STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY GEORGE DEUKMEJIAN, Governor

BOARD OF MEDICAL QUALITY ASSURANCE

1430 HOWE AVENUE
SACRAMENTO, CA 95825
(916) 920-6411

RECEIVED SACRAMENTO MEDICAL BOARD OF CALIFORNIA
JAN 16 1 30 PM '90

APPLICATION FOR PHYSICIAN AND SURGEON'S EXAMINATION OR LICENSURE

Read all instructions prior to completing this application. All questions on this application must be answered, and all supporting documents must be submitted with this application per instructions. **Please type or print neatly. When space provided is insufficient, attach additional sheets of paper.**

005347 590.00 01/90
008203 105.00 2/90
BMQA USE ONLY

PERSONAL DATA

1. Name: Last McColl First MILTON Middle BIRD
2. Other names you have used:
3. Social Security Number [redacted]
4. Address: Number and Street/Rural Route (include apartment number, if any) [redacted]
City [redacted] State [redacted] ZIP Code [redacted] Country [redacted]
5. Telephone Number: Home Work [redacted]
6. Date of Birth: Mo/Day/Yr [redacted]
7. Sex: ☐ Female ☑ Male
8. Are you a U.S. citizen? [redacted]
Submit a certified copy of birth certificate, Certificate of Naturalization, Declaration of Intention to become U.S. citizen (INS Form N300), VISA documents, or license to practice medicine. ☑
9. Have you ever filed an application for examination or licensure in California? ☐ Yes ☑ No ☐
If YES, give date of previous application:

NON-MEDICAL EDUCATION

10. List name and address of all colleges or universities attended other than schools where professional medical instruction was received. Submit an official transcript from each school attended.

Name	Address	Period of Attendance From (Mo/Yr)	To (Mo/Yr)	
STANFORD UNIV.	STANFORD, CA.	9/77	6/81	☑
				☐
				☐

MEDICAL EDUCATION

11. List name and address of all schools where professional medical instruction was received. Submit an original Certificate of Medical Education and official transcripts from each school attended.

Name	Address	Place Where Instruction Received	Period of Attendance From (Mo/Yr)	To (Mo/Yr)	CME	TRANS.
Stanford University	Stanford, CA.	Stanford CA.	9/81	3/88	☑	☑
					☐	☐
					☐	☐

12. Doctor of Medicine Degree granted by: (submit original medical diploma and a photocopy) ☑

Name of Medical School	Address of Medical School	Exact Date of Issuance
Stanford Univ.	Stanford, CA.	3/31/88

CA011
School Code

L1A

07A-100 80 86590

BMQA USE ONLY

13. Have you taken any of the following written examinations: National Boards, ECFMG, FMGEMS, FLEX, MSKP, MCAT, other related medical competency examinations? ☑ Yes ☐ No

If YES, list name, location, date and result of examination. Submit certification of scores from each examination agency.

WRITTEN EXAMINATION

Name	Location	Date	Result
MCAT	Rome, ITALY	1976	Passed
NB Part I	Stanford, CA	6/84	Passed
NB Part II	Switzerland	9/87	passed
NB Part III	California	5/89	passed

14. Have you received qualifying postgraduate training in U.S. or Canadian facilities? ☑ Yes ☐ No

If YES, list name and address of all facilities. Submit an original Certificate of Completion of ACGME Postgraduate Training (Form L3) from each facility.

POSTGRADUATE TRAINING

Name	Address	Type of Service	Period of Attendance From (Mo/Yr)	Period of Attendance To (Mo/Yr)
Santa Clara Valley	Medical Center, SAN JOSE CA	Intern	4/88	11/89

15. Have you been licensed to practice medicine in any state or country? ☐ Yes ☑ No

If YES, list state or country, license number, date issued and dates of practice in issuing agency's jurisdiction for each. Submit a Letter of Good Standing from each state in which you are licensed or have been licensed.

LICENSE DATA

LGS CE

State or Country	License Number	Date of Issuance	Dates of Practice in Issuing Agency's Jurisdiction From (Mo/Yr)	To (Mo/Yr)

16. Has any disciplinary action ever been taken regarding any healing arts license which you now hold or have ever held? Include any disciplinary actions by the U.S. Military, U.S. Public Health Service or other U.S. federal governmental entity.

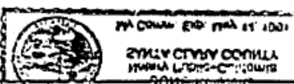
[redacted] If yes, give details below.

008503

State	Date	Charge	Disposition

07A-100

L1B



BMQA USE ONLY

LICENSE (continued)

17. Have you ever been denied a license, permission to practice medicine or any other healing arts, or permission to take an examination in any state, country, or U.S. federal jurisdiction?

If yes, give details below:

State or Country	Date of Denial	Reason for Denial

18. Have you been charged with unprofessional conduct or any other unlawful activity by any healing arts licensing authority or by the U.S. military and are awaiting final disposition by that body?

If yes, please explain on a separate sheet of paper.

19. Have you ever voluntarily surrendered a license to practice in the healing arts in another state?

If yes, please explain on a separate sheet of paper.

20. Have you ever had staff privileges in a hospital denied, suspended or revoked, or resigned from a medical staff in lieu of disciplinary action?

If yes, please explain on a separate sheet of paper.

GENERAL DATA

21. Are you now, or have you been in the past, addicted to or treated for addiction to controlled substances, such as narcotics or alcohol?

If yes, please explain on a separate sheet of paper.

22. Have you ever been convicted of, or pled nolo contendere to a violation of any federal, state or local law relating to the manufacture, distribution or dispensing of controlled substances, or to drug addiction?

If yes, give details below:

Violation and Location	Date	Penalty or Disposition

23. Have you ever been convicted of, or pled nolo contendere to any offense, misdemeanor or felony of any state, the United States, or a foreign country? (except violations of traffic laws resulting in fines of $75.00 or less.)

If yes, give details below:

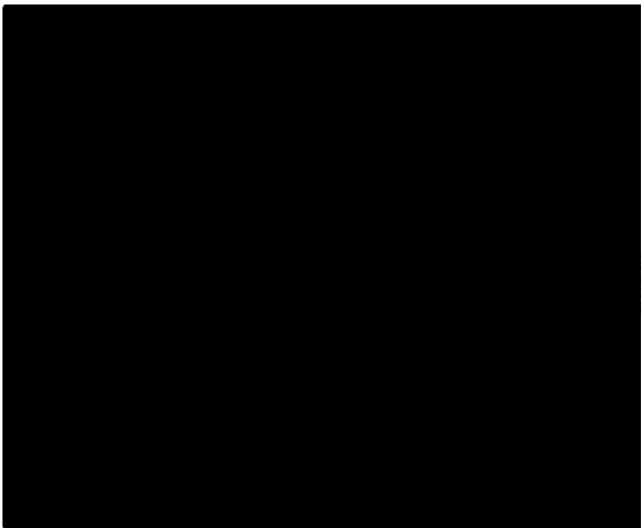
Violation and Location	Date	Penalty or Disposition

You are required to list any conviction that has been set aside and dismissed under Section 1203.4 Penal Code or under any other provision of law.

"Disclosure of your social security number is mandatory. Section 30 of the Business and Professions Code and Pub. L. 94-455 (42 U.S.C.A. 405 (c) (2) (C)) authorizes collection of your social security number. Your social security number will be used exclusively for tax enforcement purposes. If you fail to disclose your social security number, you will be reported to the Franchise Tax Board, which may assess a $100 penalty against you."

L1C

07A-100



TOP

BOTTOM

I hereby declare under penalty of perjury under the laws of the State of California, that the photo of myself attached hereto, was taken

on or about ______ 19___

my age then being ______ years;

color of hair ______;

color of eyes ______;

height ______ ft. ______ in.;

weight ______ lbs.;

identifying marks ______

NOTE: All items in 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, per Section 2080 of the Business and Professions Code which authorizes the collection of this information. Information regarding the issuance or denial of a license by the Board may be transmitted to any other medical licensing authority or the Federation of State Medical Boards. Applicants have the right to review their application subject to the provisions of the Information Practices Act. The Program Manager of the Division of Licensing is the custodian of records.

STATE OF CALIFORNIA)

COUNTY OF SANTA CLARA)

MILTON BIRD McCOLL being duly sworn, says __he is the person referred to in the foregoing application for a physician and surgeon's certificate in California and that __he has carefully read and thoroughly understands all the requirements therein and that the statements made herein and all attachments are true and correct under penalty of perjury under the laws of the State of California.

__He requests that the Division of Licensing, Board of Medical Quality Assurance, initiate a review of the records to determine their eligibility for examination, postgraduate training or licensure in California. In making this request, __he authorizes the release of any information or records held by any individual or agency, relative to their training and qualifications as a physician and surgeon, upon request by the Board for use in evaluating their file.

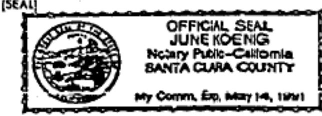
Milton Bird McColl
Signature of applicant in FULL (Do not use INITIALS ONLY)

Signed and sworn to before me this 1st day of November, 19 89

Signature of Notary Public June Koenig

Address 251 N. Bascom Ave, San Jose

[SEAL]



My commission expires 5-14-91

L1D

07A-100

STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY — GEORGE DEUKMEJIAN, Governor

DEPARTMENT OF Consumer Affairs

BOARD OF MEDICAL QUALITY ASSURANCE

1430 HOWE AVENUE, SACRAMENTO, CALIFORNIA 95825
(916) 920-6411

CERTIFICATE OF MEDICAL EDUCATION

MEDICAL SCHOOL: DO NOT COMPLETE IF PHOTOGRAPH OF APPLICANT/STUDENT IS NOT ATTACHED BELOW.

This certifies that MILTON BIRD McCALL (FULL NAME OF APPLICANT)

of [redacted] (ADDRESS WHEN ENROLLED) enrolled in STANFORD UNIV. SCHOOL OF Medicine (NAME OF MEDICAL SCHOOL)

Stanford, CA 94305 (LOCATION) on the 30th day of September (MONTH) 1981 (YEAR)

and was granted the following credits on enrollment:

Premedical Education. Two years of preprofessional postsecondary education, including the subjects of physics, chemistry, and biology (Business and Professions Code Section 2088).

______ (EDUCATIONAL INSTITUTION) ______ (DATES)

Advanced Credits. Credits previously obtained at an approved medical school.*

______ (MEDICAL SCHOOL) ______ (TOTAL CREDITS) ______ (DATES)

The undersigned further certifies that the records of this institution show that __he ~~attended in this institution ______ (SPECIFY NUMBER) courses of resident instruction of ______ (NUMBER OF WEEKS) weeks each, completing at least 4,000 hours, of which at least 80 percent actual attendance is re-~~ received sufficient hours of medical instruction and units of credit quired, in the subjects set forth hereunder (Business and Professions Code Section 2089), and that

- [X] __he was granted the degree Bachelor/Doctor of Medicine by
- [ ] __he withdrew from

the above mentioned medical school on the 31st day of March (MONTH) 1988.

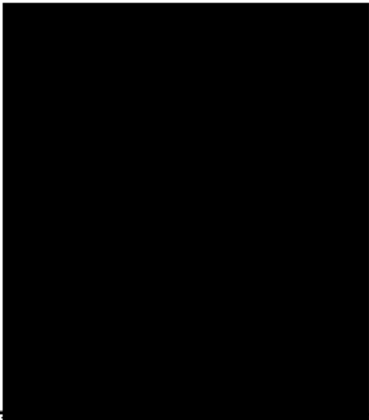
Anatomy
Otolaryngology
Obstetrics and Gynecology
Radiology, including Radiation Safety
Tropical Medicine
Physiology
Biochemistry
Pathology, Bacteriology and Immunology
Ophthalmology

Dermatology
Embryology
Histology
Human Sexuality as defined in Section 2090
Medicine
Surgery, including Orthopedic Surgery
Urology
Psychiatry
Neurology

Preventive medicine, including Nutrition
Physical Medicine
Therapeutics
Neuroanatomy
Child Abuse Detection and Treatment
Geriatric Medicine
Pediatrics
Pharmacology
Anesthesia

For the MD degree from Stanford, this graduate has had no less than 4000 hours of instruction covering the topics listed on the application.

For the MD degree from Stanford, this graduate has had no less than 4000 hours of instruction covering the topics listed on the application.



Signed and the college seal affixed this 30th day of October, 1989.

BY [signature] (PRESIDENT, SECRETARY, DEAN)
Joy Parker/Assistant Registrar and Recorder
Stanford University

Medical School Seal MUST Be Imprinted Partially on the Photograph.

TRANSCRIPTS OF PREMEDICAL EDUCATION, ADVANCED CREDITS, AND MEDICAL SCHOOL CREDITS MUST BE SUPPLIED WITH THIS CERTIFICATE

* Each school where professional medical instruction was received MUST complete one of these forms. If more than one school was attended, photocopies of the blank form may be made and used. Note that photograph and all entries to the form must be original.

L2

STATE OF CALIFORNIA—STATE AND CONSUMER SERVICES AGENCY GEORGE DEUKMEJIAN, Governor

BOARD OF MEDICAL QUALITY ASSURANCE
1430 HOWE AVENUE, SACRAMENTO, CALIFORNIA 95825
(916) 920-6411

CERTIFICATE OF COMPLETION OF ACGME POSTGRADUATE TRAINING

To be completed by the facility for every medical school graduate completing postgraduate training in the United States or Canada. Do not complete if photograph of applicant is not attached below. Please type or print.

This is to certify that Milton B. McColl (NAME OF APPLICANT)

a graduate of Stanford University (NAME OF MEDICAL SCHOOL)

formally commenced an accredited postgraduate training program at Santa Clara Valley Medical Center 751 So. Bascom Avenue San Jose CA 95128 (NAME AND ADDRESS OF FACILITY) in Transitional Year Program (SPECIALTY)

on April 1, 1988, and completed such training on November 24, 1989.

This training consisted of 12 months of actual clinical instruction and is approved by the Accreditation Council for Graduate Medical Education (ACGME) or the Coordinating Council of Medical Education of the Canadian Medical Association (CCME) and consisted of the following rotations:

(List rotations completed. If service was not rotating, indicate type of straight training performed. NOTE—To qualify for licensure in California, graduates of foreign medical schools must have completed at least four months of postgraduate training in general medicine. ACGME or CCME residencies in family practice, internal medicine, surgery, pediatrics, and ob/gyn would normally satisfy this requirement.)

ROTATION	LENGTH OF ROTATION
Medicine	3 months
Orthopedics	1 month
OB/GYN	1 month
Pediatrics	2 months
Emergency	1 month
General Surgery	1 month
Radiology	1 month
Rheumatology	1 month
Elective	1 month

(AFFIX SEAL OF HOSPITAL OR NOTARY PUBLIC)

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 facility is approved by the ACGME or the CCME to offer the type and level of training completed by the applicant and that the applicant was trained in an approved ACGME or CCME program position.

NAME Phillip M. Benaron, M.D. (DIRECTOR OF MEDICAL EDUCATION)

ADDRESS Santa Clara Valley Medical Center
751 So. Bascom Avenue San Jose, CA 95128

PHONE NUMBER [redacted]

DATE November 24, 1989

SIGNATURE [signature]

L3

Application Summary

License Type:	**Physician and Surgeon G**
License Number:	**68043**
File Number:	**219570**
Application:	**Physician's and Surgeon's Renewal**
Application Number:	**14860907**
Application Date:	**07/20/2021 (mm/dd/yyyy)**

Application Questions

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

Personal Detail

First Name:	**MILTON**
Middle Name:	**BIRD**
Last Name:	**MCCOLL**
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.**

Financial Interest Disclosure Summary

Health-Related Facility Name: **None**

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**
	Other - None
	Patient Care - 20-29 Hours
	Research - None
	Teaching - 1-9 Hours
	Telemedicine - 1-9 Hours
Patient Care Practice Location	**Zip: 95035 County: SANTA CLARA**
Telemedicine Practice Location	**Zip: 95035 County: SANTA CLARA**
Patient Care Secondary Practice Location	**Zip: County:**
Telemedicine Secondary Practice Location	**Zip: County:**
Current Training Status	**Not in Training**
Areas of Practice	**Family Medicine - Primary**
Board Certifications	**American Board of Family Medicine - Family Medicine**
Postgraduate Training Years	**4 Years**
Cultural Background	**European**
Foreign Language Proficiency	
Web Site Profile	**Cultural Background - Yes**
	Foreign Language Proficiency - No
	Gender - Yes
E-mail:	

Fees

Biennial Renewal Fee	**$783.00**
DUE TO CURES FUND	**$22.00**
StephenM.ThompsonLRP	**$25.00**

Total Amount Due: **$830.00**

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

License Type:	**Physician and Surgeon G**
License Number:	**68043**
File Number:	**219570**
Application:	**Physician's and Surgeon's Renewal**
Application Number:	**14635191**
Application Date:	**06/08/2019 (mm/dd/yyyy)**

Application Questions

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

Personal Detail

First Name:	**MILTON**
Middle Name:	**BIRD**
Last Name:	**MCCOLL**
Birthdate:	****/**/******
Gender:	**Male**

Addresses

License Related Addresses

Address of Record (Required)

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.**

Financial Interest Disclosure Summary

Health-Related Facility Name: **None**

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 - None**
	Other - 1-9 Hours
	Patient Care - 40+ Hours
	Research - 1-9 Hours
	Teaching - 1-9 Hours
	Telemedicine - None
Patient Care Practice Location	**Zip: 95128 County: SANTA CLARA**
Telemedicine Practice Location	**Zip: County:**
Patient Care Secondary Practice Location	**Zip: County:**
Telemedicine Secondary Practice Location	**Zip: County:**
Current Training Status	**Residency**
Areas of Practice	**Family Medicine - Primary**
Board Certifications	**None**
Postgraduate Training Years	**7 Years**
Cultural Background	**White**
Web Site Profile	**Cultural Background - Yes**
	Foreign Language Proficiency - Yes
	Gender - Yes
E-mail:	

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

License Type:	**Physician and Surgeon G**
License Number:	**68043**
File Number:	**219570**
Application:	**Physician's and Surgeon's Renewal**
Application Number:	**14412543**
Application Date:	**07/02/2017 (mm/dd/yyyy)**

Application Questions

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

Personal Detail

First Name:	**MILTON**
Middle Name:	**BIRD**
Last Name:	**MCCOLL**
Birthdate:	****/**/******
Gender:	**Male**

Addresses

License Related Addresses

Address of Record (Required)

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Confidential Address

Warning: **In order to protect your privacy and identity, address will not be displayed.**

Financial Interest Disclosure Summary

Health-Related Facility Name: **None**

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.	

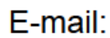
Family Physician Training Program Voluntary Fee

Voluntary Fee:	

Attachments

Physician Survey

Are you retired?	**No**
Activities in Medicine	**Administration - None**
	Other - None
	Patient Care - 40+ Hours
	Research - None
	Teaching - None
	Telemedicine - None
Patient Care Practice Location	**Zip: County: SANTA CLARA**
Telemedicine Practice Location	**Zip: County:**
Patient Care Secondary Practice Location	**Zip: County:**
Telemedicine Secondary Practice Location	**Zip: County:**
Current Training Status	**Residency**
Areas of Practice	**Family Medicine - Primary**
Board Certifications	**None**
Postgraduate Training Years	**2 Years**
Cultural Background	**White**
Foreign Language Proficiency	
Web Site Profile	**Cultural Background - Yes**
	Foreign Language Proficiency - No
	Gender - Yes



E-mail:

Fees

Biennial Renewal Fee	**$783.00**
DUE TO CURES FUND	**$12.00**
Steven M. Thompson Physician Corps Loan Repayment Program	**$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: