MEDICAL BOARD OF CALIFORNIA
Expert Reviewer Program

RENEWAL APPLICATION

The initial term of appointment as an Expert Reviewer for the Medical Board of California (Board) was for three years. If you would like to continue as an Expert Reviewer, please complete the Renewal Application and attach a current *curriculum vitae*. If you have any questions, please contact the Expert Reviewer Program Analyst at MBCMedicalExpertProgram@mbc.ca.gov.

LAST NAME:	FIRST NAME:	MIDDLE NAME:	SUFFIX

MAILING ADDRESS:	CITY:	STATE	ZIP:
		CA	
ALTERNATE MAILING ADDRESS (NOT A P.O. BOX) FOR EXPERT PACKAGES:	CITY:	STATE:	ZIP:
		CA	

TELEPHONE NUMBER: CELL NUMBER: WORK NUMBER:

CALIFORNIA PHYSICIAN/SURGEON LICENSE NUMBER	EMAIL ADDRESS:
BUSINESS NAME:	FICTICIOUS NAME PERMIT (FNP) NUMBER:

1. List all current American Board of Medical Specialties (ABMS) Certificates. Include specialty/subspecialty and date(s) of practice [e.g., internal medicine (2000-2020)/endocrinology (2002-2022)]. Also include certificates from the American Boards of Facial Plastic & Reconstructive Surgery, Pain Medicine, Sleep Medicine and Spine Surgery or any other non-ABMS 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. Also, identify any special training you have received that is not listed above.

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

4. 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.

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

Telephone: (818) 551-2129 or (818) 539-8314 **FAX:** (818) 551-2131 **Email:** MBCMedicalExpertProgram@mbc.ca.gov **Web:** www.mbc.ca.gov/enforcement/expert_reviewer/

Applicant:

Questions 6-10 (If yes, explain in "Comments" section below.)		
6.	Have you retired from active medical practice or employment? If yes, provide date of retirement and explain. Retirement Date: Reason:	☐ Yes ☐ No
7.	Have you been disciplined by the Board or any other state medical board, or have disciplinary charges been filed against you in any state since you were approved as an Expert Reviewer?	☐ Yes ☐ No
8.	Have you ever been arrested, convicted or pled *nolo contendere* to any criminal act since you were approved as an Expert Reviewer?	☐ Yes ☐ No
9.	Have you been contacted by the Board to review any cases?	☐ Yes ☐ No
10.	Have you ever testified/supported your medical opinion (as an expert witness) in court/formal setting (for the Board or otherwise)?	☐ Yes ☐ No

COMMENTS [Identify corresponding question number and/or add any comments you may have regarding the Expert Reviewer Program.]

PRIVACY NOTICE: *The information provided on this application is maintained by the Executive Office of the Medical Board of California (Board), 2005 Evergreen Street, Suite 1200, Sacramento, CA 95815, 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 Board 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 Board 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 a current *curriculum vitae* to this application.

_____ _____

Signature **Date**

Mail completed Original Application to:

Medical Board of California
Expert Reviewer Program
320 Arden Avenue, Suite 250
Glendale, CA 91203

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PRACTICE AREA DEFINERS

Please mark current active practice (practice detail) and indicate any other area of interest/expertise within your specialty(ies)

- ☐ **ADDICTION MEDICINE**
- ☐ **ALLERGY and IMMUNOLOGY**
- ☐ **ALTERNATIVE/COMPLEMENTARY/INTEGRATIVE MEDICINE**
  - ☐ Acupuncture
  - ☐ Chinese Herbal
  - ☐ Homeopathic/Naturopathic
  - ☐ Medical Marijuana
  - ☐ Other _____
- ☐ **ANESTHESIOLOGY**
  - ☐ Hospital Based
  - ☐ Office Based
  - ☐ Pain Medicine
  - ☐ Other _____
- ☐ **CARDIOLOGY**
  - ☐ General Cardiology
  - ☐ Nuclear Cardiology
  - ☐ Interventional Cardiology
  - ☐ Pediatric Cardiology
  - ☐ Non-Interventional/Non Invasive
- ☐ **CARDIOVASCULAR DISEASE**
- ☐ **COLON/RECTAL SURGERY**
- ☐ **CORRECTIONAL MEDICINE**
- ☐ **DERMATOLOGY**
  - ☐ Special Interest In Cosmetic Procedures
- ☐ **EMERGENCY MEDICINE**
- ☐ **ETHICS**
  - ☐ Hospice and Palliative
  - ☐ Professional Review/Ethics Committee Experience:
    - ☐ Current
    - ☐ Past Experience
- ☐ **FAMILY MEDICINE**
- ☐ **GASTROENTEROLOGY-HEPATOLOGY**
  - ☐ Bariatric Procedures
  - ☐ Diagnostic ERCP
  - ☐ Endoscopic Ultrasound
  - ☐ Hepatology
  - ☐ Endoscopy with Laser Usage
  - ☐ Manometry
  - ☐ Placement Of Expandable Stents
  - ☐ Pneumatic Dilatation of the Esophagus
  - ☐ Therapeutic ERCP (Sphincterotomy, Stents, Biliary Dilatation, Etc.)
- ☐ **INTERNAL MEDICINE**
  - ☐ General Internal Medicine
  - ☐ Hospitalist
  - ☐ Cystic Fibrosis
  - ☐ Pain Management
  - ☐ Other _____
- ☐ **MEDICAL GENETICS**
- ☐ **NEUROLOGICAL SURGERY**
  - ☐ Brain
  - ☐ Spine
- ☐ **NEUROLOGY**
  - ☐ Peripheral Nerve
  - ☐ Other _____
- ☐ **NEUROLOGY WITH SPECIAL QUALIFICATIONS IN CHILD NEUROLOGY**
- ☐ **NUCLEAR MEDICINE**
- ☐ **ORAL & MAXILLOFACIAL SURGERY**
- ☐ **OB-GYN**
  - ☐ General Ob-Gyn
  - ☐ Endocrinology
  - ☐ Endometrial Ablation
  - ☐ Infertility
  - ☐ High Risk Pregnancies
  - ☐ Robotic Surgery
  - ☐ Therapeutic Abortions
  - ☐ Urogynecology
  - ☐ No Obstetrics/Gynecology Only
  - ☐ Treatment of Urinary Continence Problems
  - ☐ With Experience Supervising Midwives
  - ☐ Other _____
- ☐ **OPHTHALMOLOGY**
  - ☐ General Ophthalmology
  - ☐ Corneal Surgery
  - ☐ AIDS Eye
  - ☐ Laser Surgery
  - ☐ Glaucoma
  - ☐ LASIK
  - ☐ Cataract
  - ☐ Neuro-Ophthalmology
  - ☐ Ocular Oncology (Eye Tumors)
  - ☐ Orbital and Ophthalmic Plastic Surgery
  - ☐ Pediatric Ophthalmology
  - ☐ Retina/Vitreoretinal Surgery/Uveitis
  - ☐ Other _____
- ☐ **ORTHOPAEDICS**
  - ☐ Arthroscopic Endoscopic Procedures
  - ☐ Hand Surgery
  - ☐ Elbow Surgery
  - ☐ Hip Replacement
  - ☐ Joint Replacement
  - ☐ Knee Surgery
  - ☐ Spinal Surgery
  - ☐ Pediatric Orthopaedics
  - ☐ Shoulder Surgery
  - ☐ Other _____
- ☐ **OTOLARYNGOLOGY**
  - ☐ General ENT
  - ☐ Cochlear Implant
  - ☐ Other _____
- ☐ **PAIN MEDICINE**
  - ☐ Hospital Based
  - ☐ Office Based
- ☐ **PATHOLOGY**
- ☐ **PEDIATRICS**
  - ☐ General Pediatrics
  - ☐ Pediatric Alternative/Complementary/Integrative
  - ☐ Other _____
- ☐ **PHYSICAL MEDICINE and REHABILITATION**
- ☐ **PLASTIC SURGERY**
  - ☐ Cosmetic Surgery
  - ☐ Hand Surgery
  - ☐ Laser Surgery
  - ☐ Lipectomy
  - ☐ Liposuction
  - ☐ Neograft
  - ☐ Hair Transplant
  - ☐ Gender Reassignment Surgical Procedure:
    - ☐ Female to Male
    - ☐ Male to Female
  - ☐ Other _____
- ☐ **PUBLIC HEALTH and GENERAL PREVENTIVE MEDICINE**
  - ☐ Clinical Informatics
  - ☐ Undersea & Hyperbaric Medicine
  - ☐ Other _____
- ☐ **PSYCHIATRY**
  - ☐ Addiction Psychiatry
  - ☐ Adult
  - ☐ Child/Adolescent
  - ☐ ECT
  - ☐ Epilepsy
  - ☐ Forensic Psychiatry
  - ☐ Geriatric Psychiatry
  - ☐ Pain Management
  - ☐ Psychoanalysis
  - ☐ Psychopharmacology
  - ☐ Psychosomatic
  - ☐ With Experience Supervising Psychological Assistants
- ☐ **RADIOLOGY**
- ☐ **RADIATION ONCOLOGY**
- ☐ **SLEEP MEDICINE**
- ☐ **SPINE SURGERY**
- ☐ **STEM CELL**
- ☐ **SURGERY**
  - ☐ Bariatric/Gastric Bypass Surgery
  - ☐ Laparoscopic Surgery
  - ☐ Pediatric Surgery
  - ☐ General Surgery
  - ☐ Laser Surgery
  - ☐ Robotic Surgery
  - ☐ Trauma Surgery
  - ☐ Endocrine/Thyroid Surgery
  - ☐ Other _____
- ☐ **THORACIC and CARDIAC SURGERY**
  - ☐ Congenital Cardiac Surgery
  - ☐ Pediatric Cardiac Surgery
  - ☐ Adult Cardiac Surgery
  - ☐ Other _____
- ☐ **TOXICOLOGY**
- ☐ **UROLOGY**
  - ☐ Gender Reassignment Surg. Procedure
  - ☐ Robotic Surgery
- ☐ **VASCULAR SURGERY**

Yes	No	
☐	☐	Are you willing to perform mental evaluation or physical examination of a licensee, if needed?
☐	☐	Do you supervise physician assistants?
☐	☐	Do you supervise nurse practitioners /midwives/nurse midwives?
☐	☐	Do you have special training or use any procedure, practice modalities, etc., not listed? If yes, please describe:

_____

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_____

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