

005232

STATE OF CALIFORNIA—AGRICULTURE AND SERVICES AGENCY

EDMUND G. BROWN JR., Governor



BOARD OF MEDICAL QUALITY ASSURANCE

1430 HOWE AVENUE, SACRAMENTO, CALIFORNIA 95811

TELEPHONE

Application and Examinations (916) 322-3041

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SACRAMENTO, CALIFORNIA 95811  
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APPLICATION FOR PHYSICIAN'S AND SURGEON'S CERTIFICATE  
BASED ON NATIONAL BOARD CREDENTIALS

CLASS C

001954

(Please type or print neatly. When space provided is insufficient, attach additional sheets.)

1. NAME Last First Middle Maiden  
**MARTIN, MALVERSE**

2. List other names, if any, you have used:

3. Address Street and No./Rural Route City State Zip Code  
[Redacted]

4. Birthdate (Month, Year, Day) [Redacted]

5. Professional Education Name of College or University Location  
**ALBERT EINSTEIN COLLEGE OF MEDICINE** **BRONX, NEW YORK, N.Y.**  
Period of attendance From **Aug 2, 1971** To **June 4, 1974**  
Check printed courses successfully completed:  
☒ Chemistry ☒ Physics ☒ Biology or Zoology

6. Medical School

Year	Name of Institution	Location	From	To
1st	<b>ALBERT EINSTEIN COLLEGE</b>	<b>1300 MORRIS PARK AVE.</b>	<b>Aug 2, 1971</b>	<b>June 4, 1974</b>
2nd	<b>OF MEDICINE</b>	<b>BRONX, NY 10461</b>		
3rd				
4th				
5th				
6th				

7. Doctor of Medicine Degree granted by:  
**ALBERT EINSTEIN COLLEGE OF MEDICINE** Date **JUNE 4, 1974** For office use only School Code: **NY 46**

8. 1st Year Postgraduate Training (Internship):  
**Albert Einstein College of Medicine / Bronx Municipal Hospital Center**  
Location **BRONX, NEW YORK** Type of Service **OBSTETRICS/GYN/OLOGY - MEDICAL** From **JUNE 4, 1974** To **JUNE 30, 1975**

9. List all States in which you have been licensed to practice medicine:  
**NEW YORK STATE - License # 125760**

10. Has any disciplinary action ever been taken regarding any license which you now hold or ever held? ☒ Yes ☒ No  
If Yes, indicate below:

State	Date	Charge	Disposition

11. Have you ever been denied a license to practice medicine in any State or Country? ☒ Yes ☒ No  
If Yes, indicate below:

State or Country	Date of Denial	Reason for Denial

12. Are you now or have you ever been addicted to narcotic drugs? ☒ Yes ☒ No

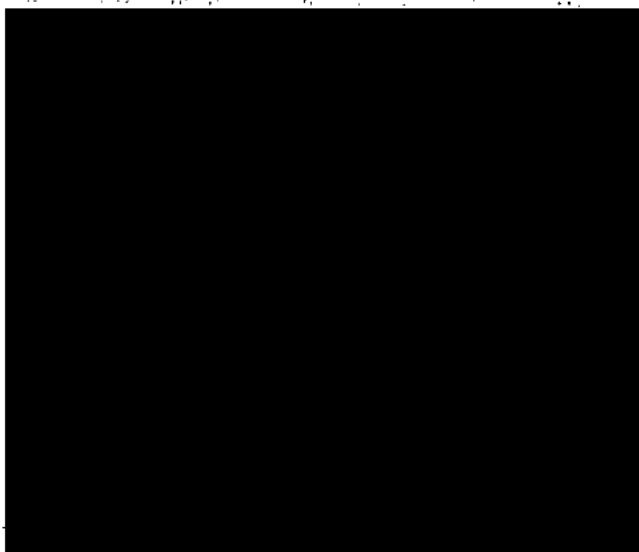
14. Have you ever been convicted of, pled guilty or nolo contendere to a violation of any Federal, State or Local law relating to the manufacture, distribution or dispensing of controlled substances, narcotics, or to drug addiction? ☒ Yes ☐ No

15. Have you ever been convicted of, pled guilty or nolo contendere to any offense, misdemeanor or felony in any state? (Except violations of traffic laws resulting in fines of \$50.00 or less.) ☒ Yes ☐ No

16. If you answered "Yes" to either No. 14 or No. 15 above, please provide the following information:

Violation and Location	Date	Penalty/Disposition

17. Have you ever had your privileges in a hospital suspended or revoked? ☒ Yes ☐ No  
If yes, please explain on another sheet of paper.



Applicant: Please complete the following:

Height: ☒ Ft. ☒ In. Weight: ☒ Lbs.

Hair color: ☒ Eye color: ☒

Identifying marks: \_\_\_\_\_

NOTE—APPLICANT WILL SIGN THIS STATEMENT IN PRESENCE OF NOTARY PUBLIC.

"I hereby certify (or declare), under penalty of perjury, that the foregoing information contained in this application and any attachments is true and correct; and that the attached photo and duplicate copy are a true likeness of myself, the applicant identified herein."

Signature of Applicant: Malvina Martin

Date: Nov. 8, 1978

Subscribed and sworn to before me this 8<sup>th</sup> day of November 19 78

Signature of Notary: John J. Bailey

SEAL

Address: 3424 Kossuth Ave

Brooklyn 10467

My commission expires: 11/1/79

JOHN J. BAILEY  
Notary Public  
State of New York  
Commission Expires 11/1/79



## BOARD OF MEDICAL QUALITY ASSURANCE

1430 HOWE AVENUE, SACRAMENTO, CALIFORNIA 95825

ALLIED HEALTH PROFESSIONS (916) 322-5043

APPLICATIONS AND EXAMINATIONS (916) 322-5040



PLEASE FORWARD TO YOUR MEDICAL SCHOOL

## CERTIFICATE OF EDUCATION

This Certifies That Malverse Martin, N.D.

Full name of applicant

enrolled in Albert Einstein College of Medicine

Name of medical school (college)

on the 2nd day of August, 19 71

Month

Year

☒ as a Freshman.☐ with advanced standing based on \_\_\_\_\_

Please specify

The undersigned further certifies that official transcripts on file show that prior to completing the study of medicine the applicant herein referred to completed at least a two-year resident course of college grade including:

☒ PHYSICS    ☒ CHEMISTRY    ☒ BIOLOGY (or) ZOOLOGY (Check course(s) completed)
at City College of New York - B.B. - 1971 and that he attended while at this

Please indicate school

medical school (college) All 3 yrs. courses of lectures of 33 weeks each.

Specify number

Specify number of weeks

completing 3 yrs hours in the subjects below listed, and that he/she: Malverse Martin, M.D.

Total hours

☒ was granted the degree Doctor of Medicine for our three-year program
☐ left the above mentioned medical school (college) for the following reason(s):

 on the 4 day of June, 19 74

Month

Year

Please indicate which of the following courses of study were successfully undertaken by the applicant:

<input type="checkbox"/> Anatomy	<input type="checkbox"/> Preventive medicine	<input type="checkbox"/> Medicine
<input type="checkbox"/> Embryology	<input type="checkbox"/> Hygiene and sanitation	<input type="checkbox"/> Pediatrics
<input type="checkbox"/> Histology	<input type="checkbox"/> Radiology, including roentgenologic technique and radiation safety	<input type="checkbox"/> Psychiatry
<input type="checkbox"/> Neuroanatomy	<input type="checkbox"/> Urology	<input type="checkbox"/> Neurology
<input type="checkbox"/> Physiology	<input type="checkbox"/> Ophthalmology	<input type="checkbox"/> Dermatology
<input type="checkbox"/> Psychobiology	<input type="checkbox"/> Anesthesia	<input type="checkbox"/> Physical medicine
<input type="checkbox"/> Biochemistry	<input type="checkbox"/> Otolaryngology	<input type="checkbox"/> Therapeutics
<input type="checkbox"/> Pathology, bacteriology and immunology	<input type="checkbox"/> Obstetrics and gynecology	<input type="checkbox"/> Tropical medicine
<input type="checkbox"/> Pharmacology		<input type="checkbox"/> Surgery, including orthopedic surgery

Signed and the College seal affixed this 5th dayof October, 19 78

Month

Year

By Dr. Stephen H. Lazer - Assoc. Dean

President, Board of Medical Quality Assurance

 [ AFFIX SEAL  
HERE ]

## Application Summary

9/28/18 3:05 PM

Page 1 of 3

License Type: Physician and Surgeon G  
License Number: 38477  
File Number: 194475  
Application: Physician's and Surgeon's Renewal  
Application Number: 14549987  
Application Date: 09/28/2018 (mm/dd/yyyy)

### Application Questions

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



### Personal Detail

First Name: MALVERSE  
Last Name: MARTIN  
Birthdate: \*\*/\*\*/\*\*\*\*  
Gender: 

### Addresses

#### License Related Addresses

##### Address of Record (Required)

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

Would you like to contribute? 

**Attachments****Physician Survey**

Are you retired?

No

Activities in Medicine

Administration - None

Other - None

Patient Care - 40+ Hours

Research - None

Teaching - None

Telemedicine - None

Patient Care Practice Location

Zip: 91304 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

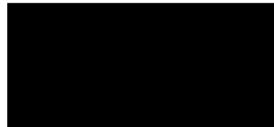
Board Certifications

None

Postgraduate Training Years

4 Years

Cultural Background



Foreign Language Proficiency

Web Site Profile

Cultural Background - No

Foreign Language Proficiency - No

Gender - No

E-mail:

**Fees**

Biennial Renewal Fee

\$783.00

DUE TO CURES FUND

\$12.00

StephenM.ThompsonLRP

\$25.00

Total Amount Due:

\$820.00

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

10/25/16 11:55 AM

Page 1 of 3

License Type: Physician and Surgeon G  
License Number: 38477  
File Number: 194475  
Application: Physician's and Surgeon's Renewal  
Application Number: 14321853  
Application Date: 10/25/2016 (mm/dd/yyyy)

### Application Questions

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



### Personal Detail

First Name: MALVERSE  
Last Name: MARTIN  
Birthdate: \*\*/\*\*/\*\*\*\*  
Gender:



### Addresses

#### License Related Addresses

##### Address of Record (Required)

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?




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**Family Physician Training Program Voluntary Fee**Voluntary Fee: **Attachments****Physician Survey**

Are you retired?

No

Activities in Medicine

Administration - None

Other - None

Patient Care - 40+ Hours

Research - None

Teaching - None

Telemedicine - None

Patient Care Practice Location

Zip: 91304 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

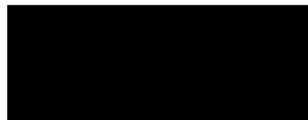
Board Certifications

None

Postgraduate Training Years

4 Years

Cultural Background



Foreign Language Proficiency

Web Site Profile

Cultural Background - No

Foreign Language Proficiency - No

Gender - No

E-mail:

**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:

## Application Summary

9/24/14 4:19 PM

Page 1 of 3

License Type: Physician and Surgeon G  
License Number: 38477  
File Number: 194475  
Application: Physician's and Surgeon's Renewal  
Application Number: 14107918  
Application Date: 09/24/2014 (mm/dd/yyyy)

### Personal Detail

First Name: MALVERSE  
Last Name: MARTIN  
Birthdate: \*\*/\*\*/\*\*\*\*  
Gender: 

### Addresses

#### License Related Addresses

##### Confidential Address (Optional)

Warning:

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

##### License Specific Public/Mailing Address (Required)

Warning:

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

### Questions

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


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Administration - None

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Patient Care - 40+ Hours

Research - None

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Telemedicine - None

Patient Care Practice Location

Zip: 91304 County: LOS ANGELES

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Obstetrics and Gynecology - Primary

Board Certifications

None

Postgraduate Training Years

4 Years

Cultural Background



Web Site Profile

Cultural Background - No

Foreign Language Proficiency - No

Gender - No

E-mail:

**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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**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: