STATE OF CALIFORNIA — STATE AND CONSUMER SERVICES AGENCY

84054 GRAY DAVIS, Governor

MEDICAL BOARD OF CALIFORNIA

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

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

805 9-1004

00143

APPLICATION FOR PHYSICIAN'S AND SURGEON'S LICENSE

CA SEP 13 3M 8 56

LICENSING PROGRAM

Please READ all instructions prior to completing this application. ALL 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.

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.

MBC USE ONLY

Personal Data

1. NAME: Last: SILVER First: ROY Middle:

2. Other names you have used (include maiden name):

3. U.S. Social Security Number*:

4A. (PUBLIC ADDRESS; will be released by the Board to the public): Number and Street/P.O. Box/Rural Route/Apartment Number, if any.

10525 Courtney Cove Ave.

City: Las Vegas State: NV Zip Code: 89144 Country: USA

4B. (CONFIDENTIAL ADDRESS): Number and Street/Rural Route/Apartment Number, if any. [Applicants must provide a confidential street address if a P. O. Box is used as the Public Address in #4A above.]

10525 Courtney Cove Ave.

City: Las Vegas State: NV Zip Code: 89144 Country: USA

5. Telephone Number:
Home: (
Work: (

6. California Driver's License Number (optional):
NUMBER EXPIRATION

7. Date of Birth (Month/Day/Year) and Place of Birth:

8. Sex: ☒ Male ☐ Female

9. Are you a U.S. citizen? ☒ Yes ☐ No

10. Have you ever filed an application for Physician's and Surgeon's examination or licensure in California?

IF YES, PLEASE GIVE DATE PREVIOUS APPLICATION WAS SUBMITTED. ☐ Yes ☒ No

Pre-Medical Education

11. List the names and locations of all colleges or universities attended where pre-professional, postsecondary instruction was received. Please submit official transcripts with the school seal affixed for each school attended. Transcripts will not be returned.

Name	City, State, Country	Dates of Attendance
BRANDEIS UNIV	WALTHAM, MA USA	08/91 - 05/94

Medical Education

L2 Trans

12. List the names and locations of all schools where professional medical instruction was received, and, where applicable, the degree awarded.
PLEASE SUBMIT: 1) an original Certificate of Medical Education (Form L2) and official transcripts with the signature of the dean or registrar and the school seal affixed from each school attended; and,
2) an original medical diploma and a 8 1/2" x 11" photocopy (original diploma will be returned).

School Name	City, State, Country	Dates of Attendance	Degree Awarded
St. George's Univ	Grenada, West Indies	08/96 - 06/00	MD

DOCTOR OF MEDICINE DEGREE, as referenced above.

Name of Medical School	Address of Medical School	Exact Date of Issuance
ST. George's Univ	Grenada, West Indies	06/16/00

* **MANDATORY DISCLOSURE OF U.S. SOCIAL SECURITY NUMBERS**
Disclosure of your U.S. social security number is mandatory. Section 30 of the Business and Professions Code and Public Law 94-455 (42 USCA 405(c)(2)(C)) authorize collection of your social security number. Your social security number will be used exclusively for tax enforcement purposes for purposes of compliance with any judgment or order for family support in accordance with Section 17520 of the Family Code or for verification of licensure or examination status by a licensing or examination entity which utilizes a national examination and where licensure is reciprocal with the requesting state. If you fail to disclose your social security number your application for initial licensure will not be processed AND you will be reported to the Franchise Tax Board, which may assess a $100 penalty against you.

MBC USE ONLY

School Code

L1A

07A-100 (Rev. 3/01)

MBC USE ONLY

13. Have you taken any of the following written examinations: National Boards, other state boards, USMLE, SPEX, FLEX, ECFMG or LMCC? ☒ Yes ☐ No

Written Examination

IF YES, LIST NAME, LOCATION, DATE AND RESULT OF EACH EXAMINATION; FAILURES MUST ALSO BE DISCLOSED. EACH EXAMINATION AGENCY MUST SUBMIT AN ORIGINAL OFFICIAL EXAMINATION HISTORY REPORT DIRECTLY TO THE MEDICAL BOARD OF CALIFORNIA. THESE REPORTS WILL NOT BE RETURNED.

Examination	Date	Result (Pass/Fail)

14. Have you ever been licensed to practice medicine in any state, territory, province, country, or U.S. federal jurisdiction? ☐ Yes ☒ No

License Data

IF YES, LIST THE JURISDICTION, LICENSE NUMBER, DATE ISSUED AND DATES OF PRACTICE IN THAT JURISDICTION. PLEASE INCLUDE PERMANENT, TEMPORARY, TRAINING, PROVISIONAL, LIMITED LICENSE, OR PERMIT. AN ORIGINAL OFFICIAL LETTER OF GOOD STANDING (LGS), OR COMPARABLE LICENSE HISTORY CERTIFICATION, IS REQUIRED FOR EACH PERMANENT, TEMPORARY, TRAINING, PROVISIONAL, LIMITED LICENSE, OR PERMIT OBTAINED IN ANY U.S. STATE, U.S. OR CANADIAN TERRITORY, CANADIAN PROVINCE, OR U.S. FEDERAL JURISDICTION. EACH LGS, OR COMPARABLE CERTIFICATION, SHOULD BE MAILED BY THE ISSUING AUTHORITY DIRECTLY TO THE MEDICAL BOARD OF CALIFORNIA.

LGS

Jurisdiction	License Number	Date of Issuance	Dates of Practice in that Jurisdiction

15. Do you hold any other professional license in any state, territory, province, country, or U.S. federal jurisdiction? ☐ Yes ☒ No

IF YES: PROFESSION: _____ LICENSE NO.: _____ JURISDICTION: _____

Other Professional Licenses

HAS THIS LICENSE EVER BEEN REVOKED, OR SUBJECT TO DISCIPLINE? IF YES, PLEASE PROVIDE ALL OFFICIAL DOCUMENTATION REGARDING THE MATTER IN ADDITION TO A WRITTEN EXPLANATION. YOU ARE ALSO REQUIRED TO REPORT ANY MATTER THAT IS PENDING OR IN WHICH CHARGES HAVE BEEN DROPPED OR EXPUNGED.

Yes No ☐

16A. Are you currently, or have you ever been, a participant in a postgraduate training program in a facility in the U.S. or Canada? (You must include every residency, internship, and fellowship, whether or not completed.) ☒ Yes ☐ No

Postgraduate Training

IF YES, LIST NAMES AND ADDRESSES OF ALL FACILITIES. SUBMIT AN ORIGINAL CERTIFICATE OF COMPLETION OF ACGME/RCPSC POSTGRADUATE TRAINING (FORM L3A) FROM EACH FACILITY. (DO NOT COMPLETE FORM L3AS TO DOCUMENT TRAINING RECEIVED IN RESEARCH FELLOWSHIP PROGRAMS.) ALL TRAINING MUST BE LISTED, REGARDLESS OF WHETHER IT WAS SATISFACTORILY COMPLETED OR WILL BE USED TO MEET LICENSING REQUIREMENTS.

Facility Name	Address	Categorial Specialty Area	Dates of Attendance
New York Univ - Downtown Hosp.		OB/Gyn	11/00 – 07/01
University Medical Center	2040 W. Charleston Blvd Ste 200 Las Vegas NV 89102	OB/Gyn	07/01 – Present

QUESTIONS 16B through 23:
If you answer YES to any of the following questions, please provide ALL official documentation regarding the matter in addition to your written personal explanations. An applicant must provide official hearing/court documents and original letters of explanation from medical schools or training program directors. If these documents are not provided with the application, they will be requested before review of the application can proceed. APPLICANTS ARE REQUIRED TO REPORT ANY MATTER THAT IS PENDING OR IN WHICH CHARGES HAVE BEEN DROPPED OR EXPUNGED.

16B. Have you ever withdrawn from, or been suspended, dismissed or expelled from a medical school or postgraduate training program OR have you ever taken a leave of absence from such a school or program?

IF YOU ANSWERED YES, BOTH APPLICANT AND SCHOOL/PROGRAM MUST PROVIDE DETAILS ON A SEPARATE ATTACHMENT. Yes No ☐

NAME OF APPLICANT: Roy [redacted] LVOR

DATE OF [redacted]H:

MBC USE ONLY

License Data

For all of the below, also include any disciplinary actions by the U.S. Military, U.S. Public Health Service, or other U.S. federal governmental entity.

17A. Have you ever been charged with, or been found to have committed, unprofessional conduct, professional incompetence, gross negligence, or repeated negligent acts or malpractice by any medical licensing board, other agency, or hospital?

17B. Has any disciplinary action ever been filed or taken, including but not limited to, informal or confidential discipline, consent orders, or letters of warning, regarding any healing arts license which you now hold or have ever held?

17C. Is any such action as described above pending?

17(A) Yes No ☑

17(B) Yes No ☑

17(C) Yes No ☑

IF YOU ANSWERED YES TO 17A, 17B OR 17C, PROVIDE DETAILS ON A SEPARATE ATTACHMENT.

18. Has a claim or action for damages ever been filed against you in the course of the practice of medicine or any other healing art which resulted in a malpractice settlement, judgement, or arbitration award of over $30,000.00?

Yes No ☑

IF YOU ANSWERED YES, PROVIDE DETAILS ON A SEPARATE ATTACHMENT.

19. Have you ever been denied a license, permission to practice medicine or any other healing art, or denied permission to take an examination in any state, territory, country, or U.S. federal jurisdiction, or is any such action pending?

Yes No ☑

IF YOU ANSWERED YES, PROVIDE DETAILS ON A SEPARATE ATTACHMENT.

20. Have you ever voluntarily surrendered a license to practice medicine or any other healing arts in this or any other state, or voluntarily surrendered your narcotic (controlled substance) permit (state or federal) to any licensing board or any other agency, or is any such action pending?

Yes No ☑

IF YOU ANSWERED YES, PROVIDE DETAILS ON A SEPARATE ATTACHMENT.

21. Have you ever had staff privileges in a hospital denied, suspended, limited, revoked, or not renewed for medical disciplinary cause, or resigned from a medical staff in lieu of disciplinary or administrative action, or is any such action pending?

Yes No ☑

YOU MUST DISCLOSE ANY INFORMAL OR CONFIDENTIAL DISCIPLINARY ACTION.

22. Do you have any condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety, including but not limited to, any of the following?

Yes No ☑

IF YES, PLEASE CHECK THE APPROPRIATE BOX(ES) BELOW:

- ☐ A condition which required admission to an inpatient psychiatric treatment facility.
- ☐ Alcohol or chemical substance dependency or addiction.
- ☐ Emotional, mental or behavioral disorder.
- ☐ Other (explain): _____

FOR ANY OF THE BOXES CHECKED ABOVE, PLEASE SUBMIT COMPLETE OFFICIAL INPATIENT AND OUTPATIENT TREATMENT RECORDS, EVIDENCE OF ONGOING REHABILITATION TREATMENT, AND A PERSONAL WRITTEN EXPLANATION.

FOR ALL OF THE BELOW, YOU ARE REQUIRED TO LIST ANY CONVICTION THAT HAS BEEN SET ASIDE AND DISMISSED OR EXPUNGED, OR WHERE A STAY OF EXECUTION HAS BEEN ISSUED.

23A. Have you ever been convicted of, or pled nolo contendere to, ANY violation (include every misdemeanor or felony) of any local, state, or federal law of any state, territory, country, or U.S. federal jurisdiction?

23B. Is any criminal action related to the above pending?

23 (A) Yes No ☑

23 (B) Yes No ☑

IF YOU ANSWERED YES TO 23A OR 23B, PROVIDE DETAILS ON A SEPARATE ATTACHMENT.

NAME OF APPLICANT: Roy Silver

DATE OF BIRTH:

L1C

[redacted]

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 and NOTARY

STATE OF NEVADA

COUNTY OF CLARK

The applicant, ROY SILVER (PLEASE PRINT FULL NAME), [redacted] (DATE OF BIRTH), being first duly sworn upon his/her oath 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: [signature] (PLEASE SIGN FULL NAME, NOT INITIALS)

Signed and sworn to before me this 12 day of August (MONTH) 2004 (YEAR)

CAROL A. ALLEN
Notary Public State of Nevada
No. 02-75388-1
My appt. exp. June 3, 2006

NOTARY SEAL

[signature]
SIGNATURE OF NOTARY PUBLIC

2040 W. Charleston Blvd. #200 Las Vegas, NV 89102
ADDRESS

My commission expires 6/3/2006

07A-100 (Rev. 3/01)

L1D

Consumer Affairs

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-MM/DD/YYYY)

enrolled in St Georges University School of Med (NAME OF MEDICAL SCHOOL) Grenada, West Indies (LOCATION)

on the 16 / 19 day of June / August (MONTH) 2000 / 1996 (YEAR) 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 9 terms for 12-18 Wks Ord 2 terms of 6 (NUMBER OF YEARS) years of resident instruction of ____ (NUMBER OF WEEKS) weeks each, completing at least 4,000 hours, of which at least 80 percent actual attendance is required, in the subjects set forth hereunder (Business and Professions Code Section 2089), and that the applicant:

☒ was granted the degree Bachelor/Doctor of Medicine by OR ☐ withdrew from

the above mentioned medical school on the 16 RE day of June (MONTH) 2000 (YEAR)

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

MEDICAL SCHOOL SEAL MUST BE IMPRINTED BELOW.

ATTENTION MEDICAL SCHOOL: The person who signs this form MAY NOT be related to the applicant by blood, marriage or adoption.

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 last 12 months.

Signed and the school seal affixed this 16 RE day of August (MONTH) 2004 (YEAR)

BY ____ (PRESIDENT, DEAN, OR REGISTRAR)

Margaret A. Lambert
Dean of Enrollment Planning
University Registrar

L2

07A-100-L2 (Rev. 3/01)

STATE OF CALIFORNIA — STATE AND CONSUMER SERVICES AGENCY

GRAY DAVIS, Governor

Consumer Affairs

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04 JAN 13 AM 9:38
LICENSING

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.

ATTENTION PROGRAM DIRECTORS AND DIRECTORS OF MEDICAL EDUCATION: THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE, OR ADOPTION. Only the Program Director or the Director of Medical Education may sign this form. If that signature authority is being delegated to another person, evidence of that delegation must be attached to this form (may be a photocopy). Such delegation must be on official letterhead and must be dated within the last 12 months.

PART 1: To be completed by the APPLICANT

LAST NAME of Applicant	First Name	Middle Initial
SILVER	BOY	

U.S. Social Security Number	Date of Birth: MM/DD/YYYY	Telephone Number: Home:	Work:

Current Address: 10525 Courtney Cove Ave.

City	State	Zip Code
Las Vegas	NV	89144

PART 2: To be completed by the PROGRAM DIRECTOR

ATTENTION PROGRAM DIRECTOR: Do not sign and date this form before the last day of any postgraduate training year which will be used by the applicant to qualify for licensure. Completion of this form will certify that the individual named in PART 1 above completed a period of accredited postgraduate training at this facility. If a period of training WAS NOT completed in a satisfactory manner, please provide a separate detailed narrative explanation. The following information is provided to certify "satisfactory" completion. PLEASE SEE THE REVERSE FOR A DEFINITION OF "SATISFACTORY."

Name of Facility:	Address of Facility:
NYU Downtown Hospital	170 William St. NY NY 10038

Name of Program Director:	Telephone Number:
Frank A. Benning, MD OK	(212) 312-5840

Signature of Program Director:	Date Signed:
	Dec 29/03 ✓

Unit Categorical Specialty Area of Training Completed by Trainee:	Date Training Commenced:	Date Training Completed:
Obstetrics & Gynecology	11 | 6 | 00 ✓	6 | 30 | 01 ✓

If the training was rotating or transitional, list the specific rotations and the number of weeks spent in each (SEE THE REVERSE FOR INFORMATION ON SATISFYING THE GENERAL MEDICINE TRAINING REQUIREMENT):

PART 3: To be completed by the DIRECTOR OF MEDICAL EDUCATION and affixed with the official facility seal.

Name of the Director of Medical Education:	Name of Facility:
Warren Light, MD	NYU Downtown Hospital

Address of Facility: 170 William Street

City	State	Zip Code	Telephone Number:
New York	NY	10038	(212) 312-5790

PART 4: Signature of DIRECTOR OF MEDICAL EDUCATION certifying satisfactory completion of training

Attention: Director of Medical Education! *Do not sign and date this form before the last day of any postgraduate training year which will be used by the applicant to qualify for licensure. This form may be signed by the current Director of Medical Education; it does not need to be signed by the person who was the Director of Medical Education at the time of the training listed above.*

Notice to Applicant: If this form is used to verify postgraduate training beyond that which is required for licensure, this form can be signed by the Director of Medical Education and the Program Director before the final day of training. However, if you are licensed after the date upon which training was completed AND if the form was signed before the final day of the training year, a new form must be completed and submitted to the Medical Board of California.

HOSPITAL OR NOTARY SEAL

OFFICIAL HOSPITAL SEAL OR NOTARY SEAL, DATE AND SIGNATURE MUST BE AFFIXED IN THE BOX TO THE LEFT TO CERTIFY TRAINING.

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

Signature of Director of Medical Education:	Date Signed:
	1/5/04

L3A

07A-100-L3 (Rev. 0611)

STATE OF CALIFORNIA — STATE AND CONSUMER SERVICES AG — GRAY DAVIS, Governor

Consumer Affairs

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

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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.

ATTENTION PROGRAM DIRECTORS AND DIRECTORS OF MEDICAL EDUCATION: THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE, OR ADOPTION. Only the Program Director and the Director of Medical Education may sign this form. If that signature authority is being delegated to another person, evidence of that delegation must be attached to this form (may be a photocopy). Such delegation must be on official letterhead and must be dated within the last 12 months.

PART 1: To be completed by the APPLICANT.

LAST NAME of Applicant	First Name	Middle Initial
SILVER	BOY	

U.S. Social Security Number:	Date of Birth: MM/DD/YYYY	Telephone Number:
[redacted]	[redacted]	Home: (Work: (

Current Address: 10525 Courtney Cove Ave.

City	State	Zip Code
Las Vegas	NV	89144

PART 2: To be completed by the PROGRAM DIRECTOR.

ATTENTION PROGRAM DIRECTOR! Do not sign and date this form before the last day of any postgraduate training year which will be used by the applicant to qualify for licensure. Completion of this form will certify that the individual named in PART 1 above completed a period of accredited postgraduate training at this facility. If a period of training WAS NOT completed in a satisfactory manner, please provide a separate detailed narrative explanation. The following information is provided to certify "satisfactory" completion. PLEASE SEE THE REVERSE FOR A DEFINITION OF "SATISFACTORY."

Name of Facility:	Address of Facility:
UNIV. OF NEVADA SCHOOL OF MEDICINE	2040 W. CHARLESTON BLVD, STE 200

Name of Program Director:	Telephone Number:
JOSEPH A. ROJAS, SR, M.D. OK	(702) 671-2300

Signature of Program Director:	Date Signed:
Joseph A Rojas sr MD	

List Categorical Specialty Area of Training Completed byTrainee:	Date Training Commenced:	Date Training Completed:
OB/GYN	7/1/2001 ✓	10/31/04 ✓

If the training was rotating or transitional, list the specific rotations and the number of weeks spent in each (SEE THE REVERSE FOR INFORMATION ON SATISFYING THE GENERAL MEDICINE TRAINING REQUIREMENT):

PART 3: To be completed by the DIRECTOR OF MEDICAL EDUCATION and affixed with the official facility seal.

Name of the Director of Medical Education:	Name of Facility:
STANLEY M. KIRSON	UNIV. NEV. SOM

Address of Facility: 2040 W CHARLESTON BLVD

City	State	Zip Code	Telephone Number:
LAS VEGAS	NV	89102	(702) 671 6407

PART 4: Signature of DIRECTOR OF MEDICAL EDUCATION certifying satisfactory completion of training.

Attention: Director of Medical Education! *Do not sign and date this form before the last day of any postgraduate training year which will be used by the applicant to qualify for licensure. This form may be signed by the current Director of Medical Education; it does not need to be signed by the person who was the Director of Medical Education at the time of the training listed above.*

Notice to Applicant: If this form is used to verify postgraduate training beyond that which is required for licensure, this form can be signed by the Director of Medical Education and the Program Director before the final day of training. However, if you are licensed after the date upon which training was completed AND if the form was signed before the final day of the training year, a new form must be completed and submitted to the Medical Board of California.

HOSPITAL OR NOTARY SEAL

CAROL A. ALLEN
Notary Public State of Nevada
No. 02-75388-1
My appt. exp. June 3, 2005

Carol A. Allen
8/13/04

OFFICIAL HOSPITAL SEAL OR NOTARY SEAL, DATE AND SIGNATURE MUST BE AFFIXED IN THE BOX TO THE LEFT TO CERTIFY TRAINING.

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

Signature of Director of Medical Education:	Date Signed:
Stanley M Kirson	8/13/04

L3A

07A-100-L3 (Rev. 3/01)

State of California Department of Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
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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 Roy Slaver (Name of Applicant) _____ (U.S. Social Security Number)

_____ (Date of Birth MM/DD/YYYY) is in an approved ACGME/RCPSC postgraduate training position that commenced on November (Month) 1 (Day) 2000 (Year) and is expected to be completed on October (Month) 31 (Day) 2004 (Year) in Obstetrics / Gynecology (Type of Training)

at University Medical Center Dept of OB/Gyn (Name and Address of Facility)
2040 W. Charleston, Ste 200
Las Vegas NV 89102

ATTENTION DIRECTORS OF MEDICAL EDUCATION: THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE, OR ADOPTION.

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

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

JOSEPH A. ROJAS, SR. M.D.
(Type or print name of Director of Medical Education)

(Signature of Director of Medical Education)

8/13/04
(Date)

702-671-2300
(Telephone Number)

CAROL A. ALLEN
Notary Public State of Nevada
No. 02-75388-1
My appt. exp. June 3, 2006

Carol A Allen 8/13/04

OFFICIAL HOSPITAL SEAL, OR NOTARY SEAL (WITH DATE AND NOTARY'S SIGNATURE) MUST BE AFFIXED IN THE BOX AT THE LEFT.

NOTE: Do not use this form in lieu of Form L3A, "Certificate of Completion of ACGME/RCPSC Postgraduate Training."

L4

Consumer Affairs

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

OFFICIAL BREAKDOWN OF UNDERGRADUATE CLINICAL CLERKSHIPS

(The completion of this form is required only of international medical school graduates. Please complete this form in the English language.)

Name of Applicant (type or print FULL name):	U.S. Social Security Number:
ROY SILVER	Date of Birth-MM/DD/YYYY:

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.

UNDERGRADUATE CLINICAL CLERKSHIPS

(Please list ALL clinical training completed prior to issuance of your medical degree in the area below and on the reverse of this form. List training in date/chronological order, commencing with the first clinical year of training.)

CLINICAL SUBJECT AREA	FACILITY NAME AND ADDRESS	DATES OF ATTENDANCE FROM – TO (Month/Day/Year)	WEEKS OR WEEKLY HOURS OF CREDIT
Medicine I	Royal Hampshire City Hosp. Winchester, Hampshire, UK	OL 10/26/98 – 11/20/98	4 ✓
Medicine II	Mayday University Hospital Thornton Heath, Surrey, UK	OL 11/23/98 – 02/12/99	12 ✓
Surgery	Mayday University Hospital Thornton Heath Surrey UK	OL 02/15/99 – 05/07/99	12 ✓
Cardiovascular Diseases / medicine	Same as above	OL 05/10/99 – 05/21/99	2
OB/Gyn	Same as above	OL 05/24/99 – 07/02/99	6 ✓
Psychiatry	Barnet General Hospital Barnet Herts UK	OL 07/05/99 – 08/13/99	6 ✓

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

Only the 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 last 12 months.

MEDICAL SCHOOL SEAL

I, Margaret A. Lambert
Dean of Enrollment Planning
University Registrar
FULL NAME of Dean or Registrar (TYPE OR PRINT)

declare under penalty of perjury, that I am/was the Dean or Registrar for the student named above and that I have carefully read this form and that the statements made herein are strictly true in every respect.

Margaret A. Lambert
Signature of Dean or Registrar

8/16/04
Date

L5A

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.)

Name of Applicant (type or print FULL name):	U.S. Social Security Number:
Roy Silva	Date of Birth-MM/DD/YYYY:

UNDERGRADUATE CLINICAL CLERKSHIPS

CLINICAL SUBJECT AREA	FACILITY NAME AND ADDRESS	DATES OF ATTENDANCE FROM – TO (Month/Day/Year)	WEEKS OR WEEKLY HOURS OF CREDIT
pediatrics	Miami Children's Hospital Miami FL OK	08/16/99 – 09/24/99	6 ✓
orthopedics surgery/	Univ of Southern CA Los Angeles, CA OK	11/08/99 – 12/17/99	6 ✓
FAMILY PRACTICE	Arrowhead Regional med ctr San Bernadino, CA OK	12/20/99 – 01/14/00	4 ✓
medicine	San Joaquin General Hospital Stockton CA OK	01/12/00 – 03/10/00	8 ✓
OB/Gyn	Brooklyn Hospital Brooklyn ny OK	03/13/00 – 04/07/00	4 ✓
OB/Gyn	Long Island college Hospital Brooklyn ny OK	04/10/00 – 05/05/00	4 ✓
pediatrics	Miami Children's Hospital Miami Florida OK	05/08/00 – 06/02/00	4 ✓
OB/Gyn	Long Island College Hospital Brooklyn ny OK	06/05/00 – 06/16/00	2 ✓

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

Only the 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 last 12 months.

MEDICAL SCHOOL SEAL

I, Margaret A. Lambert, Dean of Enrollment Planning, University Registrar
FULL NAME of Dean or Registrar (Please TYPE OR PRINT)

declare under penalty of perjury that I am/was the Dean or Registrar for the student named above and that I have carefully read this form and that the statements made herein are strictly true in every respect.

Signature of Dean or Registrar — Date: 8/16/04

L5B

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

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

Consumer Affairs

CERTIFICATE OF CLINICAL TRAINING

The completion of this form is required only 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 L5A/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 Ray Silver
STUDENT'S NAME

SS SOCIAL SECURITY NO

DATE OF BIRTH-MM/DD/YYYY

a student of St. George's University School of Medicine
MEDICAL SCHOOL

completed a clerkship offered by Long Island College Hospital
NAME AND ADDRESS OF FACILITY

339 Hicks Street, Brooklyn, N.Y. 11201

from 4 (MONTH) 10 (DAY) 00 (YEAR) through 5 (MONTH) 5 (DAY) 00 (YEAR) in the clinical area

of (03)
CLINICAL AREA

This facility ☑ is affiliated with a U.S. or International school
☐ is not affiliated with a U.S. or International school
Name of U.S. or International medical school, if affiliated:
SUNY DOWNSTATE MEDICAL CENTER @ BROOKLYN

This facility ☑ does have an ACGME-accredited residency program in the areas of: Medicine/Pediatrics
☐ does not have an ACGME-accredited residency program.

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 on official letterhead and must be dated within the last 12 months.

I, Daniel D Ricciardi, *swear or affirm that I am/was the the individual facility program director or instructor for the student named above during the clerkship indicated and that I have carefully read and completed this form and that the statements made herein are strictly true in every respect.*

Official Hospital Seal

Daniel D. Ricciardi MD
TYPE OR PRINT NAME OF FACILITY PROGRAM DIRECTOR OR INSTRUCTOR

339 Hicks Street
ADDRESS NUMBER AND STREET

Brooklyn, N.Y. 11201
CITY STATE ZIP CODE

(718) 780-1206
TELEPHONE NUMBER

SIGNATURE OF FACILITY PROGRAM DIRECTOR OR INSTRUCTOR

NOTE: IN ABSENCE OF AN OFFICIAL HOSPITAL SEAL, THE FACILITY PROGRAM DIRECTOR OR 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 _____
MONTH YEAR

Notary Seal

NOTARY PUBLIC

ADDRESS

My Commission Expires _____

L6

STATE OF CALIFORNIA — STATE AND CONSUMER SERVICES AGENCY

PETE WILSON, Governor

State of California Department of Consumer Affairs

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.

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 Roy Silver (STUDENT'S NAME), a student of St George's University School of Medicine (MEDICAL SCHOOL), completed a clerkship offered by Royal Hampshire County Hospital, Romsey Road, Winchester, Hampshire, SO22 5DG. UK (NAME AND ADDRESS OF FACILITY) from 26 October (DATE), 19 98 through 20 November (DATE), 19 98 in the clinical area of Medicine (CLINICAL AREA).

Mr Michael Buckingham ~~being duly sworn~~, says he is/was the individual instructor or program director for the student named 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 ☐ is not affiliated with a U.S. or International school

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.

POSTGRADUATE MEDICAL CENTRE
ROYAL HAMPSHIRE COUNTY HOSPITAL
WINCHESTER
HANTS SO22 5DG
TEL: 01962 824422
FAX: 01962 825168

Official Hospital Seal

Mr Michael Buckingham
TYPE OR PRINT NAME OF INSTRUCTOR OR FACILITY PROGRAM DIRECTOR

Royal Hampshire County Hospital
ADDRESS: NUMBER AND STREET

Romsey Road, Winchester, Hampshire. SO22 5DG. UK
CITY STATE ZIP CODE

01962 863535
TELEPHONE NUMBER

M Buckingham
SIGNATURE OF INSTRUCTOR/FACILITY PROGRAM DIRECTOR

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.

Signed ~~and sworn to before me~~ this 31st day of August, 19 99.

Notary Seal

NOTARY PUBLIC

ADDRESS

My Commission Expires

L6

07A-100-L 6/98 rev. 2/07)

State of California Department of Consumer Affairs

ICAL 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.

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 Roy Silver (STUDENT'S NAME), a student of St George's University School of Medicine (MEDICAL SCHOOL), completed a clerkship offered by Mayday University Hospital, Mayday Road, Thornton Heath, Surrey. CR7 7YE. UK (NAME AND ADDRESS OF FACILITY) from 23 November (DATE) 19 98 through 12 February (DATE) 19 99 in the clinical area of Medicine (CLINICAL AREA)

Dr Rupert Courtenay-Evans ~~being duly sworn~~, says he is/was the individual instructor or program director for the student named 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 ☐ is not affiliated with a U.S. or International school
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.

CROYDON CHEST CLINIC
Mayday University Hospital
Mayday Road
Thornton Heath CR7 7YE
Official Hospital Seal

Dr Rupert Courtenay-Evans
TYPE OR PRINT NAME OF INSTRUCTOR OR FACILITY PROGRAM DIRECTOR

Mayday University Hospital
ADDRESS: NUMBER AND STREET

Mayday Road, Thornton Heath, Surrey. CR7 7YE. UK
CITY STATE ZIP CODE

0181 401 3137
TELEPHONE NUMBER

SIGNATURE OF INSTRUCTOR/FACILITY PROGRAM DIRECTOR

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.

Signed ~~and sworn to before~~ me this 14th day of August, 19 99.

Notary Seal

NOTARY PUBLIC

ADDRESS

My Commission Expires

L6

State of California Department of Consumer Affairs

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

CERTIFICATE OF CLINICAL TRAINING

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

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 Roy Silver (STUDENT'S NAME), a student of St George's University School of Medicine (MEDICAL SCHOOL), completed a clerkship offered by Mayday University Hospital, Mayday Road, Thornton Heath, Surrey. CR7 7YE. UK (NAME AND ADDRESS OF FACILITY) from 15 February (DATE), 1999 through 7 May (DATE), 1999 in the clinical area of Surgery (CLINICAL AREA).

Dr Rupert Courtenay-Evans ~~being duly sworn~~, says he is/was the individual instructor or program director for the student named 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 ☐ is not affiliated with a U.S. or International school

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.

CROYDON CHEST CLINIC
Mayday University Hospital
Mayday Road
Thornton Heath CR7 7YE
Official Hospital Seal

Dr Rupert Courtenay-Evans
TYPE OR PRINT NAME OF INSTRUCTOR OR FACILITY PROGRAM DIRECTOR

Mayday University Hospital
ADDRESS: NUMBER AND STREET

Mayday Road, Thornton Heath, Surrey. CR7 7YE. UK
CITY STATE ZIP CODE

0181 401 3137
TELEPHONE NUMBER

SIGNATURE OF INSTRUCTOR/FACILITY PROGRAM DIRECTOR

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.

Signed and ~~sworn to before me~~ this 14th day of August, 19 99.

Notary Seal

NOTARY PUBLIC

ADDRESS

My Commission Expires

L6

STATE OF CALIFORNIA — STATE AND CONSUMER SERVICES AGENCY PETE WILSON, Governor

State of California Department of Consumer Affairs

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

CERTIFICATE OF CLINICAL TRAINING

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

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This is to certify that Roy Silver (STUDENT'S NAME), a student of St George's University School of Medicine (MEDICAL SCHOOL), completed a clerkship offered by Mayday University Hospital, Mayday Road, Thornton Heath, Surrey. CR7 7YE. UK (NAME AND ADDRESS OF FACILITY) from 10 May (DATE) 19 99 through 21 May (DATE) 19 99 in the clinical area of Cardiology (CLINICAL AREA).

Dr Rupert Courtenay-Evans ~~being duly sworn~~, says he is/was the individual instructor or program director for the student named 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 ☐ is not affiliated with a U.S. or International school
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.

CROYDON CHEST CLINIC
Mayday University Hospital
Mayday Road
Thornton Heath CR7 7YE
Official Hospital Seal

Dr Rupert Courtenay-Evans
TYPE OR PRINT NAME OF INSTRUCTOR OR FACILITY PROGRAM DIRECTOR

Mayday University Hospital
ADDRESS: NUMBER AND STREET

Mayday Road, Thornton Heath, Surrey. CR7 7YE. UK
CITY STATE ZIP CODE

0181 401 3137
TELEPHONE NUMBER

SIGNATURE OF INSTRUCTOR/FACILITY PROGRAM DIRECTOR

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.

Signed ~~and sworn to before me~~ this 14th day of August, 19 99.

Notary Seal

NOTARY PUBLIC

ADDRESS

My Commission Expires

L6

07A-100.1 4/87 rev. 2/97)

State of California Department of Consumer Affairs

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.

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 Roy Silver (STUDENT'S NAME), a student of St George's University School of Medicine (MEDICAL SCHOOL), completed a clerkship offered by Mayday University Hospital, Mayday Road, Thornton Heath, Surrey. CR7 7YE. UK (NAME AND ADDRESS OF FACILITY) from 24 May (DATE), 1999 through 2 July (DATE), 1999 in the clinical area of Obstetrics & Gynaecology (CLINICAL AREA).

Dr Rupert Courtenay-Evans ~~being duly sworn~~, says he is/was the individual instructor or program director for the student named 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 ☐ is not affiliated with a U.S. or International school
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.

CROYDON CHEST CLINIC
Mayday University Hospital
Mayday Road
Thornton Heath CR7 7YE
Official Hospital Seal

Dr Rupert Courtenay-Evans
TYPE OR PRINT NAME OF INSTRUCTOR OR FACILITY PROGRAM DIRECTOR

Mayday University Hospital
ADDRESS: NUMBER AND STREET

Mayday Road, Thornton Heath, Surrey. CR7 7YE. UK
CITY STATE ZIP CODE

0181 401 3137
TELEPHONE NUMBER

SIGNATURE OF INSTRUCTOR/FACILITY PROGRAM DIRECTOR

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.

Signed ~~and sworn to before me~~ this 14th day of August, 1999

Notary Seal

NOTARY PUBLIC

ADDRESS

My Commission Expires

L6

State of California Department of Consumer Affairs

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/

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

ILY UNDERGRADUATE CLINICAL CLERKSHIPS IN WHICH THE APPLICANT PARTICIPATED IN DIRECT, HANDS-ON DIAGNOSIS OR TREATMENT OF TIENTS IN A CLINICAL SETTING SHOULD BE REPORTED ON THIS FORM. ANY CLINICAL CLERKSHIPS COMPLETED THAT DO NOT MEET THE OVE CRITERIA SHOULD NOT BE REPORTED ON THIS FORM AS THEY WILL NOT SATISFY CALIFORNIA'S CLINICAL TRAINING REQUIREMENTS.

This is to certify that Roy SILVER (STUDENT'S NAME), a student of St. George's University School of Medicine (MEDICAL SCHOOL), completed a clerkship offered by Barnet General Hospital (NAME AND ADDRESS OF FACILITY) London Uk. Barnet EN5 3DJ from _____ (DATE), 19____ through _____ (DATE), 19____ in the clinical area of Psychiatry (CLINICAL AREA).

Dr. L Ratna *being duly sworn, says he is/was the individual instructor or program director for the student named 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 ☐ is not affiliated with a U.S. or International school
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.

DR. L. RATNA
CONSULTANT PSYCHIATRIST
BARNET GENERAL HOSPITAL
WELLHOUSE LANE
BARNET, HERTS. EN5 3DJ
Official Hospital Seal

Dr. L. RATNA
TYPE OR PRINT NAME OF INSTRUCTOR OR FACILITY PROGRAM DIRECTOR
BARNET GENERAL HOSPITAL
ADDRESS, NUMBER AND STREET
LONDON, U.K. BARNET EN5 3DJ
STATE ZIP CODE
0181 216 4617
TELEPHONE NUMBER
SIGNATURE OF INSTRUCTOR/FACILITY PROGRAM DIRECTOR

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.

Signed and sworn to before me this _____ day of _____, 19____.

Notary Seal

NOTARY PUBLIC

ADDRESS

My Commission Expires _____

L6

L-100-L6 (Rev. 3/99)

State of California Department of Consumer Affairs

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.

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 Roy Silver (STUDENT'S NAME), a student of St. George's University School of Medicine, Grenada (MEDICAL SCHOOL), completed a clerkship offered by Arrowhead Regional Medical Center

400 North Pepper Avenue, Colton, CA 92324 (NAME AND ADDRESS OF FACILITY) OK

from December 20 (DATE) 19 99 through January 14 (DATE) 19 00 in the clinical area of Family Medicine (CLINICAL AREA)

Andre V. Blaylock, M.D. *being duly sworn, says he is/was the individual instructor or program director for the student named 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 ☐ is not affiliated with a U.S. or international school

Name of U.S. or international medical school, if affiliated:

UC Irvine

This facility ☒ does have an ACGME-accredited residency program in the areas of: Family Medicine

☐ does not have an ACGME-accredited residency program.

Official Hospital Seal

Arrowhead Regional Medical Center
TYPE OR PRINT NAME OF INSTRUCTOR OR FACILITY PROGRAM DIRECTOR

400 North Pepper Avenue
ADDRESS NUMBER AND STREET

Colton, CA 92324
CITY STATE ZIP CODE

(909) 580-6268
TELEPHONE NUMBER

Andre V. Blaylock
SIGNATURE OF INSTRUCTOR/FACILITY PROGRAM DIRECTOR

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.

Signed and sworn to before me this 26th day of January 2000

SALLY CLARK
Comm. # 1150861
NOTARY PUBLIC - CALIFORNIA
San Bernardino County
My Comm. Expires Aug. 10, 2001

Notary Seal

Sally C. Clark
NOTARY PUBLIC

400 N. Pepper Avenue
Colton, CA 92324-1919
ADDRESS

My Commission Expires 8/10/2001

L6

07A-100-L6 (Rev. 2/97)

State of California Department of Consumer Affairs

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.

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 Roy SILVER (STUDENT'S NAME), a student of ST. George's UNIVERSITY School of Medicine (MEDICAL SCHOOL), completed a clerkship offered by Los Angeles County - USC Medical Center (NAME AND ADDRESS OF FACILITY)

from Nov. 8 (DATE), 19 99 through Dec 19 (DATE), 19 99 in the clinical area of Orthopaedic Surgery (CLINICAL AREA).

C. Thomas Vaughan, Jr., MD *being duly sworn, says he is/was the individual instructor or program director for the student named 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 ☐ is not affiliated with a U.S. or International school

Name of U.S. or International medical school, if affiliated:

This facility ☒ does have an ACGME-accredited residency program in the areas of: ORTHOPAEDICS
☐ does not have an ACGME-accredited residency program.

C. Thomas Vaughan, Jr., MD
TYPE OR PRINT NAME OF INSTRUCTOR OR FACILITY PROGRAM DIRECTOR

1510 San Pablo St. #322
ADDRESS: NUMBER AND STREET

Los Angeles, CA 90033
CITY STATE ZIP CODE

(323) 226-7346
TELEPHONE NUMBER

SIGNATURE OF INSTRUCTOR/FACILITY PROGRAM DIRECTOR

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.

Signed and sworn to before me this _____ day of _____, 19 ____.

Notary Seal

NOTARY PUBLIC

ADDRESS

My Commission Expires _____

State of California Department of Consumer Affairs

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

CERTIFICATE OF CLINICAL TRAINING

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

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This is to certify that Ray SILVER (STUDENT'S NAME), a student of ST GEORGE'S UNIVERSITY SCHOOL OF MEDICINE (MEDICAL SCHOOL), completed a clerkship offered by MIAMI CHILDREN'S HOSPITAL (NAME AND ADDRESS OF FACILITY) 3100 SW 62ND AVENUE, MIAMI, FLORIDA 33155 from Aug 16th (DATE) ~~1999~~ 2000 through Sept 24th (DATE) ~~1999~~ 2000 in the clinical area of PEDIATRICS (CLINICAL AREA).

MARCO DAVON M.D being duly sworn, says he is/was the individual instructor or program director for the student named 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 ☐ is not affiliated with a U.S. or International school

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.

Official Hospital Seal

MARCO DAVON, M.D.
TYPE OR PRINT NAME OF INSTRUCTOR OR FACILITY PROGRAM DIRECTOR

3100 SW 62nd Ave
ADDRESS: NUMBER AND STREET

Miami - FL. 33155
CITY STATE ZIP CODE

305-662-5367
TELEPHONE NUMBER

Marco Davon
SIGNATURE OF INSTRUCTOR/FACILITY PROGRAM DIRECTOR

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.

Signed and sworn to before me this 31st day of May, 2000

NOTARY PUBLIC STATE OF FLORIDA
OFFICIAL NOTARY SEAL
IRMA COTO
COMMISSION NO. CC851485
MY COMMISSION EXP. JULY 5,2003

Notary Seal

Irma Coto
NOTARY PUBLIC

3100 SW 62nd Ave Miami FL 33
ADDRESS

My Commission Expires July 5, 2003

07A-100-L6 (Rev. 2/97)

L6

STATE OF CALIFORNIA — STATE AND CONSUMER SERVICES AGE

GRAY DAVIS [redacted] Governor

State of California Department of Consumer Affairs

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

CERTIFICATE OF CLINICAL TRAINING

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This is to certify that Roy Silver (STUDENT'S NAME), a student

of St. George's University School of Medicine (MEDICAL SCHOOL), completed a

clerkship offered by San Joaquin General Hospital (NAME AND ADDRESS OF FACILITY)

500 W. Hospital Road French Camp, Ca 95231

from January 17 (DATE), ~~19~~ 2000 through March 10 (DATE), ~~19~~ 2000 in the clinical area

of Medicine Sub-Internship (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 that he has carefully read and completed this form and that the statements made herein are strictly true in every respect.*

This facility ☐ is ☒ is not affiliated with a U.S. or International school

Name of U.S. or International medical school, if affiliated:

This facility ☒ does have an ACGME-accredited residency program in the areas of: IM, FP, Surgery.
☐ does not have an ACGME-accredited residency program.

Official Hospital Seal

James K. Saffier, M.D.
TYPE OR PRINT NAME OF INSTRUCTOR OR FACILITY PROGRAM DIRECTOR

San Joaquin General Hospital
ADDRESS: NUMBER AND STREET

500 W. Hospital Road French Camp, CA 95231
CITY STATE ZIP CODE

(209) 468-6624
TELEPHONE NUMBER

James K. Saffier MD
SIGNATURE OF INSTRUCTOR/FACILITY PROGRAM DIRECTOR

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.

Signed and sworn to before me this _____ day of _____, 19 ____.

Notary Seal

NOTARY PUBLIC

ADDRESS

My Commission Expires _____

L6

07A-100-L6(Rev. 2/97)

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 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

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ONLY UNDERGRADUATE CLINICAL CLERKSHIPS IN WHICH THE APPLICANT PARTICIPATED IN DIRECT, HANDS-ON DIAGNOSIS OR TREATMEI PATIENTS IN A CLINICAL SETTING SHOULD BE REPORTED ON THIS FORM. ANY CLINICAL CLERKSHIPS COMPLETED THAT DO NOT MEET TH ABOVE CRITERIA SHOULD NOT BE REPORTED ON THIS FORM AS THEY WILL NOT SATISFY CALIFORNIA'S CLINICAL TRAINING REQUIREMEN

This is to certify that Roy Silver (STUDENT'S NAME), a stude
of St. George's Univ. Schl. of Medicine (MEDICAL SCHOOL), completed a
clerkship offered by The Brooklyn Hospital Ctr (NAME AND ADDRESS OF FACILITY) EK
121 DeKalb Avenue Brooklyn NY 11201
from March 13, 2000 (DATE) through April 7, 2000 (DATE) in the clinical ar
of Gyn. Oncology (CLINICAL AREA).

Vincent Tricomi MD *being duly sworn, says* X *he ~~is/was~~ the ~~individual instructor~~ program director for the student named above during the clerkship indicated and that* X *he has carefully read and completed this form and that the statements made herein are strictly true in every respect.*

This facility ☑ is ☐ is not affiliated with a U.S. or International school
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.

Official Hospital Seal

Vincent Tricomi MD
TYPE OR PRINT NAME OF INSTRUCTOR OR FACILITY PROGRAM DIRECTOR
121 DeKalb Avenue
ADDRESS: NUMBER AND STREET
Brooklyn NY 11201
CITY STATE ZIP CODE
718 250 6600
TELEPHONE NUMBER
SIGNATURE OF INSTRUCTOR/FACILITY PROGRAM DIRECTOR

NOTE: IN ABSENCE OF AN OFFICIAL HOSPITAL SEAL, THE INSTRUCTOR OR PROGRAM DIRECTOR MUST SIGN THIS FORM IN THE PRESEI OF A NOTARY PUBLIC WHO AFFIXES HIS/HER OFFICIAL NOTARY SEAL.

Signed and sworn to before me this _____ day of _____, 19__

Notary Seal

NOTARY PUBLIC

ADDRESS

My Commission Expires _____

State of California Department of Consumer Affairs

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

CERTIFICATE OF CLINICAL TRAINING

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This is to certify that Roy SILVER (STUDENT'S NAME), a student of ST. GEORGE'S UNIVERSITY SCHOOL OF MEDICINE (MEDICAL SCHOOL), completed a clerkship offered by MIAMI CHILDREN'S HOSPITAL (NAME AND ADDRESS OF FACILITY) 3100 SW 62ND AVENUE, MIAMI, FLORIDA 33155 from May 8th (DATE), 2000 through June 2nd (DATE), 2000 in the clinical area of PEDIATRICS (CLINICAL AREA).

MARCO DAVON M.D being duly sworn, says he is/was the individual instructor or program director for the student named 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 ☐ is not affiliated with a U.S. or International school
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.

Official Hospital Seal

MARCO DAVON, M.D.
TYPE OR PRINT NAME OF INSTRUCTOR OR FACILITY PROGRAM DIRECTOR
3100 SW 62nd Ave
ADDRESS: NUMBER AND STREET
Miami FL 33155
CITY STATE ZIP CODE
305-662-8367
TELEPHONE NUMBER
Marco Davon
SIGNATURE OF INSTRUCTOR/FACILITY PROGRAM DIRECTOR

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.

Signed and sworn to before me this 31st day of May 2000

STATE OF FLORIDA
OFFICIAL NOTARY SEAL
IRMA COTO
COMMISSION NO. CC851485
MY COMMISSION EXP. [illegible]

Irma Coto
NOTARY PUBLIC
3100 SW 62nd Ave, Miami FL 33155
ADDRESS

Notary Seal

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

Total Questions Asked For Person : 1284654 8

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-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.	YES
I 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 Care Continuing Education Requirement Because I Am A Radiologist Or Pathologist.	NO
Only For General Internists And Family Physicians Who Have 25% Of Their Patient Population Aged 65 Years Or Older: I Have Completed At Least 20% Of The Required Cme In Geriatric Medicine Or The Care Of Older Patients. Click No If Not Applicable.	NO
Enter Name/Address Of Facility Where You Or Your Immediate Family Hold Financial Interest. Type "None", If None Held.	NONE
I Certify Under Penalty Of Perjury Under The Laws Of The State Of California That The Information Contained In This Application Is True And Correct.	YES
I Have Read My Profile On The Medical Board Web Site At Www.Mbc.Ca.Gov And Acknowledge The Information Contained Therein As Current And Accurate.	YES
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?	NO

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

Total Questions Asked For Person : 1284654 8

Application Summary

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?	**No**
Have you successfully completed, and can document, the mandatory courses and hours of CME within the last two years, or you meet the conditions which would exempt you from all or part of the CME requirements, or you hold a permanent CME waiver?	**Yes**
I certify under penalty of perjury, under the laws of California, that I have disclosed the names of those health-related facilities in which I or my family have a financial interest OR I declare under penalty of perjury I have no financial interests to disclose.	**No**

Family Physician Training Program Voluntary Fee

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 - 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 processing until payment is received.

Attestation

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

Signature: Date: