Name and Address of Facility)
1200 North State Street, Los Angeles, CA 90033

(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.

Ralph C. Jung, M.D.
TYPE OR PRINT NAME OF DIRECTOR OF MEDICAL EDUCATION

SIGNATURE OF DIRECTOR OF MEDICAL EDUCATION

February 16, 1990
DATE

[redacted]
PHONE NUMBER

07M-71 (3-87)

L9

Application Summary

License Type:	**Physician and Surgeon G**
License Number:	**68399**
File Number:	**219886**
Application:	**Physician's and Surgeon's Renewal**
Application Number:	**14463654**
Application Date:	**01/11/2018 (mm/dd/yyyy)**

Application Questions

Have you served or are you currently serving in the military?	[redacted]

Personal Detail

First Name:	**SHERYL**
Middle Name:	**A**
Last Name:	**ROSS**
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.**

Confidential Address

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?	[redacted]
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?	[redacted]

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. [redacted]

Family Physician Training Program Voluntary Fee

Would you like to contribute? [redacted]

Attachments

Physician Survey

Are you retired?	**No**
Activities in Medicine	**Administration - None**
	Other - None
	Patient Care - 40+ Hours
	Research - None
	Teaching - None
	Telemedicine - None
Patient Care Practice Location	**Zip: 90404 County: LOS ANGELES**
Telemedicine Practice Location	**Zip: County:**
Patient Care Secondary Practice Location	**Zip: County:**
Telemedicine Secondary Practice Location	**Zip: County:**
Current Training Status	**Fellow**
Areas of Practice	**Obstetrics and Gynecology - Primary**
Board Certifications	**American Board of Obstetrics and Gynecology - Obstetrics and Gynecology**
Postgraduate Training Years	**4 Years**
Cultural Background	[redacted]
Web Site Profile	**Cultural Background - No**
	Foreign Language Proficiency - No
	Gender - Yes
E-mail:	[redacted]

Fees

Biennial Renewal Fee	**$783.00**
DUE TO CURES FUND	**$12.00**
StephenM.ThompsonLRP	**$25.00**
Total Amount Due:	**$820.00**

1515690365030

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:

Application Summary

License Type:	**Physician and Surgeon G**
License Number:	**68399**
File Number:	**219886**
Application:	**Physician's and Surgeon's Renewal**
Application Number:	**14239564**
Application Date:	**12/18/2015 (mm/dd/yyyy)**

Application Questions

Have you served or are you currently serving in the military?	[redacted]

Personal Detail

First Name:	**SHERYL**
Middle Name:	**A**
Last Name:	**ROSS**
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.**

Confidential Address

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?	[redacted]
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?	[redacted]

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. [redacted]

Financial Interest Disclosure Summary

Health-Related Facility Name: [redacted]

Address:

Family Physician Training Program Voluntary Fee

Voluntary Fee: **No**

Attachments

Physician Survey

Are you retired?	**No**
Activities in Medicine	**Administration - None** **Other - None** **Patient Care - 40+ Hours** **Research - None** **Teaching - None** **Telemedicine - None**
Patient Care Practice Location	**Zip: 90404 County: LOS ANGELES**
Telemedicine Practice Location	**Zip: County:**
Patient Care Secondary Practice Location	**Zip: County:**
Telemedicine Secondary Practice Location	**Zip: County:**
Current Training Status	**Not in Training**
Areas of Practice	**Obstetrics and Gynecology - Primary**
Board Certifications	**American Board of Obstetrics and Gynecology - Obstetrics and Gynecology**
Postgraduate Training Years	**4 Years**
Cultural Background	[redacted]
Foreign Language Proficiency	[redacted]
Web Site Profile	**Cultural Background - No** **Foreign Language Proficiency -** [redacted] **Gender - Yes**
E-mail:	[redacted]

Fees

Biennial Renewal Fee	**$783.00**
DUE TO CURES FUND	**$12.00**
Steven M. Thompson Physician Corps Loan Repayment Program	**$25.00**
Total Amount Due:	**$820.00**

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:

Application Summary

License Type: **Physician and Surgeon G**

License Number: **68399**

File Number: **219886**

Application: **Physician's and Surgeon's Renewal**

Application Number: **14017562**

Application Date: **12/27/2013 (mm/dd/yyyy)**

Personal Detail

First Name: **SHERYL**

Middle Name: **A**

Last Name: **ROSS**

Birthdate: [redacted]

Gender: **Female**

Addresses

License Related Addresses

Confidential Address (Optional)

Name:

Address: [redacted]

License Specific Public/Mailing Address (Required)

Name: **ROSS, SHERYL A**

Address: **2001 SANTA MONICA BLVD 970W**

SANTA MONICA, CA

90404

Phone Number: [redacted]

E-mail Address:

Financial Interest Disclosure Summary

Health-Related Facility Name: [redacted]

Address:

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?	[redacted]
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?	[redacted]
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.	[redacted]

Family Physician Training Program Voluntary Fee

Voluntary Fee: [redacted]

Attachments

Physician Survey

Are you retired?	**No**
Activities in Medicine	**Administration - None** **Other - None** **Patient Care - 40+ Hours** **Research - None** **Teaching - None** **Telemedicine - None**
Patient Care Practice Location	**Zip: 90404 County: LOS ANGELES**
Telemedicine Practice Location	**Zip: County:**
Patient Care Secondary Practice Location	**Zip: County:**
Telemedicine Secondary Practice Location	**Zip: County:**
Current Training Status	**Not in Training**
Areas of Practice	**Obstetrics and Gynecology - Primary**
Board Certifications	**American Board of Obstetrics and Gynecology - Obstetrics and Gynecology**
Cultural Background	[redacted]
Foreign Language Proficiency	

Web Site Profile

Cultural Background - No

Foreign Language Proficiency - No

Gender [redacted]

Fees

Biennial Renewal Fee	**$783.00**
Steven M. Thompson Physician Corps Loan Repayment Program	**$25.00**
Total Amount Due:	**$808.00**

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: