

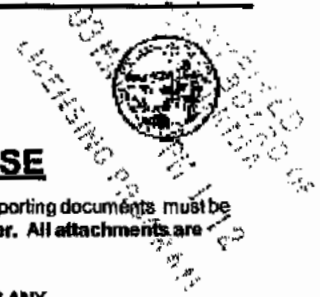
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MEDICAL BOARD OF CALIFORNIA

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

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



APPLICATION FOR PHYSICIAN'S AND SURGEON'S LICENSE

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

1. NAME: Last CHEN First ANGELA Middle Y		Personal Data		
2. Other names you have used (include maiden name):				
3. U.S. Social Security Number: [REDACTED]				
4A. (PUBLIC ADDRESS; will be released by the Board to the public): Number and Street/P.O. Box/Rural Route/Apartment Number, if any. 14364 ASHBURY DRIVE				
City CHINO HILLS	State CA		Zip Code 91709	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.]				
City [REDACTED]	State [REDACTED]		Zip Code [REDACTED]	Country [REDACTED]
5. Telephone Number: Home: [REDACTED] Work: [REDACTED]			6. California Driver's License Number (optional): NUMBER: [REDACTED] EXPIRATION: [REDACTED]	
7. Date of Birth (Month/Day/Year) and Place of Birth: [REDACTED]				
8. Sex: <input type="checkbox"/> Male <input checked="" type="checkbox"/> Female	9. Are you a U.S. citizen? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10. Have you ever filed an application for Physician's and Surgeon's examination or licensure in California? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No IF YES, PLEASE GIVE DATE PREVIOUS APPLICATION WAS SUBMITTED: _____				
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		
BOSTON UNIV	BOSTON, MA USA	8/1990 - 5/1997		
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 6 1/2" x 11" photocopy (original diploma will be returned).				
School Name	City, State, Country	Dates of Attendance	Degree Awarded	
BOSTON UNIV.	BOSTON, MA, USA	8/1993 - 5/1997	MD	
DOCTOR OF MEDICINE DEGREE, as referenced above.				
Name of Medical School	Address of Medical School	Exact Date of Issuance		
BOSTON UNIVERSITY	715 ALBANY ST BOSTON MA 02118	05/18/1997		
* 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 USC 405(e)(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		L1A		
School Code				

Written Examination

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

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)
USMLE Step 1 Boston, MA	June '95, June '96	[Redacted]
USMLE Step 2 Boston, MA	Mar '97	[Redacted]
USMLE Step 3 Boston, MA	May '98	[Redacted]

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

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.

Jurisdiction	License Number	Date of Issuance	Dates of Practice in that Jurisdiction
MA	209125	06/13/2001	2001 - current
MA	97584299	06/04/1997	1997 - 2001

License Data

LGS

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: _____

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

Other Professional Licenses

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

IF YES, LIST NAMES AND ADDRESSES OF ALL FACILITIES. SUBMIT AN ORIGINAL CERTIFICATE OF COMPLETION OF ACCME/ACFPC 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	Categorical Specialty Area	Dates of Attendance
BOSTON MEDICAL CENTER	ONE BOSTON MEDICAL CENTER PLACE BOSTON MA 02118-2393 617-414-5593	OB-GYN	7/1/1997 - 6/30/2001

Postgraduate Training

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? Yes No

IF YOU ANSWERED YES, BOTH APPLICANT AND SCHOOL/PROGRAM MUST PROVIDE DETAILS ON A SEPARATE ATTACHMENT.

NAME OF APPLICANT:

ANGELA Y. CHEN

DATE OF BIRTH:

[Redacted]

L1B

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:

ANGELA Y. CHEN

DATE OF BIRTH:

[REDACTED]

L1C

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 Massachusetts

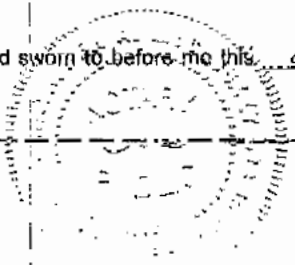
COUNTY OF Suffolk

The applicant, ANGELA Y. CHEN (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: Angela Y. Chen
(PLEASE SIGN FULL NAME, NOT INITIALS)

Signed and sworn to before me this 22 day of NOVEMBER 2002
MONTH YEAR



NOTARY SEAL

Kathleen McCluskey
SIGNATURE OF NOTARY PUBLIC
91 E. CONCORD ST., 3rd FL. BOSTON, MA
ADDRESS 02118

My commission expires 4/16/2004

L1D



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



CEED-5 11 3:29

CERTIFICATE OF MEDICAL EDUCATION

MEDICAL SCHOOL: PLEASE COMPLETE THIS FORM IN THE ENGLISH LANGUAGE.

This certifies that ANGELA CHEN FULL NAME OF APPLICANT [REDACTED] U.S. SOCIAL SECURITY NO. [REDACTED] DATE OF BIRTH-MM/DD/YYYY

enrolled in BOSTON UNIVERSITY SCHOOL OF MEDICINE 715 ALBANY STREET, BOSTON, MA 02118 NAME OF MEDICAL SCHOOL LOCATION

on the 7TH day of SEPTEMBER 1998 and was granted the following credits on enrollment: MONTH YEAR

Advanced Credits: Credits previously obtained at an approved medical, dental, or osteopathic school.*

MEDICAL SCHOOL TOTAL CREDITS DATES

The undersigned further certifies that the records of this institution show that the applicant attended in this institution 4 NUMBER OF YEARS

years of resident instruction of 40 weeks each, completing at least 4,000 hours, of which at least 80 percent actual NUMBER OF WEEKS

attendance is required, in the subjects set forth hereunder (Business and Professions Code Section 2089), and that the applicant:

[X] was granted the degree Bachelor/Doctor of Medicine by OR [] withdrew from

the above mentioned medical school on the 18TH day of MAY 1997 MONTH YEAR

- Anatomy, Embryology, Physical Medicine, Therapeutics, Neuroanatomy, Child Abuse Detection and Treatment, Geriatric Medicine, Pediatrics, Pharmacology, Anesthesia, Spousal or Partner Abuse Detection & Treatment**, Family Medicine***, Pain Management and End-of-Life Care
Otolaryngology, Histology, Human Sexuality as defined in Section 2090, Medicine, Surgery, including Orthopedic Surgery, Urology, Psychiatry, Neurology, Alcoholism and Chemical Dependency, Preventive medicine, including Nutrition

RECEIVED BOARD OF CALIFORNIA LICENSING PROGRAM 2 DEC - 1997 AM 8:39

* 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 25TH day of NOVEMBER, 2001. BY Ellen J. D. Sine, PRESIDENT, DEAN, OR REGISTRAR

L2



Commonwealth of Massachusetts
Board of Registration in Medicine

560 Harrison Avenue, G-4
Boston, Massachusetts 02118
(617) 654-9810
Fax (617) 426-9358

0-15-02 WRB
RECEIVED
MEDICAL BOARD OF
CALIFORNIA

03 APR 23 PM 1:58

Date: 04/18/2003
LICENSING PROGRAM

To Whom It May Concern:

This is to certify **ANGELA Y. CHEN, M.D.**, a graduate of
Boston University School of Medicine
in the year 1997, has been duly registered by this board as provided by the laws
of the Commonwealth.

Certificate Number 5842 was issued to Dr. CHEN on .

THIS LICENSE IS NOT CURRENT. The expiration date was Jul 1 2001.

Our files contain no open complaint information on this physician.

Our files contain no closed complaint information on this physician.

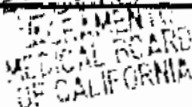
Our files contain no disciplinary information on this physician.

SEAL


Member, Board of Registration in Medicine

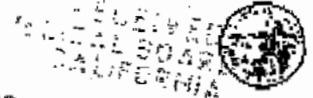
Please be advised that the above information is based entirely on examination of our open and closed complaint file. It is not based on a review of the application for licensure, renewal of licensure, or any reports that the Board is required to receive by statute (from courts, insurers, hospitals, etc...).

10-15-02 WEF



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 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.

Form fields for Part 1: LAST NAME of Applicant (Chen), First Name (Angela), Middle Initial (Y), U.S. Social Security Number, Date of Birth, Telephone Number (Home, Work), Current Address, City, State, Zip Code.

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."

Form fields for Part 2: Name of Facility (Boston Medical Center OB/GYN), Address of Facility (91 E. Concord St, Boston, MA), Name of Program Director (Phillip G. Stubblefield MD), Signature of Program Director, Telephone Number, Date Signed (4/14/03), List Categorical Specialty Area of Training Completed by Trainee (OBSTETRICS / GYNECOLOGY), Date Training Commenced (7/1/1997), Date Training Completed (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.

Form fields for Part 3: Name of the Director of Medical Education (Maxine E. Keester), Name of Facility (Boston Medical Center), Address of Facility (One Boston Medical Center Place, Maloney 4), City (Boston), State (MA), Zip Code (02118), Telephone Number.

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.

Official Hospital Seal or Notary Seal box, Declaration text: 'I hereby declare under penalty of perjury...', Signature of Director of Medical Education (Maxine Keester), Date Signed (4/7/03), L3A.

Application Summary

4/28/19 10:34 PM

Page 1 of 2

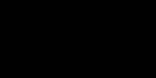
License Type: **Physician and Surgeon A**
License Number: **84353**
File Number: **74587**
Application: **Physician's and Surgeon's Renewal**
Application Number: **14639673**
Application Date: **04/28/2019 (mm/dd/yyyy)**

Application Questions

Have you served or are you currently serving in the military?



Personal Detail

First Name: **ANGELA**
Middle Name: **Y**
Last Name: **CHEN**
Birthdate: ***/*/******
Gender: 

Addresses

License Related Addresses Address of Record (Required)

Warning:

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

Questions

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



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?



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.



Family Physician Training Program Voluntary FeeWould you like to contribute? [REDACTED]**Attachments****Physician Survey**

Are you retired? **No**

Activities in Medicine **Administration - 10-19 Hours**
Patient Care - 40+ Hours
Research - 1-9 Hours
Teaching - 10-19 Hours
Telemedicine - None

Patient Care Practice Location **Zip: County:**

Telemedicine Practice Location **Zip: County:**

Patient Care Secondary Practice Location **Zip: County:**

Telemedicine Secondary Practice Location **Zip: County:**

Current Training Status **Not in Training**

Areas of Practice **Obstetrics and Gynecology - Primary**
Obstetrics and Gynecology - Secondary

Board Certifications **American Board of Obstetrics and Gynecology - Obstetrics and Gynecology**

Web Site Profile **Cultural Background - No**
Foreign Language Proficiency - No
Gender - No

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:



1556516092842


Application Summary

7/2/17 2:56 PM

Page 1 of 3

License Type: **Physician and Surgeon A**
License Number: **84353**
File Number: **74587**
Application: **Physician's and Surgeon's Renewal**
Application Number: **14415761**
Application Date: **07/02/2017 (mm/dd/yyyy)**

Application Questions

Have you served or are you currently serving in the military? 

Personal Detail

First Name: **ANGELA**
Middle Name: **Y**
Last Name: **CHEN**
Birthdate: ****pk**pk****
Gender: 

Addresses


License Related Addresses


Address of Record (Required)

Warning:

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

Questions

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

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? 

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.



Family Physician Training Program Voluntary Fee

Voluntary Fee:



Attachments

Physician Survey

Are you retired?

No

Activities in Medicine

Administration - 10-19 Hours

Patient Care - 40+ Hours

Research - 1-9 Hours

Teaching - 10-19 Hours

Telemedicine - None

Patient Care Practice Location

Zip: 90095 County:

Telemedicine Practice Location

Zip: 90095 County:

Patient Care Secondary Practice Location

Zip: County:

Telemedicine Secondary Practice Location

Zip: County:

Current Training Status

Not in Training

Areas of Practice

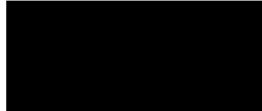
Obstetrics and Gynecology - Primary

Obstetrics and Gynecology - Secondary

Board Certifications

American Board of Obstetrics and Gynecology - Obstetrics and Gynecology

Cultural Background



Foreign Language Proficiency

Web Site Profile

Cultural Background - No

Foreign Language Proficiency - No

Gender - No

E-mail:



Fees

Biennial Renewal Fee

\$783.00

DUE TO CURES FUND

\$12.00

Application Summary

7/19/15 7:33 PM

Page 1 of 2

License Type: **Physician and Surgeon A**
License Number: **84353**
File Number: **74587**
Application: **Physician's and Surgeon's Renewal**
Application Number: **14194401**
Application Date: **07/19/2015 (mm/dd/yyyy)**

Personal Detail

First Name: **ANGELA**
Middle Name: **Y**
Last Name: **CHEN**
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.

Questions

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

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

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

Family Physician Training Program Voluntary Fee

Voluntary Fee: **[REDACTED]**



Attachments**Physician Survey**

Are you retired?	No
Activities in Medicine	Administration - 20-29 Hours Other - 1-9 Hours Patient Care - 40+ Hours Research - 1-9 Hours Teaching - 10-19 Hours Telemedicine - None
Patient Care Practice Location	Zip: 90095 County:
Telemedicine Practice Location	Zip: 90095 County:
Patient Care Secondary Practice Location	Zip: 90095 County:
Telemedicine Secondary Practice Location	Zip: 90095 County:
Current Training Status	Not in Training
Areas of Practice	Obstetrics and Gynecology - Primary Obstetrics and Gynecology - Secondary
Board Certifications	American Board of Obstetrics and Gynecology - Obstetrics and Gynecology
Postgraduate Training Years	6 Years
Web Site Profile	Cultural Background - No Foreign Language Proficiency - No Gender - No

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:

