OSTEOPATHIC MEDICAL BOARD OF CALIFORNIA

Expert Reviewer Program

ORIGINAL/RENEWAL APPLICATION

NAME: **LAST** **FIRST** **MI**			
MAILING ADDRESS:	**CITY:**	**STATE:** CA	**ZIP:**
ALTERNATE MAILING ADDRESS (NOT A P.O. BOX) FOR EXPERT PACKAGES:	**CITY:**	**STATE:** CA	**ZIP:**
DIRECT TELEPHONE NUMBER AND EXTENSION:	**OTHER TELEPHONE NUMBER: (Please identify e.g., work, cell, etc.)**		
CA PHYSICIAN/SURGEON LICENSE NUMBER:	**E-MAIL ADDRESS:**		

1. List all current Specialty Board Certifications. Include specialty/ subspecialty and date(s) of practice [e.g., internal medicine (2009-2019/ endocrinology 2010-2020)]. Also include certificates from the American Boards of Facial Plastic & Reconstructive Surgery, Pain Medicine, Sleep Medicine and Spine Surgery or any other non-ABMS or AOA certificates held.

2. Describe your active medical practice or employment. [Active practice is defined as at least 80 hours per month in direct patient care or clinical activity or teaching, of which 40 hours must involve direct patient care.] Include any special procedures (e.g., laparoscopic surgery) or modalities (e.g., alternative medicine) that you employ in your practice. Identify if OMT is used in your practice. Also, identify any special training you have received that is not listed above.

3. Have you retired from active medical practice or employment? ☐ Yes ☐ No [If yes, provide date of retirement and explain.]

4. List each hospital and location where you currently have full privileges. Identify your specialty or subspecialty for each hospital listed.

5. List any **current** faculty appointment(s); date and type of appointment(s) [e.g., full time, clinical, adjunct, emeritus, etc.]; your title; and, the name and the location of each Institution.

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1300 National Drive, Suite 150, Sacramento, CA 95834-1991 **Email**: Osteopathic@dca.ca.gov **Fax**: (916) 928-8392 **Web**: www.ombc.ca.gov

6. Describe any prior peer review experience (hospital, medical society, or equivalent).

7. Has any medical licensing board, other agency, or hospital (including the U. S. Military, U. S. Public Health Service or other U. S. federal governmental entity) filed or taken disciplinary action regarding any healing arts license which you now hold or ever held, for unprofessional conduct, professional incompetence, gross negligence, or repeated negligent acts? ☐ Yes ☐ No [If yes, please explain in "Comments" section.]

8. Has a claim or action for damages ever been filed against you in the course of the practice of medicine or any other healing art which resulted in a malpractice settlement over $30,000 or an arbitration award of any amount? ☐ Yes ☐ No [If yes, please explain in "Comments" section.]

9. Have you ever voluntarily surrendered a license to practice in the healing arts in this or any other state, or voluntarily surrendered your narcotic (controlled substance) permit (state or federal) to any licensing board or any other agency, or is any such action pending? ☐ Yes ☐ No [If yes, please explain in "Comments" section.]

10. Have you ever had staff privileges in a hospital been denied, suspended, limited, revoked or not renewed for medical disciplinary cause, or resigned from a medical staff in lieu of disciplinary or administrative action, or is any such action pending? ☐ Yes ☐ No [If yes, please explain in "Comments" section.]

11. Have you ever been arrested, convicted or pled *nolo contendere* to any violation of any federal, state or local law of any state in the United States, or a foreign country? [**You are required to list any conviction that has been set aside and dismissed or expunged, or where a stay of execution has been issued.**]
☐ Yes ☐ No [If yes, please explain in "Comments" section.]

12. Any additional information you wish to provide:

Additional contact numbers (if any): _____

Most efficient contact time/ method: _____

Have you ever testified/supported your medical opinion (as an expert witness) in court/formal setting (for OMBC or otherwise)? _____

COMMENTS [Identify corresponding question number]

PRIVACY NOTICE: ***The information provided on this application is maintained by the Executive Office of the Osteopathic Medical Board of California (OMBC), 1300 National Drive, Suite 150, Sacramento, CA 95834, under the authority granted by the Business and Professions Code, Division 2, Chapter 5, Article 13, Section 2332. It is mandatory that you provide all information requested. Omission of any item of information will result in the application being rejected as incomplete. Your completed application becomes the property of the OMBC and will be used by the authorized personnel to determine your eligibility for participation in the Expert Reviewer Program. Information on your application may be transferred to other governmental or law enforcement agencies. You have the right to review the records maintained on you by the OMBC unless the records are exempt from disclosure.***

I hereby certify that all statements made in this application are true and complete, and I understand that any misstatements of material facts will subject me to disqualification. I have attached current *curriculum vitae* to this application.

_____ _____

Signature **Date**

Mail completed Original Application to: **Osteopathic Medical Board of California**
Expert Reviewer Program
1300 National Drive, Suite 150
Sacramento, CA 95834-1991

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