



**OSTEOPATHIC MEDICAL BOARD OF CALIFORNIA**  
 1300 National Drive, Suite 150, Sacramento CA 95834-1991  
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**QUARTELRLY DECLARATION**

**INTSRUCTIONS:** Pease type and print neatly. ALL requested information and questions on this form must be answered. When space provided is insufficient, attach additional sheets of paper. All attachments are considered part of the Declaration. You may wish to make and retain a copy of the material submitted to the Osteopathic Medical Board. Submit the completed Declaration to your assigned probation monitor.

**Check Appropriate Box for Reporting Period Covered**

- Reporting Period
- January - March (First Quarter)
  - April - June (Second Quarter)
  - July - September (Third Quarter)
  - October – December (Fourth Quarter)

- Due to the Board by:
- April 10
  - July 10
  - October 10
  - January 10

Name: First	Middle	Last	Alias		
Home Address: Number & Street	City	State	Zip	Phone	
Primary Place of Practice (Include addition places of practice on reverse)					
Address: Number & Street	City	State	Zip	Phone	
Work Email	Personal				Mobile Phone
Number of hours worked this period at your primary place of practice?		Per Week	Per Month		
What is your work schedule at your primary place of practice?					

**The following questions refer to the time period since your last quarterly Declaration**

1. Have you violated any court of city ordinances, been arrested, charged, convicted of, pled nolo contendere in any state or federal court or foreign country to any misdemeanor, felony, or other offense? (If yes, specify which one in your explanation. Exclude parking tickets).	Yes	No
2. Have you violated, been arrested, convicted of, or received a citation for driving under the influence of alcohol or drugs, reckless driving, or any other vehicle code violation involving alcohol or drugs?	Yes	No
3. Are you required to undergo biological fluid testing by any directive other than what is in your Order? If yes, when were you lasted tested and what is the frequency of testing?	Yes	No
4. Is there any government, civil suit, malpractice, or peer review proceeding pending against you?	Yes	No
5. Have you resigned from any employment or has your employment been terminated?	Yes	No
6. Are you in the process of applying for any other business or professional license or certificate?	Yes	No
7. Have you had to report any theft or loss of controlled substances to the Department of Justice?	Yes	No
8. Have you had to report a patient death in an outpatient surgery setting pursuant to Business and Professions Code section 2240(a)?	Yes	No
9. Did you cease practicing since your last report? If yes, give the date you ceased practice.	Yes	No
10. Have you been denied, had a license or certificate to practice a business or profession suspended, revoked or surrendered or otherwise disciplined by any other federal, state, government agency or other country?	Yes	No
11. Have you maintained a current and valid license?	Yes	No
12. Are you in compliance with the Cost Recovery requirement of your probationary order?	Yes	No
13. Have you complied with each term and condition of your probation?	Yes	No

**\*If you answered YES to the above questions numbered 1-11 and NO to questions numbered 11-13, you must explain in detail on an attached sheet of paper.**

List the name, address and work schedule (hours/days) of any other locations where you practiced medicine. (i.e. convalescent/nursing homes etc.) Provide the phone number of the Medical Director or Chief of Staff, if applicable.

If you are required to complete additional continuing education courses, please indicate the courses you completed this quarter, if any. Attach a copy of the CME certificate.

If you are required to have a practice monitor please provide the name of the individual and how many times you met during this last quarter.

List any new staff and include their title and specialty, if applicable.

What question(s), if any, do you have for your probation monitor regarding your probation?

**Executed on** \_\_\_\_\_, **20**\_\_\_\_, **at** \_\_\_\_\_, \_\_\_\_\_  
(City) (State)

I hereby submit this Quarterly Declaration as required by the Osteopathic Medical Board of California and its Order of probation thereof and declare under penalty of perjury under the laws of the State of California that I have read the foregoing declaration and any attachments in their entirety and know their contents and that all statements made are true in every respect and I understand and acknowledge that any misstatements, misrepresentations, or omissions of material fact may be cause for further disciplinary action.

\_\_\_\_\_  
Probationer (Print Name)

\_\_\_\_\_  
Signature