



**MEDICAL BOARD OF CALIFORNIA**  
 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 check one):  License  PTAL - or -  Update

1. NAME: Last Kalantari First Gita Middle Jamshidi

Other names you have used (include maiden name): Gita Kademi

2. U.S. Social Security Number: [REDACTED]

3. Place of Birth: [REDACTED]

4. Date of Birth: [REDACTED]

5. Gender:  Male  Female

6. Public/Mailing Address: 15515 LOFTHILL DRIVE  
 (Please note: this information is public)  
 (30 characters maximum per line, including spaces)

City LA MIRADA State/Province CA Zip/Postal Code 90638 Country U-S-A

7. Telephone Numbers: (Include area code) [REDACTED] [REDACTED] [REDACTED]

8. California Driver's License Number (optional): [REDACTED]

9. E-mail Address (optional): [REDACTED]

10. Have you ever filed an Application for Physician's and Surgeon's License, or PTAL, in California?  
 Yes  No  
 previous license number, if any: \_\_\_\_\_

**MEDICAL EDUCATION**

11. LIST EACH MEDICAL SCHOOL THAT YOU HAVE ATTENDED.

School Name	City, State/Province, Country	Dates of Attendance
Medizinische Universität zu Lübeck (Medical University of Lübeck)	Lübeck / GERMANY	1/10/89 to 30/9/97
12. School of Graduation	Degree Awarded	Date of Graduation
Medizinische Universität zu Lübeck	AIP	April 1997

**EXAMINATIONS**

13. LIST ALL OF THE FOLLOWING EXAMINATIONS YOU HAVE TAKEN: USMLE, FLEX, NBME, ECFMG, SPEX, STATE BOARDS and/or QME in Canada

Examination	Date	Result (Pass/fail)
USMLE STEP 1	10/30/99	[REDACTED]
USMLE STEP 2 / USMLE Step 3	4/7/2000 / 12/28/05	[REDACTED]
TOEFL CSA	8/19/2002 valid indefinitely	[REDACTED]
	9/6/2003 valid	[REDACTED]

**GER 35 L1A**

Cashiering Use Only

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

**ACGME/RCPC ACCREDITED POSTGRADUATE TRAINING**

14. Please list each ACGME/RCPC accredited postgraduate training program in which you have participated. You must include each Internship, residency and fellowship, whether or not the program was completed or credit granted.

Facility Name	Address	Specialty Area	Dates of Attendance
① KING-DREW MEDICAL CENTER	12021 S. Wilmington Ave. LA, CA 90059	INTERNAL MEDICINE	1-16-04 to 1-15-05
② USC - Family Medicine California Hospital (Medical Center)	1400 S Grand Ave, Suite 101 LA, CA 90015	FAMILY MEDICINE	1-3-05 to 6-30-07 24 months to finish 1-28-06

**POSTGRADUATE TRAINING**

Did you ever take a leave of absence or break from your training?	YES	NO
Have you ever been terminated, dismissed or expelled from a program?	YES	NO
Have you ever resigned from a training program?	YES	NO
Were you ever placed on probation?	YES	NO
Were you ever disciplined or placed under investigation?	YES	NO
Were any incident reports ever filed by instructors?	YES	NO
Were any limitations or special requirements placed upon you for clinical performance, discipline, or for any other reason?	YES	NO
Have you ever had a postgraduate training program contract not be renewed or offered for a following year?	YES	NO

**MEDICAL LICENSURE**

15. Please list all medical licenses (other than training licenses) that have ever been issued by any state or territory in the United States or Canadian province.

Jurisdiction	License Number	Date of Issuance	Date of Practice in that Jurisdiction
N/A			

APPLICANT:

Gita Jamshidi Kalantari

DATE OF BIRTH:

[REDACTED]

**L1B**

### ABMS CERTIFICATIONS

16. Are you currently certified by a Member Board of the American Board of Medical Specialties?

YES  NO

Member Board	Expiration Date	Certificate Number
N/A		

MBs  
 Use Only  
 ABMS

### MALPRACTICE HISTORY

17. Has a claim or an action ever been filed against you for the practice of medicine which resulted in a malpractice settlement, judgment, or arbitration award of \$30,000 or more?

YES  NO

### PRACTICE IMPAIRMENT OR LIMITATIONS

18. Have you been enrolled in, required to enter into, or participated in any drug or alcohol recovery program or impaired practitioner program?

YES  NO

19. Have you been treated for or had a recurrence of a diagnosed addictive disorder?

YES  NO

20. Have you been diagnosed with an emotional, a mental, or behavioral disorder which impairs your ability to practice medicine safely?

YES  NO

21. Have you ever been diagnosed with a neurological or other physical condition that would impair your ability to practice medicine safely?

YES  NO

22. Do you have any other condition which in any way impairs or limits your ability to practice medicine safely?

YES  NO

If you do receive ongoing treatment or participate in a monitoring program, the Board will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure.

Malpractice

### CRIMINAL RECORD HISTORY

23. Have you ever been convicted of, or pled nolo contendere to ANY offense in any state in the United States or foreign country?

*This includes a citation, infraction, misdemeanor and/or felony, etc. If "YES" attach a list of each offense by arrest and conviction dates, violation, and court of jurisdiction (name and address). Matters in which you were diverted, deferred, pardoned, pled nolo contendere, or if the conviction was later expunged from the record of the court or set aside under Penal Code Section 1203.4 MUST be disclosed. If you are awaiting judgment and sentencing following entry of a plea or jury verdict, you MUST disclose the conviction; you are entitled to submit evidence that you have been rehabilitated. Serious traffic convictions such as reckless driving, driving under the influence of alcohol and/or drugs, hit and run, evading a peace officer, failure to appear, driving while the license is suspended or revoked MUST be reported. This list is not all-inclusive. If in doubt as to whether a conviction should be disclosed, it is better to disclose the conviction on the application.*

*For each conviction disclosed, you must submit with the application certified copies of the arresting agency report, certified copies of the court documents, and a descriptive explanation of the circumstances surrounding the conviction of disciplinary action (i.e., dates and location of incident and all circumstances surrounding the incident). This letter must accompany the application. If documents were purged by arresting agency and/or court, a letter of explanation from these agencies is required.*

*Applicants who answer "NO" to the question but have a previous conviction or plea, may have their application denied or license revoked for knowingly falsifying the application.*

YES  NO

APPLICANT: GITA JAMSHIDI KALANTARI

DATE OF BIRTH: XXXXXXXXXX

L1C

**CRIMINAL RECORD HISTORY (cont'd)**

WBC  
Use Only

24. Is any criminal action pending against you? YES  NO
25. Are you required to register as a Sex Offender? YES  NO

**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, or repeated negligent acts or malpractice by any medical licensing board, other agency, or hospital? YES  NO
29. Have you ever had any license to practice medicine revoked, suspended, or placed on probation? YES  NO
30. Have you ever had any license to practice medicine subjected to any action including but not limited to informal or confidential discipline, consent orders, letters of warning, letters of reprimand, or citation? YES  NO
31. Have you ever had any license to practice medicine subjected to any other disciplinary action? YES  NO
32. Is any disciplinary action pending against any of your licenses to practice medicine? YES  NO
33. Have you ever had staff privileges in a hospital terminated, denied, suspended, limited, revoked, or not renewed? YES  NO
34. Have you ever resigned from a medical staff in lieu of disciplinary or administrative action? YES  NO
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 terminated? YES  NO
38. Have you ever entered into any arrangement or plea or agreement in lieu of a federal prosecution for a drug violation regulated by the DEA? YES  NO

APPLICANT: GITA JAMSHIDI KALANTARI

DATE OF BIRTH:

**L1D**

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) [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 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.

G.K. (PLEASE INITIAL BOX)

SIGNATURE OF APPLICANT: Gita Jamshidi Kalantari (Please sign full name)

State of California

County of Orange

Subscribed and sworn to (or affirmed) before me on

this 24<sup>th</sup> day of January, 2006

by Gita Jamshidi Kalantari

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



Moon C. Lee  
SIGNATURE OF NOTARY PUBLIC

**L1E**

MEDICAL BOARD OF CALIFORNIA

1428 Howe Avenue, Suite 54, Sacramento, CA 95825-8236

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 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.

03 JUL -7 PM 11:41

Form with fields for Name (KALANTARI GITA JAMSHIDI), Social Security Number, Address (15515 LOFTHILL DR, LA MIRADA CA 90638), Telephone Numbers, Date of Birth, and License History.

QUESTIONS 11B through 12B: 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.

11B. 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?

12. 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?

\* MANDATORY DISCLOSURE OF U.S. SOCIAL SECURITY NUMBERS: Disclosure of your U.S. social security number is mandatory. Section 90 of the Business and Professions Code and Public Law 94-455 (42 USC 4051(a)(1)(C)) authorize collection of your social security number.

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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 U.S. federal governmental entity.

13A. 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?

13B. 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?

13C. Is any such action as described above pending?

13 (A) Yes [ ] No [ ]  
13 (B) Yes [ ] No [ ]  
13 (C) Yes [ ] No [ ]

IF YOU ANSWERED YES TO 13A, 13B OR 13C, PROVIDE DETAILS ON A SEPARATE ATTACHMENT.

14. 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?

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

Yes [ ] No [ ]

15. 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?

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

Yes [ ] No [ ]

16. 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?

YOU MUST DISCLOSE ANY INFORMAL OR CONFIDENTIAL DISCIPLINARY ACTION.

Yes [ ] No [ ]

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 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.

18A. Have you ever been convicted of, or pled not guilty 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?

18B. Is any criminal action related to the above pending?

18 (A) Yes [ ] No [ ]  
18 (B) Yes [ ] No [ ]

IF YOU ANSWERED YES TO 18A OR 18B, PROVIDE DETAILS ON A SEPARATE ATTACHMENT.

STATE OF California

COUNTY OF Orange

Applicant Declaration/Signature and NOTARY

The applicant, GITA JAMSHIDI KALANTARI 6-14-68 being first duly sworn upon his/her oath deposes and says: (PLEASE PRINT FULL NAME) (DATE OF BIRTH)

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:

Gita Jamshidi Kalantari  
(PLEASE SIGN FULL NAME, NOT INITIALS)

Signed and sworn to before me this 3rd day of July, 2003  
MONTH YEAR

MOON C. LEE  
COMM. # 1324215  
NOTARY PUBLIC-CALIFORNIA  
ORANGE COUNTY  
COMM. EXP. NOV. 4, 2005

Moon C. Lee  
SIGNATURE OF NOTARY PUBLIC  
5300 Beach Blvd Buena Park, CA  
ADDRESS

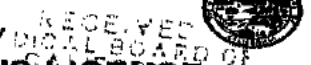
My commission expires Nov 4, 2005 **L8B**



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APPLICATION UPDATE 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. 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.

1. NAME: Last Kalantari First Gita Middle Jamshidi

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

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.  
15515 Lofthill Dr.

City LA MIRADA State CA Zip Code 90638 Country U.S.A.

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.]  
N/A

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Country \_\_\_\_\_

5. Telephone Number: Home: [REDACTED] Work: [REDACTED]

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

7. [REDACTED] and Place of Birth: [REDACTED] Sex:  Male  Female

9. 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

10. 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

11A. 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 ACGME/RCPC 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

QUESTIONS 11B through 11E:

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.

11B. Have you ever withdrawn from, or been suspended, dismissed or expelled from a medical school or postgraduate training program OR have you ever taken a leave of absence from such a school or program?  
IF YOU ANSWERED YES, BOTH APPLICANT AND SCHOOL/PROGRAM MUST PROVIDE DETAILS ON A SEPARATE ATTACHMENT.  
 Yes  No

12. 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, judgment, or arbitration award of over \$30,000.00?  
IF YOU ANSWERED YES, PROVIDE DETAILS ON A SEPARATE ATTACHMENT.  
 Yes  No

\* 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 94-456 (42 USCA 4060k(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 17820 of the Family Code, or for verification of licensure or examination status by a licensing or examination entity which utilizes a national examination and where licensure is reciprocal with the requesting state. If you fail to disclose your social security number your application for initial licensure will not be processed AND you will be reported to the Franchise Tax Board, which may assess a \$100 penalty against you.

MBC USE ONLY  
School Code \_\_\_\_\_

**L8A**



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.

MSC USE ONLY  
License Data

13A. 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?

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13 (A) Yes No  
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IF YOU ANSWERED YES, PROVIDE DETAILS ON A SEPARATE ATTACHMENT.

Yes No

15. 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?

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

Yes No

16. 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?

YOU MUST DISCLOSE ANY INFORMAL OR CONFIDENTIAL DISCIPLINARY ACTION.

Yes No

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Yes No

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

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18B. Is any criminal action related to the above pending?

18 (A) Yes No  
18 (B) Yes No

IF YOU ANSWERED YES TO 18A OR 18B, PROVIDE DETAILS ON A SEPARATE ATTACHMENT.

STATE OF CALIFORNIA

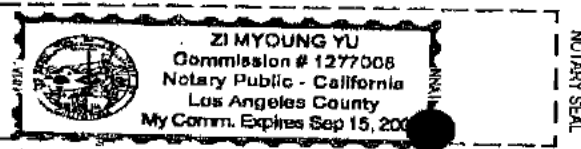
COUNTY OF LOS ANGELES



The applicant, GITA JAMSHIDI KALANTARI 6-14-68, 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.

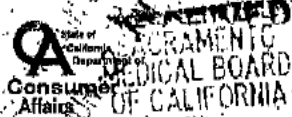
SIGNATURE OF APPLICANT: Gita J. Kalantari (PLEASE SIGN FULL NAME, NOT INITIALS)

Signed and sworn to before me this 3RD day of July 2003



SIGNATURE OF NOTARY PUBLIC: [Signature]  
ADDRESS: 15068 ROBERTSON AVE LA MIRADA CA 90638  
My commission expires 3/15/2004

L8B



**MEDICAL BOARD OF CALIFORNIA  
LICENSING PROGRAM**  
1426 Howe Avenue, Sacramento, CA 95825-3235  
(916) 263-2499

\$508 6/6/00  
014887



000 JUN 2 2 11:19 PM '00

**APPLICATION FOR PHYSICIAN AND SURGEON'S LICENSURE**

Please **READ** all instructions prior to completing this application. **ALL** questions on this application must be answered, and **all** 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.

MBC USE ONLY

**1. Name:** Last **KALANTARI** First **GITA** Middle **JAMSHIDI**

**2. Other names you have used (Include maiden name):** **GITA KADEMI**

**3. Social Security Number:** [REDACTED]

**4. Address: Number and Street/Rural Route (Include apartment number, if any)** [REDACTED]

**5. Sex:**  Female  Male

City [REDACTED] State [REDACTED] Zip Code [REDACTED] Country [REDACTED]

**6. Telephone Number:** Home: [REDACTED] Work: [REDACTED]

**7. Date of Birth: Mo/Day/Yr** [REDACTED] Place of Birth: [REDACTED]

**8. California Driver's License Number, if applicable:** NUMBER [REDACTED] EXPIRATION [REDACTED]

**9. Are you a U.S. citizen?** Yes  No   
If you are an international medical school graduate, you must provide an original full and unrestricted license to practice medicine in another state or country, OR official documentation of U.S. citizenship, OR an official Declaration of Intent to become a U.S. citizen.

**10. Have you ever filed an application for physician and surgeon examination or licensure in California?**  Yes  No  
If YES, PLEASE GIVE DATE PREVIOUS APPLICATION WAS SUBMITTED AND ATTACH ANY APPLICATION MATERIALS YOU MAY HAVE RETAINED.

**11A. List the names and addresses 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.**

Name	Address	Dates of Attendance
MEDICAL UNIVERSITY OF LUBECK	RATZBURGER ALLEE 160 D. 23538 LUBECK / GERMANY	OKT 89 to 97

**11B. Check whether the following premedical courses were successfully completed and show where completed:**

Course	Yes	No	Name of College or University
Chemistry	<input checked="" type="checkbox"/>	<input type="checkbox"/>	MEDICAL UNIVERSITY OF LUBECK
Physics	<input checked="" type="checkbox"/>	<input type="checkbox"/>	"
Biology or Zoology	<input checked="" type="checkbox"/>	<input type="checkbox"/>	"

**12. List the names and addresses 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 photocopy.**

School Name	Address	Place of Instruction	Dates of Attendance	Degree Awarded
MEDICAL UNIVERSITY OF LUBECK	RATZBURGER ALLEE 160	LUBECK / GERMANY	WINTER SEMESTER 89/90 - 97	DRZT IM PRAKTIKUM

DOCTOR OF MEDICINE DEGREE, as referenced above. (Note: A U.S. graduate may, in lieu of the original, submit an official certified photocopy that has the school seal affixed and the signature of the registrar certifying authenticity.)

Name of Medical School	Address of Medical School	Exact Date of Issuance
MEDICAL UNIVERSITY OF LUBECK	RATZBURGER ALLEE 160, 2400 LUBECK 23538	04-21-97

**MANDATORY DISCLOSURE OF SOCIAL SECURITY NUMBERS**  
Disclosure of your social security number (or federal employer identification number [FEIN], if you are a partnership) is mandatory. Section 30 of the Business and Professions Code and Public Law 94-455 (42 USCA 406(e)(2)(C)) authorize collection of your social security number. Your social security number or FEIN will be used exclusively for tax enforcement purposes, for purposes of compliance with any judgment or order for family support in accordance with Section 11350.6 of the Welfare and Institutions 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 or your FEIN, 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.

School Code **GER 35 L1A**

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

If YES, LIST NAME, LOCATION, DATE AND RESULT OF EXAMINATION. SUBMIT AN ORIGINAL OFFICIAL EXAMINATION HISTORY REPORT FROM EACH EXAMINATION AGENCY. APPLICANTS WHO HOLD CERTIFICATION THROUGH THE EDUCATIONAL COMMISSION FOR FOREIGN MEDICAL GRADUATES (ECFMG) WILL NEED TO SUBMIT AN ORIGINAL VALID ECFMG CERTIFICATE PRIOR TO LICENSURE.

Examination	Location	Date	Result
USLME STEP 1	BREA VILLAGE/FULLERTON/ <sup>CALIFORNIA</sup> LOS ANGELES	OCTOBER 30, 1999	
USLME STEP 2	BREA VILLAGE/FULLERTON/ <sup>CALIFORNIA</sup> LOS ANGELES	APRIL 7, 2000	

**14. Have you ever been licensed to practice medicine in any state or country?**  Yes  No

If YES, LIST STATE OR COUNTRY, LICENSE NUMBER, DATE ISSUED AND DATES OF PRACTICE IN EACH ISSUING AGENCY'S JURISDICTION. SUBMIT A LETTER OF GOOD STANDING FROM EACH STATE IN WHICH YOU ARE OR HAVE BEEN LICENSED. PLEASE INCLUDE TEMPORARY, TRAINING, OR PROVISIONAL LICENSES.

State or Country	License Number	Date of Issuance	Dates of Practice in that Jurisdiction

**15A. Are you currently, or have you ever been, a participant in a postgraduate training program in a facility in the U.S. or Canada?**  Yes  No

If YES, LIST NAMES AND ADDRESSES OF ALL FACILITIES. SUBMIT AN ORIGINAL CERTIFICATE OF COMPLETION OF ACGME/CCME POSTGRADUATE TRAINING (FORM L3A) FROM EACH FACILITY. (DO NOT COMPLETE FORM L3A/Bs 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	Type of Service	Dates of Attendance

**QUESTIONS 15B through 21:** For any positive response to the following questions, please provide ALL official documentation regarding the matter in addition to written explanations. If applicable, an applicant should also provide official hearing/court documents and original letters of explanation from medical school or training program directors or other appropriate authorities. APPLICANTS ARE ALSO REQUIRED TO REPORT ANY MATTER THAT IS PENDING OR IN WHICH CHARGES HAVE BEEN DROPPED OR EXPUNGED.

**15B. Have you ever withdrawn from, or been suspended, dismissed or expelled from a medical school or postgraduate training program?**  Yes  No

**16. 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 or has any disciplinary action ever been filed or taken regarding any healing arts license which you now hold or have ever held, or is any such action pending? Include any disciplinary actions by the U.S. Military, U.S. Public Health Service or other U.S. federal governmental entity. If YES, GIVE DETAILS BELOW.**  Yes  No

State	Date	Charge	Disposition

17. 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 YES, GIVE DETAILS BELOW.

Name of Claimant	Location of Court	Brief Description of the Facts

18. 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, country, or U.S. federal jurisdiction, or is any such action pending?  Yes  No

IF YES, GIVE DETAILS BELOW.

State or Country	Date of Denial	Reason for Denial

19. Have you ever voluntarily surrendered a license to practice in the 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

20. 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

21. 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.

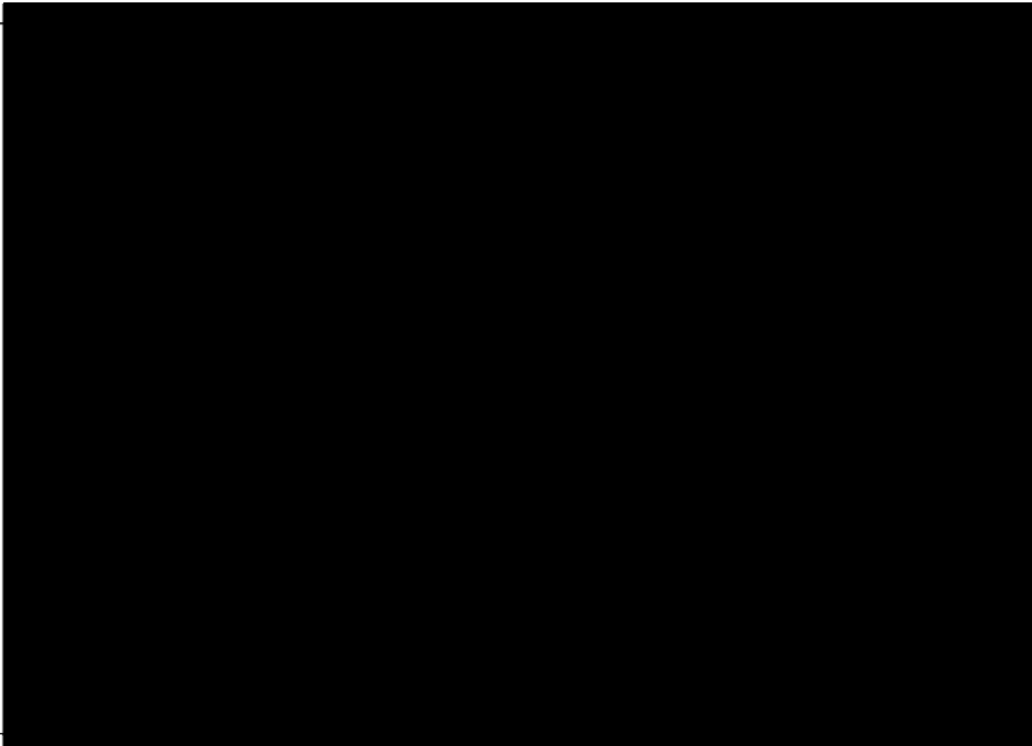
**QUESTION 22:** For any positive response to the following question, please provide ALL official documentation regarding the matter in addition to written explanations. If applicable, an applicant should also provide official hearing/court documents and original letters of explanation from appropriate authorities.

22. Have you ever been convicted of or pled nolo contendere to any violation (including misdemeanors and felonies) of any federal, state or local law of any state, the United States, or a foreign country or any violation relating to the possession, use, illegal sale, transportation, manufacture, distribution or dispensing of controlled substances, or is any such action pending? (Exclude violations of traffic laws, including speeding, which resulted in fines of \$300.00 or less.) If YES, give details below.  Yes  No

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.

Violation and Location	Date	Penalty or Disposition

L1C



**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

\_\_\_\_\_ to \_\_\_\_\_

my age then being \_\_\_\_\_ years;

my color of hair \_\_\_\_\_

my color of eyes \_\_\_\_\_

my height \_\_\_\_\_ ft. \_\_\_\_\_ in.;

my weight \_\_\_\_\_ lbs.;

and identifying marks are \_\_\_\_\_

**Signature of Applicant:**

*Gita J. Kalantari*

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 Program Manager of the Licensing Program is the custodian of records.

STATE OF California

COUNTY OF Orange



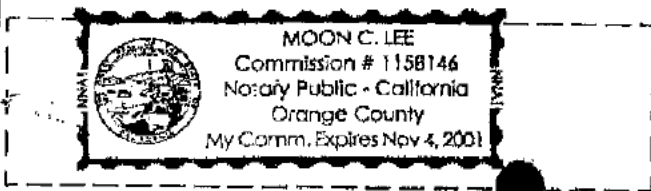
The applicant, GITA JAMSHIDI-KALANTARI, being first duly sworn upon his/her

PRINT FULL NAME OF APPLICANT

oath deposes and says: that he/she is the person herein named subscribing to this application; that he/she has read the complete application, knows the full content thereof, and declares that all of the information contained herein and evidence or other credentials submitted herewith are true and correct; that he/she is 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 the applicant is aware and that the applicant is 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 further acknowledge that falsification or misrepresentation of any item or response on this application is adequate to deny the same or to hold a hearing to revoke the same, if issued.

SIGNATURE OF APPLICANT: *Gita J. Kalantari* *Gita Jamshidi Kalantari*  
(PLEASE WRITE FULL NAME, NOT INITIALS)

Signed and sworn to before me this 30<sup>th</sup> day of May, 2000



*Sharon E. Bell*  
SIGNATURE OF NOTARY PUBLIC  
5300 Beach Bl. #110, Buena Park, CA 90621  
ADDRESS

My commission expires Nov 4, 2001





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.

This certifies that GITA KADEMI (J. KALANTARI) of [redacted] enrolled in MEDICAL UNIVERSITY OF LIBECK / GERMANY

on the 1st day of OKTOBER 19 89 and was granted the following credits on enrollment:

Premedical Education: Two years of preprofessional postsecondary education, including the subjects of physics, chemistry, and biology (Business and Professions Code Section 2088).

MEDICAL UNIVERSITY OF LIBECK 89 bis to 91

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

N/A N/A N/A

The undersigned further certifies that the records of this institution show that she attended in this institution N/A years of resident instruction of N/A weeks each, completing at least 4,000 hours, of which at least 80 percent actual attendance is required, in the subjects set forth hereunder (Business and Professions Code Section 2089), and that:

she was granted the degree Bachelor/Doctor of Medicine by OR he withdrew from

the above mentioned medical school on the 29th day of APRIL 19 97

- Anatomy Otolaryngology Obstetrics and Gynecology Radiology, including Radiation Safety Tropical Medicine Physiology Biochemistry Pathology, Bacteriology and Immunology Ophthalmology

- Dermatology Embryology Histology Human Sexuality as defined in Section 2090 Medicine Surgery, including Orthopedic Surgery Urology Psychiatry Neurology Alcoholism and Chemical Dependency

- Preventive medicine, including Nutrition Physical Medicine Therapeutics Neuroanatomy Child Abuse Detection and Treatment Geriatric Medicine Pediatrics Pharmacology Anesthesia Family Medicine\*\* Spousal or Partner Abuse Detection & Treatment\*\*\*

\* 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. Note that photograph and all entries to the form must be original.

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 September 1, 1994.

TRANSCRIPTS FOR ALL ADVANCED CREDITS AND MEDICAL SCHOOL CREDITS MUST BE SUPPLIED WITH THIS CERTIFICATE

Medical School Seal MUST be Imprinted Partially on the Photograph.

Signed and the school seal affixed this 2 day of May 19 2000

BY Prof. Dr. Dr. Jochen PRESIDENT, SECRETARY, DEAN

L2



**MEDICAL BOARD OF CALIFORNIA**  
 1426 Howe Avenue, Suite 54  
 Sacramento, CA 95825-3236  
 (916) 263-2382 FAX (916) 263-2487  
 www.caldocinfo.ca.gov



05 MAY -6 PM 1:39

LICENSING PROGRAM

**CERTIFICATE OF COMPLETION OF ACGME/RCPSC POSTGRADUATE TRAINING**

To be completed by the facility for every medical school graduate completing postgraduate training in the United States or Canada.

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

**PART 1: To be completed by the APPLICANT.**

LAST NAME of Applicant <b>KALANTARI</b>	First Name <b>GITA</b>	Middle Initial <b>J</b>
U.S. Social Security Number [REDACTED]	Date of Birth: MM/DD/YYYY [REDACTED]	Telephone Number: Home: [REDACTED] Work: ( ) [REDACTED]
Current Address: [REDACTED]		
City [REDACTED]	State [REDACTED]	Zip Code [REDACTED]

**PART 2: To be completed by the PROGRAM DIRECTOR.**

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

Name of Facility: <b>CHARLES R. DREW M.D. OF MEDICINE KING/DREW MEDICAL CENTER</b>	Address of Facility: <b>12021 S. WILMINGTON L.A. CA 90059</b>	
Name of Program Director: <b>CESAR ARAMBURI, MD</b>	Telephone Number: [REDACTED]	
Signature of Program Director: <i>[Signature]</i>	Date Signed: <b>5/2/05</b>	
List Categorical Specialty Area of Training Completed by Trainee: <b>INTERNAL MEDICAL</b>	Date Training Commenced: <b>1-16-04</b>	Date Training Completed: <b>1-15-05</b>

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

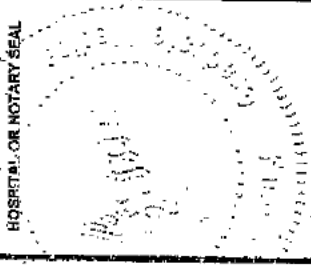
**PART 3: To be completed by the DIRECTOR OF MEDICAL EDUCATION and affixed with the official facility seal.**

Name of the Director of Medical Education: <b>Sharon Ashley, MD, MPH, MBA</b>	Name of Facility: <b>King/Drew Medical Center</b>
Address of Facility: <b>12021 S. Wilmington Ave, Suite 3-221</b>	
City: <b>Los Angeles</b>	State: <b>CA</b>
Zip Code: <b>90059</b>	Telephone Number: [REDACTED]

**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, DATE AND SIGNATURE MUST BE AFFIXED IN THE BOX TO THE LEFT TO CERTIFY TRAINING.

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

Signature of Director of Medical Education: <b>Sharon A. Ashley, MD, MPH, MBA</b>	Date Signed: <b>5/02/05</b>
--	--------------------------------

**L3A**



**MEDICAL BOARD OF CALIFORNIA**

LICENSING PROGRAM  
 1426 Howe Avenue, Suite 54  
 Sacramento, CA 95825-3238  
 (916) 263-2382 FAX (916) 263-2487  
 www.caldocinfo.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.

**PART 1: TO BE COMPLETED BY THE APPLICANT**

NAME: Last Kalantari First GITA Middle Jamshidi

U.S. Social Security Number [Redacted] Date of Birth [Redacted] Telephone Number Home [Redacted] Work ( ) [Redacted]

Public/Mailing Address 15575 LOFTHILL DR.

City LA MIRADA State/Province CA Zip/Postal Code 90638

Medical School of Graduation: MEDICAL UNIVERSITY OF LUBECK / GERMANY

**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: USC/CA Hospital Family Medicine Residency ACGME 10 digit Program number: (www.acgme.org) 1200521458

Address of Facility: 1400 S. Grand Ave Suite 101 Telephone #: [Redacted]

Categorical Specialty Area of Training Family Medicine Start Date of Training 03/01/2005 End Date (or anticipated completion date) of Training 02/28/2006

**UNUSUAL CIRCUMSTANCES:**

Did the trainee ever take a leave of absence or break from their training?	YES	NO
Was the trainee ever terminated, dismissed or expelled?	YES	NO
Did the trainee ever resign?	YES	NO
Was the trainee ever placed on probation?	YES	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 clinical incompetence, disciplinary problems or for any other reason?	YES	NO
Did the program decline to renew or offer the trainee a postgraduate training program contract for a following year?	YES	NO

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

**L3A**



## 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 licensure by July 1, 1990, must also complete four months of training in GENERAL MEDICINE prior to licensure. 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

has completed     has not completed

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

*Maureen Strohm*  
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.
	<i>Maureen Strohm</i> PRINT NAME OF PROGRAM DIRECTOR
	<i>Maureen Strohm</i> SIGNATURE OF PROGRAM DIRECTOR
	Signature Stamp is Not Acceptable
	<i>2/28/06</i> DATE SIGNED

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

State of California

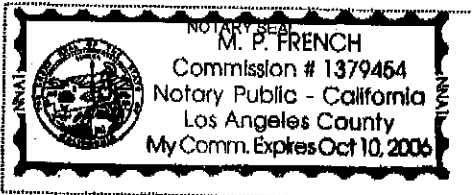
County of Los Angeles

Subscribed and sworn to (or affirmed) before me on

this 6<sup>TH</sup> day of March, 2006

by Maureen Strohm, MD

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*  
SIGNATURE OF NOTARY PUBLIC

**L3B**



MEDICAL BOARD OF CALIFORNIA

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



55 DEC -6 11 0:53
LICENSING PROGRAM

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 lieu of the Form L3A-B, "Certificate of Completion of ACGME/RCPSC Postgraduate Training."

NAME: Last Kalantari First GITA Middle Jamshidi
Date of Birth [redacted] Medical School of Graduation: MEDICAL UNIVERSITY OF LIBECK GERMANY
This is to certify that the above applicant is actively participating in an ACGME or RCPSC accredited postgraduate training position that started on 3/1/2005 and is expected to be completed on 6/30/2007 in Family Medicine at USC/CA Hospital Family Medicine Residency located at 1400 S. Grand Ave, Ste 101 Los Angeles, CA 90015
The 10 digit ACGME Program #: 1 8 0 0 5 2 1 4 5 8

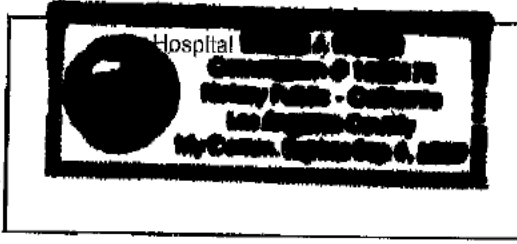
I hereby declare under penalty of perjury under the laws of the State of California that the above statements are true and correct and the above program is accredited by the ACGME or the RCPSC to offer the type and level of training completed by the applicant and that the applicant is being trained in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

Maureen Strohm, M.D.
PRINT NAME OF PROGRAM DIRECTOR
Maureen Strohm
SIGNATURE OF PROGRAM DIRECTOR - Signature Stamp Is Not Acceptable
DATE 11/28/05 TELEPHONE NUMBER [redacted]

ATTENTION PROGRAM DIRECTOR: THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE, OR ADOPTION. Only the Program Director 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.

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

State of California
County of Los Angeles
Subscribed and sworn to (or affirmed) before me on this 28th day of November, 2005
by Maureen Strohm, M.D.
personally known to me or proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.



Bobbi J. Fisher
SIGNATURE OF NOTARY PUBLIC

OFFICIAL HOSPITAL SEAL OR NOTARY SEAL (WITH JURAT COMPLETED ABOVE) MUST BE AFFIXED IN THE BOX AT THE LEFT

L4



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



**OFFICIAL BREAKDOWN OF UNDERGRADUATE CLINICAL CLERKSHIPS**

FOR GITA J. KALANTARI (KADEMI)  
 TYPE OR PRINT FULL NAME OF APPLICANT

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

**UNDERGRADUATE CLINICAL CLERKSHIPS**

(Please list all applicable training in the area below and on the reverse side of this form. List training in date order commencing with the first clinical year of training.)

CLINICAL SUBJECT AREA	FACILITY NAME AND ADDRESS	DATES OF ATTENDANCE FROM - TO (Month/Day/Year)	WEEKS OR WEEKLY HOURS OF CREDIT
SURGERY	HEIDBERG HEIDBERG / TANGSTEDTER LANDSTR. 400, 2000 HAMBURG 62	03 - 02 - 92 03 - <sup>20</sup> 15 - 92	40 h <sup>o</sup> ✓ per week 2
NEUROSURGERY	MEDICAL UNIVERSITY OF LÜBECK RATZEBURGER ALLEE 160, 2400 LÜBECK	08 - 10 - 92 09 - <sup>20</sup> 06 - 92	40 h <sup>o</sup> ✓ per week 4
OBSTETRICS AND GYNECOLOGY	MEHR HOSPITAL, ZARTOSHT AVE, TEHRAN / IRAN	07 - 16 - 93 08 - <sup>20</sup> 25 - 93	40 h <sup>o</sup> ✓ per week 6
SURGERY	MEDICAL UNIVERSITY OF LÜBECK / RATZEBURGER ALLEE 160, 2400 LÜBECK	02 - 20 - 95 04 - <sup>20</sup> 15 - 95	40 h <sup>o</sup> ✓ per 2 week
MEDICINE	UCLA / VA-HOSPITAL 11301 WILSHIRE BLVD. LA, CA. 90073	10 - 24 - 94 12 - 18 <sup>th</sup> - 94	40 h <sup>o</sup> ✓ per 8 week
SURGERY	UCI MEDICAL CENTER ORANGE, CA. 92668	12 - 19 - 94 02 - 12 - 95	MORE THAN 40 h <sup>o</sup> ✓ per week
MEDICINE	UCSD MEDICAL CENTER SAN DIEGO 300 WEST ARBOR DR.	04 - 24 - 95 05 - 27 - 95	40 h <sup>o</sup> ✓ per 4 week
MEDICINE	UCSD / VA - HOSPITAL 3350 LA JOLLA VILLAGE DR., LA JOLLA, CA. 92161	05 - 22 - 95 06 - 18 - 95	40 h <sup>o</sup> ✓ per 4 week
PSYCHIATRY	UCSD / VA - HOSPITAL 3350 LA JOLLA VILLAGE DR., LA JOLLA, CA. 92161	06 - 19 - 95 08 - 13 - 95	40 h <sup>o</sup> ✓ per 8 week

THE COMPLETION OF THIS FORM IS REQUIRED ONLY OF INTERNATIONAL MEDICAL SCHOOL GRADUATES

OFFICIAL BREAKDOWN OF UNDERGRADUATE CLINICAL CLERKSHIPS

FOR \_\_\_\_\_  
 TYPE OR PRINT FULL NAME OF APPLICANT

MEDICAL SCHOOL: SEE REVERSE SIDE FOR INSTRUCTIONS.

UNDERGRADUATE CLINICAL CLERKSHIPS (Continued from the front of this form.)

CLINICAL SUBJECT AREA	FACILITY NAME AND ADDRESS	DATES OF ATTENDANCE FROM -- TO (Month/Day/Year)	WEEKS OR WEEKLY HOURS OF CREDIT

MEDICAL SCHOOL SEAL



I, Prof. Dr. D. Jocham  
 FULL NAME of Dean ~~or Registrar~~ (Please TYPE OR PRINT)

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

Jocham Signature      May 2<sup>nd</sup> 2000 Date

(DO NOT DETACH)

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

LICENSEE NAME  
KALANTARI, GITA J

LICENSE NO.  
A95847

EXPIRATION DATE  
06/30/18


AMOUNT DUE NOW  
\$820.00

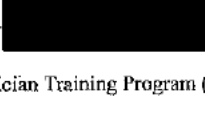
AMOUNT DUE IF POSTMARKED AFTER JULY 30, 2018  
\$898.00

**LICENSEE MUST CHECK CORRECT BOXES**

"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)

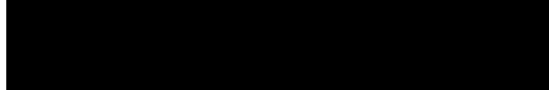
"G"  Financial Interest Statement (See Question 5)

"D" **SIGNATURE REQUIRED**

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

Signature *Kalantari* Date 3/20/18

ENTER YOUR PHONE NUMBER FOR REFERENCE:



63010100000100002000958470010630180008200000089800

CHANGE OF ADDRESS (Only if different from address above)

KALANTARI, GITA J

A95847

ADDRESS OF RECORD (Required)

Address Line 1

Address Line 2

Address Line 3

City

State

Zip

CONFIDENTIAL STREET ADDRESS (Required if PO Box used above for Address of Record)

Address Line 1

Address Line 2

Address Line 3

City

State

Zip

