



# MEDICAL BOARD OF CALIFORNIA

## Licensing Program



### APPLICATION

#### TYPE OF APPLICATION

<p style="text-align: center;">(Check One)</p> <input checked="" type="checkbox"/> U.S. or Canadian Medical School Graduate <input type="checkbox"/> International Medical School Graduate	<p style="text-align: center;">(Check All That Apply)</p> <input checked="" type="checkbox"/> Physician's and Surgeon's License <input type="checkbox"/> Postgraduate Training Authorization Letter (PTAL) <input type="checkbox"/> Update Application: File # _____ <input type="checkbox"/> Limited Practice License
---	---

MBC Use Only

Application Type

#### PRIORITY REVIEW & EXPEDITED LICENSURE

**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](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.

Priority Review

#### PERSONAL INFORMATION

Type or Print Legibly			
1. Legal Name	Last Pinson	First Kelsey	Middle Anna
2. Other Names/Alias			
3. United States Social Security Number (SSN) or Individual Taxpayer Identification Number (ITIN)			SSN ITIN
4. Date of Birth (mm/dd/yyyy)		5. Gender	<input type="checkbox"/> Male <input checked="" type="checkbox"/> Female
6. Address of Record			
Mailing Address (40 characters maximum per line, including spaces) 9300 Campus point Dr.			
Mailing Address continued (40 characters maximum per line, including spaces) MC 7433			
City La Jolla		State/Province CA	Zip/Postal Code Country 92037-7433
Confidential Address (Only required if Address of Record is a P.O. Box)			
7. Telephone Numbers		Home #	Work # Cell #
8. E-mail Address (Required)			
9.	Have you served or are you currently serving in the military?		Yes No
10.	Are you requesting expediting of this application as a spouse or domestic partner of an active duty member of the Armed Forces?		Yes No

Legal Name

SSN/ITIN

DOB Gender

Address of Record

Confidential Address

Telephone Numbers

Email

Military

MBC Use Only Cashiering 6717871/1-53285/4910/32118	Pathway 2170	School Code NY019
--	-----------------	----------------------

L1A

**APPLICANT:**  
(Print Legal Name) *Kelsay Pinson*

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

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.

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?  Yes  No
12. Have you previously held a Physician's and Surgeon's License in California?  
If yes, please provide license number: \_\_\_\_\_ Expired: \_\_\_\_\_  Yes  No

Previous Appl. License

**EXAMINATIONS**

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**

ECFMG  
 *Diploma*

Examination	Date Passed
<i>USMLE Step 1</i>	<i>2/13/16</i>
<i>USMLE Step 2 CK</i>	<i>8/18/16</i>
<i>USMLE Step 2 CS</i>	<i>9/20/16</i>
<i>USMLE Step 3</i>	<i>2/2018</i>

Exams

**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](http://www.mbc.ca.gov/Applicants/Medical_Schools/Schools_Recognized.aspx).

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)	
		Start	End
<i>New York University School of Medicine</i>	<i>545 1<sup>st</sup> Ave</i>	<i>08/01/2013</i>	
	<i>NEW YORK, NY, 10016</i>		<i>05/17/2017</i>
		Start	
		End	
		Start	
		End	

Medical Education  
  
  
  
  
  
LZ / Trans    
School Code  
*NY019*

Medical School of Graduation	Title of Degree Awarded	Issue Date of Degree (mm/dd/yyyy)
<i>NYU School of Medicine</i>	<i>2018 MAR 21 PM 3:02</i>	<i>5/17/2017</i>

Diploma

RECEIVED  
MEDICAL BOARD OF  
CALIFORNIA

**L1B**

**APPLICANT:**  
(Print Legal Name)

Kelsay Pinson

**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.

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?  Yes  No
12. Have you previously held a Physician's and Surgeon's License in California?  Yes  No  
If yes, please provide license number: \_\_\_\_\_ Expired: \_\_\_\_\_

Previous App/License

**EXAMINATIONS**

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

ECFMG

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

USMLE

Examination	Date Passed
USMLE Step 1	2/13/16
USMLE Step 2 CK	8/18/16
USMLE Step 2 CS	9/20/16
USMLE Step 3	2/2018

Exams

**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](http://www.mbc.ca.gov/Applicants/Medical_Schools/Schools_Recognized.aspx).

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

Medical Education

Medical School Name	Mailing Address	Dates of Attendance (mm/dd/yyyy)	
		Start	End
New York University School of Medicine	545 1 <sup>st</sup> Ave	08/01/2013	
	New York, NY, 10016		05/17/2017
		Start	
		End	
		Start	
		End	

L2 Trans

School Code  
NY019

Medical School of Graduation	Title of Degree Awarded	Issue Date of Degree (mm/dd/yyyy)
NYU School of Medicine	2018 MAR 21 PM 3:02	5/17/2017

Diploma

RECEIVED  
MEDICAL BOARD OF  
CALIFORNIA

**L1B**



# MEDICAL BOARD OF CALIFORNIA

## Licensing Program



### APPLICATION

TYPE OF APPLICATION				MBC Use Only
(Check One)		(Check All That Apply)		Application Type <input checked="" type="checkbox"/>
<input checked="" type="checkbox"/> U.S. or Canadian Medical School Graduate	<input type="checkbox"/> International Medical School Graduate	<input checked="" type="checkbox"/> Physician's and Surgeon's License	<input type="checkbox"/> Postgraduate Training Authorization Letter (PTAL)	
		<input type="checkbox"/> Update Application: File # _____		Priority Review <input checked="" type="checkbox"/>
		<input type="checkbox"/> Limited Practice License		
PRIORITY REVIEW & EXPEDITED LICENSURE				
<p><b>Honorably Discharged Veterans of the Armed Forces</b> - 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.</p>				
<p><b>Practice in Medically Underserved Area or Population</b> - 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 <a href="http://www.mbc.ca.gov/Applicants/Physicians_and_Surgeons/Underserved.aspx">http://www.mbc.ca.gov/Applicants/Physicians_and_Surgeons/Underserved.aspx</a>.</p>				
<p><b>Temporary License for Spouse of Active Duty Member of the Armed Forces</b> - 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.</p>				
PERSONAL INFORMATION				
Type or Print Legibly				
1. Legal Name	Last Pinson	First Kelsey	Middle Anna	Suffix  Legal Name <input type="checkbox"/>
2. Other Names/Alias				
3. United States Social Security Number (SSN) or Individual Taxpayer Identification Number (ITIN)	[REDACTED]			SSN ITIN <input type="checkbox"/>
4. Date of Birth (mm/dd/yyyy)	[REDACTED]	5. Gender	<input type="checkbox"/> Male <input checked="" type="checkbox"/> Female	DOB Gender <input checked="" type="checkbox"/> <input type="checkbox"/>
6. Address of Record <small>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.</small>	Mailing Address (40 characters maximum per line, including spaces) 9300 Campus point Dr.			
	Mailing Address continued (40 characters maximum per line, including spaces) MC 7433			
	City La Jolla	State/Province CA	Zip/Postal Code 92037-7433	Country
Confidential Address (Only required if Address of Record is a P.O. Box)				
7. Telephone Numbers	Home # [REDACTED]	Work #	Cell #	Confidential Address <input type="checkbox"/> Telephone Numbers <input checked="" type="checkbox"/>
8. E-mail Address (Required)	[REDACTED]			
9.	Have you served or are you currently serving in the military?			Yes No <input type="checkbox"/> <input checked="" type="checkbox"/>
10.	Are you requesting expediting of this application as a spouse or domestic partner of an active duty member of the Armed Forces?			Yes No <input type="checkbox"/> <input checked="" type="checkbox"/>
MBC Use Only	6717871/1-53285/4910/32118		2170 Pathway	NY019 School Code <b>L1A</b>

**APPLICANT:**  
(Print Legal Name) Kelsey Pincen

**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)

UCSD  
OB/GYN

Facility Name	City, State/Province	Specialty	Dates of Training (mm/dd/yyyy)	
			Start	End
UC SAN Diego Health	La Jolla, CA	OB/GYN	Start	06/23/2017
			End	06/30/2021
			Start	
			End	
			Start	
			End	

**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?	Yes	No
18. Have you ever taken a leave of absence or break from your training?	Yes	No
19. Have you ever been terminated, dismissed or expelled from a program?	Yes	No
20. Have you ever been placed on probation for any reason?	Yes	No
21. Have you ever been disciplined or placed under investigation?	Yes	No
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?	Yes	No
23. Have you ever had a postgraduate training program contract not be renewed or offered for a following year?	Yes	No

**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**

<b>APPLICANT:</b> (Print Legal Name) <i>Kelsey Pinson</i>		<b>DATE OF BIRTH:</b> (mm/dd/yyyy) [REDACTED]		MBC Use Only <input type="checkbox"/> Name & DOB
<b>ABMS CERTIFICATION</b>				
25. Are you currently certified by a Member Board of the American Board of Medical Specialties?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	ABMS <input type="checkbox"/>
<b>MALPRACTICE HISTORY</b>				
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?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Malpractice History <input type="checkbox"/>
<b>DISCIPLINARY HISTORY</b>				
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.				
27. Have you ever had your DEA privileges denied, suspended, restricted, or terminated?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Disciplinary History <input type="checkbox"/>
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?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/>
29. Have you ever withdrawn an application for medical licensure in lieu of denial, disciplinary action, or for any other similar reason?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/>
30. Have you ever been denied a license to practice medicine?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/>
31. Is any denial pending against you?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/>
32. Have you ever had any license to practice medicine subjected to any disciplinary action?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/>
33. Is any disciplinary action pending against any of your licenses to practice medicine?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/>
34. Have you ever surrendered a license to practice medicine?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/>
35. Have you ever had any license to practice medicine revoked, suspended, or placed on probation?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/>
36. Have you ever had any license to practice medicine subjected to any action including, <i>but not limited to</i> , informal or confidential discipline, consent orders, letters of warning, letters of reprimand, or citation?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/>
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?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/>
38. Have you ever resigned from a medical staff in lieu of disciplinary or administrative action?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/>
39. Is any disciplinary action pending against your hospital or staff privileges?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/>
40. Have you ever had staff privileges in a hospital terminated, denied, suspended, limited, revoked, or not renewed?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/>
41. Have you ever had any healing arts license or certificate disciplined by another state or federal territory?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/>
NOTE: A "yes" response to question 26-41 requires a signed and dated written explanation. The <i>Explanation For Application Question</i> form may be used to provide your explanation.				

2018 MAR 21 PM 3:02

L1D

**APPLICANT:**  
(Print Legal Name)

Kelsey Pierson

**DATE OF BIRTH:**  
(mm/dd/yyyy)

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.*

Yes No

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?

Yes No

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

Yes No

45. Are you a registered sex offender?

Yes No

**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?

Yes No

47. Have you ever been treated for or had a recurrence of a diagnosed addictive disorder?

Yes No

48. Have you ever been diagnosed with an emotional, mental, or behavioral disorder that may impair your ability to practice medicine safely?

Yes No

49. Have you ever been diagnosed with a neurological or other physical condition that may impair your ability to practice medicine safely?

Yes No

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

Yes No

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?

Yes No

**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**

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

*AM*  
*4/17/18*

Photograph

Applicant  
Name & DOB

**DECLARATION**

The applicant, Kelsey A. Pinson  
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: 3/8/18

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 San Diego

Subscribed and sworn to (or affirmed) before me on this 08 day of March, 2018.

by, Kelsey A Pinson  
(PRINT APPLICANT'S LEGAL NAME) proved to me on the basis of satisfactory evidence

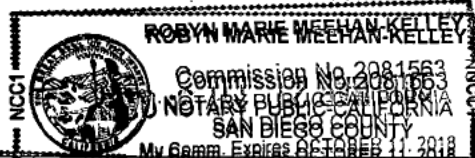
Applicant  
Name &  
Notary Date

to be the person who appeared before me.

SIGNATURE OF NOTARY PUBLIC

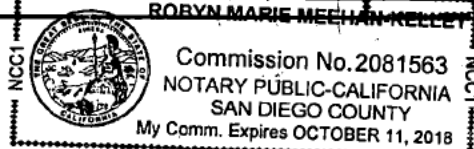
[Signature]

**NOTARY SEAL**



Notary  
Signature  
& Seal

ROBYN MARIE MEEHAN-KELLEY



**L1F**

RECEIVED  
MEDICAL BOARD OF



# MEDICAL BOARD OF CALIFORNIA

## Licensing Program



### CERTIFICATE OF MEDICAL EDUCATION

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

APPLICANT INFORMATION		MBC Use Only																																
Type or Print Legibly		Applicant Information																																
LEGAL NAME: Last <u>Pinson</u>	First <u>Kelsey</u> Middle <u>A.</u> Suffix	<input checked="" type="checkbox"/>																																
Date of Birth (mm/dd/yyyy)	Last 4 Digits of U.S. SSN or ITIN	Medical School Information																																
		<input checked="" type="checkbox"/>																																
MEDICAL SCHOOL: PLEASE COMPLETE THIS FORM IN THE ENGLISH LANGUAGE		School Code																																
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.		<u>NYU 9</u>																																
1. Name of Medical School	<u>New York University School of Medicine</u>	<input checked="" type="checkbox"/>																																
2. State/Province/Country	<u>NY, NY US</u>	<input checked="" type="checkbox"/>																																
3. The undersigned further certifies that the records of this institution show that the applicant attended in this institution <u>4</u> 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).		Rev. L2 Staff Initials & Date																																
<table border="0"> <tr> <td>Alcoholism and Chemical Dependency</td> <td>Geriatric Medicine</td> <td>Otolaryngology</td> <td>Psychiatry</td> </tr> <tr> <td>Anatomy</td> <td>Histology</td> <td>Pain Management and End-of-Life-Care**</td> <td>Radiology, including Radiation Safety</td> </tr> <tr> <td>Anesthesia</td> <td>Human Sexuality</td> <td>Pathology, Bacteriology, and Immunology</td> <td>Spousal Partner Abuse Detection &amp; Treatment***</td> </tr> <tr> <td>Biochemistry</td> <td>Medicine</td> <td>Pediatrics</td> <td>Surgery, including Orthopedic Surgery</td> </tr> <tr> <td>Child Abuse Detection and Treatment</td> <td>Neuroanatomy</td> <td>Pharmacology</td> <td>Therapeutics</td> </tr> <tr> <td>Dermatology</td> <td>Neurology</td> <td>Physical Medicine</td> <td>Tropical Medicine</td> </tr> <tr> <td>Embryology</td> <td>Obstetrics and Gynecology</td> <td>Physiology</td> <td>Urology</td> </tr> <tr> <td>Family Medicine*</td> <td>Ophthalmology</td> <td>Preventive Medicine, including Nutrition</td> <td></td> </tr> </table>		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	Preventive Medicine, including Nutrition		<u>NYU 9</u>
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	Preventive 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	<input type="checkbox"/>																																
5. What is the standard duration of the curriculum at this institution?	<u>4</u> years	<input type="checkbox"/>																																
6. Date the applicant was enrolled in medical school?	(mm/dd/yyyy) <u>8/19/13</u>	<input type="checkbox"/>																																
7. Date the applicant was issued the diploma of Bachelor/Doctor of Medicine	(mm/dd/yyyy) <u>5/17/17</u>	<input type="checkbox"/>																																
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?	Yes No	<input type="checkbox"/>																																
9. Was this applicant ever placed on probation?	Yes No	<input type="checkbox"/>																																
10. Was this applicant ever disciplined or placed under investigation?	Yes No	<input type="checkbox"/>																																
11. Were any limitations or special requirements imposed on this applicant because of questions of academic or disciplinary problems, or for any other reason?	Yes No	<input type="checkbox"/>																																
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.																																	
	<u>Maureen Deran</u> PRINTED NAME OF SCHOOL OFFICIAL	<u>Registrar</u> TITLE OF SCHOOL OFFICIAL																																
	<u>[Signature]</u> SIGNATURE OF SCHOOL OFFICIAL	<u>6/18/18</u> 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.																																		

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

07A-100 (Revised 7/2016)



## 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			
<b>LEGAL NAME:</b> Last		First		Middle		Suffix		Applicant Information <input type="checkbox"/>			
Pinson		Kelsey		Anna							
Date of Birth (mm/dd/yyyy)		Last 4 Digits of U.S. SSN or ITIN		Medical School of Graduation				Verified Program Information <input checked="" type="checkbox"/>			
[REDACTED]		[REDACTED]		New York University School of Medicine							
PROGRAM DIRECTOR TO COMPLETE ACGME OR RCPSC TRAINING INFORMATION											
Facility Name		UCSD								Unusual Circumstance <input type="checkbox"/> <input type="checkbox"/>	
Facility Address		9300 Campans Point Drive, MC 7433, La Jolla, CA 92037									
Specialty		ACGME 10-digit Program # <a href="https://apps.acgme.org/ads/Public">https://apps.acgme.org/ads/Public</a>		2200521044						Gen Med Required <input type="checkbox"/>	
Dates of Training (mm/dd/yyyy)		Start Date: 06/23/2017			End Date (or anticipated completion date): 06/30/2021						
UNUSUAL CIRCUMSTANCES											
<p><i>Program Director:</i> 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.</p>											
1. Did the applicant receive partial or no credit during his/her postgraduate training?							Yes	No	<input type="checkbox"/>		
2. Did the applicant ever take a leave of absence or break from his/her training?							Yes	No	<input type="checkbox"/>		
3. Was the applicant ever terminated, dismissed or expelled?							Yes	No	<input type="checkbox"/>		
4. Was the applicant ever placed on probation?							Yes	No	<input type="checkbox"/>		
5. Was the applicant ever disciplined or placed under investigation?							Yes	No	<input type="checkbox"/>		
6. Were any limitations or special requirements placed upon the applicant for clinical performance, professionalism, medical knowledge, discipline, or for any other reason?							Yes	No	<input type="checkbox"/>		
7. Did the program decline to renew or offer the applicant postgraduate training program contract for a following year?							Yes	No	<input type="checkbox"/>		
GENERAL MEDICINE TRAINING REQUIREMENT											
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?							<input checked="" type="checkbox"/> Yes		<input type="checkbox"/> No	<input type="checkbox"/>	
<p>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.</p>											

L3A

APPLICANT INFORMATION

LEGAL NAME: Last Pinson First Kelsey Middle Anna Suffix

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.

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.

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.

Verified PD Staff Initials & Date

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.

Handwritten initials and date: 7/23/18

D. Yvette LaCourse PRINTED NAME OF PROGRAM DIRECTOR

Program Director's Signature & Date

Signature of Program Director (Signature Stamp Is Not Acceptable)

7/6/2018 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.

SIGNATURE OF PROGRAM DIRECTOR: (SIGN FULL NAME IN THE PRESENCE OF NOTARY)

Program Director's 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 San Diego

Notary Signature & Seal

Subscribed and sworn to (or affirmed) before me on this 6th day of July, 2018

by, D. Yvette LaCourse (PRINT PROGRAM DIRECTOR'S NAME) proved to me on the basis of satisfactory evidence

Hospital Seal

to be the person who appeared before me.

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			Applicant Information
Pinson		Kelsey		Anna					
Date of Birth (mm/dd/yyyy)	Last 4 Digits of U.S. SSN or ITIN		Medical School of Graduation				Verified Program Information		
			New York University School of Medicine						
PROGRAM DIRECTOR TO COMPLETE ACGME OR RCPSC TRAINING INFORMATION								Verified PD Staff Initials & Date	
Facility Name	UCSD								
Facility Address	9300 Campus Point Drive, MC 7433 La Jolla, CA 92037								
Specialty	OB/GYN	ACGME 10-digit Program #		2200521044					
Dates of Training (mm/dd/yyyy)	Start Date: 06/23/2017			Anticipated Completion Date: 06/30/2021				Program Director's Signature & Date	
PROGRAM DIRECTOR OFFICIAL CERTIFICATION									
<p><b>ATTENTION PROGRAM DIRECTOR:</b> 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.</p> <p>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.</p> <p><u>D. Yvette LaCoursiere</u> PRINTED NAME OF PROGRAM DIRECTOR</p> <p><u>[Signature]</u> SIGNATURE OF PROGRAM DIRECTOR (Signature Stamp Is Not Acceptable)</p> <p><u>7/6/2018</u> DATE</p>								Program Director's Signature	
<p><b>NOTE:</b> If a hospital seal is not available, the program director shall also sign in the section below in the presence of a notary public.</p> <p>SIGNATURE OF PROGRAM DIRECTOR: <u>[Signature]</u> (SIGN FULL NAME IN THE PRESENCE OF NOTARY)</p> <p>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.</p> <p>State of <u>California</u> County of <u>San Diego</u> Subscribed and sworn to (or affirmed) before me on this <u>6th</u> day of <u>July</u>, 20<u>18</u>, by, <u>D. Yvette LaCoursiere</u> proved to me on the basis of satisfactory evidence (PRINT PROGRAM DIRECTOR'S NAME) to be the person who appeared before me.</p> <p><u>[Signature]</u> SIGNATURE OF NOTARY PUBLIC</p>									
<p><b>HOSPITAL OFFICIAL SEAL</b> Notary Public - California San Diego County Commission # 2151775 My Comm. Expires May 17, 2020</p>								Hospital Seal	
<p><b>L4</b></p>									

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



**Family Physician Training Program Voluntary Fee**

Would you like to contribute?

**Attachments**

**Fees**

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

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

7/17/20 8:48 PM

Page 1 of 2

License Type:	Physician and Surgeon A
License Number:	158192
File Number:	2036155
Application:	Physician's and Surgeon's Renewal
Application Number:	14753705
Application Date:	07/17/2020 (mm/dd/yyyy)

### Application Questions

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



### Personal Detail

First Name:	KELSEY
Middle Name:	ANNA
Last Name:	PINSON
Birthdate:	**/**/****
Gender:	

### Addresses

#### License Related Addresses

Address of Record

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?	<b>No</b>
Activities in Medicine	<b>Administration - None</b> <b>Other - 10-19 Hours</b> <b>Patient Care - 40+ Hours</b> <b>Research - 1-9 Hours</b> <b>Teaching - None</b> <b>Telemedicine - None</b>
Patient Care Practice Location	<b>Zip: 92037 County: SAN DIEGO</b>
Telemedicine Practice Location	<b>Zip: County:</b>
Patient Care Secondary Practice Location	<b>Zip: County:</b>
Telemedicine Secondary Practice Location	<b>Zip: County:</b>
Current Training Status	<b>Residency</b>
Areas of Practice	<b>Obstetrics and Gynecology - Primary</b>
Postgraduate Training Years	<b>3 Years</b>
Cultural Background	<b>[REDACTED]</b>
Foreign Language Proficiency	<b>[REDACTED]</b>
Web Site Profile	<b>Cultural Background - No</b> <b>Foreign Language Proficiency - No</b> <b>Gender - No</b>

**Fees**

Biennial Renewal Fee	<b>\$783.00</b>
DUE TO CURES FUND	<b>\$12.00</b>
StephenM.ThompsonLRP	<b>\$25.00</b>
Total Amount Due:	<b>\$820.00</b>

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: