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

FEB 27 1 20 PM '89

APPLICATION FOR PHYSICIAN AND SURGEON'S EXAMINATION OR LICENSURE

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.

006738 3/89
205.00 3/89
005331 157.00 3/8/9

BMQA USE ONLY

PERSONAL DATA

1. Name: Last RODRIGUEZ First FRANK Middle

2. Other names you have used:

3. Social Security Number [redacted]

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

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)
Brooklyn College	Brooklyn N.Y. 11210	9-78	8-82

☑ ☐ ☐

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)
Health Science Center @ Syracuse / ~~University of N.Y.~~	Syracuse N.Y.	Syracuse NY.	9-82	4-86

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
State University of New York Health Science Center at Syracuse	155 Elizabeth Blackwell St. Syracuse NY. 13201	4-18-86

N4050
School Code

L1A

07A-100

0002026

AMOA USE ONLY

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

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

Name	Location	Date	Result	
MCAT	Pennsylvania	19 85	[redacted]	☐
National Board	Syracuse	1988		☐
				☐
				☐

14. Have you received qualifying postgraduate training in U.S. or Canadian facilities? ☒ Yes ☐ No — POSTGRADUATE TRAINING

If YES, list name and address of all facilities. Submit an original Certificate of Completion of ACGME Postgraduate Training (Form 13) from each facility.

Name	Address	Type of Service	Period of Attendance From (Mo/Yr)	Period of Attendance To (Mo/Yr)	
State University of New York	750 East Adams St	OB/GYN	7-96	Currently enrolled.	☒
					☐
					☐
					☐

15. Have you been licensed to practice medicine in any state or country? ☐ Yes ☒ No — LICENSE DATA

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)	LGS	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	
				☑
				☐
				☐
				☐

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BMQA USE ONLY

LICENSE DATA (continued)

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

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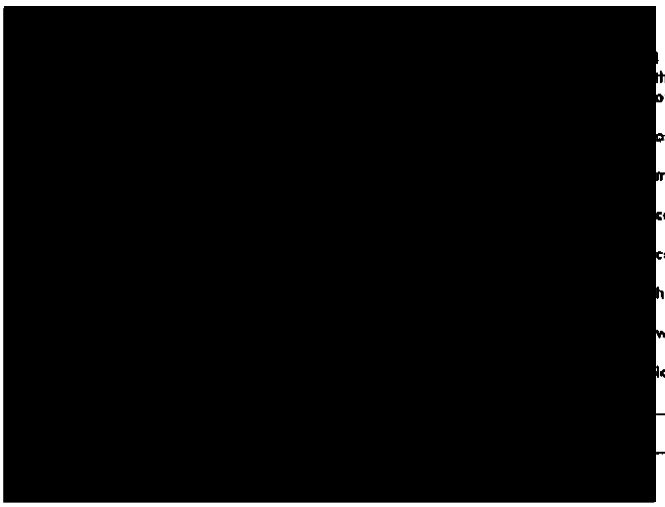

I hereby declare under penalty of perjury under the laws of the State of California, that the photo of myself attached hereto, was taken

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.;

weigh [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 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 New York)

COUNTY OF Onondaga)

FRANK ADDATTORE 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.

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

Signed and sworn to before me this 17 day of February, 1989

Signature of Notary Public Bella A. Piatoff

(SEAL) Address BELLA A. PIATOFF Notary Public, State of New York No. 34-8362880 Qualified in Onondaga County Commission Expires December 31, 1990

My commission expires _____

L1D

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

BOARD OF MEDICAL QUALITY ASSURANCE

FEB 27 2 16 PM '89

CERTIFICATE OF MEDICAL EDUCATION

MEDICAL SCHOOL: DO NOT COMPLETE IF PHOTOGRAPH OF APPLICANT/STUDENT IS NOT ATTACHED BELOW.

This certifies that FRANK MONTIGUEZ
FULL NAME OF APPLICANT

of Syracuse, New York enrolled in SUNY Health Science Center at Syracuse
ADDRESS WHEN ENROLLED NAME OF MEDICAL SCHOOL

Syracuse, New York on the 1 day of September 19 82
LOCATION MONTH 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).

EDUCATIONAL INSTITUTION 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 9 UNIT 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

☒ he was granted the degree Bachelor/Doctor of Medicine by
☐ he withdrew from
the above mentioned medical school on the 18 day of May MONTH 19 86.

Anatomy
Otolaryngology
Obstetrics and Gynecology
Radiology, including Radiation Safety
[illegible]
Physiology
Biochemistry
Pathology, Bacteriology and Immunology
Ophthalmology
Dermatology
Embryology
Histology
[illegible]
Medicine
Surgery, including Orthopedic Surgery
Urology
Psychiatry
Neurology
Preventive medicine, including Nutrition
[illegible]
[illegible]
Neuroanatomy
[illegible]
[illegible]
Pediatrics
Pharmacology
Anesthesia

[redacted]

Signed and the college seal affixed this 20 day of 2, 19 86.

BY Daniel C. Spencer, 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 the blank form may be made and used. Have that photograph and all writing on the form must be original.

L2

STATE UNIVERSITY OF NEW YORK

HEALTH SCIENCE CENTER AT SYRACUSE

ON THE RECOMMENDATION OF THE FACULTY AND BY
VIRTUE OF THE AUTHORITY VESTED IN THEM THE TRUSTEES OF THE UNIVERSITY
HAVE CONFERRED ON

FRANK RODRIGUEZ

THE DEGREE OF

DOCTOR OF MEDICINE

AND HAVE GRANTED THIS DIPLOMA AS EVIDENCE THEREOF
GIVEN IN THE CITY OF SYRACUSE IN THE STATE OF NEW YORK IN THE
UNITED STATES OF AMERICA ON THE EIGHTEENTH DAY OF MAY
ONE THOUSAND NINE HUNDRED AND EIGHTY-SIX

Certified as a true copy of original diploma.

Daniel C. Spencer, Registrar

Chairman, Board of Trustees

Chairman, Council for the Medical Center

Chancellor of the State University of New York

John Bernard Henry, M.D.
President of the Medical Center

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
20 Mar 89 10 26

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 Frank Rodriguez (NAME OF APPLICANT),

a graduate of State University of New York Health Science Center at Syracuse (NAME OF MEDICAL SCHOOL),

formally commenced an accredited postgraduate training program at SUNY, Health Science Center in Syracuse (NAME AND ADDRESS OF FACILITY)

in Obstetrics and Gynecology (SPECIALTY),

on 7/1/86 (will complete), 19____, and completed such training on 6/30, 19 90.

This training consisted of ____ 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

[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 Michael S. Baggish, M.D. (DIRECTOR OF MEDICAL EDUCATION)

(AFFIX SEAL OF HOSPITAL OR NOTARY PUBLIC)

ADDRESS 736 Irving Avenue
Suite 308 West Tower
Syracuse, New York 13210

PHONE NUMBER [redacted]

DATE 2/27/89

SIGNATURE Michael Baggish M.D.

L3

Application Summary

License Type:	**Physician and Surgeon G**
License Number:	**65514**
File Number:	**213964**
Application:	**Physician's and Surgeon's Renewal**
Application Number:	**14331002**
Application Date:	**12/07/2016 (mm/dd/yyyy)**

Application Questions

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

Personal Detail

First Name:	**FRANK**
Last Name:	**RODRIGUEZ**
Birthdate:	****/**/******
Gender:	[redacted]

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	**Administration - 1-9 Hours** **Other - None** **Patient Care - 40+ Hours** **Research - 1-9 Hours** **Teaching - 10-19 Hours** **Telemedicine - 1-9 Hours**
Patient Care Practice Location	**Zip: 33409 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 - Secondary**
Board Certifications	**American Board of Obstetrics and Gynecology - Obstetrics and Gynecology**
Postgraduate Training Years	**4 Years**
Cultural Background	[redacted]
Foreign Language Proficiency	
Web Site Profile	**Cultural Background - No** **Foreign Language Proficiency - No** **Gender - No**
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

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 G**
License Number:	**65514**
File Number:	**213964**
Application:	**Physician's and Surgeon's Renewal**
Application Number:	**14117216**
Application Date:	**08/25/2014 (mm/dd/yyyy)**

Personal Detail

First Name:	**FRANK**
Last Name:	**RODRIGUEZ**
Birthdate:	****/**/******
Gender:	**Male**

Addresses

License Related Addresses

Confidential Address (Optional)

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

License Specific Public/Mailing Address (Required)

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

Questions

Since you last renewed your license, have you had any license disciplined by a government agency or other disciplinary body, or, have you been convicted of any crime in any state, the U.S.A. and its territories, military court or a foreign country?	[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	**Administration - 1-9 Hours** **Patient Care - 40+ Hours** **Research - None** **Teaching - 1-9 Hours** **Telemedicine - None**
Patient Care Practice Location	**Zip: 33409 County: OUT OF STATE**
Telemedicine Practice Location	**Zip: County:**
Patient Care Secondary Practice Location	**Zip: 33321 County: OUT OF STATE**
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	[redacted]
Foreign Language Proficiency	**Spanish**
Web Site Profile	**Cultural Background - No** **Foreign Language Proficiency - Yes** **Gender - 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**

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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: