DEPARTMENT OF Consumer Affairs

Permit P 13918

STATE OF CALIFORNIA

BOARD OF MEDICAL QUALITY ASSURANCE

Fictitious Name Permit

THE WOMEN'S MEDICAL CLINIC
NAME

520 W. JUNIPERO, SANTA BARBARA, CA 93105
ADDRESS

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 24 *day of* MARCH 19 87

EXPIRES ON FEBRUARY 28, 1988

Secretary-Treasurer
Division of Licensing

07L-195 (4-81) OSP

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
FICTITIOUS NAME UNIT
TELEPHONE: (916) 920-6074

RECEIVED BOARD OF MEDICAL QUALITY ASSURANCE MAR 24 1 48 PM '87

RECEIVED BOARD OF MEDICAL QUALITY ASSURANCE MAY 1 8 PM '87

FEE: $20.00

APPLICATION FOR A FICTITIOUS NAME PERMIT

2010288

(SECTION 2415 OF THE BUSINESS AND PROFESSIONS CODE)

$ 10.

PLEASE READ THE BACK OF THIS APPLICATION BEFORE SIGNING

1. NAME WHICH THE APPLICANT(S) WILL USE IN THIS PRACTICE: *(See Sec. 2415(b)(4) reverse side)* — PHONE NUMBER [redacted]

THE WOMEN'S MEDICAL CLINIC

2. THE APPLICANT(S) WILL BE: *(Check appropriate box)*
☐ AN INDIVIDUAL ☐ GROUP OF INDIVIDUALS ☒ PARTNERSHIP ☐ CORPORATION

IF A CORPORATION, STATE CORPORATE NAME:

3. NAME(S) AND LICENSE NUMBER(S) OF APPLICANT(S) AND SHAREHOLDERS. LIST PROFESSIONAL EMPLOYEES ON SEPARATE SHEET.

PRINT NAMES	LICENSE NUMBER	REFERENCE NO.
KATHLEEN GRIFFIN, M.D.	G39286	
AYESHA SHAIKH, M.D.	A41130	

4. ADDRESS(ES) OF PLACE(S) OR ESTABLISHMENT(S) WHERE APPLICANT(S) WILL PRACTICE:
520 W. JUNIPERO
SANTA BARBARA, CA 93105

MAIL PERMIT TO: (IF DIFFERENT ADDRESS THAN PRACTICE ADDRESS)

5. THE PLACE OR ESTABLISHMENT, OR PORTION THEREOF, WHICH WILL BE USED IN THIS PRACTICE IS ☐ OWNED OR ☑ LEASED BY APPLICANT(S). *(check one)*

IF LEASED, STATE TERMS OF THE LEASE AND GIVE NAME AND ADDRESS OF LESSOR:
TERMS: $2716.12 /month, for 3 years, 2 three-year renewal options.
NEP SOLIS
[redacted]

6. THE MEDICAL PRACTICE AT THE ABOVE LOCATION *(check one)* ☑ 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.

Kathleen Griffin, M.D.
(SIGNATURE OF APPLICANT IN FULL)
APPLICATION MUST BE SIGNED BY A LICENSED PHYSICIAN

520 W. JUNIPERO
(ADDRESS)
SANTA BARBARA, CA. 93105
(CITY, STATE AND ZIP CODE)

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

07A-214 (5/85) OK

IMPORTANT – SEE REVERSE SIDE

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) 920-6074

RECEIVED SACRAMENTO BOARD OF MEDICAL QUALITY ASSURANCE FEB 10 12 17 PM '88

APPLICATION FOR RENEWAL OF A PERMIT UNDER SECTION 2415 OF THE BUSINESS AND PROFESSIONS CODE

DEPARTMENTAL USE ONLY
DELINQUENT FEE
210996

P 013918
THE WOMENS MEDICAL CLINIC
520 W JUNIPERO
SANTA BARBARA
CA 93105

1988 - 89 RENEWAL FEE $20.00

Your permit expires February 28, 1988. Please complete the enclosed forms and return with the $20.00 fee. Failure to renew by March 30, 1988 requires payment of $30.00 ($20.00 Renewal fee plus a $10.00 delinquent fee). Names cannot be transferred, they must be canceled and reapplied for.

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. **(This form must be signed by a Licensed Physician and Surgeon only. Signatures by other persons cannot be accepted.)**

EXECUTED AT Santa Barbara, California

PLEASE PRINT NAME Kathleen Griffin, M.D.

SIGNATURE Kathleen Griffin M.D.

DATE 2/12/88 CA. LIC. # G 039286

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

The Women's Medical Clinic

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

520 W. Junipero Str.
Street and Number

City State Zip Code

3. THIS PRACTICE IS: [ ] INDIVIDUAL [XX] PARTNERSHIP [ ] CORPORATION [ ] GROUP

THIS FORM MUST BE RETURNED WITH YOUR RENEWAL FEE

07R-195 (REV. 11/87)

4. NAME AND LICENSE NUMBER OF ALL PERSONS RENDERING PROFESSIONAL SERVICES FOR THE ORGANIZATION:

NAME	LICENSE NUMBER
Kathleen Griffin, M.D.	G 039286
Ayesha Shaikh, M.D.	A 411300

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:

Terms: $2716.12/ month, for 3 years, 2 three-year renewal options.

Nep Solis

[redacted]

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

YES XX NO

IF ANSWER IS "NO," GIVE EXPLANATION:

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 is requested under Section 2415 of the Business and Professions Code in order to determine whether the applicants qualify for a fictitious name permit. Applicants and licensees 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—STATE AND CONSUMER SERVICES AGENCY GEORGE DEUKMEJIAN, *Governor*

DEPARTMENT OF Consumer Affairs

BOARD OF MEDICAL QUALITY ASSURANCE
1430 HOWE AVENUE, SACRAMENTO, CALIFORNIA 95825
(916) 920-6074

CANCELLATION OF FICTITIOUS NAME PERMIT

Deleted 8-31-88 CR

The undersigned requests the Board of Medical Quality Assurance of the State of California to cancel a fictitious name permit issued by that Board and does hereby certify that:

1. Under the provisions of Section 2415 of the Business and Professions Code, Permit Number P13918 was issued to The Women's Medical Clinic (Name of Group or Clinic) 520 W. Junipero, Santa Barbara, CA (Address), [redacted] (Area Code & Phone Number).

2. The reason for this cancellation is: (check one)
   - (a) Out of Business [ ]
   - (b) Transfer of Ownership [ ]
   - (c) Change in Organization [X]

If (b) or (c), the name of the New Owner and/or Organization will be Kathleen Griffin, M.D.

3. The permit which is presently current is attached? Yes [X] No [ ]
   If NO, state reason: _____

ONLY AN AUTHORIZED PERSON MAY MAKE THIS REQUEST.

I DECLARE, UNDER PENALTY OF PERJURY, THAT THE FOREGOING IS TRUE AND CORRECT.

Executed at Santa Barbara, California, this 10th day of August, 1988.

Kathleen Anna Griffin, MD
SIGNATURE IN FULL, NO INITIALS
(MUST be signed by the LICENSED Physician Only.)

Kathleen Griffin, M.D.
Type or Print Name

General Partner
TITLE

[redacted]
STREET ADDRESS

[redacted]
CITY, STATE & ZIP CODE