

RECORDED & INDEXED
 BOARD OF MEDICAL EXAMINERS
 000561



BOARD OF MEDICAL EXAMINERS
 1020 H STREET, SACRAMENTO, CALIFORNIA 95814
 TELEPHONE: (916) 322-3670



NOV 9 3 21 PM '77

11790
 11791

APPLICATION FOR A WRITTEN EXAMINATION FOR A
 PHYSICIAN'S-SURGEON'S CERTIFICATE
 (CLASS A)

00318

ANSWER ALL QUESTIONS

BRENT ALAN BLUE

1. Name (Please print) First [REDACTED] Middle [REDACTED] Last [REDACTED]

2. Address No. and Street [REDACTED] City [REDACTED] State [REDACTED] Zip Code [REDACTED]

3. Date of birth (Mo./Day/Year) [REDACTED] Age today [REDACTED] Sex [REDACTED] Social No. [REDACTED]

4. State California certificate, if issued, to: No. and Street [REDACTED] City [REDACTED] State [REDACTED] Exp. Date [REDACTED]

5. Premedical education—College/University		Period of attendance	
Name of College	Location	From (mo/yr)	To (mo/yr)
VANDERBILT UNIVERSITY	NASHVILLE, TENNESSEE	Sept, '68	June, '72

6. Premed courses (required) See Page 4.

	Yes	No	College	Location	From (mo/yr)	To (mo/yr)
Chemistry	XX		Vanderbilt University	Nashville	Sept '69	June '71
Physics	XX		"	"	June '71	May '72
Biology	XX		"	"	Sept '68	June '69

7. Academic Degree of Bachelor of Arts granted by Vanderbilt University on May 5, 1972

8. Medical education

Course	Medical College	Location	From (mo/yr)	To (mo/yr)
1st ALL COURSES	UNIVERSITY OF LOUISVILLE SCHOOL OF MEDICINE	LOUISVILLE, KY	SEPT '72	MAY '76
2nd				
3rd				
4th				
5th				
6th				

9. Doctor of Medicine Degree granted by: ATTACH PROOF OF MEDICAL DEGREE
 THE U OF LOUISVILLE SCH OF MED
 Location: LE, KENTUCKY
 Exact date of issuance: MAY 9, 1976

10. Internship: ATTACH PROOF OF INTERNSHIP FROM EACH HOSPITAL

Name of hospital	Location	From (mo/yr)	To (mo/yr)
SAN FRANCISCO GENERAL HOSPITAL, SAN FRANCISCO, CALIF.		6/21/76	6/21/77

11. Have you been licensed to practice medicine in any state or country? Yes No
 If YES, where?

12. Have you ever had a medical license suspended or revoked?
 If YES, give details.

13. Have you been denied a license to practice medicine by any state or country?
 If YES, give details.

14. Are you now, or have you ever been addicted to narcotic drugs?

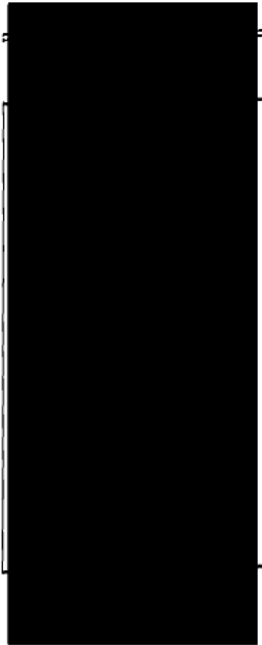
15. Have you ever been charged with drug addiction?
 If YES, explain below.

Charge	Date	Disposition

16. Have you ever been charged with a violation of a federal, state or local law relating to the manufacture, distribution, or dispensing of controlled substances (narcotics)?

17. Have you ever been convicted of or pled guilty or nolo contendere to any violation of any law of any state, the United States, or a foreign country?
 If YES, attach paper and explain.

18. Have you ever failed a written or oral examination given by this board?



I hereby declare that the photo of myself attached hereto, was taken on or about _____, 19____, my age then being _____ years, and my physical description then being as follows:
 Native of _____;
 complexion _____; color of hair _____; color of eyes _____;
 height _____; light _____; medium _____; weight _____ lbs.
 _____; heavy _____;
 marks _____.

I certify under penalty of perjury that all statements made are true in every respect, and understand that misstatements or omissions of material fact may be cause for denial of this application or invalidation of any such approval.

[Signature]
 Signature of applicant in full—see no initials

3/31/77
 Date

INFORMATION

Forward all applications, diplomas, fees, communications, etc., to the Board of Medical Examiners, 1020 N Street, Sacramento, California 95811. Incomplete or mutilated applications are not acceptable.

NO TEMPORARY OR SPECIAL PERMITS TO PRACTICE ARE ISSUED.

Section 2203. If an applicant for any form of certificate issuable under this chapter twice fails to pass the examination required for the type of certificate for which he has applied, he shall not be eligible to be examined a third time until at least one year has elapsed from the date of the second examination; and if he fails the third examination, he shall not be eligible to take the examination a fourth time until two years has elapsed from the date of the third examination. Thereafter, he may not take the examination more frequently than once in two years.

Refund of fees. If an applicant does not desire to take, or does not appear for the written examination, he is entitled to a refund of \$40.00; \$10.00 is retained for application processing. Applicants desiring a refund should notify the Board of Medical Examiners.

Notification to take the examination will be mailed to all applicants whose credentials are acceptable. This form must be presented at the door of the examining room in order to gain admission. The date, time, and place will be included on this form.

An applicant matriculating in a medical school after January 1, 1954, must show the completion of a three-year resident course of college grade including the subjects of Chemistry, Physics, and Biology.

HAVE YOU INCLUDED THE FOLLOWING WITH YOUR APPLICATION? (Indicate with mark)

- Certified check or money order is preferred.
- Two (2) personal data cards (one pink and one white)
- One fingerprint card. Please complete all information indicated on card.
- Photocopy of Medical School Diploma.
- Photocopy of Certificate of Completion of Internship.
- Two (2) photographs. Attach one to application form and one to the enclosed poster. See poster for additional instructions.
- Certificate of Medical Education Completed.

MAR 15 8 53 AM '77

STATE OF CALIFORNIA--AGRICULTURE AND SERVICES AGENCY



BOARD OF MEDICAL EXAMINERS

1020 N STREET, SACRAMENTO, CALIFORNIA 95811
TELEPHONE: (916) 322-5040



PLEASE FORWARD TO YOUR MEDICAL SCHOOL
CERTIFICATE OF EDUCATION

This Certifies That BRENT ALAN BLUE Full name of applicant
enrolled in the University of Louisville School of Medicine Name of medical school (college)
on the 5th day of September, 19 72 Month Year
 as a Freshman.
 with advanced standing based on _____ Please specify

The undersigned further certifies that official transcripts on file show that prior to completing the study of medicine the applicant herein referred to completed at least a two-year resident course of college grade including:

PHYSICS CHEMISTRY BIOLOGY (or) ZOOLOGY (Check course(s) completed)
at Vanderbilt University Please indicate school, and that he attended while at this
medical school (college). 4 courses of lectures of 36 weeks each,
Specifying number Specifying number of weeks
completing _____ hours in the subjects below listed, and that he/she
Total hours

was granted the degree { Bachelor / Doctor } of Medicine

left the above mentioned medical school (college) for the following reason(s):

on the 9th day of May, 19 76 Month Year

Please indicate which of the following courses of study were successfully undertaken by the applicant:

- Anatomy Preventive medicine Medicine
- Embryology Hygiene and sanitation Pediatrics
- Histology Radiology, including roentgenologic technique and radiation safety Psychiatry
- Neuroanatomy Urology Neurology
- Physiology Ophthalmology Dermatology
- Psychobiology Anesthesia Physical medicine
- Biochemistry Otolaryngology Therapeutics
- Pathology, bacteriology and immunology Obstetrics and gynecology Tropical medicine
- Pharmacology Surgery, including orthopedic surgery

Signed and the College seal affixed this 8th day

{ AFFIX SEAL HERE }

of March, 19 77 Month Year
By Arthur R. Keenan Secy, Board

(DO NOT PRINT)

Medical Board of California -- Physician's and Surgeon's Renewal

LICENSEE NAME
BLUE, BRENT A

LICENSE NO.
A31472

EXPIRATION
DATE
07/31/18


AMOUNT
DUE NOW
\$820.00

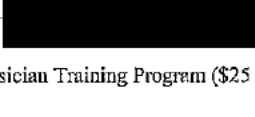
AMOUNT DUE IF
POSTMARKED AFTER
AUGUST 30, 2018
\$898.00

LICENSEE MUST CHECK CORRECT BOXES

"H" Completed Continuing Education (See Question 1)

"E" Change of Address (fill in reverse side)

"I" Conviction 

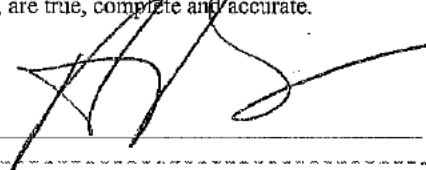
"J" Conviction 

"F" Family Physician Training Program (\$25 See Question 4)

"G" 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  Date 5/1/18

ENTER YOUR PHONE NUMBER FOR REFERENCE:



63010100000100002000314724010731180008200000089800

CHANGE OF ADDRESS (Only if different from address above)

BLUE, BRENT A

A31472

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

Application Summary

3/3/20 3:40 PM

Page 1 of 3

License Type:	Physician and Surgeon A
License Number:	31472
File Number:	27804
Application:	Physician's and Surgeon's Renewal
Application Number:	14745732
Application Date:	03/03/2020 (mm/dd/yyyy)

Application Questions

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



Personal Detail

First Name:	BRENT
Middle Name:	ALAN
Last Name:	BLUE
Birthdate:	**/**/****
Gender:	Male

Addresses

License Related Addresses

Address of Record

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.

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?



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?



1583278803130

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.



Family Physician Training Program Voluntary Fee

Would you like to contribute?



Attachments

Physician Survey

Are you retired?	No
Activities in Medicine	Administration - 1-9 Hours Other - 1-9 Hours Patient Care - 40+ Hours Research - None Teaching - 1-9 Hours Telemedicine - 1-9 Hours
Patient Care Practice Location	Zip: 83001 County: OUT OF STATE
Telemedicine Practice Location	Zip: 83001 County: OUT OF STATE
Patient Care Secondary Practice Location	Zip: County:
Telemedicine Secondary Practice Location	Zip: County:
Current Training Status	Not in Training
Areas of Practice	Aerospace Medicine - Secondary Emergency Medicine - Secondary Family Medicine - Primary Other - Not Listed - Secondary
Board Certifications	American Board of Emergency Medicine - Emergency Medicine American Board of Family Medicine - Family Medicine
Postgraduate Training Years	4 Years
Cultural Background	Decline to State

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:



Application Summary

2/14/22 2:20 PM

Page 1 of 3

License Type:	Physician and Surgeon A
License Number:	31472
File Number:	27804
Application:	Physician's and Surgeon's Renewal
Application Number:	14969120
Application Date:	02/14/2022 (mm/dd/yyyy)

Application Questions

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



Personal Detail

First Name:	BRENT
Middle Name:	ALAN
Last Name:	BLUE
Birthdate:	**/**/****
Gender:	Male

Addresses

License Related Addresses

Address of Record

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.

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?



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?



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.



Family Physician Training Program Voluntary Fee

Would you like to contribute?



Attachments

Physician Survey

Are you retired?	No
Activities in Medicine	Administration - 1-9 Hours Patient Care - 20-29 Hours Research - None Teaching - 1-9 Hours Telemedicine - 10-19 Hours
Patient Care Practice Location	Zip: 83001 County:
Telemedicine Practice Location	Zip: 83001 County:
Patient Care Secondary Practice Location	Zip: County:
Telemedicine Secondary Practice Location	Zip: County:
Current Training Status	Not in Training
Areas of Practice	Aerospace Medicine - Secondary Emergency Medicine - Secondary Family Medicine - Primary
Board Certifications	American Board of Emergency Medicine - Emergency Medicine American Board of Family Medicine - Family Medicine
Postgraduate Training Years	3 Years
Cultural Background	White

Fees

Biennial Renewal Fee	\$863.00
DUE TO CURES FUND	\$22.00
StephenM.ThompsonLRP	\$25.00
Total Amount Due:	\$910.00

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:

