BUSINESS, CONSUMER SERVICES AND HOUSING AGENCY • GAVIN NEWSOM, GOVERNOR
DEPARTMENT OF CONSUMER AFFAIRS • OSTEOPATHIC MEDICAL BOARD OF CALIFORNIA
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Quarterly Declaration

INSTRUCTIONS: Please type or 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 Quarterly Declaration. You may wish to make and retain a copy of the material submitted to the Osteopathic Medical Board of California (Board). YOU CAN MAIL or EMAIL your Quarterly Declaration.

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 10th
July 10th
October 10th
January 10th

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 Email	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 any questions numbered 1-10 and NO to any questions numbered 11-13, <u>you must explain in detail on an attached sheet of paper.</u>**

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 for 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 _____ _____
(Month & Day) (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 or failure to submit complete and timely reports may be cause for further disciplinary action.

_____ _____
Probationer (Print Name) Signature