



BOARD OF MEDICAL QUALITY ASSURANCE

1000 EAST MAIN STREET, SUITE 200, RICHMOND, VIRGINIA 23219
 (804) 775-2411



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

00519-1
 2/24/80

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

1. NAME: Last First Middle Maiden Title/Prefix Suffix
 LEVICH DEBORAH LYNN [REDACTED]

2. List other names, if any, you have used: [REDACTED]

3. Address: Street and No. (Rural Route) City State Zip
 [REDACTED]

4. Name you wish on License: DEBORAH LYNN LEVICH Birth Date (Month, Day, Year) [REDACTED]

5. Pre-medical Education: Name of College or University Location
 DICKINSON COLLEGE [REDACTED]
 Period of attendance: From 9/73 To 5/77
 Check pre-med courses successfully completed:
 Chemistry Physics Biology or Zoology

6. Medical School:

Year	Name of Institution	Location	From	To
1st	EASTERN VIRGINIA MEDICAL SCHOOL	NORFOLK, VIRGINIA	7/77	6/80
2nd	SAME	SAME	7/80	6/81
3rd	SAME	SAME	7/81	6/82
4th				
5th				
6th				

7. Doctor of Medicine Degree granted by: EASTERN VIRGINIA MEDICAL SCHOOL Date 6/82 For office use only School Code: WA001

8. 1st Year Postgraduate Training (Internship):

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

9. List all States in which you have been licensed to practice medicine: none

10. 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

11. 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

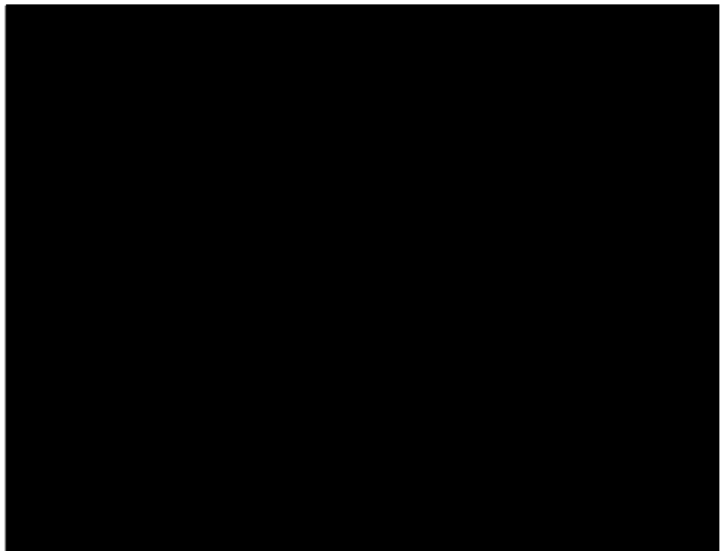
12. Are you now or have you ever been addicted to narcotic drugs? [REDACTED]

Have you ever had your license suspended or revoked?
If "No," please explain on another sheet of paper.

Yes No

Have you ever voluntarily surrendered your license to practice in another state?

Yes No



Applicant, please complete the following.

Height: [redacted] in 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 2312 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.

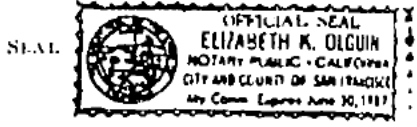
NOTE: APPLICANT WILL SIGN THIS STATEMENT IN PRESENCE OF NOTARY PUBLIC.

"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 *Elizabeth K. Olguin*

Date September 16, 1983

Subscribed and sworn to before me this 16, day of September, 1983



Signature of Notary *Elizabeth K. Olguin*

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

My commission expires June 30, 1987.



BOARD OF MEDICAL QUALITY ASSURANCE
1111 West 11th Street, Annapolis, MD 21403
(410) 326-6333

PLEASE FORWARD TO YOUR MEDICAL SCHOOL
CERTIFICATE OF EDUCATION

This Certifies That ADU BUCIWA I IN UCERAW
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
 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 Mount Holyoke College Please indicate school, and that he attended while at this
medical school (college) three years of Specify number 52 Specify number of weeks weeks each,
completing Total hours hours in the subjects below listed, and that he/she:

was granted the degree ~~B.S.~~ 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:

- | | | | |
|--|---|---|---|
| <input checked="" type="checkbox"/> Anatomy | <input checked="" type="checkbox"/> Dermatology | <input type="checkbox"/> Preventive medicine, including nutrition | <input checked="" type="checkbox"/> Otolaryngology |
| <input checked="" type="checkbox"/> Embryology | <input type="checkbox"/> Physical medicine | <input checked="" type="checkbox"/> Radiology, including radiation safety | <input checked="" type="checkbox"/> Obstetrics and gynecology |
| <input checked="" type="checkbox"/> Histology | <input type="checkbox"/> Therapeutics | <input checked="" type="checkbox"/> Medicine | <input type="checkbox"/> Human sexuality as defined in Section 2192.3 |
| <input checked="" type="checkbox"/> Neuroanatomy | <input type="checkbox"/> Tropical medicine | <input checked="" type="checkbox"/> Pediatrics | <input type="checkbox"/> Child Abuse detection and treatment |
| <input checked="" type="checkbox"/> Physiology | <input checked="" type="checkbox"/> Surgery, including orthopedic surgery | <input checked="" type="checkbox"/> Psychiatry | |
| <input checked="" type="checkbox"/> Biochemistry | <input checked="" type="checkbox"/> Urology | <input checked="" type="checkbox"/> Neurology | |
| <input checked="" type="checkbox"/> Pathology, bacteriology and immunology | <input checked="" type="checkbox"/> Ophthalmology | <input checked="" type="checkbox"/> Anesthesia | |
| | <input checked="" type="checkbox"/> 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