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

Consumer Affairs

MEDICAL BOARD OF CALIFORNIA

LICENSING PROGRAM
1426 Howe Avenue, Suite 54
Sacramento, CA 95825-3236
(916) 263-2382 FAX (916) 263-2487
www.caldocinfo.ca.gov

RECEIVED MEDICAL BOARD OF CALIFORNIA
2009 JUL 16 PM 1:04
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

MBC Use Only

1. NAME: Last Khoury First Rasha Middle S

Other names you have used (include maiden name):

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: [redacted]
(Please note: this information is public)
(30 characters maximum per line, including spaces) [redacted] USA
City State/Province Zip/Postal Code Country

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

Personal Data

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

9. E-mail Address (optional):

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: _____

☒

MEDICAL EDUCATION

11. LIST EACH MEDICAL SCHOOL THAT YOU HAVE ATTENDED.

L2 Transcript

School Name	City, State/Province, Country	Dates of Attendance	
Yale School of Medicine	New Haven CT USA	Sept 2004 – May 2008	☒ ☒
			☐ ☐
			☐ ☐

12. School of Graduation	Degree Awarded	Date of Graduation	Diploma
Yale	MD	May 2008	☒ 5/26

EXAMINATIONS

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

Exams

Examination	Date	Result (Pass/Fail)	
USMLE Step 1	5/23/2006	[redacted]	☒
USMLE Step 2	(CK) 8/8/2007 (CS) 6/8/2007	[redacted]	☒
USMLE Step 3	6/9-10/2009	[redacted]	☒

0000126 $ 493.00 REF $12 7/15/09 EG
Cashiering Use Only

CT001
School Code

L1A

07A-100 (Rev. 12/05)

2.13.12

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

Postgraduate Training

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.

Facility Name	Address	Specialty Area	Dates of Attendance
UCSF / SFGH	1001 Potrero Ave San Francisco CA 94110	Ob/gyn	6/15/2008 - present LY

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

License Data

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.

Jurisdiction	License Number	Date of Issuance	Dates of Practice in that Jurisdiction
n/a			

APPLICANT: Rasha Khoury

DATE OF BIRTH: [redacted]

L1B

MEDICAL BOARD OF CALIFORNIA
Licensing Program

ADDENDUM TO THE INITIAL AND UPDATE APPLICATION FOR PHYSICIAN'S AND SURGEON'S LICENSE OR POSTGRADUATE TRAINING AUTHORIZATION LETTER FOR FORM L1___

The applicant, Rasha Khoury, [redacted] being first duly sworn
(PLEASE PRINT FULL NAME) (DATE OF BIRTH)

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.

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. RK (PLEASE INITIAL BOX)

SIGNATURE OF APPLICANT _____ (Please sign full name)

State of CALIFORNIA

County of SAN FRANCISCO

Subscribed and sworn to (or affirmed) before me on

This 5th day of NOVEMBER, 2009

by: (applicant's name to be printed here) RASHA KHOURY

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

NOTARY PUBLIC
JULIE M. FRENCH
COMM. #1775099
Notary Public-California
SAN FRANCISCO COUNTY
My Comm. Exp. OCT 22, 2011

_____
SIGNATURE OF NOTARY PUBLIC

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

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.

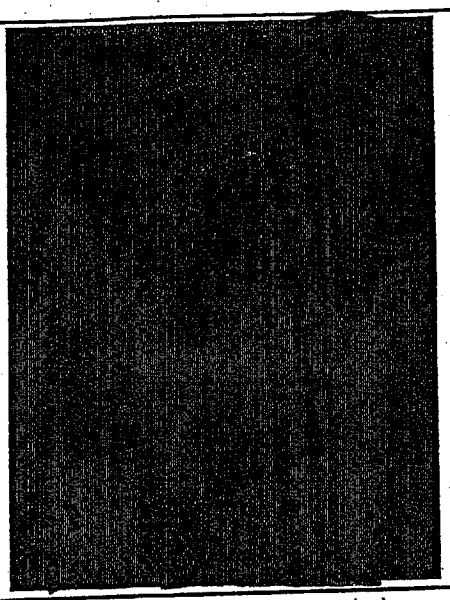
For each conviction disclosed, you must submit with the application certified copies of the arresting agency report, certified copies of the court documents, and a descriptive explanation of the circumstances surrounding the conviction of disciplinary action (i.e., dates and location of incident and 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 application denied or license revoked for knowingly falsifying the application. YES [redacted] NO [redacted]

APPLICANT: Rasha S Khoury

DATE OF BIRTH: [redacted]

L1C



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, Rasha S Khoury (PLEASE PRINT FULL NAME), [redacted] (DATE OF BIRTH) 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), 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. RK (PLEASE INITIAL BOX)

SIGNATURE OF APPLICANT: Rasha S Khoury (Please sign full name)

State of CALIFORNIA

County of SAN FRANCISCO

OK

Subscribed and sworn to (or affirmed) before me on

this July 10/09 10th day of July, 2009,

by RASHA S. KHOURY

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
ILDEFONSO M. CASTILLO
Commission # 1854117
Notary Public - California
San Francisco County
My Comm. Expires Jul 5, 2013

Ildefonso M. Castillo
SIGNATURE OF NOTARY PUBLIC

L1E

07A-100 (Rev. 12/05)

7/16/09

STATE OF CALIFORNIA – STATE AND CONSUMER SERVICES AGENCY

ARNOLD SCHWARZENEGGER, Governor

Consumer Affairs

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2009 AUG 11 AM 10:32

LICENSING PROGRAM

CERTIFICATE OF MEDICAL EDUCATION

MEDICAL SCHOOL: PLEASE COMPLETE THIS FORM IN THE ENGLISH LANGUAGE

This certifies that Rasha S Khoury [redacted]; enrolled in Yale School of Medicine

Full Name of Applicant — U.S. Social Security Number — Name of Medical School

[redacted]; located in New Haven | CT | USA on 08 / 31 / 2004.

Date of Birth — State/Province Country — Enrollment Date

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) and that the applicant

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

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

☒ was granted the degree of ~~Bachelor~~/Doctor of Medicine on the 26 day of May, 2008.

☐ withdrew from medical school on ____ day of _____, _____.

Unusual Circumstances

	Responses	
Did this individual ever take a leave of absence from their medical education?	Yes	No
Was this individual ever placed on probation?	Yes	No
Was this individual ever disciplined or under investigation?	Yes	No
Were any incident reports regarding this individual ever filed by instructors?	Yes	No
Were any limitations or special requirements imposed on this individual because of questions of academic or disciplinary problems, or for any other reason?	Yes	No

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

Medical School Seal Must Be Imprinted Below	Attention Medical School: 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.
	Signed and the school seal affixed this 22 day of July, 2009.
	By: Terri Tolson, Registrar (Printed Name and Title of School Official)
	Signature: Terri Tolson

L2

STATE OF CALIFORNIA – STATE AND CONSUMER SERVICES AGENCY

ARNOLD SCHWARZENEGGER, *Governor*

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MEDICAL BOARD OF CALIFORNIA

2009 JUL 29 PM 2:26

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.

PROGRAM

PART 1: TO BE COMPLETED BY THE APPLICANT

NAME: Last Khoury First Rasha Middle

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

Public/Mailing Address Department of OB/GYN UCSF/SFGH 1001 Potrero Ave/ward 6D

City San Francisco State/Province CA Zip/Postal Code 94110

Medical School of Graduation: Yale School of Medicine

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: University of California, San Francisco

ACGME 10 digit Program number: (www.acgme.org) 2200521047

Address of Facility: 505 Parnassus Avenue, S.F. CA 94143-0132

Telephone #: (415) 476-5192

Categorical Specialty Area of Training: Ob/Gyn

Start Date of Training: 06/18/2008

End Date (or anticipated completion date) of Training: 06/30/2012

UNUSUAL CIRCUMSTANCES:

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

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

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.

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.

OK

Amy (Meg) Autry, M.D.

PRINT NAME OF PROGRAM DIRECTOR

SIGNATURE OF PROGRAM DIRECTOR
Signature Stamp is Not Acceptable

7/21/05

DATE SIGNED

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 _____

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

L3B

STATE OF CALIFORNIA -- STATE AND CONSUMER SERVICES AGENCY

ARNOLD SCHWARZENEGGER, *Governor*

Consumer Affairs

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RECEIVED MEDICAL BOARD OF CALIFORNIA 2009 JUL 29 PM 2:26 PROGRAMS

CERTIFICATE OF CURRENT POSTGRADUATE TRAINING ENROLLMENT

At the time of licensure, you may be entitled to a reduced initial license fee if you are actively participating in a slotted position in an ACGME/RCPSC accredited postgraduate training program.

NOTE: This form may not be used in lieu of the Form L3A-B, "Certificate of Completion of ACGME/RCPSC Postgraduate Training."

NAME: Last Khoury First Rasha Middle S

U.S. Social Security Number [redacted] Date of Birth [redacted] Medical School of Graduation: Yale School of Medicine

This is to certify that the above applicant is actively participating in an ACGME or RCPSC accredited postgraduate training position that started on June (Month) 18 (Day) 2008 (Year) **and is expected to be completed on** June (Month) 30 (Day) 2012 (Year) **in** Ob/Gyn (Categorical Specialty Area of Training)

at University of California San Francisco (Name of Facility)

located at 505 Parnassus Avenue San Francisco CA 94143-0132 (Address of Facility)

The 10 digit ACGME Program # : 2 2 0 0 5 2 1 0 4 7 (Refer to http://www.acgme.org/adspublic)

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 above program is accredited by the ACGME or the RCPSC to offer the type and level of training completed by the applicant and that the applicant is being trained in an accredited ACGME or RCPSC postgraduate training position.

Amy (Mea) Autry, M.D.
PRINT NAME OF PROGRAM DIRECTOR

OK

SIGNATURE OF PROGRAM DIRECTOR – Signature Stamp Is Not Acceptable

(415) 476-5192
TELEPHONE NUMBER

7/21/09
DATE

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.

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 _____

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

Hospital or Notary Seal

_____
SIGNATURE OF NOTARY PUBLIC

OFFICIAL HOSPITAL SEAL OR NOTARY SEAL (WITH JURAT COMPLETED ABOVE) MUST BE AFFIXED IN THE BOX AT THE LEFT

L4

STATE DEPARTMENT OF CONSUMER AFFAIRS
INTERNET CASHIERING SYSTEM
MEDICAL BOARD OF CALIFORNIA
SUPPLEMENTAL INFORMATION REPORT
From Date: 09/07/2011 To Date: 09/07/2011

ATRISUPPINF

24-SEP-12 10:59:56

[redacted] Name : Khoury,Rasha

Question	Answer
I Have Completed Cme And Can Document Not Less Than 50 Hours Of Approved Cme For The Two-Year Period Immediately Preceding The Expiration Date Of My License. Or I Meet The Conditions Which Would Exempt Me From All Or Part Of The Requirements.	YES
I Have Completed 12 Hours Of Pain Management And End-Of-Life Care.	YES
I Am Exempt From The Completion Of 12 Hours Of Pain Management And End-Of-Life Care Continuing Education Requirement Because I Am A Radiologist Or Pathologist.	NO
Only For General Internists And Family Physicians Who Have 25% Of Their Patient Population Aged 65 Years Or Older: I Have Completed At Least 20% Of The Required Cme In Geriatric Medicine Or The Care Of Older Patients. Click No If Not Applicable.	NO
Enter Name/Address Of Facility Where You Or Your Immediate Family Hold Financial Interest. Type "None", If None Held.	NONE
I Certify Under Penalty Of Perjury Under The Laws Of The State Of California That The Information Contained In This Application Is True And Correct.	YES
I Have Read My Profile On The Medical Board Web Site At Www.Mbc.Ca.Gov And Acknowledge The Information Contained Therein As Current And Accurate.	YES
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?	NO

[redacted] 8

MEDICAL BOARD OF CALIFORNIA
LICENSE LOOKUP SYSTEM

License Information:

The following information is maintained by the Medical Board of California. For more information, click on the blue tabs above.

License:	**A 110207** Licensee may be a U.S. or Canadian medical school graduate whose pathway to licensure was based on the FLEX (Federation Licensing Exam), USMLE (United States Medical Licensing Exam) or LMCC (Licentiate of Medical Council of Canada) written examination and has been licensed less than four years in another state OR may be an International medical school graduate whose pathway to licensure was based on the above exams or approved combinations of the NBME (National Board Medical Exam), FLEX or USMLE.
License Type:	Physician and Surgeon
Name:	RASHA S KHOURY, M.D.
Address of Record:	**SF GENERAL HOSPITAL** **1001 POTRERO AVE 6D23** **SAN FRANCISCO, CA 94110**
Address of Record County:	SAN FRANCISCO
License Status:	**License Renewed & Current** Licensee meets requirements for the practice of medicine in California.
Public Record Action(s):	No Public Record Actions available
Original Issue Date:	December 2, 2009
Expiration Date:	December 31, 2013
School Name:	YALE UNIVERSITY SCHOOL OF MEDICINE
Year Graduated:	2008.

Survey Information:

The following information is **self-reported by the licensee and has not been verified by the Board.**

Activities In Medicine:	PATIENT CARE - 40+ HOURS RESEARCH - 20 TO 29 HOURS TEACHING - 20 TO 29 HOURS ADMINISTRATION - 1 TO 9 HOURS
Primary Practice Location Zip Code:	94110
Board Certification(s):	No board certifications identified
Primary Practice Area(s):	OBSTETRICS & GYNECOLOGY
Secondary Practice Area(s):	No secondary practice areas identified
Post Graduate Training Years:	3 YEARS
Ethnic Background:	Declined to Disclose
Foreign Language(s):	Declined to Disclose
Gender:	Declined to Disclose

Public Record Action(s):

Please select the Public Record Documents tab to view the public document database. If information is posted in the Administrative Disciplinary Actions, Court Order, Administrative Citation Issued, or License Issued with Public Letter of Reprimand categories below, documents may be available for review. To find out what information is and is not available, please click here.

Administrative Disciplinary Actions:

The Medical Board's public disclosure screens are updated periodically as new information becomes available. Please contact the Central File Room at (916) 263-2525 or at 2005 Evergreen Street, Suite 1200, Sacramento, CA 95815, to obtain a copy of public documents at a minimal charge.

No Administrative Disciplinary Actions found.

Court Order:

This information would be provided if a physician's practice has been temporarily restricted or suspended pursuant to a court order. Please contact the Central File Room at (916) 263-2525 or at 2005 Evergreen Street, Suite 1200, Sacramento, CA 95815, to obtain a copy of the public documents.

No Court Orders found.

Administrative Action Taken by Other State or Federal Government:

This information is provided by another state/federal government agency. The Medical Board of California may take administrative action based on the action imposed by another state/federal government agency. For more information or verification, contact the agency listed below that imposed the action.

No Administrative Actions Taken by Other State or Federal Government found.

Felony Conviction:

The information provided only includes felony convictions that are known to the Board. All felony convictions known to the Board are reviewed and administrative action is taken only if it is determined that a violation of the Medical Practice Act occurred. For more information regarding felony convictions, contact the court of jurisdiction listed below.

No Felony Convictions found.

Misdemeanor Conviction:

California Business and Professions Code section 2027 (A)(7) states effective 1/1/07, any misdemeanor conviction that results in a disciplinary action or an accusation that is not subsequently withdrawn or dismissed shall be posted on the Internet. To see if a conviction has been expunged or dismissed, please contact the court below.

No Misdemeanor Convictions found.

Administrative Citation Issued:

A citation and/or fine has been issued for a minor violation of the law. This is not considered disciplinary action under California law but is an administrative action. Payment of the fine amount represents satisfactory resolution of this matter.

No Administrative Citations found.

License Issued with Public Letter of Reprimand:

The Medical Board of California has concurrently issued the applicant a medical license and a Public Letter of Reprimand for a minor violation that does not require probationary status or warrant denial. The issuance of a Public Letter of Reprimand is not considered disciplinary action and is not reported to the National Practitioner Databank or the Federation of State Medical Boards.

No License Issued with Public Letter of Reprimand found.

Hospital Disciplinary Action:

The action taken by this healthcare facility against this physician's staff privileges to provide health care services at this facility was for a medical disciplinary cause or reason. The Medical Board is authorized by law to disclose only revocations and terminations of staff privileges. The Medical Board is prohibited from releasing a copy of the actual report or any other information.

No Hospital Disciplinary Actions found.

Malpractice Judgment:

A malpractice judgment is a payment for damages and does not necessarily reflect that the physician's medical competence is below the standard of care. The Medical Board reviews all such reported judgments and action is taken only if it is determined that a violation of the Medical Practice Act occurred. The Medical Board is prohibited by law from releasing a copy of the judgment report or any other information concerning the judgment. For more information contact the court of jurisdiction listed below.

No Malpractice Judgments found.

Arbitration Award:

An arbitration award is a payment for damages and does not necessarily reflect that the physician's medical competence is below the standard of care. The Medical Board reviews all such reported arbitration awards and action is taken only if it is determined that a violation of the Medical Practice Act occurred. The Medical Board is prohibited by law from releasing a copy of the arbitration award report or any other information concerning the award.

No Arbitration Awards found.

Malpractice Settlements:

A settlement entered into by the licensee is a resolution of a claim for damages for death or personal injury caused by the licensee's negligence, error, or omission in practice, or by his or her rendering of unauthorized professional services. The Medical Board is required by law to disclose certain information related to the existence of multiple settlements made on or after January 1, 2003 in an amount of $30,000 or more.

No Malpractice Settlements found.

Note: "No information available from this agency" may not indicate none exists; but indicates no information has been reported to the Medical Board of California and/or that the Board is unable to post the information on the Web site by law.

Public Record Documents:

All imaged documents provided by the Medical Board are being made available to provide immediate access for the convenience of interested persons. While the Medical Board believes the information to be reliable, human or mechanical error remains a possibility, as does delay in the posting or updating of information. Therefore, the Medical Board makes no guarantee as to the accuracy, completeness, timeliness, currency, or correct sequencing of the information. The Medical Board shall not be responsible for any errors or omissions, or for the use or results obtained from the use of this information. The types of documents which are available include, but are not limited to, accusations, decisions, suspension/restriction orders, public letters of reprimand and citations.

No documents found.

Please note that documents with an effective date prior to calendar year 2000 may not be available via the Web. To obtain a copy of the documents not posted on this site, please contact the Central File Room at (916) 263-2525 or click here for information on ordering public documents.