STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY GEORGE DEUKMEJIAN, Governor

DEPARTMENT OF CONSUMER AFFAIRS

BOARD OF MEDICAL QUALITY ASSURANCE 013211
1430 HOWE AVENUE
SACRAMENTO, CA 95825
(916) 920-6411

APPLICATION FOR PHYSICIAN AND SURGEON'S EXAMINATION OR LICENSURE

May 15 1 30 PM '89

Read all instructions prior to completing this application. All questions on this application must be answered, and all supporting documents must be submitted with this application per instructions. Please type or print neatly. When space provided is insufficient, attach additional sheets of paper.

BMQA USE ONLY

1. Name: Last: Webster First: Karen Middle: Michele

PERSONAL DATA

2. Other names you have used:

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

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

City State ZIP Code Country [redacted]

5. Telephone Number: Home Work [redacted]

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

7. Sex: ☑ Female ☐ Male

8. Are you a U.S. citizen? [redacted] Yes [redacted] No
Submit a certified copy of birth certificate, Certificate of Naturalization, Declaration of Intention to become U.S. citizen (INS Form N300), VISA documents, or license to practice medicine.

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

10. List name and address of all colleges or universities attended other than schools where professional medical instruction was received. Submit an official transcript from each school attended.

NON-MEDICAL EDUCATION

Name	Address	Period of Attendance From (Mo/Yr)	To (Mo/Yr)
Brandeis University	Waltham, Mass 02254	9/77	6/81
Johns Hopkins School of Public Health	Baltimore, Md 21205	6/85	5/86

11. List name and address of all schools where professional medical instruction was received. Submit an original Certificate of Medical Education and official transcripts from each school attended.

MEDICAL EDUCATION

Name	Address	Place Where Instruction Received	Period of Attendance From (Mo/Yr)	To (Mo/Yr)
Johns Hopkins School of Medicine	720 Rutland Ave Balt, Md 21205	Balt, Md	9/81	5/85

CME TRANS.

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
Johns Hopkins School of Medicine	720 Rutland Ave. Balt, Md 21205	5·31·85

MD207
School Code

L1A

07A-100 86 08181

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

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

Name	Location	Date	Result
FLEX	New York, NY	June 1985	[redacted]

BMQA USE ONLY — WRITTEN EXAMINATION

14. Have you received qualifying postgraduate training in U.S. or Canadian facilities? ☑ Yes ☐ No

If YES, list name and address of all facilities. Submit an original Certificate of Completion of ACGME Postgraduate Training (Form L3) from each facility.

Name	Address	Type of Service	Period of Attendance From (Mo/Yr)	To (Mo/Yr)
Georgetown University Providence Hospital Family Practice Residency Program	3001 Blacksburg Rd NE, Wash DC 20018	Family Practice Residency training	6/86	6/89

POSTGRADUATE TRAINING

15. Have you been licensed to practice medicine in any state or country? ☑ Yes ☐ No

If YES, list state or country, license number, date issued and dates of practice in issuing agency's jurisdiction for each. Submit a Letter of Good Standing from each state in which you are licensed or have been licensed.

State or Country	License Number	Date of Issuance	Dates of Practice in Issuing Agency's Jurisdiction From (Mo/Yr)	To (Mo/Yr)
New York, NY	164366	September 13, 1985	NA	NA
Washington, DC	17187	April 6, 1988	6/86	7/89

LICENSE DATA — LUS CE

16. Has any disciplinary action ever been taken regarding any healing arts license which you now hold or have ever held? Include any disciplinary actions by the U.S. Military, U.S. Public Health Service or other U.S. federal governmental entity.

[redacted] Yes [redacted] No If yes, give details below:

State	Date	Charge	Disposition

L1B

07A-100

FOR USE ONLY

17. Have you ever been denied a license, permission to practice medicine or any other healing arts, or permission to take an examination in any state, country, or U.S. federal jurisdiction? [redacted] Yes [redacted] No

If yes, give details below:

State or Country	Date of Denial	Reason for Denial

18. Have you been charged with unprofessional conduct or any other unlawful activity by any healing arts licensing authority or by the U.S. military and are awaiting final disposition by that body?
[redacted] Yes [redacted] No If yes, please explain on a separate sheet of paper.

19. Have you ever voluntarily surrendered a license to practice in the healing arts in another state?
[redacted] Yes [redacted] No If yes, please explain on a separate sheet of paper.

20. Have you ever had staff privileges in a hospital denied, suspended or revoked, or resigned from a medical staff in lieu of disciplinary action? [redacted] Yes [redacted] No If yes, please explain on a separate sheet of paper.

GENERAL DATA

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

22. Have you ever been convicted of, or pled nolo contendere to a violation of any federal, state or local law relating to the manufacture, distribution or dispensing of controlled substances, or to drug addiction? [redacted] Yes [redacted] No

If yes, give details below:

Violation and Location	Date	Penalty or Disposition

23. Have you ever been convicted of, or pled nolo contendere to any offense, misdemeanor or felony of any state, the United States, or a foreign country? (except violations of traffic laws resulting in fines of $75.00 or less.)
[redacted] Yes [redacted] No If yes, give details below:

Violation and Location	Date	Penalty or Disposition

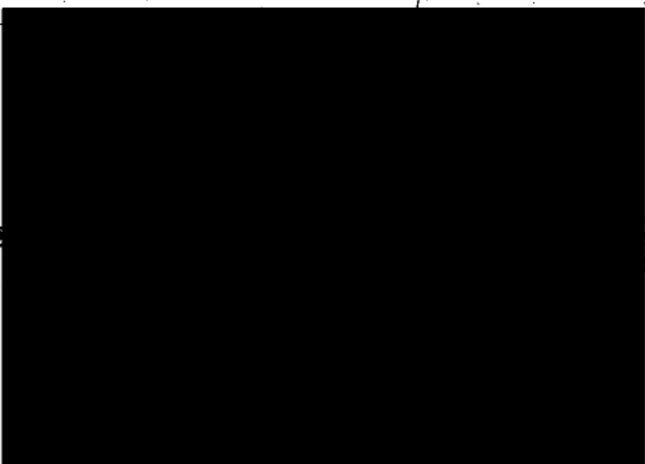
You are required to list any conviction that has been set aside and dismissed under Section 1203.4 Penal Code or under any other provision of law.

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

L1C

07A-100

TOP



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]

NOTE: All items in this application are mandatory; none are voluntary. Failure to provide any of the requested information will result in the application being rejected as incomplete. The information provided will be used to determine qualification for licensure, per Section 2080 of the Business and Professions Code which authorizes the collection of this information. Information regarding the issuance or denial of a license by the Board may be transmitted to any other medical licensing authority or the Federation of State Medical Boards. Applicants have the right to review their application subject to the provisions of the Information Practices Act. The Program Manager of the Division of Licensing is the custodian of records.

STATE OF District of Columbia

COUNTY OF

Karen Michele Webster being duly sworn, says S/he is the person referred to in the foregoing application for a physician and surgeon's certificate in California and that S/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.

S/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.

Karen Michele Webster
Signature of applicant in FULL (Do not use INITIALS ONLY)

Signed and sworn to before me this 11 day of May, 1987

Signature of Notary Public [signature]

[SEAL]

Address Providence Hospital, 1150 Varnum St. N.E. Wash DC 20017

My commission expires My Commission Expires April 30, 1993

07A-100

L1D

The Johns Hopkins University

This is a true and exact copy of the diploma that was awarded to Karen Michele Webster on May 31, 1985

Mary E. Foy
Assistant Dean/Registrar

Upon the recommendation of the Faculty of

The School of Medicine

has conferred upon

Karen Michele Webster

the degree of

Doctor of Medicine

with all the rights, honors and privileges appertaining thereto.
Given under the seal of the University at Baltimore, Maryland
on May thirty-first, nineteen hundred and eighty-five.

Richard S. Ross
Dean

Steven Muller
President

George G. Radcliffe
Chairman of the Board of Trustees

STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY GEORGE DEUKMEJIAN, Governor

DEPARTMENT OF

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 Karen Michele Webster (FULL NAME OF APPLICANT)

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

Baltimore, Maryland (LOCATION) on the 30 10th day of ~~August~~ September (MONTH) 1981 (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).

Brandeis University (EDUCATIONAL INSTITUTION) 9/77 – 6/81 (DATES)

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

______ (MEDICAL SCHOOL) ______ (TOTAL CREDITS) ______ (DATES)

The undersigned further certifies that the records of this institution show that She attended in this institution 4 (SPECIFY NUMBER) courses of resident instruction of 36 (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

[ ] _he withdrew from

the above mentioned medical school on the 31st day of May (MONTH) 19 85

Anatomy	Dermatology	Preventive medicine, including Nutrition
Otolaryngology	Embryology	Physical Medicine
Obstetrics and Gynecology	Histology	Therapeutics
Radiology, including Radiation Safety	Human Sexuality as defined in Section 2090	Neuroanatomy
Tropical Medicine	Medicine	Child Abuse Detection and Treatment
Physiology	Surgery, including Orthopedic Surgery	Geriatric Medicine
Biochemistry	Urology	Pediatrics
Pathology, Bacteriology and Immunology	Psychiatry	Pharmacology
Ophthalmology	Neurology	Anesthesia

Signed and the college seal affixed this 17th day of May, 19 89.

BY [signature]
Mary E. Foy, Assistant Dean/Registrar (PRESIDENT, SECRETARY, DEAN)

Medical School Seal MUST Be Imprinted Partially on the Photograph.

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

* Each school where professional 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 photograph and all entries in the form must be original.

L2

THE UNIVERSITY OF THE STATE OF NEW YORK
THE STATE EDUCATION DEPARTMENT
DIVISION OF PROFESSIONAL LICENSING SERVICES
CUSTOMER SERVICE UNIT
CULTURAL EDUCATION CENTER
ALBANY, NEW YORK 12230

RECEIVED
SACRAMENTO
BOARD OF MEDICAL
QUALITY ASSURANCE
JUL 5 12 52 PM '89

THIS IS TO CERTIFY THAT ACCORDING TO THE RECORDS OF THE DIVISION OF PROFESSIONAL LICENSING SERVICES, NEW YORK STATE EDUCATION DEPARTMENT, ALBANY, NEW YORK, WEBSTER KAREN MICHELE
WAS ISSUED LICENSE/CERTIFICATE NUMBER 164366 FOR THE PRACTICE OF MEDICINE ON 09/30/85.

OUR RECORDS ALSO INDICATE THE FOLLOWING INFORMATION:
DATE OF BIRTH: [redacted]
SCHOOL ATTENDED: JOHNS HOPKINS UNIVERSITY
DATE OF GRADUATION: 05/31/80
DEGREE EARNED: MD

PROGRAM WAS ACCEPTABLE IN ACCORDANCE WITH THE NYS REGULATIONS OF THE COMMISSIONER OF EDUCATION.. REQUIREMENTS MET AT THE TIME OF LICENSURE.

BASIS OF LICENSURE:

A DATE	EXAM#	COMPONENT 1	COMPONENT 2	FLEX EXAMINATION
0685	3940	76	80	

A LICENSE IS VALID DURING THE LIFE OF THE HOLDER UNLESS REVOKED, ANNULLED OR SUSPENDED BY THE BOARD OF REGENTS. A LICENSEE MUST REGISTER TRIENNIALLY WITH THIS DEPARTMENT TO PRACTICE IN THIS STATE.

CURRENTLY REGISTERED: NO TRIENNIUM ENDS:
ADDRESS: [redacted] [redacted] [redacted]

DEROGATORY INFORMATION: NO CHARGES HAVE BEEN PREFERRED AGAINST THIS LICENSEE.

COMMENTS:

I DAVID FRIBOURG , HEAD CLERK, DIVISION OF PROFESSIONAL LICENSING SERVICES OF THE NEW YORK STATE EDUCATION DEPARTMENT, DO HEREBY STATE THAT AS HEAD CLERK OF SAID DIVISION, I HAVE LEGAL CUSTODY OF THE OFFICIAL RECORDS OF THE DIVISION OF PROFESSIONAL LICENSING SERVICES AND TO THE BEST OF MY KNOWLEDGE, THE AFORESAID INFORMATION IS TRUE AND CORRECT.

SEAL

David Fribourg 06/21/89
HEAD CLERK by R. Mumby

DP026 054

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 ENDORSEMENT BY STATE LICENSING AGENCY

1. NAME: (last) (first) (middle) Webster Karen Michele
2. ADDRESS: Number and street/rural route (include apt. no., if any) — city — state — zip code — country
3. DATE OF BIRTH: mo/day/yr
4. SEX: ☑ Female ☐ Male
5. STATE LICENSING AGENCY New York State

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 attached photograph is a true likeness of myself and that the information contained in this document and any attachments are true and correct."

Karen Michele Webster
SIGNATURE OF APPLICANT IN FULL

Signed and sworn to before me this 11 day of May 1989

(SEAL)

Signature of Notary Public Edward C. Cicillianz
Address [illegible] Wash. D.C. 20017
My commission expires My Commission Expires April [illegible]

TO BE COMPLETED BY STATE LICENSING AGENCY:
(Do not complete if photograph of applicant is not attached above. Please type or print.)

I certify that ______ (NAME OF APPLICANT) who graduated from ______ (NAME OF MEDICAL SCHOOL) on ______ (DATE OF GRADUATION) was granted license number ______ on ______ (DATE LICENSE ISSUED) on the basis of ______ (FLEX, NATIONAL BOARD EXAM, LICENSING AGENCY EXAM)

NOTE: If the license was issued by written examination, complete the following certification, otherwise write across the following certification the words: Licensed on Credentials.

I further certify that this doctor passed the REGULAR WRITTEN EXAMINATION given by this Board on ______ (DATE)
and obtained a general average of ______ per cent in the following subjects:

Subjects of Examination	Per Cent	Subjects of Examination	Per Cent

I certify that this license is valid, current, has never been suspended or revoked, and will expire ______ (DATE) and that records in this office indicate that there are not now nor have there ever been any charges filed against the holder of this license.
NOTE: If any portion of the above certification is deleted or modified, please attach an explanation.

______ TYPE OR PRINT NAME AND TITLE OF AGENCY OFFICIAL (AFFIX LICENSING AGENCY SEAL) ______ NAME OF STATE LICENSING AGENCY

______ SIGNATURE OF AGENCY OFFICIAL ______ ADDRESS

______ DATE ______ PHONE NUMBER

GOVERNMENT OF THE DISTRICT OF COLUMBIA
BOARD OF MEDICINE
605 G STREET, N.W., ROOM 202-LOWER LEVEL, WASHINGTON, D.C. 20001

ADDRESS ALL COMMUNICATIONS TO THE BOARD

May 31 '89

May 22, 1989

Dear Sir/Madam:

This is to certify that the records of the Government of the District of Columbia Board of Medicine reflect that Dr. Karen Michelle Webster was issued license number 17187 dated 4-6-88 to practice medicine and surgery on the basis of Flex Endorsement.

The license is: [xx] current and in good standing.
Expiration date: 12-31-90

[ ] is not current, however, there is no derogatory information on file.

[ ] other ______

Sincerely,

John P. Hopkins
Executive Director

CERTIFIED BY: [signature]
TITLE: 5/22/89
DATE: CLERK
TELEPHONE NUMBER: [redacted]

STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY GEORGE DEUKMEJIAN, Governor

DEPARTMENT OF CONSUMER AFFAIRS

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

CERTIFICATE OF COMPLETION OF ACGME POSTGRADUATE TRAINING

To be completed by the facility for every medical school graduate completing postgraduate training in the United States or Canada. Do not complete if photograph of applicant is not attached below. Please type or print.

This is to certify that Karen M Webster
(NAME OF APPLICANT)

a graduate of Johns Hopkins School of Medicine
(NAME OF MEDICAL SCHOOL)

formally commenced an accredited postgraduate training program at Georgetown University / Providence Hospital
3001 Bladensburg Rd NE, Wash 20018 in Family Practice,
(NAME AND ADDRESS OF FACILITY) (SPECIALTY)

on July 1 / 19 86, and completed such training on June 30, 19 89.
This training consisted of 36 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

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.

AFFIX SEAL OF HOSPITAL OR NOTARY PUBLIC

NAME David C. Lanier MD
(DIRECTOR OF MEDICAL EDUCATION)

ADDRESS 3001 Bladensburg Rd, NE
Washington DC 20018

PHONE NUMBER

DATE 5/4/89

SIGNATURE David C. Lanier MD

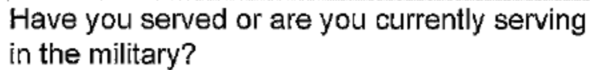
L3

BP-A 100 Margaret A. Calkins, Notary Public, District of Columbia
My commission expires 3/28/93

Application Summary

License Type:	**Physician and Surgeon A**
License Number:	**46274**
File Number:	**72902**
Application:	**Physician's and Surgeon's Renewal**
Application Number:	**14351573**
Application Date:	**12/13/2016 (mm/dd/yyyy)**

Application Questions



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

Personal Detail

First Name:	**KAREN**
Middle Name:	**MICHELE**
Last Name:	**WEBSTER**
Birthdate:	**/**/****
Gender:	**Female**

Addresses

License Related Addresses

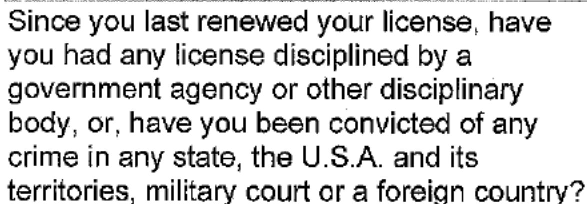
Address of Record (Required)

Warning: **In order to protect your privacy and identity, address will not be displayed.**

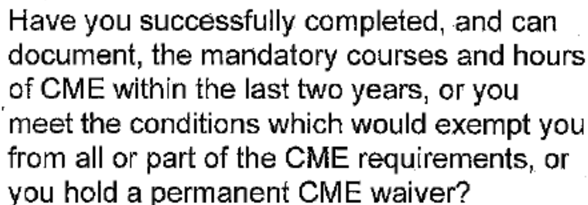
Confidential Address

Warning: **In order to protect your privacy and identity, address will not be displayed.**

Questions



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



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 - 1-9 Hours**
	Other - None
	Patient Care - 30-39 Hours
	Research - None
	Teaching - 1-9 Hours
	Telemedicine - None
Patient Care Practice Location	**Zip: 95816 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	**Family Medicine - Primary**
	Family Medicine - Secondary
Board Certifications	**None**
Postgraduate Training Years	**9+ Years**
Cultural Background	**African American**
Foreign Language Proficiency	**None**
Web Site Profile	**Cultural Background - Yes**
	Gender - Yes
E-mail:	

Fees

Biennial Renewal Fee	**$783.00**
DUE TO CURES FUND	**$12.00**

1481660857941

Steven M. Thompson Physician Corps Loan Repayment Program	**$25.00**
Total Amount Due:	**$820.00**

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

Attestation

I declare under penalty of perjury under the laws of the State of California that all statements, answers, and representations provided, including supplementary attached hereto, are true, complete and accurate.

Signature: Date:

Application Summary

License Type:	**Physician and Surgeon A**
License Number:	**46274**
File Number:	**72902**
Application:	**Physician's and Surgeon's Renewal**
Application Number:	**14135817**
Application Date:	**12/16/2014 (mm/dd/yyyy)**

Personal Detail

First Name:	**KAREN**
Middle Name:	**MICHELE**
Last Name:	**WEBSTER**
Birthdate:	**/**/****
Gender:	**Female**

Addresses

License Related Addresses

Address of Record (Required)

Warning: **In order to protect your privacy and identity, address will not be displayed.**

Confidential Address

Warning: **In order to protect your privacy and identity, address will not be displayed.**

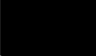
Questions

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

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 - 1-9 Hours**
	Other - None
	Patient Care - 30-39 Hours
	Research - None
	Teaching - 1-9 Hours
	Telemedicine - None
Patient Care Practice Location	**Zip: 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	**Family Medicine - Secondary**
Postgraduate Training Years	**6 Years**
Cultural Background	**African American**
Web Site Profile	**Cultural Background - Yes**
	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**

1418765220478

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:

STATE DEPARTMENT OF CONSUMER AFFAIRS
INTERNET CASHIERING SYSTEM
MEDICAL BOARD OF CALIFORNIA
SUPPLEMENTAL INFORMATION REPORT
From Date: 01/12/2013 **To Date:** 01/12/2013

ATRISUPPINF

24-APR-18 09:11:20

Person Id : 536133 **Name :** Webster,Karen

Question	Answer
I Have Completed Cme And Can Document Not Less Than 50 Hours Of Approved Cme For The Two-Year Period Immediately Preceding The Expiration Date Of My License. Or I Meet The Conditions Which Would Exempt Me From All Or Part Of The Requirements.	
I Have Completed 12 Hours Of Pain Management And End-Of-Life Care.	
I Am Exempt From The Completion Of 12 Hours Of Pain Management And End-Of-Life Care Continuing Education Requirement Because I Am A Radiologist Or Pathologist.	
Only For General Internists And Family Physicians Who Have 25% Of Their Patient Population Aged 65 Years Or Older. I Have Completed At Least 20% Of The Required Cme In Geriatric Medicine Or The Care Of Older Patients. Click No If Not Applicable.	
Enter Name/Address Of Facility Where You Or Your Immediate Family Hold Financial Interest. Type "None", If None Held.	
I Certify Under Penalty Of Perjury Under The Laws Of The State Of California That The Information Contained In This Application Is True And Correct.	
I Have Read My Profile On The Medical Board Web Site At Www.Mbc.Ca.Gov And Acknowledge The Information Contained Therein As Current And Accurate.	
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?	

Total Questions Asked For Person : 536133 8