STATE OF CALIFORNIA -- STATE AND CONSUMER SERVICES AGENCY — ARNOLD SCHWARZENEGGER, *Governor*

Consumer Affairs

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

7. Telephone Numbers: (Include area code) [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	Lübeck / GERMENY	1/10/89 to 30/9/97
(Medical University of Lübeck)		

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	
USMLE STEP 2 / TOEFEL CSA	USMLE Step 3 4/7/2000 / 12/28/05 8/19/2002 valid indefinitely 9/6/2003 valid	

Cashiering Use Only

GER35 L1A

07A-100 (Rev. 07/05)

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 POSTGRADUATE TRAINING

MBC Use Only

14. Please list each ACGME/RCPSC 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 be finish 2-28-06

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	Dates of Practice in that Jurisdiction
N/A			

APPLICANT: Gita Jamshidi Kalantari

DATE OF BIRTH: [redacted]

L1B

07A-100 (Rev. 07/05)

ABMS CERTIFICATIONS

MEC Use Only

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		

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 [redacted] NO [redacted]

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 [redacted] NO [redacted]

19. Have you been treated for or had a recurrence of a diagnosed addictive disorder? YES [redacted] NO [redacted]

20. Have you been diagnosed with an emotional, a mental, or behavioral disorder which impairs your ability to practice medicine safely? YES [redacted] NO [redacted]

21. Have you ever been diagnosed with a neurological or other physical condition that would impair your ability to practice medicine safely? YES [redacted] NO [redacted]

22. Do you have any other condition which in any way impairs or limits your ability to practice medicine safely? YES [redacted] NO [redacted]

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.

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 [redacted] NO [redacted]

APPLICANT: GITA JAMSHIDI KALANTARI | **DATE OF BIRTH:** [redacted]

L1C

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?	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

MBC use only

[redacted]

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 [redacted], being first duly sworn upon his/her
(PLEASE PRINT FULL NAME) (DATE OF BIRTH)
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 24th 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.

NOTARY SEAL
MOON C. LEE
COMM. #1611408
NOTARY PUBLIC - CALIFORNIA
ORANGE COUNTY
My Comm. Expires Nov. 4, 2009

Moon C. Lee
SIGNATURE OF NOTARY PUBLIC

L1E

STATE OF CALIFORNIA — STATE AND CONSUMER SERVICES AGENCY

GRAY DAVIS, Governor

MEDICAL BOARD OF CALIFORNIA

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

TEL: (916) 263-2499/FAX: (916) 263-2467 Internet: www.medbd.ca.gov

RECEIVED MEDICAL BOARD OF CALIFORNIA

03 JUL -7 PM 12:48

RECEIVED MEDICAL BOARD OF CALIFORNIA

03 JUL 11 11:41

LICENSING PROGRAM

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.

1. NAME: Last	First	Middle	Personal Data
KALANTARI	GITA	JAMSHIDI	

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

[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	State	Zip Code	Country	
LA MIRADA	CA	90638	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:

6. California Driver's License Number (optional): NUMBER [redacted] EXPIRATION [redacted] ☐

7. Date of Birth (Month/Day/Year) [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	LGS
				☐
				☐
				☐
				☐

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. [redacted] Yes [redacted] 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/RCPSC POSTGRADUATE TRAINING (FORM L3A) FROM EACH FACILITY. (DO NOT COMPLETE FORM L3A TO DOCUMENT TRAINING RECEIVED IN RESIDENCY FELLOWSHIP PROGRAMS.) ALL TRAINING MUST BE LISTED, REGARDLESS OF WHETHER IT WAS SATISFACTORILY COMPLETED OR WILL BE USED TO MEET LICENSING REQUIREMENTS.

Facility Name	Address	Categorial Specialty Area	Dates of Attendance	
				☐
				☐

QUESTIONS 11B through 18B:

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. [redacted] Yes [redacted] 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, judgement, or arbitration award of over $30,000.00?

IF YOU ANSWERED YES, PROVIDE DETAILS ON A SEPARATE ATTACHMENT. [redacted] Yes [redacted] 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 94-455 (42 USCA 405(c)(2)(C)) authorize collection of your social security number. Your social security number will be used exclusively for tax enforcement purposes, for purposes of compliance with any judgment or order for family support in accordance with Section 17520 of the Family Code, or for verification of licensure or examination status by a licensing or examination entity which utilizes a national examination and where licensure is reciprocal with the requesting state. If you fail to disclose your social security number your application for initial licensure will not be processed AND you will be reported to the Franchise Tax Board, which may assess a $100 penalty against you.

MBC USE ONLY

School Code

L8A

07A-43 (Rev. 03/01)

For all of the below, also include any d[redacted]inary actions by the U.S. Military, U.S. Public Health Service, o[redacted] U.S. federal governmental entity.

MBC USE ONLY

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? 13 (A) [redacted] Yes [redacted] No ☐

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? 13 (B) [redacted] Yes [redacted] No ☐

13C. Is any such action as described above pending? 13 (C) [redacted] Yes [redacted] 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? [redacted] Yes [redacted] No ☐

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

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? [redacted] Yes [redacted] No ☐

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

18. 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? [redacted] Yes [redacted] No ☐

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? [redacted] Yes [redacted] No ☐

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

[redacted] 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 nolo contendere to, ANY violation (include every misdemeanor or felony) of any local, state, or federal law of any state, territory, country, or U.S. federal jurisdiction? 18 (A) [redacted] Yes [redacted] No ☐

18B. Is any criminal action related to the above pending? 18 (B) [redacted] Yes [redacted] No ☐

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

Applicant Declaration/Signature and NOTARY

STATE OF California

COUNTY OF Orange

The applicant, GITA JAMSHIDI KALANTARI (PLEASE PRINT FULL NAME) 6-14-68 (DATE OF BIRTH) being first duly sworn upon his/her oath deposes and says: that I am the person herein named subscribing to this application; that I have read the complete application, know the full content thereof, and declare under penalty of perjury, that all of the information contained herein and evidence or other credentials submitted herewith are true and correct; that I am the lawful holder of the degree of Doctor of Medicine as prescribed by this application, that the same was procured in the regular course of instruction and examination, and that it, together with all the credentials submitted, were procured without fraud or misrepresentation or any mistake of which I am aware and that I am the lawful holder thereof. Further, I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past, present, and future), business and professional associates (past, present, and future), and all government agencies (local, state, federal, or foreign) to release to the Medical Board of California or its successors any information, files or records, including medical records, educational records, and records of psychiatric treatment and treatment for drug and/or alcohol abuse or dependency, requested by that Board in connection with this application; or any further or future investigation by that Board necessary to determine my medical competence, professional conduct, or physical or mental ability to safely engage in the practice of medicine. I further authorize the Medical Board of California or its successors to release to the organizations, individuals, or groups listed above any information which is material to this application or any subsequent licensure. **I UNDERSTAND THAT FALSIFICATION OR MISREPRESENTATION OF ANY ITEM OR RESPONSE ON THIS APPLICATION OR ANY ATTACHMENT HERETO IS A SUFFICIENT BASIS FOR DENYING OR REVOKING A LICENSE.**

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

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

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

NOTARY SEAL

SIGNATURE OF NOTARY PUBLIC

5300 Beach Blvd. Buena Park, CA
ADDRESS

My commission expires Nov 4, 2005

07A-43 (Rev. 03/01)

L8B

RECEIVED
MEDICAL BOARD OF CALIFORNIA
03 JUL -8 AM 11:42
LICENSING PROGRAM

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

Consumer Affairs

MEDICAL BOARD OF CALIFORNIA

1426 [redacted]ave Avenue, Suite 54, Sacramento, CA 95825-3236

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

RECEIVED MEDICAL BOARD OF CALIFORNIA LICENSING PROGRAM

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.

1. NAME: Last	First	Middle	MBC USE ONLY
Kalantari	Gita	Jamshidi	Personal Data

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]

8. 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 — License Data

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

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

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

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. [redacted] Yes [redacted] 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 — Postgraduate Training

IF YES, LIST NAMES AND ADDRESSES OF ALL FACILITIES. SUBMIT AN ORIGINAL CERTIFICATE OF COMPLETION OF ACGME/RCPSC POSTGRADUATE TRAINING (FORM L3A) FROM EACH FACILITY. (DO NOT COMPLETE FORM L3As TO DOCUMENT TRAINING RECEIVED IN RESEARCH FELLOWSHIP PROGRAMS.) ALL TRAINING MUST BE LISTED, REGARDLESS OF WHETHER IT WAS SATISFACTORILY COMPLETED OR WILL BE USED TO MEET LICENSING REQUIREMENTS.

Facility Name	Address	Categorial Specialty Area	Dates of Attendance

QUESTIONS 11B through 18B:

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. [redacted] Yes [redacted] 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, judgement, or arbitration award of over $30,000.00?

IF YOU ANSWERED YES, PROVIDE DETAILS ON A SEPARATE ATTACHMENT. [redacted] Yes [redacted] 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 94-455 (42 USCA 405(c)(2)(C)) authorize collection of your social security number. Your social security number will be used exclusively for tax enforcement purposes, for purposes of compliance with any judgment or order for family support in accordance with Section 17520 of the Family Code, or for verification of licensure or examination status by a licensing or examination entity which utilizes a national examination and where licensure is reciprocal with the requesting state. If you fail to disclose your social security number your application for initial licensure will not be processed AND you will be reported to the Franchise Tax Board, which may assess a $100 penalty against you.

MBC USE ONLY

School Code

L8A

07A-43 (Rev 03/01)

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.

MBC 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?

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?

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

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

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.

[redacted] Yes [redacted] 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.

[redacted] Yes [redacted] 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.

[redacted] Yes [redacted] 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?

[redacted] Yes [redacted] No ☐

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

[redacted] 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 nolo contendere to, ANY violation (include every misdemeanor or felony) of any local, state, or federal law of any state, territory, country, or U.S. federal jurisdiction?

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

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

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

Applicant Declaration/Signature and NOTARY

STATE OF CALIFORNIA

COUNTY OF LOS ANGELES

The applicant, GITA JAMSHIDI KALANTARI (PLEASE PRINT FULL NAME) 6-14-68 (DATE OF BIRTH), being first duly sworn upon his/her oath deposes and says: that I am the person herein named subscribing to this application; that I have read the complete application, know the full content thereof, and declare under penalty of perjury, that all of the information contained herein and evidence or other credentials submitted herewith are true and correct; that I am the lawful holder of the degree of Doctor of Medicine as prescribed by this application, that the same was procured in the regular course of instruction and examination, and that it, together with all the credentials submitted, were procured without fraud or misrepresentation or any mistake of which I am aware and that I am the lawful holder thereof. Further, I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past, present, and future), business and professional associates (past, present, and future), and all government agencies (local, state, federal, or foreign) to release to the Medical Board of California or its successors any information, files or records, including medical records, educational records, and records of psychiatric treatment and treatment for drug and/or alcohol abuse or dependency, requested by that Board in connection with this application; or any further or future investigation by that Board necessary to determine my medical competence, professional conduct, or physical or mental ability to safely engage in the practice of medicine. I further authorize the Medical Board of California or its successors to release to the organizations, individuals, or groups listed above any information which is material to this application or any subsequent licensure. **I UNDERSTAND THAT FALSIFICATION OR MISREPRESENTATION OF ANY ITEM OR RESPONSE ON THIS APPLICATION OR ANY ATTACHMENT HERETO IS A SUFFICIENT BASIS FOR DENYING OR REVOKING A LICENSE.**

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

Signed and sworn to before me this 30th day of July (MONTH) 2007 (YEAR)

ZI MYOUNG YU
Commission # 1277008
Notary Public - California
Los Angeles County
My Comm. Expires Sep 15, 20[redacted]

NOTARY SEAL

SIGNATURE OF NOTARY PUBLIC

ADDRESS 1508 Rogerdale Ave La Puente CA 91748

My commission expires [redacted]

07A-43 (Rev. 03/01)

L8B

STATE OF CALIFORNIA — STATE AND CONSUMER SERVICES AGENCY

GRAY DAVIS, *Governor*

Consumer Affairs

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

$508 6/16/00
014387

00 JUN -2 PM 1:19

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 malden 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: ( )

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	RATZEBURGER ALLEE 160 D 23538 LÜBECK / 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	✓		MEDICAL UNIVERSITY OF LUBECK
Physics	✓		" " "
Biology or Zoology	✓		" " "

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	L2	Trans
MEDICAL UNIVERSITY OF LUBECK	RATZEBURGER ALLEE 160	LÜBECK / GERMANY	WINTER SEMESTER 89/90 - 97	ARZT 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: MEDICAL UNIVERSITY OF LUBECK
Address of Medical School: RATZEBURGER ALLEE 160, ~~24100~~ 23538 LÜBECK
Exact Date of Issuance: 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(c)(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.

GER 35 School Code

L1A

07A-100 (Rev. 3/99)

MBC USE ONLY

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/LOS ANGELES CALIFORNIA	OCTOBER 30, 1999	[redacted]
USLME STEP 2	BREA VILLAGE/FULLERTON/LOS ANGELES CALIFORNIA	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? [redacted] Yes [redacted] 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. [redacted] Yes [redacted] No

State	Date	Charge	Disposition

MBC USE ONLY

License Data

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? [redacted] Yes [redacted] No

IF YES, GIVE DETAILS BELOW.

Name of Claimant	Location of Court	Brief Description of the Facts
[redacted]		

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? [redacted] Yes [redacted] 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? [redacted] Yes [redacted] 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? [redacted] Yes [redacted] 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? [redacted] Yes [redacted] No

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

[redacted] 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. [redacted] Yes [redacted] 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

[redacted]

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 [redacted] 19[redacted]

my age then being [redacted] years;

my color of hair [redacted]

my color of eyes [redacted]

my height [redacted] ft. [redacted] in.;

my weight [redacted] 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)

Applicant Declaration/Signature and NOTARY

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 30th day of May, 2000

MOON C. LEE
Commission # 1158146
Notary Public - California
Orange County
My Comm. Expires Nov 4, 2001

NOTARY SEAL

Simone Lee
SIGNATURE OF NOTARY PUBLIC

5300 Beach Bl. #110, Buena Park, CA 90621
ADDRESS

My commission expires [redacted] 4, 2001

L1D

07A-100 (Rev. 3/99)

STATE OF CALIFORNIA — STATE AND CONSUMER SERVICES AGEN

GRAY DAVIS, *Governor*

State of California Department of **Consumer Affairs**

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

CERTIFICATE OF 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
FULL NAME OF APPLICANT — ADDRESS WHEN ENROLLED

MEDICAL UNIVERSITY OF — LÜBECK / GERMANY
NAME OF MEDICAL SCHOOL — LOCATION

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

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 LÜBECK — 89 ~~bis~~ to 91
EDUCATIONAL INSTITUTION — DATES

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

N/A — N/A — N/A
MEDICAL SCHOOL — TOTAL CREDITS — DATES

The undersigned further certifies that the records of this institution show that ☒ she attended in this institution N/A
SPECIFY NUMBER

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

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

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

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

Anatomy
Otolaryngology
Obstetrics and Gynecology
Radiology, including Radiation Safety
Tropical Medicine
Physiology
Biochemistry
Pathology, Bacteriology and Immunology
Ophthalmology
[redacted]
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 ~~97~~ 98

BY [signature]
PRESIDENT, SECRETARY, DEAN

L2

STATE OF CALIFORNIA -- STATE AND CONSUMER SERVICES AGENCY — ARNOLD SCHWARZENEGGER, Governor

Consumer Affairs

MEDICAL BOARD OF CALIFORNIA

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

MEDICAL BOARD OF CALIFORNIA
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	First Name	Middle Initial
KALANTARI	GITA	J

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

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: CHARLES R. DREW UNIV. OF MEDICINE KING/DREW MEDICAL CENTER	Address of Facility: 12021 S. WILMINGTON LA CA 90059
Name of Program Director: CESAR ARANGURI, MD	Telephone Number: [redacted]
Signature of Program Director: [signature]	Date Signed: 5/2/05
List Categorical Specialty Area of Training Completed by Trainee: INTERNAL MEDICAL	Date Training Commenced: 1-16-04 / Date Training Completed: 1-15-05

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: Sharon Ashley, MD, MPH, MBA	Name of Facility: King/Drew Medical Center
Address of Facility: 12021 S. Wilmington Ave. Suite 3-221	
City: Los Angeles / State: CA / Zip Code: 90059	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.

HOSPITAL OR NOTARY SEAL

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

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

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

L3A

07A-100-L3 (Revised 03-01)

Consumer Affairs

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

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	First	Middle
Kalantari	GITA	Jamshidi

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

Public/Mailing Address: 15575 LOFTHILL DR.

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

Medical School of Graduation: MEDICAL UNIVERSITY OF LÜBECK / 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:	ACGME 10 digit Program number: (www.acgme.org)
USC/CA Hospital Family Medicine Residency	1200521458

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

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

UNUSUAL CIRCUMSTANCES:

Did the trainee ever take a leave of absence or break from their training?	YES [redacted]	NO [redacted]
Was the trainee ever terminated, dismissed or expelled?	YES [redacted]	NO [redacted]
Did the trainee ever resign?	YES [redacted]	NO [redacted]
Was the trainee ever placed on probation?	YES [redacted]	NO [redacted]
Was the trainee ever disciplined or placed under investigation?	YES [redacted]	NO [redacted]
Were any incident reports regarding this trainee ever filed by instructors?	YES [redacted]	NO [redacted]
Were any limitations or special requirements placed upon the trainee for clinical incompetence, disciplinary problems or for any other reason?	YES [redacted]	NO [redacted]
Did the program decline to renew or offer the trainee a postgraduate training program contract for a following year?	YES [redacted]	NO [redacted]

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 RESPONSIBILTY 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.

Maureen Strohm
PRINT NAME OF PROGRAM DIRECTOR

Maureen Strohm — 2/28/06
SIGNATURE OF PROGRAM DIRECTOR — **DATE SIGNED**
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 Los Angeles

Subscribed and sworn to (or affirmed) before me on

this 6TH day of March, 20 06,

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.

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

SIGNATURE OF NOTARY PUBLIC

L3B

07A-100-L3 (Rev. 07/05)

STATE OF CALIFORNIA – STATE AND CONSUMER SERVICES AGENCY ARNOLD SCHWARZENEGGER, Governor

Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM
1426 Howe Avenue, Suite 54
Sacramento, CA 95825-3236
(916) 263-2382 FAX (916) 263-2467
www.caldocinfo.ca.gov

05 DEC -6 AM 8:53

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

[redacted] Date of Birth [redacted] Medical School of Graduation: MEDICAL UNIVERSITY OF LUBECK 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 (Month) / 1 (Day) / 2005 (Year) and is expected to be completed on 6 (Month) / 30 (Day) / 2007 (Year) in Family Medicine (Categorical Specialty Area of Training)

at USC/CA Hospital Family Medicine Residency (Name of Facility)

located at 1400 S. Grand Ave, STE 101 Los Angeles, CA 90015 (Address of Facility)

The 10 digit ACGME Program #: 1 2 0 0 5 2 1 4 5 8 (Refer to http://www.acgme.org/adspublic

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

11/28/05
DATE

[redacted]
TELEPHONE NUMBER

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.

Hospital [redacted]

Bobbie J. Parker
SIGNATURE OF NOTARY PUBLIC

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

L4

07A-100-L4 (Rev. 07/05)

State of California Department of Consumer Affairs

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 / TANGSTEDTER LANDSTR. 400, 2000 HAMBURG 62	03-02-92 to 03-15-92	40 h° per week
NEUROSURGERY	MEDICAL UNIVERSITY OF LÜBECK RATZEBURGER ALLEE 160, 2400 LÜBECK	08-10-92 to 09-06-92	40 h° per week
OBSTETRICS AND GYNECOLOGY	MEHR HOSPITAL, ZARTOSHT AVE, TEHRAN / IRAN	07-16-93 to 08-25-93	40 h° per week
SURGERY	MEDICAL UNIVERSITY OF LÜBECK / RATZEBURGER ALLEE 160 2400 LÜBECK	02-20-95 to 04-15-95	40 h° per week
MEDICINE	UCLA / VA-HOSPITAL 11301 WILSHIRE BLVD. LA, CA. 90073	10-24-94 to 12-18-94	40 h° per week
SURGERY	UCI MEDICAL CENTER ORANGE, CA. 92668	12-19-94 to 02-12-95	MORE THAN 40h° per week
MEDICINE	UCSD MEDICAL CENTER SAN DIEGO 200 WEST ARBOR DR.	04-24-95 to 05-21-95	40h° per week
MEDICINE	UCSD / VA-HOSPITAL 3350 LA JOLLA VILLAGE DR., LA JOLLA, CA. 92161	05-22-95 to 06-18-95	40h° per week
PSYCHIATRY	UCSD / VA-HOSPITAL 3350 LA JOLLA VILLAGE DR, LA JOLLA, CA. 92161	06-19-95 to 08-13-95	40h° per 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 OFATTENDANCE FROM -- TO (Month/Day/Year)	WEEKS OR WEEKLY HOURS OF CREDIT

MEDICAL SCHOOL SEAL

MEDIZINISCHE UNIVERSITÄT ZU LÜBECK 1

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.

D. Jocham

Signature

May 2nd 2000

Date

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

L5B

(DO NOT DETACH)

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

LICENSEE NAME	LICENSE NO.	EXPIRATION DATE	AMOUNT DUE NOW	AMOUNT DUE IF POSTMARKED AFTER JULY 30, 2018
KALANTARI, GITA J	**A95847**	**06/30/18**	**$820.00**	**$898.00**

LICENSEE MUST CHECK CORRECT BOXES

"H" [redacted] Completed Continuing Education (See Question 1)

"E" [redacted] Change of Address (fill in reverse side)

"I" [redacted] Conviction

"J" [redacted] Conviction

"F" [redacted] Family Physician Training Program ($25 See Question 4)

"G" [redacted] 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:

[redacted]

6301010000010000200095847001063018000820000089800

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

(DO NOT DETACH)

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

LICENSEE NAME	LICENSE NO.	EXPIRATION DATE	AMOUNT DUE NOW	AMOUNT DUE IF POSTMARKED AFTER JULY 30, 2016
KALANTARI, GITA J	**A95847**	**06/30/16**	**$820.00**	**$898.00**

LICENSEE MUST CHECK CORRECT BOXES

"H" [redacted] Completed Continuing Education

"E" [redacted] Change of Address (fill in reverse side)

"I" [redacted] Conviction Disclosure

"J" [redacted] Conviction Disclosure

"F" [redacted] Family Physician Training Program ($25)

"G" [redacted] Financial Interest Statement-**Read instructions above**

"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 M.D. Date 3/24/16

ENTER YOUR PHONE NUMBER FOR REFERENCE: [redacted]

630101000001000020009584700106301600082000000898000

CHANGE OF MAILING ADDRESS **KALANTARI, GITA J** **A95847**

03262016 20003085 20010039

Street Address (this address is public information **except** when a PO Box is used for the public address of record; this address then becomes confidential)

City State Zip

PO Box (if used, must provide a confidential physical street address, above)

City State Zip