STATE OF CALIFORNIA -- STATE AND CONSUMER S 'ES AGENCY — ARNOLD SCHWARZENEGGER, *Governor*

Consumer Affairs

MEDICAL BOARD OF CALIFORNIA

LICENSING PROGRAM
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815
(800) 633-2322 (916) 263-2382 FAX (916) 263-2487
www.mbc.ca.gov

RECEIVED
MEDICAL BOARD OF CALIFORNIA
2010 JUN 16 AM 11:24
LICENSING PROGRAM

INITIAL AND UPDATE APPLICATION FOR PHYSICIAN'S AND SURGEON'S LICENSE *OR* POSTGRADUATE TRAINING AUTHORIZATION LETTER

Application for (please check one): ☒ License ☐ PTAL - or - ☐ Update

1. NAME: Last	First	Middle	MBC Use Only
Fernandez	Louis	Manuel	

Other names you have used (include maiden name): NONE

2. U.S. Social Security Number: [redacted]

3. Place of Birth: [redacted]

4. Date of Birth: [redacted]

5. Gender: ☒ Male ☐ Female

6. Public/Mailing Address: 1911 W. Cuyler AVE
(Please note: this information is public)
(30 characters maximum per line, including spaces)

City	State/Province	Zip/Postal Code	Country
Chicago	Illinois	60613	USA

7. Telephone Numbers: (include area code)	Home	Work	Cell
	[redacted]		[redacted]

8. California Driver's License Number (optional):

9. E-mail Address (optional): [redacted]

10. Have you ever filed an Application for Physician's and Surgeon's License, or PTAL, in California?
☒ Yes ☐ No
Previous license number, if any: _____

Personal Data ☑ GA 1/60

MEDICAL EDUCATION

11. LIST EACH MEDICAL SCHOOL THAT YOU HAVE ATTENDED.

School Name	City, State/Province, Country	Dates of Attendance	L2 Transcript
University of Illinois	Chicago IL USA	9·1985 → 6·1989	☑ ☐
			☐ ☐
			☐ ☐

12. School of Graduation	Degree Awarded	Date of Graduation	Diploma
University of Illinois	M.D.	6·1989	☑

EXAMINATIONS

13. LIST ALL OF THE FOLLOWING EXAMINATIONS YOU HAVE TAKEN: USMLE, FLEX, NBME, ECFMG, SPEX, STATE BOARDS and/or QME in Canada

Examination	Date	Result (Pass/Fail)	Exams
National Board Med Exam	1987	[redacted]	☐
"	1984		☑
"	1990		☐

1301.00 — 0005692 Cashiering Use Only — JUN 15 2010 DR — 1L011 School Code

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07A-100 (Rev. 04/2008)

A "yes" response to Questions 14 through 38 requires a written explanation on a separate sheet of paper along with any supporting materials.

ACGME/RCPSC ACCREDITED POSTGRADUATE TRAINING

MBC Use Only

14. **Please list each ACGME/RCPSC accredited postgraduate training program in which you have participated. You must include each internship, residency and fellowship, whether or not the program was completed or credit granted.**

Postgraduate Training

Facility Name	Address	Specialty Area	Dates of Attendance	
Harbor/UCLA MedCen	Torrance Ca	Psychiatry	1989 - 1990	☑
Harbor/UCLA MedCen	Torrance Ca	OB/GYN	1990 - 1994	☑
				☐
				☐
				☐

POSTGRADUATE TRAINING: (These questions are to be answered by ALL applicants)

Did you ever take a leave of absence or break from your training?	YES	NO	☑
Have you ever been terminated, dismissed or expelled from a program?	YES	NO	☐
Have you ever resigned from a training program?	YES	NO	☑
Were you ever placed on probation?	YES	NO	☑
Were you ever disciplined or placed under investigation?	YES	NO	☑
Were any incident reports ever filed by instructors?	YES	NO	☐
Were any limitations or special requirements placed upon you for clinical performance, discipline, or for any other reason?	YES	NO	☑
Have you ever had a postgraduate training program contract not be renewed or offered for a following year?	YES	NO	☐

MEDICAL LICENSURE

15. **Please list all medical licenses (other than training licenses) that have ever been issued by any state or territory in the United States or Canadian province.**

License Data

Jurisdiction	License Number	Date of Issuance	Dates of Practice in that Jurisdiction	
California	G 71660	6·25·1991	1991-1994	☑ 07
Illinois	036-089058	7·31·1994	1994 — Present	☑
				☐
				☐
				☐

APPLICANT: Louis Fernandez

DATE OF BIRTH: [redacted]

L1B

ABMS CERTIFICATIONS

MBC Use Only

ABMS

16. Are you currently certified by a Member Board of the American Board of Medical Specialties? YES ☒ NO ☐

Member Board	Expiration Date	Certificate Number
ABOG	12·31·2010	940398

MALPRACTICE HISTORY

Malpractice

17. Has a claim or an action ever been filed against you for the practice of medicine which resulted in a malpractice settlement, judgment, or arbitration award of $30,000 or more? YES [redacted] NO [redacted]

PRACTICE IMPAIRMENT OR LIMITATIONS

Limitations

18. Have you been enrolled in, required to enter into, or participated in any drug or alcohol recovery program or impaired practitioner program? YES [redacted] NO [redacted]

19. Have you been treated for or had a recurrence of a diagnosed addictive disorder? YES [redacted] NO [redacted]

20. Have you been diagnosed with an emotional, a mental, or behavioral disorder which impairs your ability to practice medicine safely? YES [redacted] NO [redacted]

21. Have you ever been diagnosed with a neurological or other physical condition that would impair your ability to practice medicine safely? YES [redacted] NO [redacted]

22. Do you have any other condition which in any way impairs or limits your ability to practice medicine safely? YES [redacted] NO [redacted]

If you do receive ongoing treatment or participate in a monitoring program, the Board will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure.

CRIMINAL RECORD HISTORY

Criminal Record

23. Have you ever been convicted of, or pled guilty or nolo contendere to ANY offense in any state in the United States or foreign country?

This includes a citation, infraction, misdemeanor and/or felony, etc. If "YES" attach a list of each offense by arrest and conviction dates, violation, and court of jurisdiction (name and address). Matters in which you were diverted, deferred, pardoned, pled nolo contendere, or if the conviction was later expunged from the record of the court or set aside under Penal Code Section 1203.4 MUST be disclosed. If you are awaiting judgment and sentencing following entry of a plea or jury verdict, you MUST disclose the conviction; you are entitled to submit evidence that you have been rehabilitated. Serious traffic convictions such as reckless driving, driving under the influence of alcohol and/or drugs, hit and run, evading a peace officer, failure to appear, driving while the license is suspended or revoked MUST be reported. This list is not all-inclusive. If in doubt as to whether a conviction should be disclosed, it is better to disclose the conviction on the application.

For each conviction disclosed, you must submit with the application certified copies of the arresting agency report, certified copies of the court documents, and a descriptive explanation of the circumstances surrounding the conviction of disciplinary action (i.e., dates and location of incident and all circumstances surrounding the incident). This letter must accompany the application. If documents were purged by arresting agency and/or court, a letter of explanation from these agencies is required.

Applicants who answer "NO" to the question but have a previous conviction or plea, may have their applicati[redacted]ed or licens[redacted] revoked for knowingly falsifying the application. YES [redacted] NO [redacted]

APPLICANT: [signature] Louis Fernandez

DATE OF BIRTH: [redacted]

L1C

CRIMINAL RECORD HISTORY (cont'd)

MBC Use Only — Criminal Record

24. Is any criminal action pending against you?	YES	NO	☐
25. Are you required to register as a Sex Offender?	YES	NO	☑

DISCIPLINARY HISTORY

MBC Use Only — Discipline

These questions refer to discipline by any U.S. military or public health service, state board or other governmental agency of any U.S. state, territory, Canadian province, or country.

26. Have you ever been denied a license to practice medicine?	YES	NO	☑
27. Is any denial pending against you?	YES	NO	☐
28. 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?	YES	NO	☑
29. Have you ever had any license to practice medicine revoked, suspended, or placed on probation?	YES	NO	☑
30. Have you ever had any license to practice medicine subjected to any action including but not limited to informal or confidential discipline, consent orders, letters of warning, letters of reprimand, or citation?	YES	NO	☑
31. Have you ever had any license to practice medicine subjected to any other disciplinary action?	YES	NO	☑
32. Is any disciplinary action pending against any of your licenses to practice medicine?	YES	NO	☐
33. Have you ever had staff privileges in a hospital terminated, denied, suspended, limited, revoked, or not renewed?	YES	NO	☐
34. Have you ever resigned from a medical staff in lieu of disciplinary or administrative action?	YES	NO	☑
35. Is any disciplinary action pending against your hospital staff privileges?	YES	NO	☐
36. Have you ever surrendered a license to practice medicine?	YES	NO	☑
37. Have your DEA privileges ever been denied, suspended, restricted, or terminated?	YES	NO	☐
38. Have you ever entered into any arrangement or plea or agreement in lieu of a federal prosecution for a drug violation regulated by the DEA?	YES	NO	☐

APPLICANT: [redacted] Louis Fernandez

DATE OF BIRTH: [redacted]

L1D

[redacted]

Notice: All items in this application, except #8 and #9, 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 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 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.

The applicant, Louis Manuel Fernandez [redacted] being first duly sworn upon his/her
(PLEASE PRINT FULL NAME) (D

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 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 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. [ ] **(PLEASE INITIAL BOX)**

SIGNATURE OF APPLICANT: _____
(Please sign full name)

State of ILLINOIS

County of Cook

Subscribed and sworn to (or affirmed) before me on this 14th day of June, 2010,

by: Louis Manuel Fernandez
(Notary to print **applicant's** name here.):

proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.

OFFICIAL SEAL
PU ZHANG
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:09/18/10

_____
SIGNATURE OF NOTARY PUBLIC

L1E

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

DEPARTMENT OF Consumer Affairs

MEDICAL BOARD OF CALIFORNIA

1426 HOWE AVENUE, SUITE 54, SACRAMENTO, CALIFORNIA 95825-3236
(916) 920-6411

CERTIFICATE OF MEDICAL EDUCATION

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

This certifies that LOUIS M. FERNANDEZ
FULL NAME OF APPLICANT

of [redacted]
ADDRESS WHEN ENROLLED

enrolled in UNIVERSITY OF ILLINOIS M.S.C.@ CHICAGO
NAME OF MEDICAL SCHOOL

CHICAGO, ILLINOIS
LOCATION

on the 11th. day of JUNE
MONTH

19 89
YEAR

and was granted the following credits on enrollment:

Sept 23, 1985 per Official Transcript

Premedical Education. Two years of preprofessional postsecondary education, including the subjects of physics, chemistry, and biology (Business and Professions Code Section 2088).

NORTHWESTERN UNIVERSITY
EDUCATIONAL INSTITUTION

JUNE, 1985
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 four year courses of resident instruction of 36 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 from

the above mentioned medical school on the 11th. day of JUNE 1989.

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
Preventive medicine, including Nutrition
Physical Medicine
Therapeutics
[illegible]anatomy
Child Abuse Detection and Treatment
Geriatric Medicine
Pediatrics
Pharmacology
Anesthesia

[redacted]

Signed and the college seal affixed this 30th. day of MAY, 1991.

BY George G. Munley (REGISTRAR)
PRESIDENT, SECRETARY, DEAN

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

* 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. Note that photograph and all entries to the form must be original.

L2

[redacted]

STATE OF CALIFORNIA - STATE AND CONSUMER SERVICES AGENCY

DEPARTMENT OF Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
1426 HOWE AVENUE, SUITE 54, SACRAMENTO, CALIFORNIA 95825-3236
(916) 920-6411

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 Louis M. Fernandez M.D.
NAME OF APPLICANT

a graduate of University of Illinois Medical School
NAME OF MEDICAL SCHOOL

formolly commenced an accredited postgraduate training program at Harbor UCLA Med Center
NAME AND ADDRESS OF FACILITY
1000 Carson St. Torrance Ca 90509 in Psychiatry
SPECIALTY

on June 24, 1989, and satisfactorily completed such training on June 23, 1990
This training consisted of 12 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 rotation completed. If service was not 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. Effective July 1, 1990, all applicants who have not completed their one year of postgraduate training necessary for licensure will be required to complete at least four months of postgraduate training in general medicine as part of the one year requirement. This general medicine requirement may be satisfied by actual clinical practice where the applicant has direct patient care responsibilities in any particular specialty or sub-specialty area for at least four months. If the general medicine requirement is satisfied by training in a specialty area other than family practice, internal medicine, surgery, pediatrics or obstetrics and gynecology, the Program Director must submit a description of the type of training in sufficient detail to allow the Division to determine if it is acceptable.

ROTATION	LENGTH OF ROTATION
STRAIGHT PSYCHIATRY TRAINING	

SUBSCRIBED AND SWORN TO BEFORE ME
THIS 30TH DAY OF May 1991
Norma J Harris
NOTARY PUBLIC

OFFICIAL SEAL
NORMA J HARRIS
Notary Public-California
LOS ANGELES COUNTY
My Commission Expires
February 26, 1993

[redacted]

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 Jerrold A. Turner, M.D.
DIRECTOR OF MEDICAL EDUCATION

AFFIX SEAL OF HOSPITAL OR NOTARY PUBLIC

ADDRESS Harbor-UCLA Medical Center
1000 W. Carson St
Torrance, CA 90509

PHONE NUMBER [redacted]

DATE May 30, 1991

SIGNATURE

L3

[redacted]

STATE OF CALIFORNIA -- STATE AND CONSUMER SERVICES AGENCY ARNOLD SCHWARZENEGGER, *Governor*

Consumer Affairs

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MEDICAL BOARD OF CALIFORNIA

2010 SEP 14 PM 12:28

LICENSING PROGRAM

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.

PART 1: TO BE COMPLETED BY THE APPLICANT

NAME: Last	First	Middle
FERNANDEZ	LOUIS	MANUEL

U.S. Social Security Number	Date of Birth	Telephone Number
[redacted]	[redacted]	Home [redacted] Work [redacted]

Public/Mailing Address: 1911 W. Cuyler Ave

City	State/Province	Zip/Postal Code
Chicago	IL	60613

Medical School of Graduation: University of Illinois

PART 2: TO BE COMPLETED BY THE PROGRAM DIRECTOR

ATTENTION PROGRAM DIRECTOR: Do not sign and date this form before 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 individual named in PART 1 above satisfactorily completed a period of accredited postgraduate training at this facility and that the trainee has acquired the skill and qualifications necessary to safely assume the unrestricted practice of medicine in this state.

Name of Facility	ACGME 10-digit Program number (www.acgme.org)
Harbor-UCLA Medical Center	2200521050

Address of Facility	Telephone #
1000 W. Carson Street, Torrance, CA. 90509	[redacted]

Categorical Specialty Area of Training	Start Date of Training	End Date (or anticipated completion date) of Training
OB/GYN	06/24/1990	06/30/1994

UNUSUAL CIRCUMSTANCES:

Did the trainee ever take a leave of absence or break from his/her training?	YES	NO
Was the trainee ever terminated, dismissed or expelled?	YES	NO
Did the trainee ever resign?	YES	NO
Was the trainee ever placed on probation?	YES	NO
Was the trainee ever disciplined or placed under investigation?	YES	NO
Were any incident reports regarding this trainee ever filed by instructors?	YES	NO
Were any limitations or special requirements placed upon the trainee for clinical incompetence, disciplinary problems or for any other reason?	YES	NO
Did the program decline to renew or offer the trainee a postgraduate training program contract for a following year?	YES	NO

A "Yes" response to ANY of the above questions requires the program director to provide a written explanation on a separate attachment.

07A-100-L3 (Rev. 12/09)

L3A

DEFINITION OF "SATISFACTORY" COMPLETION OF TRAINING

The program director signing this form is formally certifying and documenting under penalty of perjury that the trainee 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 as described below. The program director will personally be attesting to the fact that the trainee has acquired the skill and qualifications necessary to safely assume the unrestricted practice of medicine in this state.

"SATISFACTORY" IS DEFINED AS: THE TRAINEE PERFORMED AT AN ADEQUATE LEVEL BASED ON EVIDENCE OF SATISFACTORY PROGRESSIVE GROWTH INCLUDING DEMONSTRATED ABILITY TO ASSUME GRADED AND INCREASING RESPONSIBILTY FOR PATIENT CARE.

GENERAL MEDICINE TRAINING REQUIREMENT

To qualify for licensure in California, applicants who are graduates of an international medical school must complete **at least four 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 months of training in GENERAL MEDICINE prior to licensure. The GENERAL MEDICINE requirement may be satisfied by actual clinical practice where the applicant has direct patient care responsibilities in any particular specialty or sub-specialty area for at least four months.

I hereby certify as the program director, that the individual named in Part 1

☒ has completed ☐ has not completed

a minimum of four months of general medicine as part of this postgraduate training program accredited by the ACGME or the RCPSC.

Siri L. Kjos

SIGNATURE OF PROGRAM DIRECTOR

ATTENTION PROGRAM DIRECTOR: THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE, OR ADOPTION. If that signature authority is being delegated to another person, evidence of that delegation must be attached to this form (may be a photocopy). Each delegation must be on official letterhead and must be dated within the last 12 months.

HOSPITAL SEAL	OFFICIAL HOSPITAL SEAL MUST BE AFFIXED IN THE BOX TO THE LEFT TO CERTIFY TRAINING

The training program is accredited by the ACGME or the RCPSC to offer the type and level of training completed by the applicant, and the applicant was trained in an accredited ACGME or RCPSC program position. I hereby declare under penalty of perjury under the laws of the State of California that the statements are true and correct.

Siri L. Kjos

PRINT NAME OF PROGRAM DIRECTOR

Siri Kjos — 8/24/10

SIGNATURE OF PROGRAM DIRECTOR — **DATE SIGNED**

Signature Stamp Is Not Acceptable

If a hospital seal is not available, the program director shall sign this form in the presence of a notary public.

State of _____

County of _____

Subscribed and sworn to (or affirmed) before me on this _____ day of _____, 20_____,

by _____

(Notary to print Program Director's name here.)

personally known to me or proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.

NOTARY SEAL

_____

SIGNATURE OF NOTARY PUBLIC

07A-100-L3 (Rev. 12/09)

L3B