RECEIVED SACRAMENTO MEDICAL BOARD OF CALIFORNIA
00 JUL 17 AM 9:42

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

808 717 0 000535

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: DUNN First: TAYLOR Middle: MICHAEL

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

3. Social Security Number◆ [redacted]

4. Address: Number and Street/Rural Route (include apartment number, if any) [redacted]

5. Sex: ☐ Female ☑ Male

City [redacted] State [redacted] Zip Code [redacted] Country [redacted]

6. Telephone Number: Home: [redacted] Work: [redacted]

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

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

9. Are you a U.S. citizen? [redacted] Yes [redacted] 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
LEWIS & CLARK COLL	PORTLAND, OREGON 97219	9/86 – 6/90
UNIV OF WASHINGTON	SEATTLE, WASH 98195	6/94 – 8/94

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

Course	Yes	No	Name of College or University
Chemistry	✓		LEWIS AND CLARK COLLEGE
Physics	✓		UNIVERSITY OF WASHINGTON
Biology or Zoology	✓		LEWIS AND CLARK COLLEGE

LICENSING PROGRAM 00 JUL 18 PM 12:35 RECEIVED MEDICAL BOARD CALIFORNIA

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
UNIV. OF WASHINGTON	SEATTLE, WA 98195	SEATTLE, WA	8/95 – 6/99	MD

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

Name of Medical School	Address of Medical School	Exact Date of Issuance
UNIVERSITY OF WASHINGTON SCHOOL OF MEDICINE	SEATTLE, WA 98195	6/11/99

◆ 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 405(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.

WA 004
School Code

L1A

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
USMLE STEP 1	SEATTLE, WA	6/97	[redacted]
USMLE STEP 2	SEATTLE, WA	8/98	[redacted]
USMLE STEP 3	BREA, CA	2/17/00	[redacted]

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
VENTURA COUNTY MEDICAL CENTER	3291 Loma Vista Rd VENTURA, CA 93003	FAMILY PRACTICE RESIDENCY	6/99 – PRESENT

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

07A-100 (Rev. 3/99)

L1B

TOP OF PHOTO

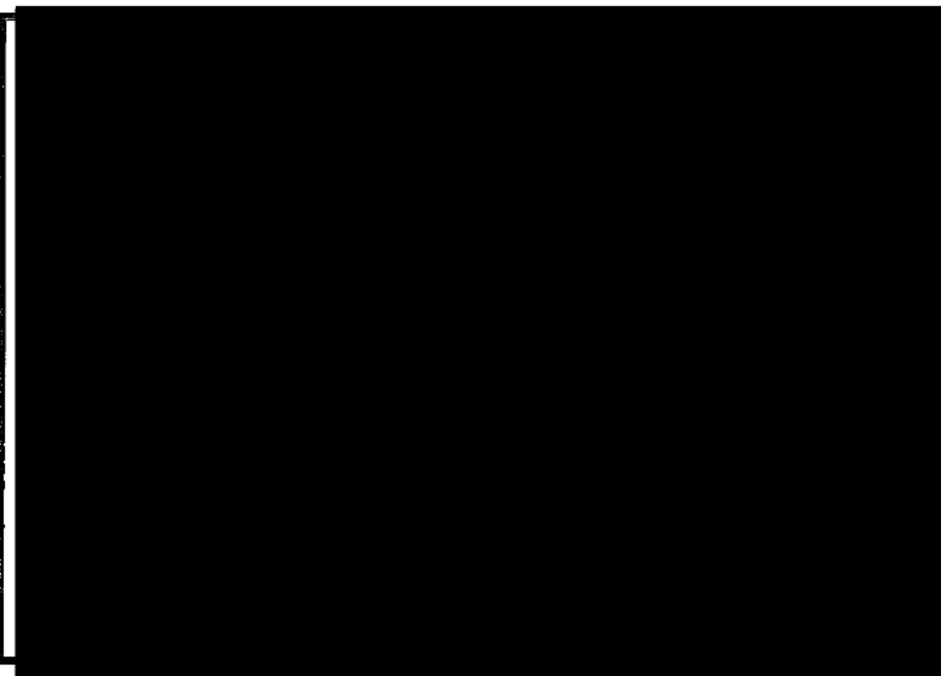


PHOTO DECLARATION

I hereby declare under penalty of perjury under the laws of the State of California, that the photo of myself attached hereto, was taken on or about ______

my age then being ______ years;

my color of hair ______;

my color of eyes ______;

my height ______ ft. ______ in.;

my weight ______ lbs.;

and identifying marks are ______

Signature of Applicant: Taylor Dunn MD

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)

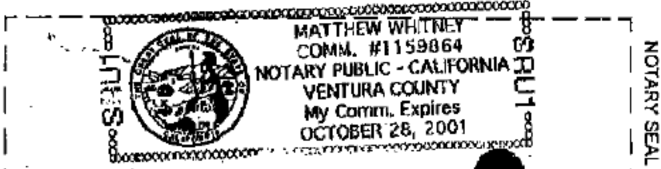
COUNTY OF VENTURA)

The applicant, TAYLOR MICHAEL DUNN, 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: Taylor Michael Dunn MD
(PLEASE WRITE FULL NAME, NOT INITIALS)

Signed and sworn to before me this 15th day of JULY, 19 2000



NOTARY SEAL

Matt Whitney
SIGNATURE OF NOTARY PUBLIC

4360 E. MAIN ST. STE A VENTURA CA 93003
ADDRESS

My commission expires OCT. 28, 2001

L1D

07A-100 (Rev. 3/99)

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

RECEIVED
JUN 15 2000
REGISTRATION-SCHEDULING

CERTIFICATE OF MEDICAL EDUCATION

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

This certifies that Taylor Michael Dunn (FULL NAME OF APPLICANT) of [redacted] (ADDRESS WHEN ENROLLED) enrolled in University of Washington School of Medicine (NAME OF MEDICAL SCHOOL) ✓ Seattle, Washington (LOCATION) on the 21st day of August (MONTH) 19 95 and was granted the following credits on enrollment:

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

Lewis & Clark College (EDUCATIONAL INSTITUTION) 6/90 (DATES)

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

______ (MEDICAL SCHOOL) ______ (TOTAL CREDITS) ______ (DATES)

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

*Dr. Dunn completed a full course of study as approved by the LCME.

[X] __he was granted the degree Bachelor/Doctor of Medicine by **OR** [ ] __he withdrew from the above mentioned medical school on the 11th day of June (MONTH), 19 99. ✓

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

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

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

◆ Each school where professional medical instruction was received MUST complete one of these forms. If more than one school was attended, photocopies of this blank form may be made and used. Note that photograph and all entries to the form must be **original**.

◆◆ ONLY applicable to medical students who graduate from medical school on or after May 1, 1998

◆◆◆ ONLY applicable to medical students who enrolled in medical school on or after September 1, 1994.

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

Medical School Seal MUST be Imprinted Partially on the Photograph.

Signed and the school seal affixed this 16th day of June 2000 ~~19~~.

BY Trudy L. Furberry, Certifying Officer (PRESIDENT, SECRETARY, DEAN)

L2

The University of Washington

To all to whom these Letters shall come, Greeting:

The Regents of the University on recommendation of the Faculty of the School of Medicine and by virtue of the Authority vested in Them by Law have this day admitted

Taylor Michael Dunn

to the degree of

Doctor of Medicine

and have granted all the Rights, Privileges and Honors thereto pertaining

Given at Seattle, in the State of Washington, this eleventh day of June, one thousand nine hundred and ninety-nine and of the University the one hundred and thirty-ninth.

"I certify this to be a true copy of the diploma for Taylor Michael Dunn, M.D., who received the M.D. degree from the University of Washington School of Medicine on June 11, 1999."

Trudy L. Furberry

Trudy L. Furberry, Certifying Officer

6/16/00
DATE

S E A L

Richard L. McCormick
President of the University

President of the Board of Regents

Paul G. Ramsey
Dean, School of Medicine

RECEIVED MEDICAL BOARD OF CALIFORNIA

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(916) 263-2499

CERTIFICATE OF COMPLETION OF ACGME/CCME POSTGRADUATE TRAINING

To be completed for each U.S./Canadian or foreign medical school graduate completing postgraduate training in the United States or Canada.

PART 1: To be completed by the applicant/trainee.

Last Name of Trainee	First Name	Middle Initial
DUNN	TAYLOR	M

Current Address: [redacted] Social Security Number: [redacted]

City: [redacted] State: [redacted] Zip Code: [redacted] Telephone Number: [redacted]

PART 2: ... PLEASE SEE THE REVERSE FOR A DEFINITION OF "SATISFACTORY."

Name of Facility: VCMC Family Practice Residency
Address of Facility: 3291 Loma Vista Rd. Ventura, CA 93003

Name of Program Director: Lanyard K. Dial, M.D.
Telephone Number: [redacted]

Signature of Program Director: [signature]
Date Signed: 07/03/00

List Categorical Specialty Area of Training Completed by Trainee:	Date Training Commenced:	Date Training Completed:
Family Practice	07/01/99	06/30/2002

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 seal.

Name of the Director of Medical Education: Lanyard K. Dial, M.D.
Facility Name: Ventura County Medical Center

Facility Address: 3291 Loma Vista Rd. Ventura, CA 93003

City: Ventura State: CA Zip Code: 93003 Telephone Number: [redacted]

PART 4: Signature ...

ATTENTION PROGRAM DIRECTOR!
IF TRAINEE IS IN HIS/HER FIRST YEAR OF POSTGRADUATE TRAINING, DO NOT SIGN OR DATE THE STATEMENT BELOW UNTIL AFTER THE COMPLETION OF THE TRAINEE'S LAST DAY OF 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 CCME to offer the type and level of training completed by the applicant and that the applicant was trained in an approved ACGME or CCME program position.

Signature of Director of Medical Education: [signature]
Date Signed: 07/03/00

OFFICIAL HOSPITAL SEAL OR NOTARY SEAL AND SIGNATURE MUST BE AFFIXED TO CERTIFY TRAINING.

L3A

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

CERTIFICATION STATEMENT

This is to certify that Taylor Dunn, M.D.
(Name of Physician)

is in an approved ACGME/CCME postgraduate training position that commenced on

July 1, 19 99 and is expected to be completed

on June 30 2002 in Family Practice
Month Day Year (Type of Training)

at Ventura County Medical Center Family Practice Residency Program
(Name and Address of Facility)
3291 Loma Vista Road Ventura, California 93003

AFFIX OFFICIAL HOSPITAL SEAL OR NOTARY SEAL IN THE BOX AT THE LEFT.

"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 facility is approved by the ACGME or the CCME to offer the type and level of training completed by the applicant and that the applicant is being trained in an approved ACGME or CCME program position."

Lanyard K. Dial, M.D.
(Type or print name of Director of Medical Education)

(Signature of Director of Medical Education)

7/3/00
(Date)

(Telephone Number)

NOTE: Do not use this form in lieu of Form L3A, "Certificate of Completion of ACGME/CCME Postgraduate Training."

L4

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

LICENSEE NAME	LICENSE NO.	EXPIRATION DATE	AMOUNT DUE NOW	AMOUNT DUE IF POSTMARKED AFTER APRIL 30, 2018
DUNN, TAYLOR M	**A73208**	**03/31/18**	**$820.00**	**$898.00**

LICENSEE MUST CHECK CORRECT BOXES

"H" Completed Continuing Education (See Question 1)

"E" Change of Address (fill in reverse side)

"I" Conviction – Yes (See Question 3)

"J" Conviction – No (See Question 3)

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

"G" Financial Interest Statement (See Question 5)

"D" **SIGNATURE REQUIRED**

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

Signature Taylor Dunn MD Date 1/19/18

ENTER YOUR PHONE NUMBER FOR REFERENCE:

63010100000100002000732081010331180008200000089800

CHANGE OF ADDRESS (Only if different from address above) **DUNN, TAYLOR M** **A73208**

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 -

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 APRIL 30, 2016
DUNN, TAYLOR M	**A73208**	**03/31/16**	**$820.00**	**$898.00**

LICENSEE MUST CHECK CORRECT BOXES

- "H" Completed Continuing Education
- "E" Change of Address (fill in reverse side)
- "I" Conviction Disclosure – Yes
- "J" Conviction Disclosure – No
- "F" Family Physician Training Program ($25)
- "G" 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 Taylor Dunn MD Date 12/20/15

ENTER YOUR PHONE NUMBER FOR REFERENCE:

63010100000100002000732081010331160008200000089800

CHANGE OF MAILING ADDRESS **DUNN, TAYLOR M** **A73208**

12302015 20061517 20010016

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)

PO BOX 22209

City: JUNEAU State: AK Zip: 99802 -

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

City State Zip -