



**MEDICAL BOARD OF CALIFORNIA**  
 LICENSING PROGRAM  
 2005 Evergreen Street, Suite 1200  
 Sacramento, CA 95815  
 (800) 633-2322 (916) 263-2382 FAX (916) 263-2487  
 www.mbc.ca.gov

MEDICAL BOARD OF CALIFORNIA



2011 MAR 24 PM 1:24

**INITIAL AND UPDATE APPLICATION FOR PHYSICIAN'S AND SURGEON'S LICENSE  
 OR POSTGRADUATE TRAINING AUTHORIZATION LETTER**

Application for (please check one):  License  PTAL - or -  Update

1. NAME: Last <u>NGO</u> First <u>LYNN</u> Middle <u>LY</u>		MBC Use Only	
Other names you have used (include maiden name):		2. U.S. Social Security Number	
3. Place of Birth		4. Date of Birth	
5. Gender: <input type="checkbox"/> Male <input checked="" type="checkbox"/> Female			
6. Public/Mailing Address: <u>200 West Arbor Drive</u> (Please note: this information is public) (30 characters maximum per line, including spaces) <u>San Mailcode 8433 Dept of Reproductive Medicine</u>			
City <u>San Diego</u>	State/Province <u>CA</u>	Zip/Postal Code <u>92103</u>	Country <u>USA</u>
7. Telephone Numbers: (include area code)	Home	Work	Cell
8. California Driver's License Number (optional):		10. Have you ever filed an Application for Physician's and Surgeon's License, or PTAL, in California? <input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No Previous license number, if any: _____	
9. E-mail Address (optional):		Personal Data	
<b>MEDICAL EDUCATION</b>			
11. LIST EACH MEDICAL SCHOOL THAT YOU HAVE ATTENDED.			
School Name	City, State/Province, Country		Dates of Attendance
<u>University of Hawaii - John A. Burns School of Medicine</u>	<u>Honolulu, HI USA</u>		<u>07/2006 - 05/2010</u>
12. School of Graduation	Degree Awarded	Date of Graduation	
<u>same</u>	<u>MD</u>	<u>05/16/2010</u>	
<b>EXAMINATIONS</b>			
13. LIST ALL OF THE FOLLOWING EXAMINATIONS YOU HAVE TAKEN: USMLE, FLEX, NBME, ECFMG, SPEX, STATE BOARDS and/or QME in Canada			
Examination	Date	Result (Pass/Fail)	
<u>USMLE Step 1</u>	<u>6/5/2008</u>		
<u>USMLE Step 2 CK</u>	<u>7/1/2009</u>		
<u>USMLE Step 2 CS</u>	<u>11/23/2009</u>		
<u>H93 -</u>	<u>CC15415</u>	<u>MAR 24 2011</u>	<u>H1001</u>
Cashiering Use Only		School Code	<b>L1A</b>



**ABMS CERTIFICATIONS**

MBC  
Use Only  
ABMS

16. Are you currently certified by a Member Board of the American Board of Medical Specialties?  
YES  NO

- 
- 
- 

Member Board	Expiration Date	Certificate Number

**MALPRACTICE HISTORY**

Malpractice

17. Has a claim or an action ever been filed against you for the practice of medicine which resulted in a malpractice settlement, judgment, or arbitration award of \$30,000 or more?  
YES  NO

- 

**PRACTICE IMPAIRMENT OR LIMITATIONS**

Limitations

18. Have you been enrolled in, required to enter into, or participated in any drug or alcohol recovery program or impaired practitioner program?  
YES  NO
19. Have you been treated for or had a recurrence of a diagnosed addictive disorder?  
YES  NO
20. Have you been diagnosed with an emotional, a mental, or behavioral disorder which impairs your ability to practice medicine safely?  
YES  NO
21. Have you ever been diagnosed with a neurological or other physical condition that would impair your ability to practice medicine safely?  
YES  NO
22. Do you have any other condition which in any way impairs or limits your ability to practice medicine safely?  
YES  NO

- 
- 
- 
- 
- 

If you do receive ongoing treatment or participate in a monitoring program, the Board will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure.

**CRIMINAL RECORD HISTORY**

Criminal Record

23. Have you ever been convicted of, or pled guilty or nolo contendere to ANY offense in any state in the United States or foreign country?

This includes a citation, infraction, misdemeanor and/or felony, etc. If "YES" attach a list of each offense by arrest and conviction dates, violation, and court of jurisdiction (name and address). Matters in which you were diverted, deferred, pardoned, pled nolo contendere, or if the conviction was later expunged from the record of the court or set aside under Penal Code Section 1203.4 MUST be disclosed. If you are awaiting judgment and sentencing following entry of a plea or jury verdict, you MUST disclose the conviction; you are entitled to submit evidence that you have been rehabilitated. Serious traffic convictions such as reckless driving, driving under the influence of alcohol and/or drugs, hit and run, evading a peace officer, failure to appear, driving while the license is suspended or revoked MUST be reported. This list is not all-inclusive. If in doubt as to whether a conviction should be disclosed, it is better to disclose the conviction on the application.

For each conviction disclosed, you must submit with the application certified copies of the arresting agency report, certified copies of the court documents, and a descriptive explanation of the circumstances surrounding the conviction of disciplinary action (i.e., dates and location of incident and all circumstances surrounding the incident). This letter must accompany the application. If documents were purged by arresting agency and/or court, a letter of explanation from these agencies is required.

Applicants who answer "NO" to the question but have a previous conviction or plea, may have their application denied or license revoked for knowingly falsifying the application.

APPLICANT:

*[Handwritten Signature]*

DATE OF BIRTH:

*[Redacted]*

**L1C**

### CRIMINAL RECORD HISTORY (cont'd)

MBC  
Use Only  
Criminal  
Record

- |   |     |                          |    |                          |
|---|-----|--------------------------|----|--------------------------|
| 24. Is any criminal action pending against you?     | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> |
| 25. Are you required to register as a Sex Offender? | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> |

### DISCIPLINARY HISTORY

Discipline

These questions refer to discipline by any U.S. military or public health service, state board or other governmental agency of any U.S. state, territory, Canadian province, or country.

- |   |     |                          |    |                          |
|---|-----|--------------------------|----|--------------------------|
| 26. Have you ever been denied a license to practice medicine?   | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> |
| 27. Is any denial pending against you?  | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> |
| 28. Have you ever been charged with, or been found to have committed, unprofessional conduct, professional incompetence, gross negligence, or repeated negligent acts or malpractice by any medical licensing board, other agency, or hospital? | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> |
| 29. Have you ever had any license to practice medicine revoked, suspended, or placed on probation?  | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> |
| 30. Have you ever had any license to practice medicine subjected to any action including but not limited to informal or confidential discipline, consent orders, letters of warning, letters of reprimand, or citation?                         | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> |
| 31. Have you ever had any license to practice medicine subjected to any other disciplinary action?  | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> |
| 32. Is any disciplinary action pending against any of your licenses to practice medicine?   | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> |
| 33. Have you ever had staff privileges in a hospital terminated, denied, suspended, limited, revoked, or not renewed?   | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> |
| 34. Have you ever resigned from a medical staff in lieu of disciplinary or administrative action?   | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> |
| 35. Is any disciplinary action pending against your hospital staff privileges?  | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> |
| 36. Have you ever surrendered a license to practice medicine?   | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> |
| 37. Have your DEA privileges ever been denied, suspended, restricted, or terminated?  | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> |
| 38. Have you ever entered into any arrangement or plea or agreement in lieu of a federal prosecution for a drug violation regulated by the DEA?   | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> |

APPLICANT:

*Lynn Ngo*

DATE OF BIRTH:

**L1D**

Notice: All items in this application, except #8 and #9, are mandatory. Failure to provide any of the requested information will delay the processing of your application. The information provided will be used to determine your qualifications for licensure per Section 2080 of the California Business and Professions Code, which authorizes the collection of this information. The information on your application may be transferred to other medical licensing authorities, the Federation of State Medical Boards, or other governmental law enforcement agencies. You have the right to review your application subject to the provisions of the Information Practices Act. The Chief of the Licensing Program is the custodian of records.

The applicant, LYNN LYN GO [REDACTED] being first duly sworn upon his/her  
(PLEASE PRINT FULL NAME) (DATE OF BIRTH)

I do hereby depose and say: that I am the person herein named subscribing to this application; that I have read the complete application, know the full content thereof, and declare under penalty of perjury, that all of the information contained herein and evidence or other credentials submitted herewith are true and correct; that I am the lawful holder of the degree of Doctor of Medicine as prescribed by this application, that the same was procured in the regular course of instruction and examination, and that it, together with all the credentials submitted, were procured without fraud or misrepresentation or any mistake of which I am aware and that I am the lawful holder thereof. Further, I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past, present and future), business and professional associates (past, present, and future), and all government agencies (local, state, federal, or foreign) to release to the Medical Board of California or its successors any information, files or records, including medical records, educational records, and records of psychiatric treatment and treatment for drug and/or alcohol abuse or dependency, requested by that Board in connection with this application; or any further or future investigation by that Board necessary to determine any medical competence, professional conduct, or physical or mental ability to safely engage in the practice of medicine. I further authorize the Medical Board of California or its successors to release to the organizations, individuals or groups listed above any information which is material to this application or any subsequent licensure.

I UNDERSTAND THAT FALSIFICATION OR MISREPRESENTATION OF ANY ITEM OR RESPONSE ON THIS APPLICATION OR ANY ATTACHMENT HERETO IS A SUFFICIENT BASIS FOR DENYING OR REVOKING A LICENSE.

W (PLEASE INITIAL BOX)

SIGNATURE OF APPLICANT: [Signature]  
(Please sign full name in presence of notary)

State of California

County of San Diego

Subscribed and sworn to (or affirmed) before me on this A day of March, 20 11, by

LYNN LYN GO  
(Notary to print name of applicant.)

proved to me on the basis of satisfactory evidence to be the person who appeared before me.

Signature [Signature] (seal).



**L1E**

267663 MW



MEDICAL BOARD OF CALIFORNIA Licensing Program



CERTIFICATE OF MEDICAL EDUCATION

MEDICAL SCHOOL: PLEASE COMPLETE THIS FORM IN THE ENGLISH LANGUAGE

This certifies that Lynn Ly Ngo; [redacted] U.S. Social Security Number [redacted] enrolled in University of Hawaii, John A. Burns School of Medicine located Honolulu, HI on 07/24/2006

The undersigned further certifies that the records of this institution show that the applicant attended in this institution 4 years of resident instruction, 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 Sections 2089.5, 2089.7, 2090, 2091.1, 2091.2) and that the applicant

- Anatomy, Otolaryngology, Obstetrics and Gynecology, Radiology, including Radiation Safety, Tropical Medicine, Physiology, Biochemistry, Pathology, Bacteriology, and Immunology, Ophthalmology, Dermatology, Embryology, Histology, Human Sexuality, Medicine, Surgery, including Orthopedic Surgery, Urology, Psychiatry, Neurology, Alcoholism and Chemical Dependency, Preventative Medicine, including Nutrition, Physical Medicine Therapeutics, Neuroanatomy, Child Abuse Detection and Treatment, Geriatric Medicine, Pediatrics, Pharmacology, Anesthesia, Spousal Partner Abuse Detection & Treatment, Family Medicine, Pain Management and End-of-Life-Care

\* ONLY applicable to medical students who enrolled in medical school on or after September 1, 1994. \*\* ONLY applicable to medical students who graduate from medical school on or after May 1, 1988. \*\*\* ONLY applicable to medical students who enrolled in medical school on or after June 1, 2000.

[X] was granted the degree of Bachelor/Doctor of Medicine on the 15th day of May, 2010 [ ] withdrew from medical school on \_\_\_ day of \_\_\_

Unusual Circumstances Responses

Did this individual ever take a leave of absence from their medical education? Yes [redacted] No [redacted] Was this individual ever placed on probation? Yes [redacted] No [redacted] Was this individual ever disciplined or under investigation? Yes [redacted] No [redacted] Were any incident reports regarding this individual ever filed by instructors? Yes [redacted] No [redacted] Were any limitations or special requirements imposed on this individual because of questions of academic or disciplinary problems, or for any other reason? Yes [redacted] No [redacted]

A "Yes" response to ANY of the above questions requires the medical school to provide a written explanation on a separate attachment.

Medical School Seal Must Be Imprinted Below Attention Medical School: Only the President, Dean, or Registrar may sign this form. If the signature is being delegated to another person, evidence of that delegation must be attached to this form (may be a photocopy). Such delegation must be on official letterhead and must be dated within the last 12 months. Signed and the school seal affixed this 15th day of June, 2011 Marilyn Nishiki, Registrar Printed Name and Title of School Official: [redacted] Signature: [redacted]

L2

3/24

267665

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The Regents of  
**The University of Hawai'i**  
 on the recommendation of the Faculty at  
**University of Hawai'i at Mānoa**

have conferred upon

**Lynn Lu Ngo**

the degree of

**Doctor of Medicine**

with all its privileges and obligations

Given at Honolulu, Hawai'i, this fifteenth day of May,  
 two thousand ten

2010

*Vivian D. Hildan*  
 Chancellor

*Robert L. ...*  
 Chairperson, Board of Regents



*Gay H. ...*  
 Regent, School of Medicine

*MRC Greenwood*  
 President

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## MEDICAL BOARD OF CALIFORNIA Licensing Program



### CERTIFICATE OF COMPLETION OF ACGME/RCPSC POSTGRADUATE TRAINING

To be completed by the facility for every medical school graduate completing postgraduate training in the United States or Canada.

#### PART 1: TO BE COMPLETED BY THE APPLICANT

NAME: Last Ngo		First Lynn		Middle Ly	
U.S. Social Security Number [REDACTED]		Date of Birth [REDACTED]		Telephone Number Home [REDACTED] Work [REDACTED]	
Public/Mailing Address 200 West Arbor Drive Mail Code 8433					
City San Diego		State/Province CA		Zip/Postal Code 92103	
Medical School of Graduation University of Hawaii John A. Burns School of Medicine					

#### PART 2: TO BE COMPLETED BY THE PROGRAM DIRECTOR

**ATTENTION PROGRAM DIRECTOR:** Do not sign and date this form before the last day of any postgraduate training year which will be used by the applicant to qualify for licensure. Completion of this form will certify that the individual named in PART 1 above satisfactorily completed a period of accredited postgraduate training at this facility and that the trainee has acquired the skill and qualifications necessary to safely assume the unrestricted practice of medicine in this state.

Name of Facility Department of Reproductive Medicine University of California San Diego		ACGME 10-digit Program number (www.acgme.org) 2200521044	
Address of Facility 200 West Arbor Dr MC 8433		Telephone # [REDACTED]	
Categorical Specialty Area of Training Obstetrics/Gynecology	Start Date of Training 06 / 23 / 2010	End Date (or anticipated completion date) of Training 06 / 30 / 2014	

#### UNUSUAL CIRCUMSTANCES:

Did the trainee ever take a leave of absence or break from his/her training?	YES	[REDACTED]	NO	[REDACTED]
Was the trainee ever terminated, dismissed or expelled?	YES	[REDACTED]	NO	[REDACTED]
Did the trainee ever resign?	YES	[REDACTED]	NO	[REDACTED]
Was the trainee ever placed on probation?	YES	[REDACTED]	NO	[REDACTED]
Was the trainee ever disciplined or placed under investigation?	YES	[REDACTED]	NO	[REDACTED]
Were any incident reports regarding this trainee ever filed by instructors?	YES	[REDACTED]	NO	[REDACTED]
Were any limitations or special requirements placed upon the trainee for clinical incompetence, disciplinary problems or for any other reason?	YES	[REDACTED]	NO	[REDACTED]
Did the program decline to renew or offer the trainee a postgraduate training program contract for a following year?	YES	[REDACTED]	NO	[REDACTED]

A "Yes" response to ANY of the above questions requires the program director to provide a written explanation on a separate attachment.

# L3A



## DEFINITION OF "SATISFACTORY" COMPLETION OF TRAINING

The program director signing this form is formally certifying and documenting under penalty of perjury that the trainee received instruction appropriate for the particular postgraduate level and that he/she satisfactorily completed periods of training in accordance with the accepted standards and the criteria defined as equating to "satisfactory" performance as described below. The program director will personally be attesting to the fact that the trainee has acquired the skill and qualifications necessary to safely assume the unrestricted practice of medicine in this state.

**"SATISFACTORY" IS DEFINED AS:** THE TRAINEE PERFORMED AT AN ADEQUATE LEVEL BASED ON EVIDENCE OF SATISFACTORY PROGRESSIVE GROWTH INCLUDING DEMONSTRATED ABILITY TO ASSUME GRADED AND INCREASING RESPONSIBILITY FOR PATIENT CARE.

## GENERAL MEDICINE TRAINING REQUIREMENT

To qualify for licensure in California, applicants who are graduates of an international medical school must complete at least four months of postgraduate training in GENERAL MEDICINE as part of the requirement. Applicants who are graduates of a U.S. or Canadian medical school, who have not completed postgraduate training required for licensure by July 1, 1990, must also complete four months of training in GENERAL MEDICINE prior to licensure. The GENERAL MEDICINE requirement may be satisfied by actual clinical practice where the applicant has direct patient care responsibilities in any particular specialty or sub-specialty area for at least four months.

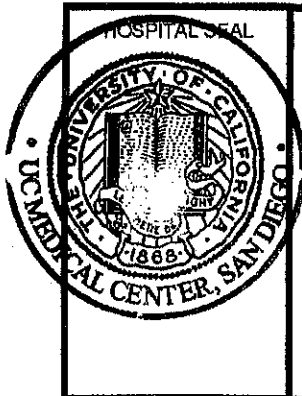
I hereby certify as the program director, that the individual named in Part 1

has completed     has not completed

a minimum of four months of general medicine as part of this postgraduate training program accredited by the ACGME or the RCPSC.

  
SIGNATURE OF PROGRAM DIRECTOR

**ATTENTION PROGRAM DIRECTOR:** THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE, OR ADOPTION. If that signature authority is being delegated to another person, evidence of that delegation must be attached to this form (may be a photocopy). Each delegation must be on official letterhead and must be dated within the last 12 months.



OFFICIAL HOSPITAL SEAL MUST BE AFFIXED IN THE BOX TO THE LEFT TO CERTIFY TRAINING

The training program is accredited by the ACGME or the RCPSC to offer the type and level of training completed by the applicant, and the applicant was trained in an accredited ACGME or RCPSC program position. I hereby declare under penalty of perjury under the laws of the State of California that the statements are true and correct.

Christine B. Miller, MD

PRINT NAME OF PROGRAM DIRECTOR

  
SIGNATURE OF PROGRAM DIRECTOR  
Signature Stamp is Not Acceptable

7/20/11  
DATE SIGNED

If a hospital seal is not available, the program director shall sign this form in the presence of a notary public.

SIGNATURE OF PROGRAM DIRECTOR: 

(Please sign full name - in presence of notary)

State of \_\_\_\_\_

County of \_\_\_\_\_

Subscribed and sworn to (or affirmed) before me on this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, by

\_\_\_\_\_  
(Notary to print director's name.)

proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.

Signature \_\_\_\_\_ (seal)

**L3B**



**MEDICAL BOARD OF CALIFORNIA**  
Licensing Program



7/21/11 2:52 PM

**CERTIFICATE OF CURRENT POSTGRADUATE TRAINING ENROLLMENT**

At the time of licensure, you may be entitled to a reduced initial license fee if you are actively participating in a slotted position in an ACGME/RCPSC accredited postgraduate training program.

**NOTE:** This form may not be used in lieu of the Form L3A-B, "Certificate of Completion of ACGME/RCPSC Postgraduate Training."

NAME: Last Ngo		First Lynn	Middle Ly
U.S. Social Security Number	Date of Birth	Medical School of Graduation University of Hawaii John A. Burns School of Medicine	
This is to certify that the above applicant is actively participating in an ACGME or RCPSC accredited postgraduate training position that started on <u>06</u> <u>23</u> <u>2010</u> and is expected to be completed on <u>06</u> <u>30</u> <u>2014</u> in <u>Obstetrics/Gynecology</u> at <u>Department of Reproductive Medicine, University of California San Diego</u> located at <u>200 West Arbor Dr MC 8433, San Diego CA 92103-8433</u> The 10 digit ACGME Program #: <u>2200521044</u>			

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 above program is accredited by the ACGME or the RCPSC to offer the type and level of training completed by the applicant and that the applicant is being trained in an accredited ACGME or RCPSC postgraduate training position.

Christine B. Miller, MD  
PRINT NAME OF PROGRAM DIRECTOR

SIGNATURE OF PROGRAM DIRECTOR - Signature Stamp is Not Acceptable

DATE

TELEPHONE NUMBER

**ATTENTION PROGRAM DIRECTOR:** THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE, OR ADOPTION.

Only the Program Director may sign this form. If that signature authority is being delegated to another person, evidence of that delegation must be attached to this form (may be a photocopy). Such delegation must be on official letterhead and must be dated within the last 12 months.



If a hospital seal is not available, the program director shall sign this form in the presence of a notary public.

SIGNATURE OF PROGRAM DIRECTOR:

*Christine B. Miller*

(Please sign full name - in presence of notary).

State of \_\_\_\_\_

County of \_\_\_\_\_

Subscribed and sworn to (or affirmed) before me on this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_ by \_\_\_\_\_

(Notary to print director's name.)

proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.

Signature \_\_\_\_\_ (seal)

**L4**

## Application Summary

5/23/17 4:21 PM

Page 1 of 3

License Type: **Physician and Surgeon A**  
License Number: **119426**  
File Number: **102497**  
Application: **Physician's and Surgeon's Renewal**  
Application Number: **14407417**  
Application Date: **05/23/2017 (mm/dd/yyyy)**

### Application Questions

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



### Personal Detail

First Name: **LYNN**  
Middle Name: **LY**  
Last Name: **NGO**  
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:

Amount - \$25.00 Minimum:



**Attachments**

**Physician Survey**

Are you retired?

No

Activities in Medicine

Administration - 1-9 Hours

Other - None

Patient Care - 40+ Hours

Research - 1-9 Hours

Teaching - 1-9 Hours

Telemedicine - None

Patient Care Practice Location

Zip: 92120 County: SAN DIEGO

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

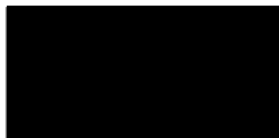
Board Certifications

American Board of Obstetrics and Gynecology - Obstetrics and Gynecology

Postgraduate Training Years

6 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
Steven M. Thompson Physician Corps Loan Repayment Program	\$25.00
Family Physician Training Fee	\$25.00
Total Amount Due:	\$845.00

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

5/19/15 10:53 AM

Page 1 of 3

License Type: **Physician and Surgeon A**  
License Number: **119426**  
File Number: **102497**  
Application: **Physician's and Surgeon's Renewal**  
Application Number: **14182838**  
Application Date: **05/19/2015 (mm/dd/yyyy)**

### Personal Detail

First Name: **LYNN**  
Middle Name: **LY**  
Last Name: **NGO**  
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

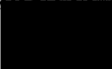
Since you last renewed your license, have you had any license disciplined by a government agency or other disciplinary body, or, have you been convicted of any crime in any state, the U.S.A. and its territories, military court or a foreign country?

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 - 10-19 Hours**

**Patient Care - 30-39 Hours**

**Research - 10-19 Hours**

**Teaching - 1-9 Hours**

**Telemedicine - None**

Patient Care Practice Location **Zip: 02120 County: OUT OF STATE**

Telemedicine Practice Location **Zip: County:**

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

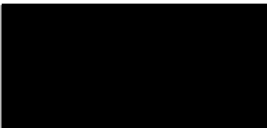
Telemedicine Secondary Practice Location **Zip: County:**

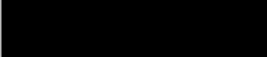
Current Training Status **Fellow**

Areas of Practice **Obstetrics and Gynecology - Secondary**

Board Certifications **None**

Postgraduate Training Years **5 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
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: