EDICAL BOARD OF CALIFORNIA

Consumer
Affairs

1426 Howe Avenue, Suite 54, Sacramento, CA 95825-3236

TEL: (916) 263-2499/FAX: (916) 263-2487 Internet: www.medbd.ca.gov

9-1004 9-1004

APPLICATION FOR PHYSICIAN'S AND SURGEON'S LICENSE

Please <u>READ</u> all instructions prior to completing this application. <u>ALL</u> questions on this application must be answered, and all supporting documents must be submitted as per instructions. Please type or print neatly. When space provided is insufficient, attach additional sheets of paper. All attachments are considered part of the application PROGRAM

	FALSIFICATION OR MIS ATTACHMENT F	REPRESENTATI IERETO IS A SUF	ON OF ANY ITEM OR FICIENT BASIS FOR	RESPONSE ON THIS DENYING OR REVOK	APPLICATION OR ING A LICENSE.	LANY	MBC US ONLY
1. NAME: Last			First	· •	Middle		Person
5/.	LVER		ROY				Data
2. Other names you have		name):	<u> </u>	3. U.S. Social	Security Number		i ei
4A. (PUBLIC ADDRESS;	will be released by the	Soard to the publi	c): Number and Stree	 et/P.O. Box/Rural Rou	te/Apartment Num	ber. If any.	⊣ 7
10525	Courtney	Love	Ave.		•		P
City		State		Zip Code 89144	Country		1/1
Las Vego		NV			1150	+	
4B.(CONFIDENTIAL ADI	address if a P	O Rovie usada	e/Apartment Number, s the Public Address	if any. [Applicants mo in #4A above.]	ust provide a confi	idential street	Þ
City	Triby Cor.	State		Zip Code	Country		- 1
Las Vegas		NV		89144	USA		
5. Telephone Number:			6. California Driver's	License Number (option			1
. Home: (Work: (NUMBER		ÉXPIRATION		Z
7. Date of Birth (Month/	lay/Vear) and Blace of I	Marin .	<u> </u>	***			
The state of the s	ON LOSS) SUG LISCO OF	erui,		-	•		1
8. Sex: 🐼 Male	☐ Female		i 9. Are you a U.S.	citizen?	Yes	□ No	ď
10. Have you ever filed a	n application for Physic	ian's and Surgeo	n's examination or lie	ensure in California?	1		
IF YES, PLEASE GIVE DATE PREV					☐ Yes	☑ No	. I
11. List the names and lo	ecations of all colleges	r universities atte	ended where pre-prof	essional postsecond	aru instruction wa	e manium d	- An
Please submit official !	ranscripts with the schoo	seal affixed for ear	h school attended. Tra	inscripts will not be re	turned.	a içbeləbu.	Medica Educati
Name		City, State, (Country		Dates of Attendance	!	
BRANDEIS UNIV	WACTHA	m, MA U	15 A	08/91	-05/94		L
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12. List the names and loc	ations of <u>all</u> schools where	professional medi	callinstruction was rece	rived, and, where applic	able, the degree aw	arded.	Medica
PLEASE SUBMIT: 1	an original Certificate of Me and the school seal affixed fi an original medical diploma	dical Education (For om each school atte	m L2) and official transcri _l nded: and .	pts with the signature of th	e dean or registrar	,	Education
School Name		City, State, Coun		Dates of Att	endance	Degree Awarded	L2 Tra
STI bearge's Univ	Gre	nada, we	st Indies	08/96-0	6/00	MD	D
				0-/10	-/	14)0	
DOCTOR OF MEDICINE DE	GREE, as referenced above	·		· · · · · · · · · · · · · · · · · · ·		<u> </u>	ہا لسان ا
Name of Medical Sc	hool A	ddress of Medical Sc	hool		Exact Date of	Issuance	
ST. beorge's Vi	1/v ()	reliada h	est Indies		06//	6/00	: /
MANDATORY DISCLOSURE O	F U.S. SOCIAL SECURITY NUM	IBERS /				BC USE	
Disclosure of your U.S. social secu- collection of your social security nu- or order for family support in accor which utilizes a hatlonal examination licensure will not be processed AN	dance with Section 17520 of the n and where licensura is reciproc	rr will be used exclusively Family Code or for verifi al with the requestion ste	y for tax enforcement purpose: cation of licensure of examina-	s for purposes of compliance viation status by a licensing or e	(2)(C)) authorize with any judgment xemination entity plication for initial	ONLY	14
A-100(Rev. 3/01)		4-17			Sch	ool Code	

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3. Have you taken any of the follow	ing written examinations: Na	itional Boards, ot	her state boards, USM1	LE, SPEX, FLE	(, ECFM	G or LMCC	7 Writte
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yes, list name. Location, date and resul Amination History Report directly to th				CT MUSI SUBMII AN	ONIGINAL	OFFICIAL	W.
Examinatio	DIT.		Date	Re	Bult (Pass	/Eail)	-LW
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Jurisdiction .	License Number	Date of iss	uance I	Dates of Practice	n that Jun	sdiction	ļ , ,
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			ntry, or U.S. federal juri	sdiction?	l Yes	Ø No	9
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A. Are you currently, or have you e to must include every residency, if es, list names and addresses of all factury. (DO NOT COMPLETE FORM LIAAS TO E SATISFACTORILY COMPLETED OR WILL BE Facility Name Vark Valv - Dount own Hap. Welsity Mullal (Cuttrice) Descriptions. An applicant must provectors. If these documents are not purise.	DELIECT TO DISCIPLINE? IF YES, PLEAS EPORT ANY MATTER THAT IS PENDING OVER been, a participant in a pr internship, and fellowship, wh CILITIES. SUBMIT AN ORIGINAL CERTIF DOCUMENT TRAINING RECEIVED IN RE USED TO MEET LICENSING REQUIREM Address Address 2040 W. Charleston W. Cas Vegas W. Sy ving questions, please provide official hearing/court do provided with the application R THAT IS PENDING OR IN W.	DE PROVIDE ALL OFFIC OR IN WHICH CHARGE DISTINUTE OF COMPLETIO SEARCH FELLOWSHIP ENTS. DE STE 200 DE ALL Official documents and originate of CHARGES HICH CHARGES	ing program in a facility pleted.) N OF ACGME/RCPSC POSTGR PROGRAMS.) ALL TRAINING Categorial Specialty Ar OB/Bya. Cumentation regarding pleted before review of the Jave BEEN DROPPER	ty in the U.S. or taouate training Must be listed, a or //o the matter in a tion from medi heapplication OR EXPUNGE	Yes Canada Yes (Form L: Egarbles stes of Att	No N	Professi Licens Postgrad Trainia H R IT
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DATE OF

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For all of the the two sisters in clude any disciplinary actions by the U.S. Military, U.S. entity.	PUBIIG MBAI	In selaice, of cilier f	1.2. 1906[S	i Boseumerital	Data
17 <u>A</u> . Have you ever been charged with, or been found to have committed, unprofess negligence, or repeated negligent acts or malpractice by any medical licensing box	isional cond ard, other ag	luct, professional in pency, or hospital?	competen	;a, gross	
17g. Has any disciplinary action ever been filed or taken, including but not limited letters of warning, regarding any healing arts license which you now hold or have	to, informal ever held?	or confidential disci	pline, cons	sent orders, or	
17 <u>C</u> . Is any such action as described above pending?	•	17(A)	Yes	No	125
IF YOU ANSWERED YES TO 17A, 17B OR 17C, PROVIDE DETAILS ON		17(B)	Yes	No	Z
A SEPARATE ATTACHMENT.		17(C)	Yes	No	pi
18. Has a claim or action for damages ever been filed against you in the course of a resulted in a maipractice settlement, judgement, or arbitration award of over \$30,00	the practice	of medicine or any o	ther healin	g art which	
	VU.QUY		Yes	No	l of
IF YOU ANSWERED YES, PROVIDE DETAILS ON A SEPARATE ATTACHMENT.			100		
19. Have you ever been denied a license, permission to practice medicine or any of	ther healing	art, or denied permis	sion		- *
to take an examination in any state, territory, country, or U.S. federal jurisdiction, o	or is any suc	h action pending?			1 . /
IF YOU ANSWERED YES, PROVIDE DETAILS ON A SEPARATE ATTACHMENT.			Yes	No	pt 1
20. Have you ever voluntarily surrendered a license to practice medicine or any ots surrendered your narcotic (controlled substance) permit (state or federal) to any lipending?	her healing censing box	arts in this or any ot ard or any other ager	her state, o	or voluntarily ny such action	
IF YOU ANSWERED YES, PROVIDE DETAILS ON A SEPARATE ATTACHMENT.		•	Yes	No	Ø
21. Have you ever had staff privileges in a hospital denied, suspended, limited, reversigned from a medical staff in fleu of disciplinary or administrative action, or is a	oked, or not ny such acti	renewed for medical on pending?	disciplina	ry cause, or	
YOU MUST DISCLOSE ANY INFORMAL OR CONFIDENTIAL DISCIPLINARY ACTION.			Yes	No	Ø
22. Do you have any condition which in any way impairs or limits your ability to pra	ctice medic	ine with reasonable			/
skill and safety, including but not limited to, any of the following?				• .	
IF YES, PLEASE CHECK THE APPROPRIATE BOX(ES) BELOW:			Yes	No	
 A condition which required admission to an inpatient psychlatri Alcohol or chemical substance dependency or addiction. Emotional, mental or behavioral disorder. Other (explain): 	c treatment	t facility.			
FOR ANY OF THE BOXES CHECKED ABOVE, PLEASE SUBMIT COMPLETE OFFICIAL INPATIENT AND REHABILITATION TREATMENT, AND A PERSONAL WRITTEN EXPLANATION.	OUTPATIENT	TREATMENT RECORDS,	EVIDENCE O	F ONGOING	
FOR ALL OF THE BELOW, YOU ARE REQUIRED TO LIST ANY CONVICTION THAT HAS BEEN SET A EXECUTION HAS BEEN ISSUED.	SIDE AND DISI	MISSED OR EXPUNGED,	OR WHERE	A STAY OF	
23 <u>A</u> . Have you ever been convicted of, or pled noto contenders to, ANY violation (in or federal law of any state, territory, country, or U.S. federal jurisdiction?	nclude even	y misdemeanor or fel	ony) of any	y local, state,	
23B. is any criminal action related to the above pending?		23 (A)	Yes	No	
IF YOU ANSWERED YES TO 23A OR 23B, PROVIDE DETAILS ON A SEPARATE ATTACHMENT.		23 (B)	Yes	No	Ø
NAME OF APPLICANT:	- :::::	DATE OF BIRTH:			
Roy SIEVER					1C



07A-100 (Rev. 3/01)

Notice: All items in this application are mandatory: none are voluntary. 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 or 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.

Applicant Declaration/Signature COUNTY OF The applicant, being first dúly sworn /(DATE OF BIRTH) upon his/her cath deposes and says: 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 my 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. SIGNATURE OF APPLICANT: (PLEASE SIGN FULL NAME, NOT INITIALS) Signed and sworn to before me this NOTARY ADDRESS My commission expires



MEDICAL BOARD OF CALIFORNIA

1426 Howe Avenue, Suite 54, Sacramento, CA 95825-3236 (916) 263-2499/FAX (916) 263-2487 Internet: www.medbd.ca.gov



CERTIFICATE OF MEDICAL EDUCATION

MEDICAL SCHOOL: PLEASE COMPLETE THIS FORM IN THE ENGLISH LANGUAGE.
This certifies that Roy SILVER FULL NAME OF APPLICANT U.S SOCIAL SECURITY NO DATE OF BIRTH-MINIODITYTY
enrolled in ST George 5 University School of Wed Grenada, West Indies
on the 16 day of TWE 2000 and was granted the following credits on enrollment:
Advanced Credits: Credits previously obtained at an approved medical, dental, or osteopathic school.* N A
MEDICAL SCHOOL TOTAL CREDITS DATES
The undersigned further certifies that the records of this institution show that the applicant attended in this institution I turn how the property of the pro
attendance is required, in the subjects set forth hereunder (Business and Professions Code Section 2089), and that the applicant:
was granted the degree Bachelor/Doctor of Medicine by OR withdrew from the above mentioned medical school on the day of day of
MONTH YEAR
Anatomy Embryology Histology Histology Disterrics and Gynecology Radiology, including Radiation Safety Fropical Medicine Physiology Biochemistry Pathology, Bacteriology and Immunology Dermatology Dermatology Dermatology Dermatology Dermatology Dermatology Dermatology Dermatology Disterrics Human Sexuality as defined in Section 2090 Medicine Surgery, including Orthopedic Surgery Disterric Surgery, including Orthopedic Surgery Disterric Surgery, including Orthopedic Surgery Dermatology Disterric Medicine Pediatrics Pharmacology Pharmacology Pharmacology Anesthesia Spousal or Partner Abuse Detection & Treatment** Pain Management and End-of-Life Care****
Each school where professional medical instruction was received MUST complete one of these forms. If more than one school was attended, photocopies of this blank form may be made and used. 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, 1998 Only applicable to medical students who enrolled in medical school on or after June 1, 2000.
ATTENTION MEDICAL SCHOOL: The person who signs this form MAY NOT be related to the applicant by blood, marriage or adaption. Only the President, Dean, or Registrar 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 past 12 months. Signed attached to this form (may be a photocopy). Such delegation must be on official months. Signed attached to this form (may be a photocopy). Such delegation must be on official months. Signed attached to this form (may be a photocopy). Such delegation must be on official months. Signed attached to this form (may be a photocopy). Such delegation must be on official months. Signed attached to this form (may be a photocopy). Such delegation must be on official months. Signed attached to this form (may be a photocopy). Such delegation must be on official months. Signed attached to this form (may be a photocopy). Such delegation must be on official months. Signed attached to the applicant by blood, marriage or charge of the properties of the photocopy. Such delegation must be on official months. Signed attached to the applicant person, and the properties of the photocopy. Such delegation must be on official months.
17A-100-L2 (Rev. 3/01)

STATE OF CALIFORNIA -- STAT : AND CONSUMER SERVICES AGENCY



MEDICAL BOARD OF CALIFORNIA

1426 Howe Avenue, Suite 54, Sacramento, CA 95825-3236 (915) 263-2499/FAX (916) 263-2487 Internet: www.medbd.ca.gov

CERTIFICATE OF COMPLETION OF ACGME/RCPSC POSTGRADUATE TRAINING

			svery medical school graduate cr			<u> </u>
417	ENTION PROGRAM DIRECT	R MS AND DIRECTORS OF M	EDICAL EPUCATION: THE PERSON WHO EIGHS	THIS FORM MAY NOT BE RELATED TO THE APP	LICANT BY BLOOD, MARRIAGE, OF	OLDOPTION,
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			tion of this form will certify that th			
рç	stgraduate triining	at this facility. If a r	period of training WAS NOT compt	eted in a satisfactory manner, ple	ase provide a soparate del	tailed
ria.	irrative explanation.	The following infoi	mation is provided to confify "satis	stactory" completion. PLEASE SE	E THE REVERSE FOR A L	DEFINITION
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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.

Only the Program Director and the Director of Medical officiated to this form (may be a photocopy). Such del	Education may sign this form. If that signals	in authority is builting classification to empti-	er person, evidence of that delegation must be
PART 1: To be completed by the APPLICA	ANT.		
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	770	7	
U.S. Social Security Number:	Date of Birth: MW/DD/YYY	Y Telephone Number:	
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Current Address:			
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Las Vegas	/ State	Zip.Code 89/	
Las vegas	100	891	44
PART 2: To be completed by the PROGRA <u>ATTENTION PROGRAM DIRECTOR!</u> Do n -applicant to quality for licensure. Comple	of sign and date this form before	the last day of any postgradus	nte training year which will be used by the
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Name of Program Director:	HOOL OF MEDICINE	: 2040 W. Ct	HARLESTON GLVD, STEZOO
James Dames	50 1	4	Telephone Number:
)OSGNA A- KOSTAS	JK. M.D.	<u></u>	(702) 671-23025
Signature of Program Director:	ici us		Date Signed:
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GENERAL MEDICINE TRAINING REQUIREMENT)	; ·		
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	APPOINT III	SONTAL SPAL OF MANAGEMENT	
To Care	MUST BE A	OSPITAL SEAL OR NOTARY SEAL, FFIXED IN THE BOX TO THE LEFT 1	DATE AND SIGNATURE
CAROL A ALLEN			
Notory Public Cont.	Thereby declare under penalty of p	enjury under the laws of the State	e of California that the above statements are
No. 02-75388-1	· Tuc and cornect and marine train	ing program is approved by the A	CGMF or the PCPSC to offer the time and I
My appr. exp. June 3, 200	Perer or training completed by the	he applicant and that the applicar	nt was trained in an approved ACCME or
allow A AAA.	.7 .	RCPSC program position	n.
\$ MAY N-HULLS	Signature of Director of Medical Ed	ucation	Data Signadi
2/13/04			Date Signed:
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* <i>{//3/07</i>	Stanly m	Icusa.	8/13/04 3/1





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ELIGIBILITY FOR REDUCED INITIAL LICENSE FEE

(If you are enrolled in an ACGME/RCPSC postgraduate training program at the time of licensure, you are entitled to a reduced initial license fee. This form is used to certify current participation in a training program.)

This is to certify that Boy SICVEIS	(U.S. Social Security Number)
(Date of Birth (MM/DD/YYYY) is in an approved.	ACGME/RCPSC costgraduate training position that
	7-1-1
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Only the Director of Medical Education may sign this form. If that signature of	Suthority is being delegged to another person, evidence of that
delegation must be attached to this form (may be a photocopy). Such dele last 12 months,	gation must be on official letterhead and must be dated within the
List 12 months,	
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I hereby declare under penalty of perjury under	er the laws of the State of California that the
above statements are true and correct and th	e facility is approved 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 approved	AUGME or RCPSC program position.
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(Type or print name of Director of Medical Education)	
(Type of brink naping of briedles of Michael Education)	
WILLIAM	
(Signature of Director of Methical Education)	
8/11/09	702-671-2300
(Date)	(Telephone Number)
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<u>)[</u>], 1	
CAROL A ALLEN	OFFICIAL HOSPITAL SEAL OF
Notary Public State of Navada	OFFICIAL HOSPITAL SEAL, OR
No. 02-75388-1 My oppt. exp. June 3, 2006	NOTARY SEAL (WITH DATE AND
7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7	NOTARY'S SIGNATURE) MUST BE
1 / Court of Allen Distar	AFFIXED IN THE BOX AT THE LEFT.
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NOTE: Do not use this form in lieu of Form L3A, "Certificate of Completion of ACGME/RCPSC Postgraduate Training."

07A-107-L4 (3/01)

L4

Name of Applicant (type or print FULL name):



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OFFICIAL BREAKDOWN OF UNDERGRADUATE CLINICAL CLERKSHIPS

(The completion of this form is required <u>only</u> of international medical school graduates.

Please complete this form in the English language.)

U.S. Social Security Number:

ROY SILVE	Date of I	Birth-MM/DD/YYYY:
PATIENTS IN A CLINICAL SETTIN	ips in which the applicant participated in DIRECT, HANI IG should be reported on this form. Any clinical clerksh eported on this form as they will NOT satisfy California's	ips completed that do not meet the above
(Please list ALL clinical trainin	UNDERGRADUATE CLINICAL CLERKS g completed prior to issuance of your medical ing in date/chronological order, commencing w	degree in the area below and on the
CLINICAL SUBJECT AREA	FACILITY NAME AND ADDRESS	DATES OFATTENDANCE FROM - TO (Month/Day/Year) WEEKS OR WEEKLY HOURS OF CREDIT
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Dry Chietry	Brinet General Hospital	107/05/99 6 V
Only the Dean or Registrar may sign this for	SON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICAN m. If that signature authority is being delegated to another person agalion must be on official letterhead and must be dated within the	, evidence of that delegation must be attached to
MEDICAL SCHOOL SEAL	Margaret A. Lar Dean of Enrollment FULL NAME of DUNIVERSITY RECE	Planning
the	clare under penalty of perjury, that I am/was the Dean out I have carefully read this with and that the statement	or Registrar for the student named above and s made herein are strictly true in every
	Signature of Dear or Registrar	8/16/04 L5A
7A-100-L5A (Rev. 3/01)	. 1 0	

OFFICIAL BREAKDOWN OF UNDERGRADUATE CLINICAL CLERKSHIPS

(Continued from the front of this form. If additional space is needed, you may photocopy this side of the form; however, original signatures and seals (below) will be required on all photocopies submitted.)

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MEDICAL SCHOOL SEAL		A. Lambert		•

that I am/was the Dean or Registrar for the student named above and

mand that the statements made herein are strictly true in every

declare under/penalty of perjury

Signature of Deanlor Registrar

that I have carefully read this

respect.

07A-100-L5B (Rev. 3/01)

Consumer Affairs

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CERTIFICATE OF CLINICAL TRAINING

The completion of this form is required <u>only</u> of international medical school graduates, BUT may be omitted if all clinical training was done in the primary teaching hospital of the medical school and such hospital is located in the same country as the medical school AND the medical school completes and certifies the "Official Breakdown of Undergraduate Clinical Clerkships form, Form L.5A/B.] Please complete this form in the English language.

Complete ONE certificate for EACH clerkship, signed by the facility program director or instructor.

Only undergraduate clinical clerkships in which the applicant participated in DIRECT. HANDS-ON DIAGNOSIS OR TREATMENT OF PATIENTS IN A CLINICAL SETTING should be reported on this form. Any clinical clerkships completed that do not meet the above criteria should NOT be reported on this form as they will NOT satisfy California's clinical training requirements.
This is to certify that
completed a clerkship offered by Long Island College Hospital NAME AND ADDRESS OF FACRITY 339 Hicks Street, Brooklyn, N.Y. 11201
from 4 10 00 through 5 5 00 in the clinical area of CLINICAL AREA
This facility is affiliated with a U.S. or International school It is not affiliated with a U.S. or International school It is not affiliated with a U.S. or International school It is not affiliated with a U.S. or International medical school, if affiliated: Suny Downstate Medical Center & Brook Lyn This facility is does have an ACGME-accredited residency program It is not affiliated with a U.S. or International school In the areas of: Medicine/Pediatrics In the a
ATTENTION FACILITY PROGRAM DIRECTORS OR INSTRUCTORS: THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE, OR ADOPTION. Only the Facility Program Director or Instructor 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 an official letterhead and must be dated within the last 12 months. I
TYPE OR PRINT ALME OF FACULTY PROGRAM DIRECTOR OR INSTRUCTOR 339. Hicks Street ADDRESS NUMBER AND STREET Brooklyn. N. Y. (1120)
TELEPHONE NUMBER CITY 1718) 780 - 1206 SIGNATURE OF FACCUTY PROGRAM DIRECTOR OR INSTRUCTOR SIGNATURE OF FACCUTY PROGRAM DIRECTOR OR INSTRUCTOR
NOTE: IN ABSENCE OF AN OFFICIAL HOSPITAL SEAL, THE FACILITY PROGRAM DIRECTOR OF INSTRUCTOR MUST SIGN THIS FORM IN THE PRESENCE OF A NOTARY PUBLIC WHO AFFIXES HIS/HER OFFICIAL NOTARY SEAL.
Signed and sworn to before me this day of
My Commission Expires



MEDICAL BOARD OF CALIFORNIA LICENSING PROGRAM

1426 Howe Avenue Sacramento, CA 95825-3236 (916) 263-2499



CERTIFICATE OF CLINICAL TRAINING

(The completion of this form is required only of international medical school graduates.)

NOTE: THIS FORM MAY BE DMITTED IF ALL CLINICAL TRUINING WAS DONE IN THE PRIMARY TEACHING HOSPITAL OF THE MEDICAL SCHOOL AND SUCH HOSPITAL IS LOCATED IN THE SAME COUNTRY AS THE MEDICAL SCHOOL AND THE MEDICAL SCHOOL COMPLETES AND CENTIFIES THE OFFICIAL BREAKDOWN OF UNDERGRADUATE CLINICAL CLERKSHIPE FORMS, FORMS LSA/B.

Complete ONE certificate for EACH clerkship, signed by the instructor or facility program director.

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ICAL BOARD OF CALIFORNIA LICENSING PROGRAM

1426 Howe Avenue Secremento, CA 95825-3236 (916) 263-2499



CERTIFICATE OF CLINICAL TRAINING

(The completion of this form is required only of International medical school graduates.)

NOTE: THIS FORM MAY BE OMITTED IF ALL CLINICAL TRAINING WAS DONE IN THE PRIMARY TEACHING HOSPITAL OF THE MEDICAL SCHOOL AND SUCH HOSPITAL IS LOCATED IN THE SAME COUNTRY AS THE MEDICAL SCHOOL AND THE MEDICAL SCHOOL AND THE MEDICAL SCHOOL ONPLETES AND CERTIFIES THE OFFICIAL BREAKDOWN OF UNDERGRADUATE CLINICAL CLERKSHIPS FORMS, FORMS LSA/B.

Complete ONE certificate for EACH clerkship, signed by the instructor or facility program director.

This is to certify that Roy Silver	, a student
STUDENT'S NAME	' annatited a
of St George's University School of Medicine	, completed a
clerkship offered by Mayday University Hospital, Mayday Road, Thornton Heath,	Surrey.
NAME AND ADDRESS OF FACILITY	
CR7 7YE, UK	
from 23 November , 1998 through 12 February , 19	99 in the clinical area
DATE	
of Medicine CLINICAL AREA	:
Dr Rupert Courtenay-Evans <u>being duly sworn</u> , says he is/was the	he individual instructor or
program director for the student named above during the clerkship indicated and thathe ha	s carefully read and
completed this form and that the statements made herein are strictly true in every	JOOPEN
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NOTE: IN ABSENCE OF AN OFFICIAL HOSPITAL SEAL, THE INSTRUCTOR OR PROGRAM DIRECTOR MUST SIGN TH	IS FORM IN THE PRESENCE
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MEDICAL BOARD OF CALIFORNIA LICENSING PROGRAM 1426 Howe Avenue

1426 Howe Avenue Sacramento, CA 95825-3236 (916) 263-2499



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This is to certify thatRoy Si			, a student
St George's University S		UDENT'S NAME	
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This facility Dis affiliated with	a U.S. or International school		CGME-accredited residency program
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MEDICAL BOARD OF CALIFORNIA LICENSING PROGRAM

1426 Howe Avenue Sacramento, CA 95825-3236 (916) 263-2499



CERTIFICATE OF CLINICAL TRAINING

(The completion of this form is required only of international medical school graduates.)

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Complete ONE certificate for EACH clerkship, signed by the instructor or facility program director.

Roy Silver	. a student
This is to deruny that	DENT'S NAME
of St George's University School of Medicine	, completed a
clerkship offered by Mayday University Hospital, Ma	nyday Road, Thornton Heath, Surrey.
CR7 7YE. UK	\sim
from 10 May 19 99 through	21 May 19 99 in the clinical area
of Cardiology	
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Dr Rupert Courtenay-Evans	being duty sworn, sayshe is/was the individual instructor or
program director for the student named above during the	clerkship indicated and thathe has carefully read and
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This facility Dis affiliated with a U.S. or International school	This facility does have an ACGME-accredited residency program
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EDICAL BOARD OF CALIFORNIA LICENSING PROGRAM 1426 Howe Avenue

1426 Howe Avenue Sacramento, CA 95825-3236 (916) 263-2499



CERTIFICATE OF CLINICAL TRAINING

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NOTE: This form may be omitted if all clinical training was done in the primary teaching rospital of the medical school and such hospital is located in the same country as the medical school and the medical school completes and certifies the Official Breakdown of Undergraduate Clinical Clerkships forms, Forms L5A/B.

Complete ONE certificate for EACH clerkship, signed by the instructor or facility program director.

This is to certify that	Roy Silver			,	, a student
•		ST Made and Market	UDENT'S NAME		
of St George's Un	iversity School o	r Medicine)		
clerkship offered by $\underline{}^{\underline{M}}$	Mayday University	Hospital, Ma	ayday Road, Th	ornton Heath	, Surrey.
	CR7 7YE. UK	NAME AND A	ADORESS OF FACILITY	61	
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MEDICAL BOARD OF CALIFORNIA LICENSING PROGRAM

1426 Howe Avenue Sacramento, CA 95825-3236 (916) 263-2499



CERTIFICATE OF CLINICAL TRAINING

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TE: This form may be omitted if all clinical training was done in the primary teaching hospital of the medical school and such hospital is located in the same untry as the medical school and the medical school completes and certifies the Official Breakdown of Undergraduate Clinical Clerkships forms, Forms L5A/

Complete ONE certificate for EACH clerkship, signed by the instructor or facility program director.

This is to certify that Roy SILVER	, a student
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Signed and sworn to before me this	day of, 19,
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MÉDICAL BOARD OF CALIFORNIA LICENSING PROGRAM 1426 Howe Avenue Sacramento, CA 95825-3236 (916) 263-2499



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Complete ONE certificate for EACH clerkship, signed by the instructor or facility program director,

This is to certify that Roy Silver
STUDENTS NAME
of St. George's University School of Medicine, Granada, completed a
clerkship offered by Arrowhead Regional Medical Center
400 North Pepper Avenue, Colton, CA 92324
from December 20 19 through January 14 00
of Family Medicine
CLINICAL AREA
•
Andre V. Blaylock, M.D.
program director for the student named above during the clerkship indicated and thathe has carefully read and completed this form and that the statements made herein are strictly true in every respect.
This facility is affiliated with a U.S. or international school. This facility is seen to be a set of the second o
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San Bernardino County My Comm. Expires Aug. 10, 2001 My Commission Expires
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MEDICAL BOARD OF CALIFORNIA LICENSING PROGRAM

1426 Howe Avenue Sacramento, CA 95825-3236 (916) 263-2499



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NOTE: This form may be contred if all clinical training was done in the primary teaching hospital of the medical school and such hospital is located in the same country as the medical school and the medical school completes and certifies the Official Breakdown of Undergraduate Clinical Clerkships forms, Forms L5A/B.

Complete ONE certificate for EACH clerkship, signed by the instructor or facility program director.

This is to certify that Roy SILVER STUDENT'S NAME of ST. George's UNIVERSITY School of Medicine completed a clerkship offered by Los Angeles County - USC Medical Center NAME AND ADDRESS OF FACILITY student A student
STUDENT'S NAME
of DI. George's UNIVERSITY School of Medicine completed a
MEDICAL SCHOOL
clerkship offered by Los Angeles County -USC Medical Conte
NAME AND ADDRESS OF FACILITY
from Nov. 8, 19 99 through Dec 19, 19 99 in the clinical area
DATE DATE
of Orthopaelic Surgery Clinical AREA
CLINICAL AREA
being duly sworn, says he is/was the individual instructor or
program director for the student named above during the clerkship indicated and thathe has carefully read and
completed this form and that the statements made herein are strictly true in every respect.
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This facility is affiliated with a U.S. or International school. This facility is down have an ACOME
is not it is facility of does have an ACGME-accredited residency program
Name of U.S. or International medical school, if affiliated:
☐ does <u>not</u> have an ACGME-accredited residency
program.
64 18MO PA
C. Thomas Vouscess, Dr., MD
TYPE OR PRINT NAME OF INSTRUCTOR OR FACILITY PROGRAM DIRECTOR
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
ADDRESS: NUMBER AND STREET
1 (2)(0) 1911/182 Los Angles CA 90033
ZIP CODE
(323)220-4346
YELEPHONE NUMBER SIGNATURE OF INSTRUCTOR/FACILITY PROGRAM DIRECTOR
3,1,1,1,1
NOTE: IN ABSENCE OF AN OFFICIAL HOSPITAL SEAL, THE INSTRUCTOR OR PROGRAM DIRECTOR MUST SIGN THIS FORM IN THE PRESENCE OF A NOTARY PUBLIC WHO AFFIXES HIS/HER OFFICIAL NOTARY SEAL.
OF A NOTARY PUBLIC WHO AFFIXES HIS/HER OFFICIAL NOTARY SEAL.
Signed and sworn to before me this day of, 19,
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NOTARY PUBLIC
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NOTARY PUBLIC OF ADDRESS ADDRESS
I Wy Commission Expires
07A-100-16 (Rev. 3/99)
07A-100-L6 (Rev. 3/99)



MEDICAL BOARD OF CALIFORNIA LICENSING PROGRAM 1426 Howe Avenue

Sacramento, CA 95825-3236 (916) 263-2499



CERTIFICATE OF CLINICAL TRAINING

(The completion of this form is required only of international medical school graduates.)

NOTE: This form may be omitted if all clinical training was done in the primary teaching hospital of the medical school and such hospital is located in the same country as the medical school <u>and</u> the medical school completes and certifies the Official Breakdown of Undergraduate Clinical Clerkships forms, Forms I,5A/B.

Complete QNE certificate for EACH clerkship, signed by the instructor or facility program director.

This is to certify that Lang STLVER	, a student
of ST GEORGE'S UNIVERSITY SOME MEDICAL SCHOOL	
	CHILDREN'S HOSPITAL
from Aug 16th 2000 through	
Of <u>PEDIATRICS</u> CUNICAL AREA	
program director for the student named above during the completed this form and that the statements in	
This facility 🗍 is affiliated with a U.S. or International school 🗇 is not Name of U.S. or International medical school, if affiliated:	This facility does have an ACGME-accredited residency program in the areas of: does not have an ACGME-accredited residency program,
TYPE OR PRINT NAME OF INSTRUCTION OR FACELY 3 1 00 50 0 ADDRESS: NUMBER AND STREET CTY TELEPHONE NAMEER	STATE TIP CODE STATE TIP CODE SIGNATURE OF HISTRUCTOR/FAGRITY PROGRAM DIRECTOR
NOTE: IN ABSENCE OF AN OFFICIAL HOSPITAL SEAL, THE INSTRUCTOR OF A NOTARY PUBLIC WHO AFFIXES HIS/HER OFFICIAL NOTARY SEAL Signer and swort to before me, this OFFICIAL NOTARY SEAL IRMA COTO COMMISSION NO. COSMIS 01A-100-LA RCV MISSION EXP. JULY 52003	m loto May -1000



GRAY DAVIS

MEDICAL BOARD OF CALIFORNIA LICENSING PROGRAM

1426 Howe Avenue Sacramento, CA 95825-3236 (916) 263-2499



CERTIFICATE OF CLINICAL TRAINING

(The completion of this form is required only of international medical school graduates.)

NOTE: This form may be omitted if all clinical training was done in the primary teaching hospital of the medical school and such hospital is located in the same country as the medical school and the medical school completes and certifies the Official Breakdown of Undergraduate Clinical Clerkships forms, Forms L5A/B.

Complete ONE certificate for EACH clerkship, signed by the instructor or facility program director.

This is to certify that Roy Silver	TUDENTS NAME., a student
	• • •
of St. George's University School of Medici	ne, completed a
clerkship offered by San Joaquin General Hospita	
12-22-1	ADDRESS OF FACILITY
500 W. Hospital Road F	rench Camp, Ca 95231
	
from January 17 , 2000 through	March 10 XXXX2000 in the clinical area
	DATE
of Medicine Sub-Internship	
CLINICAL AREA	
	hoing duly sworn save he leaves the individual instructor or
noncomm disposar for the student as and allowed the	being duly sworn, says he is/was the individual instructor or
program director for the student named above during the	
completed this form and that the statements	made herein are strictly true in every respect.
•	
This facility I is affiliated with a U.S. or International school	This facility Adoes have an ACGME-accredited residency program
☑ is <u>not</u>	inthe areas of: IM, FP, Surgery
Name of U.S. or International medical school, if affiliated:	
	does not have an ACGME-accredited residency
	program.
	· · · · · · · · · · · · · · · · · · ·
James K. Saffier,	M.D.
TYPE OR PRINT NAME OF INSTRUCTOR OR FACIL	
San Joaquin Gener	al Hognital
TYPE OR PRINT NAME OF INSTRUCTOR OR FACE. San Joaquin General ADDRESS: NUMBERAND STREET 500 W. Hospital Records City (200)	AL MODICAL
500 W Hoggital B	and To the or second
ory	pad French Camp. CA 95231
(200)	/ V //// A
(209) 468-6624.	SIGNATURE OF INSTRUCTOR FACILITY PROGRAM DIRECTOR
A CONTRACTOR OF THE PROPERTY O	SIGNAL OF ECH PROPRIES TO PROGRAM DIRECTOR
NOTE: IN ABSENCE OF AN OFFICIAL HOSPITAL SEAL, THE INSTRUCTOR	R OR PROGRAM DIRECTOR MUST SIGN THIS FORM IN THE PRESENCE
OF A NOTARY PUBLIC WHO AFFIXES HIS/HER OFFICIAL NOTARY SEAL.	
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MEDICAL BOARD OF CALIFORNIA LICENSING PROGRAM

1426 Howe Avenue Sacramento, CA 95825-3236 (916) 263-2499



CERTIFICATE OF CLINICAL TRAINING

(The completion of this form is required only of international medical school graduates.)

NOTE: This form may be omitted if all clinical training was done in the primary teaching hospital of the medical school and such hospital is located in the sa country as the medical school and the medical school completes and certifies the Official Breakdown of Undergraduate Clinical Clerkships forms, Forms L

Complete ONE certificate for EACH clerkship, signed by the instructor or facility program director.

State of College of Consumer Aligns

MEDICAL BOARD OF CALIFORNIA LICENSING PROGRAM 1426 Howe Avenue Sacramento, CA 95825-3236 (916) 263-2499



CERTIFICATE OF CLINICAL TRAINING

(The completion of this form is required only of international medical school graduates.)

THE THIS FORM MAY BE OMITTED IF ALL CLINICAL TRAINING WAS DONE IN THE PRIMARY TEACHING HOSPITAL OF THE MEDICAL SCHOOL AND SUCH HOSPITAL IS LOCATED IN THE SAME COUNTRY THE MEDICAL SCHOOL AND THE MEDICAL SCHOOL COMPLETES AND CERTIFIES THE OFFICIAL BREAKDOWN OF UNDERGRADUATE CLINICAL CLERKSHIPS FORMS, FORMS LEA/B.

Complete ONE certificate for EACH clerkship, signed by the Instructor or facility program director.

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being duly swom, says_he is/was the individual instructor program director for the student planed above during the clerkship indicated and that _he has carefully read and completed this form and that the statements made herein are strictly true in every respect. This facility is affiliated with a U.S. or International school This facility does have an ACGME-accredited residency program In the areas of In the are	om May	3 ⁹	20.00 through	June 2	, 20 <i>00</i> in th	ne clinical area
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STATE DEPARTMENT OF CONSUMER AFFAIRS INTERNET CASHIERING SYSTEM MEDICAL BOARD OF CALIFORNIA SUPPLEMENTAL INFORMATION REPORT From Date: 07/07/2009 To Date: 07/07/2009

ATRISUPPINF 20-AUG-15 15:09:30

Person Id: 1284654

Name:

Silver,Roy

Question	Answer	
I Have Completed Cme And Can Document Not Less Than 50 Hours Of Approved Cme For Year Period Immediately Preceding The Expiration Date Of My License, Or I Meet The Cond Which Would Exempt Me From All Or Part Of The Requirements.		YES
Have Completed 12 Hours Of Pain Management And End-Of-Life Care.		YES
I Am Exempt From The Completion Of 12 Hours Of Pain Management And End-Of-Life Card Continuing Education Requirement Because I Am A Radiologist Or Pathologist.		NO
Only For General Internists And Family Physicians Who Have 25% Of Their Patient Populat Years Or Older: I Have Completed At Least 20% Of The Required Cine In Geriatric Medicine Care Of Older Patients. Click No If Not Applicable.		NO
Enter Name/Address Of Facility Where You Or Your Immediate Family Hold Financial Intere "None", If None Held.	st. Type	NONE
I Certify Under Penalty Of Perjury Under The Laws Of The State Of California That The Information In This Application Is True And Correct.	mation	YES
I Have Read My Profile On The Medical Board Web Site At Www.Mbc.Ca.Gov And Acknowl Information Contained Therein As Current And Accurate.	edge The	YES
Since You Last Renewed Your License, Have You Had Any License Disciplined By A Gover Agency Or Other Disciplinary Body; Or, Have You Been Convicted Of Any Crime in Any Sta A And Its Territories, Military Court Or A Foreign Country?	nment te, The U.S	NO

Total Questions Asked For Person:

STATE DEPARTMENT OF CONSUMER AFFAIRS INTERNET CASHIERING SYSTEM MEDICAL BOARD OF CALIFORNIA SUPPLEMENTAL INFORMATION REPORT

From Date: 07/09/2011 To Date: 07/09/2011

ATRISUPPINF 20-AUG-15 14:51:09

Person Id:

1284654

Name:

Silver, Roy

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

Total Questions Asked For Person:

A And Its Territories, Military Court Or A Foreign Country?

1284654

8

STATE DEPARTMENT OF CONSUMER AFFAIRS INTERNET CASHIERING SYSTEM MEDICAL BOARD OF CALIFORNIA SUPPLEMENTAL INFORMATION REPORT From Date: 07/02/2013 To Date: 07/02/2013

ATRISUPPINF 20-AUG-15 14:46:26

Person Id:

1284654

Name:

Silver,Roy

Question	Answer	
I Have Completed Cme And Can Document Not Less Than 50 Hours Of Approved C Year Period Immediately Preceding The Expiration Date Of My License. Or I Meet T Which Would Exempt Me From All Or Part Of The Requirements.		YES
Have Completed 12 Hours Of Pain Management And End-Of-Life Care.		YES
I Am Exempt From The Completion Of 12 Hours Of Pain Management And End-Of-Continuing Education Requirement Because I Am A Radiologist Or Pathologist.	Life Care	NO
Only For General Internists And Family Physicians Who Have 25% Of Their Patient Years Or Older: I Have Completed At Least 20% Of The Required Cine In Geriatric Care Of Older Patients. Click No If Not Applicable.		NO
Enter Name/Address Of Facility Where You Or Your Immediate Family Hold Financi "None", If None Held.	al Interest. Type	NONE
Centify Under Penalty Of Perjury Under The Laws Of The State Of California That Contained in This Application is True And Correct.		YE9
Have Read My Profile On The Medical Board Web Site At Www.Mbc.Ca.Gov And Information Contained Therein As Current And Accurate.	Acknowledge The	YES
Since You Last Renewed Your License, Have You Had Any License Disciplined By Agency Or Other Disciplinary Body; Or, Have You Been Convicted Of Any Crime In A And its Territories, Military Court Or A Foreign Country?		NÖ

Total Questions Asked For Person:

8

Application Summary

7/7/15 12:23 PM Page 1 of 2 License Type: Physician and Surgeon A License Number: 92178 File Number: Application: Physician's and Surgeon's Renewal Application Number: Application Date: Personal Detail First Name: ROY Last Name: SILVER **/**/*** Birthdate: Gender: Male Addresses License Related Addresses Address of Record (Required) Warning: In order to protect your privacy and identity, address will not be displayed. Confidential Address Warning: In order to protect your privacy and identity, address will not be displayed. Questions Since you last renewed your license, have you had any license disciplined by a government agency or other disciplinary body, or, have you been convicted of any crime in any state, the U.S.A. and its territories, military court or a foreign country? Have you successfully completed, and can Yes 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 No

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 Volunta Voluntary Fee:	No
Attachments	
Physician Survey Are you retired?	No
Activities in Medicine	Administration - 10-19 Hours
	Patient Care - 40+ Hours
	Teaching - 10-19 Hours
Patient Care Practice Location	Zip: 90007 County: LOS ANGELES
Telemedicine Practice Location	Zip: County:
Patient Care Secondary Practice Location	Zip: 90048 County: LOS ANGELES
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
Cultural Background	White
Foreign Language Proficiency	Hebrew
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 p	processing until payment is received.

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: