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
(916) 920-6411

002006 472.50

RECEIVED SACRAMENTO BOARD OF MEDICAL QUALITY ASSURANCE SEP 2 9 54 AM '86

APPLICATION FOR PHYSICIAN AND SURGEON'S EXAMINATION AND LICENSURE

008172 125.00

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.

000545 127.50 9/18/86

BMQA USE ONLY

PERSONAL DATA

1. Name: Last First Middle
SPEISER DAVID MATTHEW

2. Other names you have used:

3. Address: Number and Street/Rural Route (include apartment number, if any)
[redacted]
City State ZIP Code County
[redacted] [redacted] [redacted]

4. Telephone Number: Home [redacted] Work [redacted]

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

6. Sex: ☐ Female ☒ Male

7. 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 N300), VISA documents, or license to practice medicine.

8. Have you ever filed an application in California? ☐ Yes ☒ No
If YES, give date of previous application:

9. 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)
~~UC RIVERSIDE~~	~~Riverside, Calif.~~	~~8/78~~	~~6/80~~
UC SANTA BARBARA	Santa Barbara, Calif.	8/80	6/82

10. Check whether the following premedical courses were successfully completed and show where completed:

Course	Yes	No	Name of College or University
Chemistry	X		U.C.RIVERSIDE
Physics	X		U.C. SANTA BARBARA
Biology	X		U.C. RIVERSIDE / U.C. ~~SNATA~~ SANTA BARBARA
Zoology	X		U.C. RIVERSIDE

Subscribed and sworn to before me this 12 day of August, 1986

Notary Public, State of California
Principal Office, Los Angeles County

OFFICIAL SEAL
DARLENE COBERLY
Notary Public - California
PRINCIPAL OFFICE IN LOS ANGELES COUNTY
MY COMMISSION EXPIRES JUNE 17, 1988

L1A

AMOA USE ONLY

MEDICAL EDUCATION

CME TRANS

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.

Name	Address	Place Where Instruction Received	Period of Attendance From (Mo/Yr)	Period of Attendance To (Mo/Yr)
UNIV. AUTO. OF GUAD.	MEXICO	GUAD., MEXICO	6/82	6/86

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
AUTONOMOUS UNIVERSITY OF GUADALAJARA,	MEXICO	6/86

MEX14
School Code

WRITTEN EXAMINATION

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

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

Name	Location	Date	Result
FMGEMS	L.A., CALIF.	1/22/86	[redacted]
MSKP	L.A., CALIF	6/84	
MCAT	L.A., CALIF	5/81	

POSTGRADUATE TRAINING

14. Have you received qualifying postgraduate training in U.S. or Canadian facilities? [ ] Yes [X] No

If YES, list name and address of all facilities. Submit an original Certificate of Completion of ACGME Postgraduate Training from each facility.

Name	Address	Type of Service	Period of Attendance From (Mo/Yr)	Period of Attendance To (Mo/Yr)

NEGLIGENCE DATA

LOS CC

15. Have you been licensed to practice medicine in any state or country? [ ] Yes [X] 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)	Dates of Practice in Issuing Agency's Jurisdiction To (Mo/Yr)

Subscribed and sworn to before me this [illegible] day of August 19 86

Notary Public, State of California
Principal Office in Los Angeles County

OFFICIAL SEAL
DARLENE COBERLY
Notary Public - California
PRINCIPAL OFFICE IN
LOS ANGELES COUNTY
My Commission Expires June 17, 1988

L1B

BMQA USE ONLY

16. Has any disciplinary action ever been taken regarding any healing arts licensh 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

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 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.

19. 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.

20. Are you now, or were you in the past, addicted to controlled substances, such as narcotics or alcohol?

[redacted] Yes [redacted] No

21. 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

22. 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 1203.45 Penal Code or under any other provision of law.

David M. Gruber

Subscribed and sworn to before me this 7th day of August, 1986.

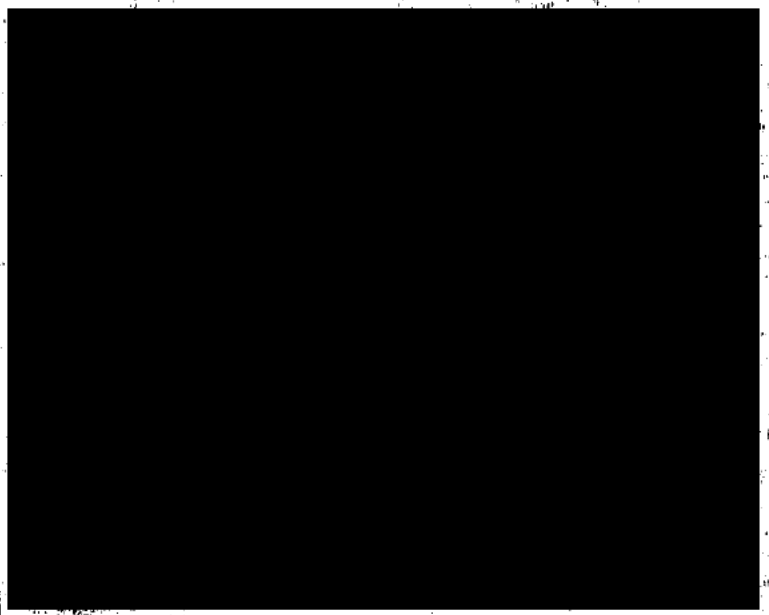
Notary Public, State of California
Principal Office, Los Angeles County

OFFICIAL SEAL
DARLENE COBERLY
Notary Public - California
PRINCIPAL OFFICE IN
LOS ANGELES COUNTY
MY COMMISSION EXPIRES JUNE 17, 1988

LICENSE DATA

GENERAL DATA

L10



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 _____

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 2089 of the Business and Professions Code which authorizes the collection of this information. 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 CALIF

COUNTY OF Los Angeles

David Matthew Spiess being duly sworn, says he is the person referred to in the foregoing application for a physician and surgeon's certificate in California and that he 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.

He 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, he 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.

David Matthew Spiess
Signature of applicant in FULL (Do not use INITIALS only)

Signed and sworn to before me this 22nd day of August, 1986.

Signature of Notary Public Darlene Coberly

Address 2801 Atlantic Ave Long Beach CA 90806

[SEAL]

OFFICIAL SEAL
DARLENE COBERLY
Notary Public - California
PRINCIPAL OFFICE IN
LOS ANGELES COUNTY
MY COMMISSION EXPIRES JUNE 17, 1988

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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 DAVID MATTHEW SPEISER [redacted] FULL NAME OF APPLICANT

of [redacted] enrolled in AUTONOMOUS UNIVERSITY of Guadalajara NAME OF MEDICAL SCHOOL

Guadalajara Jalisco MEXICO LOCATION on the 26 day of July MONTH 1982 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 2088):

UNIV. CALIF. RIVERSIDE / UNIV. CALIF. SANTA BARBARA EDUCATIONAL INSTITUTION 9/78-6/80; 9/80-6/82 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 he attended in this institution 42 (SPECIFY NUMBER) courses of resident instruction of various 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

[X] he was granted the degree Bachelor/Doctor of Medicine by Physician-Surgeon

[ ] he withdrew from

the above mentioned medical school on the 9 day of June MONTH 19 86

Anatomy 200	Dermatology 60	Preventive medicine, including Nutrition 962
Otolaryngology 60	Embryology 72	*Physical Medicine
Obstetrics and Gynecology 300	Histology 136	*Therapeutics
Radiology, including Radiation Safety 40	*Human Sexuality as defined in Section 2090	*Neuroanatomy
Tropical Medicine 160	Medicine 2116	*Child Abuse Detection and Treatment
Physiology 200	Surgery, including Orthopedic Surgery 408	*Geriatric Medicine
Biochemistry 200	Urology 60	Pediatrics 360
Pathology, Bacteriology and Immunology 414	Psychiatry 208	Pharmacology 198
Ophthalmology 60	Neurology 160	*Anesthesia

* The credit hours for this subject have been included with another subject.

[redacted]

Signed and the college seal affixed this 21 day of August 19 86

BY Alejandro Acevedo
Dean of Foreign Students
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 medical instruction was received MUST complete one of these forms. If more than one school was attended, photocopies of this blank form may be made and used. Note that photographs and all entries on the form must be original.

L2

[left margin: emblem, photograph]

D I P L O M A

The Autonomous University of Guadalajara,
State of Jalisco,
Republic of Mexico

We inform all those who read these presents that the Rector of the University, the Director and the Faculty of the School of Medicine, having noted the report of his examiners, declare that

DAVID MATTHEW SPEISER

has completed his curriculum and passed all the prescribed biannual examinations and is therefore awarded the title of

Physician and Surgeon

and is granted all the rights and privileges pertaining thereto.

In witness whereof, this diploma is signed and issued by this University on the 9th day of June, 1986

RECTOR OF UAG
[signed]
DR. LUIS GARIBAY GUTIERREZ

DIRECTOR OF THE SCHOOL OF MEDICINE
[signed]
DR. NESTOR VELASCO PEREZ

UNIVERSIDAD AUTONOMA DE GUADALAJARA

Diploma

Guadalaxarensis Universitas Autonoma Xalisciensis Districtus In Mexicana Republica,

Omnibus has Litteras inspecturis notum facimus:

Rectorem Universitatis, Directorem necnon Scholæ Medicinæ Professores Examinatoribus iudicium ferentibus,

David Matthew Speiser

eo quod tempus implevit et bis annualia examina subiit his cursibus asignata, obtinuisse approbationem studiorum quæ competunt

[redacted]edicinæ ac [redacted]hirurgiæ

Quare et iura et honores et dignitatem obtentam otorgamus.

Est ergo hoc diploma testimonium ab hac Universitate signatum die IX Junii MCMXXXVI

Rector U. A. G.

Dr. Luis Garibay Gutierrez

Director Scholæ Medicinæ

Dr. Nestor Velasco Perez

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

RECEIVED
SACRAMENTO
BOARD OF MEDICAL
QUALITY ASSURANCE
JUL 11 '88

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 DAVID MATTHEW SPEISER (NAME OF APPLICANT)

a graduate of AUTONOMOUS UNIVERSITY OF GUADALAJARA (NAME OF MEDICAL SCHOOL)

commenced postgraduate training in OBSTETRICS AND GYNECOLOGY (NAME AND ADDRESS OF FACILITY)
NEW YORK INFIRMARY BEEKMAN DOWNTOWN HOSPITAL 170 WILLIAM STREET NEW YORK CITY, NY

on 7/1/87 (July 1) 19 87, and completed such training

on 6/30/91 (June 30) 19 91. This training consisted of 48 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
OB/GYN.	4 YEARS 4 MOS
PATHOLOGY	

[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 STANLEY ZINBERG, M.D.

(AFFIX SEAL OF HOSPITAL OR NOTARY PUBLIC)

ADDRESS 170 WILLIAM STREET
NEW YORK, N.Y. 10038

PHONE NUMBER [redacted]

DATE July 5, 1988

SIGNATURE

MAE J. SAWYER
Notary Public, State of New York
No. 41-8779288
Qualified in Queens County
Commission Expires March 30, 19 17-31-88

L3

07A-100

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

RECEIVED
SACRAMENTO
BOARD OF MEDICAL
QUALITY ASSURANCE
'88 JUN 14 8 31 AM

APPLICATION FOR EXAMINATION AND UPDATE

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 including Form 17. Please type or print neatly. When space provided is insufficient, attach additional sheets of paper.

BMQA USE ONLY

1. This request is made in connection with an application now on file with this Board for:
   - ☐ A. Permission to take the following examination:
     - ☐ written examination
     - ☐ reciprocity written examination
     - ☐ oral and clinical examination
   - XXX B. Update of my application

2. Name — Last: SPEISER — First: DAVID — Middle: MATTHEW

3. Other names you have used:

4. Address: Name and Street/Rural Route (include apartment number, if any) [redacted]
   City [redacted] State [redacted] ZIP Code [redacted] Country

5. Telephone Numbers: Home [redacted] Work

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

7. 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)

8. 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

9. 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

10. 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.

11. 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.

07A-43 (Rev. 1/86)

L8A

BMQA USE ONLY

12. Are you now, or were you in the past, addicted to controlled substances, such as narcotics or alcohol?
[redacted] Yes [redacted] No

13. 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

14. 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.)
☐ Yes ☒ 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.

[redacted]

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 [redacted]

STATE OF New York)
COUNTY OF Queens)

David Matthew Speiser, being duly sworn, says he is the person referred to in the foregoing application for a physician and surgeon's certificate in California and that he 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.

David Matthew Speiser
Signature of applicant in FULL (Do not use INITIALS ONLY)

Signed and sworn to before me this 5TH day of JULY, 1988.

Signature of Notary Public Mae J. Sawyer

(SEAL)

Address 170 William St.

MAE J. SAWYER
Notary Public, State of New York
No. 41-4779095
Qualified in Queens County
Commission Expires March 30, 1989

My commission expires 7-31-88

L8B

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

RECEIVED
SACRAMENTO
BOARD OF MEDICAL
QUALITY ASSURANCE
APR 10 21 AM '87

APPLICATION FOR EXAMINATION AND UPDATE

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 including Form L7. Please type or print neatly. When space provided is insufficient, attach additional sheets of paper.

BMQA USE ONLY

1. This request is made in connection with an application now on file with this Board for:
   - ☐ A. Permission to take the following examination:
     - ☒ written examination
     - ☐ reciprocity/written examination
     - ☐ oral and clinical examination
   - ☒ B. Update of my application

2. Name: Last: Speiser First: David Middle: Matthew

3. Other names you have used: (none)

4. Address: Name and Street/Rural Route (include apartment number, if any): [redacted]
   City: [redacted] State: [redacted] ZIP Code: [redacted] Country: [redacted]

5. Telephone Numbers: Home [redacted] Work

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

7. 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)

8. 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

9. 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

10. 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.

11. 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.

07A-43 (Rev. 1/86)

L8A

BMQA USE ONLY

12. Are you now, or were you in the past, addicted to controlled substances, such as narcotics or alcohol?
[redacted] Yes [redacted] No

13. 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

14. 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

4 Penal Code or under any other provision of law.

[redacted]

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 [redacted]

STATE OF CALIFORNIA)
COUNTY OF LOS ANGELES)

DAVID MATTHEW SPEISER being duly sworn, says he is the person referred to in the foregoing application for a physician and surgeon's certificate in California and that he 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.

David Matthew Speiser
Signature of applicant in FULL (Do not use INITIALS ONLY)

Signed and sworn to before me this 10th day of APRIL, 1987.

(SEAL)

OFFICIAL SEAL
DARLENE COBERLY
Notary Public - California
PRINCIPAL OFFICE IN
LOS ANGELES COUNTY
MY COMMISSION EXPIRES JUNE 12, 1988

Signature of Notary Public Darlene Coberly

Address 2801 ATLANTIC AVE. Long Beach, Ca 90806

My commission expires 6-12-88

L8B

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

SACRAMENTO BOARD OF MEDICAL QUALITY ASSURANCE
JUL 14 8 31 AM '88

CERTIFICATION STATEMENT

This is to certify that DAVID MATTHEW SPEISER (Name of Physician) is in an ACGME/CCME postgraduate training position that commenced on JULY 1, 1987 and is expected to be completed on JUNE 30, 1991 in OBSTETRICS AND GYNECOLOGY (Type of Training)

at NEW YORK INFIRMARY BEEKMAN HOSPITAL
(Name and Address of Facility)
170 WILLIAM STREET NEW YORK CITY, NY 10038

(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.

Mae J. Sawyer

MAE J. SAWYER
Notary Public, State of New York
No. 41-4775085
Qualified in Queens County
Commission Expires March 30, 19 7-31-88

STANLEY ZINBERG, M.D.
TYPE OR PRINT NAME OF DIRECTOR OF MEDICAL EDUCATION

SIGNATURE OF DIRECTOR OF MEDICAL EDUCATION

7/5/88
DATE

[redacted]
PHONE NUMBER

074-71 (3-87)

L9

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

RECEIVED SACRAMENTO BOARD OF MEDICAL QUALITY ASSURANCE
OCT 16 2 16 PM '87

CERTIFICATE OF COMMENCEMENT OF ACGME POSTGRADUATE TRAINING FOR GRADUATES OF FOREIGN MEDICAL SCHOOLS

TO BE COMPLETED BY THE HOSPITAL FOR EVERY FOREIGN MEDICAL SCHOOL GRADUATE COMMENCING POSTGRADUATE TRAINING IN CALIFORNIA.

THIS IS TO CERTIFY THAT DAVID MATTHEW SPEISER (NAME OF DOCTOR)

A GRADUATE OF UNIVERSITY AUTONOMOUS OF GUADALAJARA/ UNIVERSITY CALIFORNIA IRVINE (NAME OF MEDICAL SCHOOL)

COMMENCED POSTGRADUATE TRAINING IN NEW YORK INFIRMARY BEEKMAN-DOWNTOWN HOSPITAL (NAME OF HOSPITAL)

ON JULY 1, 19 87, AND WILL COMPLETE SUCH TRAINING ON,

JUNE 30, 19 91, THIS TRAINING IS APPROVED BY THE ACCREDITATION COUNCIL FOR GRADUATE MEDICAL EDUCATION (ACGME) AND WILL CONSIST OF THE FOLLOWING ROTATIONS:

(LIST ROTATIONS TO BE COMPLETED. IF SERVICE IS NOT ROTATING, INDICATE TYPE OF STRAIGHT TRAINING TO BE PERFORMED. NOTE: TO QUALIFY FOR LICENSURE IN CALIFORNIA, GRADUATES OF FOREIGN MEDICAL SCHOOLS MUST COMPLETE AT LEAST FOUR MONTHS OF POST-GRADUATE TRAINING IN GENERAL MEDICINE. ACGME RESIDENCIES IN FAMILY PRACTICE, INTERNAL MEDICINE, SURGERY, PEDIATRICS, AND OB/GYN WILL NORMALLY SATISFY THIS REQUIREMENT.)

ROTATION	LENGTH OF ROTATION
GYNECOLOGY	EIGHT MONTHS
OBSTETRICS	FOUR MONTHS

THE UNDERSIGNED DECLARE UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT THE ABOVE STATEMENTS ARE TRUE AND CORRECT AND THAT THE HOSPITAL IS APPROVED BY THE ACGME TO OFFER THE TYPE AND LEVEL OF TRAINING TO BE COMPLETED BY THE APPLICANT, AND THAT THE APPLICANT HAS PRESENTED PROOF OF AUTHORIZATION TO PARTICIPATE IN POSTGRADUATE TRAINING ISSUED BY THE DIVISION OF LICENSING, BOARD OF MEDICAL QUALITY ASSURANCE. THE UNDERSIGNED UNDERSTAND AND AGREE THAT THE ABOVE NAMED PHYSICIAN WILL ONLY BE ALLOWED TO FUNCTION AT THAT LEVEL OF RESPONSIBILITY AND SUPERVISION OF THE FIRST YEAR OF POSTGRADUATE TRAINING.

NAME STANLEY ZINBERG, M.D.
DIRECTOR OF MEDICAL EDUCATION
ADDRESS 170 WILLIAM STREET
NEW YORK, N.Y. 10038
PHONE NUMBER [redacted]
DATE 15 Sept. 1987
SIGNATURE

NAME STANLEY ZINBERG, M.D.
DIRECTOR OF TRAINING PROGRAM
ADDRESS 170 WILLIAM STREET
NEW YORK, N.Y. 10038
PHONE NUMBER [redacted]
DATE 15 Sept. 1987
SIGNATURE

07M-175A (REV 4/85)

UNIVERSITY OF CALIFORNIA, IRVINE
CALIFORNIA COLLEGE OF MEDICINE

This Certificate is Awarded to

DAVID MATTHEW SPEISER

in recognition of satisfactory completion of a year of clinical education at the affiliated hospitals of the College thereby meeting the requirements for the Fifth Pathway Program

June 16, 1986 to June 13, 1987

Dean, College of Medicine

Program Director

UNIVERSITY OF CALIFORNIA, IRVINE

BERKELEY • DAVIS • IRVINE • LOS ANGELES • RIVERSIDE • SAN DIEGO • SAN FRANCISCO SANTA BARBARA • SANTA CRUZ

OFFICE OF THE ASSOCIATE DEAN
HOSPITAL AFFAIRS

IRVINE: CALIFORNIA COLLEGE OF MEDICINE
UCI MEDICAL CENTER
101 THE CITY DRIVE SOUTH
ORANGE, CALIFORNIA 92668

June 18, 1987

Board of Medical Quality Assurance
1430 Howe Avenue
Sacramento, CA

RE: FIFTH PATHWAY TRAINEE DAVID SPELSER

This is to advise you that the above-mentioned student has successfully completed all requirements for the Fifth Pathway Program conducted under the auspices of the University of California, Irvine and its affiliated institutions.

The dates of this program were 6/15/86 to 6/14/87.

The rotations completed were as follows:

6/15	-	8/14	Pediatrics	8
8/15	-	10/14	OB/GYN	8
10/15	-	11/14	Psychiatry	4
11/15	-	1/14	Radiology (elective)	8
1/15	-	2/14	Surgery	4
2/15	-	4/14	Medicine	8
4/15	-	5/14	Urology	4
5/15	-	6/14	Surgery	4

Sincerely,

Thos L. Nelson, M.D.
Associate Dean
Director, Fifth Pathway

TLN:bac

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

Speiser, David Matthew

UAG Credential No. 833497

REPORT OF JUNIOR YEAR CLINICAL ROTATIONS

Clinical Area	Type*	Facility Name and Address	Dates of Attendance From—To	Weeks of Credit	Instructor or Supervisor	Program Director
Cardiology 1.	R	Hospital Angel Leano -- Area Clinica Guadalajara, Jalisco, Mexico	8-24-84 to 9-26-84	5	Salvador Verduzco E., M.D. Chairman	
Pneumology 2.	R	Hospital Angel Leano - Area Clinica Guadalajara, Jalisco, Mexico	9-27-84 to 11-1-84	5	Manuel A. Uribina, M.D. Chairman	
Opthamology 3.	R	Hospital Angel Leano - Area Clinica Guadalajara, Jalisco, Mexico	11-2-84 to 12-7-84	5	Guillermo Mendizabal, M.D. Chairman	
Otorhino-Laryngology 4.	R	Hospital Angel Leano - Area Clinica Guadalajara, Jalisco, Mexico	11-2-84 to 12-7-84	5	Fernando Guzman Lozano, M.D. Chairman	
Gastroentero-logy 5.	R	Hospital Angel Leano -- Area Clinica Guadalajara, Jalisco, Mexico	3-18-85 to 4-30-85	5	Victoriano Saenz Felix, M.D. Chairman	
Traumatology 6.	R	Hospital Angel Leano - Area Clinica Guadalajara, Jalisco, Mexico	5-2-85 to 6-4-85	4.5	Gustavo J. Valladares, M.D. Chairman	
Dermatology 7.	R	Hospital Angel Leano - Area Clinica Guadalajara, Jalisco, Mexico	2-12-85 to 3-15-85	5	Raul Aceves, M.D. Chairman	
Forensic 8. Medicine	R	Hospital Angel Leano - Area Clinica Guadalajara, Jalisco, Mexico	2-12-85 to 3-15-85	5	Jorge Paz, M.D. Chairman	
History & Philosophy of Medicine	R	Hospital Angel Leano Area Clinica Guadalajara, Jalisco, Mexico	2-12-85- 3-15-85	5	Jorge Paz, M.D. Chairman	

*Enter "S" for elective or "R" for required. Subjects (1) - (8) are minimum allowable elective rotations.

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

"I hereby declare under penalty of perjury under the laws of the State of California that the foregoing information contained in this document and any attachments are true and correct." David Matthew Speiser

SIGNATURE OF APPLICANT IN FULL

Signed and sworn to before me this 24th day of August 19 84

[SEAL] Signature of Notary Public Darlene C. Cobbly

Address 2401 Atlantic Ave Long Beach, Ca 90806 My commission expires 6-17-88

OFFICIAL SEAL
DARLENE COBBLY
Notary Public - California
PRINCIPAL OFFICE IN
LOS ANGELES COUNTY
MY COMMISSION EXPIRES JUNE 17, 1988

...lejandro Aceves. An of Foreign Students

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

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REPORT OF SENIOR YEAR CLINICAL ROTATIONS

	Clinical Area	Type	Facility Name and Address	Dates of Attendance From—To	Weeks of Credit	Instructor or Supervisor	Program Director
1.	Social Medicine	R	Hospital Angel Leano - Area Clinica Guadalajara, Jalisco, Mexico	12-9-85- 12-13-85	1	Ing. Alberto Lopez Gudino, M.D. Chairman	
2.	Psychiatry	R	Prince George Medical Center and General Hospital 1 Hospital Drive, Cheverly, MD 20785	9/23/85- 10/13/85	3	Dr. Keller MD.	Dr. Keller MD.
3.	[illegible] Medicine	R	Prince George Medical Center and General Hospital 1 Hospital Drive, Cheverly, MD. 20785	7/29/85-9/22/85 10/14/85-11/10/85	12	Dr. Singh M.D.	Dr. Singh M.D.
4.	Neurology	R	Prince George Medical Center and General Hospital 1 Hospital Drive, Cheverly MD. 20785	11/11/85- 11/29/85	3	Dr. Singh M.D.	Dr. Singh M.D.
5.	Pediatrics	R	Prince George Medical Center and General Hospital 1 Hospital Drive, Cheverly, MD. 20785	12/29/85- 2/9/86	6	Dr. Steerman MD.	Dr. Steerman M.D.
6.	Obstetrics/Gynecology	R	Prince George Medical Center and General Hospital 1 Hospital Drive, Cheverly, MD. 20785	2/10/86- 3/23/86	6	Dr. Gazaway M.D.	Dr. Gazaway M.D.
7.	Surgery	R	Prince George Medical Center and General Hospital 1 Hospital Drive, Cheverly, MD. 20785	3/24/86- 5/14/86	8	Dr. Misra MD.	Dr. Misra M.D.
8.							
9.							
10.							

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

"I hereby declare under penalty of perjury under the laws of the State of California that the foregoing information contained in this document and any attachments are true and correct." [signature]

SIGNATURE OF APPLICANT IN FULL

Signed and sworn to before me this 7th day of August 19 86

[SEAL] Signature of Notary Public [signature]

Address 2801 Atlantic Ave Long Beach, CA 90806 My commission expires 6/17/88

OFFICIAL SEAL
DARLENE COBERLY
Notary Public - California
PRINCIPAL OFFICE IN
LOS ANGELES COUNTY
MY COMMISSION EXPIRES JUNE 11, 1988

OFFICIAL SEAL
DARLENE COBERLY
Notary Public - California
PRINCIPAL OFFICE IN
LOS ANGELES COUNTY
MY COMMISSION EXPIRES JUNE 11, 1988

STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY

DEPARTMENT OF Consumer Affairs

BOARD OF MEDICAL QUALITY ASSURANCE
1 HOWE AVENUE, SACRAMENTO, CALIFORNIA 95825
(916) 920-6411

CERTIFICATE OF CLINICAL TRAINING*

This is to certify that DAVID MATTHEW SPEISER (STUDENT'S NAME), a student of UAG U. AUTONOMA DE GUADALAJARA (MEDICAL SCHOOL), participated in a clerkship offered by PRINCE GEORGE MEDICAL CENTER & GENERAL HOSPITAL (NAME AND ADDRESS OF FACILITY) 1 HOSPITAL DR., CHEVERLY, MD. 20785 from 9/23/85 (DATE) 19__ thru 10/13/85 (DATE) 19__ in the clinical area of PSYCHIATRY (CLINICAL AREA). That the above named student successfully completed this clerkship on 10/13/85 (DATE) 19__

Carl H. Keller, M.D. being duly sworn, says XXhe XXwas the individual instructor or program director for the student named above during the clerkship indicated and that XXhe has carefully read and completed this form and that the statements made herein are strictly true in every respect.

DR KELLER
(TYPED OR PRINTED NAME OF INSTRUCTOR/PROGRAM DIRECTOR)
1 HOSPITAL DRIVE, CHEVERLY MD. 20785
(ADDRESS)
PRINCE GEORGE MEDICAL CENTER & GENERAL HOSPITAL
PHONE NUMBER [redacted]
Carl H. Keller MD
(SIGNATURE OF INSTRUCTOR/PROGRAM DIRECTOR)

Signed and sworn to before me this 9th day of Oct 19 85

Judy Johnson
NOTARY PUBLIC
PG Cty & MC Cheverly Md 20785
ADDRESS

[SEAL]

My commission expires 2/1/90

*There are certificates for each clerkship, one by instructor and one by faculty program director.

NOTE: This form may be omitted if all clinical training was done in the primary teaching hospital of the medical school and such hospital is located in the same country as the medical school and the medical school completes and certifies the Junior and Senior Year Clinical Rotations form).

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STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY

DEPARTMENT OF Consumer Affairs

BOARD OF MEDICAL QUALITY ASSURANCE
1430 HOWE AVENUE, SACRAMENTO, CALIFORNIA 95825
(916) 920-6411

CERTIFICATE OF CLINICAL TRAINING*

This is to certify that DAVID MATTHEW SPEIER (STUDENT'S NAME), a student of UNIV AUTONOMA OF GUADALAJARA (MEDICAL SCHOOL), participated in a clerkship offered by PRINCE GEORGE MEDICAL CENTER & GENERAL HOSPITAL, 1 HOSPITAL DR., CHEVERLY, MD. 20785 (NAME AND ADDRESS OF FACILITY)

from 9/23/85 (DATE) 19__ thru 10/13/85 (DATE) 19__

in the clinical area of PSYCHIATRY (CLINICAL AREA). That the above named student successfully completed this clerkship on 10/13/85 (DATE) 19__

Carl H. Keller, M.D. being duly sworn, says XX he X was the individual instructor or program director for the student named above during the clerkship indicated and that XX he has carefully read and completed this form and that the statements made herein are strictly true in every respect.

DR. KELLER
(TYPE OR PRINT NAME OF INSTRUCTOR/FACILITY PROGRAM DIRECTOR)

PRINCE GEORGE'S MEDICAL CENTER & GENERAL HOSPITAL
1 HOSPITAL DRIVE, CHEVERLY, MD 20785
(ADDRESS)

PHONE NUMBER [redacted]

(SIGNATURE OF INSTRUCTOR/FACILITY PROGRAM DIRECTOR)

Signed and sworn to before me this 9th day of July, 19 86

(NOTARY PUBLIC)

PG HOSP & MC, Cheverly, Md. 20785
(ADDRESS)

[SEAL]

My commission expires 7/1/90

*Must have two certificates for each clerkship, one by instructor and one by facility program director.

NOTE: This form may be omitted if all clinical training was done in the primary teaching hospital of the medical school and such hospital is located in the same country as the medical school and the medical school completes and certifies the Junior and Senior Year Clinical Rotations forms.

L6

STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY

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(916) 920-6411

CERTIFICATE OF CLINICAL TRAINING*

This is to certify that DAVID MATTHEW SPEISER (STUDENT'S NAME), a student of UABU AUTONOMA DE GUADALAJARA (MEDICAL SCHOOL), participated in a clerkship offered by PRINCE GEORGE MEDICAL CENTER & GENERAL HOSPITAL, 1 HOSPITAL DR., CHEVERLY, MD. 20785 (NAME AND ADDRESS OF FACILITY) from 7/29/85-9/22/85 (DATE) 19__ thru 10/14/85-11/10/85 (DATE) 19__ in the clinical area of INT. MEDICINE (CLINICAL AREA). That the above named student successfully completed this clerkship on 11/10/85 (DATE) 19__

Rishpal Singh, M.D. being duly sworn, says that XXhe/~~she~~ was the individual instructor or program director for the student named above during the clerkship indicated and that XXhe has carefully read and completed this form and that the statements made herein are strictly true in every respect.

DR SINGH
(TYPE OR PRINT, NAME OF INSTRUCTOR/FACILITY PROGRAM DIRECTOR)

PRINCE GEORGE MEDICAL CENTER & GENERAL HOSPITAL
(ADDRESS)
1 HOSPITAL DRIVE, CHEVERLY, MD. 20785

PHONE NUMBER [redacted]

(SIGNATURE OF INSTRUCTOR/FACILITY PROGRAM DIRECTOR)

Signed and sworn to before me this 19th day of June, 19 86

Diane Jarrett
(NOTARY PUBLIC)

1 Hospital Dr, Cheverly, Md
(ADDRESS)

[SEAL]

My commission expires 7/1/90

*Student must have two certificates for each clerkship, one by instructor and one by facility program director.

NOTE: This form may be omitted if all clinical training was done in the primary teaching hospital of the medical school and such hospital is located in the same country as the medical school and the medical school completes and certifies the Junior and Senior Year Clinical Rotations forms.

L6

STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY

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(916) 920-6411

CERTIFICATE OF CLINICAL TRAINING*

This is to certify that DAVID MATTHEW SPENCER (STUDENT'S NAME), a student of UAG U. AUTONOMA DE GUADALAJARA (MEDICAL SCHOOL), participated in a clerkship offered by PRINCE GEORGE MEDICAL CENTER & GENERAL HOSPITAL (NAME AND ADDRESS OF FACILITY) 1 HOSPITAL DR., CHEVERLY, MD. 20785 from 7/29/85 (DATE) 19 thru 9/22/85; 10/14/85 (DATE) - 11/10/85 19

In the clinical area of FAM. MEDICINE (CLINICAL AREA). That the above named student successfully completed this clerkship on 11/10/85 (DATE) 19

Rishbal Singh, M.D. being duly sworn, says ~~she~~ ~~he~~/was the individual instructor or program director for the student named above during the clerkship indicated and that ~~she~~ ~~he~~ has carefully read and completed this form and that the statements made herein are strictly true in every respect.

DR. SINGH
TYPE OR PRINT NAME OF INSTRUCTOR/~~PROGRAM DIRECTOR~~

PRINCE GEORGE MEDICAL CENTER & GENERAL HOSPITAL
1 HOSPITAL DRIVE, CHEVERLY, MD 20785
ADDRESS

PHONE NUMBER [redacted]

SIGNATURE OF INSTRUCTOR/~~PROGRAM DIRECTOR~~

Signed and sworn to before me this 19th day of June, 19 86

Debra Jarrett
NOTARY PUBLIC

ADDRESS 1 Hospital Dr. Cheverly, Md

[SEAL]

My commission expires 2/1/90

*Must have two certificates, for each clerkship, one by instructor and one by faculty program director.

NOTE: This form may be omitted if all clinical training was done in the primary teaching hospital of the medical school and such hospital is located in the same country as the medical school and the medical school completes and certifies the Junior and Senior Year Clinical Rotations forms.

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STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY

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

CERTIFICATE OF CLINICAL TRAINING*

This is to certify that DAVID MATTHEW SPEISER (STUDENT'S NAME), a student of UNIV. AUTONOMA OF GUADALAJARA (MEDICAL SCHOOL), participated in a clerkship offered by PRINCE GEORGE MEDICAL CENTER & GENERAL HOSPITAL (NAME AND ADDRESS OF FACILITY) HOSPITAL DR., CHERRY, MD. 20785 from 11/1/85 (DATE) 19 thru 11/29/85 (DATE) 19

In the clinical area of NEUROLOGY (CLINICAL AREA). That the above named student successfully completed this clerkship on 11/29/85 (DATE) 19

Rishpal Singh, M.D. being duly sworn, says XXhe XXwas the individual instructor or program director for the student named above during the clerkship indicated and thaXXhe has carefully read and completed this form and that the statements made hergin are strictly true in every respect.

DR. HENESY / DR. SINGH
(TYPED OR PRINT. NAME OF INSTRUCTOR/PROGRAM DIRECTOR)

PRINCE GEORGE MEDICAL CENTER & GENERAL HOSPITAL
HOSPITAL DRIVE CHERRY, MD. 20785
(ADDRESS)

PHONE NUMBER [redacted]

(SIGNATURE OF INSTRUCTOR/PROGRAM DIRECTOR)

Signed and sworn to before me this 19th day of June, 19 86

Diane Jewett
(NOTARY PUBLIC)

P.G. Hospital, Cheverly, Md.
(ADDRESS)

[SEAL]

My commission expires 7/1/90

*Must have two certificates for each clerkship, one by instructor and one by facility program director.

NOTE: This form may be omitted if all clinical training was done in the primary teaching hospital of the medical school and such hospital is located in the same country as the medical school and the medical school completes and certifies the Junior and Senior Year Clinical Rotations forms.

L6

STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY

DEPARTMENT OF Consumer Affairs

BOARD OF MEDICAL QUALITY ASSURANCE
1430 HOWE AVENUE, SACRAMENTO, CALIFORNIA 95825
(916) 920-6411

CERTIFICATE OF CLINICAL TRAINING*

This is to certify that DAVID MATTHEW SREJER (STUDENT'S NAME), a student of UNIV. AUTONOMA OF GUADALAJARA (MEDICAL SCHOOL), participated in a clerkship offered by PRINCE GEORGE MEDICAL CENTER & GENERAL HOSPITAL, 1 HOSPITAL DR., CHEVERLY, MD. 20785 (NAME AND ADDRESS OF FACILITY)

from 10/1/85 (DATE) 19__ thru 11/29/85 (DATE) 19__

in the clinical area of NEUROLOGY (CLINICAL AREA). That the above named student successfully completed this clerkship on 11/29/85 (DATE) 19__

Rishpal Singh, M.D. being duly sworn, says XXhe XX/was the individual instructor or program director for the student named above during the clerkship indicated and that XXhe has carefully read and completed this form and that the statements made herein are strictly true in every respect.

DR. HONESY / DR. SINGH
(TYPE OR PRINT NAME OF INSTRUCTOR/FACILITY PROGRAM DIRECTOR)

PRINCE GEORGE MEDICAL CENTER & GENERAL HOSPITAL
1 HOSPITAL DRIVE, CHEVERLY, MD. 20785
(ADDRESS)

PHONE NUMBER [redacted]

(SIGNATURE OF INSTRUCTOR/FACILITY PROGRAM DIRECTOR)

Signed and sworn to before me this 19th day of June, 19 86

Notary Public

P.G. Hospital Cheverly, MD
(ADDRESS)

[SEAL]

My commission expires 6/1/90

*Must have two certificates for each clerkship, one by instructor and one by facility program director.

NOTE: This form may be omitted if all clinical training was done in the primary teaching hospital of the medical school and such hospital is located in the same country as the medical school and the medical school completes and certifies the Junior and Senior Year Clinical Rotations forms.

L6

STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY

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

CERTIFICATE OF CLINICAL TRAINING*

This is to certify that DAVID MATTHEW SPEISER (STUDENT'S NAME), a student of UNIVERSITY OF CALIFORNIA AT IRVINE (MEDICAL SCHOOL) participated in a clerkship offered by PRINCE GEORGE MEDICAL CENTER & GENERAL HOSPITAL (NAME AND ADDRESS OF FACILITY) HOSPITAL DRIVE, CHEVERLY, MD. 20785 from 12/29/85 (DATE) 19__ thru 2/9/86 (DATE) 19__ in the clinical area of PEDIATRICS (CLINICAL AREA). That the above named student successfully completed this clerkship on 2/9/86 (DATE) 19__.

Ruth Steerman, M.D. being duly sworn, says S he was the individual instructor or program director for the student named above during the clerkship indicated and that S he has carefully read and completed this form and that the statements made herein are strictly true in every respect.

DR CHA/DR STEERMAN
(TYPE OR PRINT, NAME OF INSTRUCTOR/PROGRAM DIRECTOR)

PRINCE GEORGE MEDICAL CENTER & GENERAL HOSPITAL
(ADDRESS)

HOSPITAL DRIVE, CHEVERLY, MD. 20785

(PHONE NUMBER) [redacted]

Ruth L Steerman MD
(SIGNATURE OF INSTRUCTOR/PROGRAM DIRECTOR)

Signed and sworn to before me this 10th day of July, 19 86

Marie Jarrett
NOTARY PUBLIC

(ADDRESS) 16 Hospital Cheverly, Md. 20785

[SEAL]

My commission expires 7/1/90

*Use two certificates for each clerkship: one by instructor and one by facility program director.

NOTE: This form may be omitted if all clinical training was done in the primary teaching hospital of the medical school and such hospital is located in the same country as the medical school and the medical school completes and certifies the Junior and Senior Year Clinical Rotation forms.

L6

STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY

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

CERTIFICATE OF CLINICAL TRAINING*

This is to certify that DAVID MATTHEW SPEIGER (STUDENT'S NAME), a student of UABC Autonoma de Guadalajara (MEDICAL SCHOOL), participated in a clerkship offered by PRINCE GEORGE MEDICAL CENTER & GENERAL HOSPITAL (NAME AND ADDRESS OF FACILITY) HOSPITAL DR., CHEVERLY, MD 20785 from 12/29/85 (DATE) 19 thru 2/9/86 (DATE) 19 in the clinical area of PEDIATRICS (CLINICAL AREA). That the above named student successfully completed this clerkship on 2/9/86 (DATE) 19

I, Ruth Steerman, M.D., being duly sworn, says S/he XX/was the individual instructor or program director for the student named above during the clerkship indicated and that S/he has carefully read and completed this form and that the statements made herein are strictly true in every respect.

DR CHA/DR. STEERMAN (TYPE OR PRINT, NAME OF INSTRUCTOR/FACILITY PROGRAM DIRECTOR)
PRINCE GEORGE MEDICAL CENTER & GENERAL HOSPITAL (ADDRESS)
HOSPITAL DRIVE, CHEVERLY, MD 20785
PHONE NUMBER: [redacted]
Ruth S Steerman, MD (SIGNATURE OF INSTRUCTOR/FACILITY PROGRAM DIRECTOR)

Signed and sworn to before me this 14th day of July, 1986
Deborah Jarrett (NOTARY PUBLIC)
P.G. Hospital/Cheverly Md. 20785 (ADDRESS)
[SEAL]
My commission expires 9/1/90

*A student has one certificate for each clerkship, one by instructor and one by facility program director.

NOTE: This form may be omitted if all clinical training was done in the primary teaching hospital of the medical school and such hospital is located in the same country as the medical school and the medical school completes and certifies the Junior and Senior Year Clinical Rotation Forms.

L6

STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY

DEPARTMENT OF Consumer Affairs

BOARD OF MEDICAL QUALITY ASSURANCE
1430 HOWE AVENUE, SACRAMENTO, CALIFORNIA 95825
(916) 920-6411

CERTIFICATE OF CLINICAL TRAINING*

This is to certify that DAVID MATTHEW SPEISER (STUDENT'S NAME), a student of UNIV. AUTONOMA DE GUADALAJARA (MEDICAL SCHOOL), participated in a clerkship offered by PRINCE GEORGE MEDICAL CENTER & GENERAL HOSPITAL / HOSPITAL DR., CHEVERLY, MD. 20785 (NAME AND ADDRESS OF FACILITY) from 2/10/86 (DATE) 19 thru 3/23/86 (DATE) 19 in the clinical area of OB/GYN (CLINICAL AREA). That the above named student successfully completed this clerkship on 3/23/86 (DATE) 19

Preston Gazaway, M.D. being duly sworn, says XX he XX was the individual instructor or program director for the student named above during the clerkship indicated and that XX he has carefully read and completed this form and that the statements made herein are strictly true in every respect.

DR GAZAWAY / DR RAHRANI
(TYPE OR PRINT NAME OF INSTRUCTOR XXXXXXXXXXXXXXXXXX)
PRINCE GEORGE MEDICAL CENTER & GENERAL HOSPITAL
(ADDRESS)
1 HOSPITAL DRIVE, CHEVERLY, MD. 20785
PHONE NUMBER [redacted]

(SIGNATURE OF INSTRUCTOR/XXXXXXXXXXXXXXXXXX)

Signed and sworn to before me this 19th day of June 19 86

(NOTARY PUBLIC)
P.G. Hospital, Cheverly MD.
(ADDRESS)

[SEAL]

My commission expires 7/1/90

*Must have two certificates for each clerkship, one by instructor and one by facility program director.

NOTE: This form may be omitted if all clinical training was done in the primary teaching hospital of the medical school and such hospital is located in the same country as the medical school and the medical school completes and certifies the Junior and Senior Year Clinical Rotations forms.

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CERTIFICATE OF CLINICAL TRAINING*

This is to certify that DAVID MATTHEW SPEISER (STUDENT'S NAME), a student of UNIV. AUTONOMA OF GUADALAJARA (MEDICAL SCHOOL), participated in a clerkship offered by PRINCE GEORGE MEDICAL CENTER & GENERAL HOSPITAL (NAME AND ADDRESS OF FACILITY) / HOSPITAL DR., CHEVERLY, MD. 20785

from 3/10/86 (DATE) 19__ thru 3/23/86 (DATE) 19__

in the clinical area of OB/GYN (CLINICAL AREA). That the above named student successfully completed this clerkship on 3/23/86 (DATE) 19__

Preston Gazaway, M.D. being duly sworn, says XXhe XXwas the individual instructor or program director for the student named above during the clerkship indicated and that XXhe has carefully read and completed this form and that the statements made herein are strictly true in every respect.

DR. GAZAWAY / DR. BAHRAMI
(TYPE OR PRINT NAME OF INSTRUCTOR/XXXXXXXXX PROGRAM DIRECTOR)

PRINCE GEORGE MEDICAL CENTER & GENERAL HOSPITAL
(ADDRESS)
/ HOSPITAL DRIVE, CHEVERLY, MD. 20785

PHONE NUMBER [redacted]

(SIGNATURE OF INSTRUCTOR/FACULTY PROGRAM DIRECTOR)

Signed and sworn to before me this 12th day of June, 19 86

Jeanne Jarrett
(NOTARY PUBLIC)

PG Hospital Cheverly MD
(ADDRESS)

[SEAL]

My commission expires 5/1/90

*Must have two certificates for each clerkship, one by instructor and one by faculty program director.

NOTE: *This form may be omitted if all clinical training was done in the primary teaching hospital of the medical school and such hospital is located in the same country as the medical school and the medical school completes and certifies the Junior and Senior Year Clinical Rotations forms.

L6

STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY

DEPARTMENT OF Consumer Affairs

BOARD OF MEDICAL QUALITY ASSURANCE
1430 HOWE AVENUE, SACRAMENTO, CALIFORNIA 95825
(916) 920-6411

CERTIFICATE OF CLINICAL TRAINING*

This is to certify that DAVID MATTHEW SPEIGER (STUDENT'S NAME) is a student of UNIV. AUTONOMA DE GUADALAJARA (MEDICAL SCHOOL); participated in a clerkship offered by PRINCE GEORGE MEDICAL CENTER & GENERAL HOSPITAL (NAME AND ADDRESS OF FACILITY) 1 HOSPITAL DR., CHEVERLY, MD. 20785 from 3/24/86 (DATE) 19__ thru 5/16/86 (DATE) 19__ in the clinical area of SURGERY (CLINICAL AREA). That the above named student successfully completed this clerkship on 5/16/86 (DATE) 19__

Brajendra N. Misra, M.D. being duly sworn, says XXhe X/was the individual instructor for the student named above during the clerkship indicated and that X he has carefully read and completed this form and that the statements made herein are strictly true in every respect.

DR MISRA / DR BRAJESH
(TYPE OR PRINT NAME OF INSTRUCTOR)
PRINCE GEORGE MEDICAL CENTER & GENERAL HOSPITAL
(ADDRESS)
1 HOSPITAL DRIVE, CHEVERLY, MD. 20785
PHONE NUMBER [redacted]

Brajendra N. Misra
(SIGNATURE OF INSTRUCTOR)

Signed and sworn to before me this 16th day of June, 19 86

Joann Jarrett
(NOTARY PUBLIC)
(ADDRESS) P.G. Hospital, Cheverly, Md

[SEAL]

My commission expires 7/1/90

*Must have two certificates for each clerkship, one by instructor and one by facility program director.

NOTE: This form may be omitted if all clinical training was done in the primary teaching hospital of the medical school and such hospital is located in the same country as the medical school and the medical school completes and certifies the Junior and Senior Year Clinical Rotations forms.

L6

STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY

DEPARTMENT OF Consumer Affairs

BOARD OF MEDICAL QUALITY ASSURANCE
1430 HOWE AVENUE, SACRAMENTO, CALIFORNIA 95825
(916) 920-6411

CERTIFICATE OF CLINICAL TRAINING*

This is to certify that DAVID MATTHEW STRIKER (STUDENT'S NAME), a student of UNIV. AUTONOMA OF GUADALAJARA (MEDICAL SCHOOL), participated in a clerkship offered by PRINCE GEORGE MEDICAL CENTER & GENERAL HOSPITAL, 1 HOSPITAL DR., CHEVERLY, MD. 20785 (NAME AND ADDRESS OF FACILITY) from 3/24/86 (DATE) 19__ thru 5/16/86 (DATE) 19__ in the clinical area of SURGERY (CLINICAL AREA). That the above named student successfully completed this clerkship on 5/16/86 (DATE) 19__

Brajendra N. Misra, M.D. being duly sworn, says: X he XX was the individual XXXXXXX program director for the student named above during the clerkship indicated and that X he has carefully read and completed this form and that the statements made herein are strictly true in every respect.

DR MISRA/DR BANERJEE
PRINCE GEORGE MEDICAL CENTER & GENERAL HOSPITAL
(TYPE OR PRINT, NAME OF INSTRUCTOR/FACILITY PROGRAM DIRECTOR)
1 HOSPITAL DRIVE, CHEVERLY, MD. 20785
(ADDRESS)

PHONE NUMBER: [redacted]

B. Misra
(SIGNATURE OF INSTRUCTOR/FACILITY PROGRAM DIRECTOR)

Signed and sworn to before me this 19th day of January, 1986

Johnnie Jarrett
(NOTARY PUBLIC)

ADDRESS: P.G. Hospital Cheverly Md.

[SEAL]

My commission expires 4/1/90

* Must keep two certificates for each clerkship, one by instructor and one by facility program director.

NOTE: This form may be omitted if all clinical training was done in the primary teaching hospital of the medical school and such hospital is located in the same country as the medical school and the medical school completes and certifies the Junior and Senior Year Clinical Rotations forms.

L6

(DO NOT DETACH)

Medical Board of California – Physician's and Surgeon's Renewal 1-54198/820.00 3/27/18 BS

LICENSEE NAME	LICENSE NO.	EXPIRATION DATE	AMOUNT DUE NOW	AMOUNT DUE IF POSTMARKED AFTER JULY 30, 2018
SPEISER, DAVID M 3/16	**A45219**	**06/30/18**	**$820.00**	**$898.00**

LICENSEE MUST CHECK CORRECT BOXES

"H" [redacted] Completed Continuing Education (See Question 1)

"E" [redacted] Change of Address (fill in reverse side)

"I" [redacted] Conviction

"J" [redacted] Conviction

"F" [redacted] Family Physician Training Program

"G" [redacted] 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 _____ Date 3/13/19

ENTER YOUR PHONE NUMBER FOR REFERENCE: [redacted]

6301010000010000200045219301063018000820000000898000

CHANGE OF ADDRESS (Only if different from address above) **SPEISER, DAVID M** **A45219**

ADDRESS OF RECORD (Required)

Address Line 1

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

Application Summary

License Type:	**Physician and Surgeon A**
License Number:	**45219**
File Number:	**52663**
Application:	**Physician's and Surgeon's Renewal**
Application Number:	**14285571**
Application Date:	**03/21/2016 (mm/dd/yyyy)**

Application Questions

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

Personal Detail

First Name:	**DAVID**
Middle Name:	**M**
Last Name:	**SPEISER**
Birthdate:	****/**/******
Gender:	**Male**

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

Voluntary Fee: [redacted]

Attachments

Physician Survey

Are you retired?	**No**
Activities in Medicine	**Patient Care - 40+ Hours**
Patient Care Practice Location	**Zip: 90007 County:**
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	**White**
Foreign Language Proficiency	**Spanish**
Web Site Profile	**Foreign Language Proficiency - 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

1458586767363

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:

(Continued from Page 6)

Question 6: Financial Interest Disclosure (California B&P Code section 2426)

If you, or your immediate family, have any financial interests in a health-related facility, you MUST disclose the names and addresses of each interest below. If more space is needed, please attach additional listings.

	Health-Related Facility Name	Address
1)		
2)		
3)		
4)		
5)		

I certify under penalty of perjury, under the laws of California, that I have disclosed on this renewal application form 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.

- If **Yes**, check box "G," at the bottom of page 7.

Question 7: Armed Forces Personnel (military status)

If you currently hold an Armed Forces Personnel license, please update the following information:

Expected date of discharge and/or retirement from active service or full-time training (mm/dd/yyyy):

☐☐/☐☐/☐☐☐☐

(DO NOT DETACH)

Medical Board of California – Physician's and Surgeon's Initial Renewal 403210

LICENSEE NAME	LICENSE NO.	EXPIRATION DATE	AMOUNT DUE NOW	AMOUNT DUE IF POSTMARKED AFTER JULY 30, 2014
SPEISER, DAVID M	**A45219**	**06/30/14**	**$820.00**	**$898.00**

LICENSEE MUST CHECK CORRECT BOXES

"H" [redacted] Completed Continuing Education

"E" [redacted] Change of Address (fill in reverse side)

"I" [redacted] Conviction Disclosure

"J" [redacted] Conviction Disclosure

"F" [redacted] Family Physician Training Program ($25)

"G" [redacted] 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 _____ Date 4/17/14

ENTER YOUR PHONE NUMBER FOR REFERENCE: [redacted]

403280

630101000001000020004521930106301400082000000089800