STATE OF CALIFORNIA - STATE AGENCY/DEPARTMENT

6085

DEPARTMENT OF
Consumer Affairs

BOARD OF MEDICAL QUALITY ASSURANCE

APPLICATION FOR PHYSICIAN'S AND SURGEON'S CERTIFICATE
BASED ON NATIONAL BOARD CREDENTIALS
CLASS G

00519-1

(Please type or print neatly. When space provided is insufficient, attach additional sheets.)

1. NAME: Last LEVICH First DEBORAH Middle LYNN

2. Telephone No. [redacted]

3. List other names, if any, you have used:

4. Address: Street and No./Rural Route [redacted] City [redacted] State [redacted] Zip Code [redacted]

5. Name you wish on License: DEBORAH LYN LEVICH

Birthdate: Month, Day, Year [redacted]

6. Premedical Education: Name of College or University: MOUNT HOLYOKE COLLEGE

Location: [redacted]

Period of attendance: From: 9/73 To: 5/77

Check premedical courses successfully completed: ☒ Chemistry ☒ Physics ☒ Biology or Zoology

7. Medical School:

Year	Name of Institution	Location	From	To
1st	EASTERN VIRGINIA MEDICAL SCHOOL	NORFOLK, VIRGINIA	7/79	6/80
2nd	SAME	SAME	7/80	6/81
3rd	SAME	SAME	7/81	6/82
4th				
5th				
6th				

8. Doctor of Medicine Degree granted by: EASTERN VIRGINIA MEDICAL SCHOOL

Date: 6/82

For office use only: School Code: WA0071

9. 1st Year Postgraduate Training (Internship):

Location	Type of Service	From	To
KAISER FOUNDATION HOSPITAL - S.F.	OBSTETRICS - GYNECOLOGY	7/82	6/83

10. List all States in which you have been licensed to practice medicine: NONE

11. Has any disciplinary action ever been taken regarding any license which you now hold or ever held? [redacted]

If Yes, indicate below:

State	Date	Charge	Disposition

12. Have you ever been denied a license to practice medicine in any State or Country? [redacted]

If Yes, indicate below:

State or Country	Date of Denial	Reason for Denial

13. Are you now or have you ever been addicted to narcotic drugs? [redacted]

Yes ☒ No

Yes ☒ No

[redacted]

Applicant, please complete the following:

Height: [redacted] Weight [redacted] lbs.

Hair color [redacted] Eye color: [redacted]

Identifying marks: [redacted]

NOTE: The information on this application is required and maintained pursuant to Section 2512 of the Business and Professions Code. All items on 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. Applicants have the right to review their applications subject to the provisions of the California Public Records Act.

NOTE: APPLICANT WILL SIGN THIS STATEMENT IN PRESENCE OF NOTARY PUBLIC.

"I hereby certify (or declare) under penalty of perjury, that the foregoing information contained in this application and any attachments is true and correct, and that the attached photo and duplicate copy are a true likeness of myself, the applicant identified herein."

Signature of Applicant [redacted]

Date September 16, 1983

Subscribed and sworn to before me this 16, day of September, 19 83

SEAL

OFFICIAL SEAL
ELIZABETH K. OLGUIN
NOTARY PUBLIC - CALIFORNIA
CITY AND COUNTY OF SAN FRANCISCO
My Comm. Expires June 30, 1987

Signature of Notary [redacted]

Address 870 Market Street, #472
San Francisco, California 94102

My commission expires June 30, 1987.

Consumer Affairs

BOARD OF MEDICAL QUALITY ASSURANCE

PLEASE FORWARD TO YOUR MEDICAL SCHOOL
CERTIFICATE OF EDUCATION

This Certifies That [redacted]
Full name of applicant

enrolled in Eastern Virginia Medical School
Name of medical school (college)

on the 1 day of July 19 79.
Month Year

[X] 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:

[X] PHYSICS [X] CHEMISTRY [X] BIOLOGY (or) ZOOLOGY (Check course(s) completed)

at Mount Holyoke College, and that he attended while at this
Please indicate school

medical school (college) three years of courses of lectures of 52 weeks each,
Specify number Specify number of weeks

completing ____ hours in the subjects below listed, and that he/she:
Total hours

[X] was granted the degree ~~Bachelor~~ Doctor of Medicine.

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

on the 19 day of June 19 82.
Month Year

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

[X] Anatomy	[X] Dermatology	[ ] Preventive medicine, including nutrition	[X] Otolaryngology
[X] Embryology	[ ] Physical medicine	[X] Radiology, including radiation safety	[X] Obstetrics and gynecology
[X] Histology	[ ] Therapeutics	[X] Medicine	[ ] Human sexuality as defined in Section 2192.3
[X] Neuroanatomy	[ ] Tropical medicine	[X] Pediatrics	
[X] Physiology	[X] Surgery, including orthopedic surgery	[X] Psychiatry	[ ] Child Abuse detection and treatment
[X] Biochemistry	[X] Urology	[X] Neurology	
[X] Pathology, bacteriology and immunology	[X] Ophthalmology	[X] Anesthesia	
	[X] Pharmacology		

Signed and the College seal affixed this 30 day

[Affix Seal Here]

of August 19 83.
Month Year

By
President, Secretary, Dean

Robert M. McCombs, Ph.D
Executive Associate Dean

07A-32 (REV 3-82)