

Person Info

Name: VICTORIA MARIE BORGIA

Address Info

Street Address: [REDACTED] Email: [REDACTED]@comcast.net  
 Phone [REDACTED]  
 Fax [REDACTED]  
 City Philadelphia  
 State PA  
 Zipcode 19107  
 Country 82  
 County Philadelphia

Survey Response Summary

Question Response Summary

Are you submitting a name change with this renewal?	N
Have you met your current CE requirements?	Y
Have you completed 2 hours of Board-approved continuing education in child abuse recognition and reporting?	Y
Do you hold, or have you ever held, a license, certificate, permit, registration or other authorization to practice a profession or occupation in any state or jurisdiction?	Y
If you answered yes to the above questions, please provide the profession and state or jurisdiction.	Medicine, PA
Since your initial application or last renewal, whichever is later, have you had disciplinary action taken against a professional or occupational license, certificate, permit, registration or other authorization to practice a profession or occupation issued to you in any state or jurisdiction or have you agreed to voluntary surrender in lieu of discipline?	N
Do you currently have any disciplinary charges pending against your professional or occupational license, certificate, permit or registration in any state or jurisdiction?	N
Since your initial application or last renewal, whichever is later, have you withdrawn an application for a professional or occupational license, certificate, permit or registration, had an application denied or refused, or for disciplinary reasons agreed not to apply or reapply for a professional or occupational license, certificate, permit or registration in any state or jurisdiction?	N
Since your initial application or last renewal, whichever is later, have you been convicted (found guilty, pled guilty or pled nolo contendere), received probation without verdict or accelerated rehabilitative disposition (ARD), as to any criminal charges, felony or misdemeanor, including any drug law violations? Note: You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court.	N
Do you currently have any criminal charges pending and unresolved in any state or jurisdiction?	N
Since your initial application or last renewal, whichever is later, have you had your DEA registration denied, revoked or restricted?	N
Since your initial application or your last renewal, whichever is later, have you had provider privileges denied, revoked, suspended or restricted by a Medical Assistance agency, Medicare, third party payor or another authority?	N
Since your initial application or your last renewal, whichever is later, have you ever had practice privileges denied, revoked, suspended, or restricted by a hospital or any health care facility?	N
Since your initial application or your last renewal, whichever is later, have you been charged by a hospital, university, or research facility with violating research protocols, falsifying research, or engaging in other research misconduct?	N
Since your initial application or last renewal, whichever is later, have you engaged in the intemperate or habitual use or abuse of alcohol or narcotics, hallucinogenics or other drugs or substances that may impair judgment or coordination?	[REDACTED]
If yes, are you currently participating in the Pennsylvania Professional Health Monitoring Program?	[REDACTED]
Since your initial application or your last renewal, whichever is later, have you been the subject of a civil malpractice lawsuit?	N
If yes, please submit a copy of the entire Civil Complaint, which must include the filing date and the date you were served. Submit a statement which includes complete details of the complaints that have been filed against you. PLEASE NOTE: If you previously reported the complaint to the Board you will only need to provide the docket number here:	
Do you maintain current medical professional liability insurance in the Commonwealth of Pennsylvania?	Y
If you answer "No", please provide an explanation or reason for an exemption request.	

Date Submitted: Friday, October 31, 2014

Education Info

No education records

Employment Information

No employment records

<b>Person Info</b> <b>Name:</b> VICTORIA MARIE BORGIA <b>Address Info</b> <b>Street Address</b> [REDACTED] <b>Email:</b> [REDACTED]@comcast.net <b>Phone</b> [REDACTED] <b>Fax</b> [REDACTED] <b>City</b> Philadelphia <b>State</b> PA <b>Zipcode</b> 191472830 <b>Country</b> 82 <b>County</b> Philadelphia	
<div style="text-align: center;"> Survey Response Summary  Question Response Summary </div>	
Are you submitting a name change with this renewal?	N
Do you hold a license/certificate (active, inactive or expired) to practice in any other state or jurisdiction?	Y
Since your initial application or last renewal, whichever is later, have you had disciplinary action taken against your license, certificate or registration issued to you in any profession in any other state or jurisdiction?	N
Since your initial application or last renewal, whichever is later, have you been convicted, found guilty or pleaded nolo contendere, or received probation without verdict, or accelerated rehabilitative disposition(ARD) as to any felony or misdemeanor, including any drug law violations, or do you have any criminal charges pending and unresolved in any state or jurisdiction? You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court.	N
Since your initial application or last renewal, whichever is later, have you withdrawn an application for a license, certificate or registration, had an application denied or refused, or for disciplinary reasons agreed not to reapply for a license, certificate or registration in any profession in any other state or jurisdiction?	N
Since your initial application or last renewal, whichever is later, have you been arrested for criminal homicide, aggravated assault, sexual offenses or drug offenses in any state, territory or country?	N
Since your last renewal, have you been the subject of a civil malpractice law suit? If yes, please submit a copy of the entire Civil Complaint which must include the filing date and the date you were served. If you previously reported the complaint, email or fax the docket number to	N

the Board. (email at st-medicine@state.pa.us or fax at 717-787-7769)													
Since your initial application or last renewal, whichever is later, have you had your DEA registration denied, revoked or restricted?	N												
Since your initial application or last renewal, whichever is later, have you had practice privileges denied, revoked or restricted in a hospital or health care facility?	N												
Since your initial application or last renewal, whichever is later, have your provider privileges been denied, revoked or restricted by any medical assistance agency for cause?	N												
Do you maintain current medical professional liability insurance in the Commonwealth of Pennsylvania?	Y												
Have you met your current CE requirements?	Y												
<b>Education Information</b>													
<div> <a href="#">Edit</a> </div> <table> <tr> <td>Profession:</td> <td>Medicine</td> <td>School:</td> <td>STATE UNIV OF NEW YORK - BROOKLYN</td> <td>Credit Hours:</td> <td>Education Type:</td> </tr> <tr> <td>From:</td> <td>8/29/1993</td> <td>To:</td> <td>5/21/1998</td> <td></td> <td></td> </tr> </table>		Profession:	Medicine	School:	STATE UNIV OF NEW YORK - BROOKLYN	Credit Hours:	Education Type:	From:	8/29/1993	To:	5/21/1998		
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From:	8/29/1993	To:	5/21/1998										
<b>Employment Information</b>													
No employment records													
remarks Remarks: Continuing Education Information													
No CE Course records													

Person Info

Name: VICTORIA MARIE BORGIA

Address Info

Street Address: [REDACTED] Email: [REDACTED]@comcast.net  
 Phone: [REDACTED]  
 Fax: [REDACTED]  
 City: Bensalem  
 State: PA  
 Zip code: 19020  
 Country: 82  
 County: Philadelphia

Survey Response Summary

Question Response Summary

Are you submitting a name change with this renewal?	N
Have you completed your current CE requirements?	Y
Do you hold, or have you ever held, a license, certificate, permit, registration or other authorization to practice any health-related profession in any state or jurisdiction?	Y
If you answered yes to the above question, please provide the profession and state or jurisdiction.	CA
Since your initial application or last renewal, whichever is later, have you had disciplinary action taken against a professional or occupational license, certificate, permit, registration or other authorization to practice a profession or occupation issued to you in any state or jurisdiction or have you agreed to voluntary surrender in lieu of discipline?	N
Do you currently have any disciplinary charges pending against your professional or occupational license, certificate, permit or registration in any state or jurisdiction?	N
Since your initial application or last renewal, whichever is later, have you withdrawn an application for a professional or occupational license, certificate, permit or registration, had an application denied or refused, or for disciplinary reasons agreed not to apply or reapply for a professional or occupational license, certificate, permit or registration in any state or jurisdiction?	N
Since your initial application or last renewal, whichever is later, have you been convicted (found guilty, pled guilty or pled nolo contendere), received probation without verdict or accelerated rehabilitative disposition (ARD), as to any criminal charges, felony or misdemeanor, including any drug law violations? Note: You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court.	N
Do you currently have any criminal charges pending and unresolved in any state or jurisdiction?	N
Since your initial application or last renewal, whichever is later, have you had your DEA registration denied, revoked or restricted?	N
Since your initial application or your last renewal, whichever is later, have you had provider privileges denied, revoked, suspended or restricted by a Medical Assistance agency, Medicare, third party payor or another authority?	N
Since your initial application or your last renewal, whichever is later, have you ever had practice privileges denied, revoked, suspended, or restricted by a hospital or any health care facility?	N
Since your initial application or your last renewal, whichever is later, have you been charged by a hospital, university, or research facility with violating research protocols, falsifying research, or engaging in other research misconduct?	N
Since your initial application or last renewal, whichever is later, have you engaged in the intemperate or habitual use or abuse of alcohol or narcotics, hallucinogenics or other drugs or substances that may impair judgment or coordination?	[REDACTED]
Since your initial application or your last renewal, whichever is later, have you been the subject of a civil malpractice lawsuit?	N
If yes, please submit a copy of the entire Civil Complaint, which must include the filing date and the date you were served. PLEASE NOTE: If you previously reported the complaint to the Board you will only need to provide the docket number here:	
Have you completed 2 hours of Board-approved continuing education in child abuse recognition and reporting?	Y
Do you maintain current medical professional liability insurance in the Commonwealth of Pennsylvania?	Y
If you answer "No", please provide an explanation or reason for an exemption request.	
Please provide the zip code of your primary employer/practice location. This data is being collected for the purpose of identifying healthcare professionals during state emergencies and may be provided to the Pennsylvania Emergency Management Agency for official use only.	19020

Date Submitted: Friday, December 16, 2016

Education Info

No education records

Employment Information

No employment records



## Person Info

**Name:**VICTORIA MARIE BORGIA

## Address Info

**Street Address:****Email:**

comcast.net

**Phone****Fax****City**Philadelphia**State**PA**Zipcode**191472830**Country**82**County**Philadelphia

## Survey Response Summary

## Question Response Summary

Are you submitting a name change with this renewal?	N
Do you hold a license/certificate (active, inactive or expired) to practice in any other state or jurisdiction?	N
Since your initial application or last renewal, whichever is later, have you had disciplinary action taken against your license, certificate or registration issued to you in any profession in any other state or jurisdiction?	N
Since your initial application or last renewal, whichever is later, have you been convicted, found guilty or pleaded nolo contendere, or received probation without verdict, or accelerated rehabilitative disposition(ARD) as to any felony or misdemeanor, including any drug law violations, or do you have any criminal charges pending and unresolved in any state or jurisdiction? You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court.	N
Since your initial application or last renewal, whichever is later, have you withdrawn an application for a license, certificate or registration, had an application denied or refused, or for disciplinary reasons agreed not to reapply for a license, certificate or registration in any profession in any other state or jurisdiction?	N
Since your initial application or last renewal, whichever is later, have you been arrested for criminal homicide, aggravated assault, sexual offenses or drug offenses in any state, territory or country?	N
Since your last renewal, have you been the subject of a civil malpractice law suit? If yes, please submit a copy of the entire Civil Complaint which must include the filing date and the date you were served. If you previously reported the complaint, email or fax the docket number to	N

the Board. (email at st-medicine@state.pa.us or fax at 717-787-7769)																					
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Since your initial application or last renewal, whichever is later, have you had practice privileges denied, revoked or restricted in a hospital or health care facility?	N																				
Since your initial application or last renewal, whichever is later, have your provider privileges been denied, revoked or restricted by any medical assistance agency for cause?	N																				
Do you maintain current medical professional liability insurance in the Commonwealth of Pennsylvania?	Y																				
Have you met your current CE requirements?	Y																				
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<b>Employment Information</b>																					
No employment records																					
remarks Remarks: Continuing Education Information																					
No CE Course records																					



**TARGET SHEET**

**Board: Medicine**

**Date Created:**  
**11/22/2015**

**Licensee Full Name:**  
**VICTORIA MARIE BORGIA**

**License No:**  
**MD427968**

**APPL**

**2339072**

Regular Mailing Address  
**STATE BOARD OF MEDICINE**  
 P.O. BOX 2649  
 HARRISBURG, PA 17105-2649  
 717-783-1400/717-787-2381  
 www.medicine.state.pa.us  
 Courier Delivery Address  
**STATE BOARD OF MEDICINE**  
 2601 NORTH THIRD STREET  
 HARRISBURG, PA 17110

MD					
			APPL		

OFFICIAL USE ONLY

Amount \_\_\_\_\_

Date \_\_\_\_\_

**APPLICATION FOR A LICENSE TO PRACTICE MEDICINE WITHOUT RESTRICTION**  
 For Graduates of **ACCREDITED** Medical Schools

**Application Fee: \$35.00 not refundable.** Make check payable to the "Commonwealth of Pennsylvania."  
*Note: A processing fee of \$20.00 will be charged for any check or money order returned unpaid by your bank, regardless of the reason for non-payment.*

Please print or type.

NAME: BORGIA VICTORIA MARIE  
 Last First Middle

Permanent Address: \_\_\_\_\_  
 Street

All correspondence  
 and the license will be  
 mailed to this address  
 unless the Board is  
 notified of a change

PHILADELPHIA PA 19101 19142  
 City State Zip Code

Email address: \_\_\_\_\_@mac.com

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

If your medical/licensure records are listed under another name or names list below:

LIST MEDICAL SCHOOL(S) ATTENDED:

SUNY HEALTH SCIENCE @ BROOKLYN

DATES OF ATTENDANCE

From: 7/97 to 5/98  
 Mo. & Yr. Mo. & Yr.

From: \_\_\_\_\_ to 5/98  
 Mo. & Yr. Mo. & Yr.

Date of Graduation: 5/1998

Check licensing examination(s) passed:

- ( ) FLEX - indicate state where taken: \_\_\_\_\_ Date taken: Component 1 \_\_\_\_\_ Component 2 \_\_\_\_\_  
 ( ) NATIONAL BOARD - PART I \_\_\_\_\_ PART II \_\_\_\_\_ PART III \_\_\_\_\_  
☒ USMLE - STEP 1 ☒ STEP 2 ☒ STEP 3 ☒  
 ( ) LMCC - Canadian  
 ( ) STATE BOARD - indicate state where taken: \_\_\_\_\_

**ACGME Post Graduate Training:**

PGY1 Hospital: Elter Medical Ctr Santa Rosa From 7-1-98 to 7-1-99

PGY2 Hospital: same From 7-1-99 to 7-1-00

Answer the following questions. If "YES" is answered to #2 through #8, provide complete details on a separate sheet as well as certified copies of relevant documents. Sign and date below.

	YES	NO
1) Do you hold an unrestricted license or certification to practice medicine and/or surgery (active or inactive, current or expired) in another jurisdiction? <u>If yes, list the jurisdiction (s) below.</u> <u>CA</u>	X	
2) Have you ever withdrawn an application for a license, had an application denied or refused, or agreed not to reapply for a license in another state, territory or country? A license includes a registration or certification.		X
3) Has any disciplinary action been taken against your license or certificate in another state, territory or country?		X
4) Have you been convicted, found guilty, or pleaded guilty or nolo contendere, or received probation without verdict as to any felony or misdemeanor, including any drug law violation, in any state or federal court?		X
5) Since May 19, 2002, have you been arrested for criminal homicide, aggravated assault, sexual offenses or drug offenses in any state, territory or country?		X
6) Have you had practice privileges denied, revoked or restricted in a hospital or other health care facility, or have you been charged by a hospital, university, or research facility with violating research protocols, falsifying research, or engaging in other research misconduct?		X
7) Have you had your DEA registration denied, revoked or restricted or have you had your provider privileges terminated by any medical assistance agency for cause?		X
8) Are you, or have you ever been, addicted to the intemperate use of alcohol or to the habitual use of narcotics or other habit-forming drugs? <u>Note: You may answer "NO" if you are currently a participant in or have successfully completed the requirements of the Board's Professional Health Monitoring Program.</u>		
9) Since May 19, 2002, have any malpractice complaints been filed against you? <u>If yes, the Board requires that you submit a copy of the entire Civil Complaint which must include the filing date and the date you were served.</u>		X

**SIGNED STATEMENT**

Note that disclosing your social security number on this application is mandatory in order for the State Board of Medicine to comply with the requirements of the federal Social Security Act pertaining to child support enforcement, as implemented in the Commonwealth of Pennsylvania at 21 Pa. C.S. 4404 (a). In order to enforce domestic child support orders, the Commonwealth's licensing boards must provide to the Department of Public Welfare information prescribed by DPW about the licensee, including the social security number. Additionally, disclosing the number is mandatory in order for this board to comply with the reporting requirements of the federal National Practitioner Data Bank and the Healthcare Integrity and Protection Data Bank. Reports to the NPDH must include the licensee's social security number.

I verify that the statements in this application are true and correct to the best of my knowledge, information and belief. I understand that false statements are made subject to the penalties of 18 Pa. C.S. Section 4904 relating to unsworn falsification to authorities and may result in the suspension or revocation of my license. I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and institutions (local, state, federal or foreign) to release to the Pennsylvania State Board of Medicine any information, files or records requested by the Board.

SIGNATURE OF APPLICANT

DATE





## MEDICAL BOARD OF CALIFORNIA

LICENSING PROGRAM  
1426 HOWE AVE, SUITE 54  
SACRAMENTO CA 95825-3236  
TELEPHONE: (916) 263-2382  
FAX: (916) 263-2044



www.caldocinfo.ca.gov

RECEIVED DIRECT

October 21, 2005


PENNSYLVANIA STATE BOARD OF MEDICINE  
PO BOX 2649  
HARRISBURG PA 17105-2649

To Whom It May Concern:

In response to your inquiry a standard search of available records in this office has been performed. The following indicates the results of that search:

Physician:	VICTORIA MARIE BORGIA
License No.:	A 69904
Issued:	October 1, 1999
Exam Type:	A written examination
Expiration Date:	December 31, 2006
Status:	Renewed/current

If a discipline status is listed, you may obtain information concerning this action by contacting the Board's Enforcement Program, Central File Room, 1426 Howe Avenue, Sacramento, CA 95825-3236 or by faxing your request to the Central File Room at (916) 263-2420.

  
Joyce E. Hadnot  
Chief, Licensing Program

SEAL

RECEIVED DIRECT

State Board of Medicine  
P.O. Box 2649  
Harrisburg, PA 17105-2649


**Certification of Moral Character**

To be completed by two physicians who hold an unrestricted license in good standing in the United States or Canada.

Name of Applicant: VICTORIA BORCIA

I hereby certify that I know the applicant to be of good moral character and to the best of my knowledge, he/she is not addicted to the intemperate use of alcohol or to the habitual use of a narcotic or other habit forming drug. I recommend the applicant for a license to practice medicine in the Commonwealth of Pennsylvania.

I have been personally acquainted with the applicant for 6 year(s) 4 month(s).

SIGNATURE:  Date: 10/16/05


Print or type name as signed above: Lestey Ryan

State in which licensed: CA License Number A129119

Name of Applicant: VICTORIA BORCIA

I hereby certify that I know the applicant to be of good moral character and to the best of my knowledge, he/she is not addicted to the intemperate use of alcohol or to the habitual use of a narcotic or other habit forming drug. I recommend the applicant for a license to practice medicine in the Commonwealth of Pennsylvania.

I have been personally acquainted with the applicant for 7 year(s) 4 month(s).

SIGNATURE:  Date: 10/16/05

Print or type name as signed above: DANIEL R. TUBS

State in which licensed: CALIFORNIA License Number: A66495

Return Completed Form to Applicant

Regular Mailing Address  
State Board of Medicine  
P.O. Box 2649  
Harrisburg, PA 17105-2649

RECEIVED DIRECT

MD 12  
Emergency Delivery Address  
State Board of Medicine  
2601 North Third Street  
Harrisburg, PA 17110

**VERIFICATION OF ACGME APPROVED GRADUATE MEDICAL TRAINING**

Accredited Medical School Graduates

**TO BE COMPLETED BY APPLICANT**

NAME: BORGIA VICTORIA MARIE  
Last First Middle

1. If training began before July 1, 1987, one year of approved training at a first (PGY-1) or second (PGY-2) year level must be verified. If the training began on or after July 1, 1987, two (2) years of approved training are required, one at first (PGY-1) year level and one at second (PGY-2) year level.
2. Training at a first (PGY-1) year must be ACGME approved entry level (training which requires no previous training). Training at a second (PGY-2) year must be ACGME approved and can be any specialty. See listing on back.
3. If training was completed at more than one hospital, duplicate this form and submit to each hospital.

*To be completed by the program director at the hospital where the graduate training occurred. If training was in Pennsylvania, information must coincide with data on graduate license. For applicants still in the second year of training, this form may be completed and signed by the program director fifteen (15) days prior to the completion of the approved training. Forms postmarked or signed prior to the fifteen days will not be accepted.*

NAME OF HOSPITAL WHERE TRAINING WAS COMPLETED: SUTTER MEDICAL CENTER, SANTA ROSA

NAME OF SPONSORING INSTITUTION: UCSF - UNIV. OF CALIF. SAN FRANCISCO

LOCATED IN: SANTA ROSA CA  
City State

1st Year from 7/1/98 To 6/30/99 Specialty FAMILY PRACTICE Level (PGY) 1

2nd Year from 7/1/99 To 6/30/2000 Specialty FAMILY PRACTICE Level (PGY) 2

I certify that VICTORIA BORGIA successfully completed/will successfully complete this graduate medical training and that there was/is no disciplinary action outstanding against this applicant. If this applicant does not complete this training, the Board will be notified.

"I further certify that the above program was ACGME accredited at the time VICTORIA BORGIA completed the training."  
(Name of Applicant)

(Seal of Hospital) Signature of Program Director [Signature]  
Date 12-2-01

If the hospital has no seal complete the following section and have this form notarized

I hereby certify that this hospital has no seal or stamp and that this form was completed by this hospital

Program Director's Signature

Date \_\_\_\_\_ [notary seal]

RETURN COMPLETED FORM DIRECTLY TO THE BOARD IN OFFICIAL HOSPITAL ENVELOPE.



State Board of Medicine  
717-783-1400  
717-787-2381

MD. KL  
RECEIVED DIRECT

**VERIFICATION OF MEDICAL EDUCATION**  
**For Graduates of Accredited Medical Schools.**

**SECTION 1: To be completed by applicant.**

Name: BORGIA VICTORIA MARIE  
Last First Middle  
Name of medical school SUNY HEALTH SCIENCE CENTER BROOKLYN  
Location BROOKLYN NY

**SUBMIT THIS VERIFICATION OF MEDICAL EDUCATION FORM TO YOUR MEDICAL SCHOOL AND REQUEST YOUR SCHOOL TO RETURN COMPLETED FORM DIRECTLY TO THE BOARD IN OFFICIAL SCHOOL ENVELOPE.**

**SECTION 2: To be completed by Dean or Registrar of medical school.**

Name of medical student: Victoria M. Borgia

Date student began to attend this medical school: 8/29/93  
Month Day Year

Date of graduation: 5/21/98  
Month Day Year

[Seal of School]

I certify that all of the above information is correct.

Signature of

Dean or Registrar:

Date:

11/15/05

Upon completion, school must return this completed form directly to the Pennsylvania State Board of Medicine in official school envelope. DO NOT RETURN TO APPLICANT.

Regular Mailing Address  
State Board of Medicine  
P.O. Box 2649  
Harrisburg, PA 17105-2649

Courier Delivery Address  
State Board of Medicine  
2601 North Third Street  
Harrisburg, PA 17110

Printing Date : 11/15/05

**State University of New York  
Health Science Center at Brooklyn**  
also known as: SUNY Downstate Medical Center  
**Academic Transcript**

Page 1 of 1  
**RECEIVED DIRECT**

Student Name : **Borgla, Victoria Marie**

College : **College of Medicine**

IDN : [REDACTED]

Program/Class of

Matriculation Date : **Fall 1993**

Degree Awarded : **Doctor of Medicine**

Date Awarded : **5/21/98**

SUBJ NO	Course Title	Credits	Grade	SUBJ NO	Course Title	Credits	Grade
<b>Fall 1993</b>							
ANCB 1010	PBL - Gross Anatomy	4.5	A	PSYH 4304	Chemical Dependencies	3.0	B
PHYS 1010	PBL - Principles of Physiology	4.0	D	SOB 4307	Street Outreach Services, Non-Emergency Care	4.0	B
ANCB 1011	PBL - Cell Biology & Histology	3.0	HP	AMBU 4308	Antidotal Care	6.0	HP
ANCB 1012	PBL - Embryology	0.5	F		Course Credits	13.0	
	Earned Credits	14					
<b>Spring 1994</b>							
MBIM 1000	Human Genetics	0.5	D	HOVS 4416	HIV, AIDS and Antiretroviral	3.0	B
NSSC 1000	Neuroscience	1.5	D	SOB 4419	Subsistence in Medicine	3.0	HP
DECI 1010	PBL - Biochemistry	4.5	D	ASIS 4011	Drug Management	3.0	HP
PREV 1010	PBL - Biostatistics/Epidemiology	1.0	D	ISSH 4108	Walt in Clinic - Psychiatry	3.0	HP
PSYH 1010	PBL/Human Beh Health & Disease	2.0	F	HAIS 4330	Diagnostic Pathology	1.0	F
DECI 1011	PBL - Clinical Nutrition	1.0	D	SOB 4102	Control of Infections	3.0	HP
	Earned Credits	0.5			Course Credits	12.0	
					Total Earned Credits	132.0	
					No entries below this line		
<b>Fall 1994</b>							
ANCB 1000	Gross Anatomy	4.5	D				
DECI 1000	General Biochemistry	4.5	D				
	Earned Credits	9.0					
<b>Spring 1995</b>							
MBIM 1000	Human Genetics	0.5	D				
NSSC 1000	Neuroscience	1.5	D				
PREV 1011	Epidemiology	1.0	B				
PREV 1012	Biostatistics	1.0	D				
	Earned Credits	4.0					
<b>Fall 1995</b>							
PSYH 2006	Psychopathology	2.0	A				
PREV 2004	Preventive Medicine	2.0	A				
PHAR 2003	Pharmacology	3.0	A				
PATH 2000	Pathology	3.0	A				
SOB 2002	Preparation for Clinical Medicine	3.0	A				
MBIM 2001	Pathophysiology	4.0	A				
MBIM 2004	Microbiology	4.5	A				
	Earned Credits	21.5					
<b>Spring 1996</b>							
PSYH 2006	Psychopathology	2.0	D				
PREV 2005	Preventive Medicine	2.0	D				
PHAR 2003	Pharmacology	3.0	A				
PATH 2000	Pathology	3.0	D				
SOB 2002	Preparation for Clinical Medicine	3.0	F				
MBIM 2001	Pathophysiology	4.0	F				
MBIM 2004	Microbiology	4.5	F				
	Earned Credits	21.5					
<b>Fall 1996</b>							
PSYH 3300	Psychiatric Clerkship	6.0	C				
SOB 3300	OB/GYN Clerkship	6.0	HP				
SOB 3400	Medicine Clerkship	12.0	F				
	Earned Credits	24.0					
<b>Spring 1997</b>							
PELS 3400	Pediatric Clerkship	3.0	HP				
NEUR 3300	Neurology Clerkship	6.0	F				
SOB 3400	Surgery Clerkship	12.0	HP				
	Earned Credits	21.0					

No entries below this line

Completed requirements 05/15/98

Start Date 7/9/94 End Date COMMENT :  
7/9/94 REGO REPEAT 1ST YEAR

*Sophie Christoforou*

**Sophie Christoforou**  
Assistant Dean for Student Affairs and Registrar

This Academic Transcript is considered Official ONLY  
with the Impression of the Institution Seal and the  
signature stamp of the Assistant Dean for Student Affairs

In accordance with the Family Education Rights and Privacy Act of 1974, as amended, information contained herein shall not be disclosed to a third party without the written authorization of the student

Confidential record for your exclusive use only  
**NOT TO BE GIVEN TO STUDENT UNDER ANY CIRCUMSTANCES**

**VICTORIA M. BORGIA, MD**

Philadelphia, PA 19147

@mac.com

**Education**

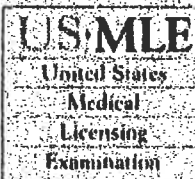
- 7/98-7/01 Sutter Medical Center of Santa Rosa Family Practice Residency.**  
In affiliation with University of California San Francisco.  
Recipient 2001 Team Player award.
- 9/93-5/98 State University New York Health Science Center at Brooklyn**  
Doctor of Medicine, May 1998
- 1/89-1/92 Columbia University, New York, NY.**  
BA Women's Studies, January 1992
- 9/87-12/88 Emory University, Atlanta, GA**

**Licensure and Certification**

American Academy of Family Practice Board certification  
California Medical License, DEA  
Neonatal Resuscitation  
Advanced Life Support for Obstetrics

**Relevant Work Experience**

- 1/05-pres childrearing**
- 7/01 -1/05 Alliance Medical Center, Healdsburg, CA.**  
Full spectrum provider at federally funded community health center  
serving predominantly low-income Spanish speaking population. Women's  
Health, colposcopy, inpatient medicine, low and high risk obstetrics  
included. Organized provider retreats, representative at health center  
strategic planning.
- 6/00-803 Southwest Community Health Center, Occidental Area Health  
Center, Sutter Medical Center Urgent Care Clinic.**  
Locum Tenens physician at local area community health centers.



United States Medical Licensing Examination™ (USMLE™)  
Certified Transcript of Scores

This document was prepared by the  
Federation of State Medical Boards of the United States, Inc.  
Federation Place, PO Box 619850, Dallas, TX 75261-9850 -- Telephone (817) 868-4041

Date: 10/14/2003

Recipient:

Pennsylvania State Board of Medicine  
ATTN: Cindy L. Warner, Administrator  
PO Box 2649  
Harrisburg, PA 17105-2649

RECEIVED DIRECT

Examinee: Borgia, Victoria  
Alt Name(s): Borgia, Victoria Marie

Examinee ID#: A-068-694-1  
Date of Birth: 12-08-1968

Results for Steps taken by this examinee (and for which results have been reported to date) are shown below. For Steps that span more than one day, the test date reflects the day on which the examination began. Where numeric scores are reported, there are two scales used and the recommended minimum passing score ("MP") on each scale is shown in parentheses.

USMLE STEP 1

Test Date	Pass/Fail	Three-Digit Score		Two-Digit Score		Comments
		Total	MP	Total	MP	
06/11/1996	Pass	216	176	86	75	

USMLE STEP 2

Clinical Knowledge (CK)

Test Date	Pass/Fail	Three-Digit Score		Two-Digit Score		Comments
		Total	MP	Total	MP	
08/26/1997	Pass	234	170	89	75	

USMLE STEP 3

	Test Date	Pass/Fail	Three-Digit Score		Two-Digit Score		Comments
			Total	MP	Total	MP	
CALIFORNIA	12/01/1998	Pass	225	177	89	75	

NOTE: A search of the Board Action Data Bank of the Federation of State Medical Boards (FSMB) reveals no reported information on this examinee.



National Practitioner Data Bank  
Healthcare Integrity and Protection Data Bank  
P.O. Box 10832  
Chantilly, VA 20153-0832

DCN: 5500000039419967  
Process Date: 10/24/2005  
Page: 1 of 1

<http://www.npdb-hipdb.com>

To: BORGIA, VICTORIA MARIE



ALBRIGHTSVILLE, PA 18210

From: The National Practitioner Data Bank

Re: Response to Your Self-Query

The enclosed information is released by the National Practitioner Data Bank (NPDB) for restricted use under the provisions of Title IV of Public Law 99-660, the Health Care Quality Improvement Act of 1986, as amended.

Title IV established the NPDB as an information clearinghouse to collect and release certain information related to malpractice payment history and professional competence or conduct of physicians, dentists, and other licensed health care practitioners. Regulations governing the NPDB are codified at 45 CFR part 60. Responsibility for operating the NPDB resides with the Secretary of the U.S. Department of Health and Human Services (HHS), HRSA, Practitioner Data Bank's Branch.

Reports from the NPDB contain limited summary information and should be used in conjunction with information from other sources in granting clinical privileges, or in making employment affiliation or licensure decisions. The NPDB response may contain more than one report on a particular incident, if two or more actions were taken as a result of a single incident (e.g., a suspension of clinical privileges and an adverse licensure action). The NPDB is a flagging system, and a report may be included for a variety of reasons that do not necessarily reflect adversely on the professional competence or conduct of the subject named in the report.

All information received from the NPDB is considered confidential and must be used solely for the purpose for which it was disclosed. ANY PERSON WHO VIOLATES THE CONFIDENTIALITY PROVISIONS AS SPECIFIED IN TITLE IV OF PUBLIC LAW 99-660, AS AMENDED, IS SUBJECT TO A CIVIL MONEY PENALTY OF UP TO \$11,000 FOR EACH VIOLATION. Subjects of reports who obtain information about themselves from the NPDB are permitted to share that information with anyone they choose.

If you require additional assistance, visit the NPDB-HIPDB web site (<http://www.npdb-hipdb.com>) or contact the NPDB-HIPDB Customer Service Center at 1-800-767-6732 (TDD: 1-703-802-9395). Information Specialists are available to speak with you weekdays from 8:30 a.m. to 6:00 p.m. (5:30 p.m. on Fridays) Eastern Time. The NPDB-HIPDB Customer Service Center is closed on all Federal holidays.

CONFIDENTIAL DOCUMENT - FOR AUTHORIZED USE ONLY

National Practitioner Data Bank  
Healthcare Integrity and Protection Data Bank  
P.O. Box 10832  
Chantilly, VA 20153-0832

DCN: 5500000039419967  
Process Date: 10/24/2005  
Page: 1 of 2

<http://www.npdb-hipdb.com>

## RESPONSE TO SELF-QUERY

### A. SUBJECT ON WHOM DISCLOSURE IS REQUESTED

Subject Name: BORGIA, VICTORIA MARIE  
Gender: FEMALE  
Date of Birth: [REDACTED]  
Other Name(s) Used:  
Organization Name:  
Organization Type:  
Other, as Specified:  
Home or Work Address: [REDACTED]  
City, State, ZIP: ALBRIGHTSVILLE, PA 18710  
Country:  
Social Security Numbers (SSN): [REDACTED]  
Individual Taxpayer Identification Numbers (ITIN):  
Federal Employer Identification Numbers (FEIN):  
National Provider Identifiers (NPI):  
Drug Enforcement Administration (DEA) Numbers: BB6621699  
Unique Physician Identification Numbers (UPIN):  
Professional School(s) & Year(s) of Graduation: SUNY USC BROOKLYN 1998  
Occupation/Field of Licensure (Code): PHYSICIAN (MD) (010)  
State License Numbers, State of Licensure: A69904, CA  
Other, as Specified:  
Specialty: GENERAL PRACTICE/FAMILY PRACTICE (111)

### B. PAYMENT INFORMATION

Payment Type: CREDIT CARD  
Account Number: [REDACTED]  
Expiration Date: 07/2007  
Transaction Date: 10/24/2005  
Transaction Number: 5500000039419967  
Total Charge: \$8.00

### C. SEARCH RESULT

Based on the subject identification information provided by you in Section A above, a search of the NPDB has located the following 0 report(s)

Recipients should verify that the subject identified in Section A is, in fact, the subject of interest.

CONFIDENTIAL DOCUMENT - FOR AUTHORIZED USE ONLY

National Practitioner Data Bank  
Healthcare Integrity and Protection Data Bank  
P.O. Box 10832  
Chantilly, VA 20153-0832

DCN: 5500000039419967  
Process Date: 10/24/2005  
Page: 2 of 2

<http://www.npdb-hipdb.com>

Copies of these reports are enclosed for restricted/limited use as prescribed by Title IV of Public Law 99-660, as amended. Recipients should verify that the subject identified in Section B of the report(s) is, in fact, the subject of interest. Information from the NPDB is confidential and must be used solely for the purpose for which it was disclosed. ANY PERSON WHO VIOLATES THE CONFIDENTIALITY PROVISIONS AS SPECIFIED IN TITLE IV IS SUBJECT TO A CIVIL MONEY PENALTY OF UP TO \$11,000 FOR EACH VIOLATION. Subjects of reports who obtain information about themselves from the NPDB are permitted to share that information with anyone they choose.

CONFIDENTIAL DOCUMENT - FOR AUTHORIZED USE ONLY

National Practitioner Data Bank  
Healthcare Integrity and Protection Data Bank  
P.O. Box 10832  
Chantilly, VA 20153-0832

DCN: 5500000039419967  
Process Date: 10/24/2005  
Page: 1 of 1

<http://www.npdb-hipdb.com>

To: BORGIA, VICTORIA MARIE

ALBRIGHTSVILLE, PA 18210

From: The Healthcare Integrity and Protection Data Bank

Re: Response to Your Self-Query

The enclosed information is released by the Healthcare Integrity and Protection Data Bank (HIPDB) for restricted use under the provisions of Section 1128E of the Social Security Act.

Section 1128E was established by Section 221(a) of Public Law 104-191, the Health Insurance Portability and Accountability Act of 1996, as amended. The statute established the HIPDB to combat fraud and abuse in health insurance and health care delivery and to improve the quality of patient care. The HIPDB serves as a source of final adverse action information on health care practitioners, providers, and suppliers. The HIPDB collects and releases information related to adverse licensure actions; health care-related convictions and judgments; exclusions from Federal and State health care programs; and other adjudicated actions or decisions. Responsibility for operating the HIPDB resides with the Secretary of the U.S. Department of Health and Human Services (HHS), Office of Inspector General, and HRSA, Practitioner Data Banks Branch. Regulations governing the HIPDB are codified at 45 CFR Part 61.

Reports from the HIPDB contain limited summary information and should be used in conjunction with information from other sources in granting clinical privileges or making employment affiliation, contracting, or licensure decisions. The HIPDB response may contain more than one report on a particular incident, if two or more actions were taken as a result of a single incident (e.g., an adverse licensure action and an exclusion from the Medicare and Medicaid programs). The HIPDB is a flagging system and a report may be included for a variety of reasons that do not necessarily reflect adversely on the professional competence or conduct of the subject named in the report.

All information received from the HIPDB is considered confidential and must be used solely for the purpose for which it was disclosed. Subjects of reports who obtain information about themselves from the HIPDB are permitted to share that information with anyone they choose.

If you require additional assistance, visit the NPDB-HIPDB web site (<http://www.npdb-hipdb.com>) or contact the NPDB-HIPDB Customer Service Center at 1-800-767-6732 (TDD: 1-703-802-9395). Information Specialists are available to speak with you weekdays from 8:30 a.m. to 6:00 p.m. (5:30 p.m. on Fridays) Eastern Time. The NPDB-HIPDB Customer Service Center is closed on all Federal holidays.

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National Practitioner Data Bank  
Healthcare Integrity and Protection Data Bank  
P.O. Box 10832  
Chantilly, VA 20153-0832

DCN: 5500000039419967  
Process Date: 10/24/2005  
Page 1 of 2

<http://www.npdb-hipdb.com>

## RESPONSE TO SELF-QUERY

### A. SUBJECT ON WHOM DISCLOSURE IS REQUESTED

Subject Name: BORGIA, VICTORIA MARIE

Gender: FEMALE

Date of Birth: [REDACTED]

Other Name(s) Used:

Organization Name:

Organization Type:

Other, as Specified:

Home or Work Address: [REDACTED]

City, State, ZIP: ABBRIGTSVILLE, PA 19210

Country:

Social Security Numbers (SSN): [REDACTED]

Individual Taxpayer Identification Numbers (ITIN):

Federal Employer Identification Numbers (FEIN):

National Provider Identifiers (NPI):

Drug Enforcement Administration (DEA) Numbers: B06621690

Unique Physician Identification Numbers (UPIN):

Professional School(s) & Year(s) of Graduation: SUNY HSC BROOKLYN 1998

Occupation/Field of Licensure (Code): PHYSICIAN (MD) 10101

State License Numbers, State of Licensure: A69904, CA

Other, as Specified:

Specialty: GENERAL PRACTICE/FAMILY PRACTICE (33)

### B. PAYMENT INFORMATION

Payment Type: CREDIT CARD

Account Number: [REDACTED]

Expiration Date: 07/2007

Transaction Date: 10/24/2005

Transaction Number: 5500000039419967

Total Charge: \$8.00

### C. SEARCH RESULT

Based on the subject identification information provided by you in Section A above, a search of the HIPDB has located the following 0 report(s).

Recipients should verify that the subject identified in Section A is, in fact, the subject of interest

CONFIDENTIAL DOCUMENT - FOR AUTHORIZED USE ONLY

National Practitioner Data Bank  
Healthcare Integrity and Protection Data Bank  
P.O. Box 10832  
Charlottesville, VA 20153-0832

DCN: 5500000039419967  
Process Date: 10/24/2005  
Page: 2 of 2

<http://www.npdb-hipdb.com>

Copies of these reports are enclosed for restricted/limited use as proscribed by Section 1120E of the Social Security Act. Recipients should verify that the subject identified in Section B of the report(s) is, in fact, the subject of interest. Information from the HIPDB is confidential and must be used solely for the purpose for which it was disclosed. Subjects of reports who obtain information about themselves from the HIPDB are permitted to share that information with anyone they choose.

CONFIDENTIAL DOCUMENT - FOR AUTHORIZED USE ONLY

State Board of Medicine  
P.O. Box 2649  
Harrisburg, PA 17105-2649  
717-783-1400 or 717-787-2381

November 21, 2005

VICTORIA MARIE BORGIA

PHILADELPHIA PA 19147

Dear Doctor:

The items checked below are required to complete your application. Additional information is listed below the item, if necessary. You may not practice in the Commonwealth of Pennsylvania until the Pennsylvania State Board of Medicine has issued a license.

- ☐ 1. Application - page 1
- ☐ 2. Application - page 2
- ☐ 3. Application page 3 - Certification of Moral Character.
- ☐ 4. Application - page 4 - Verification of ACGME Approved Graduate Medical Training must be received DIRECTLY from the Hospital(s) in official hospital envelope(s).
- ☒ 5. Application - page 6 - Verification of Medical Education - must be received DIRECTLY from the Medical School in an official Medical School envelope.

THIS FORM WAS MAILED TO YOU ON OCTOBER 24, 2005.

- ☐ 6. National Board scores - Endorsement of Certification - must be received DIRECTLY from the National Board in an official agency envelope
- ☐ 7. LMCC score certification must be received DIRECTLY from the Medical Council of Canada in an official agency envelope

**PAGE #2**

- \_\_\_ 8. USMLE scores must be received DIRECTLY from the Federation of State Medical Boards, Inc. in an official agency envelope.
- \_\_\_ 9. FLEX scores must be received DIRECTLY from the Federation of State Medical Boards, Inc. in an official agency envelope
- \_\_\_ 10. State Board certification must be received DIRECTLY from the State Medical Board in an official State Board envelope
- \_\_\_ 11. Curriculum vitae
- \_\_\_ 12. Fee in the amount of \$35.00 made payable to the "Commonwealth of Pennsylvania". Check or money order must be drawn on a US bank. **NOTE: A processing fee of \$20.00 will be charged for any check or money order returned unpaid by your bank, regardless of the reason for non-payment.**
- \_\_\_ 13. Letter(s) of good standing must be received DIRECTLY from the State Board in an official State Board envelope from the following states:
- \_\_\_ 14. **BOTH** the National Practitioner Data Bank **AND** the Healthcare Integrity and Protection Data Bank Disclosure Information -- **NPDB & HIPDB** reports are required
- \_\_\_ 15. OTHER:



**APPLICATIONS NOT COMPLETED WITHIN SIX MONTHS  
WILL REQUIRE UPDATES OF CERTAIN SECTIONS.**



State Board of Medicine  
P.O. Box 2649  
Harrisburg, PA 17105-2649  
717-783-1400 or 717-787-2381

November 7, 2005

VICTORIA MARIE BORGIA

PHILADELPHIA, PA 19147

Dear Doctor:

The items checked below are required to complete your application. Additional information is listed below the item, if necessary. You may not practice in the Commonwealth of Pennsylvania until the Pennsylvania State Board of Medicine has issued a license.

- ☐ 1. Application - page 1
- ☐ 2. Application - page 2
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- 13. Letter(s) of good standing must be received DIRECTLY from the State Board in an official State Board envelope from the following states
- 14. **BOTH** the National Practitioner Data Bank **AND** the Healthcare Integrity and Protection Data Bank Disclosure Information - **NPDB & HIPDB** reports are required  
**THE HEALTHCARE INTEGRITY AND PROTECTION DATA BANK (HIPDB) REPORT IS ALSO REQUIRED. YOU SUBMITTED ONLY THE NPDB REPORT.**
- 15. OTHER:

**APPLICATIONS NOT COMPLETED WITHIN SIX MONTHS  
WILL REQUIRE UPDATES OF CERTAIN SECTIONS.**

State Board of Medicine  
P.O. Box 2011  
Harrisburg, PA 17105-2542  
717-783-1400 or 717-787-2331

October 24, 2005

VICTORIA MARIE BORGIA  
[REDACTED]  
PHILADELPHIA, PA 19147

Dear Doctor:

The items checked below are required to complete your application. Additional information is listed below the item, if necessary. You may not practice in the Commonwealth of Pennsylvania until the Pennsylvania State Board of Medicine has issued a license.

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13. Letter(s) of good standing must be received DIRECTLY from the State Board in an official State Board envelope from the following states.
- CALIFORNIA**
- ☒ 14. BOTH the National Practitioner Data Bank AND the Healthcare Integrity and Protection Data Bank Disclosure Information -- NPD & HIPDB reports are required
15. OTHER:

**APPLICATIONS NOT COMPLETED WITHIN SIX MONTHS  
WILL REQUIRE UPDATES OF CERTAIN SECTIONS.**