STATE OF CALIFORNIA STATE AND CONSUMER SERVICES AGENCY

EDMUND G. BROWN JR., Governor

DEPARTMENT OF Consumer Affairs

BOARD OF MEDICAL QUALITY ASSURANCE
1430 HOWE AVENUE, SACRAMENTO, CA 95825
TELEPHONE
Applications and Examinations (916) 920-6411

RECEIVED
SACRAMENTO
BOARD OF MEDICAL
QUALITY ASSURANCE
JUN 16 12 23 PM '82

APPLICATION FOR PHYSICIAN'S AND SURGEON'S CERTIFICATE
BASED ON NATIONAL BOARD CREDENTIALS
CLASS G

007238
$216.55

(Please type or print neatly. When space provided is insufficient, attach additional sheets.)

1. NAME: Last: BLUMENTHAL First: PAUL Middle: D. Maiden:
2. Telephone No. [redacted]
3. List other names, if any, you have used:
4. Address: Street and No. (Rural Route) [redacted] City [redacted] State [redacted] Zip Code [redacted]
5. Name you wish on License: PAUL D BLUMENTHAL, M.D
Birthdate (Month, Day, Year) [redacted]
6. Premedical Education: Name of College or University: University of Illinois Location: Chicago
Period of attendance: From 9/70 To 8/72
Check premed courses successfully completed: ☒ Chemistry ☒ Physics ☒ Biology or Zoology
7. Medical School:

Year	Name of Institution	Location	From	To
1st	The Chicago Medical School	Chicago, IL	7/73	
2nd	" " "	"		
3rd	" " "	"		
4th	" " "	"		6/77
5th				
6th				

8. Doctor of Medicine Degree granted by: The Chicago Medical School Date: 6/77 For office use only School Code: IL 042
9. 1st Year Postgraduate Training (Internship):

Location	Type of Service	From	To
Mount Sinai Hospital	Medicine	7/77	7/78

10. List all States in which you have been licensed to practice medicine: Illinois
11. Has any disciplinary action ever been taken regarding any license which you now hold or have held? [redacted] Yes [redacted] No
If Yes, indicate below:

State	Date	Charge	Disposition

12. Have you ever been denied a license to practice medicine in any State or Country? [redacted] Yes [redacted] No
If Yes, indicate below:

State or Country	Date of Denial	Reason for Denial

13. Are you now or have you ever been addicted to narcotic drugs? [redacted] Yes [redacted] No

BPA-101 (REV. 9/80)

(Over)

14. Have you ever been convicted of, or pled nolo contendere to a violation of any Federal, State or Local law relating to the manufacture, distribution or dispensing of controlled substances/narcotics, or to drug addiction? [redacted] Yes [redacted] No

15. Have you ever been convicted of, or pled nolo contendere to any offense, misdemeanor or felony in any state? (Except violations of traffic laws resulting in fines of $50.00 or less.) [redacted] Yes [redacted] No

16. If you answered "Yes" to either No. 14 or No. 15 above, please provide the following information:

Violation and Location	Date	Penalty/Disposition

17. Have you ever had staff privileges in a hospital suspended or revoked? If "Yes", please explain on another sheet of paper. [redacted] Yes [redacted] No

18. Have you ever voluntarily surrendered your license to practice in another state? [redacted] Yes [redacted] No

[redacted]

Applicant: Please complete the following:

Height: [redacted] Ft. [redacted] In. Weight: [redacted] Lbs.

Hair color: [redacted] Eye color: [redacted]

Identifying marks: _____

_____

_____

NOTE: The information on this application is required and maintained pursuant to Section 2312 of the Business and Professions Code. All items in this application are mandatory, none are voluntary. Failure to provide any of the requested information will result in the application being rejected as incomplete. The information provided will be used to determine qualification for licensure. Applicants have the right to review their applications subject to the provisions of the California Public Records Act.

NOTE: APPLICANT WILL SIGN THIS STATEMENT IN PRESENCE OF NOTARY PUBLIC.

"I hereby certify (or declare), under penalty of perjury, under the laws of the State of California, that the foregoing information contained in this application and any attachments is true and correct, and that the attached photo and duplicate copy are a true likeness of myself, the applicant identified herein."

Signature of Applicant _____

Date _____

Subscribed and sworn to before me this 15th day of May 19 82.

Signature of Notary [signature]

SEAL

Address: [redacted] CA 90602

My commission expires: October 1984

STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY

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DEPARTMENT OF Consumer Affairs

BOARD OF MEDICAL QUALITY ASSURANCE
1430 HOWE AVENUE, SACRAMENTO, CA 95825
APPLICATIONS AND EXAMINATIONS
(916) 920-6111

JUN 1 10 35 AM '82

PLEASE FORWARD TO YOUR MEDICAL SCHOOL
CERTIFICATE OF EDUCATION

This Certifies That Paul D. Blumenthal
(Full name of applicant)

enrolled in University of Health Sciences/The Chicago Medical School
(Name of medical school (college))

on the 8th day of July (Month) 19 74 (Year)

[X] as a Freshman.

[ ] with advanced standing based on _____ (Please specify)

The undersigned further certifies that official transcripts on file show that prior to completing the study of medicine the applicant herein referred to completed at least a two-year resident course of college grade including:

[X] PHYSICS [X] CHEMISTRY [X] BIOLOGY (or) ZOOLOGY (Check course(s) completed)

at University of Illinois, Chicago B.A. degree 9/1972, and that he attended while at this
(Please indicate school)

medical school (college) 3* (Specify number) courses of lectures of at least 36 (Specify number of weeks) weeks each,

completing required (Total hours) hours in the subjects below listed, and that he/she:

*three year program

[X] was granted the degree Doctor of Medicine.

[ ] left the above-mentioned medical school (college) for the following reason(s):

on the 9th day of June (Month) 19 77 (Year).

Please indicate which of the following courses of study were successfully undertaken by the applicant:

[X] Anatomy	[ ] Dermatology	[ ] Preventive medicine, including nutrition	[ ] Otolaryngology
[X] Embryology	[ ] Physical medicine	[X] Radiology, including radiation safety	[X] Obstetrics and gynecology
[X] Histology	[ ] Therapeutics	[X] Medicine	[ ] Human sexuality as defined in Section 2192.3
[X] Neuroanatomy	[ ] Tropical medicine	[X] Pediatrics	
[ ] Physiology	[X] Surgery, including orthopedic surgery	[X] Psychiatry	[ ] Child Abuse detection and treatment
[X] Biochemistry	[ ] Urology	[X] Neurology	
[X] Pathology, bacteriology and immunology	[ ] Ophthalmology	[ ] Anesthesia	
	[X] Pharmacology		

Signed and the College seal affixed this 25th day

of May (Month) 1982 (Year)

[AFFIX SEAL HERE]

By Milton R. Sherman
Registrar (President, Secretary, Dean)

OJA-32 (REV. 3/80)

UNIVERSITY OF HEALTH SCIENCES
THE CHICAGO MEDICAL SCHOOL

on the recommendation of the Faculty of the
School of Medicine
the Board of Trustees has conferred the degree
of
DOCTOR OF MEDICINE
upon

PAUL D. BLUMENTHAL

who has honorably fulfilled all the requirements for that degree.

Given in the city of Chicago, State of Illinois, this 9th day of June, 1977

UNIVERSITY OF HEALTH SCIENCES · THE CHICAGO MEDICAL SCHOOL

Chairman of the Board of Trustees

President Emeritus

Dean

Application Summary

License Type:	**Physician and Surgeon G**
License Number:	**47601**
File Number:	**191932**
Application:	**Physician's and Surgeon's Renewal**
Application Number:	**14480644**
Application Date:	**03/05/2018 (mm/dd/yyyy)**

Application Questions

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

Personal Detail

First Name:	**PAUL**
Middle Name:	**D**
Last Name:	**BLUMENTHAL**
Birthdate:	***/***/****
Gender:	[redacted]

Addresses

License Related Addresses

Address of Record (Required)

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

Confidential Address

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

Questions

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

Have you successfully completed, and can document, the mandatory courses and hours of CME within the last two years, or you meet the conditions which would exempt you from all or part of the CME requirements, or you hold a permanent CME waiver? [redacted]

I certify under penalty of perjury, under the laws of California, that I have disclosed the names of those health-related facilities in which I or my family have a financial interest OR I declare under penalty of perjury I have no financial interests to disclose. [redacted]

Family Physician Training Program Voluntary Fee

Would you like to contribute? [redacted]

Attachments

Physician Survey

Are you retired?	**No**
Activities in Medicine	**Administration - 20-29 Hours**
	Other - 20-29 Hours
	Patient Care - 10-19 Hours
	Research - 10-19 Hours
	Teaching - 10-19 Hours
	Telemedicine - 1-9 Hours
Patient Care Practice Location	**Zip: 94305 County: SANTA CLARA**
Telemedicine Practice Location	**Zip: 94305 County: SANTA CLARA**
Patient Care Secondary Practice Location	**Zip: County:**
Telemedicine Secondary Practice Location	**Zip: County:**
Current Training Status	**Not in Training**
Areas of Practice	**Obstetrics and Gynecology - Primary**
	Public Health and General Preventive Medicine - Secondary
Board Certifications	**American Board of Obstetrics and Gynecology - Obstetrics and Gynecology**
Postgraduate Training Years	**6 Years**
Cultural Background	[redacted]
Foreign Language Proficiency	
Web Site Profile	**Cultural Background - No**
	Foreign Language Proficiency - No
	Gender - No
E-mail:	[redacted]

Fees

Biennial Renewal Fee	**$783.00**

DUE TO CURES FUND	**$12.00**
StephenM.ThompsonLRP	**$25.00**
Total Amount Due:	**$820.00**

Applications are not considered submitted for processing until payment is received.

Attestation

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

Signature: Date:

Application Summary

License Type:	**Physician and Surgeon G**
License Number:	**47601**
File Number:	**191932**
Application:	**Physician's and Surgeon's Renewal**
Application Number:	**14255848**
Application Date:	**03/09/2016 (mm/dd/yyyy)**

Application Questions

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

Personal Detail

First Name:	**PAUL**
Middle Name:	**D**
Last Name:	**BLUMENTHAL**
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

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Have you successfully completed, and can document, the mandatory courses and hours of CME within the last two years, or you meet the conditions which would exempt you from all or part of the CME requirements, or you hold a permanent CME waiver? [redacted]

I certify under penalty of perjury, under the laws of California, that I have disclosed the names of those health-related facilities in which I or my family have a financial interest OR I declare under penalty of perjury I have no financial interests to disclose. [redacted]

Family Physician Training Program Voluntary Fee

Voluntary Fee: [redacted]

Attachments

Physician Survey

Are you retired?	**No**
Activities in Medicine	**Administration - 30-39 Hours**
	Other - 1-9 Hours
	Patient Care - 10-19 Hours
	Research - 10-19 Hours
	Teaching - 10-19 Hours
	Telemedicine - 1-9 Hours
Patient Care Practice Location	**Zip: 94305 County: SANTA CLARA**
Telemedicine Practice Location	**Zip: 94305 County: SANTA CRUZ**
Patient Care Secondary Practice Location	**Zip: County:**
Telemedicine Secondary Practice Location	**Zip: County:**
Current Training Status	**Not in Training**
Areas of Practice	**Obstetrics and Gynecology - Primary**
Board Certifications	**American Board of Obstetrics and Gynecology - Obstetrics and Gynecology**
Postgraduate Training Years	**6 Years**
Cultural Background	[redacted]
Foreign Language Proficiency	**Hebrew**
Web Site Profile	**Cultural Background - No**
	Foreign Language Proficiency - Yes
	Gender - Yes
E-mail:	[redacted]

Fees

Biennial Renewal Fee	**$783.00**
DUE TO CURES FUND	**$12.00**

Steven M. Thompson Physician Corps Loan Repayment Program	**$25.00**
Total Amount Due:	**$820.00**

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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: