MEDICAL BOARD OF CALIFORNIA
Licensing Program

APPLICATION

TYPE OF APPLICATION

(Check One)
- [x] U.S. or Canadian Medical School Graduate
- [ ] International Medical School Graduate

(Check All That Apply)
- [x] Physician's and Surgeon's License
- [ ] Postgraduate Training Authorization Letter (PTAL)
- [ ] Update Application: File #_____
- [ ] Limited Practice License

MBC Use Only: Application Type ☑

PRIORITY REVIEW & EXPEDITED LICENSURE

Active Duty Member of the Armed Forces - Must supply satisfactory evidence to the Board that you are serving as an active duty member of the Armed Forces of the United States.

Honorably Discharged Veterans of the Armed Forces - Must supply satisfactory evidence to the Board that you have served as an active duty member of the Armed Forces of the United States and were honorably discharged.

Practice in Medically Underserved Area or Population - Must supply satisfactory evidence to the Board that you have accepted employment and intend to practice in an area of California formally designated as an underserved area or underserved population. Please see further details on our website at http://www.mbc.ca.gov/Applicants/Physicians_and_Surgeons/Underserved.aspx.

Temporary License for Spouse of Active Duty Member of the Armed Forces - Must supply satisfactory evidence to the Board that you are married to, or in a domestic partnership or other legal union with, an active duty member of the Armed Forces of the United States who is assigned to a duty station in California under official active duty military orders. In addition, you must meet the requirements listed in Business and Professions Code Section 115.6.

MBC Use Only: Priority Review ☐

PERSONAL INFORMATION

Type or Print Legibly

	Last	First	Middle	Suffix
1. Legal Name	Bourne	Christina	M	

MBC Use Only: Legal Name ☑

2. Other Names/Alias:

3. United States Social Security Number (SSN) or Individual Taxpayer Identification Number (ITIN): [redacted] SSN ☑ ITIN ☐

MBC Use Only: SSN/ITIN ☑

4. Date of Birth (mm/dd/yyyy): [redacted] 5. Gender: ☐ Male ☒ Female

MBC Use Only: DOB ☑ Gender ☑

6. Address of Record

This address will be used for all current correspondence during the review process and will be posted on the Board's website upon issuance of a license.

If you are using a P.O. Box please list a confidential street address below.

Mailing Address *(40 characters maximum per line, including spaces)*: [redacted] Family Med 4860 Y Street

Mailing Address continued *(40 characters maximum per line, including spaces)*

City	State/Province	Zip/Postal Code	Country
Sacramento	CA	95817	

MBC Use Only: Address of Record ☑

Confidential Address (Only required if Address of Record is a P.O. Box):

MBC Use Only: Confidential Address ☐

7. Telephone Numbers: Home # | Work # | Cell # [redacted]

MBC Use Only: Telephone Numbers ☑

8. E-mail Address (Required): [redacted]

MBC Use Only: Email ☑

9. Have you served or are you currently serving in the military? [redacted] Yes [redacted] No

10. Are you requesting expediting of this application as a spouse or domestic partner of an active duty member of the Armed Forces? [redacted] Yes [redacted] No

MBC Use Only: Military ☑ ☐

MBC Use Only: Cashiering 65156 20/1-65733/907.50/6-5-17 6-6-17 | 2170 Pathway | 12500 School Code | L1A

APPLICANT: (Print Legal Name) Christina Bourne

DATE OF BIRTH: (mm/dd/yyyy) [redacted]

MBC Use Only: Name & DOB ☐

PREVIOUS APPLICATION OR LICENSE

NOTE: A "yes" response to question 11 requires a signed and dated written explanation. The *Explanation For Application Question* form may be used to provide your explanation.

Previous App/License ☑

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?	[redacted] Yes	[redacted] No
12. Have you previously held a Physician's and Surgeon's License in California? If yes, please provide license number: _____ Expired: _____	[redacted] Yes	[redacted] No ☑

EXAMINATIONS

ECFMG ☐

13. Are you certified by the Educational Commission for Foreign Medical Graduates?	☐ Yes ☒ No

14. List all of the following examinations you have taken and passed: **USMLE, FLEX, NBME, LMCC and/or STATE BOARDS**

Exams ☑ ☑ ☑ ☑ ☐

Examination	Date Passed
USMLE 1	[redacted]
USMLE 2 CK	
USMLE 2 CS	
USMLE 3	

MEDICAL EDUCATION

NOTE: To be eligible for a PTAL or License, all schools attended must be on the Board's list of recognized or approved medical schools. If you did not attend or graduate from a recognized or approved medical school, you may be eligible for licensure pursuant to Section 2135.7 of the Business and Professions Code. To view the Board's list of recognized or approved medical schools, please refer to our website at: http://www.mbc.ca.gov/Applicants/Medical_Schools/Schools_Recognized.aspx.

Medical Education

15. List each medical school that you have attended and the medical school of graduation.

Medical School Name	Mailing Address	Dates of Attendance (mm/dd/yyyy)	
University of KS (Kansas) Wichita	1010 N. Kansas Blvd Wichita, KS 67214	Start	06/2012
		End	06/2016
		Start	
		End	
		Start	
		End	

L2 ☑ Trans ☑ School Code KS000

Medical School of Graduation	Title of Degree Awarded	Issue Date of Degree (mm/dd/yyyy)
University of KS (Kansas)	MD	06/01/2016

Diploma ☑

L1B

APPLICANT: (Print Legal Name) Bourne, Christina

DATE OF BIRTH: (mm/dd/yyyy) [redacted]

MBC Use Only ☑ Name & DOB

ACGME or RCPSC ACCREDITED POSTGRADUATE TRAINING PROGRAMS
(Internship, Residency and Fellowship Programs)

PG Training Programs ☑

16. Have you participated in any ACGME-accredited postgraduate training programs in the United States or RCPSC-accredited postgraduate training in Canada? *(If NO, please skip to question #24)* ☒ Yes ☐ No

List every program (internship, residency and fellowship) in which you have participated or are currently participating, regardless of whether the program was completed or any credit was granted.
(Use the *Addendum to Question #16 Form* if additional space is needed)

Facility Name	City, State/Province	Specialty	Dates of Training (mm/dd/yyyy)	
UC Davis	Sacramento CA	Family Med Psychiatry	Start	07/01/2016
			End	07/01/2021
			Start	
			End	
			Start	
			End	

☐ 13A1B 24

NOTE: A "yes" response to question 17-23 requires a signed and dated written explanation. The *Explanation For Application Question* form may be used to provide your explanation.

17. Have you ever received partial or no credit for a postgraduate training program?	☑
18. Have you ever taken a leave of absence or break from your training?	☑
19. Have you ever been terminated, dismissed or expelled from a program?	☑
20. Have you ever been placed on probation for any reason?	☑
21. Have you ever been disciplined or placed under investigation?	☑
22. Have you ever had any limitations or special requirements placed upon you for clinical performance, professionalism, medical knowledge, discipline, or for any other reason?	☑
23. Have you ever had a postgraduate training program contract not be renewed or offered for a following year?	☑

MEDICAL LICENSE

License ☑

24. Have you ever held or do you currently hold a medical license in any U.S. state, U.S. territory, or Canadian province?	☐ Yes ☒ No

List medical license information for all licenses ever held below. Do not list temporary, training, or provisional licenses. (Use the *Addendum to Question #24 Form* if additional space is needed.)

U.S. State, U.S. Territory or Canadian Province	License Number	Dates of Practice (mm/yyyy to mm/yyyy)
		to
		to
		to
		to

L1C

APPLICANT: (Print Legal Name) Bourne, Christina	DATE OF BIRTH: (mm/dd/yyyy) [redacted]

MBC Use Only ☑ Name & DOB

ABMS CERTIFICATION

ABMS ☑

25. Are you currently certified by a Member Board of the American Board of Medical Specialties?	☐ Yes ☒ No

MALPRACTICE HISTORY

Malpractice History ☑

26. Has a claim or an action ever been filed against you for the practice of medicine that resulted in a malpractice settlement, judgment, or arbitration?	[redacted]

DISCIPLINARY HISTORY

These questions refer to discipline by any hospital, Military or Public Health Service, State Board, or other Governmental Agency of any U.S. state, U.S. territory, Canadian province, or foreign country.

Disciplinary History ☑

27. Have you ever had your DEA privileges denied, suspended, restricted, or terminated?	[redacted]
28. Have you ever entered into any arrangement, agreement or plea in lieu of federal prosecution with the DEA to resolve an alleged violation of a federal or state drug statute or regulation?	
29. Have you ever withdrawn an application for medical licensure in lieu of denial, disciplinary action, or for any other similar reason?	
30. Have you ever been denied a license to practice medicine?	
31. Is any denial pending against you?	
32. Have you ever had any license to practice medicine subjected to any disciplinary action?	
33. Is any disciplinary action pending against any of your licenses to practice medicine?	
34. Have you ever surrendered a license to practice medicine?	
35. Have you ever had any license to practice medicine revoked, suspended, or placed on probation?	
36. 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?	
37. Have you ever been charged with, or been found to have committed unprofessional conduct, professional incompetence, gross negligence, or repeated negligent acts by any medical licensing board or hospital?	
38. Have you ever resigned from a medical staff in lieu of disciplinary or administrative action?	
39. Is any disciplinary action pending against your hospital or staff privileges?	
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?	

NOTE: A "yes" response to question 26-41 requires a signed and dated written explanation. The *Explanation For Application Question* form may be used to provide your explanation.

L1D

APPLICANT: (Print Legal Name) Bourne, Christina	DATE OF BIRTH: (mm/dd/yyyy) [redacted]

MBC Use Only
Name & DOB

CRIMINAL RECORD HISTORY

Applicants who answer "NO" to the questions below, but have a previous conviction or plea, may have their application denied for knowingly falsifying the application. If in doubt as to whether a conviction should be disclosed, it is best to disclose the conviction on the application.

For each conviction, you must submit certified copies of the arresting agency report, certified copies of the court documents (court docket) and a signed and dated descriptive explanation of the circumstances surrounding the conviction (i.e., dates and location of the incident and all circumstances surrounding the incident). If the documents were purged by the arresting agency and/or court, a letter of explanation from these agencies is required. In addition, you may submit evidence of rehabilitation.

Criminal 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?

    This includes every citation, infraction, misdemeanor and/or felony, including traffic violations. Convictions that were adjudicated in the juvenile court or convictions under California Health and Safety Code sections 11357(b), (c), (d), (e), or section 11360(b) which are two years or older should NOT be reported. Convictions that were later expunged from the record of the court or set aside pursuant to section 1203.4 of the California Penal Code or equivalent non-California law MUST be disclosed.

    [redacted]

☑ LOC Probation

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 charge or conviction that was set aside or later expunged from the record of the court?

    [redacted]

☑ LOC Probation

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

    [redacted]

☐

45. Are you a registered sex offender?

    ☐

PRACTICE IMPAIRMENT OR LIMITATIONS

An affirmative answer to any of the questions below will require the Board to 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 eligible for licensure. Please note that a Limited Practice License may be available. Refer to the *Application Information for a Limited Practice License* for further information.

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?

    ☐

50. Do you have any other condition that may in any way impair or limit your ability to practice medicine safely?

    ☐

51. Do you suffer from a progressive disorder or a health condition that will likely result in a general decline in health or function that may impair or limit your ability to practice medicine safely?

    ☐

NOTE: **A "yes" response to question 42-51 requires a signed and dated written explanation. The *Explanation For Application Question* form may be used to provide your explanation.**

L1E

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.

MBC Use Only

Rev L1A-F

Staff Initials & Date

JD 6-28-17

Photograph ☑

Applicant Name & DOB ☑

DECLARATION

The applicant, Christina Marie Bourne [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:** 3/24/17

Applicant Signature & Date ☑

NOTARY SECTION

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

Applicant Signature ☑

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 California

County of Sacramento

Subscribed and sworn to (or affirmed) before me on this 24th day of March, 20 17,

by, Christina Bourne 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
LORI A. HAYES-SIMPERMAN
Commission # 2068014
Notary Public - California
Sacramento County
My Comm. Expires May 12, 2018

Applicant Name & Notary Date ☑

Notary Signature & Seal ☑

L1F

07A-100 Revised 7/2016

BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY - Department of Consumer Affairs — EDMUND G. BROWN JR., Governor

MEDICAL BOARD OF CALIFORNIA

Licensing Program

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
Bourne	Christina	Marie	

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

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	Univ. of Kansas
2. State/Province/Country	Kansas City, KS 66160

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?	☐ Yes ☒ No
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)	7/30/12
7. Date the applicant was issued the diploma of Bachelor/Doctor of Medicine (mm/dd/yyyy)	5/15/16

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.

Maria Herron	Registrar
PRINTED NAME OF SCHOOL OFFICIAL	TITLE OF SCHOOL OFFICIAL
Maria Herron	MAY 17 2017
SIGNATURE OF SCHOOL OFFICIAL	DATE

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 KS002 ☑
☑
Rev. L2 Staff Initials & Date JD 6-8-17
☐ ☐ ☑ ☐
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.

2005 Evergreen Street, Suite 1200, Sacramento, CA 95815-3831 (916) 263-2382 (800) 633-2322 FAX: (916) 263-2487 www.mbc.ca.gov

med school

MEDICAL BOARD OF CALIFORNIA
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.

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

Type or Print Legibly	APPLICANT INFORMATION			MBC Use Only
LEGAL NAME: Last	First	Middle	Suffix	
Bourne	Christina	Marie		
Date of Birth (mm/dd/yyyy)	**Last 4 Digits of U.S. SSN or ITIN**	**Medical School of Graduation**		Applicant Information ☑
[redacted]	[redacted]	University of Kansas School of Medicine - Wichita		

PROGRAM DIRECTOR TO COMPLETE ACGME OR RCPSC TRAINING INFORMATION

Facility Name	UC Davis Health			
Facility Address	4860 "Y" Street Suite 1600 Sacramento CA 95817			Verified Program Information ☑
Specialty	Family Medicine	**ACGME 10-digit Program #** https://apps.acgme.org/ads/Public	1200511039	
Dates of Training (mm/dd/yyyy)	Start Date: 6-25-2016	End Date (or anticipated completion date): 6-30-2017		☑ ☑

UNUSUAL CIRCUMSTANCES — Unusual Circumstance

***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 — Gen Med Required

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.*

L3A

2005 Evergreen Street, Suite 1200, Sacramento, CA 95815-3831 (916) 263-2382 (800) 633-2322 FAX: (916) 263-2487 www.mbc.ca.gov

APPLICANT INFORMATION

LEGAL NAME: Last	First	Middle	Suffix
Bourne	Christina	Marie	

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
JD 7-19-17

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.

Kay Nelsen, MD
PRINTED NAME OF PROGRAM DIRECTOR

[signature]
SIGNATURE OF PROGRAM DIRECTOR
(Signature Stamp Is Not Acceptable)

7-1-2017
DATE

Program Director's Signature & Date ☑
OK

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: [signature]
(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 _____

County of _____

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

by, _____ proved to me on the basis of satisfactory evidence
(PRINT PROGRAM DIRECTOR'S NAME)

to be the person who appeared before me.

Notary Signature & Seal ☐

Hospital Seal ☑

HOSPITAL or NOTARY SEAL

_____
SIGNATURE OF NOTARY PUBLIC

L3B

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

MEDICAL BOARD OF CALIFORNIA
Licensing Program

CURRENT POSTGRADUATE TRAINING ENROLLMENT

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

Type or Print Legibly — **APPLICANT INFORMATION** — **MBC Use Only**

LEGAL NAME: Last	First	Middle	Suffix
Bourne	Christina	Marie	

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

Applicant Information ☐

PROGRAM DIRECTOR TO COMPLETE ACGME OR RCPSC TRAINING INFORMATION

Facility Name	UC Davis Health		
Facility Address	4860 "Y" St Suite 1600 Sacramento CA 95817		
Specialty	Family Medicine	**ACGME 10-digit Program #** https://apps.acgme.org/ads/Public	1200511039
Dates of Training (mm/dd/yyyy)	Start Date: 06-25-2016	Anticipated Completion Date: 06-30-2017	

Verified Program Information ☐

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.

Verified PD Staff Initials & Date: JO 7-19-17

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.

Kay Nelsen, MD
PRINTED NAME OF PROGRAM DIRECTOR

[signature] MD — 7-1-2017
SIGNATURE OF PROGRAM DIRECTOR (Signature Stamp Is Not Acceptable) — **DATE**

Program Director's Signature & 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: [signature]
(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 _____

County of _____

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

by, _____ proved to me on the basis of satisfactory evidence
(PRINT PROGRAM DIRECTOR'S NAME)

to be the person who appeared before me.

Notary Signature & Seal ☐

Hospital Seal ☐

HOSPITAL or NOTARY SEAL

_____
SIGNATURE OF NOTARY PUBLIC

L4

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

07A-100 (Revised 7/2016)

Application Summary

License Type:	**Physician and Surgeon A**
License Number:	**150575**
File Number:	**2029072**
Application:	**Physician's and Surgeon's Renewal**
Application Number:	**14616777**
Application Date:	**05/15/2019 (mm/dd/yyyy)**

Application Questions

Have you served or are you currently serving in the military?	[redacted]

Personal Detail

First Name:	**CHRISTINA**
Middle Name:	**MARIE**
Last Name:	**BOURNE**
Birthdate:	****/**/******
Gender:	[redacted]

Addresses

License Related Addresses

Address of Record (Required)

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

Financial Interest Disclosure Summary

Address:

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

Would you like to contribute? [redacted]

Attachments

Physician Survey

Are you retired?	**No**
Activities in Medicine	**Administration - 20-29 Hours**
	Other - 1-9 Hours
	Patient Care - 40+ Hours
	Research - 1-9 Hours
	Teaching - 1-9 Hours
	Telemedicine - None
Patient Care Practice Location	**Zip: 95817 County: SACRAMENTO**
Telemedicine Practice Location	**Zip: County:**
Patient Care Secondary Practice Location	**Zip: County:**
Telemedicine Secondary Practice Location	**Zip: County:**
Current Training Status	**Residency**
Areas of Practice	**Family Medicine - Primary**
	Psychiatry - Secondary
Board Certifications	**None**
Postgraduate Training Years	**3 Years**
Cultural Background	[redacted]
	[redacted]
Foreign Language Proficiency	[redacted]
Web Site Profile	**Cultural Background - No**
	Foreign Language Proficiency - No
	Gender - No
E-mail:	[redacted]

Fees

Biennial Renewal Fee	**$783.00**

DUE TO CURES FUND	**$12.00**
StephenM.ThompsonLRP	**$25.00**
Total Amount Due:	**$820.00**

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: