

LICENSING PROGRAM
1426 Howe Avenue, Suite 54
Sacramento, CA 95825-3236
(916) 263-2382 FAX (916) 263-2487
www.caldocinfo.ca.gov



INITIAL AND UPDATE APPLICATION FOR PHYSICIAN'S AND SURGEON'S LICENSE OR POSTGRADUATE TRAINING AUTHORIZATION LETTER

Application for (please of	neck one): 🕱 Licens	e □ PTAL -	or - U	pdate
1. NAME: Last Kalantari	First		Jamshidi	MBG. Usecon
Other names you have used (include mald		2, U.S. Social S		
<u>Gita Kademi</u>				
3. Place of Birth		4. Date of Birth	<u> </u>	
5. Gender:	🔀 Female			
6. Public/Mailing Address: 155/5 (Please note: this information is public)	LOFTHI	L DRIV	<u> </u>	
(30 characters maximum per line, including spaces)				
LA MIRADA	rovince A	Zip/Postal Code	Country U-S-A	
7. Telephone Numbers: (include area code)		154	Coll	
8. California Driver's License Number (op	otlonal): 10. Ha	ve you ever filed an Ap d Surgeon's License, o	■ oplication for Physici or PTAL in California	an's
9. E-mail Address (optional):		☐ Yes 🏻	No	
	revio	us license number, if a	ny;	
	MEDICAL EDUCA	TION		
11. LIST EACH MEDICAL SCHOOL THAT Y	OU HAVE ATTENDED.			
Service School America	Gity State/Pro	Vincer country	Dates of Attend	ence de la califación
Medizinische Universität	Lübeck /	GERMENY	1/10/89 to	30/9/97
zu Lübeck				
(Medical University	of Lubeck	١ .		
12. School of Graduation Medizinische Universi		Awarded	Date of Gradua	
HOW SINISONE CHIVERS!	at 24 Lubeck	AIP	April 19	97
	EXAMINATION			
13. LIST ALL OF THE FOLLOWING EXAMIN	ATIONS YOU HAVE TAI		, NBME, ECFMG, SP DS and/or QME in Ca	EX,
Examination		Date: 16 Mary 18	Result (Pa	7,404,043,033,033,033
USMLE STEPI	10/30/99)	and the second s	ar.
USMLE STEP 2/	USMLE Step 3	4/7/2000/12/	28 05	Z.
TOEFEL CSA	8/19/2002	valid indefin		- E
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Çashieging Üse (Drify.		ER35	

A "yes" response to Questions 14 through 43 requires a written explanation on a separate sheet of paper along with any supporting materials.

	ACGME/RCPSC ACCREDITED POS	rgraduate Tr	AINING		MBG Use Only
	 Please list each ACGME/RCPSC accredited postgra have participated. You must include each internsh not the program was completed or credit granted. 	duate training p ip, residency an	program in d fellowsh	which you ip, whether or	
	t tarrälliyikinine argoli er karrakoolea asaliyke jirka sp	ecialty Atea	Juaiq≥y	if Attendance	
C	KING-DREW 12021 S. Wilmington IN	TERNAL	1-16-		. ∤ U
	MEDICAL CENTER LA, CA 90059 M	EDICINE	1-/	5-05	
	O California Hospital 1400 S FI	AMILY	ا - ع	-05 to	
	(Medical Grand Ave.	MEDICINE	6 -	36-07	
	LA, CA 90015		24 m		
	POSTGRAĐUATE TRAININGS				
	Did you ever take a leave of absence or break from your tra	aining?	YES	МО	•
	Have you ever been terminated, dismissed or expelled from	n a program?	YES	NO	
	Have you ever resigned from a training program?		YES	МО	-
	Were you ever placed on probation?		YES	NO	
	Were you ever disciplined or placed under investigation?		YES	МО	2
	Were any incident reports ever filed by instructors?		YES	ИО	
	Were any limitations or special requirements placed upon y performance, discipline, or for any other reason?	ou for clinical	YES	но	Ś
	Have you ever had a postgraduate training program contractions or offered for a following year?	ot not be	YES	NO	é
	MEDICAL LICENS	JRE			
	15. Please list all medical licenses (other than training any state or territory in the United States or Canad		ave ever b	een issued by	ujcanse David
	Jurisdiction: 1/2 License (Lindberg License)	iance / Dalesion	Practice in t	hat diriscliction v-	
	M14				Ď
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	ADDITON	TE OF PERMIT			
	Gita Jamshidi Kalantari DA	TE OF PIOTU			1B

			ABMS CER	RTIFICATIO	NS			s MB& UserQhi
16. Are you c	urrently cer	tified by a M	ember Boar	d of the Ame	erican Board of		ecialties? □ No ⊠	Les ABNA
Mem	ber Board		EXPIR	dion Dates.		e Contricated	vumber .	
Alu								
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		1	MALPRACT	ICE HISTO	RY			Malpracice
17. Has a clai in a malpr	m or an ac actice settl	tion ever bee ement, judgn	n filed again ent, or arbit	ist you for th tration award	e practice of n d of \$30,000 or	nedicine whi	ch resulted	
		PRACTIC	E IMPAIRM	ENT OR LE	MITATIONS	YES	_NO	4
18. Have you drug or ald	been enrol		ed to enter in	nto, or partic	ipated in any	YES	NO	Ý
19. Have you addictive o	been treate		·			YES	NO)
20. Have you disorder w	been diagr hich impair	osed with an s your ability	emotional, to practice	a mental, or medicine sa	behavioral fely?	YES	NO	4
21. Have you condition t	ever been o hat would i	diagnosed wi mpair your al	th a neurolo bility to prac	gical or othe tice medicin	er physical e safely?	YES	МО	¥
	to practice	medicine sa	ifely?			YES	NO	
If you do recei individualized ongoing medic conditions sho	assessmer al condition	it of the natur n to determin	e, the sever e whether a	rity and the α π unrestricte	duration of the ed license sho	risks associ	ated with an	
			MINAL REC					i i i i i i i i i i i i i i i i i i i
23. Have you of United Sta	ever been d tes or forei	convicted of, gn country?	or pled nolo	contendere	to ANY offens	e in any stat	te in the	
This includes a cita dates, violation, and or if the conviction ware awaiting judgmen evidence that you hadrugs, hit and run, evidence all-inclusive. If	tion, Infraction court of jurisdic as later expung at and sentenci ve been rehabit ading a peace	n, misdemeanor: dion (name and acted from the recording ng following entry ditated. Serious tr officer, failure to a	doress). Matters of a fine court or of a plea or jury affic convictions appear, driving w	in which you we set aside under verdict, you MU such as reckles: thile the license i	ere diverted, deferre Penal Cods Section ST disclose the con s driving, driving unit s suppended or rev	d, pardoned, plea 1203.4 MUST b viction; you are a der the influence oked MUST be re	d noto contendere, e disclosed. If you infifled to submit of alcohol and/or	
For each conviction a court documents, and of incident and all cin arresting agency and	lisciosed, you r i a descriptive cumstances su	nust submit with the explanation of the grounding the inck	he application of circumstances a lent). This letter	ertified copies of surrounding the compared to	the arresting agenc	y report, certified	copies of the	
Applicants who ans revoked for knowing	wer "NO" to ti gly falsifying t	ne question but ! he application.	nave a previous	conviction or p	olea, may have the	ir application de YES	enled or license NO	1
APPLICANT:	GITA	H2 MAT	OI KALI	ANTARI	DATE OF BI	RTH:		1C

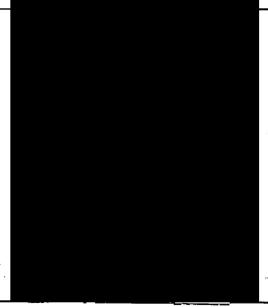
CRIMINAL RECORD HISTORY (cont d) 24. Is any criminal action pending against you? YES NO 25. Are you required to register as a Sex Offender? **DISCIPLINARY HISTORY** These questions refer to discipline by any U.S. military or public health service, state board or other governmental agency of any U.S. state, territory, Canadian province, or country. 26. Have you ever been denied a license to practice medicine? YES NO 27. Is any denial pending against you? YES NO 28. Have you ever been charged with, or been found to have committed, unprofessional conduct, professional incompetence, gross negligence, YES NO or repeated negligent acts or malpractice by any medical licensing board, other agency, or hospital? 29. Have you ever had any license to practice medicine revoked, YES ΝQ suspended, or placed on probation? 30. Have you ever had any license to practice medicine subjected to any action including but not limited to informal or confidential discipline. YES NÖ consent orders, letters of warning, letters of reprimand, or citation? 31. Have you ever had any license to practice medicine subjected to any YES NO other disciplinary action? 32. Is any disciplinary action pending against any of your licenses to YES NO practice medicine? 33. Have you ever had staff privileges in a hospital terminated, denied, YES NO suspended, limited, revoked, or not renewed? 34. Have you ever resigned from a medical staff in lieu of disciplinary or YES NO administrative action? 35. Is any disciplinary action pending against your hospital staff privileges? YES NO 36. Have you ever surrendered a license to practice medicine? YES NO. 37. Have your DEA privileges ever been denied, suspended, restricted, or YES No ferminated? 38. Have you ever entered into any arrangement or plea or agreement in

APPLICANT: GITA JAMSHIDI KALANTARI DATE OF BIRTH:

lieu of a federal prosecution for a drug violation regulated by the DEA?

NO

YES



Notice: All items in this application, except #8 and #9, are mandatory. 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 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.

The applicant, GITA JAMSHIDI KALANTARI (PLEASE PRINT FULL NAME) 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 any 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. (PLEASE INITIAL BOX)

SIGNATURE OF APPLICANT: At Tour his	di Kalantai
State of California	(Please sign full name)
County of Orange	
Subscribed and sworn to (or affirmed) before me on	
this 24th day of January	. 20 b .6 ,
by Gita Jamshid; Kalantari	
personally known to me or proved to me on the basis of satisfact	ory evidence to be the person(s) who appeared before me



SIGNATURE OF NOTARY PUBLIC

LIE

1426 Howe Avenue, Suite 54, Sacramento, CA 95625-9236 TEL: (916) 263-2499/FAX: (916) 263-2467 Internet: www.modbd.ca.gov



APPLICATION UPDATE FOR PHYSICIAN'S AND SURGEON'S LICENSE TORNIA

STATE OF DALL

GONE COMMINS

OF CALLED FAMA Risage BEN Sull instructions prior to completing this application. ALL questions on this application must be answered, and all supporting documents must be per instructions. Please type or print neatly. When space provided is insufficient, attach additional sheets of papel. All attachments are considered part of the application. FALSIFICATION OR MISHEPRESENTATION OR ANY ITEM OR RESPONSE ON THIS APPLICATION OR ANY ITEM OR RESPONSE ON THIS APPLICATION OR ANY ITEM OR RESPONSE ON THIS APPLICATION OR ANY ITEM. 03 JUL -7

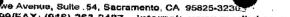
2. Other names you have used (include malden na			AAA AMELIA A	LECT WASSESS
	GITA		AMSHIDI	Persona Data
(SLIM KHUEMI	me):	1 It 9 Seets	Security Number	
A. (PUBLIC ADDRESS; will be released by the Bo	ard to the public): Number	r and Street/P.O. Box/Aural	Roule/Apartment Number H a	
15515 LOFTHILL	DR.			<u> </u>
LA MIRADA	State C:A	zio Code 90638	U.S.A.	
B. (CONFIDENTIAL ADDRESS): Number and Street reet address if a P. O. Box is used as the Public .	Marria Roule/Apartment N	lumber, if any. [Applicants	must provide a confidential	
WA	maico il see e e e e			
Dity	State	Zip Code	Country	
Home;	6. Catifornia NUMBEE	Driver's License Number (options	nai): EXPIRATION	
. Date of First (Month/Doubless) and Place of Rin				
, Date St. Title Market Market And Place NY RII	. Sex:	☐ Male)	Female .	
. Have you ever been licensed to practice medicin	e in any state, territory, pri	ovince, country, or U.S. fed	eral jurisdiction?	License
			□ Yes 🖼 No	· 🗇
YES, UST THE JURISDICTION, UCENSE NUMBER, DATE MAUED SOURIONAL, UNITED LICENSE, OR PERMIT. AN ORGANIAL OFFIC SCH PERMANENT, TEMPORARY, TRAINING, PROVISIONAL LIMITED SUB-FERMANENT, TEMPORARY, TRAINING, SUB-FERMANENT, TEMPORARY, TRAINING, SUB-FERMANENT, TEMPORARY, TRAINING, SUB-FERMANENT, TEMPORARY, TRAINING, OR COMPARABLE O ALFORNIA. JURISDICTON LICENSE Numb	HAL LETTER OF COOR BYANDING (D LICENSE, OR PERMIT DETAINED EATIFICATION, SHOULD BE MAILED	(List), or comparable lickness in in any U.S. State, U.S. or gana d by The Issuing Authority Direct	ist'ory deriyfication, is required f Dian terri'ory, canadian province	FUR 5.
			A. Marie W.	
AŞ THER LICENSE EYER BEEN REYÖKED, OR SUBJECT TO DISCIPL	UNE? IF YES, PLEASE PROVIDE A	, JARIBORTION	ARDING THE MATTER IN ADDITION TO A	Licenses
iritten explanation. You are also required to report w	yy matter that is <u>pending</u> or i	in which charges have been <u>de</u>	<u>ормир</u> од <u>вхронов</u> ер. Yes No	
1A. Are you currently, or have you ever been, a pa	rticipant in a puatgraduate	training program in a facilit	y in the U.S. or Canada?	Poeigreduste Training
You must include every residency, internship, and	tellowship, whether or not	completed.)	☐ Yes 🙇 No	
	AN ORIGINAL CERTIFICATE OF CO	MPLETION OF ADDRESS POST	SPADDATE YRAINING (FORM L3A)	
Yes, list mamas and addresses of all facilities, submit Om Each Facility. (od not complete Form 13/2 to noce		MANAGER PROFESSION CONTRACTOR	ALL YOURSE BUILDS OF LINES	- 1
OM EACH FACILITY. (DO NOT COMPLETE, FORM USAS TO DOCK MAPPLESS OF WHETHER IT WAS SATISFACTORILY COMPLETED.	OR WILL BE USED TO MEET LICEN	NTING REQUIREMENTS.	ALL YAARING LIVST DE LISTED,	
YES, UST MANSS AND ADDRESSES OF ALL FACILITIES. SUBMIT IOM EACH FACILITY. (DO NOT COMPLETE FORM 13/23 TO DOC SCAPPLESS OF WHETHER IT WAS SATISFACTORILY COMPLETED Facility Name	Address	DBA-OH FELLOWAMP (FLOURAME) NRING REQUIREMENTS. Calegorial Specialty Are	ALL TRAINING LIVET DE LIFTED,	
OM EACH FACILITY. (DO NOT COMPLETE, FORM USAS TO DOCU MAPPLESS OF WHETHER IT WAS SATISFACTORILY COMPLETED	OR WILL BE USED TO MEET LICEN	NTING REQUIREMENTS.	ALL YAARING LIVST DE LISTED,	

For all of the below, also include any degree any actions by the U.S. Military, U.S. Public Health Service governmental antity,	/ice, o	J.S. federal	MBC L	
13 <u>A</u> . Have you ever been charged with, or been found to have committed, unprofessional conduct, pro negligence, or repeated negligent acts or materactice by any medical licensing board, other agency, or				
13B. Has any disciplinary action ever been filed or taken, including but not limited to, informal or confiler or latters of warning, regarding any healing arts license which you now hold or have ever held?				RIVA
13C is any such action as described above pending?	13 (A) 13 (B)	seY (8	AH 11: 42
IF YOU ANSWERED YES TO 13A, 13B OR 13C, PROVIDE DETAILS ON A SEPARATE ATTACHMENT.	13 (C)	Yes 1-	LS IN Cre	ROGRAM
14. Have you ever been denied a license, permission to practice medicine or any other healing art, or d to take an examination in any state, territory, country, or U.S. federal jurisdiction, or is any such action	denied per			
IF YOU ANSWERED YES, PROVIDE DETAILS ON A SEPARATE ATTACHMENT.		Yes No	O	
15. Have you ever voluntarily surrandered a license to practice medicine or any other healing arts in it surrendered your narcotic (controlled substance) permit (state or federal) to any ilcensing board or any action pending?				
IF YOU ANSWERED YES, PROVIDE DETAILS ON A SEPARATE ATTACHMENT.		Yes No	=	
18. Have you ever had staff privileges in a hospital denied, suspended, limited, revoked, or not renewe resigned from a medical staff in lieu of disciplinary or administrative action, or is any such action pend		ical disciplinary cad	ISO, OF	
YOU MUST DISCLOSE ANY INFORMAL ON CONFIDENTIAL DISCIPLINARY ACTION.		Yes	D	
17. Do you have any condition which in any way impairs or limits your ability to practice medicine with skill and safety, including but not limited to, any of the following?	lı reasonabi	Yes No	a	
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 CÉRICIAL INPATIENT AND OUTPATIENT TREATMENT REHABILITATION TREATMENT, AND A PERSONAL WRITTEN EXPLANATION.	T AECCADO,	EVIDENCE OF ONGOIN	s	
FOR ALL OF THE BELOW, YOU ARE REQUIRED TO LIST ANY CONTUCTION THAT HAS BEEN SET ARIDE AND DISMISSED OR EXECUTION HAS BEEN ISSUED.	EXPUNCED, C	OR WHERE A STAY OF		
18A. Have you ever been convicted of, or pied note contenders to, ANY violation (include every misden	antennor or	(elony) of any local	ι,	
state, or federal law of any state, territory, country, or U.S. federal [urisdiction? 18B. is any criminal action related to the above pending?	18 (A)	Yes	, i un	
IF YOU ANSWERED YEB TO 18A OR 18B, PROVIDE DITAILS ON A SEPARATE ATTACHMENT.	18 (B)	Yes No		1
			pplicant	_
STATEOF California	· · · · · · · · · · · · · · · · · · ·	Declara	ion/Signature NOTARY	
COUNTY OF Orange		_		
The applicant, 6 17A TAMSH LD KALANTARI 6-14-68 being first (PLEASE PRINT FIRL NAME) (DATE OF BIRTH)	st duly swcr	n 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 under penalty of perjuty, that all of the information contained herein and evidence or other credentials submitted.	ation, know t ad herewith :	the full content there are trus-and correct	of, and declare that t am the	
lawful holder of the degree of Doctor of Medicine as prescribed by this application, that the same was procured examination, and that it, together with all the credentials submitted, were procured without fraud or misrepresented.	intation or a	ov mistaka of which i	am sware en	5
that I am the sawful holder thereof. Further, I hereby authorize all hospitate, institutions or organizations, my re- present, and future), business and professional associates (past, present, and future), and all government agen to the Medical Board of California or its successors any information, tiles or records, including medical records,	ancies flocal	state federal or to	rainn) to raken	
treatment and freatment for drug and/or alcohol abuse or dependency, requested by that Soard in connection with investigation by that Board necessary to determine my medical competence, professional conduct, or physical or	with this and	nlication: or any turb	er or future	1
of medicine. I further authorize the Medical Board of California or its successors to release to the organizations information which is material to this application or any subsequent licensure. I UNDERSTAND THAT FALSIFIC	rs, individual ICATION O	ls, or groups listed a n misaeppesent.	DOVE ANY	,
SIGNATURE OF APPLICANT: PLEASE SIGN FULL NAME, NOT INI	NITIALS)			
Signed and sworn to before me this 3 rol day of July		2003 YEAR		
		-		
COMM. # 1324215 SIGNATURE OF NOTARY PUBLIC SIGNATURE OF NOTARY PUBLIC CALIFORNIA OF SIGNATURE OF NOTARY PUBLIC SIGNATURE SIGNATURE OF NOTARY PUBLIC SIGNATURE	[vd. 13	nena Par	k CA	
			LOE	4
My commission expires N	ON 4	*L045		1

07A-43 (Rev. 03/01)







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



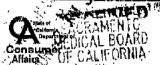
APPLICATION UPDATE FOR PHYSICIAN'S AND SURGEON'S LICENSE

Please READ all Instructions prior to complete this application. ALL questions on this application must be answered additional supporting documents must be submitted as per instructions. Please type or print neatly. When space provided is insufficient, attach additional sheets of paper l'Albate Coments 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.

1. NAME: Last	-	First		Midd	lle	MBC USE
2. Other names you have used (Inc	7	Gita.		Jam.	shidi	Personal
	DEMI		3 11 8 86	cial Security Nur	mhoet.	Data
4A. (PUBLIC ADDRESS; will be rele	eased by the Board to the pub	lic): Number and Stre	et/P.O. Box/Kur	ai Route/Apartm	ent Number, if any.	
City LA MIRADA	State	z	ip Code	Çoun	try	
48. (CONFIDENTIAL ADDRESS): N	umper and Street/Rural Boute	/\/ /Apartment Number-in	90638	de must accepta	S.A.	
street address if a P. O. Box is use NIB	ed as the Public Address in #4	A above.]	a mary a graphical	- The state of the	* COMMONINE	
City	State	· z	ip Code	Coun	try	
5. Telephone Numb Home: (6. California Driver's L NUMBER	icense Number (op	otional): EXPIRATIO	N	
Work: (and Place of Birth					
			☐ Male	Female		
9. Have you ever been licensed to p	practice medicine in any state	, territory, province, c	ountry, or U.S.	federal jurisdiction	on?	License Date
IF YES, LIST THE JURISDICTION, LICENSE NO	MARRY, DATE ISSUED AND CATCO OF O				40 (40	
IF YES, LIST THE JURISDICTION, LICENSE NU PROVISIONAL, LIMITED LICENSE, OR PERMIT. EACH PERMANENT, TEMPORARY, TRAINING, OR U.S. FEDERAL JURISDICTION. EACH LOS	PROVISIONAL LIMITED PROPERTY OF ST	COO SIMPLING (LGS), OR (COMPARABLE LICENS	RE HISTORY CERTIFICA	ATION, IS REQUIRED FOR	
OR U.S. FEDERAL JURISDICTION. EACH LGS CALIFORNIA.	, OR COMPARABLE CERTIFICATION, SH	DULD BE MAILED BY THE IS	s, State, U.S. OR C SUING AUTHORITY DI	anadian territory, Rectly to the med	, Canadian Province, DICAL BOARD OF	
Jurisdiction	Libense Number	Date of Issuance	e .	Dates of Practice	in that Jurisdiction	LGS
						
	·	/ .	-			
	- 15					
						1 👼
10. Do you hold any other profession	onal license in any state, terri	tory, province, country	, or U.S. federa	Jurisdiction?	J Yes ⊠ No	
IF YES: PROFESSION:	LICENSE I	NO.;	, Jurisbić	TION:		Licenses
MAS THIS LICENSE EVER BEEN REVOKED, OR	SUBJECT TO DISCIPLINE? IF YES, PI	LEASE PROVIDE ALL OFFICIAL			TER IN ADDITION TO A	-
WRITTEN EXPLANATION. YOU ARE ALSO REC	DURED TO REPORT ANY MATTER THAT	IN MARKETON OF THE CO.				1
		IN PENDING OR IN WHICH (CHARGES HAVE BEEN	N DROPPED OR EXPU	NGED.	
			CHARGES HAVE BEEN	-	WGED. Yes Vo	
11A. Are you currently, or have you [You must include every residency	l ever been a nucleinant in a		CHARGES HAVE BEEN	-	WGED. Yes Vo	
	ı ever been, a participant in a , internship, and fellowship, w	postgraduate training thether or not complet	program in n fa	clility in the U.S.	Yes No	Postgradusti Training
IF YES, LIST NAMES AND ADDRESSES OF ALL FROM EACH FACILITY, (DO NOT COMPLETE F	s ever been, a participant in a , Internship, and fellowship, w	postgraduate training thether or not complet REFFICATE OF COMPLETION	program in 12 failed.) OF ACOME/RCPSC P	cility in the U.S.	Yes No or Canada? Yes No	Training
	s ever been, a participant in a , Internship, and fellowship, w	Postgraduate training thether or not complete complete complete complete completion received in research fer to meet licensing received to meet licensing re	Program in 12 fated.) OF ACOME/RCPSC PLOWSHIP PROGRAM	clity in the U.S. COSTGRADUATE THAN S.) ALL TRAINING M	Yes No Or Canada? Yes M No NING (FORM L3A) HUST BE LIBTED,	Training
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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.	MEC USE
13 <u>A</u> . 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?	Licerus Data
13 <u>B.</u> 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?	.
13 <u>C</u> . is any such action as described above pending?	
IF YOU ANSWERED YES TO 13A, 13B OR 13C, PROVIDE DETAILS ON A SEPARATE ATTACHMENT.	
13 (C) Yes No. 14. Have you over 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?	
IF YOU ANSWERED YES, PROVIDE DETAILS ON A SEPARATE ATTACHMENT.	
16. Have you ever voluntarily surrendered a license to practice medicine or any other healing arts in this or any other state, or volunta surrendered your narcotic (controlled substance) permit (state or federal) to any licensing board or any other agency, or is any such	ily
IF YOU ANSWERED YES, PROVIDE DETAILS ON A SEPARATE ATTACHMENT.	· 🗇
16. Have you ever had staff privileges in a hospital denied, suspended, limited, revoked, or not renewed for medical disciplinary cause, resigned from a medical staff in lieu of disciplinary or administrative action, or is any such action pending?	or
YOU MUST DISCLOSE ANY INFORMAL OR CONFIDENTIAL DISCIPLINARY ACTION.	
17. 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?	
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 CHRCKED ABOVE, PLEASE SUBMIT COMPLETE <u>OFFICIAL</u> INPATIENT AND OUTPATIENT TREATMENT RECORDS, EVIDENCE OF ONGOING REHABILITATION TREATMENT, AND A PERSONAL WRITTEN EXPLANATION.	
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STATE OF CALIFORNIA - STATE AND CONSUMER SERVICES AGE



MEDICAL BOARD OF CALIFORNIA LICENSING PROGRAM

1426 Howe Avenue, Sacramento, CA 95825-3236 (916) 263-2499 \$508 6/6/10 014387



Supply Marge Photo Ton Physician and Surgeon's Licensure

Please <u>READ</u> all instructions prior to completing this application. <u>ALL</u> questions on this application must be answered, and <u>all</u> supporting documents must be submitted with this application as per instructions.

Please type or print neatly. When space provided is insufficient, attach additional sheets of paper.

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17. Has a claim or action for damages e which resulted in a malpractice settlement IF YES, give DETAILS BELOW.	_	nst you in the course of the practice edicine or any other healing art tration award of over \$30,000.00?	License Data
Name of Claimant Location of Court	- ie	Brief Description of the Facts	, A
A STATE OF THE STA			Ø
18. Have you ever been denied a license	e, permission to pra	ctice medicine or any other healing art, or denied permission to take	
an examination in any state, country, or Life YES, give details below.	.S. federal jurisdicti	on, or is any such action pending?	2.5
State or Country Date of Denial		Reason for Denial	1
-	•	ice in the healing arts in this or any other state, or voluntarily sor federal) to any licensing board or any other Yes No	
		suspended, limited, revoked or not renewed for medical disciplinary or administrative action, or is any such action Yes No	ø
21. Do you have any condition which in a including but not limited to, any of the folk		imits your ability to practice medicine with reasonable skill and safety, Yes Vo	ijenos nacio
A condition which required a Alcohol or chemical substant Emotional, mental or behavior Other (explain):	idmission to an inpa ce dependency or a	ntient psychiatric treatment facility. addiction.	A
For any of the boxes checked above, please rehabilitation treatment, and a personal wi		FICIAL INPATIENT AND OUTPATIENT TREATMENT RECORDS, EVIDENCE OF ONGOING	s solici /
QUESTION 22: For any positive resp matter in addition to written explanatio original letters of explanation from app	ns. If applicable, a	ng question, please provide <u>ALL official documentation</u> regarding in applicant should also provide official hearing/court documents a s.	the ind
federal, state or local law of any state, the illegal sale, transportation, manufacture, o	United States, or a listribution or disper	e to any violation (including misdemeanors and felonies) of any foreign country or any violation relating to the possession, use, using of controlled substances, or is any such action pending? resulted in fines of \$300.00 or less.) If YES, give details below.	-
YOU ARE REQUIRED TO LIST ANY CONVICTION THA	T HAS BEEN <u>SET ASIDE</u>	YES NO AND DISMISSED OR EXPUNGED, OR WHERE A STAY OF EXECUTION HAS BEEN	
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	PHOTO DECLARATION
	I hereby declare under penalty of perjury under the laws of the State of California, that the photo of myself attached hereto, was taken on or about
	my age then beingyeara;
	my color of hair
	my color of eyes
	my weight (bs.;
	and identifying marks are
	Signature of Applicant:
	fita J. Kalanta
Notice: All items in this application are mandatory; none are voluntary. Failure to provide any of the requested information. The information provided will be used to determine your qualifications for licensure per Section 2080 of the California But the collection of this information. The information on your application may be transferred to other medical licensing author of other governmental or law enforcement agencies. You have the right to review your application subject to the province of the Licensing Program is the custodian of records.	siness and Professions Code, which authorizes
STATE OF California	Applicant
country of Orange	Declaration/Signature and NOTARY
The applicant, GITA JAMSHIDI - KALANTARI PRINT FULL NAME OF APPLICANT	being first duly sworn upon his/her
oath deposes and says: that he/she is the person herein named subscribing to this application; that application, knows the full content thereof, and declares that all of the information contained herein are submitted herewith are true and correct; that he/she is the lawful holder of the degree of Doctor of Me application, that the same was procured in the regular course of instruction and examination, and that credentials submitted, were procured without fraud or misrepresentation or any mistake of which the applicant is the lawful holder thoreof.	nd evidence or other credentials dicine as prescribed by this it, together with all the
physicians, employers (past, present and future), business and professional associates (past, present	tions, my references, personal
including medical records, educational records, and records of psychiatric treatment and treatment for dency, requested by that Board in connection with this application; or any further or future investigation.	s any information, files or records, r drug and/or alcohol abuse or depen-
determine my medical competence, professional conduct or physical or mental ability to safely engage I further authorize the Medical Board of California or its successors to release to the organizations, incommation which is material to this application or any subsequent licensure. I further acknowledge the any item or response on this application is adequate to deny the same or to hold a hearing to revoke to	e in the practice of medicine. dividuals or groups listed above any lat falsification or micropresentation of
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Signed and sworm to before me this 30 th	2000
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Commission # 1158146 No:ally Public - California Orange County ADDRESS	10, Buena Park, CA 9062
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MEDICAL BOARD OF CALIFORNIA LICENSING PROGRAM

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



CERTIFICATE OF MEDICAL EDUCATION

MEDICAL SCHOOL: DO NOT COMPLETE IF PHOTOGRAPH OF APPLICANT/STUDENT IS NOT ATTACHED BELOW.

						522511.
This certifies that GT 7A	KADEMI (J.KALAN				enrolled in
MEDICAL UNIVE	RSITY OF		LIJBEC	k / GEA	RENENROLLED	
	KTOBER	_19 <i><u>89</u>_</i> and w	as granted the folio	LOCATION Dwing credits	on enrollment:	
Premedical Education:	Two years of preprofession and biology (Business and	al postsecondary Professions Code	educetlon, including Section 2088).	the subjects of	physics, chemistry,	
MEDICAL	UNIVERSITY EDUCATIONAL INSTITUTION	OF L	BECK	89	bisto 91	
Advanced Credits: Credits	previously obtained at an a	approved medical	, dental, or osteopath	ic school.•	UNICO .	
	NIA		•		RI A	
	MEDICAL SCHOOL		N/ A	<u> </u>	DATEC	
The undersigned further certifies that	t the records of this instit	tution show that	<u>S</u> he attended in t	this institution	SPECIFY NUMBER	
					たりはかけた いいいのこつ	
years of resident instruction of	MBER OF WEEKS	each, completi	ng at least 4,000 ho	ours, of which	at least 80 percent a	actual
attendance is required, in the subject	ts set forth hereunder (B	usiness and Pro	ofessions Code Se	ction 2089), a	nd that:	
⊠ ⊆ he was gra	anted the degree Bashal	er/Doctor of Me	dicine by OR	he with	hdrew from	
						,
the above mentioned med	ical school on the	24 th	day ofA	21 <u>21 L</u>	19 <u>97</u> .	1
Anatomy	Dermatology			MONTH		
Otolaryngology	Embryology		Pre Phy	ventive medici: ysical Medicine	ne, including Nutrition	
Obstetrics and Gynecology	Histology		The	ysicai Medicine Frapeutics		
Radiology, including Radiation Safety	Human Sexuality a	s defined in Secti		uroanatomy		
Tropical Medicine Physiology	Medicine		Ćhi		tion and Treatment	
Biochemistry	Surgery, including	Orthopedic Surge	ry Ger	riatric Medicine	****	
Pathology, Bacteriology and Immunology	Urology Psychiatry			diatrics		
Ophthalmology	Neurology			armacology		
	Alcoholism and Ch	emical Dependen	_	esthesia nily Medicine++		
					Abuse Detection & Tre	eatmant
	Each school will	here profession				
	these forms If	more than and	echool was attand	on was receiv	red MUST completed les of this blank form	one of
	be made and u	sed. Note that	photograph and all	ea, protocopi Lentrice to the	es of this blank form form must be origin	may.
	Control of the control		priorograph and an	enthes to the	ioitti tilust be origir	ial.
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	OM applic	able to medical : 1004	students who ento	olled in medica	al school on or after	
	9 60					
	TRANSCRI	PTS FOR ALL A	ADVANCED CRED	ITS AND ME	DICAL SCHOOL CR	ËDITS
		MUST B	E SUPPLIED WITH	THIS CERT	IFICATE	LDITO
	Medical School	ol Seal MUST	be imprinted Pa	rtially on th	e Photograph	
		//	red this 2 day		19-20-	12
	BY	Tolo	لسميمس	7		
	Pent to	e. D. Jul		PRESIDENT	, SECRETARY, DEAN	
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Sacramento, CA 95825-3236
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LICENSING PROGRAM
CERTIFICATE OF COMPLETION OF ACGME/RCPSC POSTGRADUATE TRAINING

To be completed by the facility for every medical so	chool graduate completing	g postgraduate trainir	g in the United States of	r Canada.
ATTENTION PROGRAM DIRECTORS AND DIRECTORS OF MEDICAL EDUCATION: Only the Program Director and the Director of Medical Education may sign if attached to this form (may be a photocopy). Such delegation must be an or	six form. If that cionalism andionibe	in boding a statement of the court be	E APPLICANT BY BLOOD, MARRIAGE I person, evidence of that delega	E. OR ADOPTION. dion must be
PART 1: To be completed by the APPLICANT.				
LAST NAME of Applicant	First Name		Middle Initial	
KALANTARI	GITA		J	
II S. Social Security Number Date of B	Tele	phone Number:		
	Hom	e:	Work: ()	
Current Andreas:				
City				
City State		Zip Code	•	
PART 2: 10 be completed by the PROGRAM DIRECTOR.			angara ta bagana	et i glereg vi
ATTENTION PROGRAM DIRECTOR! Do not sign and date applicant to qualify for licensure. Completion of this form	this form before the last d	y of any postgraduate	training year which will I	e used by the
postgraduate training at this facility. If a period of training	WAS NOT completed in a	satisfactory mauror in	lasca armida a compusta.	امما تعقدان
narrative explanation. The following information is provide OF "SATISFACTORY."	d to certify "satisfactory"	completion. PLEASE	SEE THE REVERSE FOR	A DEFINITION
Name of Facility: GHARLES R. DREW UNW	. BE MENVINE	Address of Facility:		
KING/DREW MEDICAL CEN	TEN	12021 8.	WILLINGTON LA	PA GAR
Name of Program Director:	d	Tolophone Mumbon	27	WAT TOWN
CESAR ARANGURI MO Signature of Program Directory		ر Date Signed:		
OUT BROUGHT	1	Loate digited, 5	12/05.	
List Categorical Specialty Area of Training Completed by Trainee:		Date Training Commen	ced: Date Training Complet	ed;
Internal MEDICAL If the training was retailing or transitional, list the specific rotations and the	ournbar of wake aport la and	1 -16 -04	1-15-0	5
GENERAL MEDICINE TRAINING REQUIREMENT):	a treatment of Meaks shellf ill 680	TORE THE REVERSE FO	K INFORMATION ON SATISFY	/ING THE
PART 3: To be completed by the DIRECTOR OF MEDICAL EDUCATI	ON and affixed with the officia	I facility seal.	The state of the s	
Name of the Director of Medical Education	Name of Fac	ility:	المألما	
Sharon Asniey, MD, MPH	, MIBH . KIM	3 I Drew PR	idical Center	
12021 S. Wilmington A	Je. Suite :	3-221		,
City	90059	Talanhara Mumbar	<u> </u>	· · · · · · · · · · · · · · · · · · ·
Los Angeles - CA	• •			
PART 4: Signature of DIRECTOR OF MEDICAL EDUCATION certifying				
Attention: Olrector of Medical Education). Do not sign and date this for licensure. This form may be signed by the current Cirector of Medical Education in the training listed above.	rm before the lest day of any po	stgraduate training year wi	ish will be used by the applicar	nt to qualify for
of the training fished above.	aranon, it ades not need to be s	igned by the person who w	as the Director of Medical Educ	eation at the time
Notice to Applicant: If this form is used to verify postgraduate training by	eyond that which is required for	licensure, this form can be	algned by the Director of Medic	s! Education and
the Program Director before the final day of training. However, if you are of the training year, a new form must be completed and submitted to the f		ich training was completed	AND if the form was signed bef	ore the final day
part of the same				
	OFFICIAL HOSPITAL SEAL OF	NOTARY SEAL, DATE A	ND SIGNATURE	
I hereby declare under cen	MUST BE AFFIXED IN THE 80 Bity of perjury under the law			
correct and that the traini	ilu urdaram is abomved by:	the ACTAME of the DCD	SC to offer the home and to	-1 -6 - 4 -
osmpicica by the applica	ant and that the applicant Wa	s trained in an approve	d ACGME or RCPSC progra	am position.
Signature of Director of Medica		_	Date Signed:	
\$ Shanon A	Ashley, MD, M	PH, MBA	5/02/05	3 Δ



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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. PART 1: TO BE ETED BY THE APPLICANT NAME: Last First Middle jamshidi alantaci GLTA U.S. Social Security Number Date of Birth Telephone Number Home Work (Public/Mailing Address 15575 LCFTHILL DR. City State/Province Zip/Postal Code 90638 Medical School of Graduation: LUBECK / GERMANY MEDICAL UNIVERSITY OF 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 satisfactorily completed a period of accredited postgraduate training at this facility and that the trainee has acquired the skill and qualifications necessary to safely assume the unrestricted practice of medicine in this state. Name of Facility: ACGME 10 digit Program number: (www.acgme.org) Hospital Family Medicine Kesidency 1200521458 Telephone #: 1400 S. Grand Age Suite 101 Categorical Specialty Area of Training Start Date of Training End Date (or anticipated completion date) of Training 031012005 0212812006 **UNUSUAL CIRCUMSTANCES:** Did the trainee ever take a leave of absence or break from their training? NO Was the trainee ever terminated, dismissed or expelled? NO Did the trainee ever resign? YES NO Was the trainee ever placed on probation? YEŞ NO Was the trainee ever disciplined or placed under investigation? YES NO Were any incident reports regarding this trainee ever filed by instructors? YES NO Were any limitations or special requirements placed upon the trainee for

A "Yes" response to ANY of the above questions requires the program director to provide a written explanation on a separate attachment.

clinical incompetence, disciplinary problems or for any other reason? .

Did the program decline to renew or offer the trainee a postgraduate training

L3A

NO

YES

YES

program contract for a following year?

DEFINITION OF "SATISFACTORY" COMPLETION OF TRAINING

The program director signing this form is formally certifying and documenting under penalty of perjury that the trainee received instruction appropriate for the particular postgraduate level and that he/she satisfactorily completed periods of training in accordance with the accepted standards and the criteria defined as equating to "satisfactory" performance as described below. The program director will personally be attesting to the fact that the trainee has acquired the skill and qualifications necessary to safely assume the unrestricted practice of medicine in this state.

"SATISFACTORY" IS DEFINED AS: THE TRAINEE PERFORMED AT AN ADEQUATE LEVEL BASED ON EVIDENCE OF SATISFACTORY PROGRESSIVE GROWTH INCLUDING DEMONSTRATED ABILITY TO ASSUME GRADED AND INCREASING RESPONSIBILITY FOR PATIENT CARE.

GENERAL MEDICINE TRAINING REQUIREMENT

To qualify for licensure in California, applicants who are graduates of an international medical school must complete at least four months of postgraduate training in GENERAL MEDICINE as part of the requirement. Applicants who are graduates of a U.S. or Canadian medical school, who have not completed postgraduate training required for Ilcensure by July 1, 1990, must also complete four months of training in GENERAL MEDICINE prior to ficensure. The GENERAL MEDICINE requirement may be satisfied by actual clinical practice where the applicant has direct patient care responsibilities in any particular specialty or sub-specialty area for at least four months.

I hereby certify as the program director, that the individual named in Part 1

a minimum of four months of general medicine as part of this postgraduate training program accredited by the ACGME or the RCPSC.

SIGNATURE OF PROGRAM DIRECTOR

ATTENTION PROGRAM DIRECTOR: THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE, OR ADOPTION. If that signature authority is being delegated to another person, evidence of that delegation must be attached to this form (may be a photocopy). Each delegation must be on official letterhead and must be dated within the last 12 months.

HOSPITAL SEAL

OFFICIAL HOSPITAL SEAL MUST BE AFFIXED IN THE BOX TO THE LEFT TO CERTIFY TRAINING

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

Maureen Strohm PRINT NAME OF PROGRAM DIRECTOR

une Stol

SIGNATURE OF PROGRAM DIRECTOR Signature Stamp is Not Acceptable

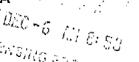
If a hospital seal is not available, the program director shall sign this form in the presence of a notary public.

State of ________California_
County of __________Angeles
Subscribed and sworn to (or affirmed) before me on

personally known to me or proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.

M. P. FRENCH Commission # 1379464 Notary Public - California & Los Angeles County My Comm. Expires Oct 10, 2006

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CERTIFICATE OF CURRENT POSTGRADUATE TRAINING ENROLLMENT

At the time of licensure, you may be entitled to a reduced initial license fee if you are actively participating in a slotted position in an ACGME/RCPSC accredited postgraduate training program.

NOTE: This form may not be used in fleu of the Form L3A-B, "Certificate of Completion of ACGME/RCPSC Postgraduate Training."

[14445 / L		
NAME: Last Kalantar	i First GITA	Jamshidi
Date of B	hth Medical School	ol of Graduation:
This is to certify that the above approant is	actively participating in an ACGME	or RCPSC accredited postgraduate
training position that started on 3	1.1 / 2005	and is expected to be
completed on 6 / 30 /	1-2007 in	Family Medicine
at USC/CA Hospital Family M	edicine Residency Cate	egorical Specialty Area of Training
located at 1400 S. Grand Aw	STE 101 Los Angeles,	CB 90015
The 10 digit ACGME Program # : 1 &	0 0 5 2 1 4 5 8	(Refer to http://www.acgme.org/adspublic
	The second secon	
I hereby declare under penalty of perjury under the I above program is accredited by the ACGME or the I applicant is being trained in an accordited ACCME.	aws of the State of California that the abov	e statements are true and correct and the
applicant is being trained in an accredited ACGME of	or RCPSC postgraduate training position.	g completed by the applicant and that the
Maureen Strohm, M.D		
PRINT NAME OF PROGRAM DIRECTOR		
SIGNATURE OF PROGRAM DIRECTOR - Signature St.	amp Is Not Acceptable	
/1/28/05 DATE		
	TELEPRONE NUMBER	
ATTENTION PROGRAM DIRECTOR: THE PERSON WHO SIGN Only the Program Director may sign this form. If that signs this form (may be a photocopy). Such delegation must be	fure authority is below delegated to	
this form (may be a photocopy). Such delegation must be	on official letterhead and must be dated within t	ne last 12 months.
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State of California		
County of Las Angeles		•
Subscribed and sworn to (or affirmed) before	me on	
this 2 day of No	vember	, 20 0.5
by Maureen Strok	m, m.D-	
personally known to me or proved to me on the	e basis of satisfactory evidence to be	the person(s) who appeared before me.
		$\bigcap \bigcap \bigcap$
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(as Angellin County)	OFFICIAL MODELTAL CT	
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07A-100-L5A (Rev. 3/99)

MEDICAL BOARD OF CALIFORNIA LICENSING PROGRAM

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OFFICIAL BREAKDOWN OF UNDERGRADUATE CLINICAL CLERKSHIPS

FOR	GITA	J. KALA.	MTARI	(KADEMI)
	TYP	'E OR PRINT I	FULL NAME	OF APPLICAT	VI

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.

(Please list all ap List training	UNDERGRADUATE CLINICAL CLERKSH oplicable training in the area below and on the reversion date order commencing with the first clinical section.	erse side of this form	
CLINICAL SUBJECT AREA	FACILITY NAME AND ADDRESS HEIDBERG	DATES OFATTENDANCE FROM TO (Month/Day/Year)	WEEKS OR WEEKLY HOURS OF CREDIT
SURGERY	HEIDBERG / TANGSTEDTER LANDSTR. 400, 2000 HAMBURG 62	03-02-92	40 h° , per wee
NEUROSURGERY	MEDICAL UNIVERSITY OF LÜBECK RATZEBURGER ALLEE 160, 2400 LÜBECK	10-11-99	40 ho v
OBSTETRICS AND GYNECOLOGY	MEHR HOSPITAL, ZARTOSHT AUE, TEHRAN / IRAN	07-16-93	40h°
SURGERY	MEDICAL UNIVERSITY OF LUBECK / RATZEBURGER ALLEE 160		40 ho v
MEDICINE	UCLA IVA-HOSPITAL 1301 WILSHIRE BIVD. LAIGH 90073	10-24-94 12-18 to -94	40 ho BEEK
SURGERY	UCI MEDICAL CENTER ORANGE, CA. 92668	12-19-94	MORE THAT 406° 8 Per WEEK
MEDICINE	UCSD MEDICAL CENTER SAN-DIEGO 200 WEST ARBORDA	04-24-95	HOLO Y
MEDICINE	I MICONI WAL MACALTAL.	05-22 -95	40hor DERY WEEK
PSYCHIATRY	1100 - 12.0 1/00 0	06-19-95_	40hers WEEK
THE COMPLE	TION OF THIS FORM IS REQUIRED ONLY	/ OF	LEA

INTERNATIONAL MEDICAL SCHOOL GRADUATES

FOR.

TYPE OR PRINT FULL NAME OF APPLICANT

MEDICAL SCHOOL: SEE REVERSE SIDE FOR INSTRUCTIONS.

CLINICAL SUBJECT AREA	FACILITY NAME AND ADDRESS	DATES OFATTENDANCE FROM TO (Month/Day/Year)	WEEKS OR WEEKLY HOU! OF CREDIT
			<u></u>



Puf. Dr. D. Jocham

FULL NAME of Dean or Registrar (Please TYPE OR PRINT)

declare under penalty of perjury, that I am/was the Dean er 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

2000 Date

07A-100-L5B (Rev. 3/99)

(DU NOT DETACH)

LICENSE NO.

A95847

EXPIRATION

DATE

06/30/18

AMOUNT DUE IF

POSTMARKED AFTER

JULY 30, 2018

\$898.00

DUE NOW

\$820.00

Medical Board of California - Physician's and Surgeon's Renewal

LICENSEE NAME

KALANTARI, GITA J

"H Completed Continuing Education (See Question 1) "E' Change of Address (fill in reverse side) "I" Conviction — "J" Conviction — "F" Family Physician Training Program (\$25 See Question 4) "G" Figure 1 Interest Statement (See Question 5)	I declare under penalty of perjury under the laws of t statements, answers, and representations on this form attached hereto, are true, complete and accurate. Signature ENTER YOUR PHONE NUMBER FO	nhe State of California that all not including supplementary Date 326
CHANGE OF ADDRESS (Only if different from address above) ADDRESS OF RECORD (Required) Address Line 1	80008200000087800 KALANTARI, GITA J	A95847
Address Late 1		
Address Line 2.		
Address Line 3		
City	State Zip	
CONFIDENTIAL STREET ADDRESS (Required if PO Box used a		
Address Line 1	ove for Address of Record)	
Address Line 2		-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1
Address Line 3		
City	State Zip	
		-

lical Board of California – Physician's and Surg .icensee name KALANTARI, GITA J	LICENSE NO. A95847	EXPIRATION DATE 06/30/16	AMOUNT DUE NOW \$820.00	POSTMARKED AFT JULY 30, 2016 \$898.00
LICENSEE MUST CHECK CORRECT BOXES	["D"	SIGNATUR	E REQUIRED	n den men van van van van van van van van van va
Completed Continuing Education	I ,	or penalty of perjury under t		
Change of Address (fill in reverse side)	■ 3	nswers, and representations to, are true, complete and ac		ling supplementary
Conviction Disclosure		o, are true, comprese and ac		
" Conviction Disclosure			/ · · · · · · · · · · · · · · · · · · ·	1 11
CONTROLOR DISSISSAN	Signature	<u>Calant</u>	h. D.	Date 3/24/16
Family Physician Training Program (\$25)	<u> </u>			
Financial Interest Statement-Read instructions above	e EN	TER YOUR PHONE NU	MRER FOR REF	ERENCE:
<u> </u>	_			
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