STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY — GEORGE DEUKMEJIAN, Governor

DEPARTMENT OF CONSUMER AFFAIRS

BOARD OF MEDICAL QUALITY ASSURANCE
1430 HOWE AVENUE
SACRAMENTO, CA 95825
(916) 920-6411

MAR 24 8 18 AM '80

APPLICATION FOR PHYSICIAN AND SURGEON'S EXAMINATION OR LICENSURE

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 per instructions. Please type or print neatly. When space provided is insufficient, attach additional sheets of paper.

500.00 3/25

009803

BMQA USE ONLY

1. Name: Last: Watson First: Edward Middle: Ray

PERSONAL DATA

2. Other names you have used: None

3. Social Security Number [redacted]
See disclosure statement on LIC

4. Address: Number and Street/Rural Route (Include apartment number, if any) [redacted]
City State Zip Code Country

5. Telephone Number: Home [redacted] Work

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

7. Sex: ☐ Female ☒ Male

8. Are you a U.S. citizen? [redacted] Yes [redacted] No
Submit a certified copy of birth certificate, Certificate of Naturalization, Declaration of Intention to become U.S. citizen (INS Form N-300), VISA document, or license to practice medicine.

☑

9. Have you ever filed an application for examination or licensure in California? ☐ Yes ☒ No
If YES, give date of previous application:

☐

10. List name and address of all colleges or universities attended other than schools where professional medical instruction was received. Submit an official transcript from each school attended.

NON-MEDICAL EDUCATION

Name	Address	Period of Attendance From (Mo/Yr)	Period of Attendance To (Mo/Yr)	
Central State University	Edmond, Oklahoma	12/69	5/71	☑
University of Oklahoma	Norman, Oklahoma	1/67	12/69	☑
				☐

11. List name and address of all schools where professional medical instruction was received. Submit an original Certificate of Medical Education and official transcripts from each school attended.

MEDICAL EDUCATION

Name	Address	Place Where Instruction Received	Period of Attendance From (Mo/Yr)	Period of Attendance To (Mo/Yr)	CME	TRANS.
University of Oklahoma College of Medicine	940 Stanton L Young Blvd Okla. City, Okla. 73190		8/76	6/78	☑	☐
					☐	☐
					☐	☐
					☐	

12. Doctor of Medicine Degree granted by: (submit original medical diploma and a photocopy)

Name of Medical School	Address of Medical School	Exact Date of Issuance
University of Oklahoma	Okla. City, Okla.	June 4th, 1978

OKLA
School Code

L1A

07A-100 (8/79)

BHQA USE ONLY

13. Have you taken any of the following written examinations: National Boards, ECFMG, FMGEMS, FLEX, MSKP, MCAT, other related medical competency examinations? ☒ Yes ☐ No

If YES, list name, location, date and result of examination. Submit certification of scores from each examination agency.

WRITTEN EXAMINATION

Name	Location	Date	Result
National Boards	Miami, Fl.	July 2, 1979	[redacted]

14. Have you received qualifying postgraduate training in U.S. or Canadian facilities? ☒ Yes ☐ No

If YES, list name and address of all facilities. Submit an original Certificate of Completion of ACGME Postgraduate Training (Form 13) from each facility.

POSTGRADUATE TRAINING

Name	Address	Type of Service	Period of Attendance	
			From (Mo/Yr)	To (Mo/Yr)
Univ. of Miami Dept. of OB-GYN	1600 N.W. 10th Ave Miami, Fl. 33136	OB-GYN	06/78	07/82

15. Have you 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 issuing agency's jurisdiction for each. Submit a Letter of Good Standing from each state in which you are licensed or have been licensed.

LICENSE DATA

State or Country	License Number	Date of Issuance	Dates of Practice in Issuing Agency's Jurisdiction		LGS	CE
			From (Mo/Yr)	To (Mo/Yr)		
Florida	035674	Oct. 1979	10/79	Present	☒	☐
Colorado	28473	Oct. 1987	10/87	Present	☒	☐
					☐	☐
					☐	☐

16. Has any disciplinary action ever been taken regarding any healing arts license which you now hold or have ever held? Include any disciplinary actions by the U.S. Military, U.S. Public Health Service or other U.S. federal governmental entity.

[redacted] Yes [redacted] No If yes, give details below.

State	Date	Charge	Disposition

07A-100

L1B

AMQA USE ONLY

17. Have you ever been denied a license or permission to practice medicine or any other healing arts, or permission to take an examination in any state, country, or U.S. federal jurisdiction? [redacted] Yes [redacted] No

If yes, give details below:

State or Country	Date of Denial	Reason for Denial

LICENSE DATA (continued)

18. Have you been charged with unprofessional conduct or any other unlawful activity by any healing arts licensing authority or by the U.S. military and are awaiting final disposition by that body?

[redacted] Yes [redacted] No If yes, please explain on a separate sheet of paper.

19. Have you ever voluntarily surrendered a license to practice in the healing arts in another state?

[redacted] Yes [redacted] No If yes, please explain on a separate sheet of paper.

20. Have you ever had staff privileges in a hospital denied, suspended or revoked, or resigned from a medical staff in lieu of disciplinary action? [redacted] Yes [redacted] No If yes, please explain on a separate sheet of paper.

21. Are you now, or were you in the past, addicted to or treated for addiction to controlled substances, such as narcotics or alcohol? [redacted] Yes [redacted] No If yes, please explain on a separate sheet of paper.

GENERAL DATA

22. Have you ever been convicted of, or pled nolo contendere to a violation of any federal, state or local law relating to the manufacture, distribution or dispensing of controlled substances, or to drug addiction? [redacted] Yes [redacted] No

If yes, give details below:

Violation and Location	Date	Penalty or Disposition

23. Have you ever been convicted of, or pled nolo contendere to any offense, misdemeanor or felony of any state, the United States, or a foreign country? (except violations of traffic laws resulting in fines of $75.00 or less.)

[redacted] Yes [redacted] No If yes, give details below:

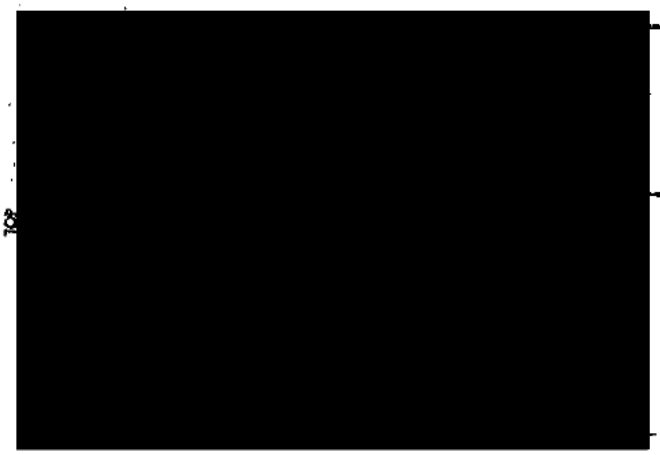
Violation and Location	Date	Penalty or Disposition

You are required to list any conviction that has been set aside and dismissed under Section 1203.4 Penal Code or under any other provision of law.

"Disclosure of your social security number is mandatory. Section 30 of the Business and Professions Code and Pub. L. 94-455 (42 U.S.C.A. 405 (c) (2) (C)) authorizes collection of your social security number. Your social security number will be used exclusively for tax enforcement purposes. If you fail to disclose your social security number, you will be reported to the Franchise Tax Board, which may assess a $100 penalty against you."

L1C

07A-100



TOP

BOTTOM

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;

color of hair [redacted];

color of eyes [redacted];

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

weight [redacted] lbs.;

Identifying marks _____

_____

_____

NOTE: All items in this application are mandatory; none are voluntary. Failure to provide any of the requested information will result in the application being rejected as incomplete. The information provided will be used to determine qualification for licensure, per Section 2080 of the Business and Professions Code which authorizes the collection of this information. Information regarding the issuance or denial of a license by the Board may be transmitted to any other medical licensing authority or the Federation of State Medical Boards. Applicants have the right to review their application subject to the provisions of the Information Practices Act. The Program Manager of the Division of Licensing is the custodian of records.

STATE OF Colorado)

COUNTY OF Pitkin)

Edward R. Watson being duly sworn, says he is the person referred to in the foregoing application for a physician and surgeon's certificate in California and that he has carefully read and thoroughly understands all the requirements therein and that the statements made herein and all attachments are true and correct under penalty of perjury under the laws of the State of California.

He requests that the Division of Licensing, Board of Medical Quality Assurance, initiate a review of the records to determine their eligibility for examination, postgraduate training or licensure in California. In making this request, he authorizes the release of any information or records held by any individual or agency, relative to their training and qualifications as a physician and surgeon, upon request by the Board for use in evaluating their file.

Edward Ray Watson

Signature of applicant in FULL (Do not use INITIALS ONLY)

Signed and sworn to before me this 23rd day of March, 1989.

Signature of Notary Public Kris Case

(SEAL)

Address Box 4830 Aspen, CO 81612

My commission expires June 6, 1992

L1D

07A-100

STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY — GEORGE DEUKMEJIAN, Governor

DEPARTMENT OF Consumer Affairs

BOARD OF MEDICAL QUALITY ASSURANCE
1430 HOWE AVENUE, SACRAMENTO, CALIFORNIA 95825
(916) 920-6411

CERTIFICATE OF MEDICAL EDUCATION

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

This certifies that Edward R. Watson M.D.
(FULL NAME OF APPLICANT)

of Aspen, Colorado (ADDRESS WHEN ENROLLED) enrolled in Universidad Autonoma de Guadalajara (NAME OF MEDICAL SCHOOL)

Guadalajara, Jalisco (LOCATION) on the ** day of August (MONTH) 19 72 (YEAR)

**Exact date not available in our archives.

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 Profession Code Section 2038).

Central State University/University of Okla. (EDUCATIONAL INSTITUTION) 1967-1971 (DATES)

Advanced Credits. Credits previously obtained at an approved medical school.*

(MEDICAL SCHOOL) (TOTAL CREDITS) (DATES)

The undersigned further certifies that the records of this institution show that he attended in this institution 18 (NUMBER OF WEEKS) courses 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

☐ he was granted the degree Bachelor/Doctor of Medicine by

☒ he withdrew, attended up to

the above mentioned medical school on the ** day of June (MONTH) 19 74

Anatomy 200
Otolaryngology
Obstetrics and Gynecology
Radiology, including Radiation Safety 40
Tropical Medicine
Physiology 200
Biochemistry 200
Pathology, Bacteriology and Immunology 414
Dermatology
Embryology 72
Histology 136
* Human Sexuality as defined in Section 2090
Medicine 797
Surgery, including Orthopedic Surgery 108
Urology
Psychiatry 48
Neurology
Preventive medicine, including Nutrition 422
Physical Medicine
Therapeutics
Neurosurgery
Child Abuse Detection and Treatment
Geriatric Medicine
Pediatrics
Pharmacology 198
Anesthesia

*The credit hours for this subject have been included with another subject

Signed and the college seal affixed this 21st day of June, 1989.

BY Alejandro A[illegible]/Dean of Foreign Students
(PRESIDENT, SECRETARY, DEAN)

Medical School Seal MUST be impressed Partially on the Photograph.

TRANSCRIPTS OF PREMEDICAL EDUCATION, ADVANCED CREDITS, AND MEDICAL SCHOOL CREDITS MUST BE SUPPLIED WITH THIS CERTIFICATE

[redacted]

L2

STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY — DEUKMEJIAN, Governor

DEPARTMENT OF CONSUMER AFFAIRS

BOARD OF MEDICAL QUALITY ASSURANCE

1430 HOWE AVENUE, SACRAMENTO, CALIFORNIA 95825
(916) 920-6411

MAY 5 4 24 PM '89

CERTIFICATE OF MEDICAL EDUCATION

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

This certifies that Edward R. Watson M.D. (FULL NAME OF APPLICANT)

of Okla. City, Okla. (ADDRESS WHEN ENROLLED) enrolled in University of Oklahoma Schl. of Med. (NAME OF MEDICAL SCHOOL)

Okla. City, Okla. (LOCATION) on the ____ day of August (MONTH) 19 76 (YEAR)

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).

Central State University/University of Okla. (EDUCATIONAL INSTITUTION) 1967-1971 (DATES)

Advanced Credit. Credits previously obtained at an approved medical school.*

University Autonoma of Guadalajara (MEDICAL SCHOOL) All Basic Sci. (TOTAL CREDITS) 1972-1974 (DATES)

The undersigned further certifies that the records of this institution show that __he attended in this institution all required (NUMBER) courses of resident instruction of all required (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

- [X] __he was granted the degree Bachelor/Doctor of Medicine by
- [ ] __he withdrew from

the above mentioned medical school on the 4th day of June (MONTH) 1978.

Anatomy	Dermatology	Preventive medicine, including Nutrition
Otolaryngology	Embryology	Physical Medicine
Obstetrics and Gynecology	Histology	Therapeutics
Radiology, including Radiation Safety	Human Sexuality as defined in Section 2090	Neuroanatomy
Tropical Medicine	Medicine	Child Abuse Detection and Treatment
Physiology	Surgery, including Orthopedic Surgery	Geriatric Medicine
Biochemistry	Urology	Pediatrics
Pathology, Bacteriology and Immunology	Psychiatry	Pharmacology
Ophthalmology	Neurology	Anesthesia

[redacted]

Signed and the college seal affixed this 2nd day of May, 19 89.

BY *Nancy K. Hall* (PRESIDENT, SECRETARY, DEAN)

Nancy K. Hall, Ph.D., Associate Dean
for Admissions and Students

Medical School Seal MUST Be Imprinted Partially on the Photograph.

TRANSCRIPTS OF PREMEDICAL EDUCATION, ADVANCED CREDITS, AND MEDICAL SCHOOL CREDITS MUST BE SUPPLIED WITH THIS CERTIFICATE

* [illegible]

L2

STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY — GEORGE DEUKMEJIAN, Governor

DEPARTMENT OF CONSUMER AFFAIRS

BOARD OF MEDICAL QUALITY ASSURANCE
1430 HOWE AVENUE, SACRAMENTO, CALIFORNIA 95825
(916) 920-6411

RECEIVED
APR 4 4 36 PM '89
BOARD OF MEDICAL QUALITY ASSURANCE

CERTIFICATE OF ENDORSEMENT BY STATE LICENSING AGENCY

[redacted]

1. NAME: (last) Watson, (first) Edward (middle) Ray — MEDICAL / NATUROPATH

2. ADDRESS [redacted] (include apt. no., if any)
ZIP CODE — COUNTRY

3. DATE OF BIRTH [redacted] (mo/day/yr) | 4. SEX: ☐ Female ☒ Male | 5. STATE LICENSING AGENCY: Florida

(NOTE: Applicant will sign this statement in presence of notary public. "I hereby declare under penalty of perjury under the laws of the State of California that the attached photograph is a true likeness of myself and that the information contained in this document and any attachments are true and correct."

Edward Ray Watson
SIGNATURE OF APPLICANT IN FULL

Signed and sworn to before me this 23rd day of March 1989.

(SEAL)

Signature of Notary Public Kurt Ane
Address Box 4980 Aspen, CO 81612
My commission expires June 4, 1992

TO BE COMPLETED BY STATE LICENSING AGENCY:
(Do not complete if photograph of applicant is not attached above. Please type or print.)

I certify that Edward P. Watson (NAME OF APPLICANT) who graduated from Univ Oklahoma Col of Med (NAME OF MEDICAL SCHOOL) on June 1978 (DATE OF GRADUATION) was granted license number ME0035674 on 10/9/79 (DATE LICENSE ISSUED) on the basis of National Board Exam (FULL NATIONAL BOARD EXAM, LICENSING AGENCY EXAM)

NOTE: If the license was issued by written examination, complete the following certification, otherwise write across the following certification the words issued on Credentials.

I further certify that this doctor passed the REGULAR WRITTEN EXAMINATION given by this Board on _____ (DATE),

and obtained a general average of _____ per cent in the following subjects:

Subjects of Examination	Per Cent	Subjects of Examination	Per Cent

I certify that this license is valid, current, has never been suspended or revoked, and will expire 12/31/89 (DATE), and that records in this office indicate that there are not now nor have there ever been any charges filed against the holder of this license.

NOTE: If any portion of the above certification is deleted or modified, please attach an explanation.

Vicki R. Grant (TYPE OR PRINT NAME AND TITLE OF AGENCY OFFICIAL) (AFFIX RECEIVING AGENCY SEAL) Florida (NAME OF STATE LICENSING AGENCY)

Vicki R. Grant (SIGNATURE OF AGENCY OFFICIAL)

3/27/89 (DATE)

130 N. Monroe St (ADDRESS)
Tallahassee, Fl
[redacted]

L4

STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY — BOARD OF MEDICAL EXAMINERS

DEPARTMENT OF Consumer Affairs

BOARD OF MEDICAL QUALITY ASSURANCE

1430 HOWE AVENUE, SACRAMENTO, CALIFORNIA 95825
(916) 920-6411

MAR 24 1989

CERTIFICATE OF ENDORSEMENT BY STATE LICENSING AGENCY OF COLORADO

TO BE COMPLETED BY APPLICANT

[redacted]

1. NAME: (last) (first) (middle)
Watson, Edward Ray

2. ADDRESS: [redacted] (include apt. no., if any)
CITY STATE ZIP CODE COUNTY

3. DATE OF BIRTH: [redacted] mo/day/yr | 4. SEX: ☐ Female ☒ Male | 5. STATE LICENSING AGENCY: Colorado

NOTE: Applicant will sign this statement in presence of notary public. "I hereby declare under penalty of perjury under the laws of the State of California that the attached photograph is a true likeness of myself and that the information contained in this document and any attachments are true and correct."

Edward Ray Watson
SIGNATURE OF APPLICANT IN FULL

Signed and sworn to before me this 23rd day of March 1989

(SEAL)

Signature of Notary Public Kuth Ouse
Address Box 1930, Eden, ID 83329
My commission expires June 16, 1992

TO BE COMPLETED BY STATE LICENSING AGENCY:
(Do not complete if photograph of applicant is not attached above. Please type or print.)

I certify that Edward Ray Watson (NAME OF APPLICANT) who graduated from Univ. of Oklahoma (NAME OF MEDICAL SCHOOL) on 1978 (DATE OF GRADUATION) was granted license number 28473 on 10/8/87 (DATE LICENSE ISSUED) on the basis of National Boards (FLEX, NATIONAL BOARD EXAM, LICENSING AGENCY EXAM)

NOTE: If the license was issued by written examination, complete the following certification, otherwise write across the following certification the words: Issued on Credentials.

I further certify that this doctor passed the REGULAR WRITTEN EXAMINATION given by this Board on _____ (DATE)

and obtained a general average of _____ per cent in the following subjects:

Subjects of Examination	Per Cent	Subjects of Examination	Per Cent
N/A			

I certify that this license is valid, current, has never been suspended or revoked, and will expire 5/31/89 (DATE) and that records in this office indicate that there are not now nor have there ever been any charges filed against the holder of this license.

NOTE: If any portion of the above certification is deleted or modified, please attach an explanation.

ARTHUR HART, VERIFICATION CLERK (AFFIX LICENSING AGENCY SEAL) Colorado Bd. of Medical Examiners
TYPE OR PRINT NAME AND TITLE OF AGENCY OFFICIAL — NAME OF STATE LICENSING AGENCY

Arthur Hart
SIGNATURE OF AGENCY OFFICIAL

3/24/89
DATE

1525 Sherman St., Rm 132
ADDRESS
Denver, Co 80203

[redacted]

L4

STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY GEORGE DEUKMEJIAN, Governor

DEPARTMENT OF CONSUMER AFFAIRS

BOARD OF MEDICAL QUALITY ASSURANCE
1430 HOWE AVENUE, SACRAMENTO, CALIFORNIA 95825
(916) 920-6411

BOARD OF MEDICAL QUALITY ASSURANCE

APR 4 9 13 AM '89

CERTIFICATE OF COMPLETION OF ACGME POSTGRADUATE TRAINING

To be completed by the facility for every medical school graduate completing postgraduate training in the United States or Canada. Do not complete if photograph of applicant is not attached below. Please type or print.

This is to certify that Edward R. Watson M.D.
NAME OF APPLICANT

a graduate of University of Oklahoma School of Medicine
NAME OF MEDICAL SCHOOL

formally commenced an accredited postgraduate training program at Univ. of Miami School of Medicine
NAME AND ADDRESS OF FACILITY

Jackson Memorial Hospital in Obstetrics & Gynecology
SPECIALTY

on June 24th, 1979, and completed such training on June 30th, 1982.

This training consisted of 48 months of actual clinical instruction and is approved by the Accreditation Council for Graduate Medical Education (ACGME) or the Coordinating Council of Medical Education of the Canadian Medical Association (CCME) and consisted of the following rotations:

(List rotations completed. If service was rotating, indicate type of straight training performed. NOTE—To qualify for licensure in California, graduates of foreign medical schools must have completed at least four months of postgraduate training in general medicine. ACGME or CCME residencies in family practice, internal medicine, surgery, pediatrics, and ob/gyn would normally satisfy this requirement.)

ROTATION	LENGTH OF ROTATION
STRAIGHT TRAINING PROGRAM – INTERNSHIP AND RESIDENCY IN OBSTETRICS AND GYNECOLOGY	

Certified to be true and correct.
Dated at Miami, Florida, this 27th March 1989.

[redacted]
Public, State of Florida
ion Expires Sept. 3, 1989
[illegible] Fain Insurance Inc.

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 was trained in an approved ACGME or CCME program position.

NAME William A. Little, M.D.
DIRECTOR OF MEDICAL EDUCATION

AFFIX SEAL OF NOTARY PUBLIC

ADDRESS 1611 N.W. 12th Ave., Dept. of Ob/Gyn

Miami, Florida 33136

PHONE NUMBER [redacted]

DATE 3/27/89

SIGNATURE

L3

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

1-44839/242-19(B)

LICENSEE NAME	LICENSE NO.	EXPIRATION DATE	AMOUNT DUE NOW	AMOUNT DUE IF POSTMARKED AFTER MARCH 30, 2019
WATSON, EDWARD R	**G66149**	**02/28/19**	**$25.00**	**$25.00**

1/31

LICENSEE MUST CHECK CORRECT BOXES

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

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

"I" Conviction – [redacted]

"J" Conviction –

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

"G" Financial Interest Statement (See Question 5)

"D" **SIGNATURE REQUIRED**

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

Signature E. Watson M.D. Date 11/30/18

ENTER YOUR PHONE NUMBER FOR REFERENCE:

[redacted]

6301070000070000600066149601022819000025000000002500

CHANGE OF ADDRESS (Only if different from address above)
ADDRESS OF RECORD (Required)

WATSON, EDWARD R **G66149**

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

Protecting consumers by advancing high quality, safe medical care.

Licensing Program
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815-5401
Phone: (916) 263-2382
Fax: (916) 263-2487
www.mbc.ca.gov

Gavin Newsom, Governor, State of California | Business, Consumer Services and Housing Agency | Department of Consumer Affairs

EDWARD RAY WATSON
[redacted]

Dear Doctor: EDWARD RAY WATSON License #: G66149 Date: February 12, 2019

This is to inform you that we are unable to process your renewal because you failed to sign the financial interest statement on your renewal application form.

New legislation requires all physicians to report to MBC any financial interests they or their immediate family may have in health-related facilities located in or outside the State of California (Business and Professions Code Section 2426). This information will be available to other government agencies and public and private third party payors. In order to comply with this mandate, please complete the Financial Interest Statement below, and enter the facility name(s) and address (es) in the space provided. If additional space is needed, please attach a page of additional listings.

FINANCIAL INTEREST means and includes any type of ownership interest, share or stock ownership, dept, land, lease, compensation, remuneration, general or limited partnership interest, discount, rebate, refund, dividend, distribution, subsidy, or other form of direct or indirect payment of money or anything else of value. It also includes an ownership interest in an entity, corporation, or partnership that leases property to a health-related facility. A "financial interest" does not include the ownership of corporate investment securities, including shares, bonds, or other debt instruments in a corporation that (1) are purchased from a licensed securities broker on terms available to the general public through a licensed securities exchange or NASDAQ, (2) do not base any distributions on the value of the physicians' referral of patients, (3) do not have a separate class or accounting for any persons who may make patient referrals to the corporation, and (4) has total gross assets exceeding $100,000.00.

HEALTH-RELATED FACILITY means a facility that provides clinical laboratory services, radiation, oncology, physical therapy, physical rehabilitation, psychometric testing, home infusion therapy, diagnostic imaging, or outpatient surgery. "Diagnostic Imaging" includes x-ray, computed axial tomography, magnetic resonance imaging, nuclear medicine, positron emission tomography, mammography, and ultrasound goods and services.

IMMEDIATE FAMILY means a spouse, child, parent of a licensee, and a spouse of a child of a licensee.

I certify under of penalty of perjury that I have disclosed on this form, the names of those health-related facilities that I or my family have financial interest in.

SIGNATURE REQUIRED HERE: E. W. Watson **DATE:** 2/16/2019

Telephone Number: _____ (Please include area code)

NOTE: This form is part of the renewal process. If you have no financial interest please sign, date, and write "None"

Please return this form to the address or fax number below, if you have any questions regarding this letter, please contact the Consumer Information Unit of the Medical Board of California at (916) 263-2382.

DISCLOSURE OF FINANCIAL INTERESTS: Please print below the names of the health-related facilities that you or members of your immediate family have financial interest in.

HEALTH RELATED FACILITY NAME(s)	ADDRESS
1	
2.	
3.	

800.DEFN16.112116

MEDICAL BOARD
OF CALIFORNIA
Protecting consumers by advancing high quality, safe medical care.

Licensing Program
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815-5401
Phone: (916) 263-2382
Fax: (916) 263-2487
www.mbc.ca.gov

Gavin Newsom, Governor, State of California | Business, Consumer Services and Housing Agency | Department of Consumer Affairs

To: EDWARD RAY WATSON
[redacted]

License #: G66149

Date: February 12, 2019

Your application for renewal has been received and cashiered. However, your license renewal is being HELD due to an incomplete renewal application. Please complete items 1 and 2 below:

1. CONVICTIONS and LICENSE DISCIPLINE:
   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 USA and its territories, military court or a foreign country?

   _____ YES ___X___ NO

2. CERTIFICATION:
   I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

   _____ Signature of Licensee

   2/16/2019 Date

Return this letter to the address below or fax as soon as possible. Upon receipt and review of the above information, your renewal application will be processed. IF YOUR LICENSE HAS EXPIRED, YOU MAY NOT ENGAGE IN ANY PRACTICE WHERE A VALID AND ACTIVE LICENSE ISSUED BY THE MEDICAL BOARD IS REQUIRED UNTIL THIS FORM IS COMPLETED AND RETURNED.

******* IMPORTANT *******

You must respond "YES" if you had any license disciplined by a government agency or other disciplinary body; or a conviction(s) whether a misdemeanor, felony, or infraction over $300 or involving alcohol or a controlled substance. You must include pleas of no contest and any convictions that were subsequently set aside or deferred pursuant to Sections 1000 or 1203.4 of the Penal Code. If you responded "YES" to Item 1 above, in order to assist the Board in determining what, if any, action need be taken against your license, please provide the following documents to the Board within 30 days from receipt of this letter (they need not be sent with this form) for each conviction or disciplinary action since you last renewed your license. Please include your license number on any correspondence with the Board.

1. A detailed written explanation describing the circumstances and events that led to your license discipline arrest(s) and conviction(s).
2. Documents relating to your license discipline or disciplinary actions taken against any other license by a government agency or disciplinary body.
3. Certified documents relating to the arrest, such as: police report, arrest report, booking report, complaint, citation or ticket.
4. Certified Court documents, such as: Notice of Charges, Complaint, or Indictment; Plea Agreement, Sentencing Order, Probation Order, or Judgment; Dismissal, Probation Release, or Court Discharge.
5. Related mitigating evidence or evidence of rehabilitation.

Please provide the requested documentation to the address below within 30 days from the date of receipt of this letter. Upon receipt and review of this documentation, the Board will determine what, if any, action will be taken.

Application Summary

License Type:	**Physician and Surgeon G**
License Number:	**66149**
File Number:	**214506**
Application:	**Physician's and Surgeon's Renewal**
Application Number:	**14359645**
Application Date:	**02/14/2017 (mm/dd/yyyy)**

Application Questions

Have you served or are you currently serving in the military? [redacted]

Personal Detail

First Name:	**EDWARD**
Middle Name:	**RAY**
Last Name:	**WATSON**
Birthdate:	****/**/******
Gender:	**Male**

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? [redacted]

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? [redacted]

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. [redacted]

Family Physician Training Program Voluntary Fee

Voluntary Fee: [redacted]

Amount - $25.00 Minimum:

Attachments

Physician Survey

Are you retired?	**Yes**
Activities in Medicine	**Administration - None** **Other - None** **Patient Care - None** **Research - None** **Teaching - None** **Telemedicine - None**
Patient Care Practice Location	**Zip: 85018 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 - Primary**
Board Certifications	**American Board of Obstetrics and Gynecology - Obstetrics and Gynecology**
Cultural Background	**White**
Foreign Language Proficiency	**Spanish**
Web Site Profile	**Cultural Background - Yes** **Foreign Language Proficiency - Yes** **Gender - Yes**
E-mail:	[redacted]

Fees

DUE TO CURES FUND	**$12.00**

Steven M. Thompson Physician Corps Loan Repayment Program	**$25.00**
Family Physician Training Fee	**$25.00**
Total Amount Due:	**$62.00**

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: