Application Summary

License Type:	**Physician's and Surgeon's**
Application:	**Physician's and Surgeon's - Initial Application**
Application Number:	**14622054**
Application Date:	**02/24/2019 (mm/dd/yyyy)**

Application Questions

Are you applying with an Individual Taxpayer Identification Number (ITIN)?	[redacted]
Have you served or are you currently serving in the military?	
Are you requesting expediting of this application for spouses or domestic partners of an active duty member of the U.S. Armed Forces?	
Are you requesting expediting of this application for honorably discharged members of the U.S. Armed Forces?	
Are you requesting expediting of this application to practice in a medically underserved area or population?	
Are you currently enrolled in an ACGME/RCPSC-accredited postgraduate training program in the United States or Canada?	**Yes**

Personal Detail

First Name:	**Camila**
Last Name:	**Bahamon**
Birthdate:	****/**/******
Gender:	**Female**
SSN/ITIN:	*************

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

Transaction [redacted]

FLOD7

1551036530632

Previous Application or License

9. Have you served or are you currently serving in the U.S. Military? [redacted]

10. Are you requesting expediting of this application as a spouse or domestic partner of an active duty member of the U.S. Armed Forces?

11. Have you ever filed an application for a Physician's and Surgeon's License or a PTAL in California that has been withdrawn, abandoned, or denied?

12. Have you previously held a Physician's and Surgeon's License in California? **No**

Examinations

13. Are you certified by the Educational Commission for Foreign Medical Graduates? **No**

Examinations 1

Examination: **United States Medical Licensing Examination (USMLE) Step 1**

Date Passed: [redacted]

Examinations 2

Examination: **United States Medical Licensing Examination (USMLE) Step 2CK**

Date Passed: [redacted]

Examinations 3

Examination: **United States Medical Licensing Examination (USMLE) Step 2CS**

Date Passed: [redacted]

Examinations 4

Examination: **United States Medical Licensing Examination (USMLE) Step 3**

Date Passed: [redacted]

Education History

Medical School Name: **Florida International University Herbert Wertheim College of Medicine**

Mailing Address of the Medical School: **11200 SW 8th Street, AHC2 Miami, FL 33199**

Attendance Start Date: **08/01/2011 (mm/dd/yyyy)**

Attendance End Date: **05/04/2015 (mm/dd/yyyy)**

Were You Awarded a Degree? **Yes**

FL007

39. Is any disciplinary action pending against your hospital or staff privileges? [redacted]

40. Have you ever had staff privileges in a hospital terminated, denied, suspended, limited, revoked, or not renewed?

41. Have you ever had any healing arts license or certificate disciplined by another state or federal territory? [redacted]

Criminal Record History

42. Have you ever been convicted of, or pled guilty or nolo contendere to ANY offense in the United States, its territories, or a foreign country? [redacted]

43. Exclusive of juvenile court adjudications and criminal charges dismissed under section 1000.3 of the California Penal Code or equivalent non-California laws, or convictions under California Health and Safety Code section 11357 (b), (c), (d), (e), or section 11360 (b) which are two years or older, have you had a conviction that was set aside or later expunged from the record of the court?

44. Is any criminal action pending against you, or are you currently awaiting judgment and sentencing following entry of a plea or jury verdict?

45. Are you a registered Sex Offender?

Practice Impairment or Limitations

46. Have you ever been enrolled in, required to enter into, or participated in any drug, alcohol, or substance abuse recovery program or impaired practitioner program? [redacted]

47. Have you ever been treated for or had a recurrence of a diagnosed addictive disorder?

48. Have you ever been diagnosed with an emotional, mental, or behavioral disorder that may impair your ability to practice medicine safely?

49. Have you ever been diagnosed with a neurological or other physical condition that may impair your ability to practice medicine safely?

PHOTOGRAPH

[redacted]

Notice: All items in this application are mandatory. 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 licensing 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 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.

DECLARATION

The applicant, Camila Bahamon [redacted]
PRINT LEGAL NAME (First, Middle, Last, Suffix) DATE OF BIRTH (mm/dd/yyyy)

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), or 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, alcohol and/or substance abuse or dependency, requested by that Board in connection with this application; or any further or future investigation by that Board necessary to determine any 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, in any investigation or proceeding, to the organizations, individuals or groups listed above any information which is material to this application or any subsequent licensure.

I UNDERSTAND THAT ANY OMISSION, 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.

SIGN LEGAL NAME: [signature] **DATE:** 02/24/2019

NOTARY SECTION

SIGNATURE OF APPLICANT: [signature]
(SIGN LEGAL NAME IN THE PRESENCE OF NOTARY)

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of Florida

County of Orange

Subscribed and sworn to (or affirmed) before me on this 24 day of February, 2019,

by, Camila Bahamon proved to me on the basis of satisfactory evidence
(PRINT APPLICANT'S LEGAL NAME)

to be the person who appeared before me.

[signature]
SIGNATURE OF NOTARY PUBLIC

NOTARY SEAL

Wanda Rivera Ruiz
NOTARY PUBLIC
STATE OF FLORIDA
Comm# GG289930
Expires 1/9/2023

MBC Use Only

Rev L1A-F Staff Initials & Date 2D 3/26/19

Photograph ☑

Applicant Name & DOB ☑

Applicant Signature & Date ☐

Applicant Signature ☐

Applicant Name & Notary Date ☐

Notary Signature & Seal ☐

L1F

Web

2/26

MEDICAL BOARD OF CALIFORNIA

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Fax: (916) 263-2487
www.mbc.ca.gov

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

CERTIFICATE OF MEDICAL EDUCATION

Check one: ■ **U.S. or Canadian Medical School Graduate** ☐ **International Medical School Graduate**

Type or Print Legibly

APPLICANT INFORMATION

LEGAL NAME: Last	First	Middle	Suffix
Bahamon	Camila		

Date of Birth (mm/dd/yyyy)	Last 4 Digits of U.S. SSN or ITIN	Medical School of Graduation
[redacted]	[redacted]	FIU Herbert Wertheim COM

MEDICAL SCHOOL: PLEASE COMPLETE THIS FORM IN THE ENGLISH LANGUAGE

NOTE: If the applicant had an accelerated or extended curriculum, withdrew from this institution, or was accepted with advanced standing, a letter of explanation from a school official is required. The letter must be on medical school letterhead, signed by a school official, and be mailed directly to the Board from the medical school.

1. Name of Medical School	FIU Herbert Wertheim COM
2. State/Province/Country	Florida, U.S.

3. The undersigned further certifies that the records of this institution show that the applicant attended in this institution 4 ***years*** of resident instruction, 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 Sections 2089, 2089.5, 2089.7, 2090, 2091.1, 2091.2).

Alcoholism and Chemical Dependency	Geriatric Medicine	Otolaryngology	Psychiatry
Anatomy	Histology	Pain Management and End-of-Life-Care**	Radiology, including Radiation Safety
Anesthesia	Human Sexuality	Pathology, Bacteriology, and Immunology	Spousal Partner Abuse Detection & Treatment***
Biochemistry	Medicine	Pediatrics	Surgery, including Orthopedic Surgery
Child Abuse Detection and Treatment	Neuroanatomy	Pharmacology	Therapeutics
Dermatology	Neurology	Physical Medicine	Tropical Medicine
Embryology	Obstetrics and Gynecology	Physiology	Urology
Family Medicine*	Ophthalmology	Preventative Medicine, including Nutrition	

*ONLY applicable to medical students who enrolled in medical school on or after May 1, 1998
**ONLY applicable to medical students who enrolled in medical school on or after June 1, 2000
***ONLY applicable to medical students who enrolled in medical school on or after September 1, 1994

4. Did the applicant withdraw or transfer from this medical school?	[redacted]
5. What is the standard duration of the curriculum at this institution?	4 years
6. Date the applicant was enrolled in medical school?	(mm/dd/yyyy) 08/01/2011
7. Date the applicant was issued the diploma of Bachelor/Doctor of Medicine	(mm/dd/yyyy) 05/04/2015

UNUSUAL CIRCUMSTANCES DURING MEDICAL SCHOOL

Any "Yes" response below requires a signed and dated letter of explanation by school official.

8. Did this applicant ever take a leave of absence from his/her medical education?	[redacted]
9. Was this applicant ever placed on probation?	
10. Was this applicant ever disciplined or placed under investigation?	
11. Were any limitations or special requirements imposed on this applicant because of questions of academic or disciplinary problems, or for any other reason?	

MEDICAL SCHOOL OFFICIAL CERTIFICATION

AFFIX MEDICAL SCHOOL SEAL

I certify that I am the President, Dean, or Registrar and hereby declare under penalty of perjury under the laws of the State of California that the above statements are true and correct.

PRINTED NAME OF SCHOOL OFFICIAL	TITLE OF SCHOOL OFFICIAL
Sachay Liriano	Asst. Registrar
SIGNATURE OF SCHOOL OFFICIAL	**DATE**
Sachay Liriano	2/25/19

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 the signature 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.

MBC Use Only
Applicant Information ☑
Medical School Information
School Code: FL007 ☑ ☑
Rev. L2 Staff Initials & Date: 20 3-26-19
☑ ☑ ☑ ☑
Unusual Circumstances ☑ ☑ ☑ ☑
School Seal ☑
Signature and Date ☑
L2

NOTE: The completed form must be mailed directly from the medical school to the Board to be acceptable.

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www.mbc.ca.gov

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

CERTIFICATE OF COMPLETION OF ACGME/RCPSC POSTGRADUATE TRAINING

To be completed by the facility for every medical school graduate completing postgraduate training in the United States or Canada.

Check one: ☒ **U.S. or Canadian Medical School Graduate** ☐ **International Medical School Graduate**

Type or Print Legibly

APPLICANT INFORMATION

LEGAL NAME: Last	First	Middle	Suffix
Bahamon	Camila		

Date of Birth (mm/dd/yyyy)	Last 4 Digits of U.S. SSN or ITIN	Medical School of Graduation
[redacted]	[redacted]	Florida International University

PROGRAM DIRECTOR TO COMPLETE ACGME OR RCPSC TRAINING INFORMATION

Facility Name	ORLANDO HEALTH		
Facility Address	1401 Lucerne Ter. 2nd Floor - Orlando FL 32806		
Specialty	OB/GYN	**ACGME 10-digit Program #** https://apps.acgme.org/ads/Public	2201112072
Dates of Training (mm/dd/yyyy)	Start Date: 07/01/2015	End Date (or anticipated completion date): 06/30/2019	

UNUSUAL CIRCUMSTANCES

***Program Director*: Please provide a signed and dated letter of explanation, including dates, for any "yes" response to questions # 1-7. The explanation must be provided on program letterhead and mailed directly to the Board with the Form L3A-L3B.**

1. Did the applicant receive partial or no credit during his/her postgraduate training?	[redacted]
2. Did the applicant ever take a leave of absence or break from his/her training?	
3. Was the applicant ever terminated, dismissed or expelled?	
4. Was the applicant ever placed on probation?	
5. Was the applicant ever disciplined or placed under investigation?	
6. Were any limitations or special requirements placed upon the applicant for clinical performance, professionalism, medical knowledge, discipline, or for any other reason?	
7. Did the program decline to renew or offer the applicant postgraduate training program contract for a following year?	

GENERAL MEDICINE TRAINING REQUIREMENT

8. Did the applicant complete a minimum of four months of general medicine as part of this postgraduate training program accredited by the ACGME or the RCPSC?	☒ Yes ☐ No

To qualify for licensure in California, applicants who are graduates of an international medical school must complete **at least four (4) months** of postgraduate training in GENERAL MEDICINE as part of the requirement. Applicants who are graduates of a U.S. or Canadian medical school, who have not completed postgraduate training required for licensure by July 1, 1990, must also complete **four (4) months** of training in GENERAL MEDICINE prior to licensure. *The GENERAL MEDICINE requirement may be satisfied by actual clinical practice where the applicant had direct patient care responsibilities for at least four months in any particular specialty or sub-specialty area.*

MBC Use Only

Applicant Information ☐

Verified Program Information ☐ ☐

Unusual Circumstance ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Gen Med Required ☐

L3A

APPLICANT INFORMATION

LEGAL NAME: Last: Bahamon | First: Camila | Middle | Suffix

MBC Use Only — Applicant's Name ☐

ATTENTION: PROGRAM DIRECTOR

Do not sign and date this form prior to the last day of any postgraduate training year which will be used by the applicant to qualify for licensure. Completion of this form will certify that the applicant has satisfactorily completed a period of accredited postgraduate training at this facility and that the applicant has acquired the skill and qualifications necessary to safely assume the unrestricted practice of medicine in this state.

THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE, OR ADOPTION. Only the Program Director 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.

PROGRAM DIRECTOR OFFICIAL CERTIFICATION

The program director signing this form is formally certifying and documenting under penalty of perjury that the applicant received instruction appropriate for the particular postgraduate level and that he/she satisfactorily completed periods of training in accordance with the accepted standards and the criteria defined as equating to satisfactory performance. The program director is attesting to the fact that the applicant has acquired the skill and qualifications necessary to safely assume the unrestricted practice of medicine in this state.

Verified PD Staff Initials & Date — 4/5/19

I hereby declare under penalty of perjury under the laws of the State of California that all of the information contained on these forms is true and correct. I further certify that the training program is accredited by the ACGME or the RCPSC to offer the type and level of training completed by the applicant named on the Form L3A, and the applicant was trained in an ACGME or RCPSC slotted program position.

Program Director's Signature & Date ☐

Jeannie McWhorter, MD, FACOG
PRINTED NAME OF PROGRAM DIRECTOR

SIGNATURE OF PROGRAM DIRECTOR (Signature Stamp Is Not Acceptable)

3/29/19
DATE

NOTE: **If a hospital seal is not available, the program director shall also sign in the section below in the presence of a notary public.**

Program Director's Signature ☐

SIGNATURE OF PROGRAM DIRECTOR: _____
(SIGN FULL NAME IN THE PRESENCE OF NOTARY)

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

Notary Signature & Seal ☐

State of Florida

County of Orange

Subscribed and sworn to (or affirmed) before me on this 29th day of MARCH, 2019,

by, JEANNIE McWHORTER MD, proved to me on the basis of satisfactory evidence

(PRINT PROGRAM DIRECTOR'S NAME)

to be the person who appeared before me.

Hospital Seal ☐

Cathy L Horowitz
SIGNATURE OF NOTARY PUBLIC

HOSPITAL NOTARY SEAL
Notary Public State of Florida
Cathy L Horowitz
My Commission GG 222128
Expires 09/04/2022

L3B

NOTE: The completed forms must be mailed directly from the program to the Board to be acceptable.

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CURRENT POSTGRADUATE TRAINING ENROLLMENT

Check one: ☒ U.S. or Canadian Medical School Graduate ☐ International Medical School Graduate

Type or Print Legibly

APPLICANT INFORMATION

LEGAL NAME: Last	First	Middle	Suffix
Bahamon	Camila		

Date of Birth (mm/dd/yyyy)	Last 4 Digits of U.S. SSN or ITIN	Medical School of Graduation
[redacted]	[redacted]	Florida International University

PROGRAM DIRECTOR TO COMPLETE ACGME OR RCPSC TRAINING INFORMATION

Facility Name	ORLANDO HEALTH		
Facility Address	1401 Lucerne Ter. 2nd Floor Orlando FL 32806		
Specialty	OB/GYN	ACGME 10-digit Program # https://apps.acgme.org/ads/Public	4201112012
Dates of Training (mm/dd/yyyy)	Start Date: 7/1/15	Anticipated Completion Date:	6/30/19

PROGRAM DIRECTOR OFFICIAL CERTIFICATION

ATTENTION PROGRAM DIRECTOR: THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE, OR ADOPTION. Only the Program Director 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.

I hereby declare under penalty of perjury under the laws of the State of California that the information contained on this form is true and correct. I further certify that the training program is accredited by the ACGME or the RCPSC to offer the type and level of training to the above named applicant and that the applicant is actively participating in a slotted position in an accredited ACGME or RCPSC postgraduate training program.

Jeannie MacWhorter
PRINTED NAME OF PROGRAM DIRECTOR

SIGNATURE OF PROGRAM DIRECTOR (Signature Stamp Is Not Acceptable) — DATE: 3/5/19

NOTE: If a hospital seal is not available, the program director shall also sign in the section below in the presence of a notary public.

SIGNATURE OF PROGRAM DIRECTOR: _____ (SIGN FULL NAME IN THE PRESENCE OF NOTARY)

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of Florida

County of Orange

Subscribed and sworn to (or affirmed) before me on this 5th day of March, 2019

by JEANNIE McWHORTER MD proved to me on the basis of satisfactory evidence
(PRINT PROGRAM DIRECTOR'S NAME)

to be the person who appeared before me.

Cathy L Horowitz
SIGNATURE OF NOTARY PUBLIC

HOSPITAL SEAL — NOTARY SEAL
Cathy L Horowitz
My Commission GG 222128
Expires 08/04/2022

MBC Use Only

Applicant Information ☐

Verified Program Information ☐

Verified PD Staff Initials & Date

Program Director's Signature & Date ☐

Program Director's Signature ☐

Notary Signature & Seal ☐

Hospital Seal ☐

L4

NOTE: The completed form must be mailed directly from the program to the Board to be acceptable.