

APPLICATION FOR PHYSICIAN AND SURGEON'S EXAMINATION AND LICENSURE

(Read all instructions carefully to completing this Application. All questions on this application must be answered, and all supporting documents must be submitted with this application. Instructions: Please type or print neatly. When responses are insufficient, attach additional sheets of paper.)

60323  
 1003

1. Name (Last, First, Middle Initial)		MR/MS		PERSONAL DATA
2. Other names you have used		None		
3. Address (Number, Street, City, State, Zip Code)				
4. Telephone Number (Home)		Date of Birth (Mo/Day/YY)		NON-MEDICAL EDUCATION
5. Have you ever filed an application for licensure in any other state?		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
6. Check whether the following premedical courses were successfully completed and show where completed.				
Name	Address	Period of Attendance		
Univ. of Calif. at Santa Barbara	University of California, Santa Barbara, California 93106	Sept. 70	June 74	
Univ. of Calif. at Berkeley	University of California, Berkeley, California	June 74	Dec. 75	
Chemistry	(Organic) Chemistry I & II, Santa Barbara Chem 10, 20 (Organic) Chem 3A, 3B, 10 Berkeley			
Physics	10 Berkeley			
Biology	10 Berkeley			
Zoology				

L1A





PHYSICIAN ONLY

16. Has any disciplinary action ever been taken against any health care license which you now hold or have ever held? Include any disciplinary action by the U.S. military, U.S. Public Health Service or other U.S. federal governmental entity.

State	Date	Charge	Discipline

17. Have you ever been denied, or refused, or had your medical or health care license or certification to take any examination in any state, county, or U.S. federal jurisdiction?

State or County	Date	Reason for Denial

18. Have you ever been denied, or refused, or had your medical or health care license or certification in any other state?

19. Have you ever had a disciplinary action which resulted in the suspension or revocation of your license or certification from a medical staff in the U.S.?

20. Have you now or were you in the past, addicted to controlled substances, such as narcotics or alcohol?

21. Have you ever been convicted of, or in violation of, or condoned to a violation of any federal, state, or local law which includes the manufacture, distribution, or possession of controlled substances, or to a drug addiction?

Violation and Citation	Penalty or Discipline

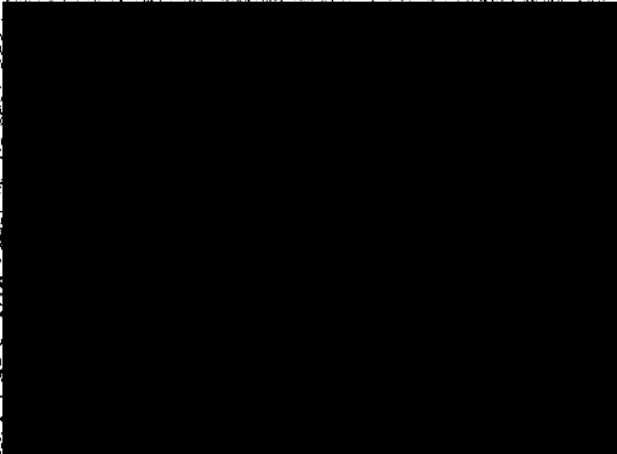
22. Have you ever been convicted of, or in violation of, or condoned to a violation of any state, federal, or foreign law which includes the manufacture, distribution, or possession of controlled substances, or to a drug addiction?

Violation and Citation	Penalty or Discipline

You are required to fill any conviction, judgment, or citation and discipline under Section 12001.45 Penal Code or under any other provision of law.

PHYSICIAN DATA (continued)

L1C



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 \_\_\_\_\_, 19\_\_\_\_, and that I am the person named therein. I have the same eyes, hair, color of hair, color of eyes, color of skin, height, weight, and other characteristics as shown in the photograph.

NOTICE: If the information provided in this application is false or incomplete, the applicant shall be liable for determining qualifications for licensure under Section 2080 of the Business and Professions Code which requires the collection of this information. Applicants have the right to review the application subject to the provisions of the Information Privacy Act. The program manager of the Division of Licensing will be notified of any such review.

STATE OF California  
 COUNTY OF San Diego

THOMAS PATRICK MORAN

I, \_\_\_\_\_, being duly sworn, depose that the person referred to in the foregoing application for admission to the medical profession in California and that \_\_\_\_\_ has carefully read and thoroughly understood all the requirements thereunder 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.

I declare that the Division of Licensing, Board of Medical Quality Assurance, in its review of the records determines the eligibility for examination, notwithstanding the filing by this State of California in making this request, the authenticity of any information or records held by any individual or agency relative to the applicant's qualifications as a physician and surgeon, upon request by the Board for verification thereof.

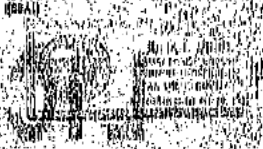
Thomas Patrick Moran

Signed and sworn to before me this 5 day of October, 1986

Signature of Notary Public Julia S. Mudd

Office Naval Hospital San Diego  
CA 92134

My commission expires October 20, 1987



**L1D**





BOARD OF MEDICAL QUALITY ASSURANCE

1800 HOWE AVENUE, SACRAMENTO, CALIFORNIA 95811



CERTIFICATE OF MEDICAL EDUCATION

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

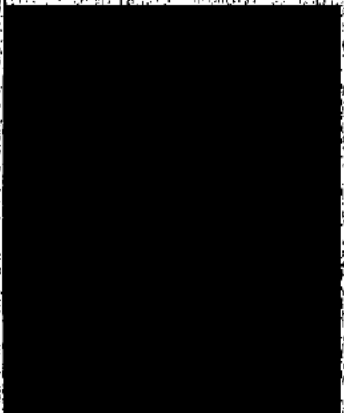
The certificate of [redacted] graduate of [redacted] University of Maryland School of Medicine 655 West Baltimore Street Baltimore, Maryland 21201

He/she was granted the following education credit: Preclinical Education - Two year (pre) professional postsecondary education including the subjects of physics, chemistry, microbiology, and anatomy and physiology (Code Section 2080)

He/she was granted the following education credit: Credits previously obtained in an approved medical school

He/she was granted the following education credit: He/she completed the requirements of the Undergraduate/Preprofessional program of the [redacted] School of Medicine at the University of Maryland School of Medicine, Baltimore, Maryland, including the completion of 100 credit hours of which at least 60 percent actual attendance is required in the subjects of [redacted] and the [redacted] was granted the degree of Bachelor of Science in Health Sciences by the [redacted] on [redacted] day of [redacted] 19[redacted]

- Anatomy, Histology, Embryology, Biochemistry, Cell Biology, Microbiology, Immunology, Pathology, Pharmacology, Physiology, Preclinical Education, Preventive Medicine, Public Health, Therapeutics, Clinical Laboratory, and Forensic, Day of Medicine, Pediatrics, Pharmacology, Anesthesiology



and the following credit: [redacted] day of November 1985

By [Signature] Bernice Sigman, M.D., Associate Dean for Student Affairs, Medical School and [redacted] Baltimore, Maryland

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

and shall have professional practice with the State Board of Medical Quality Assurance and all other State Boards of Health

L2

75.00

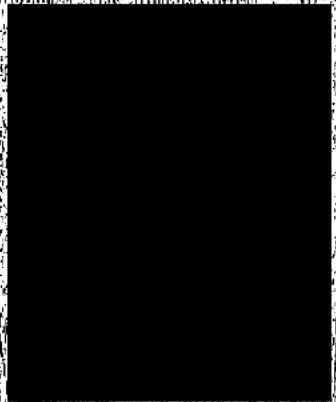


BOARD OF MEDICAL QUALITY ASSURANCE

1400 (LOWE) AVENUE, SACRAMENTO, CALIFORNIA 95833  
TELEPHONE (916) 222-3411



CERTIFICATE OF ENDORSEMENT BY STATE LICENSING AGENCY



1. NAME (Last, First, Middle) Moran, Thomas Patrick

2. ADDRESS [REDACTED]

3. DATE OF BIRTH [REDACTED] SEX M STATE LICENSING AGENCY MARYLAND

NOTE: Applicant shall provide a true and correct photograph of the applicant for use under the seal of the State of California. The photograph shall be of the applicant's face and shall be of the applicant's own making and shall be of the applicant's own making.

Signed and sealed before me on 3 day of October, 1986

Notary Public for State of Maryland

My commission expires 12/31/87

TO BE COMPLETED BY STATE LICENSING AGENCY

I certify that THOMAS PATRICK MORAN, M.D. who graduated from UNIVERSITY OF MARYLAND on 6/80 was granted license number 1D27796 on 4/19/86 on the basis of NATIONAL BOARD - GENERAL AVERAGE - 78.5

NOTE: If the license applicant with notification, contains the following conditions, otherwise write across the following conditions the words "Based on Graduate" and certify that the doctor passed the REGULAR WRITEN EXAMINATION given by the Board.

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

Subjects of Examination	Per Cent	Subjects of Examination	Per Cent
GENERAL AVERAGE	78.5		

I certify that the license holder's current has never been reported or revoked and will expire 9/30/87 and initial term in the office (include date) [REDACTED]

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

PATRICIA CARRETERO, EXECUTIVE DIRECTOR, MARYLAND BOARD OF MEDICAL EXAMINERS

201 W. PRISTON STREET, BALTIMORE, MD 21201

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BOARD OF MEDICAL QUALITY ASSURANCE

1210 HOWY AVENUE, SACRAMENTO, CALIFORNIA 95833  
(916) 223-4111



CERTIFICATE OF COMPLETION OF ACCME POSTGRADUATE TRAINING

This certificate is given to the following physician(s) who have completed postgraduate training in the specialty of OB/GYN at the University of Maryland School of Medicine in Baltimore, Maryland from 12/1/88 to 12/31/88.

This certificate is given to the following physician(s) who have completed postgraduate training in the specialty of OB/GYN at the University of Maryland School of Medicine in Baltimore, Maryland from 12/1/88 to 12/31/88.

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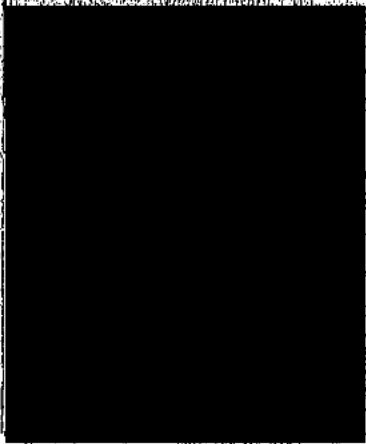
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This certificate is given to the following physician(s) who have completed postgraduate training in the specialty of OB/GYN at the University of Maryland School of Medicine in Baltimore, Maryland from 12/1/88 to 12/31/88.

ROTATION: OB/GYN LENGTH OF ROTATION: 12 Months

Specialty: OB/GYN Length of Rotation: 12 Months



I hereby declare under penalty of perjury under the laws of the State of California that the above information is true and correct and the training was approved by the ACCME of the CCME to offer the program and the training was completed in accordance with the requirements of the program as approved by the ACCME of the CCME.

NAME: Dr. R. M. [Redacted]

ADDRESS: 201 Zil University Parkway  
Baltimore, Maryland 21218

PHONE NUMBER: [Redacted]

DATE: 12/1/88

SIGNATURE: [Signature]

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## Application Summary

1/7/20 3:53 PM

Page 1 of 3

License Type: **Physician and Surgeon G**  
License Number: **59541**  
File Number: **67303**  
Application: **Physician's and Surgeon's Renewal**  
Application Number: **14722853**  
Application Date: **01/07/2020 (mm/dd/yyyy)**

### Application Questions

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

### Personal Detail

First Name: **THOMAS**  
Middle Name: **PATRICK**  
Last Name: **MORAN**  
Birthdate: **\*\*/\*\*/\*\*\*\***  
Gender: 

### Addresses

#### License Related Addresses Address of Record

Warning:


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


#### Confidential Address

Warning:

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

### Questions

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

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

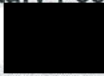


I certify under penalty of perjury, under the laws of California, that I have disclosed the names of those health-related facilities in which I or my family have a financial interest OR I declare under penalty of perjury I have no financial interests to disclose.



**Family Physician Training Program Voluntary Fee**

Would you like to contribute?



**Attachments**

**Physician Survey**

Are you retired?

No

Activities in Medicine

Administration - 1-9 Hours

Other - None

Patient Care - 40+ Hours

Research - None

Teaching - 1-9 Hours

Telemedicine - None

Patient Care Practice Location

Zip: 92101 County: SAN DIEGO

Telemedicine Practice Location

Zip: County:

Patient Care Secondary Practice Location

Zip: County:

Telemedicine Secondary Practice Location

Zip: County:

Current Training Status

Not in Training

Areas of Practice

Obstetrics and Gynecology - Primary

Board Certifications

American Board of Obstetrics and Gynecology - Obstetrics and Gynecology

Postgraduate Training Years

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

StephenM.ThompsonLRP

\$25.00

Total Amount Due:

\$820.00



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

**Attestation**

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

Signature:

Date:



## Application Summary

2/14/18 9:27 AM

Page 1 of 3

License Type: **Physician and Surgeon G**  
License Number: **59541**  
File Number: **67303**  
Application: **Physician's and Surgeon's Renewal**  
Application Number: **14499089**  
Application Date: **02/14/2018 (mm/dd/yyyy)**

### Application Questions

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

### Personal Detail

First Name: **THOMAS**  
Middle Name: **PATRICK**  
Last Name: **MORAN**  
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?



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**

Activities in Medicine

**Administration - 1-9 Hours**

**Patient Care - 30-39 Hours**

**Research - None**

**Teaching - 1-9 Hours**

**Telemedicine - None**

Patient Care Practice Location

**Zip: 92101 County: SAN DIEGO**

Telemedicine Practice Location

**Zip: County:**

Patient Care Secondary Practice Location

**Zip: 92123 County: SAN DIEGO**

Telemedicine Secondary Practice Location

**Zip: County:**

Areas of Practice

**Obstetrics and Gynecology - Primary**

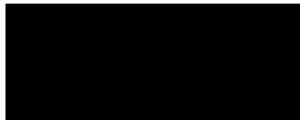
Board Certifications

**American Board of Obstetrics and Gynecology - Obstetrics and Gynecology**

Postgraduate Training Years

**4 Years**

Cultural Background



Foreign Language Proficiency

Web Site Profile

**Cultural Background - No**

**Foreign Language Proficiency - No**

**Gender - Yes**

E-mail:



**Fees**

Biennial Renewal Fee

**\$783.00**

DUE TO CURES FUND

**\$12.00**



StephenM.ThompsonLRP

\$25.00

Total Amount Due:

\$820.00

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Signature:

Date:

## Application Summary

3/3/16 7:28 AM

Page 1 of 3

License Type: **Physician and Surgeon G**  
License Number: **59541**  
File Number: **67303**  
Application: **Physician's and Surgeon's Renewal**  
Application Number: **14275290**  
Application Date: **03/03/2016 (mm/dd/yyyy)**

### Application Questions

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

### Personal Detail

First Name: **THOMAS**  
Middle Name: **PATRICK**  
Last Name: **MORAN**  
Birthdate: **\*\*/\*\*/\*\*\*\***  
Gender: **Male**

### Addresses

#### License Related Addresses

##### Address of Record (Required)

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### License Attributes Selected

Secondary Status **Military**

### Questions

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**Family Physician Training Program Voluntary Fee**

Voluntary Fee:



**Attachments**

**Physician Survey**

Are you retired?

No

Activities in Medicine

Administration - 1-9 Hours

Patient Care - 30-39 Hours

Research - 1-9 Hours

Teaching - 1-9 Hours

Telemedicine - None

Patient Care Practice Location

Zip: 92101 County: SAN DIEGO

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

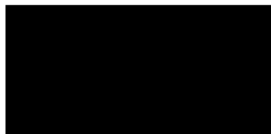
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American Board of Obstetrics and Gynecology - Obstetrics and Gynecology

Postgraduate Training Years

4 Years

Cultural Background



Foreign Language Proficiency

Cultural Background - No

Web Site Profile

Foreign Language Proficiency - No

Gender - Yes

E-mail:



**Fees**

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

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: