STATE OF CALIFORNIA—HEALTH AND CONSUMER SERVICES AGENCY — PETE WILSON, Governor

RECEIVED SACRAMENTO BOARD OF MEDICAL QUALITY ASSURANCE 97 JAN 31 AM 10:26

Consumer Affairs

DIVISION OF LICENSING

MEDICAL BOARD OF CALIFORNIA

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

RECEIVED SACRAMENTO MEDICAL BOARD OF CALIFORNIA 97 JAN 24 PM 2:52

APPLICATION FOR PHYSICIAN AND SURGEON'S EXAMINATION OR LICENSURE

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.**

C325664 808.00 1-31-97

MBC USE ONLY

1. Name: Last: van Konynenburg, First: Kristin, Middle: Marie

2. Other names you have used (include maiden name): (none)

3. Social Security Number [redacted]
See disclosure statement on L1C

4. Address: Number and Street/Rural Route (include apartment number, if any) [redacted]

City [redacted] State [redacted] ZIP Code [redacted] Country [redacted]

5. Telephone Number: Home [redacted] Work

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

7. Sex: ☒ Female ☐ Male

8. Are you a U.S. citizen?
If you are a Foreign Medical Graduate, you must provide an original Certificate of Naturalization, Declaration of Intent to become a U.S. citizen, or a full unrestricted license to practice medicine in a state or country.

9. Have you ever filed an application for examination or licensure in California? ☐ Yes ☒ No
If YES, give date previous application was submitted:

10. List name and address of all colleges or universities attended where pre-professional, postsecondary instruction was received. Please submit an official sealed transcript for each school attended.

Name	Address	Period of Attendance From (Mo/Yr)	Period of Attendance To (Mo/Yr)
University of CA Berkeley	Berkeley, CA 94720	8/86	5/91
University of CA Davis Medical School	Davis, CA 95616	9/91	6/95

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

Course	Yes	No	Name of College or University
Chemistry	X		University of California, Berkeley
Physics	X		
Biology or Zoology	X		

11. List name and address of all schools where professional medical instruction was received. Submit an original Certificate of Medical Education (Form L2) and official sealed transcripts from each school attended.

Name	Address	Place Where Instruction Received	Period of Attendance From (Mo/Yr)	Period of Attendance To (Mo/Yr)
University of CA, Davis School of Medicine	Davis, CA 95616	Davis UC Davis	9/91	6/95

12. Doctor of Medicine Degree granted by: (submit original medical diploma and a photocopy; Note, a U.S. graduate may, in lieu of the original, submit an official certified photocopy that has the school seal affixed on the signature of the registrar certifying authenticity.)

Name of Medical School	Address of Medical School	Exact Date of Issuance	School Code
University of CA, Davis School of Medicine	Davis, CA 95616	6/9/95	L1A

NOTE: APPLICANT MUST PROVIDE NAME, ADDRESS AND DATE OF ISSUANCE OF DEGREE.

MBC USE ONLY

13. Have you taken any of the following written examinations: National Boards, other State Boards, FLEX, ECFMG Certification? ☒ Yes ☐ No

If YES, list name, location, date and result of examination. Submit certification of scores from each examination agency. Applicants who hold ECFMG certification will need to submit an original valid ECFMG certificate for examination and licensure.

Name	Location	Date	Result
USMLE I	Davis, CA	6/93	[redacted]
USMLE II	Davis, CA	3/95	
USMLE III	San Mateo, CA	12/96	

14. Have you satisfactorily completed at least one year of qualifying postgraduate training in U.S. or Canadian facilities? (Note: Do not complete Form L3 (s) to document training received in research or clinical fellowship programs) ☒ Yes ☐ No

If YES, list name and address of all facilities. Submit an original Certificate of Completion of ACGME Postgraduate Training (Form L3) from each facility.

Name	Address	Type of Service	Period of Attendance	
			From (Mo/Yr)	To (Mo/Yr)
Contra Costa County Health Services	2500 Alhambra Ave Martinez, CA 94553	Family Practice Residency	6/95	4/97 (present

QUESTIONS 14A–23 For any positive response to these questions, applicant should provide, in addition to written explanations, any documentation regarding the matter.

14A. Have you ever withdrawn from, or been suspended, dismissed or expelled from, a medical school or postgraduate training program? [redacted] ✓

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. Please include temporary, limited, or provisional licenses.

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

16. Has any disciplinary action ever been filed or 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

WRITTEN EXAMINATION

L1B

MBC USE ONLY

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 been charged with unprofessional conduct or any other unlawful activity by any healing arts licensing authority or by the U.S. military and are awaiting final disposition by that body? You must also list any pending actions or accusations. [redacted]

19. Have you ever voluntarily surrendered a license to practice in the healing arts in another state? [redacted]

20. 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]

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

22. 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? [redacted]

If yes, give details below.

Violation and Location	Date	Penalty or Disposition

23. 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]

YOU ARE REQUIRED TO LIST ANY CONVICTION THAT HAS BEEN SET ASIDE AND DISMISSED UNDER SECTION 1203.4 OF THE PENAL CODE OR UNDER ANY OTHER PROVISION OF LAW. A SEPARATE LETTER EXPLAINING THE DETAILS OF THE OFFENSE IS ALSO REQUIRED, IN ADDITION TO CERTIFIED COURT DOCUMENTS.

If yes, give details below.

Violation and Location	Date	Penalty or Disposition

"Disclosure of your social security number is mandatory. Section 30 of the Business and Professions Code and Pub. L. 94-455 (42 U.S.C.A. 405 (c) (2) (C)) authorizes collection of your social security number. Your social security number will be used exclusively for tax enforcement purposes. If you fail to disclose your social security number, you will be reported to the Franchise Tax Board, which may assess a $100 penalty against you."

L1C

[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 application being rejected as incomplete. The information provided will be used to determine qualification for licensure, per Section 2080 of the Business and Professions Code which authorizes the collection of this information. Information regarding the issuance or denial of a license by the Board may be transmitted to any other medical licensing authority or the Federation of State Medical Boards. 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.

NOTARIZATION PORTION

STATE OF California)

COUNTY OF Contra Costa)

______________________ being duly sworn, says __he is the person referred to in
PRINT FULL NAME OF APPLICANT

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, Medical Board of California, 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.

____
Signature of applicant: (Write FULL name, not initials)

Signed and sworn to before me this 22nd day of January, 1997.

[NOTARY SEAL]

NANCY A. WHEELER
Comm. # 1117719
NOTARY PUBLIC - CALIFORNIA
Contra Costa County
My Comm. Expires Nov. 28, 2000

Signature of Notary Public Nancy A. Wheeler

Address 475 Edwards St, Crockett, CA

NANCY A. WHEELER
Comm. # 1117719
NOTARY PUBLIC - CALIFORNIA
Contra Costa County
My Comm. Expires Nov. 28, 2000

My commission expires ______________________

L1D

07A-100 (REV. 7/91)

STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY PETE WILSON, Governor

RECEIVED SACRAMENTO MEDICAL BOARD OF CALIFORNIA 97 JAN 31 AM 1:44

MEDICAL BOARD OF CALIFORNIA

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

Consumer Affairs

CERTIFICATE OF MEDICAL EDUCATION

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

This certifies that KRISTIN MARIE VAN KONYNENBURG
FULL NAME OF APPLICANT

of [redacted]
ADDRESS WHEN ENROLLED

enrolled in UNIVERSITY OF CALIFORNIA, DAVIS
NAME OF MEDICAL SCHOOL

DAVIS, CALIFORNIA on the 23rd day of September 19 91
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).

UNIVERSITY OF CALIFORNIA, BERKELEY — 8/86 - 5/91
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 She attended in this institution 4 years of resident instruction of 40 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

OR ☒ She was granted the degree Bachelor/Doctor of Medicine by
☐ ___he withdrew from
the above-mentioned medical school on the 16th day of JUNE 19 95

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

RECEIVED SACRAMENTO BOARD OF MEDICAL QUALITY ASSURANCE 97 FEB -3 AM 11:17 DIVISION OF LICENSING

[redacted]

Signed and the college seal affixed this 24th day of January, 19 97.

BY Ernest L. Lewis
Ernest L. Lewis, M.D.
Associate Dean for Student Affairs
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

State of California Department of Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
1426 HOWE AVENUE
SACRAMENTO, CALIFORNIA 95825-3236

CERTIFICATE OF COMPLETION
ACGME/CCME 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 on the reverse side. Also, please print or type information on the form.

PART 1: *To be completed by applicant/trainee.*

Last Name Of Trainee: VAN KONYNENBURG | First Name: KRISTIN | Middle Initial:

Current Address: [redacted] | Phone Number: [redacted]

City: [redacted] | State: | Zip Code:

PART 2: *To be completed by facility.*

Completion of this form will certify that the individual named in Part 1 above and whose photograph is attached to this form, formally completed an accredited postgraduate training program at this facility. The following information is provided to certify "satisfactory" completion. See reverse side of Form for definition of "satisfactory".

Name of Facility: FAMILY PRACTICE RESIDENCY PROGRAM
CONTRA COSTA COUNTY HEALTH SERVICES
2580 ALHAMBRA AVENUE
MARTINEZ, CALIFORNIA 94553

Address of Facility:

Name of Program Director: T. RICH MCNABB, M.D. | Phone Number: [redacted]

Signature of Program Director: J. Rich McNabb, MD. | Date Signed: 1/2/97

List Categorical Specialty Area of Training Completed by Trainee: FAMILY PRACTICE | Date Training Commenced: 7/1/95 | Date Training Completed 6/30/96

If the training was rotating or transitional, list in the space provided below, the specific rotations and the number of weeks spent in each:

Note: To qualify for licensure in California, applicants who are graduates of a foreign medical school must complete at least four months of postgraduate training in general medicine as part of the one-year requirement. Applicants who are graduates of a U.S. or Canadian medical school, who have not completed the one-year of postgraduate training required for licensure by July 1, 1990, must also complete four-months of training in general medicine as part of the one year required for 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. 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 of Licensing to make a determination regarding its acceptability.

(OVER)

L3A

PART 3: *To be completed by the Director of Medical Education and affixed with the official facility seal.*

Name of Director of Medical Education: T. RICH MCNABB, M.D.

Phone Number: [redacted]

Facility Name: FAMILY PRACTICE RESIDENCY PROGRAM CONTRA COSTA COUNTY HEALTH SERVICES 2500 ALHAMBRA AVENUE MARTINEZ, CALIFORNIA 94553

Date Form Completed: 1/2/97

Facility Address:

City: State: Zip Code:

The individual signing this form is formally certifying and documenting, under penalty of perjury, that the physician received instruction appropriate for the particular postgraduate level and that they satisfactorily completed the training program in accordance with the accepted standards and the criteria defined as equating to "satisfactory" performance as described below. In cases where the Director of Medical Education is certifying the completion of the minimum one-year of training required for licensure, he or she will personally be attesting to the fact that the physician/ trainee has acquired the skill and qualifications necessary to safely assume the unrestricted practice of medicine in this state.

Definition of "Satisfactory": The physician performed at an adequate level based on evidence of satisfactory progressive scholarship and professional growth including demonstrated ability to assume graded and increasing respon

FAMILY PRACTICE RESIDENCY PROGRAM
CONTRA COSTA COUNTY HEALTH SERVICES
2500 ALHAMBRA AVENUE
MARTINEZ, CALIFORNIA 94553

I hereby declare under penalty of perjury under the laws of the State of California that the above statements are true and correct and that the training program 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.

Signature of Director of Medical Education: T. Rich McNabb, M.D.

Date Signed: January 2, 1997

[redacted]

L3B

07A-100-L3 (Rev. 2/92)

94 27491

State of California Department of Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
1426 HOWE AVENUE
SACRAMENTO, CA 95825-3236
(916) 263-2499

CERTIFICATION STATEMENT

This is to certify that KRISTIN VANKONYNENBURG, M.D.
(Name of Physician)

is in an approved ACGME/CCME postgraduate training position that commenced on JULY 1, 19 95 and is expected to be completed on JUNE 30, 19 98 in FAMILY PRACTICE
(Type of Training)

at FAMILY PRACTICE RESIDENCY PROGRAM
CONTRA COSTA COUNTY HEALTH SERVICES
2500 ALHAMBRA AVENUE
MARTINEZ, CALIFORNIA 94553
(Name and Address of Facility)

AFFIX OFFICIAL HOSPITAL SEAL OR NOTARY SEAL IN THE BOX AT THE LEFT.

"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 is being trained in an approved ACGME or CCME program position."

T. RICH MCNABB, M.D.
(Type or print name of Director of Medical Education)

T. Rich McNabb, MD.
(Signature of Director of Medical Education)

January 2, 1997
(Date) (Telephone Number) [redacted]

NOTE: Do not use this form in lieu of Form L3, "Certificate of Completion of ACGME/CCME Postgraduate Training."

L9

07A 100-T9 (Rev. 12/92)