MEDICAL BOARD
OF CALIFORNIA
Protecting consumers by advancing high quality, safe medical care.

Enforcement Program
Refer to www.mbc.ca.gov for office locations

Gavin Newsom, Governor, State of California | Business, Consumer Services and Housing Agency | Department of Consumer Affairs

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 Medical Board of California (Board). The Board requires an original signature on each Quarterly Declaration. Mail the completed Quarterly Declaration to your assigned probation monitor. DO NOT FAX OR EMAIL your Quarterly Declaration. Signatures on faxed or emailed Quarterly Declarations will not be accepted.

Check Appropriate Box for Reporting Period Covered

Reporting Period	Due to the Board No Later Than
☐ January - March (First Quarter)	April 10
☐ April - June (Second Quarter)	July 10
☐ July - September (Third Quarter)	October 10
☐ October - December (Fourth Quarter)	January 10

Name: First	Middle	Last	Aliases
Home Address: Number & Street	City	State	Zip
Primary Place of Practice (include additional places of practice on reverse)			
Address: Number & Street	City	State	Zip

Home Phone Number	Work Phone Number	Cell Phone Number

Email Address(es):

Personal _____ Work _____

Indicate the number of hours worked this quarter at your primary place of practice:	What is your work schedule at this place of practice? Include days and time.
Per week Per month	

The Following Questions Refer to the Time Period Since Your Last Quarterly Declaration

1.	Have you violated any county or 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 last tested and what is the frequency of testing?	☐ Yes*	☐ No
4.	Have you had a medical malpractice settlement over $30,000?	☐ Yes*	☐ No
5.	Has a judgment or arbitration award of any amount been issued against you?	☐ Yes*	☐ No
6.	Have you had any peer review action taken against you?	☐ Yes*	☐ No
7.	Have you resigned from any employment or has your employment been terminated?	☐ Yes*	☐ No
8.	Are you in the process of applying for any other business or professional license or certificate?	☐ Yes*	☐ No

(Continued)

9. Have you had to report any theft or loss of controlled substances to the Department of Justice?	☐ Yes*	☐ No
10. Have you had to report a patient death in an outpatient surgery setting pursuant to Business and Professions Code section 2240(a)?	☐ Yes*	☐ No
11. Did you cease practicing since your last report? If yes, give the date you ceased practice.	☐ Yes*	☐ No
12. 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
13. Are you on probation in another state?	☐ Yes*	☐ No
14. Have you maintained a current and valid license?	☐ Yes	☐ No*
15. Are you current with your probation monitoring costs?	☐ Yes	☐ No*
16. Have you complied with each term and condition of your probation, including all time requirements outlined in your Order?	☐ Yes	☐ No*

***IF YOU ANSWERED YES, to a question numbered 1 through 13 or NO to a question numbered 14 through 16, <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 practice medicine (i.e., convalescent/ nursing homes, etc., or indicate if there has been any change to your practice address, residence address and/or Address of Record. Provide the phone number of the Medical Director or Chief of Staff, if applicable.
Provide the titles of continuing medical education (CME) courses you have completed this quarter, if any. Attach a copy of the CME certificate.
Do you practice any type of specialty? If yes, please describe which specialty.
List any new staff and include their title and license number, 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 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