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

DEPARTMENT OF Consumer Affairs

BOARD OF MEDICAL QUALITY ASSURANCE

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

APPLICATION FOR PHYSICIAN AND SURGEON'S EXAMINATION AND LICENSURE

008146 1370

007181 406.50 100.00 RIUD

Read all instructions prior to completing this application. All questions on this application must be answered, and all supporting documents must be submitted with this application per instructions. **Please type or print neatly. When space provided is insufficient, attach additional sheets of paper.**

BMQA USE ONLY

1. Name: Last: Roberts, First: James Middle: Lincoln

2. Other names you have used: 0

3. Address: Number and Street/Rural Route (include apartment number, if any) [redacted]
City [redacted] State [redacted] ZIP Code [redacted] Country [redacted]

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

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

6. Sex: ☐ Female ☒ Male

7. Are you a U.S. citizen? [redacted]
Submit a certified copy of birth certificate, Certificate of Naturalization, Declaration of Intention to become U.S. citizen (INS Form N300), VISA documents, or license to practice medicine.

8. Have you ever filed an application in California? ☐ Yes ☒ No
If YES, give date of previous application:

PERSONAL DATA

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

Name	Address	Period of Attendance From (Mo/Yr)	Period of Attendance To (Mo/Yr)
Brown University	Providence, Rhode Island	8/76	6/80

NON-MEDICAL EDUCATION

10. Check whether the following premedical courses were successfully completed and show where completed:

Course	Yes	No	Name of College or University
Chemistry	✓		Brown University
Physics	✓		" "
Biology	✓		" "
Zoology	✓		" "

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BMQA USE ONLY

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

MEDICAL EDUCATION

Name	Address	Place Where Instruction Received	Period of Attendance From (Mo/Yr)	Period of Attendance To (Mo/Yr)	CME	TRANS
George Washington U Medical School	Washington D.C.	Same	8/80	6/84	☒	☒
					☐	☐
					☐	☐
					☐	☐
					☐	☐
					☐	☐

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

Name of Medical School	Address of Medical School	Exact Date of Issuance
George Washington U Sch of Med	Wash. D.C.	5/23/84

EX 002 School Code

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

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

WRITTEN EXAMINATION

Name	Location	Date	Result
National Boards	I [redacted] George Washington	6/82	[redacted]
II	George Washington	4/84	
III	NHSD - S.D. Cal	3/85	

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

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

POSTGRADUATE TRAINING

Name	Address	Type of Service	Period of Attendance From	Period of Attendance To (Mo/Yr)
Naval Hospital S.D.	S.D. Cal	Surgical Intern	7/84	7/85
" "	" "	Urology Resident	7/86	present

15. Have you been licensed to practice medicine in any state or country? ☐ Yes ☒ No

If YES, list state or country, license number, date issued and dates of practice in issuing agency's jurisdiction for each. Submit a Letter of Good Standing from each state in which you are licensed or have been licensed.

LICENSE DATA

State or Country	License Number	Date of Issuance	Dates of Practice in Issuing Agency's Jurisdiction From (Mo/Yr)	Dates of Practice in Issuing Agency's Jurisdiction To (Mo/Yr)	LGS	CE
					☐	☐
					☐	☐
					☐	☐

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BMQA USE ONLY

LICENSE DATA (continued)

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

State	Date	Charge	Disposition

17. Have you ever been denied a license, permission to practice medicine or any other healing arts, or permission to take an examination in any state, country, or U.S. federal jurisdiction? [redacted]

If yes, give details below:

State or Country	Date of Denial	Reason for Denial

18. Have you ever voluntarily surrendered a license to practice in the healing arts in another state? [redacted] If yes, please explain on a separate sheet of paper.

19. Have you ever had staff privileges in a hospital denied, suspended or revoked, or resigned from a medical staff in lieu of disciplinary action? [redacted] If yes, please explain on a separate sheet of paper.

GENERAL DATA

20. Are you now, or were you in the past, addicted to controlled substances, such as narcotics or alcohol? [redacted]

21. Have you ever been convicted of, or pled nolo contendere to a violation of any federal, state or local law relating to the manufacture, distribution or dispensing of controlled substances, or to drug addiction? [redacted]

If yes, give details below:

Violation and Location	Date	Penalty or Disposition

22. Have you ever been convicted of, or pled nolo contendere to any offense, misdemeanor or felony of any state, the United States, or a foreign country? (except violations of traffic laws resulting in fines of $75.00 or less.) [redacted] If yes, give details below:

Violation and Location	Date	Penalty or Disposition

You are required to list any conviction that has been set aside and dismissed under Section 1203.45 Penal Code or under any other provision of law.

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[redacted]

I hereby declare under penalty of perjury under the laws of the State of California that the photo of myself attached hereto, was taken

on or about [redacted], 19[redacted]

my age then being [redacted] years;

color of hair [redacted];

color of eyes [redacted];

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

weight [redacted] lbs.;

identifying marks [redacted]

NOTE: All items in this application are mandatory; none are voluntary. Failure to provide any of the requested information will result in the applicant being rejected as incomplete. The information provided will be used to determine qualification for licensure, per Section 2020 of the Business and Professions Code which authorizes the collection of this information. Applicants have the right to review their application subject to the provisions of the Information Practices Act. The Program Manager of the Division of Licensing is the custodian of records.

STATE OF California)

COUNTY OF San Diego)

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

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

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

Signed and sworn to before me this 4 day of March, 19 87

Signature of Notary Public Barbara L Brock

(SEAL)

Address Naval Medical, San Diego CA 92134

My commission expires October 29 1987

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

DEPARTMENT OF CONSUMER AFFAIRS

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

RECEIVED BOARD OF MEDICAL QUALITY ASSURANCE
JAN 6 11 45 AM '87

CERTIFICATE OF MEDICAL EDUCATION

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

This certifies that James Lincoln Roberts
(FULL NAME OF APPLICANT)

of [redacted] enrolled in George Washington U. Med School
(ADDRESS WHEN ENROLLED) (NAME OF MEDICAL SCHOOL)

2300 Eye Street Wash D.C on the ______ day of Aug 19 80
(LOCATION) (MONTH) (YEAR)

and was granted the following credits on enrollment:

Premedical Education. Two years of preprofessional postsecondary education, including the subjects of physics, chemistry, and biology (Business and Professions Code Section 2089).

Brown University 9/76 to 6/80
(EDUCATIONAL INSTITUTION) (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 4 (NUMBER) courses of resident instruction of 36 (NUMBER OF WEEKS) weeks each, completing at least 4,000 hours, of which at least 80 percent actual attendance is required, in the subjects set forth hereunder (Business and Professions Code Section 2089), and that

☒ _he was granted the degree Bachelor/Doctor of Medicine by

☐ _he withdrew from

the above mentioned medical school on the 25th day of May 19 84
(MONTH)

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
Neuroanatomy
Child Abuse Detection and Treatment
Geriatric Medicine
Pediatrics
Pharmacology
Anesthesia

[redacted]

Signed and the college seal affixed this 30th day of December 19 86

BY Michael J. Graham - Certification Specialist
(PRESIDENT, SECRETARY, DEAN)

[signature]

Medical School Seal MUST Be Imprinted Partially on the Photograph.

NOTE: This office is unable to certify that the attached photo is of the person making this application. The applicant did not appear in person. Please see attached.

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

* [illegible]

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STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY GEORGE DEUKMEJI

DEPARTMENT OF Consumer Affairs

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

RECEIVED
SACRAMENTO
BOARD OF MEDICAL
QUALITY ASSURANCE

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 James Lincoln Rebendy [redacted]
NAME OF APPLICANT

a graduate of George Washington University Med School
NAME OF MEDICAL SCHOOL

commenced postgraduate training in Naval Hospital San Diego, San Diego,
NAME AND ADDRESS OF FACILITY

Cal 92134 in General Surgery Internship,

on July 1, 19 84, and completed such training

on June 30, 19 85. 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 rotations 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. ACGME or CCME residencies in family practice, internal medicine, surgery, pediatrics, and ob/gyn would normally satisfy this requirement.)

ROTATION	LENGTH OF ROTATION
Genl Surg	4 mos
Int Med	3 mos
ER	1 mo
Urology	1 mo
orthopedics	1 mo
OB/G	1 mo
Out patient clinic	1 mo

[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 Captain R. L. Gibbs, MC, USN
DIRECTOR OF MEDICAL EDUCATION

(OFFICIAL OF HOSPITAL OR NOTARY PUBLIC)

ADDRESS Naval Hospital
San Diego, CA 92134-5000

PHONE NUMBER [redacted]

DATE 20 February 1987

SIGNATURE [signature]

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

DEPARTMENT OF Consumer Affairs

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

RECEIVED
SACRAMENTO
BOARD OF MEDICAL
QUALITY ASSURANCE
APR 14 PM '87

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 James L Roberts
NAME OF APPLICANT

a graduate of George Washington University Med School
NAME OF MEDICAL SCHOOL

commenced postgraduate training in Naval Hospital San Diego Urology Residency
NAME AND ADDRESS OF FACILITY

on July 25, 1986, and completed such training

on projected 6, 1990. This training consisted of 48 months of actual

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

(List rotations completed. If service was 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. ACGME or CCME residencies in family practice, internal medicine, surgery, pediatrics, and ob/gyn would normally satisfy this requirement.)

ROTATION	LENGTH OF ROTATION
July 1986 → Urology residency at NHSD	Projected completion 6/90

Dr. Roberts began residency training in Urology on 25 July 1986 and is scheduled to complete on 24 July 1990.

[redacted]

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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 Captain R. L. Gibbs, MC, USN
DIRECTOR OF MEDICAL EDUCATION

(AFFIX SEAL OF HOSPITAL OR NOTARY PUBLIC)

ADDRESS Naval Hospital
San Diego, CA 92134-5000

PHONE NUMBER [redacted]

DATE 8 April 1987

SIGNATURE [signature]

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Application Summary

License Type:	**Physician and Surgeon G**
License Number:	**59945**
File Number:	**198606**
Application:	**Physician's and Surgeon's Renewal**
Application Number:	**14282413**
Application Date:	**05/21/2016 (mm/dd/yyyy)**

Application Questions

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

Personal Detail

First Name:	**JAMES**
Middle Name:	**LINCOLN**
Last Name:	**ROBERTS**
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]
Amount - $25.00 Minimum:	[redacted]

Attachments

Physician Survey

Activities in Medicine	**Administration - 1-9 Hours**
	Other - None
	Patient Care - 40+ Hours
	Research - 1-9 Hours
	Teaching - 10-19 Hours
	Telemedicine - None
Patient Care Practice Location	**Zip: 92037 County: SAN DIEGO**
Telemedicine Practice Location	**Zip: County:**
Patient Care Secondary Practice Location	**Zip: 92178 County: SAN DIEGO**
Telemedicine Secondary Practice Location	**Zip: County:**
Current Training Status	**Not in Training**
Areas of Practice	**Urology - Primary**
	Urology - Secondary
Board Certifications	**American Board of Urology - Urology**
Postgraduate Training Years	**5 Years**
Cultural Background	**White**
Foreign Language Proficiency	**None**
Web Site Profile	**Cultural Background - Yes**
	Foreign Language Proficiency - Yes

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**
Family Physician Training Fee	**$25.00**
Total Amount Due:	**$845.00**

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:

(DO NOT DETACH)

Medical Board of California – Physician's and Surgeon's Renewal 166750/ 5-25-18

LICENSEE NAME	LICENSE NO.	EXPIRATION DATE	AMOUNT DUE NOW	AMOUNT DUE IF POSTMARKED AFTER JULY 30, 2018
5-24-18 ROBERTS, JAMES L	G59945	06/30/18	$820.00	$898.00

LICENSEE MUST CHECK CORRECT BOXES

- "H" [redacted] Completed Continuing Education (See Question 1)
- "E" [redacted] Change of Address (fill in reverse side)
- "I" [redacted] Conviction – Yes (See Question 3)
- "J" [redacted] Conviction – No (See Question 3)
- "F" [redacted] Family Physician Training Program ($25 See Question 4)
- "G" [redacted] Financial Interest Statement (See Question 5)

"D" **SIGNATURE REQUIRED**

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

Signature James L Roberts Date 5/9/18

ENTER YOUR PHONE NUMBER FOR REFERENCE: [redacted]

63010700000700006000599456010630180008200000089800

CHANGE OF ADDRESS (Only if different from address above) **ROBERTS, JAMES L** **G59945**

ADDRESS OF RECORD (Required)

Address Line 1

Address Line 2

Address Line 3

City State Zip

CONFIDENTIAL STREET ADDRESS (Required if PO Box used above for Address of Record)

Address Line 1

Address Line 2

Address Line 3

City State Zip