MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815
(800) 633-2322 (916) 263-2382 FAX (916) 263-2487
www.mbc.ca.gov

MEDICAL BOARD OF CALIFORNIA
2010 DEC -3 AM 8:42
PROGRAM

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: SRIDHAR First: APARNA Middle:

Other names you have used (include maiden name):

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: 1, MT VERNON AVE
(Please note: this information is public)
(30 characters maximum per line, including spaces)

City: WEST ORANGE State/Province: NJ Zip/Postal Code: 07052 Country: USA

7. Telephone Numbers: (include area code) Home: Work: [redacted] Cell: [redacted]

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

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:

MBC Use Only — Personal Data ☑

MEDICAL EDUCATION

11. LIST EACH MEDICAL SCHOOL THAT YOU HAVE ATTENDED.

School Name	City, State/Province, Country	Dates of Attendance
MYSORE MEDICAL COLLEGE	MYSORE, KARNATAKA, INDIA	09/1999 to 05/2005

L2 Transcript ☑ ☑ ☐ ☐ ☐ ☐

12. School of Graduation	Degree Awarded	Date of Graduation
MYSORE MEDICAL COLLEGE	MBBS	03.03.2006

Diploma ☑

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	03/2006	[redacted]
USMLE STEP2 CK/CS	08/2006, 09/2006	[redacted]
USMLE STEP 3	06/2007	[redacted]

ECFMG — Exams ☑ ☑ ☑

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School Code

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A "yes" response to Questions 14 through 38 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.

Postgraduate Training

Facility Name	Address	Specialty Area	Dates of Attendance
UMDNJ, New Jersey	185, South Orange	OBGYN	07.01.2007 - Current
Medical School	Ave, Newark 07103		

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POSTGRADUATE TRAINING: (These questions are to be answered by ALL applicants)

Question		
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.

License Data

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

APPLICANT: APARNA SRIDHAR

DATE OF BIRTH:

L1B

ABMS CERTIFICATIONS

MBC Use Only

ABMS

16. Are you currently certified by a Member Board of the American Board of Medical Specialties? YES ☐ NO ☑

Member Board	Expiration Date	Certificate Number

MALPRACTICE HISTORY

Malpractice

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

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.

CRIMINAL RECORD HISTORY

Criminal Record

23. Have you ever been convicted of, or pled guilty or 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: APARNA SRIDHAR

DATE OF BIRTH:

L1C

07A-100 (Rev. 12/05)

CR[illegible]NAL RECORD HISTORY (cont'd)

MBC Use Only

Criminal Record

			MBC 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

Discipline

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: APARNA SRIDHAR

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, APARNA SRIDHAR (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. [AS] **(PLEASE INITIAL BOX)**

SIGNATURE OF APPLICANT: Aparna Sridhar
(Please sign full name – in presence of notary)

State of N. J.

County of Bergen

Subscribed and sworn to (or affirmed) before me on this 29 day of November 20 10, by

Aparna Sridhar
(Notary to print name of applicant.)

proved to me on the basis of satisfactory evidence to be the person who appeared before me.

Signature Susan Hutter (seal)

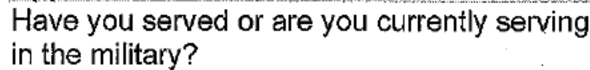
SUSAN HUTTER
NOTARY PUBLIC OF NEW JERSEY
Commission Expires 12/22/2013

L1E

Application Summary

License Type:	**Physician and Surgeon A**
License Number:	**116116**
File Number:	**123620**
Application:	**Physician's and Surgeon's Renewal**
Application Number:	**14591241**
Application Date:	**01/04/2019 (mm/dd/yyyy)**

Application Questions



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

Personal Detail

First Name:	**APARNA**
Last Name:	**SRIDHAR**
Birthdate:	**/**/****
Gender:	**Female**

Addresses

License Related Addresses

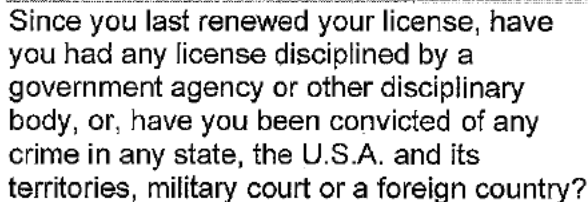
Address of Record (Required)

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

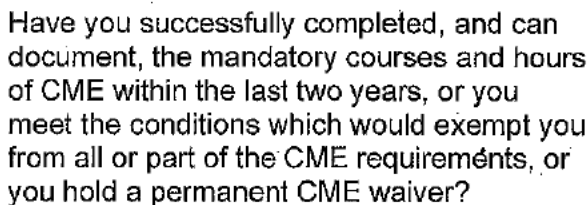
Confidential Address

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

Questions



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



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

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

Family Physician Training Program Voluntary Fee

Would you like to contribute?

Attachments

Physician Survey

Are you retired?	**No**
Activities in Medicine	**Administration - 10-19 Hours**
	Patient Care - 20-29 Hours
	Research - 10-19 Hours
	Teaching - 1-9 Hours
Patient Care Practice Location	**Zip: 90095 County:**
Telemedicine Practice Location	**Zip: County:**
Patient Care Secondary Practice Location	**Zip: County:**
Telemedicine Secondary Practice Location	**Zip: County:**
Current Training Status	**Not in Training**
Areas of Practice	**Obstetrics and Gynecology - Secondary**
Board Certifications	**American Board of Obstetrics and Gynecology - Obstetrics and Gynecology**
Postgraduate Training Years	**2 Years**
Cultural Background	
Foreign Language Proficiency	**Hindi**
	Telugu
Web Site Profile	**Cultural Background - No**
	Foreign Language Proficiency - Yes
	Gender - Yes
E-mail:	

Fees

Biennial Renewal Fee	**$783.00**
DUE TO CURES FUND	**$12.00**
StephenM.ThompsonLRP	**$25.00**
Total Amount Due:	**$820.00**

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

Attestation

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

Signature: Date:

Application Summary

License Type:	**Physician and Surgeon A**
License Number:	**116116**
File Number:	**123620**
Application:	**Physician's and Surgeon's Renewal**
Application Number:	**14362017**
Application Date:	**01/07/2017 (mm/dd/yyyy)**

Application Questions

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

Personal Detail

First Name:	**APARNA**
Last Name:	**SRIDHAR**
Birthdate:	**/**/****
Gender:	**Female**

Addresses

License Related Addresses

Address of Record (Required)

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

Confidential Address

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

Questions

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

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

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

Family Physician Training Program Voluntary Fee

Voluntary Fee:

Attachments

Physician Survey

Are you retired?	**No**
Activities in Medicine	**Administration - 10-19 Hours**
	Patient Care - 30-39 Hours
	Research - 1-9 Hours
	Teaching - 1-9 Hours
	Telemedicine - 1-9 Hours
Patient Care Practice Location	**Zip: 90095 County: LOS ANGELES**
Telemedicine Practice Location	**Zip: County:**
Patient Care Secondary Practice Location	**Zip: County:**
Telemedicine Secondary Practice Location	**Zip: County:**
Current Training Status	**Not in Training**
Areas of Practice	**Obstetrics and Gynecology - Secondary**
Board Certifications	**American Board of Obstetrics and Gynecology - Obstetrics and Gynecology**
Postgraduate Training Years	**2 Years**
Cultural Background	
Foreign Language Proficiency	**Hindi**
	Other (not listed)
	Telugu
Web Site Profile	**Cultural Background - No**
	Foreign Language Proficiency - Yes
	Gender - Yes

Fees

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

1483954415003

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

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Attestation

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

Signature: Date:

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Application Summary

License Type:	**Physician and Surgeon A**
License Number:	**116116**
File Number:	**123620**
Application:	**Physician's and Surgeon's Renewal**
Application Number:	**14144528**
Application Date:	**01/24/2015 (mm/dd/yyyy)**

Personal Detail

First Name:	**APARNA**
Last Name:	**SRIDHAR**
Birthdate:	**/**/****
Gender:	**Female**

Addresses

License Related Addresses

Address of Record (Required)

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Confidential Address

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Questions

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

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

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

Family Physician Training Program Voluntary Fee

Voluntary Fee:

Attachments

Physician Survey

Are you retired?	**No**
Activities in Medicine	**Administration - 1-9 Hours**
	Patient Care - 20-29 Hours
	Research - 10-19 Hours
	Teaching - 1-9 Hours
	Telemedicine - None
Patient Care Practice Location	**Zip: 90095 County: LOS ANGELES**
Telemedicine Practice Location	**Zip: County:**
Patient Care Secondary Practice Location	**Zip: County:**
Telemedicine Secondary Practice Location	**Zip: County:**
Current Training Status	**Not in Training**
Areas of Practice	**Obstetrics and Gynecology - Primary**
Board Certifications	**American Board of Obstetrics and Gynecology - Obstetrics and Gynecology**
Postgraduate Training Years	**5 Years**
Foreign Language Proficiency	
	Telugu
Web Site Profile	**Cultural Background - No**
	Foreign Language Proficiency - Yes
	Gender - Yes

Fees

Biennial Renewal Fee	**$783.00**
DUE TO CURES FUND	**$12.00**
Steven M. Thompson Physician Corps Loan Repayment Program	**$25.00**
Total Amount Due:	**$820.00**

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Signature: Date: