

004528



BOARD OF MEDICAL QUALITY ASSURANCE

1430 HOWE AVENUE, SACRAMENTO, CALIFORNIA 95815
APPLICATIONS AND EXAMINATIONS (916) 920-6111

SEP 29 4 37 PM '80

003264

APPLICATION FOR A WRITTEN EXAMINATION
OR
FOR AN ORAL AND CLINICAL EXAMINATION

For Graduates of Foreign Medical Schools Applying Under Sections 2193 and 2193.5
of the California Business and Professions Code

ANSWER ALL QUESTIONS

1. Name: (Please print) AYESHA SHAIKH
First Middle Last
AYESHA HUSSAIN SHAIKH

2. Other Names you have used: AYESHA HUSSAIN

3. Address: No. and Street _____ City _____ State _____ Zip Code _____

4. Date of Birth: Mo./Day/Yr. _____ Citizen of (Country) _____ Telephone No. _____

5. Send California certificate, if issued, to: No. and Street _____ City _____ State _____ Zip Code _____

6. Have you ever taken the Federal Licensure Examination (Flex)? No Where? _____ When? _____

001552

7. Premedical Education—College/University

Name of College	Location	From (mo./yr.)	To (mo./yr.)
STELLA MARIS COLLEGE/MADRAS	MADRAS, TAMILNADU STATE, INDIA	MAY '66	APRIL '67
MADRAS MEDICAL COLLEGE/MADRAS	MADRAS, INDIA	JULY '67	APRIL '68

8. Premed Courses (Required)

	Yes	No	College	Location	From (mo./yr.)	To (mo./yr.)
Chemistry	✓		STELLA MARIS COLLEGE	MADRAS, INDIA	MAY '66	APRIL '67
Physics	✓		MADRAS MEDICAL COLLEGE	MADRAS, INDIA	JULY '67	APRIL '68
			STELLA MARIS COLLEGE	MADRAS, INDIA	MAY '66	APRIL '67
Biology	✓		MADRAS MEDICAL COLLEGE	MADRAS, INDIA	JULY '67	APRIL '68
			STELLA MARIS COLLEGE	MADRAS, INDIA	MAY '66	APRIL '67

9. Medical Education

Course	Medical College	Location	From (mo./yr.)	To (mo./yr.)
1st FIRST MBBS (PRE MED)	MADRAS MEDICAL COLLEGE	MADRAS, INDIA	JULY '67	APRIL '68
2nd SECOND MBBS	STANLEY MEDICAL COLLEGE	MADRAS, INDIA	JULY '68	APRIL '70
3rd THIRD MBBS (PART I)	STANLEY MEDICAL COLLEGE	MADRAS, INDIA	JUNE '70	APRIL '71
4th THIRD MBBS (PART II)	STANLEY MEDICAL COLLEGE	MADRAS, INDIA	JUNE '71	APRIL '72
5th FINAL MBBS	STANLEY MEDICAL COLLEGE	MADRAS, INDIA	JUNE '72	APRIL '73
6th M.D. (OBSTETRICS + GYNACOLOGY)	S. MEDICAL COLLEGE	BOMBAY, INDIA	NOV '74	DEC '77

10. Doctor of Medicine Degree Granted by: ATTACH ORIGINAL MEDICAL DEGREE

Name of Institution	Location	Exact Date of Issuance
MADRAS UNIVERSITY OF MEDICAL SCIENCES	MADRAS, TAMILNADU, INDIA	NOV '71
MADRAS UNIVERSITY OF MEDICAL SCIENCES	BOMBAY, INDIA	MAR '77

11. Internship in United States Hospitals: *NIL*

Name of Hospital	Location	From (mo./yr.)	To (mo./yr.)

12. Postgraduate Instruction:

Name of Institution	Location	From (mo./yr.)	To (mo./yr.)
<i>KONARJEE NADIA MATERNITY</i>	<i>Patel, Bombay India</i>	<i>Dec / 74</i>	<i>Feb / 78</i>
<i>HOSPITAL - Post graduate institute</i>	<i>400012</i>		
<i>in Gynecology, Obstetrics + Family Planning</i>			

13. Have you been licensed to practice medicine in any state or country?
 IF YES, where? *INDIA* Yes No

14. Have you ever had a medical license suspended or revoked?
 IF YES, give details. Yes No

15. Have you been denied a license to practice medicine by any state or country?
 IF YES, give details. Yes No

16. Are you now, or have you ever been, addicted to narcotic drugs? Yes No

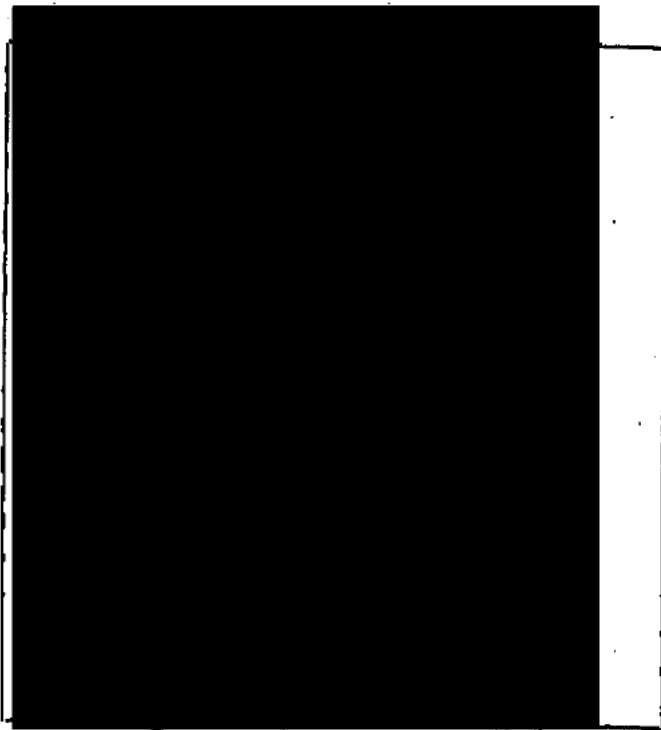
17. Have you ever been convicted of, or pled no contest to drug addiction?
 If YES, explain below.

Charge	Date	Disposition

18. Have you ever been convicted of, or pled no contest in a violation of a federal, state or local law relating to the manufacture, distribution, or dispensing of controlled substances (narcotics)?
 If YES, explain. Yes No

19. Have you ever been convicted of, or pled nolo contendere to any violation of any law of any state, the United States, or a foreign country?
If YES, explain below.

Yes No



I hereby declare that the photo of myself attached hereto, was taken on or about _____ 19____ my age then being _____ years; color of hair _____; color of eyes _____; height _____; weight _____ lbs. marks _____

STATE OF CALIFORNIA
COUNTY OF Los Angeles } ss.

AYESHA SHAIKH being duly sworn, says she is the person referred to in the foregoing application for admission to examination for a physician's 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 are strictly true in every respect.

Ayesha Shaikh
Signature of applicant IN FULL (Do not use INITIALS ONLY)

Signed and sworn to before me this 23 day of Sept, 1980



Roy Morris
Notary Public
Address 4940 No. Grand - Council

My commission expires May 27-1984



BOARD OF MEDICAL QUALITY ASSURANCE

1430 HOWE AVENUE, SACRAMENTO, CALIFORNIA 95823
APPLICATIONS AND EXAMINATIONS (916) 922-4111

STATE OF CALIFORNIA
BOARD OF MEDICAL QUALITY ASSURANCE

SEP 18 1 28 PM '80

004119

APPLICATION FOR A WRITTEN EXAMINATION
OR
FOR AN ORAL AND CLINICAL EXAMINATION

For Graduates of Foreign Medical Schools Applying Under Sections 2183 and 2183.5
of the California Business and Professions Code

ANSWER ALL QUESTIONS

1. Name: (Please print) AYESHA SHAIKH
First Middle Last

2. Other Names you have used: (MAIDEN NAME) AYESHA HUSSAIN

3. Address: No. and Street City State Zip Code

4. Date of Birth: Mo./Day/Yr. Citizen of: (Country) Telephone No.

5. Send California certificate, if issued, to: No. and Street City State Zip Code
Not Applicable

6. Have you ever taken the Federal Licensing Examination (Flex)? NO Where? When?

7. Premedical Education—College/University
Name of College Location MADRAS INDIA Period of Attendance
From (mo./yr.) To (mo./yr.)
MADRAS MEDICAL COLLEGE / MADRAS JULY/67 JUNE/68

8. Premed Courses (Required)

	Yes	No	College	Location	From (mo./yr.)	To (mo./yr.)
Chemistry	<input checked="" type="checkbox"/>	<input type="checkbox"/>	MADRAS MEDICAL COLLEGE	MADRAS, INDIA	JULY/67	JUNE/68
Physics	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Same as above	Same as above		
Biology	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Same as above	Same as above		

9. Medical Education

Course	Medical College	Location	From (mo./yr.)	To (mo./yr.)
1st <u>Pre-med course</u>	<u>MADRAS MEDICAL COLLEGE</u>	<u>MADRAS, INDIA</u>	<u>JULY/67</u>	<u>JUNE/68</u>
2nd <u>Anatomy</u>	<u>STANLEY MEDICAL COLLEGE</u>	<u>MADRAS, INDIA</u>	<u>JUNE/68</u>	<u>APRIL 70</u>
3rd <u>Biochemistry & Physiology</u>	<u>STANLEY MEDICAL COLLEGE</u>	<u>MADRAS, INDIA</u>	<u>JUNE/70</u>	<u>APRIL 71</u>
4th <u>Pharmacology</u>	<u>STANLEY MEDICAL COLLEGE</u>	<u>MADRAS, INDIA</u>	<u>JUNE 71</u>	<u>APRIL 72</u>
5th <u>Microbiology, Histology</u>	<u>STANLEY MEDICAL COLLEGE</u>	<u>MADRAS, INDIA</u>	<u>JUNE 72</u>	<u>MAY 73</u>

10. Doctor of Medicine Degree Granted by: ATTACH ORIGINAL MEDICAL DECREE
Name of Institution Location Exact Date of Issuance
UNIVERSITY OF MADRAS MADRAS, INDIA NOV/74

21. Internship in United States Hospital
 Name of Hospital: W/O Location: _____ From (mo./yr.): _____ To (mo./yr.): _____

22. Postgraduate Instruction: M.D. in Obstetrics + Gynecology
 Name of Institution: _____ Location: _____ From (mo./yr.): _____ To (mo./yr.): _____

<u>G.S. MEDICAL COLLEGE</u>	<u>BOMBAY, INDIA</u>	<u>NOV/74</u>	<u>APRIL/78</u>

23. Have you ever licensed to practice medicine in any state or country?
 IF YES, where: INDIA State of Madhya Pradesh State of Madhya Pradesh

24. Have you ever had a medical license suspended or revoked?
 IF YES, give details: _____

25. Have you ever denied a license to practice medicine by any state or country?
 IF YES, give details: _____

26. Have you ever been convicted of a crime?
 IF YES, give details: _____

27. Have you ever been convicted of, or pled no contest to, any criminal offense?
 IF YES, explain below: _____

Charge	Date	Disposition

28. Have you ever been convicted of, or pled no contest to, a violation of a federal, state or local law relating to the manufacture, distribution, or dispensing of controlled substances (narcotics)?
 IF YES, explain: _____

29. Have you ever been convicted of, or pled no contest to, any violation of any law of any state, the United States, or a foreign country?
 IF YES, explain below: _____

Three (3) photographs required.
 Attach 3" x 4" photo of applicant taken within 90 days of application.
 Best size. Proof photo not acceptable.

I hereby declare that the photo of myself attached hereto, was taken on or about _____
 my age then being _____ years, color of hair _____, color of eyes _____, height _____, weight _____, marks _____

STATE OF _____
 County of _____

AIESHA SHAIKH being duly sworn, says s/he is the person referred to in the foregoing application for admission to examination for a physician and surgeon's certificate in California and that s/he has carefully read and thoroughly understands all the requirements herein and that the statements made herein are strictly true in every respect.

Aiesha Shaikh
 Signature of Applicant

Signed and sworn to before me this _____ day of _____, 19____

Notary Public

[SEAL]

My commission expires _____



Alfred
STELLA MARIE COLLEGE
CATHEDRAL ROAD,
NAGAS - 400 014
PHONE : 21541
Dated: 9th March 81.

This is to certify that
Selvi Hussain Ayesha was a bona-
fide student of this College
having studied the Pre-University
courses during the year 1966-67.
She took the following subjects
under each part.

- Part I-English
- Part II-French
- Part III- Group A - Physics, ✓
Chemistry and ✓
Natural Science.

[Signature]
Principal.

STELLA MARIE COLLEGE
NAGAS - 400 014



BOARD OF MEDICAL QUALITY ASSURANCE

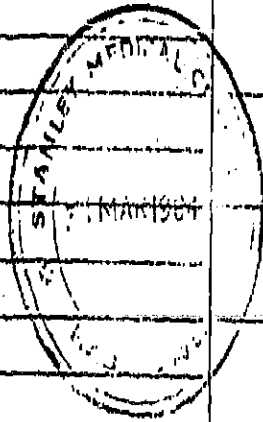
1430 HOWE AVENUE, SACRAMENTO, CALIFORNIA 95833



REPORT OF THIRD YEAR CLINICAL ROTATIONS

6/1970 to 3/1971

CLINICAL AREA	TYPE	HOSPITAL NAME AND ADDRESS	DATES OF ATTENDANCE		WEEKS OF CREDIT	INSTRUCTOR OR SUPERVISOR	PROGRAM DIRECTOR
			FROM	TO			
General	R	Govt. Stanley Hospital	6/1/1970	8/30/70	12	SK	Dr. P.K. Nambiar
1. Surgery		Madras India 600001					
Medicine	R	Govt. Stanley Hospital	9/1/1970	11/30/70	12	J	Dr. K.V. Thiruvengada
2.		Madras 600001 India					
Obstetrics	R	Govt. R.S.R.M. Lying in Hospital	1/1/1971	3/30/71	12	K L	Dr. A.K. Joseph
3. Gynecology		Madras 600001 India					
4.							
5.							
6.							
7.							
8.							
9.							
10.							



ENTER "E" FOR ELECTIVE OR "R" FOR REQUIRED.
NOTE: 10 WEEKS MAXIMUM ALLOWABLE ELECTIVE ROTATIONS.

(OVER)



BOARD OF MEDICAL QUALITY ASSURANCE

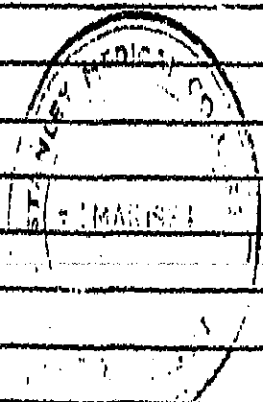
1430 HOWE AVENUE, SACRAMENTO, CALIFORNIA 95833



REPORT OF FOURTH YEAR CLINICAL ROTATIONS

6/1971 - 3/1972

CLINICAL AREA	TYPE	HOSPITAL NAME AND ADDRESS	DATES OF ATTENDANCE		WEEKS OF CREDIT	INSTRUCTOR OR SUPERVISOR	PROGRAM DIRECTOR
			FROM	TO			
General	R	Govt. Stanley Hospital	6/1/1971	to	4		Dr. K.
1. Medicine		Madras 600001 India	6/30/71				Natarajan
2. Pediatrics	R	As above	7/1/1971	to	4		
			7/30/71				
3. Dermatology	R	As above	8/1/71	to	4		
			8/31/71				
4. General Surgical	R	As Above	9/1/71	to	8		Dr. D. Jagadesu
			10/30/71				
5. Orthopedics	R	As Above	11/1/71	to	4		
			11/30/71				
6. Ophthalmology	R	As Above	1/1/1972	to	6		
			2/15/72				
7. E.N.T.	R	As Above	2/16/72	to	6		
			3/20/72				
8.							
9.							
10.							



*ENTER "E" FOR ELECTIVE OR "R" FOR REQUIRED.
NOTE - 16 WEEKS MAXIMUM ALLOWABLE ELECTIVE ROTATIONS.

(OVER)



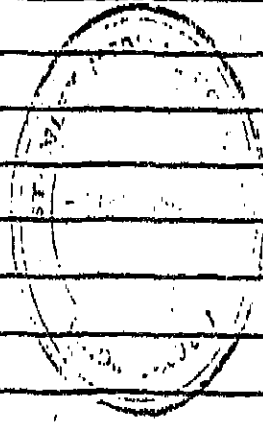
BOARD OF MEDICAL QUALITY ASSURANCE

1430 HOWE AVENUE, SACRAMENTO, CALIFORNIA 95833



FIFTH
REPORT OF FOURTH YEAR CLINICAL ROTATIONS
6/1972 TO 3/1973

CLINICAL AREA	TYPE	HOSPITAL NAME AND ADDRESS	DATES OF ATTENDANCE FROM - TO	WEEKS OF CREDIT	INSTRUCTOR OR SUPERVISOR	PROGRIAM DIRECTOR
1. Medicine	R	Govt. Stanley Hospital Madras 600001 India	6/1/72 to 8/30/72	12		Dr. K. Nataram
2. Obstetrics Gynecology	R	Govt. R.S.R.M. Lying in Hospital Madras 600001 India	9/1/72 to 11/30/72	12		Dr. A.K. Joseph
3. Surgery	R	Govt. Stanley Hospital Madras 600001 India	1/1/1973 to 3/30/73	12		Dr. Jagadeesan
4.						
5.						
6.						
7.						
8.						
9.						
10.						



ENTER "e" FOR ELECTIVE OR "r" FOR REQUIRED.
NOTE - 18 WEEKS MAXIMUM ALLOWABLE ELECTIVE ROTATIONS.

Department of Medicine, Stanley Medical College, Madras- 1.

Certified that the Medicine postings done by Dr. Ayesha Hussain formerly a student of Stanley Medical College includes:-

1. Pediatrics in IIIrd M.B.B.S., 1st Clinical year
From October 1st -- November 30th 1970.
2. Pediatrics in the IVth M.B.B.S, 2nd Clinical year
From July 1st 1971 ----- July 30th w 1971.
3. Psychiatry in the final year M.B.B.S from
1st August --- 31st August 1972.



[Handwritten Signature]
Dean
Stanley Medical College, Madras
15/5/84
8507
3584

3331

283 B

University of Sindh
FACULTY OF MEDICINE.

The Senate of the *University of Sindh* hereby
 makes known that *Kussair Ayesha* has been
 admitted to the Degree of Bachelor of Medicine and
 Surgery, she having been certified by duly appointed Examiners
 to be qualified to receive the same, and having been by them placed
 in the *Second* Class at the Examination held in the month
 of *April* 1973.

Given under the seal of the University.

Senate House,
 November 15, 1974

D. J. D. S.
 Registrar

M.A., L.T.
 Vice-Chancellor

C

Maharashtra Medical Council, Bombay Certificate of Registration

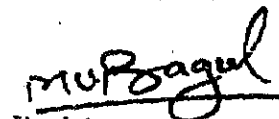
Registration No. : 32361

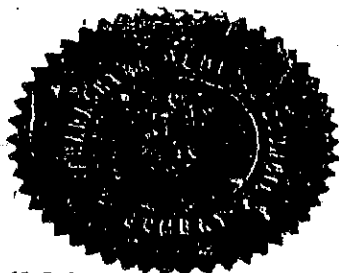
This is to certify that Doctor ~~Shri~~/Shrimati/
Kumari HUSSAIN AYESHA
possessing the qualifications of M.B.B.S., (MADRAS), 1974;

has been duly registered under the Maharashtra
Medical Council Act, 1965 (Mah. XLVI of 1965), in
Part. I of the register.

In witness whereof are herewith affixed the
seal of the Maharashtra Medical Council, Bombay
and the signature of the Registrar.

Dated the 21ST SEPTEMBER 1974.

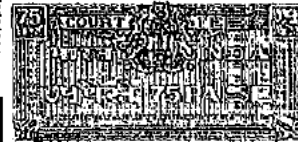

Registrar



MEDICAL REGISTRATION CERTIFICATE

Court for Stamps No. 144

Certificate No. 262 25005
Name MUSSEATH AYESHA
Father's name [REDACTED]
Qualifications M.B.B.S. (Madras) 1974.
Date and place of Registration 22-5-1974 Madras
Address [REDACTED]
Remarks _____



It is hereby certified that this is a true copy of the entry of the above specified name in the Medical Register.

MADRAS MEDICAL COUNCIL OFFICE,
MADRAS.

22-5-1974.

M. Rajasekharan
B.A.B.L.
Registrar.

Registrar's seal.



IMPORTANT NOTICES

Registered Medical Practitioners should be careful to send the Registrar immediate their registered addresses and also to answer all inquiries that may be sent to them by the Registrar, in order that their correct addresses may be duly inserted in the Medical Register. No change is made for alteration of address. A copy of the Annual Medical Register wherein the name first appears will be supplied to registered practitioners. After the publication of the name in the printed Medical Register, the possession of the legal evidence of registration. All persons registered under whatever Diploma or Degrees are only qualified for Surgery and Midwifery.



Mount Sinai Hospital
Medical Center of Chicago
GRADUATE MEDICAL EDUCATION
C. James Avenue at 15th Street
Chicago, Illinois 60605
Telephone 312 XXXX 650-6486

7

February 27, 1984

To Whom It May Concern:

Re: Ayesha Shaikh, M.D.

This is to verify that the above named physician has been engaged in the Obstetrics-Gynecology Residency Training Program at Mount Sinai Hospital Medical Center of Chicago since July 1, 1981.

Doctor Shaikh is scheduled to complete the 4th year of training on June 30, 1984.

If I may be of further assistance to you, please feel free to contact me.

Sincerely,

LeRoy P. Levitt, M.D.
Chairman, Department of
Psychiatry and
Director, Educational and
Professional Programs

LPL:bt


Application Summary

2/26/18 4:55 PM

Page 1 of 3

License Type:	Physician and Surgeon A
License Number:	41130
File Number:	58046
Application:	Physician's and Surgeon's Renewal
Application Number:	14491019
Application Date:	02/26/2018 (mm/dd/yyyy)

Application Questions

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

Personal Detail


First Name:	AYESHA
Last Name:	SHAIKH
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

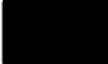
Since you last renewed your license, have you had any license disciplined by a government agency or other disciplinary body, or, have you been convicted of any crime in any state, the U.S.A. and its territories, military court or a foreign country? 

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. 

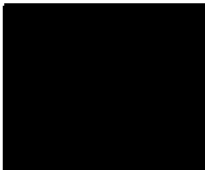
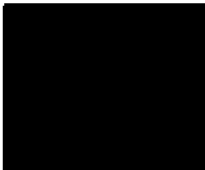

Family Physician Training Program Voluntary Fee



Would you like to contribute? 

Attachments

Physician Survey

Are you retired?	No
Activities in Medicine	Administration - None Other - None Patient Care - 10-19 Hours Research - None Teaching - None Telemedicine - None
Patient Care Practice Location	Zip: 93109 County: SANTA BARBARA
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	9+ Years
Cultural Background	
Foreign Language Proficiency	
Web Site Profile	Cultural Background - No Foreign Language Proficiency - No Gender - Yes
E-mail:	

Fees

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

Applications are not considered submitted for processing until payment is received.

Attestation



1519692946819

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

3/4/16 3:31 PM

Page 1 of 3

License Type: **Physician and Surgeon A**
License Number: **41130**
File Number: **58046**
Application: **Physician's and Surgeon's Renewal**
Application Number: **14267079**
Application Date: **03/04/2016 (mm/dd/yyyy)**

Application Questions

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

Personal Detail

First Name: **AYESHA**
Last Name: **SHAIKH**
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. 

Family Physician Training Program Voluntary FeeVoluntary Fee: **Attachments****Physician Survey**

Are you retired? **No**

Activities in Medicine **Administration - None**
Other - None
Patient Care - 10-19 Hours
Research - None
Teaching - None
Telemedicine - None

Patient Care Practice Location **Zip: 93105 County: SANTA BARBARA**

Telemedicine Practice Location **Zip: County:**

Patient Care Secondary Practice Location **Zip: County:**

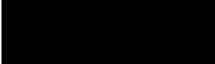
Telemedicine Secondary Practice Location **Zip: County:**

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 

Web Site Profile **Cultural Background - No**
Foreign Language Proficiency - No
Gender - Yes

E-mail: **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

1457134305447

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

4/22/14 4:03 PM

Page 1 of 3

License Type: **Physician and Surgeon A**
License Number: **41130**
File Number: **58046**
Application: **Physician's and Surgeon's Renewal**
Application Number: **14057705**
Application Date: **04/22/2014 (mm/dd/yyyy)**

Personal Detail

First Name: **AYESHA**
Last Name: **SHAIKH**
Birthdate: 
Gender: **Female**

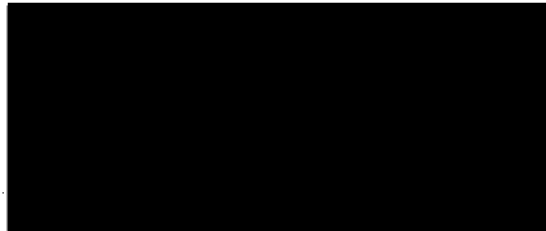
Addresses

License Related Addresses

Confidential Address (Optional)

Name:

Address:



License Specific Public/Mailing Address (Required)

Name: **SHAIKH, AYESHA**

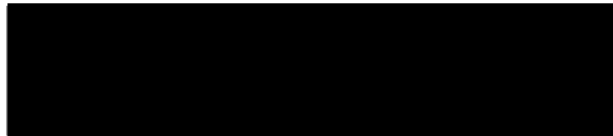
Address: **510 W PUEBLO STREET**

SANTA BARBARA, CA

93105

Phone Number:

E-mail 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?



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.



Family Physician Training Program Voluntary Fee
Voluntary Fee:



Attachments

Physician Survey

Are you retired?

No

Activities in Medicine

Administration - None

Other - None

Patient Care - 20-29 Hours

Research - None

Teaching - None

Telemedicine - None

Patient Care Practice Location

Zip: 93105 County:

Telemedicine Practice Location

Zip: County:

Patient Care Secondary Practice Location

Zip: County:

Telemedicine Secondary Practice Location

Zip: County:

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



Web Site Profile

Cultural Background - No

Foreign Language Proficiency - No

Gender - Yes

E-mail:



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: