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) 263-2487 Internet: www.medbd.ca.gov

Consumer Affairs

RECEIVED
DEPARTMENT OF CONSUMER AFFAIRS
MEDICAL BOARD
OF CALIFORNIA
02 MAR 27 AM 11:50

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2002 NOV 20 AM 8:05
118438

APPLICATION 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.

MBC USE ONLY

1. NAME: *Last* COPIT | *First* PAUL | *Middle* S.

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

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.
One Bala Avenue, Suite #120

City: Bala Cynwyd | State: PA | Zip Code: 19066 | Country: USA

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.]
[redacted]

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

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

6. California Driver's License Number (optional):
NUMBER EXPIRATION

7. Date of Birth (Month/Day/Year) and Place of Birth:
[redacted]

8. Sex: ☒ Male ☐ Female

9. Are you a U.S. citizen? [redacted] Yes [redacted] No

10. Have you ever filed an application for Physician's and Surgeon's examination or licensure in California?
IF YES, PLEASE GIVE DATE PREVIOUS APPLICATION WAS SUBMITTED. Original application date unknown ☒ Yes ☐ No

11. List the names and locations 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. Transcripts will not be returned.

Name	City, State, Country	Dates of Attendance
Temple University	Philadelphia, PA USA	June, 1945 - Sept.1948

12. List the names and locations 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 8 1/2" x 11" photocopy (original diploma will be returned).

School Name	City, State, Country	Dates of Attendance	Degree Awarded
Temple Medical	School Phila., PA USA	Sept.1948-June,1952	M.D.

DOCTOR OF MEDICINE DEGREE, as referenced above.

Name of Medical School	Address of Medical School	Exact Date of Issuance
Temple Medical School	Broad & Tioga Sts., Phila., PA	June 12,1952

*** 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

L1A

Personal Data
Pre-Medical Education
Medical Education
L2 Trans

07A-100 (Rev. 3/01)

MBC USE ONLY

13. Have you taken any of the following written examinations: National Boards, other state boards, USMLE, SPEX, FLEX, ECFMG or LMCC? ☒ Yes ☐ No

Written Examination

IF YES, LIST NAME, LOCATION, DATE AND RESULT OF EACH EXAMINATION; FAILURES MUST ALSO BE DISCLOSED. EACH EXAMINATION AGENCY MUST SUBMIT AN ORIGINAL OFFICIAL EXAMINATION HISTORY REPORT DIRECTLY TO THE MEDICAL BOARD OF CALIFORNIA. THESE REPORTS WILL NOT BE RETURNED.

Examination	Date	Result (Pass/Fail)
National Boards	Phila, Pa. June, 1953	[redacted]

14. 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.

LGS

Jurisdiction	License Number	Date of Issuance	Dates of Practice in that Jurisdiction
PA	MD-004124-E	Dec. 9, 1953	1953 to Present

15. 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: _____

Other Professional Licenses

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

16A. 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
Albert Einstein Med.	Center Phila., PA	Internship	1952-1954
HAHNEMANN Hospital	Phila., PA	Resident-OB/GYN	1954-1959
Memorial Center	New York, N.Y.	Fellow, Surgery	1959-1960

QUESTIONS 16B through 23:
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.

16B. 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

NAME OF APPLICANT: Paul S[redacted]opit, M.D.

DATE OF BIRTH: [redacted]

L1B

MBC USE ONLY

License Data

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.

17A. 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?

17B. 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?

17C. Is any such action as described above pending?

17(A) [redacted] Yes [redacted] No ☐

17(B) [redacted] Yes [redacted] No ☐

17(C) [redacted] Yes [redacted] No ☑

IF YOU ANSWERED YES TO 17A, 17B OR 17C, PROVIDE DETAILS ON A SEPARATE ATTACHMENT.

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

19. 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.

20. 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.

21. 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.

22. 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.

23A. 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?

23B. Is any criminal action related to the above pending?

23 (A) [redacted] Yes [redacted] No ☐

23 (B) [redacted] Yes [redacted] No ☑

IF YOU ANSWERED YES TO 23A OR 23B, PROVIDE DETAILS ON A SEPARATE ATTACHMENT.

NAME OF APPLICANT: Paul S. Copit, M.D.

DATE OF BIRTH: [redacted]

L1C

[redacted]

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 Chief of the Licensing Program is the custodian of records.

Applicant Declaration/Signature and NOTARY

STATE OF PENNSYLVANIA

COUNTY OF MONTGOMERY

The applicant, PAUL S. COPIT, M.D. (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 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: Paul S. Copit M.D. (PLEASE SIGN FULL NAME, NOT INITIALS)

Signed and sworn to before me this 20th day of March (MONTH) 2002 (YEAR)

Notarial Seal
Ramona Y. Savage, Notary Public
Lower Merion Twp., Montgomery County
My Commission Expires Dec. 15, 2003
Member, Pennsylvania Association of Notaries

NOTARY SEAL

SIGNATURE OF NOTARY PUBLIC Ramona Y. Savage

ADDRESS

My commission expires

Notarial Seal
Ramona Y. Savage, Notary Public
Lower Merion Twp., Montgomery County
My Commission Expires Dec. 15, 2003
Member, Pennsylvania Association of Notaries

07A-100 (Rev. 3/01)

L1D

Microfilm MMs

Certification of Secretary of the National Board of Medical Examiners

(Note—This endorsement SHOULD NOT BE EXECUTED unless the applicant has affixed the affidavit at the bottom of the preceding page (2))

NATIONAL BOARD OF MEDICAL EXAMINERS

I, ..., Secretary of the National Board of Medical Examiners

official custodian of the records of said Board, certify that the foregoing Diplomate Certificate No. ....

issued to ... Paul Copit .... M.D., on the 8 day

of .... 1953, and has been delivered to him; (2) that prior thereto said applicant filed with the

National Board, his Medical Diploma; (3) that said applicant has passed examinations given by the National Board as follows:

	Location of examination	from Month	Day	to Month	Day	19	Enter percentage
1st part	Phila., Penna.	June 16		June 21		19 50	[redacted]
2d part	Phila., Penna.	June 19		June 20		19 52	[redacted]
3d part	Phila., Penna.	June 27		—		19 53	[redacted]

that the complete record of said applicant's credentials and examination will be forwarded for inspection to the California Board on request; (5) that the "Diplomate" Certificate on the preceding page bears the original date of issue (if a Duplicate please add an explanatory note); (6) that from the records of the National Board of Medical Examiners, I believe the above applicant to be a fit, proper and fully qualified person to receive a physician's and surgeon's certificate to practice in California and so recommend. ... latest data as of July 1956.

In testimony whereof witness my hand and seal

John P. Hubbard
Signature of executive officer

[SEAL]

Official title ... Secretary

Dated at Phila., Penna. ....

Address ... 133 S. 36th Street

... day of .... 19 ...

(NOTICE.—Detach here and send to Medical College for endorsement)

It is hereby certified that Paul Copit .... entered the Freshman
Specify Freshman or later

class in the Temple-University School of Medicine on the 20th day of June 1948.
Name Medical College / Month

1. That as evidence of PRELIMINARY EDUCATION (high school) he presented a certificate of preliminary education dated June, 1945.
Specify and satisfactory evidence and date of document

2. That as evidence of PREMEDICAL EDUCATION (college) he presented Penna. State Certificate No. 136068 issued 5-17-49 having received the degree of Bachelor of Arts 6-17-48, 123 sem. hrs.
Specify documentary evidence and date of document, including number of units

XXXXX prior to commencing the .... the study of medicine he completed a one-year course of college grade in each of the subjects of chemistry, physics and biology as shown on the accompanying certification.

Every application based on a course ... since January 1, 1919, must show that prior to commencing the last half of the second year in the study of medicine, he has completed one year of college grade in the subjects of physics, chemistry and biology. After January 1, 1924, said ... must have preceded the study of medicine. After September 21, 1931, an applicant must show the completion of a two years' college course, including ... Physics, Chemistry and Biology.

... of course ... on record in your institution, and filed as matriculation requirement.

4. That he attended 38 courses of lectures given by this institution completed during a period of 4 Year and
Specify number

received the degree Doctor of Medicine .... on the 12th day of June 1952.
Month

Signed .... M. D.
Dean
President or Dean or Secretary

of Temple-University School of Medicine
Name of school

SEAL
OF
INSTITUTION

STATE OF CALIFORNIA — STATE AND CONSUMER SERVICE[illegible]NCY 3/27 [illegible], Governor

Consumer Affairs

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Internet: www.medbd.ca.gov

02 MAY 23 [illegible]

RECEIVED
MAY 2 8 2002
Office of Faculty & Student Records
TEMPLE UNIVERSITY

CERTIFICATE OF MEDICAL EDUCATION

MEDICAL SCHOOL: PLEASE COMPLETE THIS FORM IN THE ENGLISH LANGUAGE.

This certifies that Paul S. Copit [redacted] [illegible]
FULL NAME OF APPLICANT — U.S. SOCIAL SECURITY NO. — DATE OF BIRTH-MM/DD/YYYY

enrolled in Temple University School of Medicine, Broad & Ontario Sts., Phila., PA
NAME OF MEDICAL SCHOOL — LOCATION

on the 20th day of September, 1948 and ~~12th day of June, 1952~~ was granted the following credits on enrollment:

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 the applicant attended in this institution four NUMBER OF YEARS years of resident instruction of 9-12 months ~~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 the applicant:

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

the above mentioned medical school on the 12th day of June, 1952
MONTH — YEAR

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
Spousal or Partner Abuse Detection & Treatment**
Family Medicine***
Pain Management and End-of-Life Care****

* 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.
** ONLY applicable to medical students who enrolled in medical school on or after September 1, 1994.
*** 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 June 1, 2000.

MEDICAL SCHOOL SEAL MUST BE IMPRINTED BELOW.

TEMPLE UNIVERSITY
INCORPORATED MAY 13 1888
COMMONWEALTH SYSTEM OF HIGHER EDUCATION

ATTENTION MEDICAL SCHOOL: The person who signs this form MAY NOT be related to the applicant by blood, marriage or adoption.

Only the President, Dean, or Registrar 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.

Signed and the school seal affixed this 15th day of May, 2002
MONTH — YEAR

BY M. Louise Rosso
PRESIDENT, DEAN OR REGISTRAR

DIRECTOR
OF FACULTY AND STUDENT RECORDS

L2

Application Summary

License Type:	**Physician and Surgeon G**
License Number:	**4713**
File Number:	**164085**
Application:	**Physician's and Surgeon's Renewal**
Application Number:	**14677403**
Application Date:	**09/06/2019 (mm/dd/yyyy)**

Application Questions

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

Personal Detail

First Name:	**PAUL**
Middle Name:	**S**
Last Name:	**COPIT**
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.**

License Attributes Selected

Secondary Status	**Military**

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

Would you like to contribute? [redacted]

Attachments

Physician Survey

Activities in Medicine	**Administration - None**
	Other - None
	Patient Care - None
	Research - None
	Teaching - None
	Telemedicine - None
Patient Care Practice Location	**Zip: 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	**5 Years**
Cultural Background	**Native American**
Web Site Profile	**Cultural Background - Yes**
	Gender - Yes
E-mail:	[redacted]

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.

1567798455746

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 G**
License Number:	**4713**
File Number:	**164085**
Application:	**Physician's and Surgeon's Renewal**
Application Number:	**14453407**
Application Date:	**11/14/2017 (mm/dd/yyyy)**

Application Questions

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

Personal Detail

First Name:	**PAUL**
Middle Name:	**S**
Last Name:	**COPIT**
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.**

License Attributes Selected

Secondary Status: **Military**

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

Would you like to contribute? [redacted]

Attachments

Physician Survey

Are you retired?	**Yes**
Activities in Medicine	**Patient Care - None** **Telemedicine - 10-19 Hours**
Patient Care Practice Location	**Zip: 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	**8 Years**
Cultural Background	**White**
Foreign Language Proficiency	**None**
Web Site Profile	**Cultural Background - Yes** **Gender - Yes**
E-mail:	[redacted]

Fees

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

1510698991099

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 G**
License Number:	**4713**
File Number:	**164085**
Application:	**Physician's and Surgeon's Renewal**
Application Number:	**14228773**
Application Date:	**11/02/2015 (mm/dd/yyyy)**

Application Questions

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

Personal Detail

First Name:	**PAUL**
Middle Name:	**S**
Last Name:	**COPIT**
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.**

License Attributes Selected

Secondary Status	**Military**

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]

Attachments

Physician Survey

Are you retired?	**No**
Activities in Medicine	**Administration - None** **Other - None** **Patient Care - None** **Research - None** **Teaching - None** **Telemedicine - 1-9 Hours**
Patient Care Practice Location	**Zip: County:**
Telemedicine Practice Location	**Zip: 92211 County: RIVERSIDE**
Patient Care Secondary Practice Location	**Zip: County:**
Telemedicine Secondary Practice Location	**Zip: County:**
Areas of Practice	**Obstetrics and Gynecology - Primary**
Board Certifications	**American Board of Obstetrics and Gynecology - Obstetrics and Gynecology**
Postgraduate Training Years	**5 Years**
Cultural Background	[redacted]
Web Site Profile	**Cultural Background - No** **Foreign Language Proficiency - No** **Gender - Yes**
E-mail:	[redacted]

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**

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: