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The 2019 Florida Statutes

Title XXXII	Chapter 456	View Entire Chapter
REGULATION OF PROFESSIONS AND OCCUPATIONS	HEALTH PROFESSIONS AND OCCUPATIONS: GENERAL PROVISIONS	

456.072 Grounds for discipline; penalties; enforcement.—

(1) The following acts shall constitute grounds for which the disciplinary actions specified in subsection (2) may be taken:

(a) Making misleading, deceptive, or fraudulent representations in or related to the practice of the licensee's profession.

(b) Intentionally violating any rule adopted by the board or the department, as appropriate.

(c) Being convicted or found guilty of, or entering a plea of guilty or nolo contendere to, regardless of adjudication, a crime in any jurisdiction which relates to the practice of, or the ability to practice, a licensee's profession.

(d) Using a Class III or a Class IV laser device or product, as defined by federal regulations, without having complied with the rules adopted under s. 501.122(2) governing the registration of the devices.

(e) Failing to comply with the educational course requirements for human immunodeficiency virus and acquired immune deficiency syndrome.

(f) Having a license or the authority to practice any regulated profession revoked, suspended, or otherwise acted against, including the denial of licensure, by the licensing authority of any jurisdiction, including its agencies or subdivisions, for a violation that would constitute a violation under Florida law. The licensing authority's acceptance of a relinquishment of licensure, stipulation, consent order, or other settlement, offered in response to or in anticipation of the filing of charges against the license, shall be construed as action against the license.

(g) Having been found liable in a civil proceeding for knowingly filing a false report or complaint with the department against another licensee.

(h) Attempting to obtain, obtaining, or renewing a license to practice a profession by bribery, by fraudulent misrepresentation, or through an error of the department or the board.

(i) Except as provided in s. 465.016, failing to report to the department any person who the licensee knows is in violation of this chapter, the chapter regulating the alleged violator, or the rules of the department or the board. However, a person who the licensee knows is unable to practice with reasonable skill and safety to patients by reason of illness or use of alcohol, drugs, narcotics, chemicals, or any other type of material, or as a result of a mental or physical condition, may be reported to a consultant operating an impaired practitioner program as described in s. 456.076 rather than to the department.

(j) Aiding, assisting, procuring, employing, or advising any unlicensed person or entity to practice a profession contrary to this chapter, the chapter regulating the profession, or the rules of the department or the board.

(k) Failing to perform any statutory or legal obligation placed upon a licensee. For purposes of this section, failing to repay a student loan issued or guaranteed by the state or the Federal Government in accordance with the terms of the loan or failing to comply with service scholarship obligations shall be considered a failure to perform a statutory or legal obligation, and the minimum disciplinary action imposed shall be a suspension of the license until new payment terms are agreed upon or the scholarship obligation is resumed, followed by probation for the duration of the student loan or remaining scholarship obligation period, and a fine equal to 10 percent of the defaulted loan amount. Fines collected shall be deposited into the Medical Quality Assurance Trust Fund.

(l) Making or filing a report which the licensee knows to be false, intentionally or negligently failing to file a report or record required by state or federal law, or willfully impeding or obstructing another person to do so. Such reports or records shall include only those that are signed in the capacity of a licensee.

(m) Making deceptive, untrue, or fraudulent representations in or related to the practice of a profession or employing a trick or scheme in or related to the practice of a profession.

(n) Exercising influence on the patient or client for the purpose of financial gain of the licensee or a third party.

(o) Practicing or offering to practice beyond the scope permitted by law or accepting and performing professional responsibilities the licensee knows, or has reason to know, the licensee is not competent to perform.

(p) Delegating or contracting for the performance of professional responsibilities by a person when the licensee delegating or contracting for performance of the responsibilities knows, or has reason to know, the person is not qualified by training, experience, and authorization when required to perform them.

(q) Violating a lawful order of the department or the board, or failing to comply with a lawfully issued subpoena of the department.

(r) Improperly interfering with an investigation or inspection authorized by statute, or with any disciplinary proceeding.

(s) Failing to comply with the educational course requirements for domestic violence.

(t) Failing to identify through written notice, which may include the wearing of a name tag, or orally to a patient the type of license under which the practitioner is practicing. Any advertisement for health care services naming the practitioner must identify the type of license the practitioner holds. This paragraph does not apply to a practitioner while the practitioner is providing services in a facility licensed under chapter 394, chapter 395, chapter 400, or chapter 429. Each board, or the department where there is no board, is authorized by rule to determine how its practitioners may comply with this disclosure requirement.

(u) Failing to comply with the requirements of ss. 381.026 and 381.0261 to provide patients with information about their patient rights and how to file a patient complaint.

(v) Engaging or attempting to engage in sexual misconduct as defined and prohibited in s. 456.063 (1).

(w) Failing to comply with the requirements for profiling and credentialing, including, but not limited to, failing to provide initial information, failing to timely provide updated information, or making misleading, untrue, deceptive, or fraudulent representations on a profile, credentialing, or initial or renewal licensure application.

(x) Failing to report to the board, or the department if there is no board, in writing within 30 days

after the licensee has been convicted or found guilty of, or entered a plea of nolo contendere to, regardless of adjudication, a crime in any jurisdiction. Convictions, findings, adjudications, and pleas entered into prior to the enactment of this paragraph must be reported in writing to the board, or department if there is no board, on or before October 1, 1999.

(y) Using information about people involved in motor vehicle accidents which has been derived from accident reports made by law enforcement officers or persons involved in accidents under s. 316.066, or using information published in a newspaper or other news publication or through a radio or television broadcast that has used information gained from such reports, for the purposes of commercial or any other solicitation whatsoever of the people involved in the accidents.

(z) Being unable to practice with reasonable skill and safety to patients by reason of illness or use of alcohol, drugs, narcotics, chemicals, or any other type of material or as a result of any mental or physical condition. In enforcing this paragraph, the department shall have, upon a finding of the State Surgeon General or the State Surgeon General's designee that probable cause exists to believe that the licensee is unable to practice because of the reasons stated in this paragraph, the authority to issue an order to compel a licensee to submit to a mental or physical examination by physicians designated by the department. If the licensee refuses to comply with the order, the department's order directing the examination may be enforced by filing a petition for enforcement in the circuit court where the licensee resides or does business. The department shall be entitled to the summary procedure provided in s. 51.011. A licensee or certificateholder affected under this paragraph shall at reasonable intervals be afforded an opportunity to demonstrate that he or she can resume the competent practice of his or her profession with reasonable skill and safety to patients.

(aa) Testing positive for any drug, as defined in s. 112.0455, on any confirmed preemployment or employer-ordered drug screening when the practitioner does not have a lawful prescription and legitimate medical reason for using the drug.

(bb) Performing or attempting to perform health care services on the wrong patient, a wrong-site procedure, a wrong procedure, or an unauthorized procedure or a procedure that is medically unnecessary or otherwise unrelated to the patient's diagnosis or medical condition. For the purposes of this paragraph, performing or attempting to perform health care services includes the preparation of the patient.

(cc) Leaving a foreign body in a patient, such as a sponge, clamp, forceps, surgical needle, or other paraphernalia commonly used in surgical, examination, or other diagnostic procedures. For the purposes of this paragraph, it shall be legally presumed that retention of a foreign body is not in the best interest of the patient and is not within the standard of care of the profession, regardless of the intent of the professional.

(dd) Violating any provision of this chapter, the applicable practice act, or any rules adopted pursuant thereto.

(ee) With respect to making a personal injury protection claim as required by s. 627.736, intentionally submitting a claim, statement, or bill that has been "upcoded" as defined in s. 627.732.

(ff) With respect to making a personal injury protection claim as required by s. 627.736, intentionally submitting a claim, statement, or bill for payment of services that were not rendered.

(gg) Engaging in a pattern of practice when prescribing medicinal drugs or controlled substances which demonstrates a lack of reasonable skill or safety to patients, a violation of this chapter or ss. 893.055 and 893.0551, a violation of the applicable practice act, or a violation of any rules adopted under this chapter or the applicable practice act of the prescribing practitioner. Notwithstanding s.

456.073(13), the department may initiate an investigation and establish such a pattern from billing records, data, or any other information obtained by the department.

(hh) Being terminated from an impaired practitioner program that is overseen by a consultant as described in s. 456.076, for failure to comply, without good cause, with the terms of the monitoring or participant contract entered into by the licensee, or for not successfully completing any drug treatment or alcohol treatment program.

(ii) Being convicted of, or entering a plea of guilty or nolo contendere to, any misdemeanor or felony, regardless of adjudication, under 18 U.S.C. s. 669, ss. 285-287, s. 371, s. 1001, s. 1035, s. 1341, s. 1343, s. 1347, s. 1349, or s. 1518, or 42 U.S.C. ss. 1320a-7b, relating to the Medicaid program.

(jj) Failing to remit the sum owed to the state for an overpayment from the Medicaid program pursuant to a final order, judgment, or stipulation or settlement.

(kk) Being terminated from the state Medicaid program pursuant to s. 409.913, any other state Medicaid program, or the federal Medicare program, unless eligibility to participate in the program from which the practitioner was terminated has been restored.

(ll) Being convicted of, or entering a plea of guilty or nolo contendere to, any misdemeanor or felony, regardless of adjudication, a crime in any jurisdiction which relates to health care fraud.

(mm) Failure to comply with controlled substance prescribing requirements of s. 456.44.

(nn) Violating any of the provisions of s. 790.338.

(oo) Willfully failing to comply with s. 627.64194 or s. 641.513 with such frequency as to indicate a general business practice.

(2) When the board, or the department when there is no board, finds any person guilty of the grounds set forth in subsection (1) or of any grounds set forth in the applicable practice act, including conduct constituting a substantial violation of subsection (1) or a violation of the applicable practice act which occurred prior to obtaining a license, it may enter an order imposing one or more of the following penalties:

(a) Refusal to certify, or to certify with restrictions, an application for a license.

(b) Suspension or permanent revocation of a license.

(c) Restriction of practice or license, including, but not limited to, restricting the licensee from practicing in certain settings, restricting the licensee to work only under designated conditions or in certain settings, restricting the licensee from performing or providing designated clinical and administrative services, restricting the licensee from practicing more than a designated number of hours, or any other restriction found to be necessary for the protection of the public health, safety, and welfare.

(d) Imposition of an administrative fine not to exceed $10,000 for each count or separate offense. If the violation is for fraud or making a false or fraudulent representation, the board, or the department if there is no board, must impose a fine of $10,000 per count or offense.

(e) Issuance of a reprimand or letter of concern.

(f) Placement of the licensee on probation for a period of time and subject to such conditions as the board, or the department when there is no board, may specify. Those conditions may include, but are not limited to, requiring the licensee to undergo treatment, attend continuing education courses, submit to be reexamined, work under the supervision of another licensee, or satisfy any terms which are reasonably tailored to the violations found.

(g) Corrective action.

(h) Imposition of an administrative fine in accordance with s. 381.0261 for violations regarding

patient rights.

(i) Refund of fees billed and collected from the patient or a third party on behalf of the patient.

(j) Requirement that the practitioner undergo remedial education.

In determining what action is appropriate, the board, or department when there is no board, must first consider what sanctions are necessary to protect the public or to compensate the patient. Only after those sanctions have been imposed may the disciplining authority consider and include in the order requirements designed to rehabilitate the practitioner. All costs associated with compliance with orders issued under this subsection are the obligation of the practitioner.

(3)(a) Notwithstanding subsection (2), if the ground for disciplinary action is the first-time failure of the licensee to satisfy continuing education requirements established by the board, or by the department if there is no board, the board or department, as applicable, shall issue a citation in accordance with s. 456.077 and assess a fine, as determined by the board or department by rule. In addition, for each hour of continuing education not completed or completed late, the board or department, as applicable, may require the licensee to take 1 additional hour of continuing education for each hour not completed or completed late.

(b) Notwithstanding subsection (2), if the ground for disciplinary action is the first-time violation of a practice act for unprofessional conduct, as used in ss. 464.018(1)(h), 467.203(1)(f), 468.365(1)(f), and 478.52(1)(f), and no actual harm to the patient occurred, the board or department, as applicable, shall issue a citation in accordance with s. 456.077 and assess a penalty as determined by rule of the board or department.

(4) In addition to any other discipline imposed through final order, or citation, entered on or after July 1, 2001, under this section or discipline imposed through final order, or citation, entered on or after July 1, 2001, for a violation of any practice act, the board, or the department when there is no board, shall assess costs related to the investigation and prosecution of the case. The costs related to the investigation and prosecution include, but are not limited to, salaries and benefits of personnel, costs related to the time spent by the attorney and other personnel working on the case, and any other expenses incurred by the department for the case. The board, or the department when there is no board, shall determine the amount of costs to be assessed after its consideration of an affidavit of itemized costs and any written objections thereto. In any case where the board or the department imposes a fine or assessment and the fine or assessment is not paid within a reasonable time, the reasonable time to be prescribed in the rules of the board, or the department when there is no board, or in the order assessing the fines or costs, the department or the Department of Legal Affairs may contract for the collection of, or bring a civil action to recover, the fine or assessment.

(5) In addition to, or in lieu of, any other remedy or criminal prosecution, the department may file a proceeding in the name of the state seeking issuance of an injunction or a writ of mandamus against any person who violates any of the provisions of this chapter, or any provision of law with respect to professions regulated by the department, or any board therein, or the rules adopted pursuant thereto.

(6) If the board, or the department when there is no board, determines that revocation of a license is the appropriate penalty, the revocation shall be permanent. However, the board may establish by rule requirements for reapplication by applicants whose licenses have been permanently revoked. The requirements may include, but are not limited to, satisfying current requirements for an initial license.

(7) Notwithstanding subsection (2), upon a finding that a physician has prescribed or dispensed a controlled substance, or caused a controlled substance to be prescribed or dispensed, in a manner that

violates the standard of practice set forth in s. 458.331(1)(q) or (t), s. 459.015(1)(t) or (x), s. 461.013 (1)(o) or (s), or s. 466.028(1)(p) or (x), or that an advanced practice registered nurse has prescribed or dispensed a controlled substance, or caused a controlled substance to be prescribed or dispensed, in a manner that violates the standard of practice set forth in s. 464.018(1)(n) or (p)6., the physician or advanced practice registered nurse shall be suspended for a period of not less than 6 months and pay a fine of not less than $10,000 per count. Repeated violations shall result in increased penalties.

(8) The purpose of this section is to facilitate uniform discipline for those actions made punishable under this section and, to this end, a reference to this section constitutes a general reference under the doctrine of incorporation by reference.

History.—s. 69, ch. 97-261; s. 84, ch. 99-397; s. 90, ch. 2000-160; s. 26, ch. 2000-318; s. 71, ch. 2001-277; s. 2, ch. 2002-254; s. 6, ch. 2003-411; s. 19, ch. 2003-416; s. 10, ch. 2004-344; s. 1, ch. 2005-240; s. 2, ch. 2006-207; s. 111, ch. 2007-5; s. 64, ch. 2008-6; s. 25, ch. 2009-223; s. 3, ch. 2011-112; s. 1, ch. 2011-141; s. 8, ch. 2016-222; ss. 5, 23, ch. 2016-224; s. 6, ch. 2017-41; s. 2, ch. 2018-13; s. 47, ch. 2018-106.

Note.—Former s. 455.624.

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Title XXXII	Chapter 458	View Entire Chapter
REGULATION OF PROFESSIONS AND OCCUPATIONS	MEDICAL PRACTICE	

458.331 Grounds for disciplinary action; action by the board and department.—

(1) The following acts constitute grounds for denial of a license or disciplinary action, as specified in s. 456.072(2):

(a) Attempting to obtain, obtaining, or renewing a license to practice medicine by bribery, by fraudulent misrepresentations, or through an error of the department or the board.

(b) Having a license or the authority to practice medicine revoked, suspended, or otherwise acted against, including the denial of licensure, by the licensing authority of any jurisdiction, including its agencies or subdivisions. The licensing authority's acceptance of a physician's relinquishment of a license, stipulation, consent order, or other settlement, offered in response to or in anticipation of the filing of administrative charges against the physician's license, shall be construed as action against the physician's license.

(c) Being convicted or found guilty of, or entering a plea of nolo contendere to, regardless of adjudication, a crime in any jurisdiction which directly relates to the practice of medicine or to the ability to practice medicine.

(d) False, deceptive, or misleading advertising.

(e) Failing to report to the department any person who the licensee knows is in violation of this chapter or of the rules of the department or the board. However, a person who the licensee knows is unable to practice medicine with reasonable skill and safety to patients by reason of illness or use of alcohol, drugs, narcotics, chemicals, or any other type of material, or as a result of a mental or physical condition, may be reported to a consultant operating an impaired practitioner program as described in s. 456.076 rather than to the department.

(f) Aiding, assisting, procuring, or advising any unlicensed person to practice medicine contrary to this chapter or to a rule of the department or the board.

(g) Failing to perform any statutory or legal obligation placed upon a licensed physician.

(h) Making or filing a report which the licensee knows to be false, intentionally or negligently failing to file a report or record required by state or federal law, willfully impeding or obstructing such filing or inducing another person to do so. Such reports or records shall include only those which are signed in the capacity as a licensed physician.

(i) Paying or receiving any commission, bonus, kickback, or rebate, or engaging in any split-fee arrangement in any form whatsoever with a physician, organization, agency, or person, either directly or indirectly, for patients referred to providers of health care goods and services, including, but not limited to, hospitals, nursing homes, clinical laboratories, ambulatory surgical centers, or pharmacies. The provisions of this paragraph shall not be construed to prevent a physician from receiving a fee for

professional consultation services.

(j) Exercising influence within a patient-physician relationship for purposes of engaging a patient in sexual activity. A patient shall be presumed to be incapable of giving free, full, and informed consent to sexual activity with his or her physician.

(k) Making deceptive, untrue, or fraudulent representations in or related to the practice of medicine or employing a trick or scheme in the practice of medicine.

(l) Soliciting patients, either personally or through an agent, through the use of fraud, intimidation, undue influence, or a form of overreaching or vexatious conduct. A solicitation is any communication which directly or implicitly requests an immediate oral response from the recipient.

(m) Failing to keep legible, as defined by department rule in consultation with the board, medical records that identify the licensed physician or the physician extender and supervising physician by name and professional title who is or are responsible for rendering, ordering, supervising, or billing for each diagnostic or treatment procedure and that justify the course of treatment of the patient, including, but not limited to, patient histories; examination results; test results; records of drugs prescribed, dispensed, or administered; and reports of consultations and hospitalizations.

(n) Exercising influence on the patient or client in such a manner as to exploit the patient or client for financial gain of the licensee or of a third party, which shall include, but not be limited to, the promoting or selling of services, goods, appliances, or drugs.

(o) Promoting or advertising on any prescription form of a community pharmacy unless the form shall also state "This prescription may be filled at any pharmacy of your choice."

(p) Performing professional services which have not been duly authorized by the patient or client, or his or her legal representative, except as provided in s. 743.064, s. 766.103, or s. 768.13.

(q) Prescribing, dispensing, administering, mixing, or otherwise preparing a legend drug, including any controlled substance, other than in the course of the physician's professional practice. For the purposes of this paragraph, it shall be legally presumed that prescribing, dispensing, administering, mixing, or otherwise preparing legend drugs, including all controlled substances, inappropriately or in excessive or inappropriate quantities is not in the best interest of the patient and is not in the course of the physician's professional practice, without regard to his or her intent.

(r) Prescribing, dispensing, or administering any medicinal drug appearing on any schedule set forth in chapter 893 by the physician to himself or herself, except one prescribed, dispensed, or administered to the physician by another practitioner authorized to prescribe, dispense, or administer medicinal drugs.

(s) Being unable to practice medicine with reasonable skill and safety to patients by reason of illness or use of alcohol, drugs, narcotics, chemicals, or any other type of material or as a result of any mental or physical condition. In enforcing this paragraph, the department shall have, upon a finding of the State Surgeon General or the State Surgeon General's designee that probable cause exists to believe that the licensee is unable to practice medicine because of the reasons stated in this paragraph, the authority to issue an order to compel a licensee to submit to a mental or physical examination by physicians designated by the department. If the licensee refuses to comply with such order, the department's order directing such examination may be enforced by filing a petition for enforcement in the circuit court where the licensee resides or does business. The licensee against whom the petition is filed may not be named or identified by initials in any public court records or documents, and the proceedings shall be closed to the public. The department shall be entitled to the summary procedure provided in s. 51.011. A licensee or certificateholder affected under this paragraph shall at reasonable intervals be

afforded an opportunity to demonstrate that he or she can resume the competent practice of medicine with reasonable skill and safety to patients.

(t) Notwithstanding s. 456.072(2) but as specified in s. 456.50(2):

1. Committing medical malpractice as defined in s. 456.50. The board shall give great weight to the provisions of s. 766.102 when enforcing this paragraph. Medical malpractice shall not be construed to require more than one instance, event, or act.

2. Committing gross medical malpractice.

3. Committing repeated medical malpractice as defined in s. 456.50. A person found by the board to have committed repeated medical malpractice based on s. 456.50 may not be licensed or continue to be licensed by this state to provide health care services as a medical doctor in this state.

Nothing in this paragraph shall be construed to require that a physician be incompetent to practice medicine in order to be disciplined pursuant to this paragraph. A recommended order by an administrative law judge or a final order of the board finding a violation under this paragraph shall specify whether the licensee was found to have committed "gross medical malpractice," "repeated medical malpractice," or "medical malpractice," or any combination thereof, and any publication by the board must so specify.

(u) Performing any procedure or prescribing any therapy which, by the prevailing standards of medical practice in the community, would constitute experimentation on a human subject, without first obtaining full, informed, and written consent.

(v) Practicing or offering to practice beyond the scope permitted by law or accepting and performing professional responsibilities which the licensee knows or has reason to know that he or she is not competent to perform. The board may establish by rule standards of practice and standards of care for particular practice settings, including, but not limited to, education and training, equipment and supplies, medications including anesthetics, assistance of and delegation to other personnel, transfer agreements, sterilization, records, performance of complex or multiple procedures, informed consent, and policy and procedure manuals.

(w) Delegating professional responsibilities to a person when the licensee delegating such responsibilities knows or has reason to know that such person is not qualified by training, experience, or licensure to perform them.

(x) Violating a lawful order of the board or department previously entered in a disciplinary hearing or failing to comply with a lawfully issued subpoena of the department.

(y) Conspiring with another licensee or with any other person to commit an act, or committing an act, which would tend to coerce, intimidate, or preclude another licensee from lawfully advertising his or her services.

(z) Procuring, or aiding or abetting in the procuring of, an unlawful termination of pregnancy.

(aa) Presigning blank prescription forms.

(bb) Prescribing any medicinal drug appearing on Schedule II in chapter 893 by the physician for office use.

(cc) Prescribing, ordering, dispensing, administering, supplying, selling, or giving any drug which is a Schedule II amphetamine or a Schedule II sympathomimetic amine drug or any compound thereof, pursuant to chapter 893, to or for any person except for:

1. The treatment of narcolepsy; hyperkinesis; behavioral syndrome characterized by the developmentally inappropriate symptoms of moderate to severe distractability, short attention span,

hyperactivity, emotional lability, and impulsivity; or drug-induced brain dysfunction;

2. The differential diagnostic psychiatric evaluation of depression or the treatment of depression shown to be refractory to other therapeutic modalities; or

3. The clinical investigation of the effects of such drugs or compounds when an investigative protocol therefor is submitted to, reviewed, and approved by the board before such investigation is begun.

(dd) Failing to supervise adequately the activities of those physician assistants, paramedics, emergency medical technicians, advanced practice registered nurses, or anesthesiologist assistants acting under the supervision of the physician.

(ee) Prescribing, ordering, dispensing, administering, supplying, selling, or giving growth hormones, testosterone or its analogs, human chorionic gonadotropin (HCG), or other hormones for the purpose of muscle building or to enhance athletic performance. For the purposes of this subsection, the term "muscle building" does not include the treatment of injured muscle. A prescription written for the drug products listed above may be dispensed by the pharmacist with the presumption that the prescription is for legitimate medical use.

(ff) Prescribing, ordering, dispensing, administering, supplying, selling, or giving amygdalin (laetrile) to any person.

(gg) Misrepresenting or concealing a material fact at any time during any phase of a licensing or disciplinary process or procedure.

(hh) Improperly interfering with an investigation or with any disciplinary proceeding.

(ii) Failing to report to the department any licensee under this chapter or under chapter 459 who the physician or physician assistant knows has violated the grounds for disciplinary action set out in the law under which that person is licensed and who provides health care services in a facility licensed under chapter 395, or a health maintenance organization certificated under part I of chapter 641, in which the physician or physician assistant also provides services.

(jj) Being found by any court in this state to have provided corroborating written medical expert opinion attached to any statutorily required notice of claim or intent or to any statutorily required response rejecting a claim, without reasonable investigation.

(kk) Failing to report to the board, in writing, within 30 days if action as defined in paragraph (b) has been taken against one's license to practice medicine in another state, territory, or country.

(ll) Advertising or holding oneself out as a board-certified specialist, if not qualified under s. 458.3312, in violation of this chapter.

(mm) Failing to comply with the requirements of ss. 381.026 and 381.0261 to provide patients with information about their patient rights and how to file a patient complaint.

(nn) Violating any provision of this chapter or chapter 456, or any rules adopted pursuant thereto.

(oo) Providing deceptive or fraudulent expert witness testimony related to the practice of medicine.

(pp) Applicable to a licensee who serves as the designated physician of a pain-management clinic as defined in s. 458.3265 or s. 459.0137:

1. Registering a pain-management clinic through misrepresentation or fraud;

2. Procuring, or attempting to procure, the registration of a pain-management clinic for any other person by making or causing to be made, any false representation;

3. Failing to comply with any requirement of chapter 499, the Florida Drug and Cosmetic Act; 21 U.S.C. ss. 301-392, the Federal Food, Drug, and Cosmetic Act; 21 U.S.C. ss. 821 et seq., the Drug Abuse Prevention and Control Act; or chapter 893, the Florida Comprehensive Drug Abuse Prevention and

Control Act;

4. Being convicted or found guilty of, regardless of adjudication to, a felony or any other crime involving moral turpitude, fraud, dishonesty, or deceit in any jurisdiction of the courts of this state, of any other state, or of the United States;

5. Being convicted of, or disciplined by a regulatory agency of the Federal Government or a regulatory agency of another state for, any offense that would constitute a violation of this chapter;

6. Being convicted of, or entering a plea of guilty or nolo contendere to, regardless of adjudication, a crime in any jurisdiction of the courts of this state, of any other state, or of the United States which relates to the practice of, or the ability to practice, a licensed health care profession;

7. Being convicted of, or entering a plea of guilty or nolo contendere to, regardless of adjudication, a crime in any jurisdiction of the courts of this state, of any other state, or of the United States which relates to health care fraud;

8. Dispensing any medicinal drug based upon a communication that purports to be a prescription as defined in s. 465.003(14) or s. 893.02 if the dispensing practitioner knows or has reason to believe that the purported prescription is not based upon a valid practitioner-patient relationship; or

9. Failing to timely notify the board of the date of his or her termination from a pain-management clinic as required by s. 458.3265(3).

(qq) Failing to timely notify the department of the theft of prescription blanks from a pain-management clinic or a breach of a physician's electronic prescribing software within 24 hours as required by s. 458.3265(3).

(rr) Promoting or advertising through any communication media the use, sale, or dispensing of any controlled substance appearing on any schedule in chapter 893.

(ss) Dispensing a controlled substance listed in Schedule II or Schedule III in violation of s. 465.0276.

(tt) Willfully failing to comply with s. 627.64194 or s. 641.513 with such frequency as to indicate a general business practice.

(uu) Issuing a physician certification, as defined in s. 381.986, in a manner out of compliance with the requirements of that section and rules adopted thereunder.

(vv) Performing a liposuction procedure in which more than 1,000 cubic centimeters of supernatant fat is removed, a Level II office surgery, or a Level III office surgery in an office that is not registered with the department pursuant to s. 458.328 or s. 459.0138.

(2) The board may enter an order denying licensure or imposing any of the penalties in s. 456.072(2) against any applicant for licensure or licensee who is found guilty of violating any provision of subsection (1) of this section or who is found guilty of violating any provision of s. 456.072(1). In determining what action is appropriate, the board must first consider what sanctions are necessary to protect the public or to compensate the patient. Only after those sanctions have been imposed may the disciplining authority consider and include in the order requirements designed to rehabilitate the physician. All costs associated with compliance with orders issued under this subsection are the obligation of the physician.

(3) In any administrative action against a physician which does not involve revocation or suspension of license, the division shall have the burden, by the greater weight of the evidence, to establish the existence of grounds for disciplinary action. The division shall establish grounds for revocation or suspension of license by clear and convincing evidence.

(4) The board shall not reinstate the license of a physician, or cause a license to be issued to a person it deems or has deemed unqualified, until such time as it is satisfied that he or she has complied with all the terms and conditions set forth in the final order and that such person is capable of safely

engaging in the practice of medicine. However, the board may not issue a license to, or reinstate the license of, any medical doctor found by the board to have committed repeated medical malpractice based on s. 456.50, regardless of the extent to which the licensee or prospective licensee has complied with all terms and conditions set forth in the final order and is capable of safely engaging in the practice of medicine.

(5) The board shall by rule establish guidelines for the disposition of disciplinary cases involving specific types of violations. Such guidelines may include minimum and maximum fines, periods of supervision or probation, or conditions of probation or reissuance of a license. "Gross medical malpractice," "repeated medical malpractice," and "medical malpractice," under paragraph (1)(t) shall each be considered distinct types of violations requiring specific individual guidelines.

(6) Upon the department's receipt from an insurer or self-insurer of a report of a closed claim against a physician pursuant to s. 627.912 or from a health care practitioner of a report pursuant to s. 456.049, or upon the receipt from a claimant of a presuit notice against a physician pursuant to s. 766.106, the department shall review each report and determine whether it potentially involved conduct by a licensee that is subject to disciplinary action, in which case the provisions of s. 456.073 shall apply. However, if it is reported that a physician has had three or more claims with indemnities exceeding $50,000 each within the previous 5-year period, the department shall investigate the occurrences upon which the claims were based and determine if action by the department against the physician is warranted.

(7) Upon the department's receipt from the Agency for Health Care Administration pursuant to s. 395.0197 of the name of a physician whose conduct may constitute grounds for disciplinary action by the department, the department shall investigate the occurrences upon which the report was based and determine if action by the department against the physician is warranted.

(8) If any physician regulated by the Division of Medical Quality Assurance is guilty of such unprofessional conduct, negligence, or mental or physical incapacity or impairment that the division determines that the physician is unable to practice with reasonable skill and safety and presents a danger to patients, the division shall be authorized to maintain an action in circuit court enjoining such physician from providing medical services to the public until the physician demonstrates the ability to practice with reasonable skill and safety and without danger to patients.

(9) When an investigation of a physician is undertaken, the department shall promptly furnish to the physician or the physician's attorney a copy of the complaint or document which resulted in the initiation of the investigation. For purposes of this subsection, such documents include, but are not limited to: the pertinent portions of an annual report submitted to the department pursuant to s. 395.0197(6); a report of an adverse incident which is provided to the department pursuant to s. 395.0197; a report of peer review disciplinary action submitted to the department pursuant to s. 395.0193(4) or s. 458.337, providing that the investigations, proceedings, and records relating to such peer review disciplinary action shall continue to retain their privileged status even as to the licensee who is the subject of the investigation, as provided by ss. 395.0193(8) and 458.337(3); a report of a closed claim submitted pursuant to s. 627.912; a presuit notice submitted pursuant to s. 766.106(2); and a petition brought under the Florida Birth-Related Neurological Injury Compensation Plan, pursuant to s. 766.305(2). The physician may submit a written response to the information contained in the complaint or document which resulted in the initiation of the investigation within 45 days after service to the physician of the complaint or document. The physician's written response shall be considered by the probable cause panel.

(10) A probable cause panel convened to consider disciplinary action against a physician assistant alleged to have violated s. 456.072 or this section must include one physician assistant. The physician assistant must hold a valid license to practice as a physician assistant in this state and be appointed to the panel by the Council of Physician Assistants. The physician assistant may hear only cases involving disciplinary actions against a physician assistant. If the appointed physician assistant is not present at the disciplinary hearing, the panel may consider the matter and vote on the case in the absence of the physician assistant. The training requirements set forth in s. 458.307(4) do not apply to the appointed physician assistant. Rules need not be adopted to implement this subsection.

(11) The purpose of this section is to facilitate uniform discipline for those acts made punishable under this section and, to this end, a reference to this section constitutes a general reference under the doctrine of incorporation by reference.

History.—ss. 1, 8, ch. 79-302; s. 2, ch. 80-354; s. 297, ch. 81-259; ss. 2, 3, ch. 81-318; ss. 2, 4, ch. 82-32; s. 15, ch. 83-329; s. 1, ch. 85-6; s. 4, ch. 85-175; ss. 18, 25, 26, ch. 86-245; s. 25, ch. 88-1; s. 18, ch. 89-275; s. 16, ch. 89-283; ss. 11, 72, ch. 89-374; s. 2, ch. 90-44; s. 4, ch. 90-60; s. 26, ch. 90-228; s. 60, ch. 91-220; s. 4, ch. 91-429; s. 39, ch. 92-149; s. 1, ch. 92-178; s. 83, ch. 92-289; s. 218, ch. 96-410; s. 1090, ch. 97-103; s. 106, ch. 97-261; s. 23, ch. 97-264; s. 37, ch. 98-89; s. 46, ch. 98-166; s. 222, ch. 99-8; s. 99, ch. 99-397; s. 105, ch. 2000-160; ss. 21, 76, ch. 2001-277; s. 25, ch. 2003-416; s. 2, ch. 2004-303; s. 3, ch. 2005-240; s. 3, ch. 2005-266; s. 1, ch. 2006-242; s. 73, ch. 2008-6; s. 6, ch. 2010-211; s. 6, ch. 2011-141; s. 2, ch. 2011-233; s. 2, ch. 2013-166; s. 17, ch. 2016-145; s. 9, ch. 2016-222; s. 22, ch. 2016-224; s. 8, ch. 2017-41; ss. 1, 4, ch. 2017-232; s. 14, ch. 2018-13; s. 50, ch. 2018-106; s. 6, ch. 2019-112; s. 4, ch. 2019-130.

[1]**Note.**—Section 1, ch. 2017-232, provides that "[i]t is the intent of the Legislature to implement s. 29, Article X of the State Constitution by creating a unified regulatory structure. If s. 29, Article X of the State Constitution is amended or a constitutional amendment related to cannabis or marijuana is adopted, this act shall expire 6 months after the effective date of such amendment." If such amendment or adoption takes place, paragraph (1)(uu), as created by s. 4, ch. 2017-232, is repealed.

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456.0635 Health care fraud; disqualification for license, certificate, or registration.—

(1) Health care fraud in the practice of a health care profession is prohibited.

(2) Each board within the jurisdiction of the department, or the department if there is no board, shall refuse to admit a candidate to any examination and refuse to issue a license, certificate, or registration to any applicant if the candidate or applicant or any principal, officer, agent, managing employee, or affiliated person of the candidate or applicant:

(a) Has been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under chapter 409, chapter 817, or chapter 893, or a similar felony offense committed in another state or jurisdiction, unless the candidate or applicant has successfully completed a pretrial diversion or drug court program for that felony and provides proof that the plea has been withdrawn or the charges have been dismissed. Any such conviction or plea shall exclude the applicant or candidate from licensure, examination, certification, or registration unless the sentence and any subsequent period of probation for such conviction or plea ended:

1. For felonies of the first or second degree, more than 15 years before the date of application.

2. For felonies of the third degree, more than 10 years before the date of application, except for felonies of the third degree under s. 893.13(6)(a).

3. For felonies of the third degree under s. 893.13(6)(a), more than 5 years before the date of application;

(b) Has been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970, or 42 U.S.C. ss. 1395-1396, unless the sentence and any subsequent period of probation for such conviction or plea ended more than 15 years before the date of the application;

(c) Has been terminated for cause from the Florida Medicaid program pursuant to s. 409.913, unless the candidate or applicant has been in good standing with the Florida Medicaid program for the most recent 5 years;

(d) Has been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program, unless the candidate or applicant has been in good standing with a state Medicaid program for the most recent 5 years and the termination occurred at least 20 years before the date of the application; or

(e) Is currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities.

This subsection does not apply to an applicant for initial licensure, certification, or registration who was arrested or charged with a felony specified in paragraph (a) or paragraph (b) before July 1, 2009.

(3) The department shall refuse to renew a license, certificate, or registration of any applicant if the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant:

(a) Has been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under chapter 409, chapter 817, or chapter 893, or a similar felony offense committed in another state or jurisdiction, unless the applicant is currently enrolled in a pretrial diversion or drug court program that allows the withdrawal of the plea for that felony upon successful completion of that program. Any such conviction or plea excludes the applicant from licensure renewal unless the sentence and any subsequent period of probation for such conviction or plea ended:

1. For felonies of the first or second degree, more than 15 years before the date of application.

2. For felonies of the third degree, more than 10 years before the date of application, except for felonies of the third degree under s. 893.13(6)(a).

3. For felonies of the third degree under s. 893.13(6)(a), more than 5 years before the date of application.

(b) Has been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970, or 42 U.S.C. ss. 1395-1396 since July 1, 2009, unless the sentence and any subsequent period of probation for such conviction or plea ended more than 15 years before the date of the application.

(c) Has been terminated for cause from the Florida Medicaid program pursuant to s. 409.913, unless the applicant has been in good standing with the Florida Medicaid program for the most recent 5 years.

(d) Has been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program, unless the applicant has been in good standing with a state Medicaid program for the most recent 5 years and the termination occurred at least 20 years before the date of the application.

(e) Is currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities.

This subsection does not apply to an applicant for renewal of licensure, certification, or registration who was arrested or charged with a felony specified in paragraph (a) or paragraph (b) before July 1, 2009.

(4) Licensed health care practitioners shall report allegations of health care fraud to the department, regardless of the practice setting in which the alleged health care fraud occurred.

(5) The acceptance by a licensing authority of a licensee's relinquishment of a license which is offered in response to or anticipation of the filing of administrative charges alleging health care fraud or similar charges constitutes the permanent revocation of the license.

History.—s. 24, ch. 2009-223; s. 1, ch. 2012-64; s. 15, ch. 2016-230; s. 3, ch. 2017-41.

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458.311 Licensure by examination; requirements; fees.—

(1) Any person desiring to be licensed as a physician, who does not hold a valid license in any state, shall apply to the department on forms furnished by the department. The department shall license each applicant who the board certifies:

(a) Has completed the application form and remitted a nonrefundable application fee not to exceed $500.

(b) Is at least 21 years of age.

(c) Is of good moral character.

(d) Has not committed any act or offense in this or any other jurisdiction which would constitute the basis for disciplining a physician pursuant to s. 458.331.

(e) For any applicant who has graduated from medical school after October 1, 1992, has completed the equivalent of 2 academic years of preprofessional, postsecondary education, as determined by rule of the board, which shall include, at a minimum, courses in such fields as anatomy, biology, and chemistry prior to entering medical school.

(f) Meets one of the following medical education and postgraduate training requirements:

1.a. Is a graduate of an allopathic medical school or allopathic college recognized and approved by an accrediting agency recognized by the United States Office of Education or is a graduate of an allopathic medical school or allopathic college within a territorial jurisdiction of the United States recognized by the accrediting agency of the governmental body of that jurisdiction;

b. If the language of instruction of the medical school is other than English, has demonstrated competency in English through presentation of a satisfactory grade on the Test of Spoken English of the Educational Testing Service or a similar test approved by rule of the board; and

c. Has completed an approved residency of at least 1 year.

2.a. Is a graduate of an allopathic foreign medical school registered with the World Health Organization and certified pursuant to s. 458.314 as having met the standards required to accredit medical schools in the United States or reasonably comparable standards;

b. If the language of instruction of the foreign medical school is other than English, has demonstrated competency in English through presentation of the Educational Commission for Foreign Medical Graduates English proficiency certificate or by a satisfactory grade on the Test of Spoken English of the Educational Testing Service or a similar test approved by rule of the board; and

c. Has completed an approved residency of at least 1 year.

3.a. Is a graduate of an allopathic foreign medical school which has not been certified pursuant to s. 458.314;

b. Has had his or her medical credentials evaluated by the Educational Commission for Foreign Medical Graduates, holds an active, valid certificate issued by that commission, and has passed the examination utilized by that commission; and

c. Has completed an approved residency of at least 1 year; however, after October 1, 1992, the applicant shall have completed an approved residency or fellowship of at least 2 years in one specialty area. However, to be acceptable, the fellowship experience and training must be counted toward regular or subspecialty certification by a board recognized and certified by the American Board of Medical Specialties.

(g) Has submitted to the department a set of fingerprints on a form and under procedures specified by the department, along with a payment in an amount equal to the costs incurred by the Department of Health for the criminal background check of the applicant.

(h) Has obtained a passing score, as established by rule of the board, on the licensure examination of the United States Medical Licensing Examination (USMLE); or a combination of the United States Medical Licensing Examination (USMLE), the examination of the Federation of State Medical Boards of the United States, Inc. (FLEX), or the examination of the National Board of Medical Examiners up to the year 2000; or for the purpose of examination of any applicant who was licensed on the basis of a state board examination and who is currently licensed in at least one other jurisdiction of the United States or Canada, and who has practiced pursuant to such licensure for a period of at least 10 years, use of the Special Purpose Examination of the Federation of State Medical Boards of the United States (SPEX) upon receipt of a passing score as established by rule of the board. However, for the purpose of examination of any applicant who was licensed on the basis of a state board examination prior to 1974, who is currently licensed in at least three other jurisdictions of the United States or Canada, and who has practiced pursuant to such licensure for a period of at least 20 years, this paragraph does not apply.

(2) As prescribed by board rule, the board may require an applicant who does not pass the national licensing examination after five attempts to complete additional remedial education or training. The board shall prescribe the additional requirements in a manner that permits the applicant to complete the requirements and be reexamined within 2 years after the date the applicant petitions the board to retake the examination a sixth or subsequent time.

(3) Notwithstanding the provisions of subparagraph (1)(f)3., a graduate of a foreign medical school need not present the certificate issued by the Educational Commission for Foreign Medical Graduates or pass the examination utilized by that commission if the graduate:

(a) Has received a bachelor's degree from an accredited United States college or university.

(b) Has studied at a medical school which is recognized by the World Health Organization.

(c) Has completed all of the formal requirements of the foreign medical school, except the internship or social service requirements, and has passed part I of the National Board of Medical Examiners examination or the Educational Commission for Foreign Medical Graduates examination equivalent.

(d) Has completed an academic year of supervised clinical training in a hospital affiliated with a medical school approved by the Council on Medical Education of the American Medical Association and upon completion has passed part II of the National Board of Medical Examiners examination or the Educational Commission for Foreign Medical Graduates examination equivalent.

(4) The department and the board shall assure that applicants for licensure meet the criteria in subsection (1) through an investigative process. When the investigative process is not completed within the time set out in s. 120.60(1) and the department or board has reason to believe that the applicant

does not meet the criteria, the State Surgeon General or the State Surgeon General's designee may issue a 90-day licensure delay which shall be in writing and sufficient to notify the applicant of the reason for the delay. The provisions of this subsection shall control over any conflicting provisions of s. 120.60(1).

(5) The board may not certify to the department for licensure any applicant who is under investigation in another jurisdiction for an offense which would constitute a violation of this chapter until such investigation is completed. Upon completion of the investigation, the provisions of s. 458.331 shall apply. Furthermore, the department may not issue an unrestricted license to any individual who has committed any act or offense in any jurisdiction which would constitute the basis for disciplining a physician pursuant to s. 458.331. When the board finds that an individual has committed an act or offense in any jurisdiction which would constitute the basis for disciplining a physician pursuant to s. 458.331, then the board may enter an order imposing one or more of the terms set forth in subsection (8).

(6) Each applicant who meets the requirements of this chapter shall be licensed as a physician, with rights as defined by law.

(7) Upon certification by the board, the department shall impose conditions, limitations, or restrictions on a license if the applicant is on probation in another jurisdiction for an act which would constitute a violation of this chapter.

(8) When the board determines that any applicant for licensure has failed to meet, to the board's satisfaction, each of the appropriate requirements set forth in this section, it may enter an order requiring one or more of the following terms:

(a) Refusal to certify to the department an application for licensure, certification, or registration;

(b) Certification to the department of an application for licensure, certification, or registration with restrictions on the scope of practice of the licensee; or

(c) Certification to the department of an application for licensure, certification, or registration with placement of the physician on probation for a period of time and subject to such conditions as the board may specify, including, but not limited to, requiring the physician to submit to treatment, attend continuing education courses, submit to reexamination, or work under the supervision of another physician.

History.—ss. 1, 8, ch. 79-302; s. 292, ch. 81-259; ss. 2, 3, ch. 81-318; s. 3, ch. 84-222; s. 4, ch. 84-543; s. 4, ch. 84-553; s. 29, ch. 85-175; s. 1, ch. 85-344; ss. 6, 25, 26, ch. 86-245; s. 17, ch. 88-1; s. 4, ch. 88-205; s. 18, ch. 89-162; s. 1, ch. 89-266; ss. 5, 42, ch. 89-374; s. 1, ch. 89-541; s. 3, ch. 90-60; s. 25, ch. 90-228; s. 2, ch. 90-249; s. 4, ch. 91-429; s. 1, ch. 92-53; s. 77, ch. 92-149; s. 20, ch. 95-145; s. 215, ch. 96-410; s. 1086, ch. 97-103; s. 133, ch. 97-237; s. 18, ch. 97-264; s. 9, ch. 97-273; s. 1, ch. 97-295; s. 42, ch. 98-166; s. 93, ch. 99-397; s. 115, ch. 2000-153; s. 69, ch. 2008-6.

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458.313 Licensure by endorsement; requirements; fees.—

(1) The department shall issue a license by endorsement to any applicant who, upon applying to the department on forms furnished by the department and remitting a fee set by the board not to exceed $500, the board certifies:

(a) Has met the qualifications for licensure in s. 458.311(1)(b)-(g) or in s. 458.311(1)(b)-(e) and (g) and (3);

(b) Prior to January 1, 2000, has obtained a passing score, as established by rule of the board, on the licensure examination of the Federation of State Medical Boards of the United States, Inc. (FLEX), on the United States Medical Licensing Examination (USMLE), or on the examination of the National Board of Medical Examiners, or on a combination thereof, and on or after January 1, 2000, has obtained a passing score on the United States Medical Licensing Examination (USMLE); and

(c) Has submitted evidence of the active licensed practice of medicine in another jurisdiction, for at least 2 of the immediately preceding 4 years, or evidence of successful completion of either a board-approved postgraduate training program within 2 years preceding filing of an application or a board-approved clinical competency examination within the year preceding the filing of an application for licensure. For purposes of this paragraph, "active licensed practice of medicine" means that practice of medicine by physicians, including those employed by any governmental entity in community or public health, as defined by this chapter, medical directors under s. 641.495(11) who are practicing medicine, and those on the active teaching faculty of an accredited medical school.

(2) The board may require an applicant for licensure by endorsement to take and pass the appropriate licensure examination prior to certifying the applicant as eligible for licensure.

(3) The department and the board shall ensure that applicants for licensure by endorsement meet applicable criteria in this chapter through an investigative process. When the investigative process is not completed within the time set out in s. 120.60(1) and the department or board has reason to believe that the applicant does not meet the criteria, the State Surgeon General or the State Surgeon General's designee may issue a 90-day licensure delay which shall be in writing and sufficient to notify the applicant of the reason for the delay. The provisions of this subsection shall control over any conflicting provisions of s. 120.60(1).

(4) The board may promulgate rules and regulations, to be applied on a uniform and consistent basis, which may be necessary to carry out the provisions of this section.

(5) Upon certification by the board, the department shall impose conditions, limitations, or restrictions on a license by endorsement if the applicant is on probation in another jurisdiction for an act which would constitute a violation of this chapter.

(6) The department shall not issue a license by endorsement to any applicant who is under investigation in any jurisdiction for an act or offense which would constitute a violation of this chapter until such time as the investigation is complete, at which time the provisions of s. 458.331 shall apply. Furthermore, the department may not issue an unrestricted license to any individual who has committed any act or offense in any jurisdiction which would constitute the basis for disciplining a physician pursuant to s. 458.331. When the board finds that an individual has committed an act or offense in any jurisdiction which would constitute the basis for disciplining a physician pursuant to s. 458.331, the board may enter an order imposing one or more of the terms set forth in subsection (7).

(7) When the board determines that any applicant for licensure by endorsement has failed to meet, to the board's satisfaction, each of the appropriate requirements set forth in this section, it may enter an order requiring one or more of the following terms:

(a) Refusal to certify to the department an application for licensure, certification, or registration;

(b) Certification to the department of an application for licensure, certification, or registration with restrictions on the scope of practice of the licensee; or

(c) Certification to the department of an application for licensure, certification, or registration with placement of the physician on probation for a period of time and subject to such conditions as the board may specify, including, but not limited to, requiring the physician to submit to treatment, attend continuing education courses, submit to reexamination, or work under the supervision of another physician.

History.—ss. 1, 8, ch. 79-302; ss. 2, 3, ch. 81-318; s. 5, ch. 84-543; s. 5, ch. 84-553; ss. 1, 3, ch. 85-56; ss. 7, 25, 26, ch. 86-245; ss. 1, 4, ch. 87-296; s. 18, ch. 88-1; s. 7, ch. 88-277; s. 14, ch. 88-392; s. 19, ch. 89-162; s. 6, ch. 89-374; s. 1, ch. 90-52; s. 4, ch. 91-429; s. 78, ch. 92-149; s. 216, ch. 96-410; s. 1087, ch. 97-103; s. 134, ch. 97-237; s. 19, ch. 97-264; s. 10, ch. 97-273; s. 95, ch. 99-397; s. 70, ch. 2008-6.

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456.50 Repeated medical malpractice.—

(1) For purposes of s. 26, Art. X of the State Constitution and ss. 458.331(1)(t), (4), and (5) and 459.015(1)(x), (4), and (5):

(a) "Board" means the Board of Medicine, in the case of a physician licensed pursuant to chapter 458, or the Board of Osteopathic Medicine, in the case of an osteopathic physician licensed pursuant to chapter 459.

(b) "Final administrative agency decision" means a final order of the licensing board following a hearing as provided in s. 120.57(1) or (2) or s. 120.574 finding that the licensee has violated s. 458.331 (1)(t) or s. 459.015(1)(x).

(c) "Found to have committed" means the malpractice has been found in a final judgment of a court of law, final administrative agency decision, or decision of binding arbitration.

(d) "Incident" means the wrongful act or occurrence from which the medical malpractice arises, regardless of the number of claimants or findings. For purposes of this section:

1. A single act of medical malpractice, regardless of the number of claimants, shall count as only one incident.

2. Multiple findings of medical malpractice arising from the same wrongful act or series of wrongful acts associated with the treatment of the same patient shall count as only one incident.

(e) "Level of care, skill, and treatment recognized in general law related to health care licensure" means the standard of care specified in s. 766.102.

(f) "Medical doctor" means a physician licensed pursuant to chapter 458 or chapter 459.

(g) "Medical malpractice" means the failure to practice medicine in accordance with the level of care, skill, and treatment recognized in general law related to health care licensure. Only for the purpose of finding repeated medical malpractice pursuant to this section, any similar wrongful act, neglect, or default committed in another state or country which, if committed in this state, would have been considered medical malpractice as defined in this paragraph, shall be considered medical malpractice if the standard of care and burden of proof applied in the other state or country equaled or exceeded that used in this state.

(h) "Repeated medical malpractice" means three or more incidents of medical malpractice found to have been committed by a medical doctor. Only an incident occurring on or after November 2, 2004, shall be considered an incident for purposes of finding repeated medical malpractice under this section.

(2) For purposes of implementing s. 26, Art. X of the State Constitution, the board shall not license or continue to license a medical doctor found to have committed repeated medical malpractice, the finding of which was based upon clear and convincing evidence. In order to rely on an incident of

medical malpractice to determine whether a license must be denied or revoked under this section, if the facts supporting the finding of the incident of medical malpractice were determined on a standard less stringent than clear and convincing evidence, the board shall review the record of the case and determine whether the finding would be supported under a standard of clear and convincing evidence. Section 456.073 applies. The board may verify on a biennial basis an out-of-state licensee's medical malpractice history using federal, state, or other databases. The board may require licensees and applicants for licensure to provide a copy of the record of the trial of any medical malpractice judgment, which may be required to be in an electronic format, involving an incident that occurred on or after November 2, 2004. For purposes of implementing s. 26, Art. X of the State Constitution, the 90-day requirement for granting or denying a complete allopathic or osteopathic licensure application in s. 120.60(1) is extended to 180 days.

History.—s. 2, ch. 2005-266.

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458.315 Temporary certificate for practice in areas of critical need.—

(1) A physician who is licensed to practice in any jurisdiction of the United States, whose license is currently valid, and who pays an application fee of $300 may be issued a temporary certificate for practice in areas of critical need.

(2) A certificate may be issued to a physician who:

(a) Will practice in an area of critical need;

(b) Will be employed by or practice in a county health department; correctional facility; Department of Veterans' Affairs clinic; community health center funded by s. 329, s. 330, or s. 340 of the United States Public Health Services Act; or other agency or institution that is approved by the State Surgeon General and provides health care to meet the needs of underserved populations in this state; or

(c) Will practice for a limited time to address critical physician-specialty, demographic, or geographic needs for this state's physician workforce as determined by the State Surgeon General.

(3) The Board of Medicine may issue this temporary certificate with the following restrictions:

(a) The State Surgeon General shall determine the areas of critical need. Such areas include, but are not limited to, health professional shortage areas designated by the United States Department of Health and Human Services.

1. A recipient of a temporary certificate for practice in areas of critical need may use the certificate to work for any approved entity in any area of critical need or as authorized by the State Surgeon General.

2. The recipient of a temporary certificate for practice in areas of critical need shall, within 30 days after accepting employment, notify the board of all approved institutions in which the licensee practices and of all approved institutions where practice privileges have been denied.

(b) The board may administer an abbreviated oral examination to determine the physician's competency, but a written regular examination is not required. Within 60 days after receipt of an application for a temporary certificate, the board shall review the application and issue the temporary certificate, notify the applicant of denial, or notify the applicant that the board recommends additional assessment, training, education, or other requirements as a condition of certification. If the applicant has not actively practiced during the prior 3 years and the board determines that the applicant may lack clinical competency, possess diminished or inadequate skills, lack necessary medical knowledge, or exhibit patterns of deficits in clinical decisionmaking, the board may:

1. Deny the application;

2. Issue a temporary certificate having reasonable restrictions that may include, but are not limited to, a requirement for the applicant to practice under the supervision of a physician approved by the

board; or

3. Issue a temporary certificate upon receipt of documentation confirming that the applicant has met any reasonable conditions of the board which may include, but are not limited to, completing continuing education or undergoing an assessment of skills and training.

(c) Any certificate issued under this section is valid only so long as the State Surgeon General determines that the reason for which it was issued remains a critical need to the state. The Board of Medicine shall review each temporary certificateholder not less than annually to ascertain that the minimum requirements of the Medical Practice Act and its adopted rules are being complied with. If it is determined that such minimum requirements are not being met, the board shall revoke such certificate or shall impose restrictions or conditions, or both, as a condition of continued practice under the certificate.

(d) The board may not issue a temporary certificate for practice in an area of critical need to any physician who is under investigation in any jurisdiction in the United States for an act that would constitute a violation of this chapter until such time as the investigation is complete, at which time the provisions of s. 458.331 apply.

(4) The application fee and all licensure fees, including neurological injury compensation assessments, shall be waived for those persons obtaining a temporary certificate to practice in areas of critical need for the purpose of providing volunteer, uncompensated care for low-income residents. The applicant must submit an affidavit from the employing agency or institution stating that the physician will not receive any compensation for any service involving the practice of medicine.

History.—ss. 1, 8, ch. 79-302; s. 293, ch. 81-259; ss. 2, 3, ch. 81-318; ss. 25, 26, ch. 86-245; s. 19, ch. 88-1; s. 8, ch. 88-277; s. 20, ch. 89-162; s. 8, ch. 89-374; s. 1, ch. 91-145; s. 12, ch. 91-220; s. 4, ch. 91-429; s. 141, ch. 97-101; s. 202, ch. 97-103; s. 96, ch. 99-397; s. 38, ch. 2000-318; s. 18, ch. 2001-277; s. 32, ch. 2010-161; s. 2, ch. 2011-95; s. 29, ch. 2014-1.

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458.317 Limited licenses.—

(1)(a) Any person desiring to obtain a limited license shall submit to the board an application and fee not to exceed $300 and demonstrate that he or she has been licensed to practice medicine in any jurisdiction in the United States for at least 10 years and intends to practice only pursuant to the restrictions of a limited license granted pursuant to this section. However, a physician who is not fully retired in all jurisdictions may use a limited license only for noncompensated practice. If the person applying for a limited license submits a statement from the employing agency or institution stating that he or she will not receive compensation for any service involving the practice of medicine, the application fee and all licensure fees shall be waived. However, any person who receives a waiver of fees for a limited license shall pay such fees if the person receives compensation for the practice of medicine.

(b) If it has been more than 3 years since active practice was conducted by the applicant, the full-time director of the county health department or a licensed physician, approved by the board, shall supervise the applicant for a period of 6 months after he or she is granted a limited license for practice, unless the board determines that a shorter period of supervision will be sufficient to ensure that the applicant is qualified for licensure. Procedures for such supervision shall be established by the board.

(c) The recipient of a limited license may practice only in the employ of public agencies or institutions or nonprofit agencies or institutions meeting the requirements of s. 501(c)(3) of the Internal Revenue Code, which agencies or institutions are located in the areas of critical medical need as determined by the board. Determination of medically underserved areas shall be made by the board after consultation with the Department of Health and statewide medical organizations; however, such determination shall include, but not be limited to, health professional shortage areas designated by the United States Department of Health and Human Services. A recipient of a limited license may use the license to work for any approved employer in any area of critical need approved by the board.

(d) The recipient of a limited license shall, within 30 days after accepting employment, notify the board of all approved institutions in which the licensee practices and of all approved institutions where practice privileges have been denied.

Nothing herein limits in any way any policy by the board, otherwise authorized by law, to grant licenses to physicians duly licensed in other states under conditions less restrictive than the requirements of this section. Notwithstanding the other provisions of this section, the board may refuse to authorize a physician otherwise qualified to practice in the employ of any agency or institution otherwise qualified if the agency or institution has caused or permitted violations of the provisions of this chapter which it knew or should have known were occurring.

(2) The board shall notify the director of the full-time local county health department of any county in which a licensee intends to practice under the provisions of this act. The director of the full-time county health department shall assist in the supervision of any licensee within the county and shall notify the board which issued the licensee his or her license if he or she becomes aware of any actions by the licensee which would be grounds for revocation of the limited license. The board shall establish procedures for such supervision.

(3) The board shall review the practice of each licensee biennially to verify compliance with the restrictions prescribed in this section and other applicable provisions of this chapter.

(4) Any person holding an active license to practice medicine in the state may convert that license to a limited license for the purpose of providing volunteer, uncompensated care for low-income Floridians. The applicant must submit a statement from the employing agency or institution stating that he or she will not receive compensation for any service involving the practice of medicine. The application and all licensure fees, including neurological injury compensation assessments, shall be waived.

History.—ss. 1, 8, ch. 79-302; s. 294, ch. 81-259; ss. 2, 3, ch. 81-318; ss. 12, 25, 26, ch. 86-245; s. 23, ch. 89-162; s. 1, ch. 91-88; s. 4, ch. 91-429; s. 80, ch. 92-149; s. 1, ch. 97-3; s. 142, ch. 97-101; s. 205, ch. 97-103; s. 151, ch. 97-237; s. 20, ch. 97-264; s. 27, ch. 97-273; s. 243, ch. 98-166; s. 98, ch. 99-397; s. 1, ch. 2013-151.

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458.320 Financial responsibility.—

(1) As a condition of licensing and maintaining an active license, and prior to the issuance or renewal of an active license or reactivation of an inactive license for the practice of medicine, an applicant must by one of the following methods demonstrate to the satisfaction of the board and the department financial responsibility to pay claims and costs ancillary thereto arising out of the rendering of, or the failure to render, medical care or services:

(a) Establishing and maintaining an escrow account consisting of cash or assets eligible for deposit in accordance with s. 625.52 in the per claim amounts specified in paragraph (b). The required escrow amount set forth in this paragraph may not be used for litigation costs or attorney's fees for the defense of any medical malpractice claim.

(b) Obtaining and maintaining professional liability coverage in an amount not less than $100,000 per claim, with a minimum annual aggregate of not less than $300,000, from an authorized insurer as defined under s. 624.09, from a surplus lines insurer as defined under s. 626.914(2), from a risk retention group as defined under s. 627.942, from the Joint Underwriting Association established under s. 627.351(4), or through a plan of self-insurance as provided in s. 627.357. The required coverage amount set forth in this paragraph may not be used for litigation costs or attorney's fees for the defense of any medical malpractice claim.

(c) Obtaining and maintaining an unexpired, irrevocable letter of credit, established pursuant to chapter 675, in an amount not less than $100,000 per claim, with a minimum aggregate availability of credit of not less than $300,000. The letter of credit must be payable to the physician as beneficiary upon presentment of a final judgment indicating liability and awarding damages to be paid by the physician or upon presentment of a settlement agreement signed by all parties to such agreement when such final judgment or settlement is a result of a claim arising out of the rendering of, or the failure to render, medical care and services. The letter of credit may not be used for litigation costs or attorney's fees for the defense of any medical malpractice claim. The letter of credit must be nonassignable and nontransferable. Such letter of credit must be issued by any bank or savings association organized and existing under the laws of this state or any bank or savings association organized under the laws of the United States which has its principal place of business in this state or has a branch office that is authorized under the laws of this state or of the United States to receive deposits in this state.

(2) Physicians who perform surgery in an ambulatory surgical center licensed under chapter 395 and, as a continuing condition of hospital staff privileges, physicians who have staff privileges must also establish financial responsibility by one of the following methods:

(a) Establishing and maintaining an escrow account consisting of cash or assets eligible for deposit in

accordance with s. 625.52 in the per claim amounts specified in paragraph (b). The required escrow amount set forth in this paragraph may not be used for litigation costs or attorney's fees for the defense of any medical malpractice claim.

(b) Obtaining and maintaining professional liability coverage in an amount not less than $250,000 per claim, with a minimum annual aggregate of not less than $750,000 from an authorized insurer as defined under s. 624.09, from a surplus lines insurer as defined under s. 626.914(2), from a risk retention group as defined under s. 627.942, from the Joint Underwriting Association established under s. 627.351(4), through a plan of self-insurance as provided in s. 627.357, or through a plan of self-insurance which meets the conditions specified for satisfying financial responsibility in s. 766.110. The required coverage amount set forth in this paragraph may not be used for litigation costs or attorney's fees for the defense of any medical malpractice claim.

(c) Obtaining and maintaining an unexpired irrevocable letter of credit, established pursuant to chapter 675, in an amount not less than $250,000 per claim, with a minimum aggregate availability of credit of not less than $750,000. The letter of credit must be payable to the physician as beneficiary upon presentment of a final judgment indicating liability and awarding damages to be paid by the physician or upon presentment of a settlement agreement signed by all parties to such agreement when such final judgment or settlement is a result of a claim arising out of the rendering of, or the failure to render, medical care and services. The letter of credit may not be used for litigation costs or attorney's fees for the defense of any medical malpractice claim. The letter of credit must be nonassignable and nontransferable. The letter of credit must be issued by any bank or savings association organized and existing under the laws of this state or any bank or savings association organized under the laws of the United States which has its principal place of business in this state or has a branch office that is authorized under the laws of this state or of the United States to receive deposits in this state.

This subsection shall be inclusive of the coverage in subsection (1).

(3)(a) Meeting the financial responsibility requirements of this section or the criteria for any exemption from such requirements must be established at the time of issuance or renewal of a license.

(b) Any person may, at any time, submit to the department a request for an advisory opinion regarding such person's qualifications for exemption.

(4)(a) Each insurer, self-insurer, risk retention group, or Joint Underwriting Association must promptly notify the department of cancellation or nonrenewal of insurance required by this section. Unless the physician demonstrates that he or she is otherwise in compliance with the requirements of this section, the department shall suspend the license of the physician pursuant to ss. 120.569 and 120.57 and notify all health care facilities licensed under chapter 395 of such action. Any suspension under this subsection remains in effect until the physician demonstrates compliance with the requirements of this section. If any judgments or settlements are pending at the time of suspension, those judgments or settlements must be paid in accordance with this section unless otherwise mutually agreed to in writing by the parties. This paragraph does not abrogate a judgment debtor's obligation to satisfy the entire amount of any judgment.

(b) If financial responsibility requirements are met by maintaining an escrow account or letter of credit as provided in this section, upon the entry of an adverse final judgment arising from a medical malpractice arbitration award, from a claim of medical malpractice either in contract or tort, or from noncompliance with the terms of a settlement agreement arising from a claim of medical malpractice either in contract or tort, the licensee shall pay the entire amount of the judgment together with all

accrued interest, or the amount maintained in the escrow account or provided in the letter of credit as required by this section, whichever is less, within 60 days after the date such judgment became final and subject to execution, unless otherwise mutually agreed to in writing by the parties. If timely payment is not made by the physician, the department shall suspend the license of the physician pursuant to procedures set forth in subparagraphs (5)(g)3., 4., and 5. Nothing in this paragraph shall abrogate a judgment debtor's obligation to satisfy the entire amount of any judgment.

(5) The requirements of subsections (1), (2), and (3) do not apply to:

(a) Any person licensed under this chapter who practices medicine exclusively as an officer, employee, or agent of the Federal Government or of the state or its agencies or its subdivisions. For the purposes of this subsection, an agent of the state, its agencies, or its subdivisions is a person who is eligible for coverage under any self-insurance or insurance program authorized by the provisions of s. 768.28(16).

(b) Any person whose license has become inactive under this chapter and who is not practicing medicine in this state. Any person applying for reactivation of a license must show either that such licensee maintained tail insurance coverage which provided liability coverage for incidents that occurred on or after January 1, 1987, or the initial date of licensure in this state, whichever is later, and incidents that occurred before the date on which the license became inactive; or such licensee must submit an affidavit stating that such licensee has no unsatisfied medical malpractice judgments or settlements at the time of application for reactivation.

(c) Any person holding a limited license pursuant to s. 458.317 and practicing under the scope of such limited license.

(d) Any person licensed or certified under this chapter who practices only in conjunction with his or her teaching duties at an accredited medical school or in its main teaching hospitals. Such person may engage in the practice of medicine to the extent that such practice is incidental to and a necessary part of duties in connection with the teaching position in the medical school.

(e) Any person holding an active license under this chapter who is not practicing medicine in this state. If such person initiates or resumes any practice of medicine in this state, he or she must notify the department of such activity and fulfill the financial responsibility requirements of this section before resuming the practice of medicine in this state.

(f) Any person holding an active license under this chapter who meets all of the following criteria:

1. The licensee has held an active license to practice in this state or another state or some combination thereof for more than 15 years.

2. The licensee has either retired from the practice of medicine or maintains a part-time practice of no more than 1,000 patient contact hours per year.

3. The licensee has had no more than two claims for medical malpractice resulting in an indemnity exceeding $25,000 within the previous 5-year period.

4. The licensee has not been convicted of, or pled guilty or nolo contendere to, any criminal violation specified in this chapter or the medical practice act of any other state.

5. The licensee has not been subject within the last 10 years of practice to license revocation or suspension for any period of time; probation for a period of 3 years or longer; or a fine of $500 or more for a violation of this chapter or the medical practice act of another jurisdiction. The regulatory agency's acceptance of a physician's relinquishment of a license, stipulation, consent order, or other settlement, offered in response to or in anticipation of the filing of administrative charges against the physician's license, constitutes action against the physician's license for the purposes of this paragraph.

6. The licensee has submitted a form supplying necessary information as required by the department and an affidavit affirming compliance with this paragraph.

7. The licensee must submit biennially to the department certification stating compliance with the provisions of this paragraph. The licensee must, upon request, demonstrate to the department information verifying compliance with this paragraph.

A licensee who meets the requirements of this paragraph must post notice in the form of a sign prominently displayed in the reception area and clearly noticeable by all patients or provide a written statement to any person to whom medical services are being provided. The sign or statement must read as follows: "Under Florida law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. However, certain part-time physicians who meet state requirements are exempt from the financial responsibility law. YOUR DOCTOR MEETS THESE REQUIREMENTS AND HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This notice is provided pursuant to Florida law."

(g) Any person holding an active license under this chapter who agrees to meet all of the following criteria:

1. Upon the entry of an adverse final judgment arising from a medical malpractice arbitration award, from a claim of medical malpractice either in contract or tort, or from noncompliance with the terms of a settlement agreement arising from a claim of medical malpractice either in contract or tort, the licensee shall pay the judgment creditor the lesser of the entire amount of the judgment with all accrued interest or either $100,000, if the physician is licensed pursuant to this chapter but does not maintain hospital staff privileges, or $250,000, if the physician is licensed pursuant to this chapter and maintains hospital staff privileges, within 60 days after the date such judgment became final and subject to execution, unless otherwise mutually agreed to in writing by the parties. Such adverse final judgment shall include any cross-claim, counterclaim, or claim for indemnity or contribution arising from the claim of medical malpractice. Upon notification of the existence of an unsatisfied judgment or payment pursuant to this subparagraph, the department shall notify the licensee by certified mail that he or she shall be subject to disciplinary action unless, within 30 days from the date of mailing, he or she either:

a. Shows proof that the unsatisfied judgment has been paid in the amount specified in this subparagraph; or

b. Furnishes the department with a copy of a timely filed notice of appeal and either:

(I) A copy of a supersedeas bond properly posted in the amount required by law; or

(II) An order from a court of competent jurisdiction staying execution on the final judgment pending disposition of the appeal.

2. The Department of Health shall issue an emergency order suspending the license of any licensee who, after 30 days following receipt of a notice from the Department of Health, has failed to: satisfy a medical malpractice claim against him or her; furnish the Department of Health a copy of a timely filed notice of appeal; furnish the Department of Health a copy of a supersedeas bond properly posted in the amount required by law; or furnish the Department of Health an order from a court of competent jurisdiction staying execution on the final judgment pending disposition of the appeal.

3. Upon the next meeting of the probable cause panel of the board following 30 days after the date of mailing the notice of disciplinary action to the licensee, the panel shall make a determination of whether probable cause exists to take disciplinary action against the licensee pursuant to subparagraph

1.

4. If the board determines that the factual requirements of subparagraph 1. are met, it shall take disciplinary action as it deems appropriate against the licensee. Such disciplinary action shall include, at a minimum, probation of the license with the restriction that the licensee must make payments to the judgment creditor on a schedule determined by the board to be reasonable and within the financial capability of the physician. Notwithstanding any other disciplinary penalty imposed, the disciplinary penalty may include suspension of the license for a period not to exceed 5 years. In the event that an agreement to satisfy a judgment has been met, the board shall remove any restriction on the license.

5. The licensee has completed a form supplying necessary information as required by the department.

A licensee who meets the requirements of this paragraph shall be required either to post notice in the form of a sign prominently displayed in the reception area and clearly noticeable by all patients or to provide a written statement to any person to whom medical services are being provided. Such sign or statement shall state: "Under Florida law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. YOUR DOCTOR HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against noninsured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida law."

(6) Any deceptive, untrue, or fraudulent representation by the licensee with respect to any provision of this section shall result in permanent disqualification from any exemption to mandated financial responsibility as provided in this section and shall constitute grounds for disciplinary action under s. 458.331.

(7) Any licensee who relies on any exemption from the financial responsibility requirement shall notify the department, in writing, of any change of circumstance regarding his or her qualifications for such exemption and shall demonstrate that he or she is in compliance with the requirements of this section.

(8) Notwithstanding any other provision of this section, the department shall suspend the license of any physician against whom has been entered a final judgment, arbitration award, or other order or who has entered into a settlement agreement to pay damages arising out of a claim for medical malpractice, if all appellate remedies have been exhausted and payment up to the amounts required by this section has not been made within 30 days after the entering of such judgment, award, or order or agreement, until proof of payment is received by the department or a payment schedule has been agreed upon by the physician and the claimant and presented to the department. This subsection does not apply to a physician who has met the financial responsibility requirements in paragraphs (1)(b) and (2)(b).

(9) The board shall adopt rules to implement the provisions of this section.

History.—ss. 27, 50, ch. 85-175; ss. 47, 67, ch. 86-160; s. 26, ch. 86-245; s. 22, ch. 88-1; s. 2, ch. 90-158; s. 184, ch. 91-108; s. 59, ch. 91-220; s. 4, ch. 91-429; s. 106, ch. 94-218; s. 217, ch. 96-410; s. 1089, ch. 97-103; s. 144, ch. 97-237; s. 104, ch. 97-261; s. 22, ch. 97-264; s. 20, ch. 97-273; s. 9, ch. 98-166; s. 116, ch. 2000-153; s. 20, ch. 2001-277; s. 23, ch. 2003-416; s. 75, ch. 2004-5.

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458.345 Registration of resident physicians, interns, and fellows; list of hospital employees; prescribing of medicinal drugs; penalty.—

(1) Any person desiring to practice as a resident physician, assistant resident physician, house physician, intern, or fellow in fellowship training which leads to subspecialty board certification in this state, or any person desiring to practice as a resident physician, assistant resident physician, house physician, intern, or fellow in fellowship training in a teaching hospital in this state as defined in s. 408.07 or s. 395.805(2), who does not hold a valid, active license issued under this chapter shall apply to the department to be registered and shall remit a fee not to exceed $300 as set by the board. The department shall register any applicant the board certifies has met the following requirements:

(a) Is at least 21 years of age.

(b) Has not committed any act or offense within or without the state which would constitute the basis for refusal to certify an application for licensure pursuant to s. 458.331.

(c) Is a graduate of a medical school or college as specified in s. 458.311(1)(f).

(2) The board shall not certify to the department for registration any applicant who is under investigation in any state or jurisdiction for an act which would constitute grounds for disciplinary action under s. 458.331 until such time as the investigation is completed, at which time the provisions of s. 458.331 shall apply.

(3) Every hospital or teaching hospital employing or utilizing the services of a resident physician, assistant resident physician, house physician, intern, or fellow in fellowship training registered under this section shall designate a person who shall, on dates designated by the board, in consultation with the department, furnish the department with a list of such hospital's employees and such other information as the board may direct. The chief executive officer of each such hospital shall provide the executive director of the board with the name, title, and address of the person responsible for furnishing such reports.

(4) Registration under this section shall automatically expire after 2 years without further action by the board or the department unless an application for renewal is approved by the board. No person registered under this section may be employed or utilized as a house physician or act as a resident physician, an assistant resident physician, an intern, or a fellow in fellowship training in a hospital or teaching hospital of this state for more than 2 years without a valid, active license or renewal of registration under this section. Requirements for renewal of registration shall be established by rule of the board. An application fee not to exceed $300 as set by the board shall accompany the application for renewal, except that resident physicians, assistant resident physicians, interns, and fellows in fellowship training registered under this section shall be exempt from payment of any renewal fees.

(5) Notwithstanding any provision of this section or s. 120.52 to the contrary, any person who is registered under this section is subject to the provisions of s. 458.331.

(6) A person registered as a resident physician under this section may in the normal course of his or her employment prescribe medicinal drugs described in schedules set out in chapter 893 when:

(a) The person prescribes such medicinal drugs through use of a Drug Enforcement Administration number issued to the hospital or teaching hospital by which the person is employed or at which the person's services are used;

(b) The person is identified by a discrete suffix to the identification number issued to such hospital; and

(c) The use of the institutional identification number and individual suffixes conforms to the requirements of the federal Drug Enforcement Administration.

(7) Any person willfully violating this section commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

(8) The board shall promulgate rules pursuant to ss. 120.536(1) and 120.54 as necessary to implement this section.

History.—ss. 1, 8, ch. 79-302; ss. 2, 3, ch. 81-318; ss. 25, 26, ch. 86-245; s. 28, ch. 88-1; s. 25, ch. 89-162; s. 12, ch. 89-374; s. 1, ch. 91-22; s. 4, ch. 91-429; s. 83, ch. 92-149; s. 25, ch. 97-264; s. 248, ch. 98-166; s. 39, ch. 2000-318; s. 22, ch. 2001-277; s. 6, ch. 2005-81; s. 95, ch. 2018-24.

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458.3145 Medical faculty certificate.—

(1) A medical faculty certificate may be issued without examination to an individual who:

(a) Is a graduate of an accredited medical school or its equivalent, or is a graduate of a foreign medical school listed with the World Health Organization;

(b) Holds a valid, current license to practice medicine in another jurisdiction;

(c) Has completed the application form and remitted a nonrefundable application fee not to exceed $500;

(d) Has completed an approved residency or fellowship of at least 1 year or has received training which has been determined by the board to be equivalent to the 1-year residency requirement;

(e) Is at least 21 years of age;

(f) Is of good moral character;

(g) Has not committed any act in this or any other jurisdiction which would constitute the basis for disciplining a physician under s. 458.331;

(h) For any applicant who has graduated from medical school after October 1, 1992, has completed, before entering medical school, the equivalent of 2 academic years of preprofessional, postsecondary education, as determined by rule of the board, which must include, at a minimum, courses in such fields as anatomy, biology, and chemistry; and

(i) Has been offered and has accepted a full-time faculty appointment to teach in a program of medicine at:

1. The University of Florida;
2. The University of Miami;
3. The University of South Florida;
4. The Florida State University;
5. The Florida International University;
6. The University of Central Florida;
7. The Mayo Clinic College of Medicine and Science in Jacksonville, Florida;
8. The Florida Atlantic University; or
9. The Johns Hopkins All Children's Hospital in St. Petersburg, Florida.

(2) The certificate authorizes the holder to practice only in conjunction with his or her faculty position at an accredited medical school and its affiliated clinical facilities or teaching hospitals that are registered with the Board of Medicine as sites at which holders of medical faculty certificates will be practicing, or a specialty-licensed children's hospital licensed under chapter 395 that is affiliated with an accredited medical school and its affiliated clinics. Such certificate automatically expires when the

holder's relationship with the medical school is terminated or after a period of 24 months, whichever occurs sooner, and is renewable every 2 years by a holder who applies to the board on a form prescribed by the board and provides certification by the dean of the medical school that the holder is a distinguished medical scholar and an outstanding practicing physician.

(3) The holder of a medical faculty certificate issued under this section has all rights and responsibilities prescribed by law for the holder of a license issued under s. 458.311, except as specifically provided otherwise by law. Such responsibilities include compliance with continuing medical education requirements as set forth by rule of the board. A hospital or ambulatory surgical center licensed under chapter 395, health maintenance organization certified under chapter 641, insurer as defined in s. 624.03, multiple-employer welfare arrangement as defined in s. 624.437, or any other entity in this state, in considering and acting upon an application for staff membership, clinical privileges, or other credentials as a health care provider, may not deny the application of an otherwise qualified physician for such staff membership, clinical privileges, or other credentials solely because the applicant is a holder of a medical faculty certificate under this section.

(4) In any year, the maximum number of extended medical faculty certificateholders as provided in subsection (2) may not exceed 30 persons at each institution named in subparagraphs (1)(i)1.-6., 8., and 9. and at the facility named in s. 1004.43 and may not exceed 10 persons at the institution named in subparagraph (1)(i)7.

(5) Annual review of all such certificate recipients will be made by the deans of the accredited 4-year medical schools provided in paragraph (1)(i) and reported to the Board of Medicine.

(6) Notwithstanding subsection (1), any physician, when providing medical care or treatment in connection with the education of students, residents, or faculty at the request of the dean of an accredited medical school within this state or at the request of the medical director of a statutory teaching hospital as defined in s. 408.07 or a specialty-licensed children's hospital licensed under chapter 395 that is affiliated with an accredited medical school and its affiliated clinics, may do so upon registration with the board and demonstration of financial responsibility pursuant to s. 458.320(1) or (2) unless such physician is exempt under s. 458.320(5)(a). The performance of such medical care or treatment must be limited to a single period of time, which may not exceed 180 consecutive days, and must be rendered within a facility registered under subsection (2) or within a statutory teaching hospital as defined in s. 408.07. A registration fee not to exceed $300, as set by the board, is required of each physician registered under this subsection. However, no more than three physicians per year per institution may be registered under this subsection, and an exemption under this subsection may not be granted to a physician more than once in any given 5-year period.

History.—ss. 9, 26, ch. 86-245; s. 1, ch. 88-218; s. 15, ch. 88-392; s. 1, ch. 90-30; s. 4, ch. 91-429; s. 79, ch. 92-149; s. 1, ch. 95-208; ss. 9, 10, ch. 96-309; s. 50, ch. 97-98; s. 1088, ch. 97-103; s. 37, ch. 2000-318; s. 1011, ch. 2002-387; s. 1, ch. 2008-58; s. 1, ch. 2009-107; s. 1, ch. 2016-54; s. 3, ch. 2017-50.

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64B8-4.004 Approved Residency or Fellowship; Definitions.

(1) An approved residency of at least one year constitutes a course of study and training in a single program for a period of not less than twelve calendar months by a person holding a degree as a medical doctor. The hospital and the program in which the medical doctor is participating must be accredited for the training and teaching of physicians by the Accreditation Council for Graduate Medical Education (ACGME), College of Family Physicians of Canada (CFPC) or Royal College of Physicians and Surgeons of Canada (RCPSC) and the medical doctor must be assigned to one of the allocated positions or slots approved by the ACGME, CFPC or RCPSC. Fellowship training or residency training in a non-slotted position shall be considered approved residency training only in the instance when the fellowship or residency training has been recognized and accepted for that applicant toward completion of requirements for specialty board certification by a specialty board listed by the American Board of Medical Specialties or the American Board of Oral & Maxillofacial Surgery.

(2) An approved residency or approved fellowship of at least two years in one specialty area constitutes two progressive years in a course of study and training as long as each year is accepted by the American Board of Medical Specialties in that specialty for a period of not less than twenty-four months by a person holding a degree as a medical doctor. The hospital and the program in which the medical doctor is participating must be accredited for the training and teaching of physicians by the Accreditation Council for Graduate Medical Education (ACGME), College of Family Physicians of Canada (CFPC) or Royal College of Physicians and Surgeons of Canada (RCPSC) and the medical doctor must be assigned to one of the allocated positions or slots approved by the ACGME, CFPC or RCPSC. Fellowship training or residence training in a non-slotted position shall be considered approved residency training only in the instance when the fellowship or residency training has been recognized and accepted for that applicant toward completion of requirements for specialty board certification by a specialty board listed by the American Board of Medical Specialties.

Rulemaking Authority 458.309, 458.311(1)(f) FS. Law Implemented 458.311(1) FS. History–New 3-31-80, Amended 11-10-82, Formerly 21M-22.04, Amended 9-7-88, 11-30-92, Formerly 21M-22.004, 61F6-22.004, Amended 11-15-94, Formerly 59R-4.004, Amended 6-15-98, 10-1-98, 7-10-01, 9-16-03, 3-18-13.

64B8-4.009 Applications.

(1) All persons applying for licensure shall submit an application to the Department. The application shall be made on the applicable form set forth below, all of which are hereby adopted and incorporated by reference and can be obtained from the website at http://www.flhealthsource.gov/mqa-services. The application must be accompanied by the application fee.

(a) DH-MQA 1000, entitled "Florida Board of Medicine Medical Doctor Licensure Application," (12/18), available from http://www.flrules.org/Gateway/reference.asp?No=Ref-10279, or http://www.doh.state.fl.us/mqa/medical/me_applicant.html;

(b) DH-MQA 1008, entitled "Florida Board of Medicine Limited License Application," (12/18), available from http://www.flrules.org/Gateway/reference.asp?No=Ref-10280, or http://www.doh.state.fl.us/mqa/medical/me_applicant.html;

(c) DH-MQA 1009, entitled "Florida Board of Medicine Application For Temporary Certificate to Practice in an Area of Critical Need Application," (12/18), available from http://www.flrules.org/Gateway/reference.asp?No=Ref-10281, or http://www.doh.state.fl.us/mqa/medical/me_applicant.html;

(d) DH-MQA 1032, entitled "Board of Medicine Application Materials for Initial Registration and Renewal of Intern/Resident/Fellow and House Physician," (8/16), http://www.flrules.org/Gateway/reference.asp?No=Ref-07844;

(e) DH-MQA 1072, entitled "Florida Board of Medicine Medical Faculty Certificate For Allopathic Physicians Licensure Application," (12/18), available from http://www.flrules.org/Gateway/reference.asp?No=Ref-10282, or http://www.doh.state.fl.us/mqa/medical/me_applicant.html;

(f) DH-MQA 1079, entitled "Temporary Certificate For Visiting Physicians To Obtain Medical Privileges For Instructional Purposes In Conjunction With Plastic Surgery, Medical Or Surgical Training Programs and Educational Symposiums," (10/16), http://www.flrules.org/Gateway/reference.asp?No=Ref-07845.

(g) DH5001-MQA, entitled "Application Rear Admiral LeRoy Collins, Jr., Temporary Certificate for Active Duty Military and Veterans," (11/17), http://www.flrules.org/Gateway/reference.asp?No=Ref-09114.

(2) An official verification of the applicant's medical education from the medical school which comes directly from the medical school to the Board office, unless the applicant has had his or her medical credentials evaluated by the Educational Commission for Foreign Medical Graduates (ECFMG) and holds an active, valid certificate issued by the ECFMG.

(3) An applicant must submit examination score reports which come directly from the testing entity to the Board office.

Rulemaking Authority 456.031, 456.033, 458.309, 458.311, 458.313, 458.3145, 458.3151, 458.345 FS. Law Implemented 456.013(1), (13), 456.0135, 456.031, 456.033, 456.039, 456.049, 456.50, 456.0635, 458.311, 458.3124, 458.313, 458.3137, 458.3145, 458.315, 458.3151, 458.316, 458.3165, 458.317, 458.320, 458.345, 766.314 FS. History–New 3-31-80, Amended 12-4-85, Formerly 21M-22.09, Amended 9-7-88, 3-13-89, 1-1-92, 2-21-93, Formerly 21M-22.009, Amended 11-4-93, Formerly 61F6-22.009, Amended 11-15-94, 2-15-96, Formerly 59R-4.009, Amended 7-10-01, 1-31-02, 5-10-04, 5-20-04, 6-13-06, 12-26-06, 1-18-09, 3-17-09, 10-7-09, 1-7-10, 5-18-10, 2-28-12, 1-27-13, 8-5-13, 11-10-13, 1-9-14, 7-15-14, 9-10-14, 12-2-14, 3-17-15, 5-19-15, 9-28-15, 11-11-15, 8-14-16, 9-26-16, 2-6-17, 11-6-17, 2-26-18, 3-3-19.

64B8-4.025 Licensure Under Supervision.

Unless otherwise approved by the Board or its designee, or addressed by Board Order, the following are provisions applicable to Orders rendered by the Board when an applicant is certified for licensure but said licensure is restricted or conditioned in such a manner as to require a period of practice under supervision of another licensee approved by the Board.

(1) The applicant's license shall not be issued until a supervisor is approved by the Board or its designee. However, unless provided otherwise in the Board's Order, the person who is certified for licensure must have a supervisor approved within 12 months of the date the Board certifies the applicant for licensure. If the person certified for licensure does not obtain an approved supervisor within that 12 month period, the certification for licensure expires and the person must reapply for licensure.

(2) Required Supervision.

(a) Direct Supervision. If an applicant is required to work under the direct supervision of another physician, "direct supervision" shall require the physical presence of the supervising physician in the building so that the supervising physician is immediately available when needed.

(b) Indirect Supervision. If an applicant is required to work under the indirect supervision of another physician, "indirect supervision" shall mean the responsible supervision of the licensee by a supervising physician, approved by the Board, which supervision shall not require the physical presence of the supervising physician when procedures are performed, but shall require the supervisor to be reasonably available, so as to be physically present to provide consultation or direction in a timely fashion as required for appropriate care of the patient. The supervisor shall practice within a reasonable geographic proximity to the applicant, which shall be within 20 miles.

(c) Immediate Supervision. If an applicant is required to work under the immediate supervision of another physician, Respondent shall not perform designated procedures unless under the immediate supervision of a board-certified physician fully licensed under chapter 458, F.S., who has been approved by the Probationer's Committee. The physician providing immediate supervision shall be physically located in the same room with the applicant where the designated procedure is performed.

(d) If the terms of the Order include indirect or direct supervision of the applicant's practice, the applicant shall not practice medicine without an approved supervisor. If the terms of the Order include immediate supervision, the applicant shall not perform designated procedures unless under the immediate supervision of an approved supervisor.

(e) The applicant shall furnish to the proposed supervisor a copy of the Board's order requiring supervision and any other relevant orders.

(f) The applicant shall submit to the Board his or her proposed practice plan and designation of an area of practice. The applicant also shall submit to the Board the name, curriculum vitae, and a letter from the proposed supervisor stating that he or she:

1. Is willing to serve as a supervisor,
2. Has received a copy of the Board's order requiring supervision,
3. Is aware of his or her duties and responsibilities as a supervisor,
4. Discloses any conflicts of interests,
5. Specifies distance to the applicant's practice location; and,
6. Agrees to appear before the Board if required to do so.

(g) The supervisor must be licensed under chapter 458, F.S., in good standing, in active status, without restriction or limitation on his or her license, must be qualified by training and experience, and must not have any conflicts of interest that would prohibit him or her from impartially performing his or her duties as a monitor. Specific grounds for rejecting a proposed supervisor by the Board or its designee shall include but are not limited to the following:

1. The proposed supervisor has previously been subject to disciplinary action against his or her medical license in this or any other jurisdiction,
2. The proposed supervisor is currently under investigation, or is the subject of a pending disciplinary action,
3. The proposed supervisor is not actively engaged in the same or similar specialty area,
4. If under indirect supervision, the proposed supervisor is not practicing within a distance of no more than 20 miles from the applicant's practice location. If under direct supervision, the proposed supervisor is not practicing on the premises.

(h) Failure to complete the supervision in the required time period may result in an additional required appearance before the Credentials Committee and may result in extending the time to complete the required supervision.

(3) Approval. The Board confers authority on the Chair of the Credentials Committee to temporarily approve an applicant's supervisor, practice plans, and designation of an area of practice. To obtain this temporary approval, applicant shall submit to the

Board the information required in paragraph (2)(e). Absent said approval, applicant shall not practice medicine or perform designated procedures until a supervising physician is approved. Temporary approval shall only remain in effect until the next meeting of the Board. Final approval is to be made by the Board.

(4) Change in Supervisor. In the event that applicant's supervisor is unable or unwilling to fulfill his or her responsibilities as a supervisor, the applicant shall advise the Board of this fact within 24 hours of becoming aware of the situation. Applicant shall submit to the Board the name of a temporary supervisor for consideration. Applicant shall not practice medicine or perform designated procedures pending approval of this temporary supervisor by the Chair of the Credentials Committee. Temporary approval shall only remain in effect until the next meeting of the Board. Final approval is to be made by the Board.

(5) Reports. Prior to termination of the supervisory period, supervision reports, in affidavit format, shall be submitted by the applicant and the supervisor and shall contain the information set forth below:

(a) A report submitted by the applicant shall contain a brief statement of why the applicant is being supervised; the applicant's practice location; description of current practice (type and composition); compliance with supervisory terms; description of relationship with supervising physician; and advising of any problems.

(b) A report submitted by the supervising physician shall contain a brief statement of why the applicant is being supervised; description of applicant's practice; applicant's compliance with terms of supervision; applicant's relationship with supervisor; and details of any problems which may have arisen with applicant.

(6) Tolling Provisions. After the period of supervision begins, in the event that the applicant leaves the State of Florida for a period of 30 days or more or otherwise does not or may not engage in the active practice of medicine in the State of Florida, then the time period and provisions regarding supervision and required reports shall be tolled and shall remain in a tolled status until applicant returns to the active practice of medicine in the State of Florida. Applicant shall notify the Board 10 days prior to his or her return to practice in the State of Florida.

(7) Supervisors must serve as volunteers without compensation, but in instances where an applicant is unable to find a volunteer supervisor, the applicant, with the approval of the Board, may contract with a third party entity that provides supervisors for a fee.

Rulemaking Authority 458.309 FS. Law Implemented 458.311, 458.313, 458.3145, 458.315, 458.317 FS. History–New 9-21-93, Formerly 61F6-22.025, 59R-4.025, Amended 3-12-08, 7-1-13, 9-26-16, 5-7-18.

64B8-5.001 Examinations.

(1) Pursuant to Section 456.017(1)(c), F.S., the Board hereby approves and designates the use of the United States Medical Licensing Examination prepared by the Federation of State Medical Boards of the United States, Inc. and the National Board of Medical Examiners (USMLE).

(2) Any applicant who attempts to qualify for licensure by successfully completing the USMLE first used in 1994 shall meet the following requirement: An applicant must achieve a weighted score of no less than 75 on each step in order to be eligible for licensure in Florida. Any applicant who passed Step 2 of the USMLE prior to June 2004, is not required to complete the Clinical Skills portion of Step 2.

(3) Any applicant for licensure who began taking an examination for licensure prior to 1994 may utilize any of the examinations set forth in subsection (3) above or a combination thereof as follows up to the year 2000:

(a) NBME Part I or USMLE Step 1 plus NBME Part II or USMLE Step 2 plus NBME Part III or USMLE Step 3;

(b) FLEX Component 1 plus USMLE Step 3, or

(c) NBME Part I or USMLE Step 1 plus NBME Part II or USMLE Step 2 plus FLEX Component 2.

(4)(a) Pursuant to Sections 458.311(1)(h) and 458.313(2), F.S., any applicant who is currently licensed in at least one other jurisdiction of the United States or Canada, the Board approves and designates the use of the Special Purpose Examination of the Federation of State Medical Boards of the United States (SPEX). An applicant must achieve a score of no less than 75 on the SPEX to be eligible for licensure in Florida. If such score is obtained outside of Florida the applicant will not be required to re-take the SPEX or pay the fee required for purchase of the SPEX.

(b) However, for purposes of complying with the clinical competency examination requirement of Section 458.313(1)(c), F.S., the Board approves the use of the SPEX if the applicant achieved a score on the SPEX of 75 or more within the year preceding the application for licensure or passed a regular or subspecialty examination by a board recognized and certified by the American Board of Medical Specialties within the year preceding the application.

(5) A passing score on the licensure examination of the Federation of State Medical Boards of the United States, Inc. (FLEX) or on the examination of the National Board of Medical Examiners as used in Sections 458.311(1)(h) and 458.313(1)(b), F.S., shall mean a FLEX weighted average of no less than 75 percent on the FLEX taken in the organization and format used prior to 1985; a score of no less than 75 on both Part I and Part II on the FLEX taken in the new organization and format in 1985 or later, both of which parts shall have been passed within a five-year period; an average score of no less than 75 on the National Board examination; or a score of no less than 75 on Part III of the National Board examination.

Rulemaking Authority 456.017(1), 458.309, 458.311(1)(h), 458.313(4) FS. Law Implemented 456.017(1), (2), 458.311, 458.313 FS. History–New 12-5-79, Amended 11-10-82, 11-28-84, 3-13-85, 8-11-85, 12-4-85, Formerly 21M-21.01, Amended 2-16-86, 12-16-86, 5-10-89, Formerly 21M-21.001, Amended 5-9-94, Formerly 61F6-21.001, Amended 10-18-94, 1-2-95, Formerly 59R-5.001, Amended 8-18-98, 2-3-00, 8-20-02, 6-9-05, 3-12-08, 3-18-13, 10-18-15.

CHAPTER 64B8-12
FINANCIAL RESPONSIBILITY

64B8-12.001 Applicability (Repealed)
64B8-12.003 Definitions
64B8-12.005 Procedures
64B8-12.007 Exemptions for Persons Not Practicing in Florida; Change of Status

64B8-12.001 Applicability.

Rulemaking Authority 458.309, 458.320 FS. Law Implemented 458.320 FS. History–New 3-15-87, Formerly 21M-40.001, 61F6-40.001, 59R-12.001, Repealed 10-14-15.

64B8-12.003 Definitions.

The term "patient contact hours," as used in Section 458.320(5)(f)2., F.S., means the number of hours during which the physician is involved in direct patient care or is performing patient care activities, including, but not limited to, completing patient records and reviewing laboratory reports.

Rulemaking Authority 458.309, 458.320 FS. Law Implemented 458.320 FS. History–New 3-15-87, Formerly 21M-40.003, 61F6-40.003, 59R-12.003.

64B8-12.005 Procedures.

(1) At the time a person seeks initial licensure, renewal of a license or reactivation of an inactive license that person must show compliance with the requirements of Section 458.320, F.S.

(2) It is the responsibility of the licensee to timely renew his or her license. Failure to receive a notification from the Department does not relieve the licensee of the responsibility of meeting the financial responsibility or renewal requirements.

(3) A licensee seeking to renew a license, reactivate an inactive license or update a previously filed financial responsibility disclosure must complete form DH-MQA 1014, Financial Responsibility, 8/14, which is hereby incorporated by reference. To obtain the form, the licensee may contact the Board of Medicine at 4052 Bald Cypress Way, Bin #C03, Tallahassee, FL 32399-3254, or download from the Board's website at www.flboardofmedicine.gov, or at http://www.flrules.org/Gateway/reference.asp?No=Ref-04751.

(4) The licensee must retain such written documentation as may be necessary to prove his or her compliance with or exemption from the financial responsibility requirements for a period of not less than 7 years and must provide such documentation to the Board or its agent upon request.

(5) EACH LICENSEE MUST NOTIFY THE BOARD IN WRITING OF ANY CHANGE OF STATUS RELATING TO FINANCIAL RESPONSIBILITY COMPLIANCE OR EXEMPTION AT LEAST 10 CALENDAR DAYS PRIOR TO THE CHANGE.

(6) The failure to document compliance with or exemption from the financial responsibility law upon request, the furnishing of false or misleading information, or the failure to timely notify the Board of a change in status shall be grounds for disciplinary action up to and including license revocation.

Rulemaking Authority 458.309, 458.320 FS. Law Implemented 458.320 FS. History–New 3-15-87, Formerly 21M-40.005, 61F6-40.005, 59R-12.005, Amended 12-2-14, 10-29-19.

64B8-12.007 Exemptions for Persons Not Practicing in Florida; Change of Status.

Persons who are not practicing medicine in Florida may be exempt from compliance with the financial responsibility requirements pursuant to Section 458.320(5)(b), (licensees with inactive licenses) or Section 458.320(5)(e), F.S. (licensees with active licenses).

(1) A licensee who has claimed an exemption based on the fact that the license is inactive and the licensee is not practicing medicine in Florida and who applies for reactivation of the medical license must, in addition to the other requirements for reactivation, submit an affidavit stating that he or she has no unsatisfied medical malpractice judgments or settlements at the time of application for reactivation.

(2) A licensee who has claimed an exemption based on the fact that, although an active license has been maintained, the licensee has not been practicing medicine in Florida must, before initiating or resuming the practice of medicine in this state, notify the Department of the intent to practice in the state and show compliance with the requirements of the financial responsibility law or show exemption therefrom in the manner set forth in Rule 64B8-12.005, F.A.C.

(3) A licensee who is both reactivating an inactive license and initiating or resuming the practice of medicine in Florida must meet the requirements of both subsections (1) and (2) above.

Rulemaking Authority 458.309, 458.320 FS. Law Implemented 458.320 FS. History–New 3-15-87, Formerly 21M-40.007, 61F6-40.007, 59R-12.007, Amended 10-20-02.

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Claudia Kemp, J.D.

September 1, 2020

Juan De Dois De La Cruz Nova, MD
P.O Box 1554
Vega Baja, Puerto Rico 00694

Dear Dr. De La Cruz Nova:

This is in further reference to your application for licensure by endorsement.

Please be advised that you are required to make a personal appearance before the Credentials Committee of the Board of Medicine to discuss:

- New Jersey State Board Actions
- **Failure to meet section 458.313(1)(b), Florida Statutes, Examination**
- Failure to meet section 458.313(1)(a) and 458.311(1)(f)3.b., Florida Statutes, ECFMG certification
- Malpractice case(s).

In addition, the Committee may inquire into any other issues relating to your application and eligibility for licensure.

Date:	Thursday, October 1, 2020
Time:	8:00 a.m. (Meeting starts at 8:00 a.m. Interview time may vary.)
Location:	The in-person meeting scheduled in Orlando, Florida is cancelled, and the meeting will be held by a web-based meeting platform or, if appropriate, a teleconference call.

The meeting information and directions for participating in the October 2020 meeting will be posted on the Florida Board of Medicine's website: https://flboardofmedicine.gov/meeting-information.

Additionally, the Committee's recommendation on your application for licensure will be presented to the full Board of Medicine on Friday, October 2, 2020 for final action. You are not required to attend the full board meeting.

Thank you for your continued cooperation. Should you have any questions regarding this matter, please feel free to contact me. *This is your first scheduled appearance.

Sincerely,

Angela Denson
Angela Denson
Regulatory Supervisor

Pursuant to the provisions of the Americans with Disabilities Act, any person requiring special accommodations to participate in this workshop/meeting is asked to advise the agency at least 10 days before the workshop/meeting by contacting: Rebecca.Hewett@flhealth.gov or call (850) 245-4137.

*** 456.013(3)(c) In considering applications for licensure, the board, or the department when there is no board, may require a personal appearance of the applicant. If the applicant is required to appear, the time period in which a licensure application must be granted or denied shall be tolled until such time as the applicant appears. However, if the applicant fails to appear before the board at either of the next two regularly scheduled board meetings, or fails to appear before the department within 30 days if there is no board, the application for licensure shall be denied.**

4052 Bald Cypress Way, Bin C-03
Tallahassee, Florida 32399-3253
Phone: 850/245-4131
Fax: 850/488-0596 or 850/412-1268
https://www.FLBoardofMedicine.gov

Florida HEALTH

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Executive Director
Claudia Kemp, J.D.

August 18th, 2020

Juan De Dois De La Cruz Nova, MD
P.O Box 1554
Vega Baja, PR 00694

At the August 7th, 2020 full board meeting, the Board of Medicine accepted the recommendation of the Credentials Committee to table the application for licensure until the next credentials committee meeting.

If you have any additional questions or concerns, please do not hesitate to contact me at 850-617-1913 or e-mail me at Christina.Keelor@flhealth.gov .

Sincerely,

Christina Keelor

Christina Keelor
Administrative Assistant II

4052 Bald Cypress Way, Bin C-03
Tallahassee, Florida 32399-3253
Phone: 850/245-4131
Fax: 850/488-0596 or 850/412-1268
https://www.FLBoardofMedicine.gov

Florida HEALTH

Tab 2 - Bangaruswamy Vijaya Kumar, MD – Endorsement
Issue(s): Action by California Medical Board

The applicant was present. After discussion, a motion was made to table the application for six (6) months pending the evaluation and recommendation from PRN. The Credentials Committee delegated authority to the Chair to approve the application pending the PRN evaluation and compliance thereof. If there are any concerns, the applicant will be required to reappear before the Committee. The motion was seconded, which carried 4/0. The applicant waived the 90-day requirement.

Action Taken: The Committee voted to table the application for six (6) months pending the evaluation and recommendation from PRN. The Credentials Committee delegated authority to the Chair to approve the application pending the PRN evaluation and compliance thereof. If there are any concerns, the applicant will be required to reappear before the Committee.

Tab 3 - Mark R. Laftavi, MD – Endorsement
Issue(s): Failure to meet Sections 458.313(1)(a) and 458.311 (1)(f) 3.c, F.S., Postgraduate Training

The applicant was present. After discussion, a motion was made to approve the application for licensure with the condition that Dr. Laftavi practice for six (6) months in a Florida academic transplant program. If plans change, Dr. Laftavi may petition for modifications of conditions. The motion was seconded, which carried 4/0.

Action Taken: The Committee voted to approve the application for licensure with the condition that Dr. Laftavi practice for six (6) months in a Florida academic transplant program. If plans change, Dr. Laftavi may petition for modifications of conditions.

Tab 4 - Jason Acosta, MD – Endorsement
Issue(s): Failure to meet section 458.313(1)(a) and 458.311(1)(f)3.c., Florida Statutes, postgraduate training

The applicant was present. After discussion, a motion was made to allow Dr. Acosta to withdraw his application for licensure. The motion was seconded, which carried 4/0.

Action Taken: The Committee voted to allow withdrawal of the licensure application.

Scot Ackerman, MD – To Interview Tabs 6-11

Tab 6 - Juan De Dois De La Cruz Nova, MD – Endorsement
Issue(s):

- New Jersey State Board Actions
- Failure to meet section 458.313(1)(a) and 458.311(1)(f)3.b., Florida Statutes, ECFMG certification
- Malpractice case(s)

Represented by Allen Grossman, Esquire.

The applicant was not present. After discussion, a motion was made to table the application for licensure until the next credentials committee meeting. The motion was seconded, which carried 4/0.

Action Taken: The Committee voted to table the application for licensure until the next credentials committee meeting.

FLORIDA | Board *of* Medicine

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Coral Springs, Florida

Vacant, M.D.

Executive Director
Claudia Kemp, J.D.

July 5, 2020

Juan De Dois De La Cruz Nova, MD
P.O Box 1554
Vega Baja, Puerto Rico 00694

Dear Dr. De La Cruz Nova:

This is in further reference to your application for licensure by endorsement.

Please be advised that you are required to make a personal appearance before the Credentials Committee of the Board of Medicine to discuss:

- New Jersey State Board Actions
- Failure to meet section 458.313(1)(a) and 458.311(1)(f)3.b., Florida Statutes, ECFMG certification
- Malpractice case(s).

In addition, the Committee may inquire into any other issues relating to your application and eligibility for licensure.

Date:	Thursday, August 6, 2020
Time:	8:00 a.m. (Note: The meeting begins at 8:00 a.m. Your case will be presented between 8:00 a.m. – 1:00 p.m.)
Location:	Teleconference Call Call In #: 1 (888) 585-9008 Conference Room #: 432-162-565

The meeting information and directions for participating in the August 2020 meeting will be posted on the Florida Board of Medicine's website: https://flboardofmedicine.gov/meeting-information.

Additionally, the Committee's recommendation on your application for licensure will be presented to the full Board of Medicine on Friday, August 7, 2020 for final action. You are not required to attend the full board meeting.

Thank you for your continued cooperation. Should you have any questions regarding this matter, please feel free to contact me.

Sincerely,

Angela Denson

Angela Denson
Regulatory Supervisor

Pursuant to the provisions of the Americans with Disabilities Act, any person requiring special accommodations to participate in this workshop/meeting is asked to advise the agency at least 10 days before the workshop/meeting by contacting: Rebecca.Hewett@flhealth.gov or call (850) 245-4137.

*** 456.013(3)(c) In considering applications for licensure, the board, or the department when there is no board, may require a personal appearance of the applicant. If the applicant is required to appear, the time period in which a licensure application must be granted or denied shall be tolled until such time as the applicant appears. However, if the applicant fails to appear before the board at either of the next two regularly scheduled board meetings, or fails to appear before the department within 30 days if there is no board, the**

4052 Bald Cypress Way, Bin C-65
Tallahassee, Florida 32399-3253
Phone: 850/245-4131
Fax: 850/488-0596 or 850/412-1268
https://www.FLBoardofMedicine.gov

Florida HEALTH

1501
F-136659

MEDICAL DOCTOR
APPLICATION FOR LICENSURE
Apply for your license online at www.flboardofmedicine.gov

07/08/2019 955.00
ID: 136659 Type: F
BT: 3000755
R#: 919001613

Choose your application type:

☒ Endorsement (1021) ☐ Examination (1024)

☐ Military Veterans Fee Waiver

If you were honorably discharged from the U.S. armed services within 60 months of your application you will qualify for a waiver of the application fee and the initial licensure fee. In order to qualify, please check the box above indicating that you are seeking a waiver and submit **a DD-214 or NGB-22 form as proof of honorable discharge.**

☒ I plan to dispense medicinal drugs in the State of Florida for a fee or other remuneration and hereby register as required by Section 465.0276, F.S. I understand that the fee for the Dispensing Practitioner is $100.00 in addition to the required initial license fee and will submit it along with the license fee.

1. PERSONAL INFORMATION

Name: De La Cruz Nova (Last/Surname) Juan (First) De Dois (Middle) **Date of Birth:** 03/08/1939 (MM/DD/YYYY)

Mailing Address: (The address where mail and your license should be sent)

PO BOX 1554 (Street/ PO Box) ____ (Suite/Apt. No) Vega Baja (City)

PR (State) 00694 (Zip) USA (Country) 787-454-7690 (Phone Number)

Physical Location: A Post Office Box is not acceptable. This address will be posted on the Department of Health's website. *If you do not have a current practice address, your mailing address will be used. When you obtain a practice address, you will be required to update your online practitioner profile.*

Carr. Num. 2Km. 39.5 Call Box 7001 (Street/ P.O. Box) ____ (Suite/Apt. No) Vega Baja (City)

PR (State) 00694 (Zip) USA (Country) 787-585-1580 (Alternate Phone Number)

Email Address: piadeoleo@gmail.com

Under Florida law, email addresses are public records. If you do not want your e-mail address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.

Equal Opportunity Data: We are required to ask that you furnish the following information as part of your voluntary compliance with Section 2, Uniform Guidelines on Employee Selection Procedure (1978) 43 CFR 38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

SEX: ☒ Male ☐ Female **RACE:** ☐ White ☐ Black ☐ Asian/Pacific Islander ☒ Hispanic ☐ Other

☐ Yes ☒ No **Availability for Disaster:** Will you be available to provide health care services in special needs shelters or to help staff disaster medical assistance teams during times of emergency or major disaster?

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2. MEDICAL EDUCATION HISTORY

Federal Credentials Verification Services (FCVS) is not a requirement for licensure. FCVS will primary source verify and provide a copy of the medical school transcript(s), medical school diploma, medical school verification, name change document(s), national examination score report, ECFMG certificate, ECFMG verification and postgraduate training verifications. For more information about FCVS, visit their web-site at www.fcvs.org/.

☐ Yes ☒ No Are you using the FCVS to verify your core credentials?

☒ Yes ☐ No Have you completed the equivalent of 2 academic years of preprofessional, postsecondary education including, courses in anatomy, biology and chemistry prior to entering medical school?

Medical Education:
List in chronological order all medical schools attended, whether completed or not. Submit on a separate sheet if needed.

Medical School Name and Address:	From: (mm/yy)	To: (mm/yy)	Date Degree Received:
Universidad Autonoma De Santo Dgo Santo Domingo, Dominican Republic	07/1956	02/1964	02/25/1965

Fifth Pathway Certificate Holders:

If you answer "yes" to any of the following questions, you must request verifications to be sent directly to the Board office.

NA☐ Yes ☐ No Did you attend an international medical school and do not possess a valid ECFMG Certificate?

NA☐ Yes ☐ No Did you receive a bachelor's degree from an accredited United States college or University?

NA☐ Yes ☐ No Did you study at a medical school which is recognized by the World Health Organization?

NA☐ Yes ☐ No Did you complete all of the formal requirement of the International medical school, except the internship or social service requirements, and pass part I of the National board of Medical examination or the Education Commission for Foreign Medical Graduates Examination equivalent?

NA☐ Yes ☐ No Did you complete an academic year of supervised clinical training in a hospital affiliated with a medical school approved by the Council on Medical Education of the American Medical Association and upon completion passed part II of the National Board of Medical Examiners examination or the Education Commission for Foreign Medical Graduates examination Equivalent?

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Postgraduate Training:

Provide the following documentation to support your postgraduate training:

- [ ] Post-Graduate Training Form

In the table below list, in chronological order, all postgraduate training from the date you graduated from medical school to the present. Start with your first program and end with your last or current program. List all programs you began, whether you completed or received credit for the training.

Program Name and Full Mailing Address:	Specialty Area:	From: (mm/yy)	To: (mm/yy)	Did you receive credit? (Y/N)
Caguas Regional Hospital Caguas, Puerto Rico	General Surgery	07/75	06/80	Y

Loan History:

☐ Yes ☒ No Are you currently in default on any health education loan or scholarship obligation? (If "yes", explain on a separate sheet providing accurate details.)

3. EXAMINATION HISTORY

State Board (prior to 1974), State Board (after 1974) & SPEX, LMCC & SPEX, NBME, FLEX, USMLE III, or Combination (prior to 2000)

Request that the score report be sent directly to the Board of Medicine. NOTE: If you took a state Board examination and are not currently licensed in three other states, you must also request your SPEX score be sent.

Exam taken: Puerto Rico State Board Exam Date passed: 10/01/69 (mm/dd/yy)

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4. LICENSURE HISTORY

Request verification of licensure status directly from the licensing entity or www.veridoc.org. Request international license verification(s) if you have practiced outside of the U.S. for at least two of the previous four years.

☒ Yes ☐ No Do you now hold or have you ever held a license to practice medicine or any other profession in any US State or territory, or foreign country? Please list in table below.

Jurisdiction	Profession	License number
NJ	Physician	MA45725NJ
GA	Physician	079598
PR	Physician	3860
NY	Physician	298172

If you answer "yes" to any of the questions in this section, you are required to send an explanation and supporting documentation.

☐ Yes ☒ No Have you had any application for a medical license or professional license denied by any state board or other governmental agency of any state, territory, or country?

☐ Yes ☒ No Are you currently under investigation in any jurisdiction for an act or offense that would constitute a violation of Section 458.331, Florida Statutes?

☐ Yes ☒ No Have you ever had any professional license or license to practice medicine revoked, suspended, placed on probation, or other disciplinary action taken in any state, territory or country?

5. PRACTICE/EMPLOYMENT HISTORY

List the year you legally first began to practice medicine. 1975 (yyyy). This would be the year you began practicing medicine and could be the date you began your postgraduate training.

☒ Yes ☐ No Have you practiced medicine in any jurisdiction for two of the last four years **or** completed a board approved post-graduate training program within the last two years?

☐ Yes ☐ No If your answer to the question above was "No," have you passed a board approved clinical competency exam within the last year? If yes, then submit supporting documentation.

List in chronological order all employment for the last four (4) years.

Name and address of practice or employment	Type of employment	From: mm/yy	To: mm/yy
Hospital Wilma N Vazquez Car. #2 Km 39.5 Call Box 7001,Vega Baja,Puerto Rico 00694	Staff Privileges	03/13	Current

6. CRIMINAL HISTORY

If you answer "Yes" to the following question you are required to send the following items:

a. Self-explanation describing in detail the circumstances surrounding each offense, including dates, city and state, charges and final results
b. Final Dispositions and Arrest Records for all offenses. The Clerk of the Court in the arresting jurisdiction will provide you with these documents. Unavailability of these documents must come in the form of a letter from the Clerk of the Court.
c. Completion of Sentence Documents. You may obtain documentation from the Department of Corrections. The report must include the start date, end date and that the conditions were met

☐ Yes ☒ No Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to, a crime in any jurisdiction other than a minor traffic offense? You must include all misdemeanors and felonies, **even if adjudication was withheld. Driving under the influence (DUI) or driving while impaired (DWI) are not minor traffic offenses for purposes of this question.**

Yes ☒ I have been provided and read the statement from the Florida Department of Law Enforcement regarding the sharing, retention, privacy and right to challenge incorrect criminal history records and the "Privacy Statement" document from the Federal Bureau of Investigation.

7. MILITARY HISTORY

A. ☐ Yes ☒ No Have you ever been in the United States Military and/or Public Health Service?

B. ☐ Yes ☒ No Have you ever been disciplined by any branch of the United States Armed Services or Public Health Services? If you answered "yes" please provide a detailed explanation and supporting documentation

8. CRIMINAL AND MEDICAID/MEDICARE FRAUD QUESTIONS

Applicants for licensure, certification or registration and candidates for examination may be excluded from licensure, certification or registration if their felony conviction falls into certain timeframes as established in Section 456.0635(2), Florida Statutes. If you answer "Yes" to any of the following questions, please provide a written explanation for each question. Supporting documentation includes court dispositions or agency orders where applicable.

1. ☐ Yes ☒ No Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, F.S. (relating to social and economic assistance), Chapter 817, F.S. (relating to fraudulent practices), Chapter 893, F.S. (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction?

If you responded "No" to the question above, skip to question 2.

a. ☐ Yes ☐ No If "yes" to 1, for the felonies of the first or second degree, has it been more than 15 years from the date of the plea, sentence and completion of any subsequent probation?

b. ☐ Yes ☐ No If "Yes" to 1, for felonies of the third degree, has it been more than 10 years from the date of the plea, sentence and completion of any subsequent probation? (This question does not apply to felonies of the third degree under Section 893.13(6)(a), Florida Statutes)

c. ☐ Yes ☐ No If "Yes" to 1, for the felonies of the third degree under Section 893.13(6)(a), Florida Statutes, has it been more than 5 years from the date of the plea, sentence and completion of any subsequent probation?

d ☐ Yes ☐ No If "Yes" to 1, have you successfully completed a drug court program that resulted in the plea for the felony offense being withdrawn or charges dismissed?

2. ☐ Yes ☒ No Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970 (relating to controlled substances) or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)?

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☒ Yes ☐ No Do you currently hold staff privileges in any hospital, health institution, clinic or medical facility? List each facility below.

Name of facility
Hospital Wilma N Vazquez- Vega Baja, PR

If you answer "yes" to the following questions, you are required to send an explanation and supporting documentation.

☐ Yes ☒ No Have you ever had any staff privileges denied, suspended, revoked, modified, restricted, not renewed, or placed on probation, or have you been asked to resign or take a temporary leave of absence or were otherwise acted against by any facility?

☐ Yes ☒ No Do you currently, or have you had, responsibility for graduate medical education within the last 10 years?

In the table below, list all institutions where you have had responsibility for graduate medical education or faculty appointment(s) at any medical school.

Name of institution
NA

☒ Yes ☐ No Are you certified by any specialty board recognized by the American Board of Medical Specialties or specialty board approved by the Florida Board of Medicine?

Board Name	Certification/ Specialty/Sub-Specialty	Date of Certification (mm/yy)
The American board of Abdominal Surgery	Abdominal Surgery	03/98

If you answer "yes" to any of the following questions, please explain on a separate sheet providing accurate details.

☐ Yes ☒ No Have you ever had any final disciplinary action taken against you by a specialty board or other similar national organization?

☐ Yes ☒ No Have you ever been denied or surrendered a DEA registration?

If you responded "No" to the question above, skip to question 3.

a. ☐ Yes ☐ No If "Yes" to 2, has it been more than 15 years before the date of application since the sentence and any subsequent period of probation for such conviction or plea ended?

3. ☐ Yes ☒ No Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409 913, Florida Statutes?

If you responded "No" to the question above, skip to question 4.

a. ☐ Yes ☐ No If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years?

4. ☐ Yes ☒ No Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid Program?

If you responded "No" to the question above, skip to question 5.

a. ☐ Yes ☐ No Have you been in good standing with a state Medicaid program for the most recent five years?

b. ☐ Yes ☐ No Did the termination occur at least 20 years before the date of this application?

5. ☐ Yes ☒ No Are you currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities?

If you answer "Yes" to the questions below, you are required to send the following items:

- **A statement indicating the date of each incident and the number for each case.**
- **An explanation of details for each case and your involvement for each case.**
- **Submit the enclosed Exhibit 1 form.**
- **A copy of the complaint, judgments and/or settlements for each case.**
- **Submit a complete copy of the trial record(s) of each case, including the trial transcript, evidentiary exhibits and final judgment in electronic format.**

☐ Yes ☒ No Have you ever had a judgment entered against you for medical malpractice where the incident(s) of malpractice occurred after November 2, 2004?

☐ Yes ☒ No Within the last 10 years have you had any liability claim(s) or action(s) for damages for personal injury settled or finally adjudicated in an amount that exceeds $100,000.00?

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10. FINANCIAL RESPONSIBILITY

The Financial Responsibility options are divided into two categories, coverage and exemptions. Check only one option of the ten provided as required by s. 458.320, Florida Statutes.

Category I: Financial Responsibility Coverage

☐1. I do not have hospital staff privileges, I do not perform surgery at an ambulatory surgical center and I have established an irrevocable letter or credit or an escrow account in an amount of $100,000/$300,000, in accord with Chapter 675, F. S., for a letter of credit and s. 625.52, F. S., for an escrow account.

☐2. I have hospital staff privileges or I perform surgery at an ambulatory surgical and I have established an irrevocable letter of credit or escrow account in an amount of $250,000/$750,000, in accord with Chapter 675, F. S., for a letter of credit and s. 625.52, F. S. for an escrow account.

☐3. I do not have hospital staff privileges, I do not perform surgery at an ambulatory surgical center and I have obtained and maintain professional liability coverage in an amount not less than $100,000 per claim, with a minimum annual aggregate of not less than $300,000 from an authorized insurer as defined under s. 624.09, F. S., from a surplus lines insurer as defined under s. 626.914(2), F. S., from a risk retention group as defined under s. 627.942, F. S., from the Joint Underwriting Association established under s. 627.351(4), F. S., or through a plan of self-insurance as provided in s. 627.357, F. S.

☐4. I have hospital staff privileges or I perform surgery at an ambulatory surgical and I have professional liability coverage in an amount not less than $250,000 per claim, with a minimum annual aggregate of not less than $750,000 from an authorized insurer as defined under s. 624.09, F. S., from a surplus lines insurer as defined under s. 626.914(2), F. S., from a risk retention group as defined under s. 627.942, F. S., from the Joint Underwriting Association established under s. 627.351(4), F. S., or through a plan of self-insurance as provided in s. 627.357, F. S.

☐5. I have elected not to carry medical malpractice insurance however, I agree to satisfy any adverse judgments up to the minimum amounts pursuant to s. 458.320(5)(g)1, F. S. I understand that I must either post notice in a sign prominently displayed in my reception area or provide a written statement to any person to whom medical services are being provided that I have decided not to carry medical malpractice insurance. I understand that such a sign or notice must contain the wording specified in s. 458.320(5)(g), F. S.

Category II: Financial Responsibility Exemptions

☐6. I practice medicine exclusively as an officer, employee, or agent of the federal government, the state, or its agencies or subdivisions.

☐7. I hold a limited license issued pursuant to s. 458.317, F. S., and practice only under the scope of the limited license.

☒8. I do not practice medicine in the State of Florida.

☐9. I meet all of the following criteria:

(a) I have held an active license to practice in this state or another state or some combination thereof for more than 15 years,

(b) I am retired or maintain part time practice of no more than 1000 patient contact hours per year,

(c) I have had no more than two claims resulting in an indemnity exceeding $25,000 within the previous five-year period,

(d) I have not been convicted of or pled guilty or nolo contendere to any criminal violation specified in Chapter 458, F. S. or the medical practice act in any other state; and

(e) I have not been subject, within the past ten years of practice, to license revocation, suspension, or probation for a period of three years or longer, or a fine of $500 or more for a violation of Chapter 458, F. S., or the medical practice act of another jurisdiction. A regulatory agency's acceptance of a relinquishment of license, stipulation, consent order, or other settlement offered in response to or in anticipation of filing of administrative charges against a license is construed as action against a license. I understand if I am claiming an exception under this section that I must either post notice in a sign prominently displayed in my reception area or provide a written statement to any person to whom medical services are being provided that I have decided not to carry medical malpractice insurance. See Section 458.320(5)(f), Florida Statutes, for specific notice requirements.

☐10. I practice only in conjunction with my teaching duties at an accredited medical school or its teaching hospitals (Interns and residents do not qualify for this exemption).

If you select an exemption based on number 9, you must also complete the affidavit on the following page.

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11. FLORIDA BIRTH RELATED NEUROLOGICAL COMPENSATION ASSOCIATION

You must choose one of the three options described below. Please be sure to view the information about each exemption at www.nica.com. Check only one.

☐	☒	☐	
$5,000	$250	$0	$250.00
Participating	Non-participating	Exempt	Amount enclosed

If you choose "$0 Exempt" provide appropriate documentation to the Board of Medicine and to NICA.

I have read the explanatory information provided by NICA, and I choose the option above.

Signature 6/18/19 Date

Juan De La Cruz Nova, MD
Name
PO Box 1554
Street Address
Vega Baja, PR 00694
City, State, Zip

If you are a participating or non-participating physician, or a physician claiming exemption, you must complete, sign and date this form and return it with your payment to this address.

Board of Medicine
4052 Bald Cypress Way, #C-03
Tallahassee, FL 32399-3253

If you are a physician claiming exemption, you must also send a copy of your completed, signed, and dated form with proof of your exemption to:

NICA
2360 Christopher Place
Tallahassee, FL 32308

If you have any questions about NICA or this form, please contact NICA at www.nica.com or (850) 488-8191.

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12. STATEMENT OF APPLICANT

I state that these statements are true and correct. I recognize that providing false information may result in denial of licensure, disciplinary action against my license, or criminal penalties pursuant to Sections 456.067, 775.083, and 775.084, Florida Statutes. I state that I have read Chapters 456, 458 and 766.301-.316, Florida Statutes and Chapter 64B8, Florida Administrative Code.

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Florida Board of Medicine information which is material to my application for licensure.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind. I state that my answers and all statements made by me herein are true and correct.

Should I furnish any false information in this application, I hereby agree that such act constitutes cause for denial, suspension, or revocation of my license to practice medicine in the State of Florida. If there are any changes to my status or any change that would affect any of my answers to this application I must notify the board within 30 days.

I understand that my records are protected under federal and state regulations governing Confidentiality of Mental Health Patient Records and cannot be disclosed without my written consent unless otherwise provided in the regulations. I understand that my records are protected under federal and state regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it.

Juan De La Cruz Nova, MD
Print name

Signature

6/18/19
Date

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3586636

SPECIFIC POWER OF ATTORNEY

I, Juan De La Cruz Nova,

do hereby authorize and direct Elizabeth Collins, by this Specific Power of Attorney to carry out and execute certain duties pursuant to my request and necessary in Elizabeth Collins's reasonable judgment in connection with my pursuit of a license to practice medicine in the State of Florida ("Licensed State"). It is expressly understood and agreed that this Specific Power of Attorney authorizes Elizabeth Collins to make inquiries as to the status of my application for a medical license in the Licensed State and provide additional information or clarification of any discrepancies on my behalf. This Specific Power of Attorney does not authorize Elizabeth Collins to act on my behalf for any other purpose and shall expire on the date I am granted a license in the Licensed State, the date my application for a medical license is denied, or upon the **Florida Board of Medicine's** receipt of written notice from me of revocation of this Specific Power of Attorney. I hereby release Elizabeth Collins and the Licensing State from any and all liability, damages, claims for damages, suits, actions and causes of action which may accrue as a result of Elizabeth Collins acting on my behalf in connection with my pursuit of a medical license in the Licensed State.

2019 JUL 23 PM 1:26
MEDICINE BOARD

PRINTED NAME OF APPLICANT

Juan De La Cruz Nova

SIGNATURE OF APPLICANT

Being duly sworn, says that he/she is the person who executed the above application for a license to practice medicine and surgery in the State of Florida; and that all the statements herein contained are true in every respect.

Sworn and subscribed to me this 15 day of July, 2019

(Notary Public)

My Commission Expires
does not expire

Yahil Quintero Santos
Vega Baja
Sello
Melao Melao

RECIBO
9397
07/03/2019
$5.00
Sello de Asistencia Legal
80101-2019-0703-76014005

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July 16, 2019

Juan De Dois De La Cruz Nova
P.o. Box 1554
Vega Baja, PR 00694

Dear Dr. De La Cruz Nova:
File: 136659

Thank you for considering Florida for physician licensure. Your application for medical licensure has been received. The application is incomplete for the reasons set out in the attached deficiency notice. Please address these deficiencies as soon as possible to avoid delay in processing your application.

Information received by this office may require additional explanation or documentation to determine licensure eligibility. After all requested documentation is received, your application will be submitted for supervisory review. We will notify you if additional information is required.

Applicants with a history of malpractice, criminal activity, discipline, physical or mental impairment, unfavorable evaluations, or other matters that need explanation may require a personal appearance before the Board of Medicine Credentials Committee for determination of licensure eligibility. If your appearance is required, you will be notified in writing once your application is complete.

You can now follow the progress of your application through our website at: www.FLHealthSource.gov/mqa-services. If you are a returning user, select "Yes" and enter the user ID and password you selected during the registration process under Returning User. If you did not apply for licensure through this screen, select "No" and follow the prompts to create an account. You must have a valid email address to create your account.

Once you are logged in, you will be prompted to add your application to your account. Once you have successfully added your application, you will be directed to your dashboard. Under the "Additional Activities" section, select "Check Application Status" to review any open deficiencies, upload documents or print out instructional documents.

THIS IS IMPORTANT: Your application will remain incomplete until all deficiencies are completed. In addition, you are required to notify the Board office immediately in writing of any occurrence(s) that would in any way change or affect any answer given in the application or an answer provided in response to any of our direct questions to you.

If you have any questions, please contact me at serena.mylescrossley@flhealth.gov, call 850-901-6408.

Sincerely,

Serena Myles-Crossley
Regulatory Specialist II

Enclosure(s)

Juan De Dois De La Cruz Nova **Date: July 16, 2019**

REMINDER: Chapter 456.013(1)(a), Florida Statutes, provides that an incomplete application shall expire one year after initial filing with the department.

YOUR APPLICATION'S EXPIRATION DATE IS **07/07/2020**

APPLICATION SUBMITTED REMAINS DEFICIENT FOR LACK OF THE FOLLOWING:

Your ECFMG status report, directly from the ECFMG, has not been received.

An official verification of your medical license from the state of Georgia and New York has not been received.

You did not submit a NICA form with your application. Please submit this completed form to our office.

The inquiry you mailed to your medical school has not been received.

Your Postgraduate Training Verification Forms have not been received.

We await your FLEX/USMLE/SPEX/National Board exam scores, direct from the Federation of State Medical Boards, which must be requested by the applicant. Please clarify which one of these exams you have taken.

Please verify your date of birth, there is a discrepancy between your application and other documents.

If you have any questions, please contact me at serena.mylescrossley@flhealth.gov, call 850-901-6408. The Florida Board of Medicine has assigned **136659** as your **tracking number**. Please indicate this number if you leave a message, and try to ensure that other sources include it on their communications to us as well.

PLAS

Post-Licensure Assessment System

Post-Licensure Assessment System (PLAS)
Certified Transcript of Scores

This Transcript was prepared by the Federation of State Medical Boards

Recipient:

FLORIDA BOARD OF MEDICINE

Examinee: De La Cruz Nova, Juan De-Dios
Examinee ID: 01116854
Date of Birth: 03/08/1939
Alt Name(s):

It is certified that the above named physician took the Special Purpose Examination on the date(s) entered below for the State Medical Licensing Board(s) listed and obtained the following scores:

Date of Certification: 04/04/2018

Date of Exam	State Exam Taken For	SPEX	Comments
9/19/2016	SELF NOMINATED	65.00	
	SELF NOMINATED		

SPEX is a cognitive examination to assist licensing jurisdictions in their assessment of current competence requisite for general, undifferentiated medical practice by physicians who hold or have a valid, unrestricted license in a United States or Canadian jurisdiction.

NOTE: A search of the Physician Data Center of the Federation of State Medical Boards (FSMB) reveals information on this examinee. The Physician Data Center Report is enclosed.

PLAS

Post-Licensure Assessment System

Post-Licensure Assessment System (PLAS)
Certified Transcript of Scores

This Transcript was prepared by the Federation of State Medical Boards

Examinee ID: 01116854

Examinee: De La Cruz Nova, Juan De-Dios

Date of Birth: 03/08/1939

INTERPRETATION OF RESULTS

SPEX transcripts include a complete results history and notations of any examinations for which the examinee sat and no results were reported, e.g., Incomplete. SPEX examinations are reported using a two-digit scale on which a score of 75 is the recommended minimum passing score.

ANNOTATIONS APPEARING UNDER "COMMENTS"

Circumstances in connection with an administration shown on this transcript may result in one or more annotations listed next to the score. A description of each Comment is provided below:

Indeterminate - Results that cannot be certified as representing a valid measure of the examinee's knowledge or competence as sampled by the examination. Decisions to classify results as inde-terminate may be made on the basis of factors that include, but are not limited to, unexplained inconsistency of performance within the examination or between administrations of the same Step. **No score is reported.** Information regarding the nature of the indeterminate score and the determination of the PLAS Committee on Irregular Behavior and Score Validity is available. If such information is not enclosed with this transcript, it may be obtained by contacting the PLAS Secretariat, Suite 300, 400 Fuller Wiser Rd, Euless, TX 76039-3856, telephone (817) 868-4000.

Incomplete - The examinee sat for some, but not all, of the scheduled examination. **No score is reported.**

Irregular Behavior - The PLAS Committee on Irregular Behavior and Score Validity determined that the examinee engaged in irregular behavior. Examples of irregular behavior are described in the current edition of the *SPEX Information Bulletin.* Information regarding the nature of the irregular behavior and the determination of the Committee is available. If such information is not enclosed with this transcript, it may be obtained by contacting the PLAS Secretariat, Suite 300, 400 Fuller Wiser Rd, Euless, TX 76039-3856, telephone (817) 868-4000.

Score Not Available - The score is not available. Further review and/or analysis may be pending, or it may have been determined that the score cannot be reported.

ANNOTATIONS APPEARING AS "NOTE"

Circumstances <u>not</u> in connection with an administration shown on this transcript may result in one or more annotations and an explanation or instructions to contact the appropriate individual or organization. The Note will appear at the end of the document.

PHYSICIAN DATA CENTER INFORMATION APPEARING AS "NOTE"

The Physician Data Center of the Federation of State Medical Boards (FSMB) contains actions reported to the FSMB by U.S. licensing and disciplinary boards, the U.S. Department of Health and Human Services, government regulatory entities and international licensing authorities. To be included in the Physician Data Center, an action must be a matter of public record or be legally releasable to state medical boards or other entities with recognized authority to review physician credentials. Certain actions reported to and released by the Physician Data Center are not disciplinary or otherwise prejudicial in nature. Such actions are reported to ensure that records are complete and to assist in preventing misrepresentation or the use of lost or stolen credentials by unauthorized persons. Once reported to the FSMB, an action becomes part of the permanent record of the individual physician, and the existence of such an action may be indicated on the SPEX transcript by a Note.

03/2015

This document was printed from a secure website and accurately reflects score information maintained by the FSMB.

PLAS

Post-Licensure Assessment System

Post-Licensure Assessment System (PLAS)
Certified Transcript of Scores

This Transcript was prepared by the Federation of State Medical Boards

Recipient:

FLORIDA BOARD OF MEDICINE

Examinee: De La Cruz Nova, Juan De-Dios
Examinee ID: 01116854
Date of Birth: 03/08/1939
Alt Name(s):

It is certified that the above named physician took the Special Purpose Examination on the date(s) entered below for the State Medical Licensing Board(s) listed and obtained the following scores:

Date of Certification: 07/02/2019

Date of Exam	State Exam Taken For	SPEX	Comments
4/29/2019	SELF NOMINATED	67.00	
9/19/2016	SELF NOMINATED	65.00	

SPEX is a cognitive examination to assist licensing jurisdictions in their assessment of current competence requisite for general, undifferentiated medical practice by physicians who hold or have a valid, unrestricted license in a United States or Canadian jurisdiction.

NOTE: A search of the Physician Data Center of the Federation of State Medical Boards (FSMB) reveals information on this examinee. The Physician Data Center Report is enclosed.

PLAS

Post-Licensure Assessment System

Post-Licensure Assessment System (PLAS)
Certified Transcript of Scores

This Transcript was prepared by the Federation of State Medical Boards

Examinee: De La Cruz Nova, Juan De-Dios

Examinee ID: 01116854

Date of Birth: 03/08/1939

INTERPRETATION OF RESULTS

SPEX transcripts include a complete results history and notations of any examinations for which the examinee sat and no results were reported, e.g., Incomplete. SPEX examinations are reported using a two-digit scale on which a score of 75 is the recommended minimum passing score.

ANNOTATIONS APPEARING UNDER "COMMENTS"

Circumstances in connection with an administration shown on this transcript may result in one or more annotations listed next to the score. A description of each Comment is provided below:

Indeterminate - Results that cannot be certified as representing a valid measure of the examinee's knowledge or competence as sampled by the examination. Decisions to classify results as inde-terminate may be made on the basis of factors that include, but are not limited to, unexplained inconsistency of performance within the examination or between administrations of the same Step. **No score is reported.** Information regarding the nature of the indeterminate score and the determination of the PLAS Committee on Irregular Behavior and Score Validity is available. If such information is not enclosed with this transcript, it may be obtained by contacting the PLAS Secretariat, Suite 300, 400 Fuller Wiser Rd, Euless, TX 76039-3856, telephone (817) 868-4000.

Incomplete - The examinee sat for some, but not all, of the scheduled examination. **No score is reported.**

Irregular Behavior - The PLAS Committee on Irregular Behavior and Score Validity determined that the examinee engaged in irregular behavior. Examples of irregular behavior are described in the current edition of the *SPEX Information Bulletin*. Information regarding the nature of the irregular behavior and the determination of the Committee is available. If such information is not enclosed with this transcript, it may be obtained by contacting the PLAS Secretariat, Suite 300, 400 Fuller Wiser Rd, Euless, TX 76039-3856, telephone (817) 868-4000.

Score Not Available - The score is not available. Further review and/or analysis may be pending, or it may have been determined that the score cannot be reported.

ANNOTATIONS APPEARING AS "NOTE"

Circumstances <u>not</u> in connection with an administration shown on this transcript may result in one or more annotations and an explanation or instructions to contact the appropriate individual or organization. The Note will appear at the end of the document.

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03/2015

This document was printed from a secure website and accurately reflects score information maintained by the FSMB.

Chair
Zachariah Zachariah, M.D.
Ft. Lauderdale, Florida

Members
Hector Vila, M.D.
Tampa, Florida
Vice-Chair

Luz Marina Pages, M.D.
Miami Beach, Florida

Scot N. Ackerman, M.D.
Jacksonville, Florida

Eleonor Pimentel, M.D.
Miami, Florida

David A. Diamond, M.D.
Winter Park, Florida

Vacant, Consumer Member

Robert London, M.D.
Maitland, Florida

Jorge J. Lopez, M.D.
Maitland, Florida

Andre M. Perez
Miami, Florida

Kevin Cairns, M.D.
Fort Lauderdale, Florida

Nicholas W. Romanello, Esq.
Melbourne, Florida

Sarvam TerKonda, M.D.
Jacksonville, Florida

Shailesh Gupta, M.D.
Coral Springs, Florida

Vacant, M.D.

Executive Director
Claudia Kemp, J.D.

September 5, 2020

Maryann Sandy, MD
9827 NW 57th Manor
Coral Springs, FL 33076

Dear Dr. Sandy:

This is in further reference to your application for licensure by endorsement.

Please be advised that you are required to make a personal appearance before the Credentials Committee of the Board of Medicine to discuss:

- **Action by Texas Medical Board**
- **Health History**

In addition, the Committee may inquire into any other issues relating to your application and eligibility for licensure.

Date:	Thursday, October 1, 2020
Time:	8:00 a.m. (Meeting starts at 8:00 a.m. Interview time may vary.)
Location:	The in-person meeting scheduled in Orlando, Florida is cancelled, and the meeting will be held by a web-based meeting platform or, if appropriate, a teleconference call.

The meeting information and directions for participating in the October 2020 meeting will be posted on the Florida Board of Medicine's website: https://flboardofmedicine.gov/meeting-information.

Additionally, the Committee's recommendation on your application for licensure will be presented to the full Board of Medicine on Friday, October 2, 2020 for final action. You are not required to attend the full board meeting.

Thank you for your continued cooperation. Should you have any questions regarding this matter, please feel free to contact me. *This is your first scheduled appearance.

Sincerely,

Karrell D. Goldwire

Karrell D. Goldwire
Regulatory Supervisor

Pursuant to the provisions of the Americans with Disabilities Act, any person requiring special accommodations to participate in this workshop/meeting is asked to advise the agency at least 10 days before the workshop/meeting by contacting: Rebecca.Hewett@flhealth.gov or call (850) 245-4137.

*** 456.013(3)(c) In considering applications for licensure, the board, or the department when there is no board, may require a personal appearance of the applicant. If the applicant is required to appear, the time period in which a licensure application must be granted or denied shall be tolled until such time as the applicant appears. However, if the applicant fails to appear before the board at either of the next two regularly scheduled board meetings, or fails to appear before the department within 30 days if there is no board, the application for licensure shall be denied.**

1501

F-132819

MEDICAL DOCTOR
APPLICATION FOR LICENSURE
Apply for your license online at www.flboardofmedicine.gov

04/02/2020 805.00
ID: 132819 Type: F
BT: 3013469
R#: 919027906

Choose your application type:

☑ Endorsement (1021) ☐ Examination (1024)

☐ Military Veterans Fee Waiver

If you were honorably discharged from the U.S. armed services within 60 months of your application you will qualify for a waiver of the application fee and the initial licensure fee. In order to qualify, please check the box above indicating that you are seeking a waiver and submit **a DD-214 or NGB-22 form as proof of honorable discharge.**

☑ I plan to dispense medicinal drugs in the State of Florida for a fee or other remuneration and hereby register as required by Section 465.0276, F.S. I understand that the fee for the Dispensing Practitioner is $100.00 in addition to the required initial license fee and will submit it along with the license fee.

1. PERSONAL INFORMATION

Name: Sandy (Last/Surname) Maryann (First) _____ (Middle) **Date of Birth:** 09/09/1986 (MM/DD/YYYY)

Mailing Address: (The address where mail and your license should be sent)

9827 NW 57th Manor (Street/ PO Box) _____ (Suite/Apt. No) Coral Springs (City)

FL (State) 33076 (Zip) USA (Country) 561-866-4505 (Phone Number)

Physical Location: A Post Office Box is not acceptable. This address will be posted on the Department of Health's website. *If you do not have a current practice address, your mailing address will be used. When you obtain a practice address, you will be required to update your online practitioner profile.*

9827 NW 57th Manor (Street/ P.O. Box) _____ (Suite/Apt. No) Coral Springs (City)

FL (State) 33076 (Zip) USA (Country) 561-866-4505 (Alternate Phone Number)

Email Address: maryann.sandy@gmail.com

Under Florida law, email addresses are public records. If you do not want your e-mail address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.

Equal Opportunity Data: We are required to ask that you furnish the following information as part of your voluntary compliance with Section 2, Uniform Guidelines on Employee Selection Procedure (1978) 43 CFR 38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

SEX: ☐ Male ☑ Female **RACE:** ☑ White ☐ Black ☐ Asian/Pacific Islander ☐ Hispanic ☐ Other

☑ Yes ☐ No **Availability for Disaster:** Will you be available to provide health care services in special needs shelters or to help staff disaster medical assistance teams during times of emergency or major disaster?

2. MEDICAL EDUCATION HISTORY

Federal Credentials Verification Services (FCVS) is not a requirement for licensure. FCVS will primary source verify and provide a copy of the medical school transcript(s), medical school diploma, medical school verification, name change document(s), national examination score report, ECFMG certificate, ECFMG verification and postgraduate training verifications. For more information about FCVS, visit their web-site at www.fcvs.org/.

☑ Yes ☐ No Are you using the FCVS to verify your core credentials?

☐ Yes ☑ No Have you completed the equivalent of 2 academic years of preprofessional, postsecondary education including, courses in anatomy, biology and chemistry prior to entering medical school?

Medical Education:
List in chronological order all medical schools attended, whether completed or not. Submit on a separate sheet if needed.

Medical School Name and Address:	From: (mm/yy)	To: (mm/yy)	Date Degree Received:
American University of the Caribbean	08/2009	08/2013	08/2013

Fifth Pathway Certificate Holders:

If you answer "yes" to any of the following questions, you must request verifications to be sent directly to the Board office.

☐ Yes ☐ No Did you attend an international medical school and do not possess a valid ECFMG Certificate?

☐ Yes ☐ No Did you receive a bachelor's degree from an accredited United States college or University?

☐ Yes ☐ No Did you study at a medical school which is recognized by the World Health Organization?

☐ Yes ☐ No Did you complete all of the formal requirement of the International medical school, except the internship or social service requirements, and pass part I of the National board of Medical examination or the Education Commission for Foreign Medical Graduates Examination equivalent?

☐ Yes ☐ No Did you complete an academic year of supervised clinical training in a hospital affiliated with a medical school approved by the Council on Medical Education of the American Medical Association and upon completion passed part II of the National Board of Medical Examiners examination or the Education Commission for Foreign Medical Graduates examination Equivalent?

Postgraduate Training:

Provide the following documentation to support your postgraduate training:

☑ Post-Graduate Training Form

In the table below list, in chronological order, all postgraduate training from the date you graduated from medical school to the present. Start with your first program and end with your last or current program. List all programs you began, whether you completed or received credit for the training.

Program Name and Full Mailing Address:	Specialty Area:	From: (mm/yy)	To: (mm/yy)	Did you receive credit? (Y/N)
Baton Rouge General 3600 Florida Blvd Baton Rouge, LA 70806	Family Medicine	07/14	06/17	Y

Loan History:

☐ Yes ☑ No Are you currently in default on any health education loan or scholarship obligation? (If "yes", explain on a separate sheet providing accurate details.)

3. EXAMINATION HISTORY

State Board (prior to 1974), State Board (after 1974) & SPEX, LMCC & SPEX, NBME, FLEX, USMLE III, or Combination (prior to 2000)

Request that the score report be sent directly to the Board of Medicine. NOTE: If you took a state Board examination and are not currently licensed in three other states, you must also request your SPEX score be sent.

Exam taken: American Board of Family Medicine Date passed: 04/17/2017 (mm/dd/yy)

☐ Yes ☑ No Do you currently hold staff privileges in any hospital, health institution, clinic or medical facility? List each facility below.

Name of facility

If you answer "yes" to the following questions, you are required to send an explanation and supporting documentation.

☐ Yes ☑ No Have you ever had any staff privileges denied, suspended, revoked, modified, restricted, not renewed, or placed on probation, or have you been asked to resign or take a temporary leave of absence or were otherwise acted against by any facility?

☐ Yes ☑ No Do you currently, or have you had, responsibility for graduate medical education within the last 10 years?

In the table below, list all institutions where you have had responsibility for graduate medical education or faculty appointment(s) at any medical school.

Name of institution

☑ Yes ☐ No Are you certified by any specialty board recognized by the American Board of Medical Specialties or specialty board approved by the Florida Board of Medicine?

Board Name	Certification/ Specialty/Sub-Specialty	Date of Certification (mm/yy)
American Board of Family Medicine	Family Medicine	07/17

If you answer "yes" to any of the following questions, please explain on a separate sheet providing accurate details.

☐ Yes ☑ No Have you ever had any final disciplinary action taken against you by a specialty board or other similar national organization?

☐ Yes ☑ No Have you ever been denied or surrendered a DEA registration?

6. CRIMINAL HISTORY

If you answer "Yes" to the following question you are required to send the following items:

a. Self-explanation describing in detail the circumstances surrounding each offense, including dates, city and state, charges and final results.
b. Final Dispositions and Arrest Records for all offenses. The Clerk of the Court in the arresting jurisdiction will provide you with these documents. Unavailability of these documents must come in the form of a letter from the Clerk of the Court.
c. Completion of Sentence Documents. You may obtain documentation from the Department of Corrections. The report must include the start date, end date and that the conditions were met.

☐ Yes ☑ No Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to, a crime in any jurisdiction other than a minor traffic offense? You must include all misdemeanors and felonies, **even if adjudication was withheld. Driving under the influence (DUI) or driving while impaired (DWI) are not minor traffic offenses for purposes of this question.**

Yes ☑ I have been provided and read the statement from the Florida Department of Law Enforcement regarding the sharing, retention, privacy and right to challenge incorrect criminal history records and the "Privacy Statement" document from the Federal Bureau of Investigation.

7. MILITARY HISTORY

A. ☐ Yes ☑ No Have you ever been in the United States Military and/or Public Health Service?

B. ☐ Yes ☑ No Have you ever been disciplined by any branch of the United States Armed Services or Public Health Services? If you answered "yes" please provide a detailed explanation and supporting documentation

8. CRIMINAL AND MEDICAID/MEDICARE FRAUD QUESTIONS

Applicants for licensure, certification or registration and candidates for examination may be excluded from licensure, certification or registration if their felony conviction falls into certain timeframes as established in Section 456.0635(2), Florida Statutes. If you answer "Yes" to any of the following questions, please provide a written explanation for each question. Supporting documentation includes court dispositions or agency orders where applicable.

1. ☐ Yes ☑ No Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, F.S. (relating to social and economic assistance), Chapter 817, F.S. (relating to fraudulent practices), Chapter 893, F.S. (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction?

If you responded "No" to the question above, skip to question 2.

a. ☐ Yes ☐ No If "yes" to 1, for the felonies of the first or second degree, has it been more than 15 years from the date of the plea, sentence and completion of any subsequent probation?

b. ☐ Yes ☐ No If "Yes" to 1, for felonies of the third degree, has it been more than 10 years from the date of the plea, sentence and completion of any subsequent probation? (This question does not apply to felonies of the third degree under Section 893.13(6)(a), Florida Statutes)

c. ☐ Yes ☐ No If "Yes" to 1, for the felonies of the third degree under Section 893.13(6)(a), Florida Statutes, has it been more than 5 years from the date of the plea, sentence and completion of any subsequent probation?

d. ☐ Yes ☐ No If "Yes" to 1, have you successfully completed a drug court program that resulted in the plea for the felony offense being withdrawn or charges dismissed?

2. ☐ Yes ☑ No Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970 (relating to controlled substances) or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)?

If you responded "No" to the question above, skip to question 3.

a. ☐ Yes ☐ No If "Yes" to 2, has it been more than 15 years before the date of application since the sentence and any subsequent period of probation for such conviction or plea ended?

3. ☐ Yes ☑ No Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes?

If you responded "No" to the question above, skip to question 4.

a. ☐ Yes ☐ No If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years?

4. ☐ Yes ☑ No Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid Program?

If you responded "No" to the question above, skip to question 5.

a. ☐ Yes ☐ No Have you been in good standing with a state Medicaid program for the most recent five years?

b. ☐ Yes ☐ No Did the termination occur at least 20 years before the date of this application?

5. ☐ Yes ☑ No Are you currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities?

If you answer "Yes" to the questions below, you are required to send the following items:

- **A statement indicating the date of each incident and the number for each case.**
- **An explanation of details for each case and your involvement for each case.**
- **Submit the enclosed Exhibit 1 form.**
- **A copy of the complaint, judgments and/or settlements for each case.**
- **Submit a complete copy of the trial record(s) of each case, including the trial transcript, evidentiary exhibits and final judgment in electronic format.**

☐ Yes ☑ No Have you ever had a judgment entered against you for medical malpractice where the incident(s) of malpractice occurred after November 2, 2004?

☐ Yes ☑ No Within the last 10 years have you had any liability claim(s) or action(s) for damages for personal injury settled or finally adjudicated in an amount that exceeds $100,000.00?

10. FINANCIAL RESPONSIBILITY

The Financial Responsibility options are divided into two categories, coverage and exemptions. Check only one option of the ten provided as required by s. 458.320, Florida Statutes.

Category I: Financial Responsibility Coverage

☐1. I do not have hospital staff privileges, I do not perform surgery at an ambulatory surgical center and I have established an irrevocable letter or credit or an escrow account in an amount of $100,000/$300,000, in accord with Chapter 675, F. S., for a letter of credit and s. 625.52, F. S., for an escrow account.

☐2. I have hospital staff privileges or I perform surgery at an ambulatory surgical and I have established an irrevocable letter of credit or escrow account in an amount of $250,000/$750,000, in accord with Chapter 675, F. S., for a letter of credit and s. 625.52, F. S., for an escrow account.

☑3. I do not have hospital staff privileges, I do not perform surgery at an ambulatory surgical center and I have obtained and maintain professional liability coverage in an amount not less than $100,000 per claim, with a minimum annual aggregate of not less than $300,000 from an authorized insurer as defined under s. 624.09, F. S., from a surplus lines insurer as defined under s. 626.914(2), F. S., from a risk retention group as defined under s. 627.942, F. S., from the Joint Underwriting Association established under s. 627.351(4), F. S., or through a plan of self-insurance as provided in s. 627.357, F. S.

☐4. I have hospital staff privileges or I perform surgery at an ambulatory surgical and I have professional liability coverage in an amount not less than $250,000 per claim, with a minimum annual aggregate of not less than $750,000 from an authorized insurer as defined under s. 624.09, F. S., from a surplus lines insurer as defined under s. 626.914(2), F. S., from a risk retention group as defined under s. 627.942, F. S., from the Joint Underwriting Association established under s. 627.351(4), F. S., or through a plan of self-insurance as provided in s. 627.357, F. S.

☐5. I have elected not to carry medical malpractice insurance however, I agree to satisfy any adverse judgments up to the minimum amounts pursuant to s. 458.320(5)(g)1, F. S. I understand that I must either post notice in a sign prominently displayed in my reception area or provide a written statement to any person to whom medical services are being provided that I have decided not to carry medical malpractice insurance. I understand that such a sign or notice must contain the wording specified in s. 458.320(5)(g), F. S.

Category II: Financial Responsibility Exemptions

☐6. I practice medicine exclusively as an officer, employee, or agent of the federal government, the state, or its agencies or subdivisions.

☐7. I hold a limited license issued pursuant to s. 458.317, F. S., and practice only under the scope of the limited license.

☐8. I do not practice medicine in the State of Florida.

☐9. I meet all of the following criteria:

(a) I have held an active license to practice in this state or another state or some combination thereof for more than 15 years;

(b) I am retired or maintain part time practice of no more than 1000 patient contact hours per year;

(c) I have had no more than two claims resulting in an indemnity exceeding $25,000 within the previous five-year period;

(d) I have not been convicted of or pled guilty or nolo contendere to any criminal violation specified in Chapter 458, F. S. or the medical practice act in any other state; and

(e) I have not been subject, within the past ten years of practice, to license revocation, suspension, or probation for a period of three years or longer, or a fine of $500 or more for a violation of Chapter 458, F. S., or the medical practice act of another jurisdiction. A regulatory agency's acceptance of a relinquishment of license, stipulation, consent order, or other settlement offered in response to or in anticipation of filing of administrative charges against a license is construed as action against a license. I understand if I am claiming an exception under this section that I must either post notice in a sign prominently displayed in my reception area or provide a written statement to any person to whom medical services are being provided that I have decided not to carry medical malpractice insurance. See Section 458.320(5)(f), Florida Statutes, for specific notice requirements.

☐10. I practice only in conjunction with my teaching duties at an accredited medical school or its teaching hospitals. (Interns and residents do not qualify for this exemption).

If you select an exemption based on number 9, you must also complete the affidavit on the following page.

Ann B

11. FLORIDA BIRTH RELATED NEUROLOGICAL COMPENSATION ASSOCIATION

You must choose one of the three options described below. Please be sure to view the information about each exemption at www.nica.com. Check only one.

☐ $5,000 Participating	☑ $250 Non-participating	☐ $0 Exempt	$250 Amount enclosed

If you choose "$0 Exempt" provide appropriate documentation to the Board of Medicine and to NICA.

1501 F- 132819

I have read the explanatory information provided by NICA, and I choose the option above.

Maryann Sandy

Name

Signature 02/19/2020 Date

9827 NW 57th Manor

Street Address

Coral Springs, FL 33076

City, State, Zip

If you are a participating or non-participating physician, or a physician claiming exemption, you must complete, sign and date this form and return it with your payment to this address.

Board of Medicine
4052 Bald Cypress Way, #C-03
Tallahassee, FL 32399-3253

05/01/2020 250.00
ID: 132819 Type: F
BT: 3014631
R#: 919030618

If you are a physician claiming exemption, you must also send a copy of your completed, signed, and dated form with proof of your exemption to:

NICA
2360 Christopher Place
Tallahassee, FL 32308

If you have any questions about NICA or this form, please contact NICA at www.nica.com or (850) 488-8191.

BOARD OF MEDICINE
2020 MAY -5 PM 12:32

12. STATEMENT OF APPLICANT

I state that these statements are true and correct. I recognize that providing false information may result in denial of licensure, disciplinary action against my license, or criminal penalties pursuant to Sections 456.067, 775.083, and 775.084, Florida Statutes. I state that I have read Chapters 456, 458 and 766.301-.316, Florida Statutes and Chapter 64B8, Florida Administrative Code.

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Florida Board of Medicine information which is material to my application for licensure.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind. I state that my answers and all statements made by me herein are true and correct.

Should I furnish any false information in this application, I hereby agree that such act constitutes cause for denial, suspension, or revocation of my license to practice medicine in the State of Florida. If there are any changes to my status or any change that would affect any of my answers to this application I must notify the board within 30 days.

I understand that my records are protected under federal and state regulations governing Confidentiality of Mental Health Patient Records and cannot be disclosed without my written consent unless otherwise provided in the regulations. I understand that my records are protected under federal and state regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it.

Maryann Sandy

Print name

Signature

02/19/2020

Date

April 10, 2020

Maryann Sandy, M.D.
9827 Nw 57th Manor
Coral Springs, FL 33076

Dear Dr. Sandy:
File: 132819

Thank you for considering Florida for physician licensure. Your application for medical licensure has been received. The application is incomplete for the reasons set out in the attached deficiency notice. Please address these deficiencies as soon as possible to avoid delay in processing your application.

Information received by this office may require additional explanation or documentation to determine licensure eligibility. After all requested documentation is received, your application will be submitted for supervisory review. We will notify you if additional information is required.

Applicants with a history of malpractice, criminal activity, discipline, physical or mental impairment, unfavorable evaluations, or other matters that need explanation may require a personal appearance before the Board of Medicine Credentials Committee for determination of licensure eligibility. If your appearance is required, you will be notified in writing once your application is complete.

You can now follow the progress of your application through our website at: www.FLHealthSource.gov/mqa-services. If you are a returning user, select "Yes" and enter the user ID and password you selected during the registration process under Returning User. If you did not apply for licensure through this screen, select "No" and follow the prompts to create an account. You must have a valid email address to create your account.

Once you are logged in, you will be prompted to add your application to your account. Once you have successfully added your application, you will be directed to your dashboard. Under the "Additional Activities" section, select "Check Application Status" to review any open deficiencies, upload documents or print out instructional documents.

THIS IS IMPORTANT: Your application will remain incomplete until all deficiencies are completed. In addition, you are required to notify the Board office immediately in writing of any occurrence(s) that would in any way change or affect any answer given in the application or an answer provided in response to any of our direct questions to you.

If you have any questions, please contact me at AnnMarie.Bissoo@flhealth.gov, or call 850-617-1909.

Sincerely,

Ann-Marie Bissoo

Ann-Marie Bissoo
Regulatory Specialist II

Enclosure(s)

07/20/2020 08:54:25 AM

Louisiana State Board of Medical Examiners

License Verification

Licensee Information

Name	Public Address
MARYANN SANDY	3401 North Blvd, 200, Baton Rouge, LA 70806

Credential Information

Credential Number	Practitioner Type	Current Status	Discipline Status	Issue Date	Expiration Date	Reinstatement Date
306705	PHYSICIAN & SURGEON	Inactive	None	07/21/2017	09/30/2018	
GETP.201310	GRADUATE EDUCATION TEMPORARY PERMIT	Inactive	None	07/01/2014	06/30/2017	

Specialities

Speciality 1	Speciality 2	Speciality 3	Speciality 4
Family Medicine			

Discipline History

If Discipline Status is Conditional, Limited, Probation, Reprimanded, Revoked, Suspended, Past Disciplinary Action or Voluntary Surrender of License, a Board issued order can be found on our Disciplinary Actions page

Credential Number	Discipline Status	Public Document

PRIMARY SOURCE VERIFICATION STATEMENT: Verification service provides data extracted by the LSBME from its own database. The data in this web site is provided by and controlled entirely by the LSBME and therefore constitutes a primary source verification as authentic as a direct inquiry to the LSBME. The information provided through the verification service is all of the information pertinent and available in that field of information in the LSBME database.

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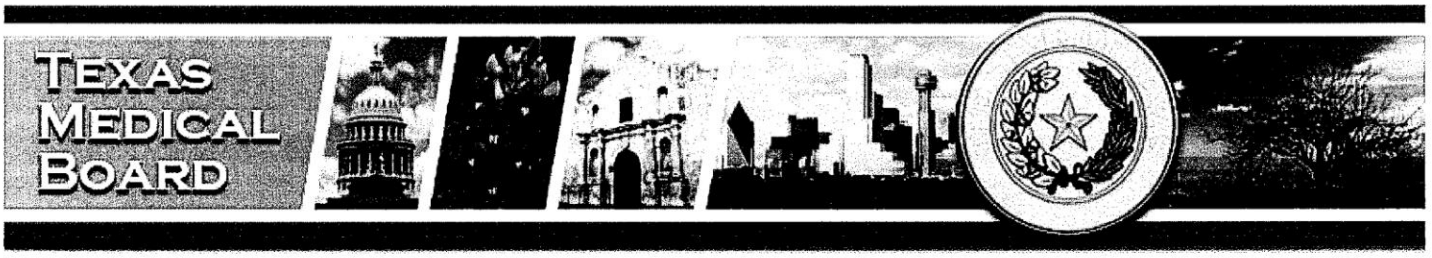


PUBLIC VERIFICATION / PHYSICIAN PROFILE

PHYSICIAN

NAME: MARYANN SANDY MD **DATE:** 07/20/2020

THE INFORMATION IN THIS BOX HAS BEEN VERIFIED BY THE TEXAS MEDICAL BOARD

Date of Birth: 1986
License Number: R4897 Full Medical License
Issuance Date: 10/06/2017
Expiration Date of Physician's Registration Permit: 11/30/2021

Registration Status: ACTIVE
Disciplinary Status: NONE
Licensure Status: NONE

Registration Date: 10/18/2017
Disciplinary Date: NONE
Licensure Date: NONE

Medical School of Graduation:
At the time of licensure, TMB verified the physician's graduation from medical school as follows:
AMERICAN UNIV OF THE CARIBBEAN SCH OF MED, CUPECOY, SINT MAARTEN

Medical School Graduation Year: 2013

TMB Filings, Actions and License Restrictions

The Texas Medical Board has the following board actions against this physician. (This may include any formal complaints filed by TMB, as well as petitions and/or responses related to licensure contested matters, at the State Office of Administrative Hearings.)

NONE

Investigations by TMB of Medical Malpractice

Section 164.201 of the Act requires that: the board review information relating to a physician against whom three or more malpractice claims have been reported within a five year period. Based on these reviews, the following investigations were conducted with the listed resolutions.

NONE

Status History

Status history contains entries for any updates to the individual's registration, licensure or disciplinary status types (beginning with 1/1/78, when the board's records were first automated). Entries are in reverse chronological order; new entries of each type supersede the previous entry of that same type. These records do not display status type. Should you have any questions, please contact our Customer Information Center at 512-305-7030 or verifcic@tmb.state.tx.us

Status Code: AC **Effective Date:** 10/18/2017
Description: ACTIVE

Status Code: LI **Effective Date:** 10/06/2017
Description: LICENSE ISSUED

THE INFORMATION IN THIS BOX WAS REPORTED BY THE LICENSEE AND HAS NOT BEEN VERIFIED BY THE TEXAS MEDICAL BOARD

Gender: FEMALE
***Ethnicity:** DID NOT ANSWER
Race: WHITE
* We are in the process of transitioning from the current ethnic origin values to federal standards for race and Hispanic origin. The transition period will allow time for individuals to submit updated race and Hispanic origin data to the TMB.
Place of Birth: FLORIDA
Current Primary Practice Address:
12600 HILL COUNTRY BLVD BLDG R-103
SUITE R-103
AUSTIN , TX 78738

Years of Active Practice in the U.S. or Canada:
The physician reports that he/she has actively practiced medicine in the United States or Canada for **5** year(s).

Years of Active Practice in Texas:
The physician reports that, of the above years he/she has actively practiced in the State of Texas for **2** year(s).

Specialty Board Certification

The physician reports that he/she holds the following specialty certifications issued by a board that is a member of the American Board of Medical Specialties or the Bureau of Osteopathic Specialists:

Specialty Certification: AMERICAN BOARD OF FAMILY MEDICINE
Date: 2017

Primary Specialty

The physician reports his/her primary practice is in the area of FAMILY MEDICINE.

Secondary Specialty

The physician did not report a secondary practice area.

Name, Location and Graduation Date of All Medical Schools Attended

Name: AMERICAN UNIV OF THE CARIBBEAN SCHOOL OF MEDICINE CUPECOY SINT MAARTEN
Location:
Graduation Date: 08/2013

Graduate Medical Education In The United States Or Canada

Program Name: BATON ROUGE GENERAL FAMILY MEDICINE PROGRAM
Location: BATON ROUGE/LA **Begin Date:** 07/2014
Type: INTERNSHIP **End Date:** 06/2015
Specialty: FAMILY MEDICINE

Program Name: BATON ROUGE GENERAL FAMILY MEDICINE PROGRAM
Location: BATON ROUGE/LA **Begin Date:** 07/2015
Type: RESIDENCY **End Date:** 06/2017
Specialty: FAMILY MEDICINE

Hospital Privileges

The physician reports that he/she has hospital privileges in the following in the State of Texas:

NONE

Utilization Review

The physician did not report whether he/she provides utilization review.

NONE REPORTED

Patient Services

Accessibility: The physician reports that the patient service area **is** accessible to persons with disabilities as defined by federal law.

Language Translation Services: The physician did not report whether he/she provided any language translation services for patients.

Medicaid Participant: The physician reports that he/she **does not** participate in the Medicaid program.

Awards, Honors, Publications and Academic Appointments

Optional Information
The physician may optionally report descriptions of up to five such honors and has reported the following:

Description: BEHAVIORAL HEALTH SCIENCES AWARD

Malpractice Information

Section 154.006(b)(16) of the Act requires that: a physician profile display a description of any medical malpractice claim against the physician, not including a description of any offers by the physician to settle the claim, for which the physician was found liable, a jury awarded monetary damages to the claimant, and the award has been determined to be final and not subject to further appeal. The physician has the following reportable claims.

Description: NONE

Criminal History

Self-Reported Criminal Offenses: The physician is required to report a description of (1) "any conviction for an offense constituting a felony, a Class A or Class B misdemeanor, or a Class C misdemeanor involving moral turpitude" and (2) "any charges reported to the board to which the physician has pleaded no contest, for which the physician is the subject of deferred adjudication or pretrial diversion, or in which sufficient facts of guilt were found and the matter was continued by a court of competent jurisdiction."

The physician has reported the following:

Description: NONE

Criminal history information is also obtained by TMB from the Texas Department of Public Safety. Resulting action, if any, will be reported under the TMB Action and Non-Disciplinary Restrictions section above.

Disciplinary Actions By Other State Medical Boards

The physician has reported the following:

Description: NONE

Physician Assistant Supervision

To obtain primary source

verifications, click name

Description: NONE

Advanced Practice Nurse Delegation

To obtain primary source verifications, click name

Description: NONE

Summary of all License/Permit Types

Issue Date:	Type:
09/26/2017	PHYSICIAN TEMPORARY LICENSE
10/06/2017	LICENSED PHYSICIAN

Chair
Zachariah Zachariah, M.D.
Ft. Lauderdale, Florida

Members
Hector Vila, M.D.
Tampa, Florida
Vice-Chair

Luz Marina Pages, M.D.
Miami Beach, Florida

Scot N. Ackerman, M.D.
Jacksonville, Florida

Eleonor Pimentel, M.D.
Miami, Florida

David A. Diamond, M.D.
Winter Park, Florida

Vacant, Consumer Member

Robert London, M.D.
Maitland, Florida

Jorge J. Lopez, M.D.
Maitland, Florida

Andre M. Perez
Miami, Florida

Kevin Cairns, M.D.
Fort Lauderdale, Florida

Nicholas W. Romanello, Esq.
Melbourne, Florida

Sarvam TerKonda, M.D.
Jacksonville, Florida

Shailesh Gupta, M.D.
Coral Springs, Florida

Vacant, M.D.

Executive Director
Claudia Kemp, J.D.

September 5, 2020

Enrique Marcos Bursztyn, MD
129 Mariposa Drive
Clovis, NM 88101

Dear Dr. Bursztyn:

This is in further reference to your application for licensure by endorsement.

Please be advised that you are required to make a personal appearance before the Credentials Committee of the Board of Medicine to discuss:

- **Action by New York Medical Board**
- **Action by Maryland Medical Board**
- **Action by New Jersey Medical Board**
- **Denial of Clinical Privileges**
- **Malpractice History**

In addition, the Committee may inquire into any other issues relating to your application and eligibility for licensure.

Date:	Thursday, October 1, 2020
Time:	8:00 a.m. (Meeting starts at 8:00 a.m. Interview time may vary.)
Location:	The in-person meeting scheduled in Orlando, Florida is cancelled, and the meeting will be held by a web-based meeting platform or, if appropriate, a teleconference call.

The meeting information and directions for participating in the October 2020 meeting will be posted on the Florida Board of Medicine's website: https://flboardofmedicine.gov/meeting-information.

Additionally, the Committee's recommendation on your application for licensure will be presented to the full Board of Medicine on Friday, October 2, 2020 for final action. You are not required to attend the full board meeting.

Thank you for your continued cooperation. Should you have any questions regarding this matter, please feel free to contact me. *This is your first scheduled appearance.

Sincerely,

Karrell D. Goldwire

Karrell D. Goldwire
Regulatory Supervisor

Pursuant to the provisions of the Americans with Disabilities Act, any person requiring special accommodations to participate in this workshop/meeting is asked to advise the agency at least 10 days before the workshop/meeting by contacting: Rebecca.Hewett@flhealth.gov or call (850) 245-4137.

*** 456.013(3)(c) In considering applications for licensure, the board, or the department when there is no board, may require a personal appearance of the applicant. If the applicant is required to appear, the time period in which a licensure application must be granted or denied shall be tolled until such time as the applicant appears. However, if the applicant fails to appear before the board at either of the next two regularly scheduled board meetings, or fails to appear before the department within 30 days if there is no board, the application for licensure shall be denied.**

Application

Application Detail

License Type:	**Medical Doctor**
Profession Number:	**1501 - Medical Doctor**
File Number:	**144612**
Application:	**Medical Doctor Endorsement Application**
Application Date:	**07/26/2019**

Suitability Question(s)

Are you an osteopathic physician?	**No**

Application Questions

Military Veteran Fee Waiver - I have been honorably discharged from a branch of the United States Armed Forces within the previous 60 months.	**No**
I am selecting NICA Non-Participating - (I understand that a $250.00 fee will be included if I select this option.)	**Yes**
I will qualify for "In Training" status at the approval of my licensure application.	**No**
I plan to dispense medicinal drugs in the State of Florida for a fee or other remuneration and hereby register as required by Section 465.0276,F.S. I understand that the fee for the Dispensing Practitioner is $100.00 over and above the required initial license fee and will submit it along with the license fee.	**No**
I completed a board approved post-graduate training program within the last two years or have practiced medicine in another jurisdiction for two of the last four years.	**Yes**

Street Address Line 1:	**Avenida 18 de Julio 1824**
Street Address Line 2:	**N/A**
City:	**Montevideo**
State:	**N/A**
Postal/Zip:	**11100**
Country:	**URUGUAY**
Date of Graduation (mm/dd/yyyy):	**02/07/1977**
Attended From (mm/dd/yyyy):	**02/07/1969**
Attended To (mm/dd/yyyy):	**02/07/1977**

Additional Education Questions

Are you currently in default on any health education loan or scholarship obligation?	**No**
Have you completed the equivalent of 2 academic years of preprofessional, postsecondary education including, courses in anatomy, biology, and chemistry prior to entering medical school?	**Yes**

Fifth Pathway

Did you attend an international medical school and do not possess a valid ECFMG Certificate?	**No**
Did you receive a bachelor's degree from an accredited United States college or University?	**No**
Did you study at a medical school which is recognized by the World Health Organization?	**No**
Did you complete all of the formal requirement of the International medical school, except the internship or social service requirements, and pass part I of the National board of Medical examination or the Education Commission for Foreign Medical Graduates Examination equivalent?	**No**
Did you complete an academic year of supervised clinical training in a hospital affiliated with a medical school approved by the Council on Medical Education of the American Medical Association and upon completion passed part II of the National Board of Medical Examiners examination or the Education Commission for Foreign Medical Graduates examination Equivalent?	**No**

Postgraduate Training 1

Program Name:	**The Jewish Hospital - Mercy Hospital**

Mailing Address:	**4777 E. Galbraith Rd.**
Program City:	**Cincinnati**
Program State or Country:	**OHIO**
Program Type:	**INTERNSHIP**
Specialty Area:	**GS - SURGERY**
Attended From (mm/dd/yyyy):	**01/01/1978**
Attended To (mm/dd/yyyy):	**12/31/1978**
Did you receive credit?	**Yes**

Postgraduate Training 2

Program Name:	**Temple Univ. Hospital**
Mailing Address:	**3401 N. Board St.**
Program City:	**Philadelphia**
Program State or Country:	**PENNSYLVANIA**
Program Type:	**RESIDENCY**
Specialty Area:	**RADIOLOGY**
Attended From (mm/dd/yyyy):	**01/01/1979**
Attended To (mm/dd/yyyy):	**06/30/1981**
Did you receive credit?	**Yes**

Postgraduate Training 3

Program Name:	**New York Presbyterian Hospital**
Mailing Address:	**525 East 68th St. Box 312**
Program City:	**New York**
Program State or Country:	**NEW YORK**
Program Type:	**FELLOWSHIP**
Specialty Area:	**DR - NEURORADIOLOGY**
Attended From (mm/dd/yyyy):	**07/01/1981**
Attended To (mm/dd/yyyy):	**06/30/1983**
Did you receive credit?	**Yes**

Exam History

Examination:	**Flex/US/Canada**

Date Passed (mm/dd/yyyy): **06/03/1978**

United States Military and/or Public Health

Have you ever been in the United States Military and/or Public Health Service? **No**

Have you ever been disciplined by any branch of the United States Armed Services or Public Health Service? **No**

Other State Licenses 1

Do you now hold or have you ever held a license to practice medicine or any other profession in any US State or territory, or foreign country? **Yes**

Request verification of licensure status directly from the licensing entity or www.veridoc.org. Request international license verification(s) if you have practiced outside of the U.S. for at least two of the previous four years.

License Number: **49797**

Profession: **Medical Doctor**

Jurisdiction - Country: **UNITED STATES**

Jurisdiction - State: **ARIZONA**

Other State Licenses 2

Do you now hold or have you ever held a license to practice medicine or any other profession in any US State or territory, or foreign country? **Yes**

Request verification of licensure status directly from the licensing entity or www.veridoc.org. Request international license verification(s) if you have practiced outside of the U.S. for at least two of the previous four years.

License Number: **01063267A**

Profession: **Medical Doctor**

Jurisdiction - Country: **UNITED STATES**

Jurisdiction - State: **INDIANA**

Other State Licenses 3

Do you now hold or have you ever held a license to practice medicine or any other profession in any US State or territory, or foreign country? **Yes**

Request verification of licensure status directly from the licensing entity or www.veridoc.org. Request international license verification(s) if you have practiced outside of the U.S. for at least two of the previous four years.

License Number: **4301040460**

Profession: **Medical Doctor**

Jurisdiction - Country: **UNITED STATES**

Jurisdiction - State: **MICHIGAN**

Other State Licenses 4

Do you now hold or have you ever held a license to practice medicine or any other profession in any US State or territory, or foreign country? **Yes**

Request verification of licensure status directly from the licensing entity or www.veridoc.org. Request international license verification(s) if you have practiced outside of the U.S. for at least two of the previous four years.

License Number: **25MA03698900**

Profession: **Medical Doctor**

Jurisdiction - Country: **UNITED STATES**

Jurisdiction - State: **NEW JERSEY**

Other State Licenses 5

Do you now hold or have you ever held a license to practice medicine or any other profession in any US State or territory, or foreign country? **Yes**

Request verification of licensure status directly from the licensing entity or www.veridoc.org. Request international license verification(s) if you have practiced outside of the U.S. for at least two of the previous four years.

License Number: **MD2016-0635**

Profession: **Medical Doctor**

Jurisdiction - Country: **UNITED STATES**

Jurisdiction - State: **NEW MEXICO**

Other State Licenses 6

Do you now hold or have you ever held a license to practice medicine or any other profession in any US State or territory, or foreign country? **Yes**

Request verification of licensure status directly from the licensing entity or www.veridoc.org. Request international license verification(s) if you have practiced outside of the U.S. for at least two of the previous four years.

License Number: **145707**

Profession: **Medical Doctor**

Jurisdiction - Country: **UNITED STATES**

Jurisdiction - State: **NEW YORK**

Other State Licenses 7

Do you now hold or have you ever held a license to practice medicine or any other profession in any US State or territory, or foreign country? **Yes**

Request verification of licensure status directly from the licensing entity or www.veridoc.org. Request international license verification(s) if you have practiced outside of the U.S. for at least two of the previous four years.

License Number: **MD021961E**

Profession: **Medical Doctor**

Jurisdiction - Country: **UNITED STATES**

Jurisdiction - State: **PENNSYLVANIA**

Additional Employment Questions

Have you practiced medicine in any jurisdiction for two of the last four years or completed a board approved post-graduate training program within the last two years? **Yes**

Graduate Education

Do you currently, or have you had, responsibility for graduate medical education within the last 10 years? **No**

Initial Graduate Medical Education Responsibility and Faculty Appointments

List all institutions where you have had responsibility for graduate medical education or faculty appointment(s) at any medical school.

Name of Institution: **N/A**

Staff Privileges 1

Do you currently hold staff privileges in any hospital, health institution, clinic or medical facility? **Yes**

The facilities listed are Florida facilities. If your privileges are for a facility in another state, select "Out of State".

Name of Facility: **OUT OF STATE**

Out of State Facility: **Presbyterian Plains Regional Medical Center**

Staff Privileges 2

Do you currently hold staff privileges in any hospital, health institution, clinic or medical facility? **Yes**

The facilities listed are Florida facilities. If your privileges are for a facility in another state, select "Out of State".

Name of Facility: **OUT OF STATE**

Out of State Facility: **Dr. Dan Trigg Memorial Hospital**

Staff Privileges 3

Do you currently hold staff privileges in any hospital, health institution, clinic or medical facility? **Yes**

The facilities listed are Florida facilities. If your privileges are for a facility in another state, select "Out of State".

Name of Facility: **OUT OF STATE**

Out of State Facility: **Presbyterian Kaseman Hospital**

Staff Privileges 4

Do you currently hold staff privileges in any hospital, health institution, clinic or medical facility? **Yes**

The facilities listed are Florida facilities. If your privileges are for a facility in another state, select "Out of State".

Name of Facility: **OUT OF STATE**

Out of State Facility: **Presbyterian Rust Medical Center**

Staff Privileges 5

Do you currently hold staff privileges in any hospital, health institution, clinic or medical facility? **Yes**

The facilities listed are Florida facilities. If your privileges are for a facility in another state, select "Out of State".

Name of Facility: **OUT OF STATE**

Out of State Facility: **Presbyterian Medical Center**

Staff Privileges 6

Do you currently hold staff privileges in any hospital, health institution, clinic or medical facility? **Yes**

The facilities listed are Florida facilities. If your privileges are for a facility in another state, select "Out of State".

Name of Facility: **OUT OF STATE**

Out of State Facility: **Socorro General Hospital**

Specialty Board Certifications

Are you certified by any specialty board recognized by the American Board of Medical Specialties or specialty board approved by the Florida Board of Medicine? **Yes**

Specialty Brd: **AMERICAN BOARD OF RADIOLOGY**

Specialty Cert: **DR - NEURORADIOLOGY**

Date Certified: 06/03/1983

DEA

Have you ever been denied, or surrendered, a DEA registration?	No

Criminal History

Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to, a crime in any jurisdiction other than a minor traffic offense?	No

You must include all misdemeanors and felonies, even if adjudication was withheld. Driving under the influence (DUI) or driving while impaired (DWI) are not minor traffic offenses for purposes of this question.

Medicaid / Medicare

1. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, F.S. (relating to social and economic assistance), Chapter 817, F.S. (relating to fraudulent practices), Chapter 893, F.S. (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction?	No
2. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970 (relating to controlled substances) or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)?	No
3. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, F.S.?	No
4. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program?	No
5. Are you currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities?	No

Health History

In the last five years, have you been enrolled in, required to enter into, or participated in any drug and/or alcohol recovery program or impaired practitioner program for treatment of drug or alcohol abuse that occurred within the past five years?	No
In the last five years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental disorder or impairment?	No

Address Line 1:	**4111 The 25 Way N.E.**
Address Line 2:	**Ste. 150**
City:	**Albuquerque**
State:	**NM**
Type of Employment:	**Full Time Radiologist**
Begin Date (mm/dd/yyyy):	**06/30/2017**
End Date (mm/dd/yyyy):	**07/26/2019**

If 'to present', enter today's date.

Practice Employment 2

Place of Employment:	**Medicus Healthcare Solutions**
Address Line 1:	**Alice Hyde Medical Center**
Address Line 2:	**133 Park St.**
City:	**Malone**
State:	**NY**
Type of Employment:	**Locum Tenens**
Begin Date (mm/dd/yyyy):	**09/22/2014**
End Date (mm/dd/yyyy):	**05/05/2017**

If 'to present', enter today's date.

Fees

Application	**$350.00**
Unlicensed Activity	**$5.00**
NICA Fee	**$250.00**
Initial License	**$350.00**
Total Amount Due:	**$955.00**

Attestation

I state that these statements are true and correct. I recognize that providing false information may result in denial of licensure, disciplinary action against my license, or criminal penalties pursuant to Sections 456.067, 775.083, and 775.084, Florida Statutes. I state that I have read Chapters 456, 458 and 766.301-.316, Florida Statutes and Chapter 64B8, Florida Administrative Code.

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Florida Board of Medicine information which is material to my application for licensure.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind. I state that my answers and all statements made by me herein are true and correct.

Should I furnish any false information in this application, I hereby agree that such act constitutes cause for denial, suspension, or revocation of my license to practice Medicine in the State of Florida. If there are any changes to my status or any change that would affect any of my answers to this application I must notify the board within 30 days.

I understand that my records are protected under federal and state regulations governing Confidentiality of Mental Health Patient Records and cannot be disclosed without my written consent unless otherwise provided in the regulations. I understand that my records are protected under federal and state regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it.

Attestation Answer: Yes

AUTHORIZATION TO RELEASE INFORMATION

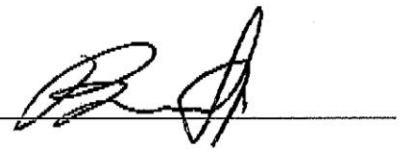
Enrique Bursztyn MD
129 Mariposa Drive
Clovis, NM 88101

I, ENRIQUE BURSZTYN, hereby authorize all hospitals, institutions, organizations, educational institutions, personal and professional references, employers (past and present), business and professional associates (past and present), legal entities, and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the State Board of Medical Examiners/Boards of Medicine and Doctors Licensure Group, Inc. any information, files or records requested by the Medical Board and Doctors Licensure Group, Inc.

I further authorize the State Board of Medical Examiners to release to any organizations, individuals and groups listed above, and Doctors Licensure Group, any information which is material to my application, relating to clinical, residency or postgraduate programs as well as hospital privileges or staff appointments.

I also authorize Mrs. Kim Tomas and Ms. Barbara England, of Doctors Licensure Group, Inc. to act on my behalf in all manners relating to obtaining medical licensure, including requesting information and signing of all documents relating to these matters. Any and all acts carried out by Mrs. Kim Tomas and Ms. Barbara England, on my behalf, shall have the same effect as acts of my own.

This authorization is valid until further written notice from ENRIQUE BURSZTYN M.D.
(Print Name of Applicant)

Signature  Date 03/13/2019

Doctor's Licensure Group, Inc.
P.O. Box 199
Cantonment, FL32533
Office (850) 478-9620, Fax (855) 829-3490
kimt@doclicense.com and barbara@doclicense.com

*All signatures and initials must be done by hand not typed.

July 31, 2019

Enrique Marcos Bursztyn , M.D.
129 Mariposa Dr.
Clovis, NM 88101

Dear Dr. Bursztyn:
File: 144612

Thank you for considering Florida for physician licensure. Your application for medical licensure has been received. The application is incomplete for the reasons set out in the attached deficiency notice. Please address these deficiencies as soon as possible to avoid delay in processing your application.

Information received by this office may require additional explanation or documentation to determine licensure eligibility. After all requested documentation is received, your application will be submitted for supervisory review. We will notify you if additional information is required.

Applicants with a history of malpractice, criminal activity, discipline, physical or mental impairment, unfavorable evaluations, or other matters that need explanation may require a personal appearance before the Board of Medicine Credentials Committee for determination of licensure eligibility. If your appearance is required, you will be notified in writing once your application is complete.

You can now follow the progress of your application through our website at: www.FLHealthSource.gov/mqa-services. If you are a returning user, select "Yes" and enter the user ID and password you selected during the registration process under Returning User. If you did not apply for licensure through this screen, select "No" and follow the prompts to create an account. You must have a valid email address to create your account.

Once you are logged in, you will be prompted to add your application to your account. Once you have successfully added your application, you will be directed to your dashboard. Under the "Additional Activities" section, select "Check Application Status" to review any open deficiencies, upload documents or print out instructional documents.

THIS IS IMPORTANT: Your application will remain incomplete until all deficiencies are completed. In addition, you are required to notify the Board office immediately in writing of any occurrence(s) that would in any way change or affect any answer given in the application or an answer provided in response to any of our direct questions to you.

If you have any questions, please contact me at Lamya.Mollay@flhealth.gov, call 850-617-1914, or fax (850) 412-1294.

Sincerely,

Lamya Mollay

Lamya Mollay
Regulatory Specialist II

Enclosure(s)

Enrique Marcos Bursztyn, MD **Date: July 31, 2019**

REMINDER: Chapter 456.013(1)(a), Florida Statutes, provides that an incomplete application shall expire one year after initial filing with the department.

YOUR APPLICATION'S EXPIRATION DATE IS **July 25, 2020**

APPLICATION SUBMITTED REMAINS DEFICIENT FOR LACK OF THE FOLLOWING:

1. Your ECFMG status report, directly from the ECFMG, has not been received.

2. An official verification of your medical license from the states of IN, NJ, NY, and PA have not been received

3. REGARDING MALPRACTICE, please submit the following:

    a. A statement COMPOSED BY YOU saying how many malpractice cases you have been named in and a statement of the details of each case and your involvement.
    b. For each case, you must obtain a copy of the complaint from the county court in which the case was filed and send a copy to our office
    c. FOR EACH CLOSED CASE, submit a copy of the disposition. If the case was dismissed, submit a copy of the terms of settlement, if applicable.
    d. FOR EACH PENDING CASE, have your attorney submit an original letter addressed to the Florida Board with the current litigation status.
    e. If a case went to arbitration only, submit a copy of the "Notice To File Suit" or the" Statement of Claim" and a certified copy of the Arbitration results.
    f. Completed Exhibit 1 form

4. The inquiry you mailed to your medical school has not been received.

5. Your Postgraduate Training Verification Forms directly from the following institutions have not been received:

    a. The Jewish Hospital 01/1978-12/1978
    b. Temple University Hospital 01/1979-06/1981

Goldwire, Karrell

From: Kim Tomas <kimt@doclicense.com>
Sent: Wednesday, September 4, 2019 12:59 PM
To: Goldwire, Karrell
Subject: file 144612 - Enrique Marcos Bursztyn #3
Attachments: Exhibit 1 Signed.pdf; 2. Detailed Narrative of Cotenoff case.docx; 010.17.05 Cotenoff Complt, Amnd Comp, 2nd Amnd Comp.pdf; 04.08.10 Order_Guardian Cotenoff Case File 30001.pdf; 04.12.10 Stip of DismissalCotenoff Case File 30001.pdf; 04.21.10 Order Cotenoff Case File 30001.pdf; 05.25.10 Order for Distribution Cotenoff Case File 30001.pdf; 06.08.10 Stip of Dismissal Cotenoff Case File 30001.pdf

Hello. I am a third party assisting Dr. Bursztyn with his FL app. We are questioning why he is being asked how many malpractice cases he has been in and to list details of all cases. Yes the doctor has other malpractice cases but they do not pertain to the application questions. The application is specific in its questions.

"Medical Malpractice Question" Have you ever had a judgment entered against you for medical malpractice where the incident(s) of malpractice occurred **after** November 2, 2004? **No,** he has not.
"Liability Claims" Within the last 10 years have you had any liability claim(s) or action(s) for damages for personal injury settled or finally adjudicated in an amount that exceeds $100,000.00? **Yes,** he has had one case that we listed in the application and a summary was given in the application.

See attached documents pertaining to liability questions. NPDB to follow in separate email.
Exhibit 1
Case Narrative
Court complaints
Orders of Guardian
Stipulation of Dismissal

Hopefully the information in this email will cover items needed for #3 on the deficiency list.

Kim Tomas
Research/Bookkeeping
kimt@doclicense.com

Doctors Licensure Group
P.O. Box 199
Cantonment, FL 32533
Ph: (850) 478-9620
Preferred Fax line: (855) 829-3490

Please Note: This message and any attachments are confidential and intended solely for the use of the individual or entity to which they are addressed. If you are not the intended recipient, you are prohibited from printing, copying, forwarding, saving, or otherwise using or relying upon them in any manner.
Please notify the sender immediately if you have received this message by mistake and delete it from your system.
Thank you for your cooperation.

September 23, 2019

Dr, Enrique Marcos Bursztyn
129 Mariposa Dr.
Clovis, NM 88101

Dear Dr. Bursztyn:
File #: 144612

Thank you for considering Florida for physician licensure. Your application has been received and processed. However, the application is incomplete and remains deficient for the following:

a) Verification of MD Degree form directly from the medical school.

b) ECFMG certification status report directly from ECFMG.

c) Verification of Postgraduate Training form directly from:

- Jewish Hospital – 01/1978 to 12/1978
- Temple Univ. Hospital – 01/1979 to 06/1981
- New York Presbyterian Hospital – 07/1981 to 06/1983

d) Verification of licensure status directly from the Indiana and New Jersey state Medical Boards.

e) Statement directly from Alice Hyde Medical Center explaining the reason for denial of Clinical Privileges.

f) Regarding MALPRACTICE, please submit the following:

- A detailed statement listing the case(s) history for each case (your involvement), from start to settlement, and stating that this/these is/are the only malpractice case(s) filed against you. Specify if any monies were paid, and refer to plaintiff(s), locale(s) by name.

- A copy of the initial complaint and any amended complaints filed at the county court where the case was filed.

- Copy of court records from the trial(s). Copy of the trial record(s) of each case, including the trial transcripts, evidentiary exhibits and final judgment.

- For each closed case, a copy of the disposition with terms of settlement which was filed at the county court. For example, if the case was dismissed, submit a copy of the dismissal. If money was paid, submit a copy of the judgment with satisfaction of payment.

- For each pending case, submit an original letter from the attorney, addressed to the Florida Board of Medicine, which gives the current litigation status.

- Completed Exhibit 1 Form for each case.

After all deficient items are received; your file will be submitted for a secondary review. You will be notified if additional information is required.

Section 456.013(1)(a), Florida Statutes, provides that an incomplete application shall expire one year after initial filing with the department. Your application will expire JULY 25, 2020.

If you have any questions, please contact me at Karrell.Goldwire@flhealth.gov, call (850) 617-1907, or fax (850) 412-1279.

Sincerely,

Karrell D. Goldwire

Karrell D. Goldwire
Regulatory Supervisor

Enclosure(s)

July 31, 2020

Enrique Marcos Bursztyn, M.D.
129 Mariposa Dr.
Clovis, NM 88101

Dear Dr. Bursztyn:

It has been determined that you will be required to make a personal appearance before the Credentials Committee for consideration of your application.

This letter is to advise that you are required to appear before the Credentials Committee of the Florida Board of Medicine upon completion of your application file to discuss your application for licensure.

You will receive a letter in the mail approximately 2 weeks prior to the meeting notifying you of the meeting location and time you are required to appear. If you move, please notify our office immediately of your new address. Address changes must be sent in writing and signed by you. Please mail your address change to the address listed below.

If you have any questions, please contact me at Karrell.Goldwire@flhealth.gov, call (850) 617-1907, or fax (850) 412-1279. Your tracking number in our database is 144612. Indicate your tracking number if you leave a message, and try to ensure that other sources include it on their communications to us as well.

Sincerely,

Karrell D. Goldwire

Karrell D. Goldwire
Regulatory Supervisor
Florida Board of Medicine

POST-GRADUATE TRAINING VERIFICATION FORM

Please have this form completed by the Chairman/Director of the post-graduate training program you attended. Please note that if you are using FCVS, do not submit these items.

The form should be emailed or faxed to:

FLORIDA BOARD OF MEDICINE
4052 BALD CYPRESS WAY, BIN C-03
TALLAHASSEE, FLORIDA 32399-3253
~~(850) 412-1279~~ Facsimile **Email to karrell.goldwire@flhealth.gov**

Jewish Hospital
Name of School

General Surgery
Department

4777 E. Galbraith Rd.
Address

Cincinnati, OH 45236
City, State, Zip

* No active records to reference

1. Name of Resident: Enrique Marcos Bursztyn

2. Internship/Residency/Fellowship: From: 1/74 To: 12/74

3. Matriculation Date: 1/74

4. Completion Date: 12/74

5. Specialty: General Surgery

6. Levels completed (check all that apply):

PGY I ✓ PGY II___ PGY III___ PGY IV___ PGY V___

Signed: _____

Chairman or Program Director Only

(No stamped signatures please).

Temple University Hospital
Temple University Health System

3401 N. Broad Street
Philadelphia, PA 19140

Tel: (215) 707-2640
Fax: (215) 707-2060

Beverly L. Hershey, M.D.
Professor of Clinical Radiology
Residency Program Director
Department of Radiology

July 21, 2020

Florida Board of Medicine
4052 Bald Cypress Way, BIN C-03
Tallahassee, Florida 32399-3253

RE: Enrique Marcos Bursztym, MD Training Verification

To Whom It May Concern:

This letter will confirm that **Dr. Enrique Marcos Bursztyn** completed his Diagnostic Radiology Residency training at Temple University Hospital in the Department of Diagnostic Radiology, from **January 1, 1979 through June 30, 1981.** While I was not faculty at that time (and unable to evaluate him first-hand), his record confirms that he completed his training in good standing.

If there are any further questions, please feel free to contact the Graduate Medical Education Program Administrator, Quiara Quinones at 215-707-2640, or email Quiara.Quinones@tuhs.temple.edu

Sincerely,

Beverly L. Hershey, M.D.
Professor of Clinical Radiology
Residency Program Director

POST-GRADUATE TRAINING VERIFICATION FORM

Please have this form completed by the Chairman/Director of the post-graduate training program you attended. Please note that if you are using FCVS, do not submit these items.

The form should be mailed or faxed to:

FLORIDA BOARD OF MEDICINE
4052 BALD CYPRESS WAY, BIN C-03
TALLAHASSEE, FLORIDA 32399-3253
~~(850) 412-1268~~ Facsimile (850) 412-1279 or **email Karrell.Goldwire@flhealth.gov**

Temple University Hospital
Name of School

Diagnostic Raiology
Department

3401 N. Broad St.
Address

Philadelphia, PA 19140
City, State, Zip

1. Name of Resident: Enrique Marcos Bursztyn

2. Internship/**Residency**/Fellowship: From: 1/1/1979 To: 6/30/1981

3. Matriculation Date: 1/1/1979

4. Completion Date: 6/30/1981

5. Specialty: Diagnostic Radiology

6. Levels completed (check all that apply):

PGY I___ PGY II__X__ PGY III__X__ PGY IV__X__ PGY V___

Signed: _____
Chairman or Program Director Only
(No stamped signatures please).

POST-GRADUATE TRAINING VERIFICATION FORM

Please have this form completed by the Chairman/Director of the post-graduate training program you attended. Please note that if you are using FCVS, do not submit these items.

The form should be emailed or faxed to:

FLORIDA BOARD OF MEDICINE
4052 BALD CYPRESS WAY, BIN C-03
TALLAHASSEE, FLORIDA 32399-3253
~~(850) 412-1279~~ Facsimile **Email to: karell.goldwire@flhealth.gov**

New York Presbyterian Hospital
Name of School

Neuroradiology
Department

525 E. 68th Street
Address

New York, NY 10065
City, State, Zip

1. Name of Resident: Enrique Marcos Bursztyn

2. Internship/Residency/**Fellowship:** From: 7/1/1981 To: 6/30/1983

3. Matriculation Date: 7/1/1981

4. Completion Date: 6/30/1983

5. Specialty: Neuroradiology

6. Levels completed (check all that apply):

PGY I ✓ PGY II ✓ PGY III ✓ PGY IV ✓ PGY V ✓

Signed: _____
Chairman or Program Director Only
(No stamped signatures please).

STATE OF INDIANA

Eric J. Holcomb

Indiana Professional Licensing Agency
402 W. Washington St. Room W072
Indianapolis, IN 46204
Phone: (317) 232-2960
Fax: (317) 233-4236

Official Proof of Licensure
Digitally Certified Record

Personal Information

Name:	Enrique Marcos Bursztyn
Address:	129 Mariposa Dr Clovis, NM 88101
Date of Birth:	09/24/1951

License Information

Number Issued:	01063267A
License Type:	Physician
Status:	Active
Issue date:	02/23/2007
Expiration Date:	10/31/2021
Obtained By:	Endorsement

This licensee has met ALL requirements for licensure in the State of Indiana - including successfully passing all required exams.

For disciplinary action information, please visit our License Search & Verify service at www.in.gov/pla/3119.htm. Disciplinary action will either show under Previous Action or Violations. For additional information including questions regarding Disciplinary Action, contact the appropriate Board or Commission at http://www.in.gov/pla/boards.htm.

Digitally Certified on: Thu Nov 14 08:28:50 AM EST 2019

STATE OF MICHIGAN

GRETCHEN WHITMER
GOVERNOR

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

VERIFICATION OF LICENSURE

MICHIGAN BOARD OF MEDICINE

VERIFICATION OF LICENSURE AS OF June 03, 2019

NAME: Enrique M Bursztyn **BIRTHDATE:** 09/24/1951

ADDRESS: 3124 Harbour Dr
Palmyra NJ 080650000

TYPE: Medical Doctor **ORIGINAL DATE:** 01/02/1979

LICENSE NUMBER: 4301040460 **STATUS:** Lapsed **EXPIRATION DATE:** 01/31/1981

OBTAINED BY: Not Available

EXAM DATE	EXAM TYPE	EXAM SCORE OR RESULT

DISCIPLINARY ACTION NONE

OPEN FORMAL COMPLAINTS NONE

2019 JUN -3 PM 4:04
BOARD OF MEDICINE

This verification was produced by VeriDoc on behalf of the State of Michigan with license information last updated on: 4/19/2019.

3612693

New Jersey Office of the Attorney

Division of Consumer Affairs
State Board of Medical Examiners
P.O. Box 183, Trenton, NJ 08625-0183

PHILIP D. MURPHY
Governor

SHEILA Y. OLIVER
Lt. Governor

GURBIR S. GREWAL
Attorney General

PAUL R. RODRÍGUEZ
Acting Director

For Delivery Services:
140 East Front St.
PO Box 183 2nd Floor
Trenton, NJ 08608
(609) 826-7100
(609) 777-0956 *FAX*

MEDICINE BOARD
2019 SEP 25 AM 9:24

September 17, 2019

ORIGINAL

Florida Medical Board
4052 Bald Cypress Way Bin C03
Tallahassee , FL 32399-3253

To Whom It May Concern:

The New Jersey State Board of Medical Examiners has been requested by ENRIQUE M BURSZTYN to forward a letter of good standing regarding the Medical Doctor's license to practice in the State of New Jersey.

A review of the Board's files indicates that ENRIQUE M BURSZTYN was issued a New Jersey license 25MA03698900 on or about 12/06/1979 and is currently Inactive with an expiration date of 06/30/2011. A review of the Board's files further indicates that no public disciplinary action has been taken against this Medical Doctor.

Very truly yours,
BOARD OF MEDICAL EXAMINERS

William V. Roeder
Executive Director

WVR/sdp

New Mexico Medical Board
2055 S. Pacheco Street, Bldg. 400
Santa Fe, New Mexico 87505
505-476-7220

LICENSE VERIFICATION

June 03, 2019

This is to certify that the records of the New Mexico Medical Board indicate the following information regarding the below mentioned physician.

Name: Enrique Marcos Bursztyn, M.D.

Date of Birth: 09/24/1951

School Name **Graduation Date**

Specialties
Radiology - Board Certified

License #	Issue Date	Expiration Date	Status	License Type
MD2016-0635	08/18/2016	07/01/2020	Active	Medical Doctor

Our records indicate there is No Derogatory Information and the license is in good standing.

This license information was last updated on: 05/29/2019

NEW MEXICO MEDICAL BOARD

BOARD OF MEDICINE
2019 JUN -3 PM 4:04

Antoinette Griego

Antoinette Griego, Licensing Manager

Date: June 03, 2019

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE

BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS
POST OFFICE BOX 2649
HARRISBURG, PA 17105-2649

www.dos.pa.gov

09/04/2019

Verification/Certification of License

This is to certify that the individual or business named below is licensed by the Department of State, Bureau of Professional and Occupational Affairs:

NAME:	ENRIQUE MARCOS BURSZTYN
LICENSE TYPE:	Medical Physician and Surgeon
LICENSE #:	MD021961E
LICENSE STATUS:	Inactive
LICENSE ISSUE DATE:	04/27/1979
LICENSE EXPIRATION DATE:	12/31/2018
DISCIPLINARY HISTORY:	No Disciplinary Action Exists

K. Kalonji Johnson, Acting Commissioner
Bureau of Professional and Occupational Affairs

Chair
Zachariah Zachariah, M.D.
Ft. Lauderdale, Florida

Members
Hector Vila, M.D.
Tampa, Florida
Vice-Chair

Luz Marina Pages, M.D.
Miami Beach, Florida

Scot N. Ackerman, M.D.
Jacksonville, Florida

Eleonor Pimentel, M.D.
Miami, Florida

David A. Diamond, M.D.
Winter Park, Florida

Vacant, Consumer Member

Robert London, M.D.
Maitland, Florida

Jorge J. Lopez, M.D.
Maitland, Florida

Andre M. Perez
Miami, Florida

Kevin Cairns, M.D.
Fort Lauderdale, Florida

Nicholas W. Romanello, Esq.
Melbourne, Florida

Sarvam TerKonda, M.D.
Jacksonville, Florida

Shailesh Gupta, M.D.
Coral Springs, Florida

Vacant, M.D.

Executive Director
Claudia Kemp, J.D.

September 1, 2020

Carlos Guillermo Miranda, MD
295 Lenox Avenue
Paterson, New Jersey 07502-1033

Dear Dr. Miranda:

This is in further reference to your application for licensure by endorsement.

Please be advised that you are required to make a personal appearance before the Credentials Committee of the Board of Medicine to discuss:

- **Volunteer Surrender of Clinical Privileges**

In addition, the Committee may inquire into any other issues relating to your application and eligibility for licensure.

Date:	Thursday, October 1, 2020
Time:	8:00 a.m. (Meeting starts at 8:00 a.m. Interview time may vary.)
Location:	The in-person meeting scheduled in Orlando, Florida is cancelled, and the meeting will be held by a web-based meeting platform or, if appropriate, a teleconference call.

The meeting information and directions for participating in the October 2020 meeting will be posted on the Florida Board of Medicine's website: https://flboardofmedicine.gov/meeting-information.

Additionally, the Committee's recommendation on your application for licensure will be presented to the full Board of Medicine on Friday, October 2, 2020 for final action. You are not required to attend the full board meeting.

Thank you for your continued cooperation. Should you have any questions regarding this matter, please feel free to contact me. *This is your first scheduled appearance.

Sincerely,

Angela Denson

Angela Denson
Regulatory Supervisor

Pursuant to the provisions of the Americans with Disabilities Act, any person requiring special accommodations to participate in this workshop/meeting is asked to advise the agency at least 10 days before the workshop/meeting by contacting: Rebecca.Hewett@flhealth.gov or call (850) 245-4137.

*** 456.013(3)(c) In considering applications for licensure, the board, or the department when there is no board, may require a personal appearance of the applicant. If the applicant is required to appear, the time period in which a licensure application must be granted or denied shall be tolled until such time as the applicant appears. However, if the applicant fails to appear before the board at either of the next two regularly scheduled board meetings, or fails to appear before the department within 30 days if there is no board, the application for licensure shall be denied.**

1501 CARLOS G. MIRANDA - 7

MEDICAL DOCTOR APPLICATION FOR LICENSURE F-148698

Apply for your license online at www.flboardofmedicine.gov

04/21/2020 316.00
ID: 148698 Type: F
BT: 3014215
R#: 919029679

Choose your application type:

☑ Endorsement (1021) ☐ Examination (1024)

☐ Military Veterans Fee Waiver

If you were honorably discharged from the U.S. armed services within 60 months of your application you will qualify for a waiver of the application fee and the initial licensure fee. In order to qualify, please check the box above indicating that you are seeking a waiver and submit **a DD-214 or NGB-22 form as proof of honorable discharge.**

☐ I plan to dispense medicinal drugs in the State of Florida for a fee or other remuneration and hereby register as required by Section 465.0276, F.S. I understand that the fee for the Dispensing Practitioner is $100.00 in addition to the required initial license fee and will submit it along with the license fee.

1. PERSONAL INFORMATION

Name: MIRANDA (Last/Surname) CARLOS (First) GUILLERMO (Middle) **Date of Birth:** 05/15/1957 (MM/DD/YYYY)

Mailing Address: (The address where mail and your license should be sent)

295 LENOX AVE (Street/ PO Box) ____ (Suite/Apt. No) PATERSON (City)

NJ (State) 07502-1033 (Zip) USA (Country) 201-341-4541 (Phone Number)

Physical Location: A Post Office Box is not acceptable. This address will be posted on the Department of Health's website. *If you do not have a current practice address, your mailing address will be used. When you obtain a practice address, you will be required to update your online practitioner profile.*

OPTUM PRIMARY CARE 2301 13th STREET (US 192) (Street/ P.O. Box) ____ (Suite/Apt. No) SAINT CLOUD (City)

FLORIDA (State) 34769 (Zip) USA (Country) 1(407)891-7244 (Alternate Phone Number)

Email Address: _____

Under Florida law, email addresses are public records. If you do not want your e-mail address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.

Equal Opportunity Data: We are required to ask that you furnish the following information as part of your voluntary compliance with Section 2, Uniform Guidelines on Employee Selection Procedure (1978) 43 CFR 38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

SEX: ☑ Male ☐ Female **RACE:** ☐ White ☐ Black ☐ Asian/Pacific Islander ☑ Hispanic ☐ Other

☑ Yes ☐ No **Availability for Disaster:** Will you be available to provide health care services in special needs shelters or to help staff disaster medical assistance teams during times of emergency or major disaster?

CARLOS G. MIRANDA - 8

2. MEDICAL EDUCATION HISTORY

Federal Credentials Verification Services (FCVS) is not a requirement for licensure. FCVS will primary source verify and provide a copy of the medical school transcript(s), medical school diploma, medical school verification, name change document(s), national examination score report, ECFMG certificate, ECFMG verification and postgraduate training verifications. For more information about FCVS, visit their web-site at www.fcvs.org/.

☑ Yes ☐ No Are you using the FCVS to verify your core credentials?

☐ Yes ☑ No Have you completed the equivalent of 2 academic years of preprofessional, postsecondary education including, courses in anatomy, biology and chemistry prior to entering medical school?

Medical Education:
List in chronological order all medical schools attended, whether completed or not. Submit on a separate sheet if needed.

Medical School Name and Address:	From: (mm/yy)	To: (mm/yy)	Date Degree Received:
NATIONAL UNIVERSITY FEDERICO VILLARREAL	04/76	12/84	MEDICAL DOCTOR
JR. RIO CHEPEN NO 240 EL AGUSTINO LIMA-10, PERU			

Fifth Pathway Certificate Holders:

If you answer "yes" to any of the following questions, you must request verifications to be sent directly to the Board office.

☐ Yes ☑ No Did you attend an international medical school and do not possess a valid ECFMG Certificate?

☐ Yes ☑ No Did you receive a bachelor's degree from an accredited United States college or University?

☑ Yes ☐ No Did you study at a medical school which is recognized by the World Health Organization?

☐ Yes ☑ No Did you complete all of the formal requirement of the International medical school, except the internship or social service requirements, and pass part I of the National board of Medical examination or the Education Commission for Foreign Medical Graduates Examination equivalent?

☐ Yes ☑ No Did you complete an academic year of supervised clinical training in a hospital affiliated with a medical school approved by the Council on Medical Education of the American Medical Association and upon completion passed part II of the National Board of Medical Examiners examination or the Education Commission for Foreign Medical Graduates examination Equivalent?

CARLOS G. MIRANDA - 9

Postgraduate Training:

Provide the following documentation to support your postgraduate training:

☑ Post-Graduate Training Form

In the table below list, in chronological order, all postgraduate training from the date you graduated from medical school to the present. Start with your first program and end with your last or current program. List all programs you began, whether you completed or received credit for the training.

Program Name and Full Mailing Address:	Specialty Area:	From: (mm/yy)	To: (mm/yy)	Did you receive credit? (Y/N)
RARITAN BAY MEDICAL CENTER	INTERNAL MEDICINE	07/06	06/09	Y
530 New Brunswick Ave				
Perth Amboy NJ 08861				
USA 732-442-3700				

Loan History:

☐ Yes ☑ No Are you currently in default on any health education loan or scholarship obligation? (If "yes", explain on a separate sheet providing accurate details.)

3. EXAMINATION HISTORY

State Board (prior to 1974), State Board (after 1974) & SPEX, LMCC & SPEX, NBME, FLEX, USMLE III, or Combination (prior to 2000)

Request that the score report be sent directly to the Board of Medicine. NOTE: If you took a state Board examination and are not currently licensed in three other states, you must also request your SPEX score be sent.

Exam taken: USMLE. 0-510-754-5 Date passed: 3/30/98 (mm/dd/yy)

CARLOS G. MIRANDA - 11

☐ Yes ☑ No Do you currently hold staff privileges in any hospital, health institution, clinic or medical facility? List each facility below.

Name of facility

If you answer "yes" to the following questions, you are required to send an explanation and supporting documentation.

☐ Yes ☐ No Have you ever had any staff privileges denied, suspended, revoked, modified, restricted, not renewed, or placed on probation, or have you been asked to resign or take a temporary leave of absence or were otherwise acted against by any facility?

☑ Yes ☐ No Do you currently, or have you had, responsibility for graduate medical education within the last 10 years?

In the table below, list all institutions where you have had responsibility for graduate medical education or faculty appointment(s) at any medical school.

Name of institution
RARITAN BAY MEDICAL CENTER (HACKENSACK MERIDIAN Health System), PERTH AMBOY, NJ. (2017-2018)
ST. JOSEPH'S UNIVERSITY MEDICAL CENTER (PATERSON, NJ) 2019

☑ Yes ☐ No Are you certified by any specialty board recognized by the American Board of Medical Specialties or specialty board approved by the Florida Board of Medicine?

Board Name	Certification/ Specialty/Sub-Specialty	Date of Certification (mm/yy)
AMERICAN BOARD OF INTERNAL MEDICINE	INTERNAL MEDICINE	

If you answer "yes" to any of the following questions, please explain on a separate sheet providing accurate details.

☐ Yes ☑ No Have you ever had any final disciplinary action taken against you by a specialty board or other similar national organization?

☐ Yes ☑ No Have you ever been denied or surrendered a DEA registration?

Carlos G. Miranda - 13

If you responded "No" to the question above, skip to question 3.

a. ☐ Yes ☐ No If "Yes" to 2, has it been more than 15 years before the date of application since the sentence and any subsequent period of probation for such conviction or plea ended?

3. ☐ Yes ☑ No Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes?

If you responded "No" to the question above, skip to question 4.

a. ☐ Yes ☐ No If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years?

4. ☐ Yes ☑ No Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid Program?

If you responded "No" to the question above, skip to question 5.

a. ☐ Yes ☐ No Have you been in good standing with a state Medicaid program for the most recent five years?

b. ☐ Yes ☐ No Did the termination occur at least 20 years before the date of this application?

5. ☐ Yes ☑ No Are you currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities?

If you answer "Yes" to the questions below, you are required to send the following items:

- **A statement indicating the date of each incident and the number for each case.**
- **An explanation of details for each case and your involvement for each case.**
- **Submit the enclosed Exhibit 1 form.**
- **A copy of the complaint, judgments and/or settlements for each case.**
- **Submit a complete copy of the trial record(s) of each case, including the trial transcript, evidentiary exhibits and final judgment in electronic format.**

☐ Yes ☑ No Have you ever had a judgment entered against you for medical malpractice where the incident(s) of malpractice occurred after November 2, 2004?

☐ Yes ☑ No Within the last 10 years have you had any liability claim(s) or action(s) for damages for personal injury settled or finally adjudicated in an amount that exceeds $100,000.00?

Carlos G. Miranda - 15

10. FINANCIAL RESPONSIBILITY

The Financial Responsibility options are divided into two categories, coverage and exemptions. Check only one option of the ten provided as required by s. 458.320, Florida Statutes.

Category I: Financial Responsibility Coverage

- ☑ 1. I do not have hospital staff privileges, I do not perform surgery at an ambulatory surgical center and I have established an irrevocable letter or credit or an escrow account in an amount of $100,000/$300,000, in accord with Chapter 675, F. S., for a letter of credit and s. 625.52, F. S., for an escrow account.
- ☐ 2. I have hospital staff privileges or I perform surgery at an ambulatory surgical and I have established an irrevocable letter of credit or escrow account in an amount of $250,000/$750,000, in accord with Chapter 675, F. S., for a letter of credit and s. 625.52, F. S., for an escrow account.
- ☐ 3. I do not have hospital staff privileges, I do not perform surgery at an ambulatory surgical center and I have obtained and maintain professional liability coverage in an amount not less than $100,000 per claim, with a minimum annual aggregate of not less than $300,000 from an authorized insurer as defined under s. 624.09, F. S., from a surplus lines insurer as defined under s. 626.914(2), F. S., from a risk retention group as defined under s. 627.942, F. S., from the Joint Underwriting Association established under s. 627.351(4), F. S., or through a plan of self-insurance as provided in s. 627.357, F. S.
- ☐ 4. I have hospital staff privileges or I perform surgery at an ambulatory surgical and I have professional liability coverage in an amount not less than $250,000 per claim, with a minimum annual aggregate of not less than $750,000 from an authorized insurer as defined under s. 624.09, F. S., from a surplus lines insurer as defined under s. 626.914(2), F. S., from a risk retention group as defined under s. 627.942, F. S., from the Joint Underwriting Association established under s. 627.351(4), F. S., or through a plan of self-insurance as provided in s. 627.357, F. S.
- ☐ 5. I have elected not to carry medical malpractice insurance however, I agree to satisfy any adverse judgments up to the minimum amounts pursuant to s. 458.320(5)(g)1, F. S. I understand that I must either post notice in a sign prominently displayed in my reception area or provide a written statement to any person to whom medical services are being provided that I have decided not to carry medical malpractice insurance. I understand that such a sign or notice must contain the wording specified in s. 458.320(5)(g), F. S.

Category II: Financial Responsibility Exemptions

- ☐ 6. I practice medicine exclusively as an officer, employee, or agent of the federal government, the state, or its agencies or subdivisions.
- ☐ 7. I hold a limited license issued pursuant to s. 458.317, F. S., and practice only under the scope of the limited license.
- ☑ 8. I do not practice medicine in the State of Florida.
- ☐ 9. I meet all of the following criteria:
  - (a) I have held an active license to practice in this state or another state or some combination thereof for more than 15 years;
  - (b) I am retired or maintain part time practice of no more than 1000 patient contact hours per year;
  - (c) I have had no more than two claims resulting in an indemnity exceeding $25,000 within the previous five-year period;
  - (d) I have not been convicted of or pled guilty or nolo contendere to any criminal violation specified in Chapter 458, F. S. or the medical practice act in any other state; and
  - (e) I have not been subject, within the past ten years of practice, to license revocation, suspension, or probation for a period of three years or longer, or a fine of $500 or more for a violation of Chapter 458, F. S., or the medical practice act of another jurisdiction. A regulatory agency's acceptance of a relinquishment of license, stipulation, consent order, or other settlement offered in response to or in anticipation of filing of administrative charges against a license is construed as action against a license. I understand if I am claiming an exception under this section that I must either post notice in a sign prominently displayed in my reception area or provide a written statement to any person to whom medical services are being provided that I have decided not to carry medical malpractice insurance. See Section 458.320(5)(f), Florida Statutes, for specific notice requirements.
- ☐ 10. I practice only in conjunction with my teaching duties at an accredited medical school or its teaching hospitals. (Interns and residents do not qualify for this exemption).

If you select an exemption based on number 9, you must also complete the affidavit on the following page.

Carlos G. Miranda -17-

11. FLORIDA BIRTH RELATED NEUROLOGICAL COMPENSATION ASSOCIATION

You must choose one of the three options described below. Please be sure to view the information about each exemption at www.nica.com. Check only one.

☐ $5,000 Participating	☑ $250 Non-participating	☐ $0 Exempt	_____ Amount enclosed

If you choose "$0 Exempt" provide appropriate documentation to the Board of Medicine and to NICA.

I have read the explanatory information provided by NICA, and I choose the option above.

Carlos Miranda 3/11/2020
Signature Date

CARLOS G. MIRANDA
Name
295 LENOX AVE
Street Address
PATERSON NJ 07502
City, State, Zip

If you are a participating or non-participating physician, or a physician claiming exemption, you must complete, sign and date this form and return it with your payment to this address.

Board of Medicine
4052 Bald Cypress Way, #C-03
Tallahassee, FL 32399-3253

If you are a physician claiming exemption, you must also send a copy of your completed, signed, and dated form with proof of your exemption to:

NICA
2360 Christopher Place
Tallahassee, FL 32308

If you have any questions about NICA or this form, please contact NICA at www.nica.com or (850) 488-8191.

Carlos G. Miranda - 21

N/A

EXHIBIT 1 - REPORT ON PROFESSIONAL LIABILITY CLAIMS AND ACTIONS

Include information relating to liability actions occurring within the previous 10 years. The actions are required to be reported under section 456.039(1)(b) F. S. You must submit a completed form for each occurrence. If you are an allopathic, osteopathic, or podiatric physician, to satisfy this reporting requirement you may submit copies of reports previously submitted under the requirements of s. 456.049 F. S. instead of this exhibit.

Date of occurrence: / /____ Date reported to licensee: / /____ Date claim reported to insurer or self-insurer / /_____

Injured person's name: (last, first, middle initial)_____

Street Address:_____

City:_____ State:_____ Zip Code: _____

Age:_____ Sex: _____

Date of suit, if filed: / /____

List all defendants with their health care provider license number involved in this claim:

1._____ 2._____

3._____ 4._____

Date of final claim disposition:_____/_____/_____

Date and amount of judgment or settlement, if any: _____

Was there an itemized verdict? [ ] Yes [ ] No (If "YES", attach copy of settlement verdict)

Indemnity paid on behalf of this defendant: $_____

Loss adjustment expense paid to defense counsel: $_____

All other loss adjustment expense paid: $_____

The date and reason for final disposition, if no judgment or settlement: _____

Name of institution at which the injury occurred: _____

Location of injury occurrence:

[ ] Patient's Room [ ] Physical Therapy Dept. [ ] Radiology [ ] Labor & Delivery Room

[ ] Operating Suite [ ] Nursery [ ] Emergency Room

[ ] Recovery Room [ ] Critical Care Unit [ ] Other [ ] Special Procedure Room

Final diagnosis for which treatment was sought or rendered: _____

Describe misdiagnosis made, if any, of the patient's actual condition. _____

Describe the operation, diagnostic, or treatment procedure causing the injury. Use nomenclature and/or descriptions of the procedures used. Include method of anesthesia, or name of drug used for treatment, with detail of administration. _____

Describe the principal injury giving rise to the claim. Use nomenclature and/or descriptions of the injury. Include type of adverse effect from drugs where applicable. _____

Safety management steps taken by the licensee to make similar occurrences less likely: _____

I represent that these statements are true and correct pursuant to s. 837.06, Florida Statutes. I recognize that providing any false statements made in writing with the intent to mislead the Department staff in the performance of their official duties, shall be punishable as provided in s. 775.082 and 775.083, Florida Statutes.

Signature of physician: _____

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Affidavit and Release

fsmb

I, the undersigned, hereby certify under oath that I am the person named in this application, that all statements I have or shall make with respect thereto are true, that I am the original and lawful possessor and person named in the various forms and credentials furnished or to be furnished with respect to my application and that all documents, forms or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

I acknowledge that I have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to me being prosecuted under appropriate federal and state laws.

I authorize and request every person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me to furnish to the Federation Credentials Verification Service any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data and to permit the Federation Credentials Verification Service or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application.

Notary:
Your seal (or stamp) must be partly upon the photo and partly upon the signature of the applicant.

I hereby release, discharge and exonerate the Federation Credentials Verification Service, its agents or representatives and any person furnishing information, of any and all liability of every nature and kind arising out of investigation made by the Federation Credentials Verification Service. I authorize the Federation Credentials Verification Service to release information, material, documents, orders or the like relating to me or this application to any entity at my request.

Carlos Miranda Castillo

Applicant's Signature (must be signed in the presence of a notary)

Miranda Castillo

Applicant's Printed Last Name

Carlos, G.

Applicant's Printed First Name, Middle Initial, and Suffix (e.g., Jr.)

04/23/2020

Date of Signature (must correspond to date of notarization)

PHYLICIA BOZEMAN
ELECTRONIC NOTARY PUBLIC
REG # 7567967
EXPIRES 11/30/2022
COMMONWEALTH OF VIRGINIA

State of Virginia, County of City of Colonial Heights,

I certify that on the date set forth below the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document. The statements on this document are subscribed and sworn to before me by the applicant on this 23 day of April, 20 20.

Notary Public Signature: Phylicia Bozeman

My Notary Commission Expires: 11/30/2022

Please complete and mail this original document to the Federation of State Medical Boards at:

400 FULLER WISER ROAD | EULESS, TX 76039 | TEL(817)868-5000

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FCVS ID Number

FID Number

NotaryCam DocID:5ea21dff98b4674f45ceaa4e

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Identity

Biographic Information

Medical professional Name(s):	**Miranda, Carlos Guillermo**
	Miranda Castillo, Carlos Guillermo
Date of Birth:	May 15, 1957
Place of Birth:	Lima, Lima, PERU

Contact Information

Home Address:	295 Lenox Avenue Paterson, NJ 075021033 UNITED STATES
Mobile Phone:	(201) 341-4541
Email:	cgmirand57@gmail.com

Credentials Analysis Information for Identity

There is no Omission/Discrepancy/Miscellaneous information identified.

República del Perú

Municipalidad Metropolitana de Lima

0241

239814

Nombre Miranda Castillo Carlos Guillermo

Fecha 15-5 #1011

Registros Civiles

PARTIDA NUMERO

En los Registros Civiles del C. P. de Lima, a las doce y treinta —

del día veintidós de mayo de mil novecientos cincuenta y siete

DON Carlos Miranda Elliot

de veintinueve años casado, Jefe de la Guardia

natural de Lima - Lima de nacionalidad peruana

domiciliado en el jirón Callao número ochocientos

identificado con

manifestó un varón — nacido el día quince

de este mes — a las doce y quince minutos —

en la calle especificada

llamado Carlos Guillermo

hijo legítimo del declarante

y de DOÑA Elsa Castillo de Miranda de

veintisiete años natural de Lima

Presentó como testigos a Don Amaydo Martínez Fau,

de treinta — años Jefe de la Guardia Civil domiciliado en

el jirón Callao número ochocientos setenta y

y Don Arturo Menendez de cuarenta y cuatro años

Guardia civil domiciliado en el jirón Lima

número mil ochocientos treinta y cuatro — Ambos identificados

con

En fe de lo cual suscriben:

SEAL VERIFIED

EL DECLARANTE

TESTIGO

EL REGISTRADOR

TESTIGO

EL JEFE DE LOS REGISTROS CIVILES

NACIMIENTOS - POBLACION

MUNICIPALIDAD METROPOLITANA DE LIMA
CERTIFICADO
COPIAS 30.00
SERVICIO
IMPORTE
No COMPROBANTE
FOLIO

Registros Civiles

MUNICIPALIDAD METROPOLITANA DE LIMA
DIRECCION DE REGISTROS CIVILES
División de Procesamiento de Copias
Ing° EDUARDO F. ASTE HUERTA
CERTIFICADO.

COPIA LEGALIZADA PARA USO EN EL EXTRANJERO
170599

MUNICIPALIDAD METROPOLITANA DE LIMA
Dirección Municipal de Servicios a la Ciudad
DIRECCION DE REGISTROS CIVILES
Dra. ROSA GRACIELA ALVA LEON
Directora

00203435

El que suscribe, CERTIFICA
la autenticidad del documento
que es copia fiel del original
Lima, 05 FEB 2002

THOMAS GREG & SONS.

EL REGISTRO NACIONAL DE IDENTIFICACIÓN y ESTADO CIVIL, Da Fé:
Que la firma que antecede corresponde al Jefe de Oficina de Registro de Estado Civil

Sr.(a) .....

La misma que se encuentra registrada en el Registro Único de Identificación de Firma de Registradores

Certificación N° 239416

Lima, 06 FEB. 2002

Nota Se certifica la firma sin juzgar el contenido del documento.

Hugo A. Rospigliosi Troncos
Gerencia de Asesoría Jurídica
REGISTRO NACIONAL DE IDENTIFICACION Y ESTADO CIVIL

0241
23981
Name:
Miranda Castillo
Carlos Guillermo

REPUBLIC OF PERU
METROPOLITAN MUNICIPALITY OF LIMA

At the Civil Registry office in Lima, at five thirty p.m. on the 22nd of May of 1957, appearing before this Office of Civil Status Records, Carlos Miranda of twenty nine years of age and married, presented a male child that was born on May 15th, 1957 named Carlos Guillermo, his legitimate son, and of Elsa Castillo de Miranda, twenty six years of age.

They signed in witness where of :

Declarant
[signature]

Witness
[signature]

Witness
[signature]

The Registrar
[signature]

The Director of the Civil Registrar
[signature]

Translated by Tizoc's Inc.

The National Records of Identification and Civil State: Certifies that the person who undersigns, corresponds to the chief of the civil registry.

[illegible signature]

The same that is on the national archives of the General Registration Office for Identifications and Signatures of officers of the civil registry. Certification No

239416

Lima Feb. 08, 2002

[illegible signature]

Hugo …illegible last name
Legal Council Assurance

NATIONAL RECORDS OF IDENTIFICATION AND CIVIL STATE

Translated by Tizoc's Inc.

TIZOC'S

International Language & Marketing Consultants

CERTIFICATION

We hereby certify that this is a true and accurate translation of the attached document from the SPANISH language into the ENGLISH language, to the best of our knowledge and ability.

Acela Garrett-Vice President
Tizoc's International Language and Marketing Consultants

1/15/2009

Date

2730 N. Stemmons Freeway • West Tower Suite 200 • Dallas, Texas 75207
Phone 214-634-8400 • Toll Free 877-408-4265 • Fax 214-634-7775
E-mail info@tizoc.com • www.tizoc.com

Pt Set ID: 95727

EXPLANATION OF ALTERNATE NAME FORM

Use this form to explain the use of any name(s) not supported by the identity document(s) submitted with your application. Do not write on the back of this form. If additional space is required, please make a photocopy(ies). Be certain to sign the form in the space provided at the bottom of the page. Please do not change the information already typed on the form.

Documented Name The name reported here must be the name on your identity document.	Last Name: Miranda Castillo Rest of Name: Carlos Guillermo
Reported Name	Last Name: Miranda Rest of Name: Carlos Guillermo Explanation of Use of Name: In South America is customary to use both the paternal and maternal last name. In America only the paternal last name is used.
	Last Name: Rest of Name: Explanation of Use of Name: ———
	Last Name: Rest of Name: Explanation of Use of Name: ———

Signature: Carlos Miranda **Date:** 10/09/2008

By typing my name above, I hereby certify that I am the individual referenced in the FCVS application and that I agree to the terms and conditions set forth therein. Furthermore, I acknowledge that I have answered all questions and reported all information on this application page truthfully and completely.

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Chronology of Activities

fsmb

The Chronology of Activities is a comprehensive report of a medical professional's activities as reported to FCVS in the medical professional application.

Start Date	End Date	Activity Type	Location
04/01/1976	12/01/1984	Medical Education	Universidad Nacional Federico Villarreal Lima Lima PERU
05/01/1985	02/28/1987	Work	General Practitioner/Public Health Department Hierro Peru Mining Company San Juan 11421, Peru Marcona, Ica PERU
04/01/1986	02/01/1987	Work	Community Health Center at Vargas Guerra County (Jungle) Orellana, Vargas Guerra County, Ucayali ,Peru Vargas Guerra, Loreto PERU
04/01/1987	03/31/1990	PGT/Education	National University Mayor de San Marcos,Graduate School of Medicine (Lima-Peru), Lima Lima PERU
01/01/1990	05/01/1993	Work	Navy Medical Center, Attending Pediatrician,Outpatient/Inpatient Clinic Ave Republic of Venezuela S/N, Bellavista,Lima Peru Bellavista, Lima PERU
03/01/1990	11/30/1991	Work	San Jose Clinic (Lima-Peru) San Jose Ave, Cercado de Lima, 07006, Peru Bellavista, Lima PERU
04/01/1990	12/31/1990	Work	Navy Medical Center/First Lieutenant/Pediatrician Ave Republica de Venezuela S/N, Bellavista, Peru Bellavista, Lima PERU
01/01/1991	12/31/1991	Work	Navy Hospital,Attending Physician Ave Republic of Venezuela S/N , Bellavista, Lima ,Peru Bellavista, Lima PERU
01/01/1993	05/01/1993	Work	Navy Medical Center/Attending Physician ave Republic of Venezuela S/N, Bellavista, Lima Peru Bellavista, Lima PERU
05/30/1993	05/30/1998	Work	Medical & Surgical Family Practice of Passaic 121 Prospect Ave, Passaic NJ 07055 Passaic, New Jersey UNITED STATES
07/01/1998	06/01/2006	Work	Medical & Surgical Family Practice of Passaic 121 Prospect street, Passaic , NJ 07055 Passaic, New Jersey UNITED STATES
07/01/2006	06/30/2009	Postgraduate Training	Jersey Shore University Medical Center (Perth Amboy) Program Perth Amboy New Jersey UNITED STATES

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Chronology of Activities

fsmb

End of Chronology of Activities report for: Miranda, Carlos Guillermo

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Medical Education

fsmb

Medical Education

Medical School: **Universidad Nacional Federico Villarreal**

Location: Lima, LIM

PERU

Credentials Analysis Information for Medical Education

There is no Omission/Discrepancy/Miscellaneous information identified.

FEDERATION CREDENTIALS VERIFICATION SERVICE (FCVS)

VERIFICATION OF MEDICAL EDUCATION

(This form must be completed by the medical school)

INSTRUCTIONS TO THE DEAN

The individual identified on the attached Authorization For Release of Information, Documents and Records form has authorized your medical school to provide to the Federation Credentials Verification Service (FCVS) any and all information pertaining to their education at your institution. **Please complete this form and forward it to FCVS in the enclosed postage-paid, self-addressed envelope.**

Please note: If your institution processes transcript requests through another office, FCVS has likely made such a request under separate cover. **If your office also processes transcript requests, please attach the individual's official transcript (which indicates courses taken, dates and hours of attendance, and scores, grades, or evaluation).**

VERIFICATION OF MEDICAL EDUCATION

Name of Institution: *Facultad de Medicina "Hipólito Unanue" Universidad Nacional Federico Villarreal*

Complete Address: *Jr Río Chepen N° 290 El Agustino Lima –Perú*

Street Address: _____

City: *El Agustino –Lima* **State:** *Perú* **ZIP Code (Postal Code):** *Lima10 –Perú*

If name of institution was different when this individual attended, please note this name below:

_____

Premedical Education:

Years of education required for admission to your medical school: *N/A*

Credential/degree presented by the applicant for admission to your medical school: *N/A*

Enrollment and Participation: Our records indicate that *Carlos Guillermo MIRANDA CASTILLO*
(type/print individual's name: Last, First, Middle, Suffix)

attended our medical school for total of _____ weeks of medical education on the following dates (mm/dd/yy):

From ____/____/*1976* (Month / Date / Year) **To** ____/____/*1984* (Month / Date / Year)

This individual (check one):

RECEIVED
DEC 07 2009
ECFMG
MAILROOM JY

[X] was awarded the degree of *Medico Cirujano (M.D.)* on *Julio* / *14* / *1993* (Month / Date / Year)

[ ] was NOT awarded a degree (please attach an explanation)

Certification: By my signature, I, *Dr. Felix Mauro Cordero Pinedo* (type/print name), certify that the above information is an accurate account of the above named individual's official records maintained in this and is true and correct to my knowledge.

SEAL VERIFIED

UNIVERSIDAD NACIONAL FEDERICO VILLARREAL
FACULTAD DE MEDICINA "HIPÓLITO UNANUE"
DECANO
LIMA - PERU

If it's institutional Seal Here. Which seal is available this form must be notarized.

Signature: _____

Title: *Decano de la Facultad de Medicina "Hipólito Unanue"*
Universidad Nacional Federico Villarreal

Date of Signature: *29 Octubre del 2009*

Phone: (____) *+ 51 3624699* **Fax:** (____)_____

Email: *correo@medicinaunfv.org*

VERIFICATION OF MEDICAL EDUCATION (continued)

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the individual's medical education. Please check the appropriate response and provide dates and requested information. "Yes" responses to any of these questions require a copy of explanatory records or a written explanation (attach additional pages as necessary).

1. Do this individual's official records reflect (an) interruption(s) or extension(s) in his/her medical education?
   Response **YES** ☐ **NO** ☒

   If YES, please select the reason(s) for, indicate the dates of the interruption(s) or extension(s) and check whether the interruption/extension was approved or unapproved.

	From Mo/Yr	To Mo/Yr	Approved	Unapproved
Personal/Family			☐	☐
Academic remediation			☐	☐
Health			☐	☐
Financial			☐	☐
Participation in joint degree Program (e.g., MD/PhD)			☐	☐
Participation in non-research special study (e.g., fellowship, international experience)			☐	☐
Participation in non-degree research			☐	☐
Other			☐	☐

   Please Specify: _____

2. Do this individual's official records reflect that he/she was ever placed on academic or disciplinary probation during his/her medical education? Response **YES** ☐ **NO** ☒

   If YES, please select the reason(s) for the probation, indicate the date(s) of placement on and removal from probation and attach additional documentation to this report.

	From Mo/Yr	To Mo/Yr
Academic Probation		
Probation for unprofessional conduct/behavioral		
Probation for other reason		

   Please specify reason: _____

3. Do this individual's official records reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons by the medical school or parent university? Response **YES** ☐ **NO** ☒

   If YES, please provide detailed documentation/information about the circumstances and outcome(s):

4. Do this individual's official records reflect that he/she was ever the subject of negative reports or an investigation by the medical school or parent university? Response **YES** ☐ **NO** ☒

   If YES, please provide detailed documentation/information about the circumstances and outcome(s):

5. Do this individual's official records reflect that there were any limitations or special requirements imposed on the individual because of questions of academic imcompetence, disciplinary problems, or any other reason?
   Response **YES** ☐ **NO** ☒

   If YES, please provide detailed documentation/information about the nature of the limitations or special requirements.

SPANISH ORIGINAL	ENGLISH TRANSLATION
Facultad de Medicina "*Hipólito Unanue*" *Universidad Nacional Federico Villareal*	Federico Villareal National University School of Medicine "*Hipólito Unanue*"
Medico Cirujano (M.D.)	Doctor of Medicine and Surgery (M.D.)
Julio/14/1993	July/14/1993
Decano de la Facultad de Medicina "*Hipólito Unanue*"	Dean of the School of Medicine "*Hipólito Unanue*"
Universidad Nacional Federico Villareal	Federico Villareal National University
29 Octubre del 2009	October 29, 2009
[Seal: UNIVERSIDAD NACIONAL FEDERICO VILLAREAL FACULTAD DE MEDICINA "Hipólito Unanue DECANO LIMA-PERU]	[Seal: FEDERICO VILLAREAL NATIONAL UNIVERSITY SCHOOL OF MEDICINE "Hipólito Unanue" LIMA-PERU]

Certificate of Accurate Translation

No. 06222020-309

Teneo Linguistics Company, LLC,

a translation company based in Tarrant County, state of Texas (TX state vendor ID: 120511285800), hereby certifies that the attached is a true and accurate translation of the original submitted, completed to the best of our knowledge, ability and belief by a qualified and certified translator of the Spanish and English languages. *

Original Language:	Spanish
Target Language:	English
No. of pages:	1
Type of Document:	Bilingual Table (Carlos Guillermo Miranda Castillo)
Date of Translation:	June 22, 2020

Tori Gugino

Digitally signed by Tori Gugino
DN: cn=Tori Gugino, o=Teneo Linguistics Company, LLC, email=tori@tlctranslation.com, c=US
Date: 2020.06.22 11:21:04 -05'00'

Tori Gugino
Project Manager

* Teneo Linguistics Co. does not warrant the authenticity of the original document.

4700 Bryant Irvin Court
Ste 301
Fort Worth, TX 76107

Tel. (817) 441 9974
Fax. (817) 231 0052

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Applicant Reported Unusual Circumstances

fsmb

Medical School

Medical Professional Name: Miranda, Carlos Guillermo

Universidad Nacional Federico Villarreal

Unusual Circumstances

Did you have any interruption(s) or extension(s) in your medical education?	**No**
Were you ever placed on probation?	**No**
Were you ever disciplined or placed under investigation?	**No**
Were any negative reports for behavioral reasons ever filed by instructors?	**No**
Were any limitations or special requirements imposed on you because of academic performance, incompetence, disciplinary problems or for any other reason?	**No**

End of Applicant Reported Unusual Circumstances report for: Miranda, Carlos Guillermo

400 FULLER WISER ROAD | EULESS, TX 76039 | TEL (817) 868 - 5000 | FAX (817) 868 - 5099

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Universidad Nacional
Federico Villarreal

Facultad de Medicina "Hipólito Unanue"

Lima, October 28, 2009.

Dear Sirs:

I am very please to introduce MIRANDA CASTILLO Carlos Guillermo, graduate from our School of Medicine, who is graduated from our University in 1993 and to support application to your Medical License.

Throughout his medical education, Carlos ha always shown an outstanding dedication, competitive, willingness to lean, excellent background of knowledge and skills in the care of patients. He has been a distinguished and highly motivated student, ranking number 02 among 110.

During his years of training, including the internship, Carlos has shown to be extremely diligent and hard working; persistent in reaching his objectives.

As a person Carlos is kind, honest and sincere. He has a very pleasing personality and gets along very well with patients and members of the house staff. He is always willing to help other and is very cooperative in any work group.

From my point of view, Carlos is a highly qualified physician who will represent an extraordinary contribution. It is certain that if he is given the opportunity you will corroborate my opinion about him.

For any further information about him, please do not hesitate to contact me through the phone numbers shown above.

Sincerely yours.

UNIVERSIDAD NACIONAL FEDERICO VILLARREAL
FACULTAD DE MEDICINA "HIPÓLITO UNANUE"
DECANO
LIMA - PERU

DR. FÉLIX MAURO CORDERO PINEDO
DECANO
FACULTAD DE MEDICINA "HIPÓLITO UNANUE"

FCP/rosario CV.

Jirón Río Chepén 290, El Agustino
Telefax: 362-4699 / 219-3600, anexo 8526, Postgrado 8524

LA SECRETARIA GENERAL DE LA UNIVERSIDAD NACIONAL FEDERICO VILLARREAL, *que suscribe,* ***CERTIFICA,*** *que este documento es* ***AUTENTICO*** *y ha sido expedido y suscrito por las autoridades competentes de la Universidad, cuya(s) firma(s) son* ***auténticas.*** *Se expide la presente certificación* ***a solicitud del*** *interesado.*

San Miguel, 10 NOV. 2009

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LIMA

PATRICIA VELASCO VALDERAS
SECRETARIA GENERAL

REPUBLICA DEL PERU
MINISTERIO DE EDUCACION
SECRETARIA GENERAL
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N° 63457
Lima, 12 NOV. 2009

BELEN HUAMAN VIDALON
LEGALIZACIONES

FACULTAD DE MEDICINA "HIPOLITO UNANUE"
DECANO
LIMA - PERU

RECEIVED
DEC 23 2009
BY

Universidad Nacional
Federico Villarreal

Certificado de Estudios

Nº 0175150

El Jefe de la Oficina Central de Registros Académicos
y Centro de Cómputo

Certifica Que: Código de Matrícula: 0007604023

Don(ña) MIRANDA CASTILLO CARLOS GUILLERMO

Facultad : MEDICINA "HIPOLITO UNANUE"
Escuela : MEDICINA
Especialidad :

Ha aprobado las siguientes asignaturas con los resultados que se indican:

Código	Asignaturas	Nota	Crd.	Ciclo
CB101	BIOLOGIA	14	04	1976-1
FQ101	FISICA	12	04	1976-1
FQ103	QUIMICA INORGANICA Y ORGANICA	15	04	1976-1
HS141	HISTORIA DEL PERU Y SU PROBLEMATICA	15	04	1976-1
LL101	INGLES I	12	02	1976-1
MA102	MATEMATICA BASICA	16	04	1976-1
CB103	ANATOMIA COMPARADA	11	04	1976-2
FQ106	FISICO QUIMICA	14	04	1976-2
FQ107	QUIMICA II ANALITICA	14	04	1976-2
LL104	LENGUAJE Y COMUNICACION	14	04	1976-2
LL116	INGLES II	11	02	1976-2
MA108	MATEMATICA APLICADA	13	04	1976-2
CM201	ANATOMIA HUMANA	13	10	1977-1
CM202	HISTOLOGIA	14	06	1977-1
CM203	EMBRIOLOGIA Y GENETICA	14	04	1978-1
CM204	NEUROLOGIA BASICA	16	04	1978-1
FQ204	BIOQUIMICA	13	09	1978-1
CC102	MEDICINA PREVENTIVA Y SOCIAL I	14	03	1978-2
CC316	PRINCIPIOS DE ENFERMERIA	14	03	1978-2
CM301	FISIOLOGIA	15	06	1978-2
CM302	MICROBIOLOGIA	13	06	1978-2
CC215	MEDICINA PREVENTIVA Y SOCIAL II	15	03	1979-1
CC512	INTRODUCCION A LA PSIQUIATRIA	11	03	1979-1
CM315	FARMACOLOGIA	15	06	1979-1
CM316	PATOLOGIA I	13	06	1979-1
CC401	MEDICINA I	14	13	1979-2
CC402	RADIOLOGIA Y MEDICINA NUCLEAR	13	04	1979-2
CC319	MEDICINA PREVENTIVA Y SOCIAL III	13	03	1980-2
CC403	MEDICINA II	15	13	1980-2
CC404	PATOLOGIA II	13	03	1980-2
CI901	CIRUGIA I TECNICA QUIRURGICA	14	14	1981-1
ME901	MEDICINA III	16	14	1981-1
ME902	NEUROLOGIA	11	08	1981-1
MP901	PSIQUIATRIA	15	08	1981-1
CI902	CIRUGIA II	16	14	1982-1
ME601	NUTRICION	14	03	1982-1
ME602	MEDICINA FISICA Y REHABILITACION	14	03	1982-1
MI901	GINECO OBSTETRICIA	15	10	1982-1
MI902	PEDIATRIA	16	10	1982-1
MP601	MEDICINA PREVENTIVA Y SOCIAL IV	14	02	1982-1
MP602	PATOLOGIA FORENSE MEDICINA LEGAL	17	02	1982-1
MP902	INTERNADO URBANO	20	36	1984-1

Código	Asignaturas	Nota	Crd.	Ciclo

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OFICINA CENTRAL DE REGISTROS ACADEMICOS Y CENTRO DE COMPUTO

SEAL VERIFIED

Total de Créditos 273

Asi consta en las actas finales de evaluación correspondientes.
Toda raspadura o enmendadura invalida el presente certificado

Observaciones:

VERIFICADO POR:
LIDIA MACAVILCA MINAYA
02
02
01

Lima, 24 de JUNIO de 2009

UNIVERSIDAD NACIONAL FEDERICO VILLARREAL
OFICINA CENTRAL DE REGISTROS ACADEMICOS Y CENTRO DE COMPUTO
LIMA - PERÚ

Jefe de la Oficina Central de Registro Académicos y Centros de Cómputo

MG. ZONIA GUDELIA GELDRES BENITES
JEFE (e)

OCRACC118(MCOLONIOR)

LA SECRETARIA GENERAL DE LA UNIVERSIDAD NACIONAL "FEDERICO VILLARREAL", que suscribe,

CERTIFICA:

Que EL presente

CERTIFICADO DE ESTUDIOS

otorgado por la OFICINA CENTRAL DE REGISTROS ACADÉMICOS Y C. CÓMPUTO de esta Universidad a favor de:

MIRANDA CASTILLO CARLOS GUILLERMO

es auténtico.

Se expide la presente certificación, a solicitud del interesado.

Lima, 07 de 07 del 2009

UNIVERSIDAD NACIONAL FEDERICO VILLARREAL SECRETARIA GENERAL SECRETARIO LIMA

PATRICIA J. VELASCO VALDERAS
SECRETARIA GENERAL

REPUBLICA DEL PERU
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En la fecha se legaliza la firma que antecede
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N° 41900
Lima, 16 JUL 2009

BELEN HUAMAN VIDALON
LEGALIZACIONES

SEAL VERIFIED

MINISTERIO DE RELACIONES EXTERIORES
DIRECCIÓN GENERAL DE POLITICA CONSULAR
Legalización Nº 292145
Se legaliza la firma que antecede del Sr.(a)
BELEN HUAMAN VIDALON
SIN JUZGAR EL CONTENIDO DEL DOCUMENTO

Julia Adela Moreano de Dueñas
Departamento de Legalizaciones
Dirección de Trámites Consulares

REPÚBLICA DEL PERU Dirección de Trámites Consulares LEGALIZACIONES Ministerio de Relaciones Exteriores

RECEIVED
DEC 23 2009

LIMA 16 JUL. 2009

IMPRESO POR 24
Código: 98337 06
Nombre: Juan Jose Jmau 04
Firma:

MAIRA SAWAYA HARB
traductora pública juramentada JVT 54
traductora colegiada CTP 0149

OFFICIAL TRANSLATION

TRANSCRIPTS

UNIVERSIDAD NACIONAL FEDERICO VILLARREAL

Carlos Guillermo MIRANDA CASTILLO

MAIRA SAWAYA HARB
Sworn Public Translator
Register No. 54

Jirón Estados Unidos N° 982, Lima 11 - Perú • (511) 463 2368 / 2618793 / 99965 9717 Fax: 461 6571 • msawaya@terra.com.pe

OFFICIAL TRANSLATION *Nº 1321-09a*

UNIVERSIDAD NACIONAL FEDERICO VILLARREAL
(Federico Villarreal National University)

TRANSCRIPT

Nº 0175150

(Photograph)

The Head of the Central Office of Academic Records and Computer Center certifies that **Carlos Guillermo MIRANDA CASTILLO** with code of enrolment Nº 0007604023 has pursued the following subjects as stated herein:

Department : Medicine "Hipolito Unanue"

School : Medicine

Code	Subjects	Grade	Cr	Term
CB101	BIOLOGY	14	04	1976-1
FQ101	PHYSICS	12	04	1976-1
FQ103	INORGANIC AND ORGANIC CHEMISTRY	15	04	1976-1
HS141	HISTORY OF PERU AND ITS PROBLEMS	15	04	1976-1
LL101	ENGLISH I	12	02	1976-1
MA102	MASIC MATHEMATICS	16	04	1976-1
CB103	COMPARED ANATOMY	11	04	1976-2
FQ106	PHYSICAL CHEMISTRY	14	04	1976-2
FQ107	ANALYTICAL CHEMISTRY II	14	04	1976-2
LL104	LANGUAGE AND COMMUNICATION	14	04	1976-2
LL116	ENGLISH II	11	02	1976-2
MA108	APPLIED MATHEMATICS	13	04	1976-2
CM201	HUMAN ANATOMY	13	10	1977-1
CM202	HISTOLOGY	14	06	1977-1
CM203	EMBRYOLOGY AND GENETICS	14	04	1978-1
CM204	BASIC NEUROLOGY	16	04	1978-1
FQ204	BIOCHEMISTRY	13	09	1978-1
CC102	PREVENTIVE AND SOCIAL MEDICINE I	14	03	1978-2
CC316	PRINCIPLES OF NURSING	14	03	1978-2
CM301	PHYSIOLOGY	15	06	1978-2
CM302	MICROBIOLOGY	13	06	1978-2
CC215	PREVENTIVE AND SOCIAL MEDICINE II	15	03	1979-1
CC512	INTRODUCTION TO PSYCHIATRICS	11	03	1979-1
CM315	PHARMACOLOGY	15	06	1979-1
CM316	PATHOLOGY I	13	06	1979-1
CC401	MEDICINE I	14	13	1979-2
CC402	RADIOLOGY AND NUCLEAR MEDICINE	13	04	1979-2
CC319	PREVENTIVE AND SOCIAL MEDICINE III	13	03	1980-2
CC403	MEDICINE II	15	13	1980-2
CC404	PATHOLOGY II	13	03	1980-2
CI901	SURGERY I - SURGICAL TECHNIQUE	14	14	1981-1
ME901	MEDICINE III	16	14	1981-1
ME902	NEUROLOGY	11	08	1981-1
MP901	PSYCHIATRICS	15	08	1981-1
CI902	SURGERY II	16	14	1982-1
ME601	NUTRITION	14	03	1982-1

MAIRA SAWAYA HARB
Sworn Public Translator
Register No. 54

ME602	PHYSICAL MEDICINE AND REHABILITATION	14	03	1982-1
MI901	GYNECOLOGY AND OBSTETRICS	15	10	1982-1
MI902	PEDIATRICS	16	10	1982-1
MP601	PREVENTIVE AND SOCIAL MEDICINE IV	14	02	1982-1
MP602	FORENSIC PATHOLOGY, LEGAL MEDICINE	17	02	1982-1
MP902	URBAN INTERNSHIP	20	36	1984-1

TOTAL OF CREDITS 273

Lima, June 24, 2009

As stated in the corresponding final records of evaluation.

Any amendment o erasure voids this transcript.

REMARKS:

VERIFIED BY: Lidia MACAVILCA MINAYA 07-02-09

OCRACC118 (NCOLONIOR)

(signature and seal) Zonia Gudelia GELDRES BENITES – Head (e) – *Universidad Nacional Federico Villareal* – Lima – Peru – Central Office of Academic Records

---

Printed by: Juana JUAN (illegible)

Code: 88333

(Signature) (illegible)

Date: 06.24.09

The undersigned Secretary General of *Universidad Nacional Federico Villarreal* hereby certifies that this Transcript, awarded by the Central Office of Academic Registry and Computer Center of this University to Carlos Guillermo MIRANDA CASTILLO is authentic.

This certification is issued at the interested party's request.

Lima, July 07, 2009

(seal and signature) Patricia J. VELASCO VALDERAS – Secretary General

---

MAIRA SAWAYA HARE
Sworn Public Translator
Register No. 54

REPUBLIC OF PERU - MINISTRY OF EDUCATION - SECRETARY GENERAL'S OFFICE - OFFICE OF DOCUMENTARY FORMALITIES - The preceding signature is authenticated on this date without judging the contents of the document. Nº 41900 - Lima, July 16, 2009 - (Signature) Belen HUAMAN VIDALON – Authentications

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MINISTRY OF FOREIGN AFFAIRS OF PERU – GENERAL DIRECTORATE OF CONSULAR POLICY - AUTHENTICATION Nº 292145 – The preceding signature of Belen HUAMAN VIDALON is hereby authenticated without judging the contents of the document. - Lima, July 16, 2009 - (seal and illegible signature) – Julia Adela MOREANO DE DUEÑAS - Department of Authentications – Office of Consular Formalities – (Raised seal of the Ministry of Foreign Affairs)

I,the undersigned Sworn Public Translator,do hereby certify that the foregoing is a true and correct translation of the original text in.....attached hereto.This translation shall not be considered as an acknowledgement of the authenticity of the original document

In witness whereof,I set my hand and affix my seal in the city of Lima (Peru). this 20th **day of** July **2009**

MAIRA SAWAYA HARE
Sworn Public Translator
Register No. 54

NOTARIA GOMEZ VERASTEGUI

República del Perú

A Nombre de la Nación

El Rector de la Universidad Nacional "Federico Villarreal"

Por cuanto: El Consejo de Facultad de Medicina Humana

con fecha 12 de Febrero de 1985 ha aprobado

el otorgamiento del Título de Médico Cirujano

A Carlos Guillermo Miranda Castillo

Y el Consejo Universitario con fecha 14 de Julio de 1993

le ha conferido el Título correspondiente.

Por tanto: le expido el presente Diploma para que se le reconozca como tal.

Dado en la ciudad de Lima, a los 14 días del mes de Julio de 1993

UNIVERSIDAD NACIONAL FEDERICO VILLARREAL
RECTOR
LIMA - PERU

RECTOR

SECRETARIO GENERAL

UNIVERSIDAD NACIONAL FEDERICO VILLARREAL
SECRETARIA GENERAL
SECRETARIO
LIMA

ELECTRONIC SEAL VERIFIED

INTERESADO

Registrado a fojas 66 del Libro 34 respectivo con el No 24676

UNIVERSIDAD NACIONAL FEDERICO VILLARREAL
FACULTAD DE MEDICINA HUMANA
DECANO
LIMA PERU

DECANO

SECRETARIO de Facultad

FACULTAD

LEGALIZACION AL DORSO

EN VIAS DE REGULARIZACION, SE EXPIDE EL PRESENTE DIPLOMA DE TITULO DE MEDICO CIRUJANO, A FAVOR DE DON CARLOS GUILLERMO MIRANDA CASTILLO, DE CONFORMIDAD CON LAS RESOLUCIONES RECTORALES Nºs.0021-86-UNFV Y 0163-86-UNFV DE 26-01-86 Y 19-03-86 - RESPECTIVAMENTE.

LIMA, 14 DE JULIO DE 1993.

UNIVERSIDAD NACIONAL FEDERICO VILLARREAL
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REPUBLICA DEL PERU
SECRETARIO

ECRETARIO GENERAL.

REPUBLICA DEL PERU
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SECRETARIA GENERAL
DIRECCION DE TRAMITE DOCUMENTARIO

UDO PARA SEGUIR ESTUDIOS EN EL EXTRANJERO
ta fecha queda Legalizada la firma que ante
nda.

25066 Lima 23 JUL. 1993

[illegible] BUSTAMANTE TORRES
[illegible]

MINISTERIO DE RELACIONES EXTERIORES DEL PERU
DIRECCION DE LEGALIZACIONES
Nº. 253514 -J
Se Legaliza la Firma que antecede del Sr.
Magdalena Sobrino Torres
Quien desempeña las funciones que señala
Nota : Se Legaliza la Firma sin entrar a juzgar el contenido del documento.
Lima, 02 AGO. 1993
Antonieta Salazar Guzmán
Dirección de Legalizaciones

DIRECCION DE LEGALIZACIONES Ministerio de Relaciones Exteriores

CERTIFICO: Que esta copia fotostática es la REDUCCION de su original que he tenido a la vista, con el cual lo confronté.
Lima, 23 NOV. 1999

COLEGIO DE NOTARIOS LIMA PERU

Dr. Luis Manuel Gómez Verástegui
ABOGADO
NOTARIO DE LIMA

UNFV
O M N I L

O. T. 140 - 92 - 5,000 Nº 0021637

(18) #95727

Universidad Nacional Federico Villarreal
Escuela de Graduados

Republic of Peru
In the Name of the Nation

The Rector of the Universidad Nacional "Federico Villareal" ("Federico Villareal" National University)

WHEREAS: The Council of the School of Human Medicine, on February 12, 1985, approved the conferral of the

PHYSICIAN- SURGEON DEGREE

to /photograph/

CARLOS GUILLERMO MIRANDA CASTILLO

And the University Council, on July 14, 1993 awarded him the corresponding Degree.

THEREFORE: does issue him this Diploma so that he may be acknowledged as such.

Given in the city of Lima, on the 14th day of the month of July, 1993

/University seal/
/signature/
Rector

/University seal/
/signature/
Dean

/signature/
Bearer

/University seal/
/signature/
Secretary General

/University seal/
/signature/
School Secretary

Registered on page 66 of the corresponding book 34 under No. 24676.

BACK OF PAGE:
/illegible/ IT IS EXPEDITED THE PRESENT DIPLOMA OF TITLE OF PHYSICIAN SURGEON, IN FAVOR OF MR. CARLOS GUILLERMO MIRANDA CASTILLO, IN ACCORDANCE WITH THE RECTORAL RESOLUTIONS #'S /ILLEGIBLE/ OF 1/26/86 AND 3/19/86, RESPECTIVELY.

Lima, July 14, 1993
/signature/
/illegible/

ELECTRONIC SEAL VERIFIED

Secretary General
/University Seal/

/illegible/
25066
/signature/
Ministry of Foreign Affairs in Peru
Authentications Office

No. 253514-7
This authenticates the signature of
Magdalena Sobenes /illegible/
Who holds the position indicated.
Note: The signature is authenticated without
Judging the content of the document.
Lima, August 2,1993
/signature/
Antonieta Salazar Guzman
Authentications Office
/Ministry seal/

/emblem/
/illegible/- 92- 5,000 No. 0021637

/partial seal/
/signature/

Jessica La Torre certifies that I am a competent translator of both the Spanish and English languages and have done this translation of this PHYSICIAN-SURGEON Degree conferred to CARLOS GUILLERMO MIRANDA CASTILLO on July 14th 1993.

J La Torre

Jeannie Castro

JEANNIE CASTRO
NOTARY PUBLIC OF NEW JERSEY
Commission Expires 5/2010

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EDUCATIONAL COMMISSION FOR FOREIGN MEDICAL GRADUATES

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www.ecfmg.org

Issue Date: 23 Jun 2020

To: FLORIDA BOARD OF MEDICINE
SERENA MYLES-CROSSLEY
LICENSURE ANALYST
4052 BALD CYPRESS WAY
BIN# C03
TALLAHASSEE, FL 32399-3253

State Board Code:
010
Please include this number on all requests.

ECFMG® CERTIFICATION STATUS REPORT

USMLE®/ECFMG Identification Number: 0-510-754-5
Applicant's Name: Carlos Guillermo Miranda
Applicant's Date of Birth: 15 May 1957
ECFMG Certified: Yes
Certificate Issue Date: 27 Mar 1998
English Test Valid Through: Valid Indefinitely
Clinical Skills Assessment Valid Through:

Passing Performance on Medical Science Examinations:

Examination	Date	Two Digit Score	Three Digit Score
USMLE Step 1	16 Oct 1996	*	*
USMLE Step 2 CK	31 Aug 1995	*	*

Most Recent Passing Performance on Clinical Skills Examination:

Examination	Date
ECFMG Clinical Skills Assessment	

Most Recent Passing Performance on English Test: Nov 2003

Name of Medical School and Country: Universidad Nacional Federico Villarreal Facultad de Medicina 'Hipólito Unanue', Lima, PERU

Degree Year: 1985

Medical Education Credentials Status†: Complete

How to Verify the Authenticity of this Report:

This report was issued to the named recipient on the date shown above. To verify the authenticity of this report, visit https://cvsonline2.ecfmg.org/verify/verify.asp and enter the unique verification code listed below. The information contained in this report is current as of the issue date. Any changes to the physician's status after the issue date will not be reflected, and you are encouraged to request an updated report.

Report Verification Code: CNPYAWM743

The purpose of this Status Report is to indicate whether this individual is certified by ECFMG. It reflects only examinations that were used to fulfill requirements for ECFMG Certification. The most recent passing performance on the clinical skills examination is reflected, regardless of whether this individual was required to take a clinical skills examination for ECFMG Certification. This Status Report is not a complete score history of all examinations for this individual. This Status Report does not include examinations that were taken but not passed. Furthermore, if this individual passed examinations that were not used to fulfill the requirements for ECFMG Certification, these examinations are not included.

* To obtain a complete USMLE examination history for this individual, contact the appropriate registration entity to request a USMLE transcript.

†Since July 1986, ECFMG has verified medical school credentials directly with the issuing medical schools, or through a reasonable alternative that has been approved by the ECFMG Medical Education Credentials Committee.

Important Note:

Requesting organizations must normally secure and retain the physician's signed authorization to obtain certification information. Organizations may not resell the information or make it available to any party beyond the initial request as authorized by the physician. The information may only be used to confirm ECFMG Certification for the purpose for which the physician provided authorization.

EDUCATIONAL COMMISSION
for
FOREIGN MEDICAL GRADUATES

CERTIFIES THAT

CARLOS GUILLERMO MIRANDA

HAS SATISFIED ALL THE REQUIREMENTS OF THE COMMISSION,

SUCCESSFULLY PASSED ITS EXAMINATIONS

AND HAS BEEN AWARDED THIS CERTIFICATE.

CERTIFICATE NUMBER 0-510-754-5

MEDICAL EXAMINATION

BASIC SCIENCE OCTOBER 16, 1996

CLINICAL SCIENCE AUGUST 31, 1995

ENGLISH EXAMINATION

VALID THROUGH

CERTIFICATE NUMBER
0-510-754-5
ENGLISH EXAMINATION
November 19, 2003
VALID INDEFINITELY

ECFMG

CHAIRMAN, BOARD OF TRUSTEES

PRESIDENT, CHIEF EXECUTIVE OFFICER

DATE ISSUED MARCH 30, 1998

ID # 95724

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Postgraduate Training

fsmb

Postgraduate Training

Accreditation ID: **1403321466**

Institution: **Jersey Shore University Medical Center (Perth Amboy) Program**

Location: Perth Amboy, NJ
UNITED STATES

Credentials Analysis Information for Postgraduate Training

There is no Omission/Discrepancy/Miscellaneous information identified.

Federation of STATE MEDICAL BOARDS

Fe tion Credentials Verification Service (FCV

Federation Place, P.O. Box 619850, Dallas, TX 75261-9850
Tel: (817) 868-5000 Fax: (817) 868-4186

Verification of Postgraduate Medical Education

Institution: Raritan Bay Medical Center

Address: INTERNAL MEDICINE

Perth Amboy, NJ 08861

Attention: **Program Director**

Affiliated University: _____

Verification For:

Name: **Miranda, Carlos Guillermo**

DOB: **05/15/1957**

Individual's Name on Record (If different from above): _____

Program Participation:

Important:

Report Incomplete postgraduate years (PGY) separate from those that were successfully completed.

If the postgraduate year is currently in progress report the expected completion date in the "To" field.

Report Internships, Residencies and Fellowships separately.

Use one section per Department/Specialty. If the Department/Specialty is rotating or transitional, please provide a schedule of rotations.

PGY: 1

☐Internship ☒Residency ☐Chief Residency ☐Fellowship ☐Research

Specialty/Subspecialty: Internship Medicine

From: 07/01/06 To: 06/30/07

Successfully Completed?: ☒Yes ☐No ☐In Progress

Accredited by: ☒ACGME ☐AOA ☐LCGME ☐RSC ☐CFPC ☐RCPSC ☐APPAP ☐None of these

PGY: 2

☐Internship ☒Residency ☐Chief Residency ☐Fellowship ☐Research

Specialty/Subspecialty: Internal Medicine

From: 07/01/07 To: 06/30/08

Successfully Completed?: ☒Yes ☐No ☐In Progress

Accredited by: ☒ACGME ☐AOA ☐LCGME ☐RSC ☐CFPC ☐RCPSC ☐APPAP ☐None of these

PGY: 3

☐Internship ☒Residency ☐Chief Residency ☐Fellowship ☐Research

Specialty/Subspecialty: Internal Medicine

From: 07/01/08 To: 06/30/09

Successfully Completed?: ☒Yes ☐No ☐In Progress

Accredited by: ☒ACGME ☐AOA ☐LCGME ☐RSC ☐CFPC ☐RCPSC ☐APPAP ☐None of these

Unusual Circumstances:

Check the correct response. Omitted responses require written explanation.

If necessary, you may continue your explanation on a separate sheet of paper.

1. Did this individual ever take a leave of absence or break from his/her training?	☐Yes	☒No
2. Was this individual ever placed on probation?	☐Yes	☒No
3. Was this individual ever disciplined or placed under investigation?	☐Yes	☒No
4. Were any negative reports for behavioral reasons ever filed by instructors?	☐Yes	☒No
5. Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason?	☐Yes	☒No

Please explain any "Yes" response from above:

_____

_____

ELECTRONIC SEAL VERIFIED

Certification:

Affix your institutional seal in this space. If no seal is available, you must have this form notarized

Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct. The signature line must contain the original signature, or the electronic typed signature, of the program director (M.D./D.O. only).

Name: Constante Gil, M.D.

Signature: *Constante Gil, M.D.*

Title: Program Director

Date of Signature: 7/9/09

Tel: (732) 324-5080 Fax: 732 324-4669 E-Mail: cgil@rbmc.org

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Applicant Reported Unusual Circumstances

fsmb

Graduate Medical Education

Medical Professional Name:	Miranda, Carlos Guillermo
Accreditation ID:	1403321466
Institution:	Jersey Shore University Medical Center (Perth Amboy) Program
Specialty:	Internal Medicine

Unusual Circumstances

Training Period: 7/1/2006 - 6/30/2009 **Residency**

Did you have any interruption(s) or extension(s) in your medical education?	**No**
Were you ever placed on probation?	**No**
Were you ever disciplined or placed under investigation?	**No**
Were any negative reports for behavioral reasons ever filed by instructors?	**No**
Were any limitations or special requirements imposed on you because of academic performance, incompetence, disciplinary problems or for any other reason?	**No**

End of Applicant Reported Unusual Circumstances report for: Miranda, Carlos Guillermo

400 FULLER WISER ROAD | EULESS, TX 76039 | TEL (817) 868 - 5000 | FAX (817) 868 - 5099

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Licensure / Examinations

Exam: USMLE

Credential Analysis Information for Licensure / Examinations

There is no Omission/Discrepancy/Miscellaneous information identified.

United States Medical Licensing Examination® (USMLE®)
Certified Transcript of Scores

This document was prepared by
Federation of State Medical Boards of the United States, Inc. (FSMB)
400 Fuller Wiser Road, Euless, TX 76039-3856 - Telephone (817) 868-4000

Date: 06/23/2020

Federation Credentials Verification Service
ATTN: FCVS

FCVSID: 524654

Examinee: Miranda, Carlos Guillermo
Alt Name(s): Miranda Castillo, Carlos Guillermo

Examinee ID: 0-510-754-5
Date of Birth: 05/15/1957

Results for Steps taken by this examinee (and for which results have been reported to date) are shown below. For Steps that span more than one day, the test date reflects the day on which the examination began. Pass/fail outcomes are based upon the minimum passing level in place at the time of test administration and are not altered by subsequent revisions to the minimum passing level. Effective April 1, 2013, test results are reported on a three-digit scale only; two-digit scores reported for prior administrations will no longer be reported. Test results reported as passing represent an exam score of 75 or higher on a two-digit scoring scale.

USMLE STEP 1

Test Date	Pass/Fail	Score	Minimum Pass	Comments
10/15/1996	Pass	178	(176)	
06/11/1996	Fail	175	(176)	
09/27/1995	Fail	167	(176)	
06/14/1995	Fail	156	(176)	
09/21/1993	Fail	160	(176)	

USMLE STEP 2

Clinical Knowledge (CK)

Test Date	Pass/Fail	Score	Minimum Pass	Comments
08/30/1995	Pass	172	(167)	

USMLE STEP 3

Test Date	Pass/Fail	Score	Minimum Pass	Comments
11/06/2000	Pass	184	(177)	

End of Exam History

NOTE: A search of the Physician Data Center of the Federation of State Medical Boards (FSMB) reveals no reported information on this examinee.

United States Medical Licensing Examination® (USMLE®)
Certified Transcript of Scores

This document was prepared by
Federation of State Medical Boards of the United States, Inc. (FSMB)
400 Fuller Wiser Road, Euless, TX 76039-3856 - Telephone (817) 868-4000

Examinee: Miranda, Carlos Guillermo

Examinee ID: 0-510-754-5
Date of Birth: 05/15/1957

INTERPRETATION OF RESULTS
USMLE transcripts include a complete examination history. On those Step examinations for which numeric scores are reported, a three-digit scale is used. Most scores fall between 140 and 260 on this scale. The recommended minimum passing score is shown on the front of the transcript next to the examinee's score for each administration along with a pass/fail outcome. Test results reported as passing represent an exam score of 75 or higher on a two-digit scoring scale. The level of proficiency required to meet the recommended minimum passing level for each USMLE Step is reviewed periodically and is subject to change. Such changes do not alter pass/fail outcomes from prior test administrations.

For examinations with reported scores, the Standard Error of Measurement (SEM) provides an index of the variation that would be expected to occur if an examinee were tested repeatedly using different sets of items covering similar content. The SEM is usually in the range of 4 to 8 points.

STEP 2 CLINICAL SKILLS (CS)
Step 2 CS results are reported as pass or fail, with no numeric score. Had the two-digit reporting scale been used, examinees would have had to achieve a score of 75 or higher in order to pass.

ANNOTATIONS APPEARING UNDER "COMMENTS"
Circumstances in connection with an administration shown on this transcript may result in one or more annotations listed next to the score. A description of each Comment is provided below:

Indeterminate - Results are at or above the passing level but cannot be certified as representing a valid measure of the examinee's knowledge or competence as sampled by the examination. No score is reported. Information regarding the nature of the indeterminate score is available. If such information is not enclosed with this transcript, it may be obtained by contacting the organization from which you received the transcript or the USMLE Secretariat, 3750 Market Street, Philadelphia, PA 19104, telephone (215) 590-9700.

Incomplete - The examinee sat for some, but not all, of the scheduled examination. No score is reported.

Irregular Behavior - The Committee for Individualized Review determined that the examinee engaged in irregular behavior. Examples of irregular behavior are described in the current edition of the USMLE Bulletin of Information. Information regarding the nature of the irregular behavior and the determination of the Committee is available. If such information is not enclosed with this transcript, it may be obtained by contacting the organization from which you received the transcript or the USMLE Secretariat, 3750 Market Street, Philadelphia, PA 19104, telephone (215) 590-9700.

Score Not Available - The score is not available. Further review and/or analysis may be pending, or it may have been determined that the score cannot be reported.

ANNOTATIONS APPEARING AS "NOTE"
Circumstances not in connection with an administration shown on this transcript may result in one or more annotations and an explanation or instructions to contact the appropriate individual or organization. The Note will appear at the end of the document.

PHYSICIAN DATA CENTER INFORMATION APPEARING AS "NOTE"
The Physician Data Center of the Federation of State Medical Boards (FSMB) contains actions reported to the FSMB by U.S. licensing and disciplinary boards, the U.S. Department of Health and Human Services, government regulatory entities and international licensing authorities. To be included in the Physician Data Center, an action must be a matter of public record or be legally releasable to state medical boards or other entities with recognized authority to review physician credentials. Certain actions reported to and released by the Physician Data Center are not disciplinary or otherwise prejudicial in nature. Such actions are reported to ensure that records are complete and to assist in preventing misrepresentation or the use of lost or stolen credentials by unauthorized persons. Once reported to the FSMB, an action becomes part of the permanent record of the individual physician, and the existence of such an action may be indicated on the USMLE transcript by a Note.

03/2015

This document was printed from a secure website and accurately reflects score information maintained by the FSMB.

PDC PHYSICIAN DATA CENTER

fsmb

PRACTITIONER PROFILE

Prepared for:	FCVS	As of Date:6/23/2020

PRACTITIONER INFORMATION

Name:	Miranda, Carlos Guillermo
Alternate Name(s):	Miranda Castillo, Carlos Guillermo
DOB:	5/15/1957
Medical School:	Universidad Nacional Federico Villarreal Lima, Lima, PERU
Year of Grad:	1993
Degree Type:	PS
NPI:	1376879031

BOARD ACTIONS

To date, there have been no actions reported to the FSMB

NATIONAL PROVIDER IDENTIFIER (NPI)

NPI	NPI Type	Deactivation Date	Reactivation Date	Last Reported
1376879031	Individual			04/27/2020

LICENSE HISTORY

Jurisdiction	License Number	Issue Date	Expiration Date	Last Updated
FLORIDA	ME105965	12/08/2009	01/31/2016	02/15/2018
NEW JERSEY	25MA08679200	10/28/2009	06/30/2021	05/20/2020

US DRUG ENFORCEMENT ADMINISTRATION (DEA)

DEA Number	Schedule	Address	Expiration Date	Last Reported
FM1773921	22N 33N 4 5	HOPELAWN,NJ 08861	01/31/2022	06/12/2020

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PDC PHYSICIAN DATA CENTER

fsmb

PRACTITIONER PROFILE

Prepared for:	FCVS	As of Date:6/23/2020
Practitioner Name:	Miranda, Carlos Guillermo	

ABMS® CERTIFICATION HISTORY

Certifying Board: American Board of Internal Medicine
Participating in MOC: Yes

Certifying Board: American Board of Internal Medicine
Certificate: Internal Medicine
Certification Type: General
Certification Status: Certified

Status	Duration	Effective Date	Expiration Date	Reverification Date	Occurrence	Last Reported
Active	MOC	10/04/2019		04/01/2021	Recertification	05/28/2020
Expired	Time Limited	08/18/2009	12/31/2019		Initial	05/28/2020

The presence and display of ABMS certification data in no way constitutes any affiliation, association with or endorsement of any advertising, promotion or sponsorship by ABMS, its Member Boards and the Board Certified Physicians listed in this directory. ABMS disclaims any responsibility or affiliation for other data that is provided in the directory that is not ABMS sourced information.

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AOA® CERTIFICATION HISTORY

No AOA Certifications found.

PLEASE NOTE: For more information regarding the above data, please contact the reporting board or reporting agency. The information contained in this report was supplied by the respective state medical boards and other reporting agencies. The Federation makes no representations or warranties, either express or implied, as to the accuracy, completeness or timeliness of such information and assumes no responsibility for any errors or omissions contained therein. Additionally, the information provided in this profile may not be distributed, modified or reproduced in whole or in part without the prior written consent of the Federation of State Medical Boards.

6. The Financial Responsibility page of your application was completed incorrectly. Please submit a completed form to our office with only one selection chosen.

7. The inquiry you mailed to your medical school has not been received.

8. Your FCVS Profile has not been received. Please contact FCVS to check the status of your profile.

9. Please submit the National Practitioner Data Bank (NPDB) report to our office. You may contact the NPDB at 1-800-767-6732 to obtain this information.

10. We await your FLEX/USMLE/SPEX/National Board exam scores, direct from the Federation of State Medical Boards, which must be requested by the applicant.

11. We await the background check results from the fingerprinting process (FDLE/FBI processes this information). Applicants can utilize any FDLE approved Livescan Service Provider to submit their fingerprints. The applicant is fully responsible for selecting the Livescan Service Provider and ensuring the results are reported to the department. Please contact the Livescan Service Provider for instructions before contacting the Florida Board of Medicine; the Board no longer has jurisdiction over the fingerprinting process.

    Visit the link(s) below to choose from the list of approved providers. Our ORI# is **EDOH2014Z**. If you do not provide the Livescan Service Provider with this number, we will not receive your fingerprint results.

    If you use a Livescan Provider out of state, they will print your prints on a fingerprint card. You are to then contact a Livescan Service Provider in Florida and submit your fingerprint card(s) to the entity for processing.

    Florida Providers: http://www.flhealthsource.gov/background-screening#livescan-providers
    Out of State Providers: http://www.flhealthsource.gov/out-of-state-providers

    Should your Criminal Background Check disclose an arrest record(s), you will need to provide documentation related to each criminal event revealed in your background, if you have not already done so. You can find a detailed description of documents that will be required by visiting the FAQs on the Background Screening Website at http://www.flhealthsource.gov/background-screening/ (Click on FAQs)
    Note: Criminal History will be reviewed by the Background Screening Unit, not the Board Office. Please email all criminal history documents to mqa.backgroundscreen@flhealth.gov . Any original certified documents must be mailed to the following address:
    Attn: Background Screening Unit
    Florida Department of Health
    4052 Bald Cypress Way, Bin BSU-01
    Tallahassee, FL 32399
    850-488-0595(Call for further assistance with the fingerprinting process

If you have any questions, please contact me at Hazel.Myles@flhealth.gov , call (850) 617-1915, or fax (850) 412-1277. The Florida Board of Medicine has assigned **148698** as your **tracking number**. Please indicate this number if you leave a message, and try to ensure that other sources include it on their communications to us as well.

Myles, Hazel

From: C Miranda <cgmirand57@gmail.com>
Sent: Friday, April 24, 2020 2:33 PM
To: Myles, Hazel
Subject: additional information

Dear Mss Hazel Myles

the information has been emailed to you and faxed to 850-412-1277 (16 pages).

I have work at Florida from 2010-2012 and from 2013-2015 in the JSA/Davita Health partners Corporation , and I will returning again to the same company. (family reasons were the cause of my departure), my records of previous licensure must to be available to you (ME105965).
sincerely:
--

Carlos G. Miranda, M.D.
cgmirand57@gmail.com
(201)-341-4541

Myles, Hazel

From: Myles, Hazel
Sent: Monday, April 27, 2020 3:46 PM
To: C Miranda
Subject: RE: additional document (item 6) #148698

Hello

The background results must come to our office electronically. So I hope you read the process and complete it correction. I will update the financial responsibility form.

If I could be of any assistance, or if you should have any questions please feel free to call or respond to this email.

Thanks

Hazel Myles
Regulatory Specialist II
MQA Board Medicine
Phone:(850)617-1915
Fax:(850)412-1277
Email:Hazel.Myles@flhealth.gov

New Website: www.flboardofmedicine.gov
Twitter: www.twitter.com/FLBoardofMed

Attention Health Care Practitioners: There have been changes to the license renewal process. To learn more about CE/CME@Renewal visit www.flhealthsource.com. For questions, contact the Florida Department of Health toll-free at (855) 410-3344 or email us at MQAReportCE@flhealth.gov.

Mission: To protect, promote and improve the health of all people in Florida through integrated state, county, and community efforts.

Vision: To be the **Healthiest State** in the Nation.
Purpose: To protect the public through health care licensure, enforcement and information.
Focus: To be the nation's leader in quality health care regulation.
Values: I.C.A.R.E. (Innovation, Collaboration, Accountability, Responsiveness, Excellence)

Please Note: Florida has a very broad public records law. Most written communications to or from state officials regarding state business are public records available to the public and media upon request. Your e-mail communications may therefore be subject to public disclosure.

From: C Miranda <cgmirand57@gmail.com>
Sent: Friday, April 24, 2020 5:54 PM
To: Myles, Hazel <Hazel.Myles@flhealth.gov>
Subject: additional document (item 6)

Dear Mss Hazel Myles

1- Financial responsability document attached

1

2- The Background fingerprinting was send to your email.

Have a good evening an a better weekend, keep safe

--

Carlos G. Miranda, M.D.
cgmirand57@gmail.com
(201)-341-4541

Myles, Hazel

From: Myles, Hazel
Sent: Monday, May 11, 2020 10:30 AM
To: C Miranda
Subject: RE: update information #148698

Hello

Remember you can check the status of your application daily by login your online account. Your application remains incomplete for the following:

Provide supporting docs regarding staff privileges from St Joseph's Health.

Medical school inquiry not received.

ECFMG status report not received.

Exam scores not received.

Postgraduate training evaluation not received.

FCVS not received. Once received this will take care of our exam scores, medical school inquiry and training verification.]

Background results not received.

If I could be of any assistance, or if you should have any questions please feel free to call or respond to this email.

Thanks

Hazel Myles
Regulatory Specialist II
MQA Board Medicine
Phone:(850)617-1915
Fax:(850)412-1277
Email:Hazel.Myles@flhealth.gov

New Website: www.flboardofmedicine.gov
Twitter: www.twitter.com/FLBoardofMed

Attention Health Care Practitioners: There have been changes to the license renewal process. To learn more about CE/CME@Renewal visit www.flhealthsource.com. For questions, contact the Florida Department of Health toll-free at (855) 410-3344 or email us at MQAReportCE@flhealth.gov.

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Vision: To be the **Healthiest State** in the Nation.
Purpose: To protect the public through health care licensure, enforcement and information.
Focus: To be the nation's leader in quality health care regulation.
Values: I.C.A.R.E. (Innovation, Collaboration, Accountability, Responsiveness, Excellence)

Please Note: Florida has a very broad public records law. Most written communications to or from state officials regarding state business are public records available to the public and media upon request. Your e-mail communications may therefore be subject to public disclosure.

From: C Miranda <cgmirand57@gmail.com>
Sent: Friday, May 8, 2020 4:32 PM
To: Myles, Hazel <Hazel.Myles@flhealth.gov>
Subject: Re: update information

Good afternoon Ms. Myles,
Would you happen to have any updates on licensure status and/or any additional information you might need.

Thank you so much for your guidance during this process.

Sent from my iPhone

On May 1, 2020, at 4:22 PM, Myles, Hazel <Hazel.Myles@flhealth.gov> wrote:

Hello

I am sorry the attached verification is unacceptable. This is primary source document and come directly from that Board to our office. Please request them to email it to me directly.

If I could be of any assistance, or if you should have any questions please feel free to call or respond to this email.

Thanks

Hazel Myles
Regulatory Specialist II
MQA Board Medicine
Phone:(850)617-1915
Fax:(850)412-1277
Email:Hazel.Myles@flhealth.gov

New Website: www.flboardofmedicine.gov
Twitter: www.twitter.com/FLBoardofMed

Attention Health Care Practitioners: There have been changes to the license renewal process. To learn more about CE/CME@Renewal visit www.flhealthsource.com. For questions, contact the Florida Department of Health toll-free at (855) 410-3344 or email us at MQAReportCE@flhealth.gov.

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Values: I.C.A.R.E. (Innovation, Collaboration, Accountability, Responsiveness, Excellence)

Please Note: Florida has a very broad public records law. Most written communications to or from state officials regarding state business are public records available to the public and media upon request. Your e-mail communications may therefore be subject to public disclosure.

From: C Miranda <cgmirand57@gmail.com>
Sent: Friday, May 1, 2020 1:35 PM
To: Myles, Hazel <Hazel.Myles@flhealth.gov>
Subject: update information

Dear Mss Hazel Myles

I hope you are having a nice day

Here I am sending a clear copy of the email send by Board of Medicine of New Jersey; an previous e-mail has been send it to you.
--

Carlos G. Miranda, M.D.
cgmirand57@gmail.com
(201)-341-4541

FEDERATION CREDENTIALS VERIFICATION SERVICE (FCVS)

VERIFICATION OF MEDICAL EDUCATION (continued)

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the individual's medical education. Please check the appropriate response and provide dates and requested information. "Yes" responses to any of these questions require a copy of explanatory records or a written explanation (attach additional pages as necessary).

1. Do this individual's official records reflect (an) interruption(s) or extension(s) in his/her medical education?
   Response **YES** ☐ **NO** ☒

   If YES, please select the reason(s) for, indicate the dates of the interruption(s) or extension(s) and check whether the interruption/extension was approved or unapproved.

	From Mo/Yr	To Mo/Yr	Approved	Unapproved
Personal/Family			☐	☐
Academic remediation			☐	☐
Health			☐	☐
Financial			☐	☐
Participation in joint degree Program (e.g., MD/PhD)			☐	☐
Participation in non-research special study (e.g., fellowship, international experience)			☐	☐
Participation in non-degree research			☐	☐
Other			☐	☐

   Please Specify: _____

2. Do this individual's official records reflect that he/she was ever placed on academic or disciplinary probation during his/her medical education? Response **YES** ☐ **NO** ☒

   If YES, please select the reason(s) for the probation, indicate the date(s) of placement on and removal from probation and attach additional documentation to this report.

	From Mo/Yr	To Mo/Yr
Academic Probation		
Probation for unprofessional conduct/behavioral		
Probation for other reason		

   Please specify reason: _____

3. Do this individual's official records reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons by the medical school or parent university? Response **YES** ☐ **NO** ☒

   If YES, please provide detailed documentation/information about the circumstances and outcome(s):

4. Do this individual's official records reflect that he/she was ever the subject of negative reports or an investigation by the medical school or parent university? Response **YES** ☐ **NO** ☒

   If YES, please provide detailed documentation/information about the circumstances and outcome(s):

5. Do this individual's official records reflect that there were any limitations or special requirements imposed on the individual because of questions of academic imcompetence, disciplinary problems, or any other reason?
   Response **YES** ☐ **NO** ☒

   If YES, please provide detailed documentation/information about the nature of the limitations or special requirements.

Federation of STATE MEDICAL BOARDS

Fe tion Credentials Verification Service (FCV

Federation Place, P.O. Box 619850, Dallas, TX 75261-9850
Tel: (817) 868-5000 Fax: (817) 868-4186

Verification of Postgraduate Medical Education

Institution: Raritan Bay Medical Center
Address: INTERNAL MEDICINE
Perth Amboy, NJ 08861

Attention: **Program Director**
Affiliated University: _____

Verification For:

Name: **Miranda, Carlos Guillermo**

DOB: **05/15/1957**

Individual's Name on Record (If different from above): _____

Program Participation:

Important:
Report incomplete postgraduate years (PGY) separate from those that were successfully completed

If the postgraduate year is currently in progress report the expected completion date in the "To" field

Report Internships, Residencies and Fellowships separately

Use one section per Department/Specialty. If the Department/Specialty is rotating or transitional, please provide a schedule of rotations

PGY: 1
☐Internship ☒Residency ☐Chief Residency ☐Fellowship ☐Research
Specialty/Subspecialty: Internal Medicine
From: 07/01/06 **To:** 06/30/07
Successfully Completed?: ☒Yes ☐No ☐In Progress
Accredited by: ☒ACGME ☐AOA ☐LCGME ☐RSC ☐CFPC ☐RCPSC ☐APPAP ☐None of these

PGY: 2
☐Internship ☒Residency ☐Chief Residency ☐Fellowship ☐Research
Specialty/Subspecialty: Internal Medicine
From: 07/01/07 **To:** 06/30/08
Successfully Completed?: ☒Yes ☐No ☐In Progress
Accredited by: ☒ACGME ☐AOA ☐LCGME ☐RSC ☐CFPC ☐RCPSC ☐APPAP ☐None of these

PGY: 3
☐Internship ☒Residency ☐Chief Residency ☐Fellowship ☐Research
Specialty/Subspecialty: Internal Medicine
From: 07/01/08 **To:** 06/30/09
Successfully Completed?: ☒Yes ☐No ☐In Progress
Accredited by: ☒ACGME ☐AOA ☐LCGME ☐RSC ☐CFPC ☐RCPSC ☐APPAP ☐None of these

Unusual Circumstances:

Check the correct response. Omitted responses require written explanation

If necessary, you may continue your explanation on a separate sheet of paper

1. Did this individual ever take a leave of absence or break from his/her training? ☐Yes ☒No
2. Was this individual ever placed on probation? ☐Yes ☒No
3. Was this individual ever disciplined or placed under investigation? ☐Yes ☒No
4. Were any negative reports for behavioral reasons ever filed by instructors? ☐Yes ☒No
5. Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason? ☐Yes ☒No

Please explain any "Yes" response from above:

_____

_____

ELECTRONIC SEAL VERIFIED

Certification:

Affix your institutional seal in this space. If no seal is available, you must have this form notarized

Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct. The signature line must contain the original signature, or the electronic typed signature, of the program director (M.D./D.O. only).

Name: Constante Gil, M.D. Signature: *Constante Gil, M.D.*

Title: Program Director Date of Signature: 7/9/09

Tel: (732) 324-5080 Fax: 732 324-4669 E-Mail: cgil@rbmc.org

FCVS | FEDERATION CREDENTIALS VERIFICATION SERVICE

Applicant Reported Unusual Circumstances

fsmb

Graduate Medical Education

Medical Professional Name:	Miranda, Carlos Guillermo
Accreditation ID:	1403321466
Institution:	Jersey Shore University Medical Center (Perth Amboy) Program
Specialty:	Internal Medicine

Unusual Circumstances

Training Period: 7/1/2006 - 6/30/2009 **Residency**

Did you have any interruption(s) or extension(s) in your medical education?	**No**
Were you ever placed on probation?	**No**
Were you ever disciplined or placed under investigation?	**No**
Were any negative reports for behavioral reasons ever filed by instructors?	**No**
Were any limitations or special requirements imposed on you because of academic performance, incompetence, disciplinary problems or for any other reason?	**No**

End of Applicant Reported Unusual Circumstances report for: Miranda, Carlos Guillermo

400 FULLER WISER ROAD | EULESS, TX 76039 | TEL (817) 868 - 5000 | FAX (817) 868 - 5099

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CARLOS G. MIRANDA II-A.

1

American Board of Internal Medicine®

510 Walnut Street Suite 1700 Philadelphia, PA 19106-3699 800.441.2246 | www.abim.org request@abim.org

Verification of Certification Status

Richard J. Baron, MD
President
Chief Executive Officer

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January 08, 2020

Dr. Carlos Guillermo Miranda
295 Lenox Ave
Paterson, NJ 07502-1033

Below is the certification status of this physician as of January 08, 2020. In addition to reporting board certification, ABIM reports whether or not ABIM Board Certified physicians are participating in Maintenance of Certification (MOC). Because ABIM's MOC program requires continuous activities to maintain certification, we no longer issue certificates with end dates; however, we recognize that some entities may still require current certification status to complete primary-source verification.

Our website, www.abim.org/verify, is the primary verification source for ABIM Board Certification. We will update this status on an annual basis. Therefore, we encourage credentialers to use the **ABIM's annual re-verification date of April 1** to verify your physician's status. By using the annual re-verification date suggested, you will have accurate information about a physician's current certification status. Visit www.abim.org/moc to review ABIM's Maintenance of Certification policies.

If you have questions, please call 1 (800) 441-ABIM (2246), Mon. - Fri., 8:30 a.m. to 6 p.m. ET, or email us at request@abim.org.

Name: **Dr. Carlos Guillermo Miranda**

Internal Medicine: **Certified**

Participating in MOC: **Yes**

INITIAL CERTIFICATION
Internal Medicine: 2009

American Board of Internal Medicine

A MEMBER BOARD OF THE AMERICAN BOARD OF MEDICAL SPECIALTIES (ABMS)

Department of Health

CARLOS GUILLERMO MIRANDA

License Number: ME105965

Data As Of 9/6/2020

Profession	Medical Doctor
License	ME105965
License Status	NULL AND VOID/
License Expiration Date	1/31/2016
License Original Issue Date	12/08/2009
Address of Record	If further information is needed, please contact the Department of Health at (850) 488-0595.
Controlled Substance Prescriber (for the Treatment of Chronic Non-malignant Pain)	Yes
Discipline on File	No
Public Complaint	No

The information on this page is a secure, primary source for license verification provided by the Florida Department of Health, Division of Medical Quality Assurance. This website is maintained by Division staff and is updated immediately upon a change to our licensing and enforcement database.

PHILIP D. MURPHY
Governor

SHEILA Y. OLIVER
Lt. Governor

New Jersey Office of the Attorney General

Division of Consumer Affairs
State Board of Medical Examiners
P.O. Box 183, Trenton, NJ 08625-0183

GURBIR S. GREWAL
Attorney General

PAUL R. RODRÍGUEZ
Acting Director

For Delivery Services:
140 East Front St.
PO Box 183 2nd Floor
Trenton, NJ 08608
(609) 826-7100
(609) 777-0956 *FAX*

May 1, 2020

Florida Department of Health, Board of Medicine
4052 Bald Cypress Way BIN#C03
Tallahassee, Florida 32399-3253

To Whom It May Concern:

The New Jersey State Board of Medical Examiners has been requested by CARLOS G MIRANDA to forward a letter of good standing regarding the Medical Doctor's license to practice in the State of New Jersey.

A review of the Board's files indicates that CARLOS G MIRANDA was issued a New Jersey license 25MA08679200 on or about 10/28/2009 and is currently Active with an expiration date of 06/30/2021. A review of the Board's files further indicates that no public disciplinary action has been taken against this Medical Doctor.

Very truly yours,
BOARD OF MEDICAL EXAMINERS

William V. Roeder
Executive Director

WVR/sdp

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Chair
Zachariah Zachariah, M.D.
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Members
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Vacant, Consumer Member

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Nicholas W. Romanello, Esq.
Melbourne, Florida

Sarvam TerKonda, M.D.
Jacksonville, Florida

Shailesh Gupta, M.D.
Coral Springs, Florida

Vacant, M.D.

Executive Director
Claudia Kemp, J.D.

September 1, 2020

Mauricio Mandel Brigido, MD
9 Killdeer Road
Hamden, Connecticut 06517

Dear Dr. Brigido:

This is in further reference to your application for licensure by endorsement.

Please be advised that you are required to make a personal appearance before the Credentials Committee of the Board of Medicine to discuss:

- Failure to meet section 458.313(1)(a) and 458.311(1)(f)3.c., Florida Statutes, postgraduate training

In addition, the Committee may inquire into any other issues relating to your application and eligibility for licensure.

Date:	Thursday, October 1, 2020
Time:	8:00 a.m. (Meeting starts at 8:00 a.m. Interview time may vary.)
Location:	The in-person meeting scheduled in Orlando, Florida is cancelled, and the meeting will be held by a web-based meeting platform or, if appropriate, a teleconference call.

The meeting information and directions for participating in the October 2020 meeting will be posted on the Florida Board of Medicine's website: https://flboardofmedicine.gov/meeting-information.

Additionally, the Committee's recommendation on your application for licensure will be presented to the full Board of Medicine on Friday, October 2, 2020 for final action. You are not required to attend the full board meeting.

Thank you for your continued cooperation. Should you have any questions regarding this matter, please feel free to contact me. *This is your first scheduled appearance.

Sincerely,

Angela Denson

Angela Denson
Regulatory Supervisor

Pursuant to the provisions of the Americans with Disabilities Act, any person requiring special accommodations to participate in this workshop/meeting is asked to advise the agency at least 10 days before the workshop/meeting by contacting: Rebecca.Hewett@flhealth.gov or call (850) 245-4137.

*** 456.013(3)(c) In considering applications for licensure, the board, or the department when there is no board, may require a personal appearance of the applicant. If the applicant is required to appear, the time period in which a licensure application must be granted or denied shall be tolled until such time as the applicant appears. However, if the applicant fails to appear before the board at either of the next two regularly scheduled board meetings, or fails to appear before the department within 30 days if there is no board, the application for licensure shall be denied.**

Mission:
To protect, promote & improve the health of all people in Florida through integrated state, county & community efforts.

Florida HEALTH

Ron DeSantis
Governor

Scott A. Rivkees, MD
State Surgeon General

Vision: To be the **Healthiest State** in the Nation

Application

Application Detail	
License Type:	**Medical Doctor**
Profession Number:	**1501 - Medical Doctor**
File Number:	**146608**
Application:	**Medical Doctor Endorsement Application**
Application Date:	**01/08/2020**

Suitability Question(s)	
Are you an osteopathic physician?	**No**

Application Questions	
Military Veteran Fee Waiver - I have been honorably discharged from a branch of the United States Armed Forces within the previous 60 months.	**No**
I am selecting NICA Non-Participating - (I understand that a $250.00 fee will be included if I select this option.)	**No**
I will qualify for "In Training" status at the approval of my licensure application.	**Yes**
I plan to dispense medicinal drugs in the State of Florida for a fee or other remuneration and hereby register as required by Section 465.0276,F.S. I understand that the fee for the Dispensing Practitioner is $100.00 over and above the required initial license fee and will submit it along with the license fee.	**Yes**
Military Veteran Spouse Fee Waiver - I am the spouse of a military veteran who has been honorably discharged from a branch of the United States Armed Forces within the previous 60 months.	**No**

Federal Credentials Verification Services (FCVS)	
Are you using the FCVS to verify your core credentials?	**Yes**

Education History	
School Name:	**UNIVERSIDADE DE SAO PAULO**
Street Address Line 1:	**Av. Dr. Arnaldo, 455**
Street Address Line 2:	**N/A**
City:	**Sao Paulo**
State:	**N/A**
Postal/Zip:	**01246-903**
Country:	**BRAZIL**
Date of Graduation (mm/dd/yyyy):	**11/24/2004**
Attended From (mm/dd/yyyy):	**02/01/1999**
Attended To (mm/dd/yyyy):	**11/24/2004**

Additional Education Questions	
Are you currently in default on any health education loan or scholarship obligation?	**No**
Have you completed the equivalent of 2 academic years of preprofessional, postsecondary education including, courses in anatomy, biology, and chemistry prior to entering medical school?	**No**

Fifth Pathway	
Did you attend an international medical school and do not possess a valid ECFMG Certificate?	**No**
Did you receive a bachelor's degree from an accredited United States college or University?	**No**
Did you study at a medical school which is recognized by the World Health Organization?	**Yes**
Did you complete all of the formal requirement of the International medical school, except the internship or social service requirements, and pass part I of the National board of Medical examination or the Education Commission for Foreign Medical Graduates Examination equivalent?	**Yes**

Did you complete an academic year of supervised clinical training in a hospital affiliated with a medical school approved by the Council on Medical Education of the American Medical Association and upon completion passed part II of the National Board of Medical Examiners examination or the Education Commission for Foreign Medical Graduates examination Equivalent?	**No**

Postgraduate Training 1

Program Name:	**Hospital das Clinicas of University of Sao Paulo**
Mailing Address:	**Rua, Av. Dr. Enéas Carvalho de Aguiar, 255 - Cerqueira César, São Paulo - SP, 05403-000, Brazil**
Program City:	**Sao Paulo**
Program State or Country:	**BRAZIL**
Program Type:	**INTERNSHIP**
Specialty Area:	**OTHER**
Attended From (mm/dd/yyyy):	**01/02/2003**
Attended To (mm/dd/yyyy):	**11/24/2004**
Did you receive credit?	**Yes**

Postgraduate Training 2

Program Name:	**Mayo Clinic School of Medicine**
Mailing Address:	**200 1st St SW, Rochester, MN 55905**
Program City:	**Rochester**
Program State or Country:	**MINNESOTA**
Program Type:	**INTERNSHIP**
Specialty Area:	**IM - INTERNAL MEDICINE**
Attended From (mm/dd/yyyy):	**09/01/2004**
Attended To (mm/dd/yyyy):	**10/05/2004**
Did you receive credit?	**Yes**

Postgraduate Training 3

Program Name:	**Hospital das Clinicas of University of Sao Paulo Medical Sch**
Mailing Address:	**Rua, Av. Dr. Enéas Carvalho de Aguiar, 255 - Cerqueira César, São Paulo - SP, 05403-000, Brazil**
Program City:	**Sao Paulo**
Program State or Country:	**BRAZIL**

Program Type:	**RESIDENCY**
Specialty Area:	**NEUROSURGERY**
Attended From (mm/dd/yyyy):	**02/01/2005**
Attended To (mm/dd/yyyy):	**01/31/2009**
Did you receive credit?	**Yes**

Postgraduate Training 4

Program Name:	**Hospital das Clinicas of University of Sao Paulo Medical Sch**
Mailing Address:	**Rua, Av. Dr. Enéas Carvalho de Aguiar, 255 - Cerqueira César, São Paulo - SP, 05403-000, Brazil**
Program City:	**Sao Paulo**
Program State or Country:	**BRAZIL**
Program Type:	**OTHER PROGRAM**
Specialty Area:	**NEUROSURGERY**
Attended From (mm/dd/yyyy):	**12/13/2013**
Attended To (mm/dd/yyyy):	**02/22/2018**
Did you receive credit?	**Yes**

Postgraduate Training 5

Program Name:	**Stanford University**
Mailing Address:	**300 Pasteur Drive, R281 Stanford, CA 94305-5327**
Program City:	**Stanford**
Program State or Country:	**CALIFORNIA**
Program Type:	**FELLOWSHIP**
Specialty Area:	**NEUROSURGERY**
Attended From (mm/dd/yyyy):	**07/01/2019**
Attended To (mm/dd/yyyy):	**07/30/2020**
Did you receive credit?	**No**

Exam History

Examination:	**USMLE/FOREIGN**
Date Passed (mm/dd/yyyy):	**11/28/2015**

United States Military and/or Public Health

Have you ever been in the United States Military and/or Public Health Service?	**No**
Have you ever been disciplined by any branch of the United States Armed Services or Public Health Service?	**No**

Practice Employment

Place of Employment:	**Hospital das Clinicas of University of Sao Paulo**
Address Line 1:	**Rua, Av. Dr. Enéas Carvalho**
Address Line 2:	**255 - Cerqueira César,**
City:	**Sao Paulo**
State:	**SP**
Type of Employment:	**Neurosurgeon**
Begin Date (mm/dd/yyyy):	**02/01/2010**
End Date (mm/dd/yyyy):	**06/22/2019**

If 'to present', enter today's date.

Other State Licenses 1

Do you now hold or have you ever held a license to practice medicine or any other profession in any US State or territory, or foreign country?	**Yes**

Request verification of licensure status directly from the licensing entity or www.veridoc.org. Request international license verification(s) if you have practiced outside of the U.S. for at least two of the previous four years.

License Number:	**F598**
Profession:	**Medical Doctor**
Jurisdiction - Country:	**UNITED STATES**
Jurisdiction - State:	**CALIFORNIA**

Other State Licenses 2

Do you now hold or have you ever held a license to practice medicine or any other profession in any US State or territory, or foreign country?	**Yes**

Request verification of licensure status directly from the licensing entity or www.veridoc.org. Request international license verification(s) if you have practiced outside of the U.S. for at least two of the previous four years.

License Number:	**116095**
Profession:	**Medical Doctor**

Jurisdiction - Country: **BRAZIL**

Additional Employment Questions

Have you practiced medicine in any jurisdiction for two of the last four years or completed a board approved post-graduate training program within the last two years? **Yes**

Graduate Education

Do you currently, or have you had, responsibility for graduate medical education within the last 10 years? **Yes**

Initial Graduate Medical Education Responsibility and Faculty Appointments

List all institutions where you have had responsibility for graduate medical education or faculty appointment(s) at any medical school.

Name of Institution: **STANFORD HOSPITAL AND CLINICS**

Staff Privileges 1

Do you currently hold staff privileges in any hospital, health institution, clinic or medical facility? **Yes**

The facilities listed are Florida facilities. If your privileges are for a facility in another state, select "Out of State".

Name of Facility: **OUT OF STATE**

Out of State Facility: **Stanford Hospital**

Staff Privileges 2

Do you currently hold staff privileges in any hospital, health institution, clinic or medical facility? **Yes**

The facilities listed are Florida facilities. If your privileges are for a facility in another state, select "Out of State".

Name of Facility: **OUT OF STATE**

Out of State Facility: **Stanford Childrens Hospital**

Specialty Board Certifications

Are you certified by any specialty board recognized by the American Board of Medical Specialties or specialty board approved by the Florida Board of Medicine? **No**

DEA

Have you ever been denied, or surrendered, a DEA registration? **No**

Criminal History

Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to, a crime in any jurisdiction other than a minor traffic offense? **No**

You must include all misdemeanors and felonies, even if adjudication was withheld. Driving under the influence (DUI) or driving while impaired (DWI) are not minor traffic offenses for purposes of this question.

Medicaid / Medicare

1. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, F.S. (relating to social and economic assistance), Chapter 817, F.S. (relating to fraudulent practices), Chapter 893, F.S. (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction?	**No**
2. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970 (relating to controlled substances) or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)?	**No**
3. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, F.S.?	**No**
4. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program?	**No**
5. Are you currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities?	**No**

Health History

In the last five years, have you been enrolled in, required to enter into, or participated in any drug and/or alcohol recovery program or impaired practitioner program for treatment of drug or alcohol abuse that occurred within the past five years?	**No**
In the last five years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental disorder or impairment?	**No**
During the last five years, have you been treated for or had a recurrence of a diagnosed mental disorder that has impaired your ability to practice medicine within the past five years?	**No**
During the last five years, have you been treated for or had a recurrence of a diagnosed physical disorder that has impaired your ability to practice medicine?	**No**

In the last five years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol/drug) disorder or, if you were previously in such a program, did you suffer a relapse within the last five years?	**No**
During the last five years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol/drug) disorder that impaired your ability to practice medicine within the last five years?	**No**

Electronic Fingerprinting

I have been provided and read the statement from the Florida Department of Law Enforcement regarding the sharing, retention, privacy and right to challenge incorrect criminal history records and the 'Privacy Statement' document from the Federal Bureau of Investigation.	**Yes**
Enter in today's date	**01/08/2020**

Medical Malpractice Question

Have you ever had a judgment entered against you for medical malpractice where the incident(s) of malpractice occurred after November 2, 2004?	**No**

Liability Claims

Within the last 10 years have you had any liability claim(s) or action(s) for damages for personal injury settled or finally adjudicated in an amount that exceeds $100,000.00?	**No**

Financial Responsibility/Exemption

Financial Responsibility	**5. NOT TO CARRY MEDICAL MALPRACTICE**

FDA Institution

Have you ever had any staff privileges denied, suspended, revoked, modified, restricted, not renewed or placed on probation, or have you been asked to resign or take a temporary leave of absence or were otherwise acted against by any facility?	**No**

FDA Licensing

Have you ever had any professional license or license to practice medicine revoked, suspended, placed on probation, or other disciplinary action taken in any state, territory or country?	**No**

FDANP Denied

Have you had any application for a medical license or professional license denied by any state board or other governmental agency of any state, territory, or country?	**No**

FDANP Investigation

Are you currently under investigation in any jurisdiction for an act or offense that would constitute a violation of Section 458.331, Florida Statutes?	**No**

Specialty Board Discipline History

Have you ever had any final disciplinary action taken against you by a specialty board or other similar national organization?	**No**

Year Began Practice

Year Began Practice:	**02/01/2005**

Availability for Disaster

Are you willing to provide health care services in special need shelters or to work with disaster medical teams during times of emergency or major disasters?	**Yes**

Attachments

Document Type: Certificate File Name: Medical Diploma - Mauricio Mandel - reduced + TRADUCAO.pdf

Document Type: Certificate File Name: PHD - doctor in Science - reduced size.pdf

Document Type: Miscellaneous Documents File Name: Medical School Transcripts - translated - reduced size - Maurici Mandel.pdf

Document Type: Miscellaneous Documents File Name: PhD Transcripts - translated - reduced size - Mauricio Mandel.pdf

Document Type: Letters of Reference File Name: Carta de recomendao - Mj - recente.pdf

Document Type: Letters of Reference File Name: Carta de recomendao Paiva - recente.pdf

Document Type: Letters of Reference File Name: Eberval - letter of recomendation.pdf

Document Type: Letters of Reference File Name: MAYO - letter of recomendation.pdf

Document Type: Education Documents File Name: ECFMG - Mauricio Mandel.pdf

Document Type: Certificate File Name: Neurosurgical%20Residency%20-%20Mauricio%20Mandel.pdf

Fees

Initial License -	**$-350.00**
NICA Fee -	**$-250.00**
Application	**$350.00**
Initial License TRNG	**$200.00**

Unlicensed Activity	**$5.00**
NICA Fee	**$250.00**
Dispensing	**$100.00**
NICA Part. Phys. Fee	**$4750.00**
Initial License	**$350.00**
Total Amount Due:	**$5405.00**

Attestation

I state that these statements are true and correct. I recognize that providing false information may result in denial of licensure, disciplinary action against my license, or criminal penalties pursuant to Sections 456.067, 775.083, and 775.084, Florida Statutes. I state that I have read Chapters 456, 458 and 766.301-.316, Florida Statutes and Chapter 64B8, Florida Administrative Code.

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Florida Board of Medicine information which is material to my application for licensure.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind. I state that my answers and all statements made by me herein are true and correct.

Should I furnish any false information in this application, I hereby agree that such act constitutes cause for denial, suspension, or revocation of my license to practice Medicine in the State of Florida. If there are any changes to my status or any change that would affect any of my answers to this application I must notify the board within 30 days.

I understand that my records are protected under federal and state regulations governing Confidentiality of Mental Health Patient Records and cannot be disclosed without my written consent unless otherwise provided in the regulations. I understand that my records are protected under federal and state regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it.

Attestation Answer: Yes

Myles, Hazel

From: Mauricio Mandel <mauricio.mandel@gmail.com>
Sent: Monday, July 27, 2020 1:23 PM
To: Myles, Hazel
Subject: Re: FL medical license status # 146608

Dear Hazel,

I am not Board Eligible. I will have completed 2 years of training in Jun/2021 (I have already completed 1 year at Stanford and I am doing 1 more year at Yale). However, I applied for the Florida license because I have 9 years of training outside of the US (5 of residency, 4 of clinical PhD), and I read that sometimes the Florida Medical Board subcommittee can also consider this as part of the requirements. (And I already have a full license in NY).

Best Regards,

Mauricio Mandel, M.D., Ph.D.

Department of Neurosurgery

Yale School of Medicine

Yale University

On Mon, Jul 27, 2020 at 10:16 AM Myles, Hazel <Hazel.Myles@flhealth.gov> wrote:

> Hello and please response regarding the matter below.
>
> Chapter 458.311 Florida Statutes states that an international medical graduate must have completed an ACGME approved residency or fellowship program of at least two progressive years in one specialty area. However, to be acceptable, the fellowship experience and training must be counted toward regular or subspecialty certification by a board recognized and certified by the American Board of Medical Specialties. Provide proof that you meet this requirement.
>
> Are you Board eligible?
>
> If I could be of any assistance, or if you should have any questions please feel free to call or respond to this email.
>
> Thanks

Hazel Myles
Regulatory Specialist II
MQA Board Medicine
Phone:(850)617-1915
Fax:(850)412-1277
Email:Hazel.Myles@flhealth.gov

New Website: www.flboardofmedicine.gov
Twitter: www.twitter.com/FLBoardofMed

Attention Health Care Practitioners: There have been changes to the license renewal process. To learn more about CE/CME@Renewal visit www.flhealthsource.com. For questions, contact the Florida Department of Health toll-free at (855) 410-3344 or email us at MQAReportCE@flhealth.gov.

Mission: To protect, promote and improve the health of all people in Florida through integrated state, county, and community efforts.

Vision: To be the **Healthiest State** in the Nation.
Purpose: To protect the public through health care licensure, enforcement and information.
Focus: To be the nation's leader in quality health care regulation.
Values: I.C.A.R.E. (Innovation, Collaboration, Accountability, Responsiveness, Excellence)

Please Note: Florida has a very broad public records law. Most written communications to or from state officials regarding state business are public records available to the public and media upon request. Your e-mail communications may therefore be subject to public disclosure.

POST-GRADUATE TRAINING VERIFICATION FORM

Please have this form completed by the Chairman/Director of the post-graduate training program you attended. Please note that if you are using FCVS, do not submit these items.

The form should be mailed or faxed to:

FLORIDA BOARD OF MEDICINE
4052 BALD CYPRESS WAY, BIN C-03
TALLAHASSEE, FLORIDA 32399-3253
(850) 412-1268 Facsimile

University of Sao Paulo Medical School
Name of School

Neurosurgery
Department

Av. Dr. Enéas Carvalho de Aguiar, 255
Address

Sao Paulo - Cerqueira César, São Paulo - SP, 05403-000, Brazil
City, State, Zip

1. Name of Resident: Mauricio Mandel Brigido

2. Internship/Residency/Fellowship: From: 02/01/2005 To: 01/31/2010
Residency - Neurosurgery

3. Matriculation Date: 02/01/2005

4. Completion Date: 01/31/2010

5. Specialty: Neurosurgery

6. Levels completed (check all that apply):

PGY I X PGY II X PGY III X PGY IV X PGY V X

Signed: _____
Chairman or Program Director Only
(No stamped signatures please).

Prof. Dr. Manoel Jacobsen Teixeira
Chefe do Serviço de Divisão de Saúde
Divisão de Clínica Neurocirúrgico
HCHC - FMUSP
CRM 17.968 - Matric. HC 13.138

POST-GRADUATE TRAINING VERIFICATION FORM

Please have this form completed by the Chairman/Director of the post-graduate training program you attended. Please note that if you are using FCVS, do not submit these items.

The form should be mailed or faxed to:

FLORIDA BOARD OF MEDICINE
4052 BALD CYPRESS WAY, BIN C-03
TALLAHASSEE, FLORIDA 32399-3253
(850) 412-1268 Facsimile

University of Sao Paulo Medical School
Name of School

Neurosurgery
Department

Av. Dr. Enéas Carvalho de Aguiar, 255
Address

Sao Paulo - Cerqueira César, São Paulo - SP, 05403-000, Brazil
City, State, Zip

1. Name of Resident: Mauricio Mandel Brigido

2. Internship/Residency/Fellowship: From: 12/13/2013 To: 02/22/2018
Clinical PhD - Neurosurgery - Cerebrovascular

3. Matriculation Date: 12/13/2013

4. Completion Date: 02/22/2018

5. Specialty: Neurosurgery

6. Levels completed (check all that apply):

PGY I___PGY II___ PGY III___PGY IV___ PGY V___ PGY > 5

Signed: Prof. Dr. Manoel Jacobsen Teixeira
Diretor Técnico da Divisão de Saúde
Divisão de Clínica Neurocirúrgica
ICHC - FMUSP
CRM 13.138
Chairman or Program Director Only
(No stamped signature please)

Stanford MEDICINE | Neurosurgery

Gary K. Steinberg, MD, PhD, Chair
Bernard and Ronni Lacroute-William Randolph Hearst Professor of Neurosurgery and the Neurosciences

Lawrence M. Shuer, MD
John R. Adler, MD (Emeritus)
Michael S.B. Edwards, MD (Emeritus)
Steven D. Chang, MD
Graham H. Creasey, MD (Emeritus)
James R. Doty, MD
Laurence Katznelson, MD
Jaimie M. Henderson, MD
Jamshid Ghajar, MD, PhD
Michel Kliot, MD
Odette A. Harris, MD, MPH
Jon Park, MD
John Ratliff, MD
Gerald Grant, MD
Juan C. Fernandez-Miranda, MD
Randal Peoples, MD
Stephen L. Skirboll, MD
Robert L. Dodd, MD, PhD
Marco Lee, MD, PhD
Harman Singh, MD
Gordon Li, MD
Ciara Harraher, MD, MPH
Melanie Hayden Gephart, MD, MAS
Atman Desai, MD
Suzanne Tharin, MD, PhD
Casey Halpern, MD
David Hong, MD
Anand Veeravagu, MD
Thomas J. Wilson, MD
Kelly Mahaney, MD
Tene A. Cage, MD
Corinna Zygourakis, MD
Joshua Levin, MD
Mahendra T. Bhati, MD
Jayant Menon, MD
J. Dawn Waters, MD
Antonio Meola, MD, PhD

Research:
Pak H. Chan, PhD (Emeritus)
Albert J. Wong, MD
Robert M. Sapolsky, PhD
E.J. Chichilnisky, PhD
Ivan Soltesz, PhD
Peter Tass, MD, PhD
John Huguenard, PhD
Thomas Südhof, MD
Lu Chen, PhD
Theo D. Palmer, PhD
Mehrdad Shamloo, PhD
Heng Zhao, PhD
Jin Hyung Lee, PhD
Giles Plant, PhD
Julia Kaltschmidt, PhD
Marion S. Buckwalter, MD, PhD
Maheen M. Adamson, PhD
Xinnan Wang, PhD
Jun Ding, PhD
Summer Han, PhD
J. Bradley Zuchero, PhD
Paul Nuyujukian, MD, PhD
Claudia Petritsch, PhD

June 12, 2020

To Whom it may concern,

I am pleased to confirm that Mauricio Mandel Brigido, M.D. Ph.D., started a one-year program as Clinical Instructor in the Department of Neurosurgery at Stanford University on July 1st, 2019.

During this academic appointment his primary focus and experience was in the area of cerebrovascular neurosurgery. In addition to his clinical activity, he is involved in the teaching residents in the Stanford Neurosurgery ACGME-accredited Residency Training Program.

Should you have any further questions please feel free to contact me.

Sincerely,

Gary K. Steinberg, M.D., Ph.D.
Bernard and Ronni Lacroute - William Randolph Hearst
Professor of Neurosurgery and the Neurosciences
Chair, Department of Neurosurgery

Phone (650) 723-5575 | Fax (650) 723-1948 | 300 Pasteur Drive, R281, Stanford, California 94305-5327 | med.stanford.edu/neurosurgery

Federation Credentials Verification Service (FCVS)
400 Fuller Wiser Rd, Euless, TX 76039
Tel: (817) 868-5099 Fax: (817) 868-5099 Email: fcvsgme@fsmb.org

Verification of Postgraduate Medical Education

Institution: Stanford Health Care-Sponsored Stanford University Program
Specialty: Neurological Surgery
Address: Stanford, CA

Attention: **Program Director**
Affiliated University: Stanford University

Verification For:

Name: Mauricio Mandel Brigido
DOB: 05/10/1981
Individual's Name on Record (If different from above): _____

Program Participation:

Important:
Report incomplete postgraduate years (PGY) separate from those that were successfully completed.

If the postgraduate year is currently in progress report the expected completion date in the "To" field.

Report Internships, Residencies and Fellowships separately.

Use one section per Department/Specialty. If the Department/Specialty is rotating or transitional, please provide a schedule of rotations.

PGY: 8
☐ Internship ☐ Residency ☐ Chief Residency ☑ Fellowship ☐ Research
Specialty/Subspecialty: Neurosurgery
From: 07/2019 To: 06/2020
Successfully Completed?: ☐ Yes ☐ No ☑ In Progress
Accredited by: ☐ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

PGY: _____
☐ Internship ☐ Residency ☐ Chief Residency ☐ Fellowship ☐ Research
Specialty/Subspecialty: _____
From: _____ To: _____
Successfully Completed?: ☐ Yes ☐ No ☐ In Progress
Accredited by: ☐ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

PGY: _____
☐ Internship ☐ Residency ☐ Chief Residency ☐ Fellowship ☐ Research
Specialty/Subspecialty: _____
From: _____ To: _____
Successfully Completed?: ☐ Yes ☐ No ☐ In Progress
Accredited by: ☐ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Unusual Circumstances:

Check the correct response. Omitted responses require written explanation.

If necessary, you may continue your explanation on a separate sheet of paper.

ELECTRONIC SEAL VERIFIED

1. Did this individual ever take a leave of absence or break from his/her training? ☐ Yes ☑ No
2. Was this individual ever placed on probation? ☐ Yes ☑ No
3. Was this individual ever disciplined or placed under investigation? ☐ Yes ☑ No
4. Were any negative reports for behavioral reasons ever filed by instructors? ☐ Yes ☑ No
5. Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason? ☐ Yes ☑ No

Please explain any "Yes" response from above:

Certification:

Affix your institutional seal in this space. If no seal is available, you must have this form notarized

Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct. The signature line must contain the original signature, or the electronic typed signature, of the program director (M.D./D.O. only).

Name: Gerald Grant Signature: _____
Title: Reidency Program Director Date of Signature: 10/2/2019
Tel: 6507250701 Fax: _____ E-Mail: ggrant2@stanford.edu

MEDICAL BOARD OF CALIFORNIA

LICENSING DETAILS FOR: SPI 598

NAME: BRIGIDO, MAURICIO MANDEL
LICENSE TYPE: SPECIAL PROGRAMS - INDIVIDUAL
PRIMARY STATUS: PERMIT RENEWED & CURRENT
SCHOOL NAME: UNIVERSITY OF SAO PAULO FACULTY OF MEDICINE
GRADUATION YEAR: 2004
ADDRESS NOT DISCLOSED

ISSUANCE DATE
JULY 31, 2019

EXPIRATION DATE
JULY 31, 2021

CURRENT DATE / TIME
JULY 21, 2020
7:44:28 AM

PUBLIC RECORD ACTIONS

› THERE ARE NO PUBLIC RECORD ACTIONS.

PUBLIC DOCUMENTS

› DOCUMENTS (NO RECORDS)

HAZEL
146808

THE UNIVERSITY OF THE STATE OF NEW YORK
THE STATE EDUCATION DEPARTMENT
DIVISION OF PROFESSIONAL LICENSING SERVICES
89 WASHINGTON AVENUE
ALBANY, NEW YORK 12234

This is to certify that according to the records of the Division of Professional Licensing Services, New York State Education Department Albany, New York, MANDEL BRIGIDO MAURICIO
was issued license/certificate number 303833 for the practice of MEDICINE on 03/25/2020.

Our records also indicate the following information:
Date of birth: 05/10/1981
School attended: UNIVERSITY OF SAO PAULO
Date of graduation: 11/24/04
Degree earned: PHYS

Program was acceptable in accordance with the NYS Regulations of the Commissioner of Education. Requirements met at the time of licensure.

MEDICINE BOARD
2020 JUN -8 AM 8:44

Basis of licensure:

DATE	FLEX1	NBME1	USML1	NBME2	FLEX2	USML2	NBME3	USML3	OTHER
11/15									0000P
07/05						0000P			
03/04			0000P						

EXMS TAKEN=03

A license is valid during the life of the holder unless revoked, annulled or suspended by the Board of Regents. A licensee must register periodically with this Department to practice in this state.

Currently Registered: YES Reg period ends: 02/28/22
Address: 350 SHARON PARK DR APT B4
MENLO PARK CA 94025-0000
Disciplinary information: No charges have been preferred against this licensee
Comments:

I, Sandra Barsallo, Education Credentials Specialist, Division of Professional Licensing Services of the New York State Education Department, do hereby state that as Education Credentials Specialist of said Division, I have legal custody of the official records of the Division of Professional Licensing Services and to the best of my knowledge, the aforesaid information is true and correct.

SEAL

Sandra Barsallo 06/03/20
Education Credentials Specialist

Chair
Zachariah Zachariah, M.D.
Ft. Lauderdale, Florida

Members
Hector Vila, M.D.
Tampa, Florida
Vice-Chair

Luz Marina Pages, M.D.
Miami Beach, Florida

Scot N. Ackerman, M.D.
Jacksonville, Florida

Eleonor Pimentel, M.D.
Miami, Florida

David A. Diamond, M.D.
Winter Park, Florida

Vacant, Consumer Member

Robert London, M.D.
Maitland, Florida

Jorge J. Lopez, M.D.
Maitland, Florida

Andre M. Perez
Miami, Florida

Kevin Cairns, M.D.
Fort Lauderdale, Florida

Nicholas W. Romanello, Esq.
Melbourne, Florida

Sarvam TerKonda, M.D.
Jacksonville, Florida

Shailesh Gupta, M.D.
Coral Springs, Florida

Vacant, M.D.

Executive Director
Claudia Kemp, J.D.

September 9, 2020

Jose Guillermo Alvarez Fontes, MD
3 Ocean West Blvd, 4B4
Daytona Beach Shores, FL 32118

Dear Dr. Alvarez Fontes:

This is in further reference to your application for licensure by endorsement.

Please be advised that you are required to make a personal appearance before the Credentials Committee of the Board of Medicine to discuss:

- Failure to meet section 458.313(1)(a) and 458.311(1)(f)3.c., Florida Statutes, postgraduate training

In addition, the Committee may inquire into any other issues relating to your application and eligibility for licensure.

Date:	Thursday, October 1, 2020
Time:	8:00 a.m. (Meeting starts at 8:00 a.m. Interview time may vary.)
Location:	The in-person meeting scheduled in Orlando, Florida is cancelled, and the meeting will be held by a web-based meeting platform or, if appropriate, a teleconference call.

The meeting information and directions for participating in the October 2020 meeting will be posted on the Florida Board of Medicine's website: https://flboardofmedicine.gov/meeting-information.

Additionally, the Committee's recommendation on your application for licensure will be presented to the full Board of Medicine on Friday, October 2, 2020 for final action. You are not required to attend the full board meeting.

Thank you for your continued cooperation. Should you have any questions regarding this matter, please feel free to contact me. *This is your ***second*** scheduled appearance.

Sincerely,

Karrell D. Goldwire

Karrell D. Goldwire
Regulatory Supervisor

Pursuant to the provisions of the Americans with Disabilities Act, any person requiring special accommodations to participate in this workshop/meeting is asked to advise the agency at least 10 days before the workshop/meeting by contacting: Rebecca.Hewett@flhealth.gov or call (850) 245-4137.

*** 456.013(3)(c) In considering applications for licensure, the board, or the department when there is no board, may require a personal appearance of the applicant. If the applicant is required to appear, the time period in which a licensure application must be granted or denied shall be tolled until such time as the applicant appears. However, if the applicant fails to appear before the board at either of the next two regularly scheduled board meetings, or fails to appear before the department within 30 days if there is no board, the application for licensure shall be denied.**

Chair
Zachariah Zachariah, M.D.
Ft. Lauderdale, Florida

Members
Hector Vila, M.D.
Tampa, Florida
Vice-Chair

Luz Marina Pages, M.D.
Miami Beach, Florida

Scot N. Ackerman, M.D.
Jacksonville, Florida

Eleonor Pimentel, M.D.
Miami, Florida

David A. Diamond, M.D.
Winter Park, Florida

Barbara Fonte
Cutler Bay, Florida

Robert London, M.D.
Maitland, Florida

Jorge J. Lopez, M.D.
Maitland, Florida

Andre M. Perez
Miami, Florida

Kevin Cairns, M.D.
Fort Lauderdale, Florida

Nicholas W. Romanello, Esq.
Melbourne, Florida

Sarvam TerKonda, M.D.
Jacksonville, Florida

Shailesh Gupta, M.D.
Coral Springs, Florida

Vacant, M.D.

Executive Director
Claudia Kemp, J.D.

August 18th, 2020

Jose Guillermo Alvarez Fontes, MD
3 Ocean West Blvd, 4B4
Daytona Beach Shores, FL 32118

At the August 7th, 2020 full board meeting, the Board of Medicine accepted the recommendation of the Credentials Committee to table the application for licensure until the next credentials committee meeting.

If you have any additional questions or concerns, please do not hesitate to contact me at 850-617-1913 or e-mail me at Christina.Keelor@flhealth.gov .

Sincerely,

Christina Keelor

Christina Keelor
Administrative Assistant II

Tab 27 - Abhishek Mishra, MD – Examination
Issue(s): Health History

No action was required by the Credentials Committee. The license was issued administratively.

Tab 28 - Robert M. Frankle, MD – Endorsement
Issue(s): Action by Illinois Medical Board

The applicant was present. After discussion, a motion was made to approve the application for licensure. The motion was seconded, which carried 4/0.

Action Taken: The Committee voted to approve the application for licensure.

Tab 5 - Joseph A. Greco, MD – Endorsement
Issue(s): Tennessee State Board Action(s)

The applicant was not present. After discussion, a motion was made to table the application for licensure until the next credentials committee meeting. The motion was seconded, which carried 4/0.

Action Taken: The Committee voted to table the application for licensure until the next credentials committee meeting.

Tab 7 - Jose Guillermo Alvarez Fontes, MD – Endorsement
Issue(s): Failure to meet section 458.313(1)(a) and 458.311(1)(f)3.c., Florida Statutes, postgraduate training

The applicant was not present. After discussion, a motion was made to table the application for licensure until the next credentials committee meeting. The motion was seconded, which carried 4/0.

Action Taken: The Committee voted to table the application for licensure until the next credentials committee meeting.

Tab 8 - Daimis Vazquez Rosabal, MD – Endorsement
Issue(s): Failure to meet section 458.313(1)(a) and 458.311(1)(f)3.c., Florida Statutes, postgraduate training

The applicant was present. After discussion, a motion was made to allow Dr. Vazquez Rosabal to withdraw her application for licensure. The motion was seconded, which carried 4/0.

Action Taken: The Committee voted to allow withdrawal of the licensure application.

Tab 16 - Odelaisys Enriquez, MD – Endorsement
Issue(s): Failure to meet section 458.313(1)(a) and 458.311(1)(f)3.c., Florida Statutes, postgraduate training

The applicant was present. After discussion, a motion was made to allow Dr. Enriquez to withdraw her application for licensure. The motion was seconded, which carried 4/0.

Action Taken: The Committee voted to allow withdrawal of the licensure application.

INDIVIDUAL CONSIDERATIONS

Robert London, MD – To Interview Tabs 29-36

Tab 29 - Gorana Kuka Epstein, MD – Medical Faculty Certificate
Issue(s): To determine if your postgraduate training is equivalent to the 1-year residency requirement pursuant to section 458.3145(1)(d), Florida Statutes.

The applicant was not present. After discussion, a motion was made to allow Dr. Kuka Epstein to withdraw her application for licensure. The motion was seconded, which carried 4/0.

Action Taken: The Committee voted to allow withdrawal of the licensure application.

Chair
Zachariah Zachariah, M.D.
Ft. Lauderdale, Florida

Members
Hector Vila, M.D.
Tampa, Florida
Vice-Chair

Luz Marina Pages, M.D.
Miami Beach, Florida

Scot N. Ackerman, M.D.
Jacksonville, Florida

Eleonor Pimentel, M.D.
Miami, Florida

David A. Diamond, M.D.
Winter Park, Florida

Barbara Fonte
Cutler Bay, Florida

Robert London, M.D.
Maitland, Florida

Jorge J. Lopez, M.D.
Maitland, Florida

Andre M. Perez
Miami, Florida

Kevin Cairns, M.D.
Fort Lauderdale, Florida

Nicholas W. Romanello, Esq.
Melbourne, Florida

Sarvam TerKonda, M.D.
Jacksonville, Florida

Shailesh Gupta, M.D.
Coral Springs, Florida

Vacant, M.D.

Executive Director
Claudia Kemp, J.D.

July 8, 2020

Jose Guillermo Alvarez Fontes, MD
3 Oceans West Blvd., 4B4
Daytona Beach Shores, FL 32118

Dear Dr. Alvarez Fontes:

This is in further reference to your application for licensure by Endorsement.

Please be advised that you are required to make a personal appearance before the Credentials Committee of the Board of Medicine to discuss:

- **Failure to meet section 458.313(1)(a) and 458.311(1)(f)3.c., Florida Statutes, postgraduate training**

In addition, the Committee may inquire into any other issues relating to your application and eligibility for licensure.

Date:	Thursday, August 6, 2020
Time:	8:00 a.m. **(**Note: The meeting begins at 8:00 a.m. Your case will be presented between 8:00 a.m. – 1:00 p.m.)
Location:	Teleconference Call Call In #: 1 (888) 585-9008 Conference Room #: 432-162-565

The meeting information and directions for participating in the August 2020 meeting will be posted on the Florida Board of Medicine's website: https://flboardofmedicine.gov/meeting-information.

Additionally, the Committee's recommendation on your application for licensure will be presented to the full Board of Medicine on Friday, August 7, 2020 for final action. You are not required to attend the full board meeting.

Thank you for your continued cooperation. Should you have any questions regarding this matter, please feel free to contact me.

Sincerely,

Karrell D. Goldwire

Karrell D. Goldwire
Regulatory Supervisor

Pursuant to the provisions of the Americans with Disabilities Act, any person requiring special accommodations to participate in this workshop/meeting is asked to advise the agency at least 10 days before the workshop/meeting by contacting: Rebecca.Hewett@flhealth.gov or call (850) 245-4137.

*** 456.013(3)(c) In considering applications for licensure, the board, or the department when there is no board, may require a personal appearance of the applicant. If the applicant is required to appear, the time period in which a licensure application must be granted or denied shall be tolled until such time as the applicant appears. However, if the applicant fails to appear before the board at either of the next two regularly scheduled board meetings, or fails to appear before the department within 30 days if there is no board, the application for licensure shall be denied.**

Application

Application Detail	
License Type:	**Medical Doctor**
Profession Number:	**1501 - Medical Doctor**
File Number:	**148172**
Application:	**Medical Doctor Endorsement Application**
Application Date:	**03/24/2020**
Suitability Question(s)	
Are you an osteopathic physician?	**No**
Application Questions	
Military Veteran Fee Waiver - I have been honorably discharged from a branch of the United States Armed Forces within the previous 60 months.	**No**
I am selecting NICA Non-Participating - (I understand that a $250.00 fee will be included if I select this option.)	**Yes**
I will qualify for "In Training" status at the approval of my licensure application.	**No**
I plan to dispense medicinal drugs in the State of Florida for a fee or other remuneration and hereby register as required by Section 465.0276,F.S. I understand that the fee for the Dispensing Practitioner is $100.00 over and above the required initial license fee and will submit it along with the license fee.	**Yes**
Military Veteran Spouse Fee Waiver - I am the spouse of a military veteran who has been honorably discharged from a branch of the United States Armed Forces within the previous 60 months.	**No**

Education History

School Name:	**UNIVERSIDAD DE CIENCIAS MEDICAS DE CAMAGUEY**
Street Address Line 1:	**Carretera Central Oeste Km 2 1/2**
Street Address Line 2:	**N/A**
City:	**Camaguey**
State:	**N/A**
Postal/Zip:	**70100**
Country:	**CUBA**
Date of Graduation (mm/dd/yyyy):	**07/30/1993**
Attended From (mm/dd/yyyy):	**09/01/1987**
Attended To (mm/dd/yyyy):	**07/24/1993**

Additional Education Questions

Are you currently in default on any health education loan or scholarship obligation?	**No**
Have you completed the equivalent of 2 academic years of preprofessional, postsecondary education including, courses in anatomy, biology, and chemistry prior to entering medical school?	**Yes**

Fifth Pathway

Did you attend an international medical school and do not possess a valid ECFMG Certificate?	**No**
Did you receive a bachelor's degree from an accredited United States college or University?	**Yes**
Did you study at a medical school which is recognized by the World Health Organization?	**Yes**
Did you complete all of the formal requirement of the International medical school, except the internship or social service requirements, and pass part I of the National board of Medical examination or the Education Commission for Foreign Medical Graduates Examination equivalent?	**Yes**
Did you complete an academic year of supervised clinical training in a hospital affiliated with a medical school approved by the Council on Medical Education of the American Medical Association and upon completion passed part II of the National Board of Medical Examiners examination or the Education Commission for Foreign Medical Graduates examination Equivalent?	**Yes**

Postgraduate Training 1

Program Name:	**Universidad de Ciencias Medicas**
Mailing Address:	**University Hospital of Pediatric Surgery**
Program City:	**Camaguey**
Program State or Country:	**CUBA**
Program Type:	**RESIDENCY**
Specialty Area:	**GS - PEDIATRIC SURGERY**
Attended From (mm/dd/yyyy):	**10/01/1996**
Attended To (mm/dd/yyyy):	**12/30/1999**
Did you receive credit?	**Yes**

Postgraduate Training 2

Program Name:	**Dr. Negrin University hospital**
Mailing Address:	**Canary islands . Spain**
Program City:	**Canary islands**
Program State or Country:	**SPAIN**
Program Type:	**OTHER PROGRAM**
Specialty Area:	**IM - INTERNAL MEDICINE**
Attended From (mm/dd/yyyy):	**07/01/2008**
Attended To (mm/dd/yyyy):	**12/20/2011**
Did you receive credit?	**Yes**

Postgraduate Training 3

Program Name:	**Hospital HIMA San Pablo Caguas**
Mailing Address:	**Caguas, Puerto Rico**
Program City:	**Caguas**
Program State or Country:	**PUERTO RICO**
Program Type:	**ROTATING INTERNSHIP**
Specialty Area:	**TY - TRANSITIONAL YEAR**
Attended From (mm/dd/yyyy):	**07/01/2017**
Attended To (mm/dd/yyyy):	**07/30/2018**
Did you receive credit?	**Yes**

Exam History

Examination:	**USMLE/FOREIGN**
Date Passed (mm/dd/yyyy):	**09/24/2019**

United States Military and/or Public Health

Have you ever been in the United States Military and/or Public Health Service?	**No**
Have you ever been disciplined by any branch of the United States Armed Services or Public Health Service?	**No**

Practice Employment 1

Place of Employment:	**CENMED Deutche Klinic Jandia**
Address Line 1:	**Spain**
Address Line 2:	**N/A**
City:	**Canary island**
State:	**FC**
Type of Employment:	**Medical coordinator of urgent care service**
Begin Date (mm/dd/yyyy):	**01/05/2012**
End Date (mm/dd/yyyy):	**06/10/2017**

If 'to present', enter today's date.

Practice Employment 2

Place of Employment:	**HIMA San Pablo Caguas hospital**
Address Line 1:	**Carr 172**
Address Line 2:	**Exit 21 Urb Turabo Gardens**
City:	**Caguas**
State:	**PR**
Type of Employment:	**Rotating medical Internship**
Begin Date (mm/dd/yyyy):	**07/01/2017**
End Date (mm/dd/yyyy):	**06/30/2018**

If 'to present', enter today's date.

Practice Employment 3

Place of Employment:	**Hospital HIMA San Pablo Caguas**
Address Line 1:	**Carr 172**
Address Line 2:	**Exit 21 Urb Turabo Gardens**
City:	**Caguas**

State:	**PR**
Type of Employment:	**Intership program coordinator**
Begin Date (mm/dd/yyyy):	**08/10/2018**
End Date (mm/dd/yyyy):	**12/05/2019**

If 'to present', enter today's date.

Practice Employment 4

Place of Employment:	**Lazaro Fraga MD PA**
Address Line 1:	**4131 Sw 6th St**
Address Line 2:	**N/A**
City:	**Coral Gables**
State:	**FL**
Type of Employment:	**Physician in training**
Begin Date (mm/dd/yyyy):	**02/02/2020**
End Date (mm/dd/yyyy):	**03/23/2020**

If 'to present', enter today's date.

Other State Licenses 1

Do you now hold or have you ever held a license to practice medicine or any other profession in any US State or territory, or foreign country? **Yes**

Request verification of licensure status directly from the licensing entity or www.veridoc.org. Request international license verification(s) if you have practiced outside of the U.S. for at least two of the previous four years.

License Number:	**ACN 1217**
Profession:	**MD**
Jurisdiction - Country:	**UNITED STATES**
Jurisdiction - State:	**FLORIDA**

Other State Licenses 2

Do you now hold or have you ever held a license to practice medicine or any other profession in any US State or territory, or foreign country? **Yes**

Request verification of licensure status directly from the licensing entity or www.veridoc.org. Request international license verification(s) if you have practiced outside of the U.S. for at least two of the previous four years.

License Number:	**21588**

Profession:	**MD**
Jurisdiction - Country:	**UNITED STATES**
Jurisdiction - State:	**PUERTO RICO**

Additional Employment Questions

Have you practiced medicine in any jurisdiction for two of the last four years or completed a board approved post-graduate training program within the last two years?	**Yes**

Graduate Education

Do you currently, or have you had, responsibility for graduate medical education within the last 10 years?	**No**

Initial Graduate Medical Education Responsibility and Faculty Appointments

List all institutions where you have had responsibility for graduate medical education or faculty appointment(s) at any medical school.

Name of Institution:	**N/A**

Staff Privileges

Do you currently hold staff privileges in any hospital, health institution, clinic or medical facility?	**No**

Specialty Board Certifications

Are you certified by any specialty board recognized by the American Board of Medical Specialties or specialty board approved by the Florida Board of Medicine?	**No**

DEA

Have you ever been denied, or surrendered, a DEA registration?	**No**

Criminal History

Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to, a crime in any jurisdiction other than a minor traffic offense?	**No**

You must include all misdemeanors and felonies, even if adjudication was withheld. Driving under the influence (DUI) or driving while impaired (DWI) are not minor traffic offenses for purposes of this question.

Medicaid / Medicare

1. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, F.S. (relating to social and economic assistance), Chapter 817, F.S. (relating to fraudulent practices), Chapter 893, F.S. (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction?	**No**

I have been provided and read the statement from the Florida Department of Law Enforcement regarding the sharing, retention, privacy and right to challenge incorrect criminal history records and the 'Privacy Statement' document from the Federal Bureau of Investigation.	**Yes**
Enter in today's date	**03/23/2020**

Medical Malpractice Question

Have you ever had a judgment entered against you for medical malpractice where the incident(s) of malpractice occurred after November 2, 2004?	**No**

Liability Claims

Within the last 10 years have you had any liability claim(s) or action(s) for damages for personal injury settled or finally adjudicated in an amount that exceeds $100,000.00?	**No**

Financial Responsibility/Exemption

Financial Responsibility	**1. IRREVOCABLE LETTER OF CREDIT $100,000**

FDA Institution

Have you ever had any staff privileges denied, suspended, revoked, modified, restricted, not renewed or placed on probation, or have you been asked to resign or take a temporary leave of absence or were otherwise acted against by any facility?	**No**

FDA Licensing

Have you ever had any professional license or license to practice medicine revoked, suspended, placed on probation, or other disciplinary action taken in any state, territory or country?	**No**

FDANP Denied

Have you had any application for a medical license or professional license denied by any state board or other governmental agency of any state, territory, or country?	**No**

FDANP Investigation

Are you currently under investigation in any jurisdiction for an act or offense that would constitute a violation of Section 458.331, Florida Statutes?	**No**

Specialty Board Discipline History

Have you ever had any final disciplinary action taken against you by a specialty board or other similar national organization?	**No**

Year Began Practice

Year Began Practice:	**07/30/1993**

Availability for Disaster

Are you willing to provide health care services in special need shelters or to work with disaster medical teams during times of emergency or major disasters?	**Yes**

Attachments

Document Type: Initial Application Supporting Documentation	File Name: Power of Attorney.pdf
Document Type: Initial Application Supporting Documentation	File Name: CV.pdf
Document Type: Initial Application Supporting Documentation	File Name: ECFMG Certificate.pdf
Document Type: Education Documents	File Name: Spain diploma.pdf
Document Type: Initial Application Supporting Documentation	File Name: NPDB ALVAREZ.pdf
Document Type: Education Documents	File Name: Intership certificate.pdf
Document Type: Education Documents	File Name: Escuela de medicina.pdf

Fees

Application	**$350.00**
Unlicensed Activity	**$5.00**
Dispensing	**$100.00**
Initial License	**$350.00**
NICA Fee	**$250.00**
Total Amount Due:	**$1055.00**

Attestation

I state that these statements are true and correct. I recognize that providing false information may result in denial of licensure, disciplinary action against my license, or criminal penalties pursuant to Sections 456.067, 775.083, and 775.084, Florida Statutes. I state that I have read Chapters 456, 458 and 766.301-.316, Florida Statutes and Chapter 64B8, Florida Administrative Code.

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Florida Board of Medicine information which is material to my application for licensure.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind. I state that my answers and all statements made by me herein are true and correct.

Should I furnish any false information in this application, I hereby agree that such act constitutes cause for denial, suspension, or revocation of my license to practice Medicine in the State of Florida. If there are any changes to my status or any change that would affect any of my answers to this application I must notify the board within 30 days.

I understand that my records are protected under federal and state regulations governing Confidentiality of Mental Health Patient Records and cannot be disclosed without my written consent unless otherwise provided in the regulations. I understand that my records are protected under federal and state regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it.

Attestation Answer: Yes

April 1, 2020

Jose Guillermo Alvarez Fontes, M.D.
Jose Alvarez C/O Lilia Waldero
3 Ocean West Blvd, 4b4
Daytona Beach Shores, FL 32118

Dear Dr. Alvarez Fontes:
File: 148172

Thank you for considering Florida for physician licensure. Your application for medical licensure has been received. The application is incomplete for the reasons set out in the attached deficiency notice. Please address these deficiencies as soon as possible to avoid delay in processing your application.

Information received by this office may require additional explanation or documentation to determine licensure eligibility. After all requested documentation is received, your application will be submitted for supervisory review. We will notify you if additional information is required.

Applicants with a history of malpractice, criminal activity, discipline, physical or mental impairment, unfavorable evaluations, or other matters that need explanation may require a personal appearance before the Board of Medicine Credentials Committee for determination of licensure eligibility. If your appearance is required, you will be notified in writing once your application is complete.

You can now follow the progress of your application through our website at: www.FLHealthSource.gov/mqa-services. If you are a returning user, select "Yes" and enter the user ID and password you selected during the registration process under Returning User. If you did not apply for licensure through this screen, select "No" and follow the prompts to create an account. You must have a valid email address to create your account.

Once you are logged in, you will be prompted to add your application to your account. Once you have successfully added your application, you will be directed to your dashboard. Under the "Additional Activities" section, select "Check Application Status" to review any open deficiencies, upload documents or print out instructional documents.

THIS IS IMPORTANT: Your application will remain incomplete until all deficiencies are completed. In addition, you are required to notify the Board office immediately in writing of any occurrence(s) that would in any way change or affect any answer given in the application or an answer provided in response to any of our direct questions to you.

If you have any questions, please contact me at AnnMarie.Bissoo@flhealth.gov, or call 850-617-1909.

Sincerely,

Ann-Marie Bissoo

Ann-Marie Bissoo
Regulatory Specialist II

Enclosure(s)

Dr Jose Guillermo Alvarez Fontes **Date: April 1, 2020**

REMINDER: Chapter 456.013(1)(a), Florida Statutes, provides that an incomplete application shall expire one year after initial filing with the department.

YOUR APPLICATION'S EXPIRATION DATE IS 03/23/2021.

APPLICATION SUBMITTED REMAINS DEFICIENT FOR LACK OF THE FOLLOWING:

1. An official verification of your medical license from the Commonwealth of Puerto Rico has not been received

2. Please clarify, is this entity (Lazaro Fraga (02/20 to 03/23/20) is listed as "Physician in Training." Is this work or are you in training?

3. Your ECFMG status report, directly from the ECFMG, has not been received.

4. Your Postgraduate Training Verification Forms have not been received.

   Hospital HIMA San Pablo Caguas (07/17 to 07/2018)

If you have any questions, please contact me at AnnMarie.Bissoo@flhealth.gov, or call 850-617-1909. The Florida Board of Medicine has assigned **148172** as your **tracking number**. Please indicate this number if you leave a message, and try to ensure that other sources include it on their communications to us as well.

Department of Health

JOSE GUILLERMO ALVAREZ FONTES

License Number: ACN1217

Data As Of 5/11/2020

Profession	Medical Doctor-Temporary Area of Critical Need
License	ACN1217
License Status	CLEAR/ACTIVE
License Expiration Date	1/31/2022
License Original Issue Date	12/13/2019
Address of Record	15610 SW 46 TERRACE MIAMI, FL 33185 UNITED STATES
Controlled Substance Prescriber (for the Treatment of Chronic Non-malignant Pain)	No
Discipline on File	No
Public Complaint	No

The information on this page is a secure, primary source for license verification provided by the Florida Department of Health, Division of Medical Quality Assurance. This website is maintained by Division staff and is updated immediately upon a change to our licensing and enforcement database.

Chair
Zachariah Zachariah, M.D.
Ft. Lauderdale, Florida

Members
Hector Vila, M.D.
Tampa, Florida
Vice-Chair

Luz Marina Pages, M.D.
Miami Beach, Florida

Scot N. Ackerman, M.D.
Jacksonville, Florida

Eleonor Pimentel, M.D.
Miami, Florida

David A. Diamond, M.D.
Winter Park, Florida

Vacant, Consumer Member

Robert London, M.D.
Maitland, Florida

Jorge J. Lopez, M.D.
Maitland, Florida

Andre M. Perez
Miami, Florida

Kevin Cairns, M.D.
Fort Lauderdale, Florida

Nicholas W. Romanello, Esq.
Melbourne, Florida

Sarvam TerKonda, M.D.
Jacksonville, Florida

Shailesh Gupta, M.D.
Coral Springs, Florida

Vacant, M.D.

Executive Director
Claudia Kemp, J.D.

September 5, 2020

Moamen Gabr, MD
3600 Winthrop Drive, Apt. 5201
Lexington, KY 40514

Dear Dr. Gabr:

This is in further reference to your application for licensure by endorsement.

Please be advised that you are required to make a personal appearance before the Credentials Committee of the Board of Medicine to discuss:

- **Failure to meet section 458.313(1)(a) and 458.311(1)(f)3.c., Florida Statutes, postgraduate training**

In addition, the Committee may inquire into any other issues relating to your application and eligibility for licensure.

Date:	Thursday, October 1, 2020
Time:	8:00 a.m. (Meeting starts at 8:00 a.m. Interview time may vary.)
Location:	The in-person meeting scheduled in Orlando, Florida is cancelled, and the meeting will be held by a web-based meeting platform or, if appropriate, a teleconference call.

The meeting information and directions for participating in the October 2020 meeting will be posted on the Florida Board of Medicine's website: https://flboardofmedicine.gov/meeting-information.

Additionally, the Committee's recommendation on your application for licensure will be presented to the full Board of Medicine on Friday, October 2, 2020 for final action. You are not required to attend the full board meeting.

Thank you for your continued cooperation. Should you have any questions regarding this matter, please feel free to contact me. *This is your first scheduled appearance.

Sincerely,

Karrell D. Goldwire

Karrell D. Goldwire
Regulatory Supervisor

Pursuant to the provisions of the Americans with Disabilities Act, any person requiring special accommodations to participate in this workshop/meeting is asked to advise the agency at least 10 days before the workshop/meeting by contacting: Rebecca.Hewett@flhealth.gov or call (850) 245-4137.

*** 456.013(3)(c) In considering applications for licensure, the board, or the department when there is no board, may require a personal appearance of the applicant. If the applicant is required to appear, the time period in which a licensure application must be granted or denied shall be tolled until such time as the applicant appears. However, if the applicant fails to appear before the board at either of the next two regularly scheduled board meetings, or fails to appear before the department within 30 days if there is no board, the application for licensure shall be denied.**

MEDICAL DOCTOR
APPLICATION FOR LICENSURE
Apply for your license online at www.flboardofmedicine.gov

016508

Choose your application type:

☒ Endorsement (1021) ☐ Examination (1024)

☐ Military Veterans Fee Waiver

If you were honorably discharged from the U.S. armed services within 60 months of your application you will qualify for a waiver of the application fee and the initial licensure fee. In order to qualify, please check the box above indicating that you are seeking a waiver and submit **a DD-214 or NGB-22 form as proof of honorable discharge.**

☐ I plan to dispense medicinal drugs in the State of Florida for a fee or other remuneration and hereby register as required by Section 465.0276, F.S. I understand that the fee for the Dispensing Practitioner is $100.00 in addition to the required initial license fee and will submit it along with the license fee.

1. PERSONAL INFORMATION

Name: GABR (Last/Surname) MOAMEN (First) _____ (Middle) **Date of Birth:** 08/22/1985 (MM/DD/YYYY)

Mailing Address: (The address where mail and your license should be sent)

3600 Winthrop Dr., (Street/ PO Box) Apt 5201 (Suite/Apt. No) Lexington (City)

KY (State) 40514 (Zip) USA (Country) 646-744-5509 (Phone Number)

Physical Location: A Post Office Box is not acceptable. This address will be posted on the Department of Health's website. *If you do not have a current practice address, your mailing address will be used. When you obtain a practice address, you will be required to update your online practitioner profile.*

_____ (Street/ P.O. Box) _____ (Suite/Apt. No) _____ (City)

_____ (State) _____ (Zip) _____ (Country) _____ (Alternate Phone Number)

Email Address: GABR.MOAMEN@gmail.com

Under Florida law, email addresses are public records. If you do not want your e-mail address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.

Equal Opportunity Data: We are required to ask that you furnish the following information as part of your voluntary compliance with Section 2, Uniform Guidelines on Employee Selection Procedure (1978) 43 CFR 38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

SEX: ☒ **Male** ☐ **Female** **RACE:** ☒ **White** ☐ **Black** ☐ **Asian/Pacific Islander** ☐ **Hispanic** ☐ **Other**

☒ Yes ☐ No **Availability for Disaster:** Will you be available to provide health care services in special needs shelters or to help staff disaster medical assistance teams during times of

2. MEDICAL EDUCATION HISTORY

Federal Credentials Verification Services (FCVS) is not a requirement for licensure. FCVS will primary source verify and provide a copy of the medical school transcript(s), medical school diploma, medical school verification, name change document(s), national examination score report, ECFMG certificate, ECFMG verification and postgraduate training verifications. For more information about FCVS, visit their web-site at www.fcvs.org/.

☒ Yes ☐ No Are you using the FCVS to verify your core credentials?

☐ Yes ☒ No Have you completed the equivalent of 2 academic years of preprofessional, postsecondary education including, courses in anatomy, biology and chemistry prior to entering medical school?
(was included in medical school)

Medical Education:
List in chronological order all medical schools attended, whether completed or not. Submit on a separate sheet if needed.

Medical School Name and Address:	From: (mm/yy)	To: (mm/yy)	Date Degree Received:
Tanta Faculty of Medicine	09/02	11/08	06/2010

Fifth Pathway Certificate Holders:

If you answer "yes" to any of the following questions, you must request verifications to be sent directly to the Board office.

☐ Yes ☒ No Did you attend an international medical school and do not possess a valid ECFMG Certificate?

☐ Yes ☒ No Did you receive a bachelor's degree from an accredited United States college or University?

☐ Yes ☒ No Did you study at a medical school which is recognized by the World Health Organization?

☐ Yes ☒ No Did you complete all of the formal requirement of the International medical school, except the internship or social service requirements, and pass part I of the National board of Medical examination or the Education Commission for Foreign Medical Graduates Examination equivalent?

☐ Yes ☒ No Did you complete an academic year of supervised clinical training in a hospital affiliated with a medical school approved by the Council on Medical Education of the American Medical Association and upon completion passed part II of the National Board of Medical Examiners examination or the Education Commission for Foreign Medical Graduates examination Equivalent?

Postgraduate Training:

Provide the following documentation to support your postgraduate training:

- ☐ Post-Graduate Training Form

In the table below list, in chronological order, all postgraduate training from the date you graduated from medical school to the present. Start with your first program and end with your last or current program. List all programs you began, whether you completed or received credit for the training.

Program Name and Full Mailing Address:	Specialty Area:	From: (mm/yy)	To: (mm/yy)	Did you receive credit? (Y/N)
Weill Cornell Medicine 1300 York Ave, NYC, NY 10065	Clinical Research Fellowship Advanced Therapeutic Endoscopy	12/14	12/16	Y
Harvard Medical School Beth Israel Deaconess Medical Center 330 Brookline Ave, Boston, MA 02215	Advanced Therapeutic Endoscopy Fellowship	01/17	12/17	Y

Loan History:

☐ Yes ☒ No Are you currently in default on any health education loan or scholarship obligation? (If "yes", explain on a separate sheet providing accurate details.)

3. EXAMINATION HISTORY

State Board (prior to 1974), State Board (after 1974) & SPEX, LMCC & SPEX, NBME, FLEX, USMLE III, or Combination (prior to 2000)

Request that the score report be sent directly to the Board of Medicine. NOTE: If you took a state Board examination and are not currently licensed in three other states, you must also request your SPEX score be sent.

Exam taken: USMLE III Date passed: 08/03/16 (mm/dd/yy)

4. LICENSURE HISTORY

Request verification of licensure status directly from the licensing entity or www.veridoc.org. Request international license verification(s) if you have practiced outside of the U.S. for at least two of the previous four years.

☒ Yes ☐ No Do you now hold or have you ever held a license to practice medicine or any other profession in any US State or territory, or foreign country? Please list in table below.

Jurisdiction	Profession	License number
MA	Medical Fellowship License	269173
KY	Faculty License	FL053
Ky	Full Medical License	53155
Egypt	Medical License	210676

If you answer "yes" to any of the questions in this section, you are required to send an explanation and supporting documentation.

☐ Yes ☒ No Have you had any application for a medical license or professional license denied by any state board or other governmental agency of any state, territory, or country?

☐ Yes ☒ No Are you currently under investigation in any jurisdiction for an act or offense that would constitute a violation of Section 458.331, Florida Statutes?

☐ Yes ☒ No Have you ever had any professional license or license to practice medicine revoked, suspended, placed on probation, or other disciplinary action taken in any state, territory or country?

5. PRACTICE/EMPLOYMENT HISTORY

List the year you legally first began to practice medicine, 2010 (yyyy). This would be the year you began practicing medicine and could be the date you began your postgraduate training.

☒ Yes ☐ No Have you practiced medicine in any jurisdiction for two of the last four years **or** completed a board approved post-graduate training program within the last two years?

☐ Yes ☐ No If your answer to the question above was "No," have you passed a board approved clinical competency exam within the last year? If yes, then submit supporting documentation.

List in chronological order all employment for the last four (4) years.

Name and address of practice or employment	Type of employment	From: mm/yy	To: mm/yy
University of Kentucky 800 Rose St., Lexington, KY 40536	Assistant Professor of Medicine	01/18	Current

☒ Yes ☐ No Do you currently hold staff privileges in any hospital, health institution, clinic or medical facility? List each facility below.

Name of facility
University of Kentucky Medical Center

If you answer "yes" to the following questions, you are required to send an explanation and supporting documentation.

☐ Yes ☒ No Have you ever had any staff privileges denied, suspended, revoked, modified, restricted, not renewed, or placed on probation, or have you been asked to resign or take a temporary leave of absence or were otherwise acted against by any facility?

☒ Yes ☐ No Do you currently, or have you had, responsibility for graduate medical education within the last 10 years?

In the table below, list all institutions where you have had responsibility for graduate medical education or faculty appointment(s) at any medical school.

Name of institution
University of Kentucky
Tanta University (Egypt)

☐ Yes ☒ No Are you certified by any specialty board recognized by the American Board of Medical Specialties or specialty board approved by the Florida Board of Medicine?

Board Name	Certification/ Specialty/Sub-Specialty	Date of Certification (mm/yy)

If you answer "yes" to any of the following questions, please explain on a separate sheet providing accurate details.

☐ Yes ☒ No Have you ever had any final disciplinary action taken against you by a specialty board or other similar national organization?

☐ Yes ☒ No Have you ever been denied or surrendered a DEA registration?

6. CRIMINAL HISTORY

If you answer "Yes" to the following question you are required to send the following items:

a. Self-explanation describing in detail the circumstances surrounding each offense, including dates, city and state, charges and final results.
b. Final Dispositions and Arrest Records for all offenses. The Clerk of the Court in the arresting jurisdiction will provide you with these documents. Unavailability of these documents must come in the form of a letter from the Clerk of the Court.
c. Completion of Sentence Documents. You may obtain documentation from the Department of Corrections. The report must include the start date, end date and that the conditions were met.

☐ Yes ☒ No Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to, a crime in any jurisdiction other than a minor traffic offense? You must include all misdemeanors and felonies, **even if adjudication was withheld. Driving under the influence (DUI) or driving while impaired (DWI) are not minor traffic offenses for purposes of this question.**

Yes ☒ I have been provided and read the statement from the Florida Department of Law Enforcement regarding the sharing, retention, privacy and right to challenge incorrect criminal history records and the "Privacy Statement" document from the Federal Bureau of Investigation.

7. MILITARY HISTORY

A. ☐ Yes ☒ No Have you ever been in the United States Military and/or Public Health Service?

B. ☐ Yes ☒ No Have you ever been disciplined by any branch of the United States Armed Services or Public Health Services? If you answered "yes" please provide a detailed explanation and supporting documentation

8. CRIMINAL AND MEDICAID/MEDICARE FRAUD QUESTIONS

Applicants for licensure, certification or registration and candidates for examination may be excluded from licensure, certification or registration if their felony conviction falls into certain timeframes as established in Section 456.0635(2), Florida Statutes. If you answer "Yes" to any of the following questions, please provide a written explanation for each question. Supporting documentation includes court dispositions or agency orders where applicable.

1. ☐ Yes ☒ No Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, F.S. (relating to social and economic assistance), Chapter 817, F.S. (relating to fraudulent practices), Chapter 893, F.S. (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction?

If you responded "No" to the question above, skip to question 2.

a. ☐ Yes ☐ No If "yes" to 1, for the felonies of the first or second degree, has it been more than 15 years from the date of the plea, sentence and completion of any subsequent probation?

b. ☐ Yes ☐ No If "Yes" to 1, for felonies of the third degree, has it been more than 10 years from the date of the plea, sentence and completion of any subsequent probation? (This question does not apply to felonies of the third degree under Section 893.13(6)(a), Florida Statutes)

c. ☐ Yes ☐ No If "Yes" to 1, for the felonies of the third degree under Section 893.13(6)(a), Florida Statutes, has it been more than 5 years from the date of the plea, sentence and completion of any subsequent probation?

d. ☐ Yes ☐ No If "Yes" to 1, have you successfully completed a drug court program that resulted in the plea for the felony offense being withdrawn or charges dismissed?

2. ☐ Yes ☒ No Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970 (relating to controlled substances) or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)?

If you responded "No" to the question above, skip to question 3.

a. ☐ Yes ☐ No If "Yes" to 2, has it been more than 15 years before the date of application since the sentence and any subsequent period of probation for such conviction or plea ended?

3. ☐ Yes ☒ No Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes?

If you responded "No" to the question above, skip to question 4.

a. ☐ Yes ☐ No If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years?

4. ☐ Yes ☒ No Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid Program?

If you responded "No" to the question above, skip to question 5.

a. ☐ Yes ☐ No Have you been in good standing with a state Medicaid program for the most recent five years?

b. ☐ Yes ☐ No Did the termination occur at least 20 years before the date of this application?

5. ☐ Yes ☒ No Are you currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities?

If you answer "Yes" to the questions below, you are required to send the following items:

- **A statement indicating the date of each incident and the number for each case.**
- **An explanation of details for each case and your involvement for each case.**
- **Submit the enclosed Exhibit 1 form.**
- **A copy of the complaint, judgments and/or settlements for each case.**
- **Submit a complete copy of the trial record(s) of each case, including the trial transcript, evidentiary exhibits and final judgment in electronic format.**

☐ Yes ☒ No Have you ever had a judgment entered against you for medical malpractice where the incident(s) of malpractice occurred after November 2, 2004?

☐ Yes ☒ No Within the last 10 years have you had any liability claim(s) or action(s) for damages for personal injury settled or finally adjudicated in an amount that exceeds $100,000.00?

10. FINANCIAL RESPONSIBILITY

The Financial Responsibility options are divided into two categories, coverage and exemptions. Check only one option of the ten provided as required by s. 458.320, Florida Statutes.

Category I: Financial Responsibility Coverage

☐1. I do not have hospital staff privileges, I do not perform surgery at an ambulatory surgical center and I have established an irrevocable letter or credit or an escrow account in an amount of $100,000/$300,000, in accord with Chapter 675, F. S., for a letter of credit and s. 625.52, F. S., for an escrow account.

☐2. I have hospital staff privileges or I perform surgery at an ambulatory surgical and I have established an irrevocable letter of credit or escrow account in an amount of $250,000/$750,000, in accord with Chapter 675, F. S., for a letter of credit and s. 625.52, F. S., for an escrow account.

☐3. I do not have hospital staff privileges, I do not perform surgery at an ambulatory surgical center and I have obtained and maintain professional liability coverage in an amount not less than $100,000 per claim, with a minimum annual aggregate of not less than $300,000 from an authorized insurer as defined under s. 624.09, F. S., from a surplus lines insurer as defined under s. 626.914(2), F. S., from a risk retention group as defined under s. 627.942, F. S., from the Joint Underwriting Association established under s. 627.351(4), F. S., or through a plan of self-insurance as provided in s. 627.357, F. S.

☐4. I have hospital staff privileges or I perform surgery at an ambulatory surgical and I have professional liability coverage in an amount not less than $250,000 per claim, with a minimum annual aggregate of not less than $750,000 from an authorized insurer as defined under s. 624.09, F. S., from a surplus lines insurer as defined under s. 626.914(2), F. S., from a risk retention group as defined under s. 627.942, F. S., from the Joint Underwriting Association established under s. 627.351(4), F. S., or through a plan of self-insurance as provided in s. 627.357, F. S.

☐5. I have elected not to carry medical malpractice insurance however, I agree to satisfy any adverse judgments up to the minimum amounts pursuant to s. 458.320(5)(g)1, F. S. I understand that I must either post notice in a sign prominently displayed in my reception area or provide a written statement to any person to whom medical services are being provided that I have decided not to carry medical malpractice insurance. I understand that such a sign or notice must contain the wording specified in s. 458.320(5)(g), F. S.

Category II: Financial Responsibility Exemptions

☐6. I practice medicine exclusively as an officer, employee, or agent of the federal government, the state, or its agencies or subdivisions.

☐7. I hold a limited license issued pursuant to s. 458.317, F. S., and practice only under the scope of the limited license.

☒8. I do not practice medicine in the State of Florida.

☐9. I meet all of the following criteria:

(a) I have held an active license to practice in this state or another state or some combination thereof for more than 15 years;

(b) I am retired or maintain part time practice of no more than 1000 patient contact hours per year;

(c) I have had no more than two claims resulting in an indemnity exceeding $25,000 within the previous five-year period;

(d) I have not been convicted of or pled guilty or nolo contendere to any criminal violation specified in Chapter 458, F. S. or the medical practice act in any other state; and

(e) I have not been subject, within the past ten years of practice, to license revocation, suspension, or probation for a period of three years or longer, or a fine of $500 or more for a violation of Chapter 458, F. S., or the medical practice act of another jurisdiction. A regulatory agency's acceptance of a relinquishment of license, stipulation, consent order, or other settlement offered in response to or in anticipation of filing of administrative charges against a license is construed as action against a license. I understand if I am claiming an exception under this section that I must either post notice in a sign prominently displayed in my reception area or provide a written statement to any person to whom medical services are being provided that I have decided not to carry medical malpractice insurance. See Section 458.320(5)(f), Florida Statutes, for specific notice requirements.

☐10. I practice only in conjunction with my teaching duties at an accredited medical school or its teaching hospitals. (Interns and residents do not qualify for this exemption).

If you select an exemption based on number 9, you must also complete the affidavit on the following page.

11. FLORIDA BIRTH RELATED NEUROLOGICAL COMPENSATION ASSOCIATION

You must choose one of the three options described below. Please be sure to view the information about each exemption at www.nica.com. Check only one.

☐	☑	☐	
$5,000	$250	$0	
Participating	Non-participating	Exempt	Amount enclosed

If you choose "$0 Exempt" provide appropriate documentation to the Board of Medicine and to NICA.

I have read the explanatory information provided by NICA, and I choose the option above.

Signature _____ Date 6/8/2020

Moamen Gabr
Name
3600 Winthrop Dr, Apt 5201
Street Address
Lexington, KY 40514
City, State, Zip

If you are a participating or non-participating physician, or a physician claiming exemption, you must complete, sign and date this form and return it with your payment to this address.

Board of Medicine
4052 Bald Cypress Way, #C-03
Tallahassee, FL 32399-3253

If you are a physician claiming exemption, you must also send a copy of your completed, signed, and dated form with proof of your exemption to:

NICA
2360 Christopher Place
Tallahassee, FL 32308

If you have any questions about NICA or this form, please contact NICA at www.nica.com or (850) 488-8191.

12. STATEMENT OF APPLICANT

I state that these statements are true and correct. I recognize that providing false information may result in denial of licensure, disciplinary action against my license, or criminal penalties pursuant to Sections 456.067, 775.083, and 775.084, Florida Statutes. I state that I have read Chapters 456, 458 and 766.301-.316, Florida Statutes and Chapter 64B8, Florida Administrative Code.

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Florida Board of Medicine information which is material to my application for licensure.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind. I state that my answers and all statements made by me herein are true and correct.

Should I furnish any false information in this application, I hereby agree that such act constitutes cause for denial, suspension, or revocation of my license to practice medicine in the State of Florida. If there are any changes to my status or any change that would affect any of my answers to this application I must notify the board within 30 days.

I understand that my records are protected under federal and state regulations governing Confidentiality of Mental Health Patient Records and cannot be disclosed without my written consent unless otherwise provided in the regulations. I understand that my records are protected under federal and state regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it.

MOAMEN GABR

Print name

Signature

6/8/2020

Date

June 25, 2020

Moamen Gabr, M.D.
3600 Winthrop Dr
Apt 5201
Lexington, KY 40514

Dear Dr. Gabr:
File: 149597

Thank you for considering Florida for physician licensure. Your application for medical licensure has been received. The application is incomplete for the reasons set out in the attached deficiency notice. Please address these deficiencies as soon as possible to avoid delay in processing your application.

Information received by this office may require additional explanation or documentation to determine licensure eligibility. After all requested documentation is received, your application will be submitted for supervisory review. We will notify you if additional information is required.

Applicants with a history of malpractice, criminal activity, discipline, physical or mental impairment, unfavorable evaluations, or other matters that need explanation may require a personal appearance before the Board of Medicine Credentials Committee for determination of licensure eligibility. If your appearance is required, you will be notified in writing once your application is complete.

You can now follow the progress of your application through our website at: www.FLHealthSource.gov/mqa-services. If you are a returning user, select "Yes" and enter the user ID and password you selected during the registration process under Returning User. If you did not apply for licensure through this screen, select "No" and follow the prompts to create an account. You must have a valid email address to create your account.

Once you are logged in, you will be prompted to add your application to your account. Once you have successfully added your application, you will be directed to your dashboard. Under the "Additional Activities" section, select "Check Application Status" to review any open deficiencies, upload documents or print out instructional documents.

THIS IS IMPORTANT: Your application will remain incomplete until all deficiencies are completed. In addition, you are required to notify the Board office immediately in writing of any occurrence(s) that would in any way change or affect any answer given in the application or an answer provided in response to any of our direct questions to you.

If you have any questions, please contact me at AnnMarie.Bissoo@flhealth.gov, or call 850-617-1909.

Sincerely,

Ann-Marie Bissoo

Ann-Marie Bissoo
Regulatory Specialist II

Enclosure(s)

Dr Moamen Gabr **Date: June 25, 2020**

REMINDER: Chapter 456.013(1)(a), Florida Statutes, provides that an incomplete application shall expire one year after initial filing with the department.

YOUR APPLICATION'S EXPIRATION DATE IS 06/15/2021.

APPLICATION SUBMITTED REMAINS DEFICIENT FOR LACK OF THE FOLLOWING:

1. The total application fee, background check, & fingerprint fee is $955.00. Submit a cashier's check or money order (not Personal Check) in the amount of $5.00, made payable to the Florida Board of Medicine, fees are mailed to, Florida Department of Health, Board of Medicine, P.O. Box 6330, Tallahassee, FL 32399.

2. Please email me your Physical Location answer.

3. Please email me your answer: Yes or No: Have you completed the equivalent of 2 academic years of preprofessional, postsecondary education including, courses in anatomy, biology, and chemistry prior to entering medical school?

4. Please email me your full medical school name and address.

5. Please email me the employment/non-employment activities for the last four years.

6. Please submit the National Practitioner Data Bank (NPDB) report to our office. You may contact the NPDB at 1-800-767-6732 to obtain this information. After you have received the NPDB, please email this to me as a PDF attachment. This can come directly from you. (If you are using FCVS, this item does not come from FCVS). Their website is http://www.npdb.hrsa.gov

7. An official verification of your medical licenses from the states/places have not been received:

   MA-269173 KY-FL053 Egypt-210676 (with English Translation)

   KY-53155--active physician submitted with paper app

8. Your FCVS Profile has not been received. Please contact FCVS to check the status of your profile. (Items number 9-10-11-12 should be in FCVS). If not, the information will still be required.

9. Your ECFMG status report, directly from the ECFMG, has not been received.

10. The inquiry you mailed to your medical school has not been received.

11. Your Postgraduate Training Verification Forms have not been received.

12. We await your FLEX/USMLE/SPEX/National Board exam scores, direct from the Federation of State Medical Boards, which must be requested by the applicant.

If you have any questions, please contact me at AnnMarie.Bissoo@flhealth.gov, or call 850 617 1909. The Florida Board of Medicine has assigned **149597** as your **tracking number**. Please indicate this number if you leave a message, and try to ensure that other sources include it on their communications to us as well.

Bissoo, AnnMarie

From: Bissoo, AnnMarie
Sent: Wednesday, July 1, 2020 1:39 PM
To: Moamen Gabr
Subject: RE: Answers to Q - Gabr: File: 149597

Thanks for your responses – this will be added to your file.

From: Moamen Gabr <gabr.moamen@gmail.com>
Sent: Wednesday, July 1, 2020 1:23 PM
To: Bissoo, AnnMarie <AnnMarie.Bissoo@flhealth.gov>
Subject: Re: Answers to Q - Gabr: File: 149597

Please see below the answers to the questions:

2- My practice location currently is:
University of Kentucky Medical Center
800 Rose St, MN649,
Lexington, KY 40536

3- Have you completed the equivalent of 2 academic years of preprofessional, postsecondary education including, courses in
anatomy, biology, and chemistry prior to entering medical school?

Yes (as a part of medical school, 6 academic years in Egypt)

4- Medical School address:

Tanta Faculty of Medicine, Tanta University
El Bahr Street, Tanta, Egypt 31111

5- Please email me the employment/non-employment activities for the last four years:

1/1/2018 – current	Assistant Professor of Medicine
	University of Kentucky – Internal Medicine Department – Division of Gastroenterology
	800 Rose Street, MN649
	Lexington, KY 40536
	Tel: 859-323-5203

1/2017 – 12/2017	Clinical Fellow in Advanced Endoscopy at Beth Israel Deaconess Medical Center/ Harvard Medical School
12/2014 – 12/2016	Clinical Research Fellow in Advanced Endoscopy at Weill Cornell Medicine

On Thu, Jun 25, 2020 at 9:26 AM Bissoo, AnnMarie <AnnMarie.Bissoo@flhealth.gov> wrote:

Moamen Gabr, M.D.

3600 Winthrop Dr

Apt 5201

Lexington, KY United States 40514

Dear Dr. Gabr: File: 149597

Hello and good morning,

Attached is the Deficiency Letter. (Your fingerprints were received)

Regards,

Ann-Marie Bissoo

Regulatory Specialist II

Department of Health (DOH) / Division of Medical Quality Assurance (MQA)

Board of Medicine

4052 Bald Cypress Way, # C03 / Tallahassee, Fl. 32399-3256

Phone: (850) 617-1909

www.flboardofmedicine.gov

www.twitter.com/FLBoardofMed

Department's Mission: To protect, promote and improve the health of all people in Florida through integrated state, county and community efforts.

Department's Vision: To be the Healthiest State in the nation.

Department's Purpose: To protect the public through health care licensure, enforcement and information.

Department's Focus: To be the nation's leader in quality health care regulation.

Department's Values: (ICARE)

I nnovation: We search for creative solutions and manage resources wisely.

C ollaboration: We use teamwork to achieve common goals and solve problems.

A ccountability: We perform with integrity and respect.

R esponsiveness: We achieve our mission by serving our customers and engaging our partners.

E xcellence: We promote quality outcomes through learning and continuous performance improvement.

Florida has a very broad public records law. Most written communications to or from state officials regarding state business are public records available to the public and media upon request. Your e-mail communications may therefore be subject to public disclosure.

How am I communicating? Please feel free to contact my supervisor at Karrell.Goldwire@flhealth.gov.

Bissoo, AnnMarie

From: Bissoo, AnnMarie
Sent: Monday, July 6, 2020 10:26 AM
To: Moamen Gabr
Subject: RE: File number 149597: Dr. MOAMEN GABR

This email has been uploaded to your file.

From: Moamen Gabr <gabr.moamen@gmail.com>
Sent: Thursday, July 2, 2020 8:00 AM
To: Bissoo, AnnMarie <AnnMarie.Bissoo@flhealth.gov>
Subject: Re: File number 149597: Dr. MOAMEN GABR

Hello Ms. Bissoo,
I am afraid this part might have not been clear from our phone conversation today. In addition to completing my residency and GI fellowship in Egypt, **I actually completed 3 years of post-graduate training in the US.**
2 years of Clinical Research Fellowship in Advanced Endoscopy at Weill Cornell in New York, NY
1 year of Clinical Fellowship in Advanced Endoscopy at Beth Israel Deaconess Medical Center/ Harvard Medical School in Boston, MA
I would like to get source verification for these fellowships to be added to my application if possible.

I am not board certified.

I have worked for the last 3 years with an active medical license in Kentucky and continue to work on an active Kentucky full medical license.

Since 1/1/2018, I have worked as a faculty with a rank of Assistant Professor of Medicine in the University of Kentucky. Besides my clinical duties, I am responsible for teaching residents and fellows in our residency and GI fellowship programs.

I also attached my CV for further details.

Please let me know if you have any questions.
Best regards,
Moamen Gabr

On Wed, Jul 1, 2020 at 13:58 Bissoo, AnnMarie <AnnMarie.Bissoo@flhealth.gov> wrote:

> Hello Doctor Gabr,
>
> Per our phone conversation today:
>
> You do not have any post graduate training in the USA. Is that correct?

Also, you are not Board Certified. Is that correct?

You indicated that you have worked in the last 2/4 years with an Active License. Please send me a short email on your job. Thanks. I will add this to your file.

Regards,

Ann-Marie Bissoo

Regulatory Specialist II

Department of Health (DOH) / Division of Medical Quality Assurance (MQA)

Board of Medicine

4052 Bald Cypress Way, # C03 / Tallahassee, Fl. 32399-3256

Phone: (850) 617-1909

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KENTUCKY BOARD OF MEDICAL LICENSURE

Andy Beshear
Governor

Hurstbourne Office Park
310 Whittington Parkway, Suite 1B
Louisville, Kentucky 40222

www.kbml.ky.gov
(502) 429-7150

From: Melinda Swinney, Verification Coordinator MS

RE: License Verification for Moamen M Gabr MD

Date: 06/25/2020

In response to your inquiry as to whether or not the above mentioned physician holds a medical license in Kentucky, please be advised of the following:

Kentucky License Number: FL053

Date Issued: 09/22/2017

Date Expired: 09/19/2019

Derogatory Information:

☒ None

☐ Yes

Basis of Licensure:

☒ Examination

☐ Endorsement

License is Currently:

☐ Active

☒ Inactive

Kentucky Board of Medical Licensure

Hurstbourne Office Park
310 Whittington Parkway, Suite 1B
Louisville, KY 40222
Telephone (502) 429-7150
www.kbml.ky.gov

Name: Moamen M Gabr M.D.
Address: 800 Rose St , Digestive Diseases and Nutrition
City, State Zip: Lexington, KY 40536
Phone: (646) 744-5509
License: 53155
Status: Active Physician
Expiration: 02/28/2021
Practice County: Fayette
***Area of Practice:** Gastroenterology
Type of Practice: Faculty
Year Licensed in KY: 09/19/2019
Medical School: Tanta University
Year Graduated: 2008
Board Action: None

*The Board does not verify current specialties. For more information please see the American Board of Medical Specialties at: http://www.abms.org to determine if the physician has earned a specialty certification from this private agency.

Michael S. Rodman, Executive Director

This is an official copy downloaded from the Kentucky Board of Medical Licensure website on 06/08/2020.

Steven L. Beshear
Governor

Preston P. Nunnelley, M.D.
President

KENTUCKY BOARD OF MEDICAL LICENSURE

Hurstbourne Office Park
310 Whittington Parkway, Suite 1B
Louisville, Kentucky 40222
Telephone (502) 429-7150
www.kbml.ky.gov

Memorandum

TO: Whom It May Concern

FROM: Michael S. Rodman, Executive Director

RE: Verification of Licensure/Certification

DATE: June 5, 2014

The Kentucky Board of Medical Licensure launched an online verification system effective June 5, 2014. All **active** licensees in the state are now required to purchase verification of licensure via the Board's online system. Inactive license verifications will still be processed by the Board.

The downloadable verification will provide license information, the KBML Executive Director signature, KBML seal and an official download statement showing the date the verification was purchased. Please make note of this new system as the Board will no longer be mailing verification of licensure for active licensees.

Should you have any questions, please contact the Board at (502) 429-7150.

MSR/skb

FLORIDA | Board *of* Medicine

Ron DeSantis
Governor

Scott A. Rivkees, MD
State Surgeon General

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Zachariah Zachariah, M.D.
Ft. Lauderdale, Florida

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Miami Beach, Florida

Scot N. Ackerman, M.D.
Jacksonville, Florida

Eleonor Pimentel, M.D.
Miami, Florida

David A. Diamond, M.D.
Winter Park, Florida

Vacant, Consumer Member

Robert London, M.D.
Maitland, Florida

Jorge J. Lopez, M.D.
Maitland, Florida

Andre M. Perez
Miami, Florida

Kevin Cairns, M.D.
Fort Lauderdale, Florida

Nicholas W. Romanello, Esq.
Melbourne, Florida

Sarvam TerKonda, M.D.
Jacksonville, Florida

Shailesh Gupta, M.D.
Coral Springs, Florida

Vacant, M.D.

Executive Director
Claudia Kemp, J.D.

September 5, 2020

Suraj Vijay Parekh, MD
13333 Northwest FWY
Suite 540
Houston, TX 77040

Dear Dr. Parekh:

This is in further reference to your application for licensure by endorsement.

Please be advised that you are required to make a personal appearance before the Credentials Committee of the Board of Medicine to discuss:

- **Criminal History**

In addition, the Committee may inquire into any other issues relating to your application and eligibility for licensure.

Date:	Thursday, October 1, 2020
Time:	8:00 a.m. (Meeting starts at 8:00 a.m. Interview time may vary.)
Location:	The in-person meeting scheduled in Orlando, Florida is cancelled, and the meeting will be held by a web-based meeting platform or, if appropriate, a teleconference call.

The meeting information and directions for participating in the October 2020 meeting will be posted on the Florida Board of Medicine's website: https://flboardofmedicine.gov/meeting-information.

Additionally, the Committee's recommendation on your application for licensure will be presented to the full Board of Medicine on Friday, October 2, 2020 for final action. You are not required to attend the full board meeting.

Thank you for your continued cooperation. Should you have any questions regarding this matter, please feel free to contact me. *This is your first scheduled appearance.

Sincerely,

Karrell D. Goldwire

Karrell D. Goldwire
Regulatory Supervisor

Pursuant to the provisions of the Americans with Disabilities Act, any person requiring special accommodations to participate in this workshop/meeting is asked to advise the agency at least 10 days before the workshop/meeting by contacting: Rebecca.Hewett@flhealth.gov or call (850) 245-4137.

*** 456.013(3)(c) In considering applications for licensure, the board, or the department when there is no board, may require a personal appearance of the applicant. If the applicant is required to appear, the time period in which a licensure application must be granted or denied shall be tolled until such time as the applicant appears. However, if the applicant fails to appear before the board at either of the next two regularly scheduled board meetings, or fails to appear before the department within 30 days if there is no board, the application for licensure shall be denied.**

4052 Bald Cypress Way, Bin C-03
Tallahassee, Florida 32399-3253
Phone: 850/245-4131
Fax: 850/488-0596 or 850/412-1268
https://www.FLBoardofMedicine.gov

Florida HEALTH

Application

Application Detail

License Type:	**Medical Doctor**
Profession Number:	**1501 - Medical Doctor**
File Number:	**149310**
Application:	**Medical Doctor Endorsement Application**
Application Date:	**05/27/2020**

Suitability Question(s)

Are you an osteopathic physician?	**No**

Application Questions

Military Veteran Fee Waiver - I have been honorably discharged from a branch of the United States Armed Forces within the previous 60 months.	**No**
I am selecting NICA Non-Participating - (I understand that a $250.00 fee will be included if I select this option.)	**Yes**
I will qualify for "In Training" status at the approval of my licensure application.	**No**
I plan to dispense medicinal drugs in the State of Florida for a fee or other remuneration and hereby register as required by Section 465.0276,F.S. I understand that the fee for the Dispensing Practitioner is $100.00 over and above the required initial license fee and will submit it along with the license fee.	**No**
Military Veteran Spouse Fee Waiver - I am the spouse of a military veteran who has been honorably discharged from a branch of the United States Armed Forces within the previous 60 months.	**No**

City:	**Piscataway**
State:	**NEW JERSEY**
Postal/Zip:	**11215**
Country:	**UNITED STATES OF AMERICA**
Date of Graduation (mm/dd/yyyy):	**05/25/2011**
Attended From (mm/dd/yyyy):	**08/01/2007**
Attended To (mm/dd/yyyy):	**05/25/2011**

Additional Education Questions

Are you currently in default on any health education loan or scholarship obligation?	**No**
Have you completed the equivalent of 2 academic years of preprofessional, postsecondary education including, courses in anatomy, biology, and chemistry prior to entering medical school?	**Yes**

Fifth Pathway

Did you attend an international medical school and do not possess a valid ECFMG Certificate?	**No**
Did you receive a bachelor's degree from an accredited United States college or University?	**No**
Did you study at a medical school which is recognized by the World Health Organization?	**No**
Did you complete all of the formal requirement of the International medical school, except the internship or social service requirements, and pass part I of the National board of Medical examination or the Education Commission for Foreign Medical Graduates Examination equivalent?	**No**
Did you complete an academic year of supervised clinical training in a hospital affiliated with a medical school approved by the Council on Medical Education of the American Medical Association and upon completion passed part II of the National Board of Medical Examiners examination or the Education Commission for Foreign Medical Graduates examination Equivalent?	**No**

Postgraduate Training 1

Program Name:	**NY Presbyterian Brooklyn Methodist Hospital**
Mailing Address:	**506 6th St.**
Program City:	**Brooklyn**

Program State or Country:	**NEW YORK**
Program Type:	**RESIDENCY**
Specialty Area:	**GS - SURGERY**
Attended From (mm/dd/yyyy):	**07/01/2011**
Attended To (mm/dd/yyyy):	**06/30/2013**
Did you receive credit?	**Yes**

Postgraduate Training 2

Program Name:	**Zucker School of Medicine Hofstra/Northwell at SIUH**
Mailing Address:	**275 Seaview Ave**
Program City:	**Staten Island**
Program State or Country:	**NEW YORK**
Program Type:	**RESIDENCY**
Specialty Area:	**RADIOLOGY**
Attended From (mm/dd/yyyy):	**07/01/2015**
Attended To (mm/dd/yyyy):	**06/30/2019**
Did you receive credit?	**Yes**

Postgraduate Training 3

Program Name:	**University of California San Francisco**
Mailing Address:	**500 Parnassus Ave** **MU 250 E**
Program City:	**San Francisco**
Program State or Country:	**CALIFORNIA**
Program Type:	**FELLOWSHIP**
Specialty Area:	**RADIOLOGY**
Attended From (mm/dd/yyyy):	**07/01/2019**
Attended To (mm/dd/yyyy):	**06/30/2020**
Did you receive credit?	**Yes**

Exam History

Examination:	**USMLE/US/CANADA**
Date Passed (mm/dd/yyyy):	**08/01/2013**

United States Military and/or Public Health

Have you ever been in the United States Military and/or Public Health Service?	**No**
Have you ever been disciplined by any branch of the United States Armed Services or Public Health Service?	**No**

Practice Employment

Place of Employment:	**Northwell Health - Staten Island University Hospital**
Address Line 1:	**475 Seaview Ave**
Address Line 2:	**N/A**
City:	**Staten Island**
State:	**NY**
Type of Employment:	**Staff Radiologist**
Begin Date (mm/dd/yyyy):	**10/28/2019**
End Date (mm/dd/yyyy):	**12/31/2020**

If 'to present', enter today's date.

Other State Licenses 1

Do you now hold or have you ever held a license to practice medicine or any other profession in any US State or territory, or foreign country?	**Yes**

Request verification of licensure status directly from the licensing entity or www.veridoc.org. Request international license verification(s) if you have practiced outside of the U.S. for at least two of the previous four years.

License Number:	**274773**
Profession:	**Physician**
Jurisdiction - Country:	**UNITED STATES**
Jurisdiction - State:	**NEW YORK**

Other State Licenses 2

Do you now hold or have you ever held a license to practice medicine or any other profession in any US State or territory, or foreign country?	**Yes**

Request verification of licensure status directly from the licensing entity or www.veridoc.org. Request international license verification(s) if you have practiced outside of the U.S. for at least two of the previous four years.

License Number:	**A160018**
Profession:	**Physician**

Jurisdiction - Country: **UNITED STATES**

Jurisdiction - State: **CALIFORNIA**

Additional Employment Questions

Have you practiced medicine in any jurisdiction for two of the last four years or completed a board approved post-graduate training program within the last two years? **Yes**

Graduate Education

Do you currently, or have you had, responsibility for graduate medical education within the last 10 years? **No**

Initial Graduate Medical Education Responsibility and Faculty Appointments

List all institutions where you have had responsibility for graduate medical education or faculty appointment(s) at any medical school.

Name of Institution: **N/A**

Staff Privileges

Do you currently hold staff privileges in any hospital, health institution, clinic or medical facility? **Yes**

The facilities listed are Florida facilities. If your privileges are for a facility in another state, select "Out of State".

Name of Facility: **OUT OF STATE**

Out of State Facility: **Northwell Health - Staten Island University Hospital**

Specialty Board Certifications

Are you certified by any specialty board recognized by the American Board of Medical Specialties or specialty board approved by the Florida Board of Medicine? **No**

DEA

Have you ever been denied, or surrendered, a DEA registration? **No**

Criminal History

Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to, a crime in any jurisdiction other than a minor traffic offense? **No**

You must include all misdemeanors and felonies, even if adjudication was withheld. Driving under the influence (DUI) or driving while impaired (DWI) are not minor traffic offenses for purposes of this question.

Medicaid / Medicare

1. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, F.S. (relating to social and economic assistance), Chapter 817, F.S. (relating to fraudulent practices), Chapter 893, F.S. (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction?	**No**
2. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970 (relating to controlled substances) or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)?	**No**
3. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, F.S.?	**No**
4. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program?	**No**
5. Are you currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities?	**No**

Health History

In the last five years, have you been enrolled in, required to enter into, or participated in any drug and/or alcohol recovery program or impaired practitioner program for treatment of drug or alcohol abuse that occurred within the past five years?	**No**
In the last five years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental disorder or impairment?	**No**
During the last five years, have you been treated for or had a recurrence of a diagnosed mental disorder that has impaired your ability to practice medicine within the past five years?	**No**
During the last five years, have you been treated for or had a recurrence of a diagnosed physical disorder that has impaired your ability to practice medicine?	**No**
In the last five years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol/drug) disorder or, if you were previously in such a program, did you suffer a relapse within the last five years?	**No**

During the last five years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol/drug) disorder that impaired your ability to practice medicine within the last five years?	**No**

Electronic Fingerprinting

I have been provided and read the statement from the Florida Department of Law Enforcement regarding the sharing, retention, privacy and right to challenge incorrect criminal history records and the 'Privacy Statement' document from the Federal Bureau of Investigation.	**Yes**
Enter in today's date	**05/27/2020**

Medical Malpractice Question

Have you ever had a judgment entered against you for medical malpractice where the incident(s) of malpractice occurred after November 2, 2004?	**No**

Liability Claims

Within the last 10 years have you had any liability claim(s) or action(s) for damages for personal injury settled or finally adjudicated in an amount that exceeds $100,000.00?	**No**

Financial Responsibility/Exemption

Financial Responsibility	**Financial Exemption**

Category II: Financial Responsibility ExemptionsIf you select an exemption based on # 9, you must also complete the affidavit that will be emailed to you upon submission of this application. 6. I practice medicine exclusively as an officer, employee, or agent of the federal government, the state, or its agencies or subdivisions. 7. I hold a limited license issued pursuant to s. 458.317, F. S., and practice only under the scope of the limited license. 8. I do not practice medicine in the State of Florida. 9. I meet all of the following criteria (a) I have held an active license to practice in this state or another state or some combination thereof for more than 15 years; (b) I am retired or maintain part time practice of no more than 1000 patient contact hours per year; (c) I have had no more than two claims resulting in an indemnity exceeding $25,000 within the previous five-year period; (d) I have not been convicted of or pled guilty or nolo contendere to any criminal violation specified in Chapter 458, F. S. or the medical practice act in any other state; and (e) I have not been subject, within the past ten years of practice, to license revocation, suspension, or probation for a period of three years or longer, or a fine of $500 or more for a violation of Chapter 458, F. S., or the medical practice act of another jurisdiction. A regulatory agency's acceptance of a relinquishment of license, stipulation, consent order, or other settlement offered in response to or in anticipation of filing of administrative charges against a license is construed as action against a license. I understand if I am claiming an exception under this section that I must either post notice in a sign prominently displayed in my reception area or provide a written statement to any person to whom medical services are being provided that I have decided not to carry medical malpractice insurance. See Section 458.320(5)(f), Florida Statutes, for specific notice requirements. 10. I practice only in conjunction with my teaching duties at an accredited medical school or its teaching hospitals. (Interns and residents do not qualify for this exemption).

FDA Institution

Have you ever had any staff privileges denied, suspended, revoked, modified, restricted, not renewed or placed on probation, or have you been asked to resign or take a temporary leave of absence or were otherwise acted against by any facility?	**No**

FDA Licensing

Have you ever had any professional license or license to practice medicine revoked, suspended, placed on probation, or other disciplinary action taken in any state, territory or country?	**No**

FDANP Denied

Have you had any application for a medical license or professional license denied by any state board or other governmental agency of any state, territory, or country?	**No**

FDANP Investigation

Are you currently under investigation in any jurisdiction for an act or offense that would constitute a violation of Section 458.331, Florida Statutes?	**No**

Specialty Board Discipline History

Have you ever had any final disciplinary action taken against you by a specialty board or other similar national organization?	**No**

Year Began Practice

Year Began Practice:	**07/01/2011**

Availability for Disaster

Are you willing to provide health care services in special need shelters or to work with disaster medical teams during times of emergency or major disasters?	**No**

Fees

Application	**$350.00**
Unlicensed Activity	**$5.00**
Initial License	**$350.00**
NICA Fee	**$250.00**
Total Amount Due:	**$955.00**

Attestation

I state that these statements are true and correct. I recognize that providing false information may result in denial of licensure, disciplinary action against my license, or criminal penalties pursuant to Sections 456.067, 775.083, and 775.084, Florida Statutes. I state that I have read Chapters 456, 458 and 766.301-.316, Florida Statutes and Chapter 64B8, Florida Administrative Code.

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Florida Board of Medicine information which is material to my application for licensure.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind. I state that my answers and all statements made by me herein are true and correct.

Should I furnish any false information in this application, I hereby agree that such act constitutes cause for denial, suspension, or revocation of my license to practice Medicine in the State of Florida. If there are any changes to my status or any change that would affect any of my answers to this application I must notify the board within 30 days.

I understand that my records are protected under federal and state regulations governing . Confidentiality of Mental Health Patient Records and cannot be disclosed without my written consent unless otherwise provided in the regulations. I understand that my records are protected under federal and state regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it.

Attestation Answer: Yes

May 28, 2020

Suraj Vijay Parekh, M.D.
13333 Northwest Fwy
Suite 540
Houston, TX 77040

Dear Dr. Parekh:
File: 149310

Thank you for considering Florida for physician licensure. Your application for medical licensure has been received. The application is incomplete for the reasons set out in the attached deficiency notice. Please address these deficiencies as soon as possible to avoid delay in processing your application.

Information received by this office may require additional explanation or documentation to determine licensure eligibility. After all requested documentation is received, your application will be submitted for supervisory review. We will notify you if additional information is required.

Applicants with a history of malpractice, criminal activity, discipline, physical or mental impairment, unfavorable evaluations, or other matters that need explanation may require a personal appearance before the Board of Medicine Credentials Committee for determination of licensure eligibility. If your appearance is required, you will be notified in writing once your application is complete.

You can now follow the progress of your application through our website at: www.FLHealthSource.gov/mqa-services. If you are a returning user, select "Yes" and enter the user ID and password you selected during the registration process under Returning User. If you did not apply for licensure through this screen, select "No" and follow the prompts to create an account. You must have a valid email address to create your account.

Once you are logged in, you will be prompted to add your application to your account. Once you have successfully added your application, you will be directed to your dashboard. Under the "Additional Activities" section, select "Check Application Status" to review any open deficiencies, upload documents or print out instructional documents.

THIS IS IMPORTANT: Your application will remain incomplete until all deficiencies are completed. In addition, you are required to notify the Board office immediately in writing of any occurrence(s) that would in any way change or affect any answer given in the application or an answer provided in response to any of our direct questions to you.

If you have any questions, please contact me at Deondra.McMillan@flhealth.gov, call 850-617-1914, or fax 850-412-1268.

Sincerely,

Deondra McMillan

Deondra McMillan
Regulatory Specialist II

Enclosure(s)

Dr. Suraj Vijay Parekh **Date: May 28, 2020**

REMINDER: Chapter 456.013(1)(a), Florida Statutes, provides that an incomplete application shall expire one year after initial filing with the department.

YOUR APPLICATION'S EXPIRATION DATE IS **05/26/2021**.

APPLICATION SUBMITTED REMAINS DEFICIENT FOR LACK OF THE FOLLOWING:

An official verification of your medical licenses from the states of New York and California have not been received. These documents must come from the entities themselves by mail, fax, or email.

Your FCVS Profile, which includes these documents has not been received:

- Medical School Verification from University of Medicine and Dentistry
- USMLE Exam Scores
- Postgraduate Training Verifications from the following entities:

1. NY Presbyterian Brooklyn Methodist Hospital (07/2011-06/2013)
2. Zucker School of Medicine Hofstra / Northwell at SIUH (07/2015-06/2019)
3. University of California (07/2019-06/2020)

Please submit the National Practitioner Data Bank (NPDB) report to our office. You may contact the NPDB at 1-800-767-6732 to obtain this information.

We have not received your Livescan results. If you have already had your electronic fingerprinting completed, please allow 24-72 hours for receipt of your results. You can find more information on this process, including how to find a provider in your area and your ORI number, by visiting the Background Screening Website at http://www.flhealthsource.gov/background-screening/. Should your Criminal Background Check disclose an arrest record(s), you will need to provide documentation related to each criminal event revealed in your background, if you have not already done so. You can find a detailed description of documents that will be required by visiting the FAQs on the Background Screening Website (Click on 'General FAQs'). Note: Criminal History will be reviewed by the Background Screening Unit, not the Board Office. Please email all criminal history documents to mqa.backgroundscreen@flhealth.gov. Any original certified documents must be mailed to the following address:

Attn: Background Screening Unit
Florida Department of Health
4052 Bald Cypress Way, Bin BSU-01
Tallahassee, FL, 32399

If you have any questions, please contact me at Deondra.McMillan@flhealth.gov, call 850-617-1914, or fax 850-412-1268. The Florida Board of Medicine has assigned **149310** as your **tracking number**. Please indicate this number if you leave a message and try to ensure that other sources include it on their communications to us as well.

July 31, 2020

Suraj Vijay Parekh, M.D.
13333 Northwest Fwy
Suite 540
Houston, TX 77040

Dear Dr. Parekh:

It has been determined that you will be required to make a personal appearance before the Credentials Committee for consideration of your application.

This letter is to advise that you are required to appear before the Credentials Committee of the Florida Board of Medicine upon completion of your application file to discuss your application for licensure.

You will receive a letter in the mail approximately 2 weeks prior to the meeting notifying you of the meeting location and time you are required to appear. If you move, please notify our office immediately of your new address. Address changes must be sent in writing and signed by you. Please mail your address change to the address listed below.

If you have any questions, please contact me at Karrell.Goldwire@flhealth.gov, call (850) 617-1907, or fax (850) 412-1279. Your tracking number in our database is 149310. Indicate your tracking number if you leave a message, and try to ensure that other sources include it on their communications to us as well.

Sincerely,

Karrell D. Goldwire

Karrell D. Goldwire
Regulatory Supervisor
Florida Board of Medicine

POST-GRADUATE TRAINING VERIFICATION FORM

Please have this form completed by the Chairman/Director of the post-graduate training program you attended. Please note that if you are using FCVS, do not submit these items.

The form should be mailed or faxed to:

FLORIDA BOARD OF MEDICINE
4052 BALD CYPRESS WAY, BIN C-03
TALLAHASSEE, FLORIDA 32399-3253
(850) 412-1268 Facsimile

University of CA San Francisco
Name of School

Radiology
Department

500 Parnassus Ave, MU 250 E
Address

San Francisco, CA 94143
City, State, Zip

1. Name of Resident: Surai Parekh

2. Internship/Residency/Fellowship: From: 07/2019 To: 06/2020 (current)

3. Matriculation Date: 7/1/2019

4. Completion Date: 6/2020

5. Specialty: Radiology - Abdominal Imaging

6. Levels completed (check all that apply):

PGY I___PGY II___ PGY III___PGY IV___ PGY V___ PGY VI ✓

Signed: SPENCER BEAL
Chairman or Program Director Only
(No stamped signatures please). PROGRAM DIRECTOR

Jun/16/2020 11:03:59 AM UCSF Radiology 4154760616 1/1

MEDICAL BOARD OF CALIFORNIA

LICENSING DETAILS FOR: A 160018

NAME: PAREKH, SURAJ VIJAY
LICENSE TYPE: PHYSICIAN AND SURGEON A
PRIMARY STATUS: LICENSE RENEWED & CURRENT
SCHOOL NAME: UMDNJ ROBERT WOOD JOHNSON MEDICAL SCHOOL
GRADUATION YEAR: 2011
ADDRESS OF RECORD
DEPT OF RADIOLOGY & BIOMEDICAL IMAGING
513 PARNASSUS AVE S 261 BX 0628
SAN FRANCISCO CA 94143-2205
SAN FRANCISCO COUNTY

ISSUANCE DATE
DECEMBER 19, 2018
EXPIRATION DATE
DECEMBER 31, 2020
CURRENT DATE / TIME
AUGUST 19, 2020
11:13:31 AM

PUBLIC RECORD ACTIONS

- ADMINISTRATIVE DISCIPLINARY ACTIONS (NO INFORMATION TO MEET THE CRITERIA FOR POSTING (HTTP://WWW.MBC.CA.GOV/CONSUMERS/PUBLIC_DISCLOSURE.ASPX))
- COURT ORDER (NO INFORMATION TO MEET THE CRITERIA FOR POSTING (HTTP://WWW.MBC.CA.GOV/CONSUMERS/PUBLIC_DISCLOSURE.ASPX))
- MISDEMEANOR CONVICTION (NO INFORMATION TO MEET THE CRITERIA FOR POSTING (HTTP://WWW.MBC.CA.GOV/CONSUMERS/PUBLIC_DISCLOSURE.ASPX))
- PROBATIONARY LICENSE (NO INFORMATION TO MEET THE CRITERIA FOR POSTING (HTTP://WWW.MBC.CA.GOV/CONSUMERS/PUBLIC_DISCLOSURE.ASPX))
- FELONY CONVICTION (NO INFORMATION TO MEET THE CRITERIA FOR POSTING (HTTP://WWW.MBC.CA.GOV/CONSUMERS/PUBLIC_DISCLOSURE.ASPX))
- MALPRACTICE JUDGMENT (NO INFORMATION TO MEET THE CRITERIA FOR POSTING (HTTP://WWW.MBC.CA.GOV/CONSUMERS/PUBLIC_DISCLOSURE.ASPX))
- HOSPITAL DISCIPLINARY ACTION (NO INFORMATION TO MEET THE CRITERIA FOR POSTING (HTTP://WWW.MBC.CA.GOV/CONSUMERS/PUBLIC_DISCLOSURE.ASPX))
- LICENSE ISSUED WITH PUBLIC LETTER OF REPRIMAND (NO INFORMATION TO MEET THE CRITERIA FOR POSTING (HTTP://WWW.MBC.CA.GOV/CONSUMERS/PUBLIC_DISCLOSURE.ASPX))
- ADMINISTRATIVE CITATION ISSUED (NO INFORMATION TO MEET THE CRITERIA FOR POSTING (HTTP://WWW.MBC.CA.GOV/CONSUMERS/PUBLIC_DISCLOSURE.ASPX))
-

ADMINISTRATIVE ACTION TAKEN BY OTHER STATE OR FEDERAL GOVERNMENT (NO INFORMATION TO MEET THE CRITERIA FOR POSTING (HTTP://WWW.MBC.CA.GOV/CONSUMERS/PUBLIC_DISCLOSURE.ASPX))

› ARBITRATION AWARD (NO INFORMATION TO MEET THE CRITERIA FOR POSTING (HTTP://WWW.MBC.CA.GOV/CONSUMERS/PUBLIC_DISCLOSURE.ASPX))

› MALPRACTICE SETTLEMENTS (NO INFORMATION TO MEET THE CRITERIA FOR POSTING (HTTP://WWW.MBC.CA.GOV/CONSUMERS/PUBLIC_DISCLOSURE.ASPX))

PUBLIC DOCUMENTS

› DOCUMENTS (NO RECORDS)

SURVEY INFORMATION

THE FOLLOWING INFORMATION IS SELF-REPORTED BY THE LICENSEE AND HAS NOT BEEN VERIFIED BY THE BOARD.

ARE YOU RETIRED?	NO
ACTIVITIES IN MEDICINE	PATIENT CARE - 40+ HOURS TEACHING - 1-9 HOURS ADMINISTRATION - 1-9 HOURS
PATIENT CARE PRACTICE LOCATION	ZIP - 94143 COUNTY - SAN FRANCISCO
PATIENT CARE SECONDARY PRACTICE LOCATION	NOT IDENTIFIED
TELEMEDICINE PRACTICE LOCATION	NOT IDENTIFIED
TELEMEDICINE SECONDARY PRACTICE LOCATION	NOT IDENTIFIED
CURRENT TRAINING STATUS	RESIDENCY
AREAS OF PRACTICE	RADIOLOGY - SECONDARY
BOARD CERTIFICATIONS	AMERICAN BOARD OF RADIOLOGY - DIAGNOSTIC RADIOLOGY
POSTGRADUATE TRAINING YEARS	6 YEARS
CULTURAL BACKGROUND	INDIAN

FOREIGN LANGUAGE PROFICIENCY	GUJARATI
GENDER	MALE

Chair
Zachariah Zachariah, M.D.
Ft. Lauderdale, Florida

Members
Hector Vila, M.D.
Tampa, Florida
Vice-Chair

Luz Marina Pages, M.D.
Miami Beach, Florida

Scot N. Ackerman, M.D.
Jacksonville, Florida

Eleonor Pimentel, M.D.
Miami, Florida

David A. Diamond, M.D.
Winter Park, Florida

Vacant, Consumer Member

Robert London, M.D.
Maitland, Florida

Jorge J. Lopez, M.D.
Maitland, Florida

Andre M. Perez
Miami, Florida

Kevin Cairns, M.D.
Fort Lauderdale, Florida

Nicholas W. Romanello, Esq.
Melbourne, Florida

Sarvam TerKonda, M.D.
Jacksonville, Florida

Shailesh Gupta, M.D.
Coral Springs, Florida

Vacant, M.D.

Executive Director
Claudia Kemp, J.D.

September 1, 2020

Carol Ola Landgren, M.D.
425 Mail Str 425 Mail Street
Apartment 10 N
New York City, New York 10044

Dear Dr. Landgren:

This is in further reference to your application for licensure by endorsement.

Please be advised that you are required to make a personal appearance before the Credentials Committee of the Board of Medicine to discuss:

- Failure to meet section 458.313(1)(a) and 458.311(1)(f)3.b., Florida Statutes, ECFMG certification
- Failure to meet section 458.313(1)(a) and 458.311(1)(f)3.c., Florida Statutes, postgraduate training
- Failure to meet section 458.313(1)(b), Florida Statutes, examination

In addition, the Committee may inquire into any other issues relating to your application and eligibility for licensure.

Date:	Thursday, October 1, 2020
Time:	8:00 a.m. (Meeting starts at 8:00 a.m. Interview time may vary.)
Location:	The in-person meeting scheduled in Orlando, Florida is cancelled, and the meeting will be held by a web-based meeting platform or, if appropriate, a teleconference call.

The meeting information and directions for participating in the October 2020 meeting will be posted on the Florida Board of Medicine's website: https://flboardofmedicine.gov/meeting-information.

Additionally, the Committee's recommendation on your application for licensure will be presented to the full Board of Medicine on Friday, October 2, 2020 for final action. You are not required to attend the full board meeting.

Thank you for your continued cooperation. Should you have any questions regarding this matter, please feel free to contact me. *This is your first scheduled appearance.

Sincerely,

Angela Denson
Angela Denson
Regulatory Supervisor

Pursuant to the provisions of the Americans with Disabilities Act, any person requiring special accommodations to participate in this workshop/meeting is asked to advise the agency at least 10 days before the workshop/meeting by contacting: Rebecca.Hewett@flhealth.gov or call (850) 245-4137.

*** 456.013(3)(c) In considering applications for licensure, the board, or the department when there is no board, may require a personal appearance of the applicant. If the applicant is required to appear, the time period in which a licensure application must be granted or denied shall be tolled until such time as the applicant appears. However, if the applicant fails to appear before the board at either of the next two regularly**

Application

Application Detail

License Type:	**Medical Doctor**
Profession Number:	**1501 - Medical Doctor**
File Number:	**149574**
Application:	**Medical Doctor Endorsement Application**
Application Date:	**06/16/2020**

Suitability Question(s)

Are you an osteopathic physician?	**No**

Application Questions

Military Veteran Fee Waiver - I have been honorably discharged from a branch of the United States Armed Forces within the previous 60 months.	**No**
I am selecting NICA Non-Participating - (I understand that a $250.00 fee will be included if I select this option.)	**No**
I will qualify for "In Training" status at the approval of my licensure application.	**No**
I plan to dispense medicinal drugs in the State of Florida for a fee or other remuneration and hereby register as required by Section 465.0276,F.S. I understand that the fee for the Dispensing Practitioner is $100.00 over and above the required initial license fee and will submit it along with the license fee.	**No**
Military Veteran Spouse Fee Waiver - I am the spouse of a military veteran who has been honorably discharged from a branch of the United States Armed Forces within the previous 60 months.	**No**

License Attributes Selected	
Qualification	**NICA Part. Physician (FEE)**

Federal Credentials Verification Services (FCVS)	
Are you using the FCVS to verify your core credentials?	**Yes**

Education History 1	
School Name:	**KAROLINSKA INSTITUTET**
Street Address Line 1:	**Nobels vag 12 A**
Street Address Line 2:	**N/A**
City:	**Solna**
State:	**N/A**
Postal/Zip:	**SE-171 65**
Country:	**SWEDEN**
Date of Graduation (mm/dd/yyyy):	**06/15/1995**
Attended From (mm/dd/yyyy):	**01/15/1994**
Attended To (mm/dd/yyyy):	**06/15/1995**

Education History 2	
School Name:	**LUND UNIVERSITY**
Street Address Line 1:	**Box 117**
Street Address Line 2:	**N/A**
City:	**Lund**
State:	**N/A**
Postal/Zip:	**SE-221 00**
Country:	**SWEDEN**
Date of Graduation (mm/dd/yyyy):	**01/15/1994**
Attended From (mm/dd/yyyy):	**01/15/1990**
Attended To (mm/dd/yyyy):	**01/15/1994**

Additional Education Questions	
Are you currently in default on any health education loan or scholarship obligation?	**No**

Have you completed the equivalent of 2 academic years of preprofessional, postsecondary education including, courses in anatomy, biology, and chemistry prior to entering medical school?	**No**

Fifth Pathway

Did you attend an international medical school and do not possess a valid ECFMG Certificate?	**Yes**
Did you receive a bachelor's degree from an accredited United States college or University?	**No**
Did you study at a medical school which is recognized by the World Health Organization?	**Yes**
Did you complete all of the formal requirement of the International medical school, except the internship or social service requirements, and pass part I of the National board of Medical examination or the Education Commission for Foreign Medical Graduates Examination equivalent?	**No**
Did you complete an academic year of supervised clinical training in a hospital affiliated with a medical school approved by the Council on Medical Education of the American Medical Association and upon completion passed part II of the National Board of Medical Examiners examination or the Education Commission for Foreign Medical Graduates examination Equivalent?	**No**

Postgraduate Training 1

Program Name:	**Residency**
Mailing Address:	**Nykopings Lasarett SE-611 85 Nykoping Sweden**
Program City:	**Nykoping**
Program State or Country:	**SWEDEN**
Program Type:	**RESIDENCY**
Specialty Area:	**IM - INTERNAL MEDICINE**
Attended From (mm/dd/yyyy):	**07/01/1995**
Attended To (mm/dd/yyyy):	**06/01/1997**
Did you receive credit?	**Yes**

Postgraduate Training 2

Program Name:	**Fellowship - Internal medicine**

Mailing Address:	**Karolinska University Hospital Eugeniavagen 3 SE-171 64 Solna Sweden**
Program City:	**Stockholm**
Program State or Country:	**SWEDEN**
Program Type:	**FELLOWSHIP**
Specialty Area:	**IM - INTERNAL MEDICINE**
Attended From (mm/dd/yyyy):	**06/01/1997**
Attended To (mm/dd/yyyy):	**11/29/2002**
Did you receive credit?	**Yes**

Postgraduate Training 3

Program Name:	**Fellowship - Hematology**
Mailing Address:	**Karolinska University Hospital Eugeniavagen 3 SE-171 64 Solna Sweden**
Program City:	**Stockholm**
Program State or Country:	**SWEDEN**
Program Type:	**FELLOWSHIP**
Specialty Area:	**IM - HEMATOLOGY**
Attended From (mm/dd/yyyy):	**11/29/2002**
Attended To (mm/dd/yyyy):	**05/03/2004**
Did you receive credit?	**Yes**

Exam History

Examination:	**National Board**
Date Passed (mm/dd/yyyy):	**05/03/2004**

United States Military and/or Public Health

Have you ever been in the United States Military and/or Public Health Service?	**No**
Have you ever been disciplined by any branch of the United States Armed Services or Public Health Service?	**No**

Practice Employment

Place of Employment:	**Memorial Sloan Kettering Cancer Center**
Address Line 1:	**1275 York Ave**

Address Line 2:	**N/A**
City:	**New York**
State:	**NY**
Type of Employment:	**Chief Attending Physician**
Begin Date (mm/dd/yyyy):	**05/01/2014**
End Date (mm/dd/yyyy):	**06/16/2020**

If 'to present', enter today's date.

Other State Licenses 1

Do you now hold or have you ever held a license to practice medicine or any other profession in any US State or territory, or foreign country?	**Yes**

Request verification of licensure status directly from the licensing entity or www.veridoc.org. Request international license verification(s) if you have practiced outside of the U.S. for at least two of the previous four years.

License Number:	**280052**
Profession:	**Medical License**
Jurisdiction - Country:	**UNITED STATES**
Jurisdiction - State:	**NEW YORK**

Other State Licenses 2

Do you now hold or have you ever held a license to practice medicine or any other profession in any US State or territory, or foreign country?	**Yes**

Request verification of licensure status directly from the licensing entity or www.veridoc.org. Request international license verification(s) if you have practiced outside of the U.S. for at least two of the previous four years.

License Number:	**D0048409**
Profession:	**Medical License**
Jurisdiction - Country:	**UNITED STATES**
Jurisdiction - State:	**MARYLAND**

Other State Licenses 3

Do you now hold or have you ever held a license to practice medicine or any other profession in any US State or territory, or foreign country?	**Yes**

Request verification of licensure status directly from the licensing entity or www.veridoc.org. Request international license verification(s) if you have practiced outside of the U.S. for at least two of the previous four years.

License Number: **670301-4073**

Profession: **Medical License**

Jurisdiction - Country: **SWEDEN**

Additional Employment Questions

Have you practiced medicine in any jurisdiction for two of the last four years or completed a board approved post-graduate training program within the last two years? **Yes**

Graduate Education

Do you currently, or have you had, responsibility for graduate medical education within the last 10 years? **Yes**

Initial Graduate Medical Education Responsibility and Faculty Appointments 1

List all institutions where you have had responsibility for graduate medical education or faculty appointment(s) at any medical school.

Name of Institution: **CORNELL UNIVERSITY MEDICAL COLLEGE**

Initial Graduate Medical Education Responsibility and Faculty Appointments 2

List all institutions where you have had responsibility for graduate medical education or faculty appointment(s) at any medical school.

Name of Institution: **MEMORIAL SLOAN-KETTERING CANCER CENTER**

Staff Privileges

Do you currently hold staff privileges in any hospital, health institution, clinic or medical facility? **Yes**

The facilities listed are Florida facilities. If your privileges are for a facility in another state, select "Out of State".

Name of Facility: **OUT OF STATE**

Out of State Facility: **Memorial Sloan Kettering Cancer Center, New York City**

Specialty Board Certifications

Are you certified by any specialty board recognized by the American Board of Medical Specialties or specialty board approved by the Florida Board of Medicine? **No**

DEA

Have you ever been denied, or surrendered, a DEA registration? **No**

Criminal History

Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to, a crime in any jurisdiction other than a minor traffic offense?	**No**

You must include all misdemeanors and felonies, even if adjudication was withheld. Driving under the influence (DUI) or driving while impaired (DWI) are not minor traffic offenses for purposes of this question.

Medicaid / Medicare

1. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, F.S. (relating to social and economic assistance), Chapter 817, F.S. (relating to fraudulent practices), Chapter 893, F.S. (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction?	**No**
2. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970 (relating to controlled substances) or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)?	**No**
3. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, F.S.?	**No**
4. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program?	**No**
5. Are you currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities?	**No**

Health History

In the last five years, have you been enrolled in, required to enter into, or participated in any drug and/or alcohol recovery program or impaired practitioner program for treatment of drug or alcohol abuse that occurred within the past five years?	**No**
In the last five years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental disorder or impairment?	**No**
During the last five years, have you been treated for or had a recurrence of a diagnosed mental disorder that has impaired your ability to practice medicine within the past five years?	**No**

During the last five years, have you been treated for or had a recurrence of a diagnosed physical disorder that has impaired your ability to practice medicine?	**No**
In the last five years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol/drug) disorder or, if you were previously in such a program, did you suffer a relapse within the last five years?	**No**
During the last five years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol/drug) disorder that impaired your ability to practice medicine within the last five years?	**No**

Electronic Fingerprinting

I have been provided and read the statement from the Florida Department of Law Enforcement regarding the sharing, retention, privacy and right to challenge incorrect criminal history records and the 'Privacy Statement' document from the Federal Bureau of Investigation.	**Yes**
Enter in today's date	**06/16/2020**

Medical Malpractice Question

Have you ever had a judgment entered against you for medical malpractice where the incident(s) of malpractice occurred after November 2, 2004?	**No**

Liability Claims

Within the last 10 years have you had any liability claim(s) or action(s) for damages for personal injury settled or finally adjudicated in an amount that exceeds $100,000.00?	**No**

Financial Responsibility/Exemption

Financial Responsibility	**4. LIABILITY NOT LESS THAN $250,000**

FDA Institution

Have you ever had any staff privileges denied, suspended, revoked, modified, restricted, not renewed or placed on probation, or have you been asked to resign or take a temporary leave of absence or were otherwise acted against by any facility?	**No**

FDA Licensing

Have you ever had any professional license or license to practice medicine revoked, suspended, placed on probation, or other disciplinary action taken in any state, territory or country?	**No**

FDANP Denied

Have you had any application for a medical license or professional license denied by any state board or other governmental agency of any state, territory, or country?	**No**

FDANP Investigation

Are you currently under investigation in any jurisdiction for an act or offense that would constitute a violation of Section 458.331, Florida Statutes?	**No**

Specialty Board Discipline History

Have you ever had any final disciplinary action taken against you by a specialty board or other similar national organization?	**No**

Year Began Practice

Year Began Practice:	**06/15/1995**

Availability for Disaster

Are you willing to provide health care services in special need shelters or to work with disaster medical teams during times of emergency or major disasters?	**No**

Fees

Application	**$350.00**
Unlicensed Activity	**$5.00**
NICA Part. Phys. Fee	**$4750.00**
Initial License	**$350.00**
NICA Fee	**$250.00**
Total Amount Due:	**$5705.00**

Attestation

I state that these statements are true and correct. I recognize that providing false information may result in denial of licensure, disciplinary action against my license, or criminal penalties pursuant to Sections 456.067, 775.083, and 775.084, Florida Statutes. I state that I have read Chapters 456, 458 and 766.301-.316, Florida Statutes and Chapter 64B8, Florida Administrative Code.

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Florida Board of Medicine information which is material to my application for licensure.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind. I state that my answers and all statements made by me herein are true and correct.

Should I furnish any false information in this application, I hereby agree that such act constitutes cause for denial, suspension, or revocation of my license to practice Medicine in the State of Florida. If there are any changes to my status or any change that would affect any of my answers to this application I must notify the board within 30 days.

I understand that my records are protected under federal and state regulations governing Confidentiality of Mental Health Patient Records and cannot be disclosed without my written consent unless otherwise provided in the regulations. I understand that my records are protected under federal and state regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it.

Attestation Answer: Yes

June 16, 2020

Dr Carl Ola Landgren, M.D.
425 Mail Str 425 Mail Street
Apt 10n
New York City, NY 10044

Dear Dr. Landgren:
File: 149574

Thank you for considering Florida for physician licensure. Your application for medical licensure has been received. The application is incomplete for the reasons set out in the attached deficiency notice. Please address these deficiencies as soon as possible to avoid delay in processing your application.

Information received by this office may require additional explanation or documentation to determine licensure eligibility. After all requested documentation is received, your application will be submitted for supervisory review. We will notify you if additional information is required.

Applicants with a history of malpractice, criminal activity, discipline, physical or mental impairment, unfavorable evaluations, or other matters that need explanation may require a personal appearance before the Board of Medicine Credentials Committee for determination of licensure eligibility. If your appearance is required, you will be notified in writing once your application is complete.

You can now follow the progress of your application through our website at: www.FLHealthSource.gov/mqa-services. If you are a returning user, select “Yes” and enter the user ID and password you selected during the registration process under Returning User. If you did not apply for licensure through this screen, select “No” and follow the prompts to create an account. You must have a valid email address to create your account.

Once you are logged in, you will be prompted to add your application to your account. Once you have successfully added your application, you will be directed to your dashboard. Under the “Additional Activities” section, select “Check Application Status” to review any open deficiencies, upload documents or print out instructional documents.

THIS IS IMPORTANT: Your application will remain incomplete until all deficiencies are completed. In addition, you are required to notify the Board office immediately in writing of any occurrence(s) that would in any way change or affect any answer given in the application or an answer provided in response to any of our direct questions to you.

If you have any questions, please contact me at Tashunda.Brown@flhealth.gov or call (850) 617-1901.

Sincerely,

Tashunda Brown
Regulartory Specialist II

Enclosure(s)

Dr Carl Ola Landgren **Date: June 16, 2020**

REMINDER: Chapter 456.013(1)(a), Florida Statutes, provides that an incomplete application shall expire one year after initial filing with the department.

YOUR APPLICATION'S EXPIRATION DATE IS June 15, 2021

APPLICATION SUBMITTED REMAINS DEFICIENT FOR LACK OF THE FOLLOWING:

An official verification of your medical license from the State of Maryland and New York have not been received

Your Postgraduate Training Verification Forms have not been received.

Your medical degree verification form from Lund University has not been received.

Your FCVS Profile has not been received. Please contact FCVS to check the status of your profile.

Please submit the National Practitioner Data Bank (NPDB) report to our office. You may contact the NPDB at 1-800-767-6732 to obtain this information.

We await your FLEX/USMLE/SPEX/National Board exam scores, direct from the Federation of State Medical Boards, which must be requested by the applicant.

We have not received your Livescan results. If you have already had your electronic fingerprinting completed, please allow 24-72 hours for receipt of your results. You can find more information on this process, including how to find a provider in your area and your ORI number, by visiting the Background Screening Website at http://www.flhealthsource.gov/background-screening/. Should your Criminal Background Check disclose an arrest record(s), you will need to provide documentation related to each criminal event revealed in your background, if you have not already done so. You can find a detailed description of documents that will be required by visiting the FAQs on the Background Screening Website (Click on 'General FAQs'). Note: Criminal History will be reviewed by the Background Screening Unit, not the Board Office. Please email all criminal history documents to mqa.backgroundscreen@flhealth.gov. Any original certified documents must be mailed to the following address: Attn: Background Screening Unit Florida Department of Health 4052 Bald Cypress Way, Bin BSU-01 Tallahassee, FL, 32399

If you have any questions, please contact me at Tashunda.Brown@flhealth.gov or call (850) 617-1901 .
The Florida Board of Medicine has assigned **149574** as your **tracking number**.

Brown, Tashunda

From: monicafelder7 <monicafelder7@gmail.com>
Sent: Tuesday, July 7, 2020 10:44 AM
To: Brown, Tashunda
Cc: landgrec@mskcc.org; Riccio, Irma; Ismail, Ali
Subject: RE: Dr. Ola Landgren

Thank you so much! Dr. Landgren is supposed to start for UM in October, so we want to make sure his application goes to Credentials in early October and are trying to ensure we get everything in to you in a timely manner. I just wanted to let you know he does not have US exams or residency. We will be asking the Committee to consider his application anyway with conditions and I will send a letter about that as we get closer to the meeting, but I wanted to let you know so you don't hold up his file for that. Please keep me in the loop about anything missing. He also has people at UM helping to ensure all required information is provided to you asap. Thank you and I look forward to working with you to get this completed.

Monica Felder
305-812-2111

-------- Original message --------
From: "Brown, Tashunda" <Tashunda.Brown@flhealth.gov>
Date: 7/7/20 8:15 AM (GMT-05:00)
To: 'monicafelder7' <monicafelder7@gmail.com>
Subject: RE: Dr. Ola Landgren

Good Morning,

Thank you for your email.

How can I assist you?

Sincerely,

Tashunda Brown

Florida Department of Health

4052 Bald Cypress Way

Tallahassee, Florida 32399

Website: www.flboardofmedicine.gov

How is my customer service? Feel free to contact my supervisor at Angela.Denson@flhealth.gov.

Mission: To protect, promote and improve the health of all people in Florida through integrated state, county, and community efforts.

Vision: To be the **Healthiest State** in the Nation.
Purpose: To protect the public through health care licensure, enforcement and information.
Focus: To be the nation's leader in quality health care regulation.
Values: I.C.A.R.E. (Innovation, Collaboration, Accountability, Responsiveness, Excellence)

Please Note: Florida has a very broad public records law. Most written communications to or from state officials regarding state business are public records available to the public and media upon request. Your e-mail communications may therefore be subject to public disclosure.

From: Alls, Wendy <Wendy.Alls@flhealth.gov>
Sent: Monday, July 6, 2020 9:52 PM
To: 'monicafelder7' <monicafelder7@gmail.com>
Cc: Brown, Tashunda <Tashunda.Brown@flhealth.gov>
Subject: RE: Dr. Ola Landgren

Ms. Monica,

Tashunda Brown is the processor and she can be reached at Tashunda.Brown@flhealth.gov.

I have also copied her on this email.

From: monicafelder7 <monicafelder7@gmail.com>
Sent: Monday, July 6, 2020 6:38 PM
To: Alls, Wendy <Wendy.Alls@flhealth.gov>
Subject: RE: Dr. Ola Landgren

I thought so.... File no 149574.

-------- Original message --------

From: "Alls, Wendy" <Wendy.Alls@flhealth.gov>

Date: 7/6/20 5:52 PM (GMT-05:00)

To: 'monicafelder7' <monicafelder7@gmail.com>

Subject: RE: Dr. Ola Landgren

Hi Monica,

I am unable to locate the physician in our database system. Is the name spelled correctly?

From: monicafelder7 <monicafelder7@gmail.com>
Sent: Monday, July 6, 2020 4:19 PM
To: Alls, Wendy <Wendy.Alls@flhealth.gov>
Subject: Dr. Ola Landgren

Dear Wendy,

I am helping Dr. Landgren with his license application, which was submitted but we can't see the name of the person working on the application. Can you tell me how to find that or let me know who it is?

I hope all is well with you.

Monica

POST-GRADUATE TRAINING VERIFICATION FORM

Please have this form completed by the Chairman/Director of the post-graduate training program you attended. Please note that if you are using FCVS, do not submit these items.

The form should be mailed or faxed to:

FLORIDA BOARD OF MEDICINE
4052 BALD CYPRESS WAY, BIN C-03
TALLAHASSEE, FLORIDA 32399-3253
(850) 412-1268 Facsimile

Karolinska University Hospital
Name of School

Center for Hematology, Dept of Medicine
Department

Solna Campus
Address

171 76 Stockholm, Sweden
City, State, Zip

1. Name of Resident: Carl Ola Landgren

2. Internship/Residency/Fellowship: From: 1998 To: 2002

3. Matriculation Date: Oct 1998

4. Completion Date: Oct 2002

5. Specialty: Hematology / Internal Medicine

6. Levels completed (check all that apply): Fellowship

PGY I___PGY II___ PGY III___PGY IV___ PGY V___

Signed: _____

Chairman or Program Director Only
(No stamped signatures please).

Hakan Magnusson, MD, PhD
Acting chair of Department

MARYLAND
Department of Health Board of Physicians

Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Robert R. Neall, Secretary

July 9, 2020

Florida Board of Medicine
4052 Bald Cypress Way
BIN #C03
Tallahassee FL 32399-3256

This is to verify the records of the Maryland Board of Physicians. The following information is available under the Maryland Public Information Act, State Government Article, Section 4-333, regarding the following practitioner:

Carl Ola Landgren

For the Practice of:	Physician-M.D.
License Number:	D48409
Date Issued:	**08/28/2013**
Current Status:	**Active**
Expiration Date	**09/30/2020**
*Disciplinary Actions	**No disciplinary actions.**

*Disciplinary information can be found on our website. Go to https://www.mbp.state.md.us and select Lookup a License.

For malpractice claim information, please contact the Maryland Health Care Alternative Dispute Resolution Office 410.767.8200.

Respectfully,

Maryland Board of Physicians
Verification Unit

4201 Patterson Avenue – Baltimore, Maryland 21215
Toll Free 1-800-492-6836 – TTY/Maryland Relay Service 1-800-735-2258
Web Site: www.mbp.state.md.us

Chair
Zachariah Zachariah, M.D.
Ft. Lauderdale, Florida

Members
Hector Vila, M.D.
Tampa, Florida
Vice-Chair

Luz Marina Pages, M.D.
Miami Beach, Florida

Scot N. Ackerman, M.D.
Jacksonville, Florida

Eleonor Pimentel, M.D.
Miami, Florida

David A. Diamond, M.D.
Winter Park, Florida

Vacant, Consumer Member

Robert London, M.D.
Maitland, Florida

Jorge J. Lopez, M.D.
Maitland, Florida

Andre M. Perez
Miami, Florida

Kevin Cairns, M.D.
Fort Lauderdale, Florida

Nicholas W. Romanello, Esq.
Melbourne, Florida

Sarvam TerKonda, M.D.
Jacksonville, Florida

Shailesh Gupta, M.D.
Coral Springs, Florida

Vacant, M.D.

Executive Director
Claudia Kemp, J.D.

September 5, 2020

Michael Schlewet, MD
169 Gerry Road
Dorchester, MA 02467

Dear Dr. Schlewet:

This is in further reference to your application for licensure by endorsement.

Please be advised that you are required to make a personal appearance before the Credentials Committee of the Board of Medicine to discuss:

- **Failure to meet section 458.313(1)(a) and 458.311(1)(f)3.c., Florida Statutes, postgraduate training**

In addition, the Committee may inquire into any other issues relating to your application and eligibility for licensure.

Date:	Thursday, October 1, 2020
Time:	8:00 a.m. (Meeting starts at 8:00 a.m. Interview time may vary.)
Location:	The in-person meeting scheduled in Orlando, Florida is cancelled, and the meeting will be held by a web-based meeting platform or, if appropriate, a teleconference call.

The meeting information and directions for participating in the October 2020 meeting will be posted on the Florida Board of Medicine's website: https://flboardofmedicine.gov/meeting-information.

Additionally, the Committee's recommendation on your application for licensure will be presented to the full Board of Medicine on Friday, October 2, 2020 for final action. You are not required to attend the full board meeting.

Thank you for your continued cooperation. Should you have any questions regarding this matter, please feel free to contact me. *This is your first scheduled appearance.

Sincerely,

Karrell D. Goldwire

Karrell D. Goldwire
Regulatory Supervisor

Pursuant to the provisions of the Americans with Disabilities Act, any person requiring special accommodations to participate in this workshop/meeting is asked to advise the agency at least 10 days before the workshop/meeting by contacting: Rebecca.Hewett@flhealth.gov or call (850) 245-4137.

*** 456.013(3)(c) In considering applications for licensure, the board, or the department when there is no board, may require a personal appearance of the applicant. If the applicant is required to appear, the time period in which a licensure application must be granted or denied shall be tolled until such time as the applicant appears. However, if the applicant fails to appear before the board at either of the next two regularly scheduled board meetings, or fails to appear before the department within 30 days if there is no board, the application for licensure shall be denied.**

Application

Application Detail

License Type:	**Medical Doctor**
Profession Number:	**1501 - Medical Doctor**
File Number:	**149404**
Application:	**Medical Doctor by Exam Application**
Application Date:	**06/02/2020**

Suitability Question(s)

Have you passed all parts of a United States national examination (NBME, FLEX, or USMLE)? OR Are you licensed on the basis of a state board examination and currently hold a license in at least one other jurisdiction of the United States or Canada, have practiced pursuant to such licensure for a period of at least 10 years, and have received a passing score on the Special Purpose Examination of the Federation of State Medical Boards of the United States (SPEX)? OR Were you licensed prior to 1974 on the basis of a state board examination, are currently licensed in at least three other jurisdictions of the United States or Canada, and have practiced pursuant to such licensure for a period of at least 20 years	**Yes**

Application Questions

Military Veteran Fee Waiver - I have been honorably discharged from a branch of the United States Armed Forces within the previous 60 months.	**No**
I am selecting NICA Non-Participating - (I understand that a $250.00 fee will be included if I select this option.)	**Yes**

DORCHESTER, MA

02124

US

Federal Credentials Verification Services (FCVS)

Are you using the FCVS to verify your core credentials?	Yes

Education History

School Name:	UNIVERSITY OF DAMASCUS
Street Address Line 1:	Mazzeh Highway
Street Address Line 2:	N/A
City:	Damascus
State:	N/A
Postal/Zip:	000
Country:	SYRIAN ARAB REPUBLIC
Date of Graduation (mm/dd/yyyy):	03/19/2002
Attended From (mm/dd/yyyy):	09/01/1995
Attended To (mm/dd/yyyy):	02/01/2002

Additional Education Questions

Are you currently in default on any health education loan or scholarship obligation?	No
Have you completed the equivalent of 2 academic years of preprofessional, postsecondary education including, courses in anatomy, biology, and chemistry prior to entering medical school?	Yes

Fifth Pathway

Did you attend an international medical school and do not possess a valid ECFMG Certificate?	No
Did you receive a bachelor's degree from an accredited United States college or University?	No
Did you study at a medical school which is recognized by the World Health Organization?	Yes
Did you complete all of the formal requirement of the International medical school, except the internship or social service requirements, and pass part I of the National board of Medical examination or the Education Commission for Foreign Medical Graduates Examination equivalent?	No

Did you complete an academic year of supervised clinical training in a hospital affiliated with a medical school approved by the Council on Medical Education of the American Medical Association and upon completion passed part II of the National Board of Medical Examiners examination or the Education Commission for Foreign Medical Graduates examination Equivalent?	**No**

Postgraduate Training 1

Program Name:	**Sinai Hospital of Baltimore- Otolaryngology fellowship**
Mailing Address:	**2401 W Belvedere Ave, Baltimore, MD 21215**
Program City:	**Baltimore**
Program State or Country:	**MARYLAND**
Program Type:	**FELLOWSHIP**
Specialty Area:	**OTO - OTOLARYNGOLOGY**
Attended From (mm/dd/yyyy):	**07/01/2015**
Attended To (mm/dd/yyyy):	**06/30/2016**
Did you receive credit?	**Yes**

Postgraduate Training 2

Program Name:	**St. Elizabeth's Medical Center- Rhinology Fellowship**
Mailing Address:	**736 Cambridge Street SMC-8**
Program City:	**Brighton**
Program State or Country:	**MASSACHUSETTS**
Program Type:	**FELLOWSHIP**
Specialty Area:	**OTO - OTOLARYNGOLOGY**
Attended From (mm/dd/yyyy):	**11/03/2016**
Attended To (mm/dd/yyyy):	**11/02/2019**
Did you receive credit?	**Yes**

Exam History

Examination:	**USMLE/FOREIGN**
Date Passed (mm/dd/yyyy):	**03/28/2017**

United States Military and/or Public Health

Have you ever been in the United States Military and/or Public Health Service?	**No**

Have you ever been disciplined by any branch of the United States Armed Services or Public Health Service?	**No**

Practice Employment

Place of Employment:	**Carney Hospital**
Address Line 1:	**2100 Dorchester Ave**
Address Line 2:	**N/A**
City:	**Dorchester**
State:	**MA**
Begin Date (mm/dd/yyyy):	**12/31/2019**
End Date (mm/dd/yyyy):	**06/02/2020**

If 'to present', enter today's date.

Other State License

Do you now hold or have you ever held a license to practice medicine or any other profession in any US State or territory?	**Yes**

Request verification of licensure status directly from the licensing entity or www.veridoc.org. Request international license verification(s) if you have practiced outside of the U.S. for at least two of the previous four years.

License Number:	**277861**
Type:	**full unrestricted**
Jurisdiction - Country:	**UNITED STATES**
Jurisdiction - State:	**Massachusetts**

Additional Employment Questions

Have you practiced medicine in any jurisdiction for two of the last four years or completed a board approved post-graduate training program within the last two years?	**Yes**

Graduate Education

Do you currently, or have you had, responsibility for graduate medical education within the last 10 years?	**No**

Initial Graduate Medical Education Responsibility and Faculty Appointments

List all institutions where you have had responsibility for graduate medical education or faculty appointment(s) at any medical school.

Name of Institution:	**N/A**

Staff Privileges

Do you currently hold staff privileges in any hospital, health institution, clinic or medical facility?	**Yes**

The facilities listed are Florida facilities. If your privileges are for a facility in another state, select "Out of State".

Name of Facility:	**OUT OF STATE**
Out of State Facility:	**Carney Hospital, Boston, MA**

Specialty Board Certifications

Are you certified by any specialty board recognized by the American Board of Medical Specialties or specialty board approved by the Florida Board of Medicine?	**No**

DEA

Have you ever been denied, or surrendered, a DEA registration?	**No**

Criminal History

Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to, a crime in any jurisdiction other than a minor traffic offense?	**No**

You must include all misdemeanors and felonies, even if adjudication was withheld. Driving under the influence (DUI) or driving while impaired (DWI) are not minor traffic offenses for purposes of this question.

Medicaid / Medicare

1. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, F.S. (relating to social and economic assistance), Chapter 817, F.S. (relating to fraudulent practices), Chapter 893, F.S. (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction?	**No**
2. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970 (relating to controlled substances) or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)?	**No**
3. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, F.S.?	**No**
4. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program?	**No**
5. Are you currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities?	**No**

Health History

In the last five years, have you been enrolled in, required to enter into, or participated in any drug and/or alcohol recovery program or impaired practitioner program for treatment of drug or alcohol abuse that occurred within the past five years?	**No**
In the last five years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental disorder or impairment?	**No**
During the last five years, have you been treated for or had a recurrence of a diagnosed mental disorder that has impaired your ability to practice medicine within the past five years?	**No**
During the last five years, have you been treated for or had a recurrence of a diagnosed physical disorder that has impaired your ability to practice medicine?	**No**
In the last five years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol/drug) disorder or, if you were previously in such a program, did you suffer a relapse within the last five years?	**No**
During the last five years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol/drug) disorder that impaired your ability to practice medicine within the last five years?	**No**

Electronic Fingerprinting

I have been provided and read the statement from the Florida Department of Law Enforcement regarding the sharing, retention, privacy and right to challenge incorrect criminal history records and the 'Privacy Statement' document from the Federal Bureau of Investigation.	**Yes**
Enter in today's date	**06/02/2020**

Medical Malpractice Question

Have you ever had a judgment entered against you for medical malpractice where the incident(s) of malpractice occurred after November 2, 2004?	**No**

Liability Claims

Within the last 10 years have you had any liability claim(s) or action(s) for damages for personal injury settled or finally adjudicated in an amount that exceeds $100,000.00?	**No**

Financial Responsibility/Exemption

Financial Responsibility	**4. LIABILITY NOT LESS THAN $250,000**

FDA Licensing

Have you ever had any professional license or license to practice medicine revoked, suspended, placed on probation, or other disciplinary action taken in any state, territory or country?	**No**

FDA Institution

Have you ever had any staff privileges denied, suspended, revoked, modified, restricted, not renewed or placed on probation, or have you been asked to resign or take a temporary leave of absence or were otherwise acted against by any facility?	**No**

FDANP Denied

Have you had any application for a medical license or professional license denied by any state board or other governmental agency of any state, territory, or country?	**No**

FDANP Investigation

Are you currently under investigation in any jurisdiction for an act or offense that would constitute a violation of Section 458.331, Florida Statutes?	**No**

Specialty Board Discipline History

Have you ever had any final disciplinary action taken against you by a specialty board or other similar national organization?	**No**

Year Began Practice

Year Began Practice:	**07/01/2015**

Availability for Disaster

Are you willing to provide health care services in special need shelters or to work with disaster medical teams during times of emergency or major disasters?	**Yes**

Attachments

Document Type: Initial Application Supporting Documentation File Name: self query.pdf

Document Type: Education Documents File Name: St. E fellowship certificate.pdf

Document Type: Education Documents File Name: fellowship certificate.pdf

Fees

Application Fee	**$350.00**
Unlicensed Activity	**$5.00**
Initial License	**$350.00**
NICA Fee	**$250.00**
Total Amount Due:	**$955.00**

Attestation

I state that these statements are true and correct. I recognize that providing false information may result in denial of licensure, disciplinary action against my license, or criminal penalties pursuant to Sections 456.067, 775.083, and 775.084, Florida Statutes. I state that I have read Chapters 456, 458 and 766.301-.316, Florida Statutes and Chapter 64B8, Florida Administrative Code.

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Florida Board of Medicine information which is material to my application for licensure.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind. I state that my answers and all statements made by me herein are true and correct.

Should I furnish any false information in this application, I hereby agree that such act constitutes cause for denial, suspension, or revocation of my license to practice Medicine in the State of Florida. If there are any changes to my status or any change that would affect any of my answers to this application I must notify the board within 30 days.

I understand that my records are protected under federal and state regulations governing Confidentiality of Mental Health Patient Records and cannot be disclosed without my written consent unless otherwise provided in the regulations. I understand that my records are protected under federal and state regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it.

Attestation Answer: Yes

June 3, 2020

Michael Schlewet, M.D.
169 Gerry Rd
Chestnut Hill
Dorchester, MA 02467

Dear Dr. Schlewet:
File: 149404

Thank you for considering Florida for physician licensure. Your application for medical licensure has been received. The application is incomplete for the reasons set out in the attached deficiency notice. Please address these deficiencies as soon as possible to avoid delay in processing your application.

Information received by this office may require additional explanation or documentation to determine licensure eligibility. After all requested documentation is received, your application will be submitted for supervisory review. We will notify you if additional information is required.

Applicants with a history of malpractice, criminal activity, discipline, physical or mental impairment, unfavorable evaluations, or other matters that need explanation may require a personal appearance before the Board of Medicine Credentials Committee for determination of licensure eligibility. If your appearance is required, you will be notified in writing once your application is complete.

You can now follow the progress of your application through our website at: www.FLHealthSource.gov/mqa-services. If you are a returning user, select "Yes" and enter the user ID and password you selected during the registration process under Returning User. If you did not apply for licensure through this screen, select "No" and follow the prompts to create an account. You must have a valid email address to create your account.

Once you are logged in, you will be prompted to add your application to your account. Once you have successfully added your application, you will be directed to your dashboard. Under the "Additional Activities" section, select "Check Application Status" to review any open deficiencies, upload documents or print out instructional documents.

THIS IS IMPORTANT: Your application will remain incomplete until all deficiencies are completed. In addition, you are required to notify the Board office immediately in writing of any occurrence(s) that would in any way change or affect any answer given in the application or an answer provided in response to any of our direct questions to you.

If you have any questions, please contact me at Deondra.McMillan@flhealth.gov, call 850-617-1914, or fax 850-412-1268.

Sincerely,

Deondra McMillan

Deondra McMillan
Regulatory Specialist II

Enclosure(s)

Dr. Michael Schlewet **Date: June 3, 2020**

REMINDER: Chapter 456.013(1)(a), Florida Statutes, provides that an incomplete application shall expire one year after initial filing with the department.

YOUR APPLICATION'S EXPIRATION DATE IS **06/01/2021.**

APPLICATION SUBMITTED REMAINS DEFICIENT FOR LACK OF THE FOLLOWING:

An official verification of your medical license from the state of Massachusetts has not been received. This must come from the board directly by fax, mail, or email.

Your FCVS Profile, which includes the following documents has not been received:

- ECFMG Status Report
- Medical School Verification from University of Damascus
- USMLE Exam Scores
- Postgraduate Training Verifications from the following entities:

1. Sinai Hospital of Baltimore (07/2015-06/2016)
2. St. Elizabeth's Medical Center (11/2016-11/2019)

We have not received your Livescan results. If you have already had your electronic fingerprinting completed, please allow 24-72 hours for receipt of your results. You can find more information on this process, including how to find a provider in your area and your ORI number, by visiting the Background Screening Website at http://www.flhealthsource.gov/background-screening/. Should your Criminal Background Check disclose an arrest record(s), you will need to provide documentation related to each criminal event revealed in your background, if you have not already done so. You can find a detailed description of documents that will be required by visiting the FAQs on the Background Screening Website (Click on 'General FAQs'). Note: Criminal History will be reviewed by the Background Screening Unit, not the Board Office. Please email all criminal history documents to mqa.backgroundscreen@flhealth.gov. Any original certified documents must be mailed to the following address:

Attn: Background Screening Unit
Florida Department of Health
4052 Bald Cypress Way, Bin BSU-01
Tallahassee, FL, 32399

If you have any questions, please contact me at Deondra.McMillan@flhealth.gov, call 850-617-1914, or fax 850412-1268. The Florida Board of Medicine has assigned **149404** as your **tracking number**. Please indicate this number if you leave a message and try to ensure that other sources include it on their communications to us as well.

Goldwire, Karrell

From: Goldwire, Karrell
Sent: Wednesday, September 9, 2020 11:11 AM
To: Michael Schlewet
Subject: RE: Personal Appearance Notification

Thank You … I will make sure this document is placed in your file.

From: Michael Schlewet <michaelschlewet@gmail.com>
Sent: Wednesday, September 9, 2020 11:05 AM
To: Goldwire, Karrell <Karrell.Goldwire@flhealth.gov>
Subject: Re: Personal Appearance Notification

Hello Ms. Goldwire,

Thanks for your letter and I will definitely attend the virtual meeting on October,1st.

Please find attached a copy of my current CV.

Would you please also include the following message with my CV and forward it to the credentialing committee?.

Best regards,

Michael

Michael schlewet, MD

" I graduated from my medical school in Syria in 2002 and went on to complete a residency program in Otolaryngology. I started my own practice after that and continued to work as an Otolaryngologist until I left my country due to the political and religious conflict that resulted in the current civil war. I lost my practice, my house and everything I had been building for many years. And over that, I lost good friends and loving relatives.

I left Syria and I realized that going back is not an option any more. Finally, I landed in the U.S with my family in late 2013, and we applied for asylum.

I started to rebuild my life again from the ground, and decided to do my best to continue the career that I love. I passed the USMLE exams and started to look for training positions.

Due to Being away from medical school for many years, I failed to secure a residency position in ACGME accredited program. The only option I had was to apply for fellowship programs. I have completed two fellowships(total of 4 years)

in Otolaryngology to update and maximize my clinical and surgical skills that in turn will give me the confidence to provide medical care to my patients safely and efficiently.

Even though, those fellowship programs are accredited only by American Rhinologic Society, and not ACGME, but I had the good fortune to be in those two hospitals (Sinai Hospital of Baltimore and St. Elizabeth's Hospital of Boston) where the Otolaryngology division is part of the General Surgery department which has a ACGME general surgery residency program, I as a fellow had a daily collaboration with surgery residents, dealing with different types of cases in ED, ICU, and Operating room, and from Rhinology and surgical airway cases to Head and Neck surgeries to trauma; I was exposed to a very good number of diverse cases.

Both programs have also multiple residents and medical students rotating with fellows, and I had participated effectively in teaching and guiding those residents and Med students.

I have also been focusing on research projects since I started my first fellowship and participated in multiple clinical studies. I wrote 5 papers so far. Two of them were published and the rest have been submitted already for peer review and mostly will be published soon. I also attended multiple local and national conferences and workshops(about two every year in the past three years) and presented my papers in those local and national meetings. I have been participating effectively in my specialty communities activities(AAOHNS, and ARS), and recently I was elected to be the delegate of the young physicians section of the American Academy of otolaryngology at the American Medical Association for the term of 2020-2021 and 2021-2022.

During my last year of my second fellowship, I was offered a job in Boston, MA. I accepted the offer, applied for a MA full license and started my current job as otolaryngologist at Carney Hospital in Boston.

I have visited Florida multiple times with my wife and my two kids, and we enjoyed the trip every time. I would like at some point in the future to explore my options in finding a job and moving with my family to Florida.

I hope the board committee members will consider all the hardships, circumstances and efforts mentioned above while considering my application.

Thank you,

Michael Schlewet, MD “

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Commonwealth of Massachusetts
Board of Registration in Medicine

200 Harvard Mill Square, Suite 330
Wakefield, Massachusetts 01880
(781) 876-8200

www.mass.gov/massmedboard
Enforcement Division Fax: (781) 876-8381
Legal Division Fax: (781) 876-8380
Licensing Division Fax: (781) 876-8383

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GEORGE ZACHOS, ESQ.
Executive Director

6/30/2020

To Whom It May Concern:

This certifies that Michael Schlewet, M.D., a 2002 graduate of Faculty of Medicine, Damascus University, has been duly registered by this board as provided by the laws of the Commonwealth.

Certificate Number 277861 was issued to Dr. Schlewet on 05/15/2019. The license status is: Active. The expiration date is 10/20/2021.

Listed below is certain complaint and disciplinary information on this physician. Please note that the Board can neither confirm nor deny the existence of open complaints.

BOARD OF MEDICINE
2020 JUL -6 AM 11:18

Closed Complaint Information

Our files contain 0 closed complaint(s) on this physician.

Final Board Disciplinary Action

Our files contain 0 disciplinary action(s) taken against this physician by the Board.

This information is derived from Board files from January 1, 1987 to the present. It does not include all the information contained in a license application.

As a service to the public and to designated agencies, the Massachusetts Board of Registration in Medicine offers an online profile of all physicians with full licenses who are licensed in the Commonwealth. This profile is updated daily and may include public information that is not otherwise contained in this certification letter. You may access this information at the Board's website:

www.mass.gov/massmedboard

Finally, the Board tallies closed complaints separately from disciplinary actions. If the same underlying incident gives rise to both a complaint and a disciplinary action, the Board counts this as two separate actions. In the same way, multiple disciplinary actions are tallied separately, even if they arise from a single set of circumstances.

Francee L Mulero

SEAL

Staff Member, Board of Registration in Medicine

Francee Mulero

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Executive Director
Claudia Kemp, J.D.

September 1, 2020

Adamar Gonzalez Figueroa, M.D.
2889 Spring Breeze Way
Kissimmee, FL 34744

Dear Dr. Gonzalez Figueroa:

This is in further reference to your application for licensure by endorsement.

Please be advised that you are required to make a personal appearance before the Credentials Committee of the Board of Medicine to discuss:

- Failure to meet section 458.313(1)(a) and 458.311(1)(f)3.b., Florida Statutes, ECFMG certification
- Failure to meet section 458.313(1)(a) and 458.311(1)(f)3.c., Florida Statutes, postgraduate training
- Failure to meet section 458.313(1)(b), Florida Statutes, examination

In addition, the Committee may inquire into any other issues relating to your application and eligibility for licensure.

Date:	Thursday, October 1, 2020
Time:	8:00 a.m. (Meeting starts at 8:00 a.m. Interview time may vary.)
Location:	The in-person meeting scheduled in Orlando, Florida is cancelled, and the meeting will be held by a web-based meeting platform or, if appropriate, a teleconference call.

The meeting information and directions for participating in the October 2020 meeting will be posted on the Florida Board of Medicine's website: https://flboardofmedicine.gov/meeting-information.

Additionally, the Committee's recommendation on your application for licensure will be presented to the full Board of Medicine on Friday, October 2, 2020 for final action. You are not required to attend the full board meeting.

Thank you for your continued cooperation. Should you have any questions regarding this matter, please feel free to contact me. *This is your first scheduled appearance.

Sincerely,

Angela Denson
Angela Denson
Regulatory Supervisor

Pursuant to the provisions of the Americans with Disabilities Act, any person requiring special accommodations to participate in this workshop/meeting is asked to advise the agency at least 10 days before the workshop/meeting by contacting: Rebecca.Hewett@flhealth.gov or call (850) 245-4137.

*** 456.013(3)(c) In considering applications for licensure, the board, or the department when there is no board, may require a personal appearance of the applicant. If the applicant is required to appear, the time period in which a licensure application must be granted or denied shall be tolled until such time as the applicant appears. However, if the applicant fails to appear before the board at either of the next two regularly scheduled board meetings, or fails to appear before the department within 30 days if there is no board, the application for licensure shall be denied.**

MEDICAL DOCTOR
APPLICATION FOR LICENSURE

0 1 6 3 0 2

Apply for your license online at www.flboardofmedicine.gov

Choose your application type:

☒ Endorsement (1021) ☐ Examination (1024)

☐ Military Veterans Fee Waiver

If you were honorably discharged from the U.S. armed services within 60 months of your application you will qualify for a waiver of the application fee and the initial licensure fee. In order to qualify, please check the box above indicating that you are seeking a waiver and submit a **DD-214 or NGB-22 form as proof of honorable discharge.**

☐ I plan to dispense medicinal drugs in the State of Florida for a fee or other remuneration and hereby register as required by Section 465.0276, F.S. I understand that the fee for the Dispensing Practitioner is $100.00 in addition to the required initial license fee and will submit it along with the license fee.

1. PERSONAL INFORMATION

Name: Gonzalez Figueroa (Last/Surname) Adamar (First) (Middle) **Date of Birth:** 04/01/1975 (MM/DD/YYYY)

Mailing Address: (The address where mail and your license should be sent)

2889 Spring Breeeze way (Street/ PO Box) ____ (Suite/Apt. No) Kissimmee (City)

Florida (State) 34744 (Zip) USA (Country) 583539075 (Phone Number)

Physical Location: A Post Office Box is not acceptable. This address will be posted on the Department of Health's website. *If you do not have a current practice address, your mailing address will be used. When you obtain a practice address, you will be required to update your online practitioner profile.*

2889 Spring Breeeze way (Street/ P.O. Box) ____ (Suite/Apt. No) Kissimme (City)

Florida (State) 34744 (Zip) USA (Country) ____ (Alternate Phone Number)

Email Address: Gadamar2019@outlook.com

Under Florida law, email addresses are public records. If you do not want your e-mail address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.

Equal Opportunity Data: We are required to ask that you furnish the following information as part of your voluntary compliance with Section 2, Uniform Guidelines on Employee Selection Procedure (1978) 43 CFR 38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

SEX: ☐ Male ☒ Female **RACE:** ☐ White ☐ Black ☐ Asian/Pacific Islander ☒ Hispanic ☐ Other

☒ Yes ☐ No **Availability for Disaster:** Will you be available to provide health care services in special needs shelters or to help staff disaster medical assistance teams during times of emergency or major disaster?

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2. MEDICAL EDUCATION HISTORY

Federal Credentials Verification Services (FCVS) is not a requirement for licensure. FCVS will primary source verify and provide a copy of the medical school transcript(s), medical school diploma, medical school verification, name change document(s), national examination score report, ECFMG certificate, ECFMG verification and postgraduate training verifications. For more information about FCVS, visit their web-site at www.fcvs.org/.

☐ Yes ☒ No Are you using the FCVS to verify your core credentials?

☒ Yes ☐ No Have you completed the equivalent of 2 academic years of preprofessional, postsecondary education including, courses in anatomy, biology and chemistry prior to entering medical school?

Medical Education:
List in chronological order all medical schools attended, whether completed or not. Submit on a separate sheet if needed.

Medical School Name and Address:	From: (mm/yy)	To: (mm/yy)	Date Degree Received:
Universidad Autonoma de Guadalajara Av. Patria 1201, Lomas del valle, 3a sección ZIP 45129 , Zapopan, Jallsco, Mexico Apdo. Postal 1-440	01/2001	12/2004	

Fifth Pathway Certificate Holders:

If you answer "yes" to any of the following questions, you must request verifications to be sent directly to the Board office.

☐ Yes ☐ No Did you attend an International medical school and do not possess a valid ECFMG Certificate?

☐ Yes ☐ No Did you receive a bachelor's degree from an accredited United States college or University?

☐ Yes ☐ No Did you study at a medical school which is recognized by the World Health Organization?

N/A

☐ Yes ☐ No Did you complete all of the formal requirement of the International medical school, except the internship or social service requirements, and pass part I of the National board of Medical examination or the Education Commission for Foreign Medical Graduates Examination equivalent?

☐ Yes ☐ No Did you complete an academic year of supervised clinical training in a hospital affiliated with a medical school approved by the Council on Medical Education of the American Medical Association and upon completion passed part II of the National Board of Medical Examiners examination or the Education Commission for Foreign Medical Graduates examination Equivalent?

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Postgraduate Training:

Provide the following documentation to support your postgraduate training:

☐ Post-Graduate Training Form

In the table below list, in chronological order, all postgraduate training from the date you graduated from medical school to the present. Start with your first program and end with your last or current program. List all programs you began, whether you completed or received credit for the training.

Program Name and Full Mailing Address:	Specialty Area:	From: (mm/yy)	To: (mm/yy)	Did you receive credit? (Y/N)
Buen Samaritano community hospital Carr #2 Km141-1 Ave, Severiano Cuevas, Aguadilla, PR 00603	Medical Intership Program	June 2007	July 2008	Yes

Loan History:

☐ Yes ☒ No Are you currently in default on any health education loan or scholarship obligation? (If "yes", explain on a separate sheet providing accurate details.)

3. EXAMINATION HISTORY

State Board (prior to 1974), State Board (after 1974) & SPEX, LMCC & SPEX, NBME, FLEX, USMLE III, or Combination (prior to 2000)

Request that the score report be sent directly to the Board of Medicine. NOTE: If you took a state Board examination and are not currently licensed in three other states, you must also request your SPEX score be sent.

Exam taken: N/A Letter will be directed to the Board Date passed: _____ mm/dd/yy

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4. LICENSURE HISTORY

Request verification of licensure status directly from the licensing entity or www.veridoc.org. Request international license verification(s) if you have practiced outside of the U.S. for at least two of the previous four years.

☒ Yes ☐ No Do you now hold or have you ever held a license to practice medicine or any other profession in any US State or territory, or foreign country? Please list in table below.

Jurisdiction	Profession	License number
Florida	Medical Doctor	ACN 397
Puerto Rico	Medical Doctor	017330

If you answer "yes" to any of the questions in this section, you are required to send an explanation and supporting documentation.

☐ Yes ☒ No Have you had any application for a medical license or professional license denied by any state board or other governmental agency of any state, territory, or country?

☐ Yes ☒ No Are you currently under investigation in any jurisdiction for an act or offense that would constitute a violation of Section 458.331, Florida Statutes?

☐ Yes ☒ No Have you ever had any professional license or license to practice medicine revoked, suspended, placed on probation, or other disciplinary action taken in any state, territory or country?

5. PRACTICE/EMPLOYMENT HISTORY

List the year you legally first began to practice medicine, 2007 (yyyy). This would be the year you began practicing medicine and could be the date you began your postgraduate training.

☒ Yes ☐ No Have you practiced medicine in any jurisdiction for two of the last four years or completed a board approved post-graduate training program within the last two years?

☐ Yes ☐ No If your answer to the question above was "No," have you passed a board approved clinical competency exam within the last year? If yes, then submit supporting documentation.

List in chronological order all employment for the last four (4) years.

Name and address of practice or employment	Type of employment	From: mm/yy	To: mm/yy
Advantage Medical Center Kissimme , Florida	Primary care physician	11/2019	Present
Site Medical Director Sumter County Jail Busnell Florida	Primary care physician	11/2018	Present
Dr Fleites, Medical Offices Orlando, Florida	Primary care physician	06/2016	07/2019
Corizon Health Southeast Region for Jails and Prisons	Regional Medical Director	04/2014	04/2016

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☐ Yes ☒ No Do you currently hold staff privileges in any hospital, health institution, clinic or medical facility? List each facility below.

Name of facility
N/A

If you answer "yes" to the following questions, you are required to send an explanation and supporting documentation.

☐ Yes ☒ No Have you ever had any staff privileges denied, suspended, revoked, modified, restricted, not renewed, or placed on probation, or have you been asked to resign or take a temporary leave of absence or were otherwise acted against by any facility?

☐ Yes ☒ No Do you currently, or have you had, responsibility for graduate medical education within the last 10 years?

In the table below, list all institutions where you have had responsibility for graduate medical education or faculty appointment(s) at any medical school.

Name of institution
N/A

☐ Yes ☒ No Are you certified by any specialty board recognized by the American Board of Medical Specialties or specialty board approved by the Florida Board of Medicine?

Board Name	Certification/ Specialty/Sub-Specialty	Date of Certification (mm/yy)
	N/A	

If you answer "yes" to any of the following questions, please explain on a separate sheet providing accurate details.

☐ Yes ☒ No Have you ever had any final disciplinary action taken against you by a specialty board or other similar national organization?

☐ Yes ☒ No Have you ever been denied or surrendered a DEA registration?

6. CRIMINAL HISTORY

If you answer "Yes" to the following question you are required to send the following items:

a. Self-explanation describing in detail the circumstances surrounding each offense, including dates, city and state, charges and final results.
b. Final Dispositions and Arrest Records for all offenses. The Clerk of the Court in the arresting jurisdiction will provide you with these documents. Unavailability of these documents must come in the form of a letter from the Clerk of the Court.
c. Completion of Sentence Documents. You may obtain documentation from the Department of Corrections. The report must include the start date, end date and that the conditions were met.

☐ Yes ☒ No Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to, a crime in any jurisdiction other than a minor traffic offense? You must include all misdemeanors and felonies, **even if adjudication was withheld. Driving under the influence (DUI) or driving while impaired (DWI) are not minor traffic offenses for purposes of this question.**

Yes ☒ I have been provided and read the statement from the Florida Department of Law Enforcement regarding the sharing, retention, privacy and right to challenge incorrect criminal history records and the "Privacy Statement" document from the Federal Bureau of Investigation.

7. MILITARY HISTORY

A. ☐ Yes ☒ No Have you ever been in the United States Military and/or Public Health Service?

B. ☐ Yes ☒ No Have you ever been disciplined by any branch of the United States Armed Services or Public Health Services? If you answered "yes" please provide a detailed explanation and supporting documentation

8. CRIMINAL AND MEDICAID/MEDICARE FRAUD QUESTIONS

Applicants for licensure, certification or registration and candidates for examination may be excluded from licensure, certification or registration if their felony conviction falls into certain timeframes as established in Section 456.0635(2), Florida Statutes. If you answer "Yes" to any of the following questions, please provide a written explanation for each question. Supporting documentation includes court dispositions or agency orders where applicable.

1. ☐ Yes ☒ No Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, F.S. (relating to social and economic assistance), Chapter 817, F.S. (relating to fraudulent practices), Chapter 893, F.S. (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction?

If you responded "No" to the question above, skip to question 2.

a. ☐ Yes ☐ No If "yes" to 1, for the felonies of the first or second degree, has it been more than 15 years from the date of the plea, sentence and completion of any subsequent probation?

b. ☐ Yes ☐ No If "Yes" to 1, for felonies of the third degree, has it been more than 10 years from the date of the plea, sentence and completion of any subsequent probation? (This question does not apply to felonies of the third degree under Section 893.13(6)(a), Florida Statutes)

● ☐ Yes ☐ No If "Yes" to 1, for the felonies of the third degree under Section 893.13(6)(a), Florida Statutes, has it been more than 5 years from the date of the plea, sentence and completion of any subsequent probation?

d. ☐ Yes ☐ No If "Yes" to 1, have you successfully completed a drug court program that resulted in the plea for the felony offense being withdrawn or charges dismissed?

2. ☐ Yes ☒ No Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970 (relating to controlled substances) or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)?

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If you responded "No" to the question above, skip to question 3.

a. ☐ Yes ☐ No If "Yes" to 2, has it been more than 15 years before the date of application since the sentence and any subsequent period of probation for such conviction or plea ended?

3. ☐ Yes ☒ No Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes?

If you responded "No" to the question above, skip to question 4.

a. ☐ Yes ☐ No If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years?

4. ☐ Yes ☒ No Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid Program?

If you responded "No" to the question above, skip to question 5.

a. ☐ Yes ☐ No Have you been in good standing with a state Medicaid program for the most recent five years?

b. ☐ Yes ☐ No Did the termination occur at least 20 years before the date of this application?

5. ☐ Yes ☒ No Are you currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities?

If you answer "Yes" to the questions below, you are required to send the following items:

- **A statement indicating the date of each incident and the number for each case.**
- **An explanation of details for each case and your involvement for each case.**
- **Submit the enclosed Exhibit 1 form.**
- **A copy of the complaint, judgments and/or settlements for each case.**
- **Submit a complete copy of the trial record(s) of each case, including the trial transcript, evidentiary exhibits and final judgment in electronic format.**

☐ Yes ☒ No Have you ever had a judgment entered against you for medical malpractice where the incident(s) of malpractice occurred after November 2, 2004?

☐ Yes ☒ No Within the last 10 years have you had any liability claim(s) or action(s) for damages for personal injury settled or finally adjudicated in an amount that exceeds $100,000.00?

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10. FINANCIAL RESPONSIBILITY

The Financial Responsibility options are divided into two categories, coverage and exemptions. Check only one option of the ten provided as required by s. 458.320, Florida Statutes.

Category I: Financial Responsibility Coverage

- [X] 1. I do not have hospital staff privileges, I do not perform surgery at an ambulatory surgical center and I have established an irrevocable letter or credit or an escrow account in an amount of $100,000/$300,000, in accord with Chapter 675, F. S., for a letter of credit and s. 625.52, F. S., for an escrow account.
- [ ] 2. I have hospital staff privileges or I perform surgery at an ambulatory surgical and I have established an irrevocable letter of credit or escrow account in an amount of $250,000/$750,000, in accord with Chapter 675, F. S., for a letter of credit and s. 625.52, F. S., for an escrow account.
- [ ] 3. I do not have hospital staff privileges, I do not perform surgery at an ambulatory surgical center and I have obtained and maintain professional liability coverage in an amount not less than $100,000 per claim, with a minimum annual aggregate of not less than $300,000 from an authorized insurer as defined under s. 624.09, F. S., from a surplus lines insurer as defined under s. 626.914(2), F. S., from a risk retention group as defined under s. 627.942, F. S., from the Joint Underwriting Association established under s. 627.351(4), F. S., or through a plan of self-insurance as provided in s. 627.357, F. S.
- [ ] 4. I have hospital staff privileges or I perform surgery at an ambulatory surgical and I have professional liability coverage in an amount not less than $250,000 per claim, with a minimum annual aggregate of not less than $750,000 from an authorized insurer as defined under s. 624.09, F. S., from a surplus lines insurer as defined under s. 626.914(2), F. S., from a risk retention group as defined under s. 627.942, F. S., from the Joint Underwriting Association established under s. 627.351(4), F. S., or through a plan of self-insurance as provided in s. 627.357, F. S.
- [ ] 5. I have elected not to carry medical malpractice insurance however, I agree to satisfy any adverse judgments up to the minimum amounts pursuant to s. 458.320(5)(g)1, F. S. I understand that I must either post notice in a sign prominently displayed in my reception area or provide a written statement to any person to whom medical services are being provided that I have decided not to carry medical malpractice insurance. I understand that such a sign or notice must contain the wording specified in s. 458.320(5)(g), F. S.

Category II: Financial Responsibility Exemptions

- [ ] 6. I practice medicine exclusively as an officer, employee, or agent of the federal government, the state, or its agencies or subdivisions.
- [ ] 7. I hold a limited license issued pursuant to s. 458.317, F. S., and practice only under the scope of the limited license.
- [ ] 8. I do not practice medicine in the State of Florida.
- [ ] 9. I meet all of the following criteria:
  - (a) I have held an active license to practice in this state or another state or some combination thereof for more than 15 years;
  - (b) I am retired or maintain part time practice of no more than 1000 patient contact hours per year;
  - (c) I have had no more than two claims resulting in an indemnity exceeding $25,000 within the previous five-year period;
  - (d) I have not been convicted of or pled guilty or nolo contendere to any criminal violation specified in Chapter 458, F. S. or the medical practice act in any other state; and
  - (e) I have not been subject, within the past ten years of practice, to license revocation, suspension, or probation for a period of three years or longer, or a fine of $500 or more for a violation of Chapter 458, F. S., or the medical practice act of another jurisdiction. A regulatory agency's acceptance of a relinquishment of license, stipulation, consent order, or other settlement offered in response to or in anticipation of filing of administrative charges against a license is construed as action against a license. I understand if I am claiming an exception under this section that I must either post notice in a sign prominently displayed in my reception area or provide a written statement to any person to whom medical services are being provided that I have decided not to carry medical malpractice insurance. See Section 458.320(5)(f), Florida Statutes, for specific notice requirements.
- [ ] 10. I practice only in conjunction with my teaching duties at an accredited medical school or its teaching hospitals. (Interns and residents do not qualify for this exemption).

If you select an exemption based on number 9, you must also complete the affidavit on the following page.

Interamerican Medical

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11. FLORIDA BIRTH RELATED NEUROLOGICAL COMPENSATION ASSOCIATION

You must choose one of the three options described below. Please be sure to view the information about each exemption at www.nica.com. Check only one.

☐	☒	☐	
$5,000	$250	$0	$250
Participating	Non-participating	Exempt	Amount enclosed

If you choose "$0 Exempt" provide appropriate documentation to the Board of Medicine and to NICA.

I have read the explanatory information provided by NICA, and I choose the option above.

Adamar Gonzalez Figueroa 5/17/2020.

Signature Date

Adamar Gonzalez Figueroa, MD
Name
2889 Spring Breeeze way
Street Address
Kissimme, Florida, 34744
City, State, Zip

If you are a participating or non-participating physician, or a physician claiming exemption, you must complete, sign and date this form and return it with your payment to this address.

Board of Medicine
4052 Bald Cypress Way, #C-03
Tallahassee, FL 32399-3253

If you are a physician claiming exemption, you must also send a copy of your completed, signed, and dated form with proof of your exemption to:

NICA
2360 Christopher Place
Tallahassee, FL 32308

If you have any questions about NICA or this form, please contact NICA at www.nica.com or (850) 488-8191.

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Mission:
To protect, promote & improve the health of all people in Florida through integrated state, county & community efforts.

Florida HEALTH

Ron DeSantis
Governor

Scott A. Rivkees, MD
State Surgeon General

Vision: To be the **Healthiest State** in the Nation

June 12, 2020

Adamar Gonzalez Figueroa, M.D.
2889 Spring Breeze Way
Kissimmee, FL United States 34744

Dear Dr. Gonzalez Figueroa:
File: 149503

Thank you for considering Florida for physician licensure. Your application for medical licensure has been received. The application is incomplete for the reasons set out in the attached deficiency notice. Please address these deficiencies as soon as possible to avoid delay in processing your application.

Information received by this office may require additional explanation or documentation to determine licensure eligibility. After all requested documentation is received, your application will be submitted for supervisory review. We will notify you if additional information is required.

Applicants with a history of malpractice, criminal activity, discipline, physical or mental impairment, unfavorable evaluations, or other matters that need explanation may require a personal appearance before the Board of Medicine Credentials Committee for determination of licensure eligibility. If your appearance is required, you will be notified in writing once your application is complete.

You can now follow the progress of your application through our website at: www.FLHealthSource.gov/mqa-services. If you are a returning user, select "Yes" and enter the user ID and password you selected during the registration process under Returning User. If you did not apply for licensure through this screen, select "No" and follow the prompts to create an account. You must have a valid email address to create your account.

Once you are logged in, you will be prompted to add your application to your account. Once you have successfully added your application, you will be directed to your dashboard. Under the "Additional Activities" section, select "Check Application Status" to review any open deficiencies, upload documents or print out instructional documents.

THIS IS IMPORTANT: Your application will remain incomplete until all deficiencies are completed. In addition, you are required to notify the Board office immediately in writing of any occurrence(s) that would in any way change or affect any answer given in the application or an answer provided in response to any of our direct questions to you.

If you have any questions, please contact me at cheryl.smiley@flhealth.gov, call (850) 617-1917, or fax (850) 412-1278.

Sincerely,

Cheryl Smiley
Regulatory Specialist II

Enclosure(s)

Florida Department of Health
Division of Medical Quality Assurance • Bureau of HCPR
4052 Bald Cypress Way, Bin C03 • Tallahassee, FL 32399-3253
PHONE: (850)245-4131 • FAX : (850) 488-0596

PHAB Accredited Health Department
Public Health Accreditation Board

Mission:
To protect, promote & improve the health of all people in Florida through integrated state, county & community efforts.

Florida HEALTH

Ron DeSantis
Governor

Scott A. Rivkees, MD
State Surgeon General

Vision: To be the **Healthiest State** in the Nation

Adamar Gonzalez Figueroa **Date: June 12, 2020**

REMINDER: Chapter 456.013(1)(a), Florida Statutes, provides that an incomplete application shall expire one year after initial filing with the department.

YOUR APPLICATION'S EXPIRATION DATE IS June 9, 2021.

APPLICATION SUBMITTED REMAINS DEFICIENT FOR LACK OF THE FOLLOWING:

An official verification of your medical license from the state of Puerto Rico has not been received

The inquiry you mailed to your medical school has not been received.

Your Postgraduate Training Verification Forms have not been received.

- Buena Samaritano Community Hospital – 06/07 – 07/08

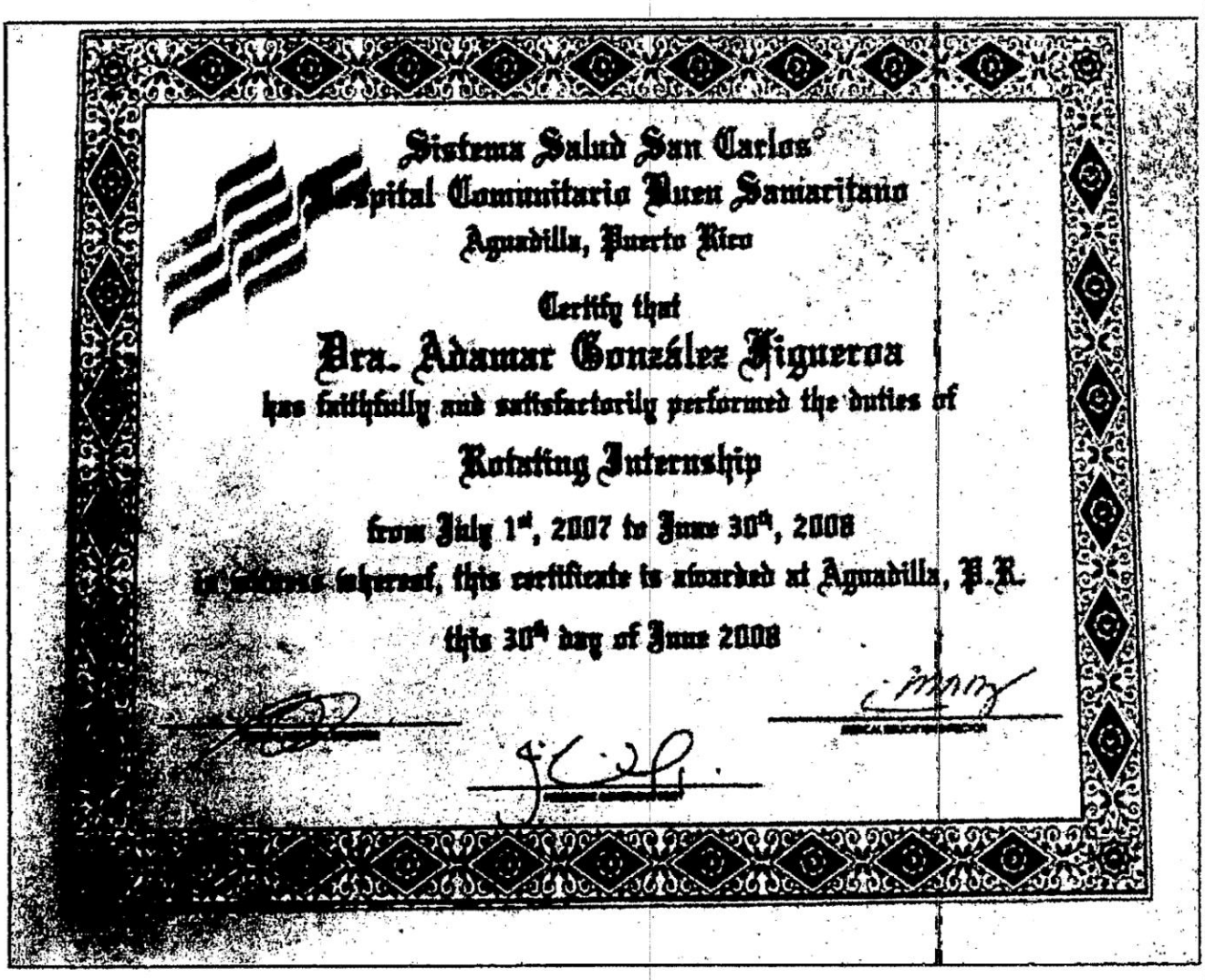
We have not received your Livescan results. If you have already had your electronic fingerprinting completed, please allow 24-72 hours for receipt of your results. You can find more information on this process, including how to find a provider in your area and your ORI number, by visiting the Background Screening Website at http://www.flhealthsource.gov/background-screening/. Should your Criminal Background Check disclose an arrest record(s), you will need to provide documentation related to each criminal event revealed in your background, if you have not already done so. You can find a detailed description of documents that will be required by visiting the FAQs on the Background Screening Website (Click on 'General FAQs'). Note: Criminal History will be reviewed by the Background Screening Unit, not the Board Office. Please email all criminal history documents to mqa.backgroundscreen@flhealth.gov. Any original certified documents must be mailed to the following address: Attn: Background Screening Unit Florida Department of Health 4052 Bald Cypress Way, Bin BSU-01 Tallahassee, FL, 32399

We await your FLEX/USMLE/SPEX/National Board exam scores, direct from the Federation of State Medical Boards, which must be requested by the applicant.

If you have any questions, please contact me at cheryl.smiley@flhealth.gov, call (850) 617-1917, or fax (850) 412-1278. The Florida Board of Medicine has assigned **149503** as your **tracking number**. Please indicate this number if you leave a message, and try to ensure that other sources include it on their communications to us as well.

Florida Department of Health
Division of Medical Quality Assurance • Bureau of HCPR
4052 Bald Cypress Way, Bin C03 • Tallahassee, FL 32399-3253
PHONE: (850)245-4131 • FAX : (850) 488-0596

PHAB Accredited Health Department
Public Health Accreditation Board



Sistema Salud San Carlos
Hospital Comunitario Buen Samaritano
Aguadilla, Puerto Rico

Certify that

Dra. Adamar González Figueroa

has faithfully and satisfactorily performed the duties of

Rotating Internship

from July 1st, 2007 to June 30th, 2008

In witness whereof, this certificate is awarded at Aguadilla, P.R.

this 30th day of June 2008

POST-GRADUATE TRAINING VERIFICATION FORM

Please have this form completed by the Chairman/Director of the post-graduate training program you attended. Please note that if you are using FCVS, do not submit these items.

The form should be mailed or faxed to:

FLORIDA BOARD OF MEDICINE
4052 BALD CYPRESS WAY, BIN C-03
TALLAHASSEE, FLORIDA 32399-3253
(850) 412-1268 Facsimile

Hospital Buen Samaritano
Name of School

Dirección Médica
Department

P.O. BOX 4055
Address

Aguadilla, P.R., 00605
City, State, Zip

1. Name of Resident: Adamar Gonzalez-Figueroa, MD
2. Internship/Residency/Fellowship: From: 07/01/2007 To: 06/30/2008
3. Matriculation Date: 07/01/2007
4. Completion Date: 06/30/2008
5. Specialty: Rotating Internship in General Medicine
6. Levels completed (check all that apply):

PGY I___ PGY II___ PGY III___ PGY IV___ PGY V___

HOSPITAL COMUNITARIO BUEN SAMARITANO HCBS Julio 1998 PROGRAMA DE EDUCACION MEDICA

Signed: _____
Chairman or Program Director Only
(No stamped signatures please).

Page 20 of 21
64B8-4.009, F.A.C. DH-MQA 1000
Revised 11/2017

Department of Health

License Verification

Printer Friendly Version

ADAMAR GONZALEZ-FIGUEROA

License Number: ACN397

Data As Of 9/3/2020

License Information | Secondary Locations | Discipline/Admin Action | Practitioner Profile

Back

Profession

Area of Critical Need Medical Doctor

License

ACN397

License Status

CLEAR/ACTIVE

Qualifications

Dispensing Practitioner

License Expiration Date

1/31/2022

License Original Issue Date

07/06/2011

Address of Record

5580 E. GRANT STREET

UNLIMITED MEDICAL SERVICES OF FLORIDA

ORLANDO, FL 32822

Controlled Substance Prescriber (for the Treatment of Chronic Non-malignant Pain)

Yes

Discipline on File

No

Public Complaint

No

Primary Source Verified

For instructions on how to request a license certification of your Florida license to be sent to another state from the Florida Department of Health, please visit the License Certifications web page.

Department of Health

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ESTADO LIBRE ASOCIADO DE PUERTO RICO
Commonwealth of Puerto Rico

DEPARTAMENTO DE SALUD
Department of Health

JUNTA DE LICENCIAMIENTO Y DISCIPLINA MEDICA
Puerto Rico Board of Licensing and Medical Disciplines

CERTIFICATION OF REGISTRY AND MEDICAL EDUCATION

CERTIFY THAT: THIS DOCTOR HAS MET THE REQUIREMENTS FOR REGISTRATION, LICENSE AND CONTINUING MEDICAL EDUCATION FOR THE TRIENNIUM 2016-2019, IN ACCORDANCE WITH THE PROVISIONS OF LAW NUMBER 139 OF AUGUST 1ST, 2008, AND NUMBER 11 OF JUNE 23, 1976, AS AMMENDED.

THIS CERTIFICATION IS VALID UNTIL APRIL 1, 2019.

ADAMAR GONZALEZ FIGUEROA
2889 SPRING BREEZE WAY
KISSIMEE FL
FLORIDA 34744

LICENSE : 017330
REGISTRY : 186139

IN TESTIMONY WHICH I sing this that contains the official seal of the Puerto Rico Medical Discipline and Licensure Board, in San Juan, Puerto Rico, today 8 day of MARCH 2016.

PRESIDENT OR ACTING DIRECTOR PUERTO RICO
MEDICAL DISCIPLINE AND LICENSURE BOARD.

20160308201904013244 73

Warning: Any alteration make this certification null and void

ESTE DOCUMENTO NO ES TRANSFERIBLE / THIS DOCUMENT IS NOT TRANSFERABLE

GOBIERNO DE PUERTO RICO
Government of Puerto Rico

DEPARTAMENTO DE SALUD
Department of Health

JUNTA DE LICENCIAMIENTO Y DISCIPLINA MEDICA DE PUERTO RICO
Puerto Rico Medical Discipline and Licensure Board

LICENSE VERIFICATION
"GOOD STANDING"

Name:	ADAMAR GONZALEZ FIGUEROA
Social Security:	XXX-XX-9075
Board:	P.R. MEDICAL DISCIPLINE AND LICENSURE BOARD
License Type:	REGULAR LICENSE
Registry Number:	186139
Expiration Date:	APRIL 1, 2022
License Number:	17330
License Expedition Date:	AUGUST 26, 2008
License Status:	ACTIVE

Restrictions or Comments:

We hereby certify that this Physician has met all requirements established in Law 11, as amended in June 23, 1976. The license should be recertified on or before its expedition date:

In San Juan, Puerto Rico on Tuesday, June 23, 2020.

BOARD OF LICENSING AND MEDICAL DISCIPLINES OF PUERTO RICO

President or Director
Puerto Rico Medical Discipline and Licensure Board

FLORIDA BOARD OF MEDICINE/CHERYL.SMILEY@FLHEALTH.GOV, /FILE149503
4052 BALD CYPRESS WAY BIN-C03
THALLAHASSEE FL 32399-0000

20200623202204019783 58

This Licensure Verification is valid for one (1) year.

ESTE DOCUMENTO NO ES TRANSFERIBLE / THIS DOCUMENT IS NOT TRANSFERABLE 37319

Chair
Zachariah Zachariah, M.D.
Ft. Lauderdale, Florida

Members
Hector Vila, M.D.
Tampa, Florida
Vice-Chair

Luz Marina Pages, M.D.
Miami Beach, Florida

Scot N. Ackerman, M.D.
Jacksonville, Florida

Eleonor Pimentel, M.D.
Miami, Florida

David A. Diamond, M.D.
Winter Park, Florida

Vacant, Consumer Member

Robert London, M.D.
Maitland, Florida

Jorge J. Lopez, M.D.
Maitland, Florida

Andre M. Perez
Miami, Florida

Kevin Cairns, M.D.
Fort Lauderdale, Florida

Nicholas W. Romanello, Esq.
Melbourne, Florida

Sarvam TerKonda, M.D.
Jacksonville, Florida

Shailesh Gupta, M.D.
Coral Springs, Florida

Vacant, M.D.

Executive Director
Claudia Kemp, J.D.

September 5, 2020

Barbara Maday Calderon, MD
13309 Krameria Way
Tampa, FL 33626

Dear Dr. Calderon:

This is in further reference to your application for licensure by endorsement.

Please be advised that you are required to make a personal appearance before the Credentials Committee of the Board of Medicine to discuss:

- **Failure to meet section 458.313(1)(a) and 458.311(1)(f)3.c., Florida Statutes, postgraduate training**

In addition, the Committee may inquire into any other issues relating to your application and eligibility for licensure.

Date:	Thursday, October 1, 2020
Time:	8:00 a.m. (Meeting starts at 8:00 a.m. Interview time may vary.)
Location:	The in-person meeting scheduled in Orlando, Florida is cancelled, and the meeting will be held by a web-based meeting platform or, if appropriate, a teleconference call.

The meeting information and directions for participating in the October 2020 meeting will be posted on the Florida Board of Medicine's website: https://flboardofmedicine.gov/meeting-information.

Additionally, the Committee's recommendation on your application for licensure will be presented to the full Board of Medicine on Friday, October 2, 2020 for final action. You are not required to attend the full board meeting.

Thank you for your continued cooperation. Should you have any questions regarding this matter, please feel free to contact me. *This is your first scheduled appearance.

Sincerely,

Karrell D. Goldwire

Karrell D. Goldwire
Regulatory Supervisor

Pursuant to the provisions of the Americans with Disabilities Act, any person requiring special accommodations to participate in this workshop/meeting is asked to advise the agency at least 10 days before the workshop/meeting by contacting: Rebecca.Hewett@flhealth.gov or call (850) 245-4137.

*** 456.013(3)(c) In considering applications for licensure, the board, or the department when there is no board, may require a personal appearance of the applicant. If the applicant is required to appear, the time period in which a licensure application must be granted or denied shall be tolled until such time as the applicant appears. However, if the applicant fails to appear before the board at either of the next two regularly scheduled board meetings, or fails to appear before the department within 30 days if there is no board, the application for licensure shall be denied.**

MEDICAL DOCTOR
APPLICATION FOR LICENSURE

015579

Apply for your license online at www.flboardofmedicine.gov

Choose your application type:

☒ Endorsement (1021) ☐ Examination (1024)

☐ Military Veterans Fee Waiver

If you were honorably discharged from the U.S. armed services within 60 months of your application you will qualify for a waiver of the application fee and the initial licensure fee. In order to qualify, please check the box above indicating that you are seeking a waiver and submit **a DD-214 or NGB-22 form as proof of honorable discharge.**

☒ I plan to dispense medicinal drugs in the State of Florida for a fee or other remuneration and hereby register as required by Section 465.0276, F.S. I understand that the fee for the Dispensing Practitioner is $100.00 in addition to the required initial license fee and will submit it along with the license fee.

1. PERSONAL INFORMATION

Name: Calderon (Last/Surname) Barbara (First) Maday (Middle) **Date of Birth:** 11/19/1973 (MM/DD/YYYY)

Mailing Address: (The address where mail and your license should be sent)

13309 Krameria Way (Street/ PO Box) ____ (Suite/Apt. No) Tampa (City)

FL (State) 33626 (Zip) United States (Country) 305-394-2471 (Phone Number)

Physical Location: A Post Office Box is not acceptable. This address will be posted on the Department of Health's website. *If you do not have a current practice address, your mailing address will be used. When you obtain a practice address, you will be required to update your online practitioner profile.*

13309 Krameria Way (Street/ P.O. Box) ____ (Suite/Apt. No) Tampa (City)

FL (State) 33626 (Zip) U.S. (Country) 786-260-2603 (Alternate Phone Number)

Email Address: bcalderonfl@gmail.com

Under Florida law, email addresses are public records. If you do not want your e-mail address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.

Equal Opportunity Data: We are required to ask that you furnish the following information as part of your voluntary compliance with Section 2, Uniform Guidelines on Employee Selection Procedure (1978) 43 CFR 38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

SEX: ☐ Male ☒ Female **RACE:** ☐ White ☐ Black ☐ Asian/Pacific Islander ☒ Hispanic ☐ Other

☒ Yes ☐ No **Availability for Disaster:** Will you be available to provide health care services in special needs shelters or to help staff disaster medical assistance teams during times of

2. MEDICAL EDUCATION HISTORY

Federal Credentials Verification Services (FCVS) is not a requirement for licensure. FCVS will primary source verify and provide a copy of the medical school transcript(s), medical school diploma, medical school verification, name change document(s), national examination score report, ECFMG certificate, ECFMG verification and postgraduate training verifications. For more information about FCVS, visit their web-site at www.fcvs.org/.

☐ Yes ☒ No Are you using the FCVS to verify your core credentials?

☒ Yes ☐ No Have you completed the equivalent of 2 academic years of preprofessional, postsecondary education including, courses in anatomy, biology and chemistry prior to entering medical school?

Medical Education:
List in chronological order all medical schools attended, whether completed or not. Submit on a separate sheet if needed.

Medical School Name and Address:	From: (mm/yy)	To: (mm/yy)	Date Degree Received:
Please see Attachment			

Fifth Pathway Certificate Holders:

If you answer "yes" to any of the following questions, you must request verifications to be sent directly to the Board office.

☐ Yes ☒ No Did you attend an international medical school and do not possess a valid ECFMG Certificate?

☐ Yes ☒ No Did you receive a bachelor's degree from an accredited United States college or University?

☒ Yes ☐ No Did you study at a medical school which is recognized by the World Health Organization?

☒ Yes ☐ No Did you complete all of the formal requirement of the International medical school, except the internship or social service requirements, and pass part I of the National board of Medical examination or the Education Commission for Foreign Medical Graduates Examination equivalent?

☒ Yes ☐ No Did you complete an academic year of supervised clinical training in a hospital affiliated with a medical school approved by the Council on Medical Education of the American Medical Association and upon completion passed part II of the National Board of Medical Examiners examination or the Education Commission for Foreign Medical Graduates examination Equivalent?

Medical school name and address	From	To	Date degree received
(1) Instituto Superior de Ciencias Medicas de La Habana	9/1991	12/1992	
address: Calle 146 No 2504 e/ 25 y 31 Cubanacan CP11600			07/21/1997
(2) Hospital "Carlos J. Finlay"	01/1993	07/1997	
Address: Ave 31 LA HABana/Cuba			
(3) Hospital "Buen Samaritano"	06/2017	06/2018	06/30/2018
Address: Calle JOSE Diego Aguadilla 00603			

Postgraduate Training:

Provide the following documentation to support your postgraduate training:

☐ Post-Graduate Training Form

In the table below list, in chronological order, all postgraduate training from the date you graduated from medical school to the present. Start with your first program and end with your last or current program. List all programs you began, whether you completed or received credit for the training.

Program Name and Full Mailing Address:	Specialty Area:	From: (mm/yy)	To: (mm/yy)	Did you receive credit? (Y/N)
Medicina General Integral. Calle 29 y 18 y 20 Artemisa Artemisa / Cuba Filial Provincia Habana	Family Medicine	09/1999	12/2002	Yes.
ROTATING Inter Ship HOSPITAL BUEN SAMARITANO Calle JOSE Diego, Aguadilla 00603	ROTATING Intership	6/1/2017	6/30/2018	Y

Loan History:

☐ Yes ☒ No Are you currently in default on any health education loan or scholarship obligation? (If "yes", explain on a separate sheet providing accurate details.)

3. EXAMINATION HISTORY

State Board (prior to 1974), State Board (after 1974) & SPEX, LMCC & SPEX, NBME, FLEX, USMLE III, or Combination (prior to 2000)

Request that the score report be sent directly to the Board of Medicine. NOTE: If you took a state Board examination and are not currently licensed in three other states, you must also request your SPEX score be sent.

Exam taken: USMLE III Date passed: 09/17/2018
mm/dd/yy

4. LICENSURE HISTORY

Request verification of licensure status directly from the licensing entity or www.veridoc.org. Request international license verification(s) if you have practiced outside of the U.S. for at least two of the previous four years.

☒ Yes ☐ No Do you now hold or have you ever held a license to practice medicine or any other profession in any US State or territory, or foreign country? Please list in table below.

Jurisdiction	Profession	License number
(1) JUNTA DE Licenciamiento y disciplina Medica de Puerto Rico	Medical Doctor	21,151
(2) Florida Board of Medicine	Medical Doctor Area critical need.	ACN 1127

If you answer "yes" to any of the questions in this section, you are required to send an explanation and supporting documentation.

☐ Yes ☒ No Have you had any application for a medical license or professional license denied by any state board or other governmental agency of any state, territory, or country?

☐ Yes ☒ No Are you currently under investigation in any jurisdiction for an act or offense that would constitute a violation of Section 458.331, Florida Statutes?

☐ Yes ☒ No Have you ever had any professional license or license to practice medicine revoked, suspended, placed on probation, or other disciplinary action taken in any state, territory or country?

5. PRACTICE/EMPLOYMENT HISTORY

List the year you legally first began to practice medicine, 1997 (yyyy). This would be the year you began practicing medicine and could be the date you began your postgraduate training.

☒ Yes ☐ No Have you practiced medicine in any jurisdiction for two of the last four years **or** completed a board approved post-graduate training program within the last two years?

☐ Yes ☐ No If your answer to the question above was "No," have you passed a board approved clinical competency exam within the last year? If yes, then submit supporting documentation.

List in chronological order all employment for the last four (4) years.

Name and address of practice or employment	Type of employment	From: mm/yy	To: mm/yy

Name and address of practice or employment	Type of employment	From	To
(1) David Eschelbacher M.D. Interinist in Tampa (Office).	Medical Assistant	06/2016	08/2016
Addresss: 2912 N 22nd St Tampa FL 33605			
(2) Xinmin Tang M.D. (Office.)	Medical Assistant	08/2016	11/2016
Address: 8441 W Linebaugh Ave, Tampa, FL 33625			
(3) Caban Skin Institute	Medical Assistant	11/2016	06/2017
Address: 4164 N Armenia Ave, Tampa, FL 33607			
(4) Hospital Buen Samaritano	(Post graduate training) Intership	06/2017	06/2018
Address: Calle Jose Diego Aguadilla 00603			
(5) Caban Skin Institute	Medical Assistant	10/2018	12/2018
Address: 4164 N Armenia Ave Tampa, FL 33607			
(6) Pain & Wellness Institute	Medical Doctor	01/2019	02/2019
Address: 4509 N Armenia Ave Tampa FL 33603	PCN1127		

Name and address of practice or employment	Type of employment	From	To
(7) American Care	Medical Doctor	03/2019	Present
11211 N Nebraska Ave Tampa, FL 33612	ACN1127		

☐ Yes ☒ No Do you currently hold staff privileges in any hospital, health institution, clinic or medical facility? List each facility below.

Name of facility

If you answer "yes" to the following questions, you are required to send an explanation and supporting documentation.

☐ Yes ☒ No Have you ever had any staff privileges denied, suspended, revoked, modified, restricted, not renewed, or placed on probation, or have you been asked to resign or take a temporary leave of absence or were otherwise acted against by any facility?

☐ Yes ☒ No Do you currently, or have you had, responsibility for graduate medical education within the last 10 years?

In the table below, list all institutions where you have had responsibility for graduate medical education or faculty appointment(s) at any medical school.

Name of institution

☐ Yes ☒ No Are you certified by any specialty board recognized by the American Board of Medical Specialties or specialty board approved by the Florida Board of Medicine?

Board Name	Certification/ Specialty/Sub-Specialty	Date of Certification (mm/yy)

If you answer "yes" to any of the following questions, please explain on a separate sheet providing accurate details.

☐ Yes ☒ No Have you ever had any final disciplinary action taken against you by a specialty board or other similar national organization?

☐ Yes ☒ No Have you ever been denied or surrendered a DEA registration?

6. CRIMINAL HISTORY

If you answer "Yes" to the following question you are required to send the following items:

a. Self-explanation describing in detail the circumstances surrounding each offense, including dates, city and state, charges and final results.
b. Final Dispositions and Arrest Records for all offenses. The Clerk of the Court in the arresting jurisdiction will provide you with these documents. Unavailability of these documents must come in the form of a letter from the Clerk of the Court.
c. Completion of Sentence Documents. You may obtain documentation from the Department of Corrections. The report must include the start date, end date and that the conditions were met.

☐ Yes ☒ No Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to, a crime in any jurisdiction other than a minor traffic offense? You must include all misdemeanors and felonies, **even if adjudication was withheld. Driving under the influence (DUI) or driving while impaired (DWI) are not minor traffic offenses for purposes of this question.**

Yes ☒ I have been provided and read the statement from the Florida Department of Law Enforcement regarding the sharing, retention, privacy and right to challenge incorrect criminal history records and the "Privacy Statement" document from the Federal Bureau of Investigation.

7. MILITARY HISTORY

A. ☐ Yes ☒ No Have you ever been in the United States Military and/or Public Health Service?

B. ☐ Yes ☒ No Have you ever been disciplined by any branch of the United States Armed Services or Public Health Services? If you answered "yes" please provide a detailed explanation and supporting documentation

8. CRIMINAL AND MEDICAID/MEDICARE FRAUD QUESTIONS

Applicants for licensure, certification or registration and candidates for examination may be excluded from licensure, certification or registration if their felony conviction falls into certain timeframes as established in Section 456.0635(2), Florida Statutes. If you answer "Yes" to any of the following questions, please provide a written explanation for each question. Supporting documentation includes court dispositions or agency orders where applicable.

1. ☐ Yes ☒ No Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, F.S. (relating to social and economic assistance), Chapter 817, F.S. (relating to fraudulent practices), Chapter 893, F.S. (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction?

If you responded "No" to the question above, skip to question 2.

a. ☐ Yes ☐ No If "yes" to 1, for the felonies of the first or second degree, has it been more than 15 years from the date of the plea, sentence and completion of any subsequent probation?

b. ☐ Yes ☐ No If "Yes" to 1, for felonies of the third degree, has it been more than 10 years from the date of the plea, sentence and completion of any subsequent probation? (This question does not apply to felonies of the third degree under Section 893.13(6)(a), Florida Statutes)

c. ☐ Yes ☐ No If "Yes" to 1, for the felonies of the third degree under Section 893.13(6)(a), Florida Statutes, has it been more than 5 years from the date of the plea, sentence and completion of any subsequent probation?

d. ☐ Yes ☐ No If "Yes" to 1, have you successfully completed a drug court program that resulted in the plea for the felony offense being withdrawn or charges dismissed?

2. ☐ Yes ☒ No Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970 (relating to controlled substances) or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)?

If you responded "No" to the question above, skip to question 3.

a. ☐ Yes ☐ No If "Yes" to 2, has it been more than 15 years before the date of application since the sentence and any subsequent period of probation for such conviction or plea ended?

3. ☐ Yes ☒ No Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes?

If you responded "No" to the question above, skip to question 4.

a. ☐ Yes ☐ No If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years?

4. ☐ Yes ☒ No Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid Program?

If you responded "No" to the question above, skip to question 5.

a. ☐ Yes ☐ No Have you been in good standing with a state Medicaid program for the most recent five years?

b. ☐ Yes ☐ No Did the termination occur at least 20 years before the date of this application?

5. ☐ Yes ☒ No Are you currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities?

If you answer "Yes" to the questions below, you are required to send the following items:

- **A statement indicating the date of each incident and the number for each case.**
- **An explanation of details for each case and your involvement for each case.**
- **Submit the enclosed Exhibit 1 form.**
- **A copy of the complaint, judgments and/or settlements for each case.**
- **Submit a complete copy of the trial record(s) of each case, including the trial transcript, evidentiary exhibits and final judgment in electronic format.**

☐ Yes ☒ No Have you ever had a judgment entered against you for medical malpractice where the incident(s) of malpractice occurred after November 2, 2004?

☐ Yes ☒ No Within the last 10 years have you had any liability claim(s) or action(s) for damages for personal injury settled or finally adjudicated in an amount that exceeds $100,000.00?

10. FINANCIAL RESPONSIBILITY

The Financial Responsibility options are divided into two categories, coverage and exemptions. Check only one option of the ten provided as required by s. 458.320, Florida Statutes.

Category I: Financial Responsibility Coverage

☐1. I do not have hospital staff privileges, I do not perform surgery at an ambulatory surgical center and I have established an irrevocable letter or credit or an escrow account in an amount of $100,000/$300,000, in accord with Chapter 675, F. S., for a letter of credit and s. 625.52, F. S., for an escrow account.

☐2. I have hospital staff privileges or I perform surgery at an ambulatory surgical and I have established an irrevocable letter of credit or escrow account in an amount of $250,000/$750,000, in accord with Chapter 675, F. S., for a letter of credit and s. 625.52, F. S., for an escrow account.

☒3. I do not have hospital staff privileges, I do not perform surgery at an ambulatory surgical center and I have obtained and maintain professional liability coverage in an amount not less than $100,000 per claim, with a minimum annual aggregate of not less than $300,000 from an authorized insurer as defined under s. 624.09, F. S., from a surplus lines insurer as defined under s. 626.914(2), F. S., from a risk retention group as defined under s. 627.942, F. S., from the Joint Underwriting Association established under s. 627.351(4), F. S., or through a plan of self-insurance as provided in s. 627.357, F. S.

☐4. I have hospital staff privileges or I perform surgery at an ambulatory surgical and I have professional liability coverage in an amount not less than $250,000 per claim, with a minimum annual aggregate of not less than $750,000 from an authorized insurer as defined under s. 624.09, F. S., from a surplus lines insurer as defined under s. 626.914(2), F. S., from a risk retention group as defined under s. 627.942, F. S., from the Joint Underwriting Association established under s. 627.351(4), F. S., or through a plan of self-insurance as provided in s. 627.357, F. S.

☐5. I have elected not to carry medical malpractice insurance however, I agree to satisfy any adverse judgments up to the minimum amounts pursuant to s. 458.320(5)(g)1, F. S. I understand that I must either post notice in a sign prominently displayed in my reception area or provide a written statement to any person to whom medical services are being provided that I have decided not to carry medical malpractice insurance. I understand that such a sign or notice must contain the wording specified in s. 458.320(5)(g), F. S.

Category II: Financial Responsibility Exemptions

☐6. I practice medicine exclusively as an officer, employee, or agent of the federal government, the state, or its agencies or subdivisions.

☐7. I hold a limited license issued pursuant to s. 458.317, F. S., and practice only under the scope of the limited license.

☐8. I do not practice medicine in the State of Florida.

☐9. I meet all of the following criteria:

(a) I have held an active license to practice in this state or another state or some combination thereof for more than 15 years;

(b) I am retired or maintain part time practice of no more than 1000 patient contact hours per year;

(c) I have had no more than two claims resulting in an indemnity exceeding $25,000 within the previous five-year period;

(d) I have not been convicted of or pled guilty or nolo contendere to any criminal violation specified in Chapter 458, F. S. or the medical practice act in any other state; and

(e) I have not been subject, within the past ten years of practice, to license revocation, suspension, or probation for a period of three years or longer, or a fine of $500 or more for a violation of Chapter 458, F. S., or the medical practice act of another jurisdiction. A regulatory agency's acceptance of a relinquishment of license, stipulation, consent order, or other settlement offered in response to or in anticipation of filing of administrative charges against a license is construed as action against a license. I understand if I am claiming an exception under this section that I must either post notice in a sign prominently displayed in my reception area or provide a written statement to any person to whom medical services are being provided that I have decided not to carry medical malpractice insurance. See Section 458.320(5)(f), Florida Statutes, for specific notice requirements.

☐10. I practice only in conjunction with my teaching duties at an accredited medical school or its teaching hospitals. (Interns and residents do not qualify for this exemption).

If you select an exemption based on number 9, you must also complete the affidavit on the following page.

11. FLORIDA BIRTH RELATED NEUROLOGICAL COMPENSATION ASSOCIATION

You must choose one of the three options described below. Please be sure to view the information about each exemption at www.nica.com. Check only one.

☐	☒	☐	$250.00
$5,000 Participating	$250 Non-participating	$0 Exempt	Amount enclosed

If you choose "$0 Exempt" provide appropriate documentation to the Board of Medicine and to NICA.

I have read the explanatory information provided by NICA, and I choose the option above.

Signature 05/17/2020 Date

Barbara M. Calderon
Name
8309 Krameria Way
Street Address
Tampa FL 33626
City, State, Zip

If you are a participating or non-participating physician, or a physician claiming exemption, you must complete, sign and date this form and return it with your payment to this address.

Board of Medicine
4052 Bald Cypress Way, #C-03
Tallahassee, FL 32399-3253

If you are a physician claiming exemption, you must also send a copy of your completed, signed, and dated form with proof of your exemption to:

NICA
2360 Christopher Place
Tallahassee, FL 32308

If you have any questions about NICA or this form, please contact NICA at www.nica.com or (850) 488-8191.

12. STATEMENT OF APPLICANT

I state that these statements are true and correct. I recognize that providing false information may result in denial of licensure, disciplinary action against my license, or criminal penalties pursuant to Sections 456.067, 775.083, and 775.084, Florida Statutes. I state that I have read Chapters 456, 458 and 766.301-.316, Florida Statutes and Chapter 64B8, Florida Administrative Code.

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Florida Board of Medicine information which is material to my application for licensure.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind. I state that my answers and all statements made by me herein are true and correct.

Should I furnish any false information in this application, I hereby agree that such act constitutes cause for denial, suspension, or revocation of my license to practice medicine in the State of Florida. If there are any changes to my status or any change that would affect any of my answers to this application I must notify the board within 30 days.

I understand that my records are protected under federal and state regulations governing Confidentiality of Mental Health Patient Records and cannot be disclosed without my written consent unless otherwise provided in the regulations. I understand that my records are protected under federal and state regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it.

Barbara M. Calderon Izquierdo
Print name

Signature

05/17/2020
Date

June 8, 2020

Barbara Maday Calderon , M.D.
13309 Krameria Way
Tampa, FL 33626

Dear Dr. Calderon:
File: 149329

Thank you for considering Florida for physician licensure. Your application for medical licensure has been received. The application is incomplete for the reasons set out in the attached deficiency notice. Please address these deficiencies as soon as possible to avoid delay in processing your application.

Information received by this office may require additional explanation or documentation to determine licensure eligibility. After all requested documentation is received, your application will be submitted for supervisory review. We will notify you if additional information is required.

Applicants with a history of malpractice, criminal activity, discipline, physical or mental impairment, unfavorable evaluations, or other matters that need explanation may require a personal appearance before the Board of Medicine Credentials Committee for determination of licensure eligibility. If your appearance is required, you will be notified in writing once your application is complete.

You can now follow the progress of your application through our website at: www.FLHealthSource.gov/mqa-services. If you are a returning user, select "Yes" and enter the user ID and password you selected during the registration process under Returning User. If you did not apply for licensure through this screen, select "No" and follow the prompts to create an account. You must have a valid email address to create your account.

Once you are logged in, you will be prompted to add your application to your account. Once you have successfully added your application, you will be directed to your dashboard. Under the "Additional Activities" section, select "Check Application Status" to review any open deficiencies, upload documents or print out instructional documents.

THIS IS IMPORTANT: Your application will remain incomplete until all deficiencies are completed. In addition, you are required to notify the Board office immediately in writing of any occurrence(s) that would in any way change or affect any answer given in the application or an answer provided in response to any of our direct questions to you.

If you have any questions, please contact me at latayvia.alexander@flhealth.gov, call 850-901-6842, or fax (850) 412-1282.

Sincerely,

Latayvia Alexander

Enclosure(s)

Barbara Maday Calderon **Date: June 8, 2020**

REMINDER: Chapter 456.013(1)(a), Florida Statutes, provides that an incomplete application shall expire one year after initial filing with the department.

YOUR APPLICATION'S EXPIRATION DATE IS: **MAY 28, 2021**

APPLICATION SUBMITTED REMAINS DEFICIENT FOR LACK OF THE FOLLOWING:

An official verification of your medical license from the state of Puerto Rico has not been received

Your ECFMG status report, directly from the ECFMG, has not been received.

Your Postgraduate Training Verification Forms from Medicina General Intergrad 09/1999-12/2002 and Rotating Internship Hospital Buen Samaritan 06/01/17-06/30/18 have not been received.

Please submit the National Practitioner Data Bank (NPDB) report to our office. You may contact the NPDB at 1-800-767-6732 to obtain this information.

We have not received your Livescan results. If you have already had your electronic fingerprinting completed, please allow 24-72 hours for receipt of your results. You can find more information on this process, including how to find a provider in your area and your ORI number, by visiting the Background Screening Website at http://www.flhealthsource.gov/background-screening/. Should your Criminal Background Check disclose an arrest record(s), you will need to provide documentation related to each criminal event revealed in your background, if you have not already done so. You can find a detailed description of documents that will be required by visiting the FAQs on the Background Screening Website (Click on 'General FAQs'). Note: Criminal History will be reviewed by the Background Screening Unit, not the Board Office. Please email all criminal history documents to mqa.backgroundscreen@flhealth.gov. Any original certified documents must be mailed to the following address: Attn: Background Screening Unit Florida Department of Health 4052 Bald Cypress Way, Bin BSU-01 Tallahassee, FL, 32399

We await your USMLE exam scores, direct from the Federation of State Medical Boards, which must be requested by the applicant.

If you have any questions, please contact me at latayvia.alexander@flhealth.gov, call 850-901-6842, or fax (850) 412-1282. The Florida Board of Medicine has assigned **149329** as your **tracking**

number. Please indicate this number if you leave a message, and try to ensure that other sources include it on their communications to us as well.

Department of Health

BARBARA MADAY CALDERON IZQUIERDO

License Number: ACN1127

Data As Of 8/10/2020

Profession	Area of Critical Need Medical Doctor
License	ACN1127
License Status	CLEAR/ACTIVE
Qualifications	Dispensing Practitioner
License Expiration Date	1/31/2022
License Original Issue Date	01/16/2019
Address of Record	11211 N. NEBRASKA AVE AMERICAN CARE OF TAMPA, INC TAMPA, FL 33612
Controlled Substance Prescriber (for the Treatment of Chronic Non-malignant Pain)	Yes
Discipline on File	No
Public Complaint	No

The information on this page is a secure, primary source for license verification provided by the Florida Department of Health, Division of Medical Quality Assurance. This website is maintained by Division staff and is updated immediately upon a change to our licensing and enforcement database.

Chair
Zachariah Zachariah, M.D.
Ft. Lauderdale, Florida

Members
Hector Vila, M.D.
Tampa, Florida
Vice-Chair

Luz Marina Pages, M.D.
Miami Beach, Florida

Scot N. Ackerman, M.D.
Jacksonville, Florida

Eleonor Pimentel, M.D.
Miami, Florida

David A. Diamond, M.D.
Winter Park, Florida

Vacant, Consumer Member

Robert London, M.D.
Maitland, Florida

Jorge J. Lopez, M.D.
Maitland, Florida

Andre M. Perez
Miami, Florida

Kevin Cairns, M.D.
Fort Lauderdale, Florida

Nicholas W. Romanello, Esq.
Melbourne, Florida

Sarvam TerKonda, M.D.
Jacksonville, Florida

Shailesh Gupta, M.D.
Coral Springs, Florida

Vacant, M.D.

Executive Director
Claudia Kemp, J.D.

September 5, 2020

Donald William Ketterhagen, MD
3130 Guadalupe Drive
Punta Gorda, FL 33950

Dear Dr. Ketterhagen:

This is in further reference to your application for licensure by examination.

Please be advised that you are required to make a personal appearance before the Credentials Committee of the Board of Medicine to discuss:

- **Action by Florida Medical Board**
- **Clinical Privileges**

In addition, the Committee may inquire into any other issues relating to your application and eligibility for licensure.

Date:	Thursday, October 1, 2020
Time:	8:00 a.m. (Meeting starts at 8:00 a.m. Interview time may vary.)
Location:	The in-person meeting scheduled in Orlando, Florida is cancelled, and the meeting will be held by a web-based meeting platform or, if appropriate, a teleconference call.

The meeting information and directions for participating in the October 2020 meeting will be posted on the Florida Board of Medicine's website: https://flboardofmedicine.gov/meeting-information.

Additionally, the Committee's recommendation on your application for licensure will be presented to the full Board of Medicine on Friday, October 2, 2020 for final action. You are not required to attend the full board meeting.

Thank you for your continued cooperation. Should you have any questions regarding this matter, please feel free to contact me. *This is your first scheduled appearance.

Sincerely,

Karrell D. Goldwire

Karrell D. Goldwire
Regulatory Supervisor

Pursuant to the provisions of the Americans with Disabilities Act, any person requiring special accommodations to participate in this workshop/meeting is asked to advise the agency at least 10 days before the workshop/meeting by contacting: Rebecca.Hewett@flhealth.gov or call (850) 245-4137.

*** 456.013(3)(c) In considering applications for licensure, the board, or the department when there is no board, may require a personal appearance of the applicant. If the applicant is required to appear, the time period in which a licensure application must be granted or denied shall be tolled until such time as the applicant appears. However, if the applicant fails to appear before the board at either of the next two regularly scheduled board meetings, or fails to appear before the department within 30 days if there is no board, the application for licensure shall be denied.**

MEDICAL DOCTOR
APPLICATION FOR LICENSURE
Apply for your license online at www.flboardofmedicine.gov

000613

Choose your application type:

☐ Endorsement (1021) ☒ Examination (1024)

☐ Military Veterans Fee Waiver

If you were honorably discharged from the U.S. armed services within 60 months of your application you will qualify for a waiver of the application fee and the initial licensure fee. In order to qualify, please check the box above indicating that you are seeking a waiver and submit **a DD-214 or NGB-22 form as proof of honorable discharge.**

☐ I plan to dispense medicinal drugs in the State of Florida for a fee or other remuneration and hereby register as required by Section 465.0276, F.S. I understand that the fee for the Dispensing Practitioner is $100.00 in addition to the required initial license fee and will submit it along with the license fee.

1. PERSONAL INFORMATION

Name: Ketterhagen (Last/Surname) Donald (First) William (Middle) **Date of Birth:** 03/29/1949 (MM/DD/YYYY)

Mailing Address: (The address where mail and your license should be sent)

3130 Guadalupe Dr (Street/ PO Box) ____ (Suite/Apt. No) Punta Gorda (City)

Florida (State) 33950 (Zip) USA (Country) 941-505-5681 (Phone Number)

Physical Location: A Post Office Box is not acceptable. This address will be posted on the Department of Health's website. *If you do not have a current practice address, your mailing address will be used. When you obtain a practice address, you will be required to update your online practitioner profile.*

3130 Guadalupe Dr (Street/ P.O. Box) ____ (Suite/Apt. No) Punta Gorda (City)

Florida (State) 33950 (Zip) United States (Country) 239-336-9882 (Alternate Phone Number)

Email Address: dwk@ketterhagen.com

Under Florida law, email addresses are public records. If you do not want your e-mail address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.

Equal Opportunity Data: We are required to ask that you furnish the following information as part of your voluntary compliance with Section 2, Uniform Guidelines on Employee Selection Procedure (1978) 43 CFR 38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

SEX: ☑ Male ☐ Female **RACE:** ☑ White ☐ Black ☐ Asian/Pacific Islander ☐ Hispanic ☐ Other

☑ Yes ☐ No **Availability for Disaster:** Will you be available to provide health care services in special needs shelters or to help staff disaster medical assistance teams during times of emergency or major disaster?

D W Ketterhagen

2. MEDICAL EDUCATION HISTORY

Federal Credentials Verification Services (FCVS) is not a requirement for licensure. FCVS will primary source verify and provide a copy of the medical school transcript(s), medical school diploma, medical school verification, name change document(s), national examination score report, ECFMG certificate, ECFMG verification and postgraduate training verifications. For more information about FCVS, visit their web-site at www.fcvs.org/.

☑ Yes ☐ No Are you using the FCVS to verify your core credentials?

☑ Yes ☐ No Have you completed the equivalent of 2 academic years of preprofessional, postsecondary education including, courses in anatomy, biology and chemistry prior to entering medical school?

Medical Education:
List in chronological order all medical schools attended, whether completed or not. Submit on a separate sheet if needed.

Medical School Name and Address:	From: (mm/yy)	To: (mm/yy)	Date Degree Received:
Medical College of Wisconsin Milwaukee, WI, United States	08/28/1970	05/25/1974	05/26/1974

Fifth Pathway Certificate Holders:

If you answer "yes" to any of the following questions, you must request verifications to be sent directly to the Board office.

☐ Yes ☐ No Did you attend an international medical school and do not possess a valid ECFMG Certificate?

☐ Yes ☐ No Did you receive a bachelor's degree from an accredited United States college or University?

☐ Yes ☐ No Did you study at a medical school which is recognized by the World Health Organization?

☐ Yes ☐ No Did you complete all of the formal requirement of the International medical school, except the internship or social service requirements, and pass part I of the National board of Medical examination or the Education Commission for Foreign Medical Graduates Examination equivalent?

☐ Yes ☐ No Did you complete an academic year of supervised clinical training in a hospital affiliated with a medical school approved by the Council on Medical Education of the American Medical Association and upon completion passed part II of the National Board of Medical Examiners examination or the Education Commission for Foreign Medical Graduates examination Equivalent?

Donald William Kettelhagen
DWKettelhagen
3-29-49

4. LICENSURE HISTORY

Request verification of licensure status directly from the licensing entity or www.veridoc.org. Request international license verification(s) if you have practiced outside of the U.S. for at least two of the previous four years.

☑ Yes ☐ No Do you now hold or have you ever held a license to practice medicine or any other profession in any US State or territory, or foreign country? Please list in table below.

Jurisdiction	Profession	License number
United States—Florida	Medical Doctor	ME32448
United States—Wisconsin	Medical Doctor	19509-20

If you answer "yes" to any of the questions in this section, you are required to send an explanation and supporting documentation.

☐ Yes ☑ No Have you had any application for a medical license or professional license denied by any state board or other governmental agency of any state, territory, or country?

☐ Yes ☑ No Are you currently under investigation in any jurisdiction for an act or offense that would constitute a violation of Section 458.331, Florida Statutes?

☐ Yes ☑ No Have you ever had any professional license or license to practice medicine revoked, suspended, placed on probation, or other disciplinary action taken in any state, territory or country?

5. PRACTICE/EMPLOYMENT HISTORY

List the year you legally first began to practice medicine, 1974 (yyyy). This would be the year you began practicing medicine and could be the date you began your postgraduate training.

☐ Yes ☑ No Have you practiced medicine in any jurisdiction for two of the last four years **or** completed a board approved post-graduate training program within the last two years?

☐ Yes ☑ No If your answer to the question above was "No," have you passed a board approved clinical competency exam within the last year? If yes, then submit supporting documentation.

List in chronological order all employment for the last four (4) years.

Name and address of practice or employment	Type of employment	From: mm/yy	To: mm/yy
None			

Donald William Ketterhagen
DWK 3-29-19

6. CRIMINAL HISTORY

If you answer "Yes" to the following question you are required to send the following items:

a. Self-explanation describing in detail the circumstances surrounding each offense, including dates, city and state, charges and final results.
b. Final Dispositions and Arrest Records for all offenses. The Clerk of the Court in the arresting jurisdiction will provide you with these documents. Unavailability of these documents must come in the form of a letter from the Clerk of the Court.
c. Completion of Sentence Documents. You may obtain documentation from the Department of Corrections. The report must include the start date, end date and that the conditions were met.

☐ Yes ☑ No Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to, a crime in any jurisdiction other than a minor traffic offense? You must include all misdemeanors and felonies, **even if adjudication was withheld. Driving under the influence (DUI) or driving while impaired (DWI) are not minor traffic offenses for purposes of this question.**

Yes ☑ I have been provided and read the statement from the Florida Department of Law Enforcement regarding the sharing, retention, privacy and right to challenge incorrect criminal history records and the "Privacy Statement" document from the Federal Bureau of Investigation.

7. MILITARY HISTORY

A. ☐ Yes ☑ No Have you ever been in the United States Military and/or Public Health Service?

B. ☐ Yes ☑ No Have you ever been disciplined by any branch of the United States Armed Services or Public Health Services? If you answered "yes" please provide a detailed explanation and supporting documentation

8. CRIMINAL AND MEDICAID/MEDICARE FRAUD QUESTIONS

Applicants for licensure, certification or registration and candidates for examination may be excluded from licensure, certification or registration if their felony conviction falls into certain timeframes as established in Section 456.0635(2), Florida Statutes. If you answer "Yes" to any of the following questions, please provide a written explanation for each question. Supporting documentation includes court dispositions or agency orders where applicable.

1. ☐ Yes ☑ No Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, F.S. (relating to social and economic assistance), Chapter 817, F.S. (relating to fraudulent practices), Chapter 893, F.S. (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction?

If you responded "No" to the question above, skip to question 2.

a. ☐ Yes ☐ No If "yes" to 1, for the felonies of the first or second degree, has it been more than 15 years from the date of the plea, sentence and completion of any subsequent probation?

b. ☐ Yes ☐ No If "Yes" to 1, for felonies of the third degree, has it been more than 10 years from the date of the plea, sentence and completion of any subsequent probation? (This question does not apply to felonies of the third degree under Section 893.13(6)(a), Florida Statutes)

c. ☐ Yes ☐ No If "Yes" to 1, for the felonies of the third degree under Section 893.13(6)(a), Florida Statutes, has it been more than 5 years from the date of the plea, sentence and completion of any subsequent probation?

d. ☐ Yes ☐ No If "Yes" to 1, have you successfully completed a drug court program that resulted in the plea for the felony offense being withdrawn or charges dismissed?

2. ☐ Yes ☑ No Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970 (relating to controlled substances) or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)?

Donald William Ketterhagen
Donald W. Ketterhagen
3-29-19

If you responded "No" to the question above, skip to question 3.

a. ☐ Yes ☐ No If "Yes" to 2, has it been more than 15 years before the date of application since the sentence and any subsequent period of probation for such conviction or plea ended?

3. ☐ Yes ☑ No Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes?

If you responded "No" to the question above, skip to question 4.

a. ☐ Yes ☐ No If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years?

4. ☐ Yes ☑ No Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid Program?

If you responded "No" to the question above, skip to question 5.

a. ☐ Yes ☐ No Have you been in good standing with a state Medicaid program for the most recent five years?

b. ☐ Yes ☐ No Did the termination occur at least 20 years before the date of this application?

5. ☐ Yes ☑ No Are you currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities?

If you answer "Yes" to the questions below, you are required to send the following items:

- **A statement indicating the date of each incident and the number for each case.**
- **An explanation of details for each case and your involvement for each case.**
- **Submit the enclosed Exhibit 1 form.**
- **A copy of the complaint, judgments and/or settlements for each case.**
- **Submit a complete copy of the trial record(s) of each case, including the trial transcript, evidentiary exhibits and final judgment in electronic format.**

☐ Yes ☑ No Have you ever had a judgment entered against you for medical malpractice where the incident(s) of malpractice occurred after November 2, 2004?

☐ Yes ☑ No Within the last 10 years have you had any liability claim(s) or action(s) for damages for personal injury settled or finally adjudicated in an amount that exceeds $100,000.00?

Donald William Ketterhagen

3-29-19

10. FINANCIAL RESPONSIBILITY

The Financial Responsibility options are divided into two categories, coverage and exemptions. Check only one option of the ten provided as required by s. 458.320, Florida Statutes.

Category I: Financial Responsibility Coverage

☐1. I do not have hospital staff privileges, I do not perform surgery at an ambulatory surgical center and I have established an irrevocable letter or credit or an escrow account in an amount of $100,000/$300,000, in accord with Chapter 675, F. S., for a letter of credit and s. 625.52, F. S., for an escrow account.

☐2. I have hospital staff privileges or I perform surgery at an ambulatory surgical and I have established an irrevocable letter of credit or escrow account in an amount of $250,000/$750,000, in accord with Chapter 675, F. S., for a letter of credit and s. 625.52, F. S., for an escrow account.

☐3. I do not have hospital staff privileges, I do not perform surgery at an ambulatory surgical center and I have obtained and maintain professional liability coverage in an amount not less than $100,000 per claim, with a minimum annual aggregate of not less than $300,000 from an authorized insurer as defined under s. 624.09, F. S., from a surplus lines insurer as defined under s. 626.914(2), F. S., from a risk retention group as defined under s. 627.942, F. S., from the Joint Underwriting Association established under s. 627.351(4), F. S., or through a plan of self-insurance as provided in s. 627.357, F. S.

☐4. I have hospital staff privileges or I perform surgery at an ambulatory surgical and I have professional liability coverage in an amount not less than $250,000 per claim, with a minimum annual aggregate of not less than $750,000 from an authorized insurer as defined under s. 624.09, F. S., from a surplus lines insurer as defined under s. 626.914(2), F. S., from a risk retention group as defined under s. 627.942, F. S., from the Joint Underwriting Association established under s. 627.351(4), F. S., or through a plan of self-insurance as provided in s. 627.357, F. S.

☑5. I have elected not to carry medical malpractice insurance however, I agree to satisfy any adverse judgments up to the minimum amounts pursuant to s. 458.320(5)(g)1, F. S. I understand that I must either post notice in a sign prominently displayed in my reception area or provide a written statement to any person to whom medical services are being provided that I have decided not to carry medical malpractice insurance. I understand that such a sign or notice must contain the wording specified in s. 458.320(5)(g), F. S.

Category II: Financial Responsibility Exemptions

☐6. I practice medicine exclusively as an officer, employee, or agent of the federal government, the state, or its agencies or subdivisions.

☐7. I hold a limited license issued pursuant to s. 458.317, F. S., and practice only under the scope of the limited license.

☑8. I do not practice medicine in the State of Florida.

☐9. I meet all of the following criteria:

(a) I have held an active license to practice in this state or another state or some combination thereof for more than 15 years;

(b) I am retired or maintain part time practice of no more than 1000 patient contact hours per year;

(c) I have had no more than two claims resulting in an indemnity exceeding $25,000 within the previous five-year period;

(d) I have not been convicted of or pled guilty or nolo contendere to any criminal violation specified in Chapter 458, F. S. or the medical practice act in any other state; and

(e) I have not been subject, within the past ten years of practice, to license revocation, suspension, or probation for a period of three years or longer, or a fine of $500 or more for a violation of Chapter 458, F. S., or the medical practice act of another jurisdiction. A regulatory agency's acceptance of a relinquishment of license, stipulation, consent order, or other settlement offered in response to or in anticipation of filing of administrative charges against a license is construed as action against a license. I understand if I am claiming an exception under this section that I must either post notice in a sign prominently displayed in my reception area or provide a written statement to any person to whom medical services are being provided that I have decided not to carry medical malpractice insurance. See Section 458.320(5)(f), Florida Statutes, for specific notice requirements.

☐10. I practice only in conjunction with my teaching duties at an accredited medical school or its teaching hospitals. (Interns and residents do not qualify for this exemption).

If you select an exemption based on number 9, you must also complete the affidavit on the following page.

Donald William Kattenhagen

Donald W Kattenhagen

3-29-19

11. FLORIDA BIRTH RELATED NEUROLOGICAL COMPENSATION ASSOCIATION

You must choose one of the three options described below. Please be sure to view the information about each exemption at www.nica.com. Check only one.

☐	☑	☐	$250
$5,000 Participating	$250 Non-participating	$0 Exempt	Amount enclosed

If you choose "$0 Exempt" provide appropriate documentation to the Board of Medicine and to NICA.

I have read the explanatory information provided by NICA, and I choose the option above.

Donald W Ketterhagen 7-1-2020

Signature Date

Donald W Ketterhagen

Name

3130 Guadalupe Dr

Street Address

Punta Gorda, Florida, 33950

City, State, Zip

If you are a participating or non-participating physician, or a physician claiming exemption, you must complete, sign and date this form and return it with your payment to this address.

Board of Medicine
4052 Bald Cypress Way, #C-03
Tallahassee, FL 32399-3253

If you are a physician claiming exemption, you must also send a copy of your completed, signed, and dated form with proof of your exemption to:

NICA
2360 Christopher Place
Tallahassee, FL 32308

If you have any questions about NICA or this form, please contact NICA at www.nica.com or (850) 488-8191.

Donald William Ketterhagen
Donald W Ketterhagen
3-29-49

12. STATEMENT OF APPLICANT

I state that these statements are true and correct. I recognize that providing false information may result in denial of licensure, disciplinary action against my license, or criminal penalties pursuant to Sections 456.067, 775.083, and 775.084, Florida Statutes. I state that I have read Chapters 456, 458 and 766.301-.316, Florida Statutes and Chapter 64B8, Florida Administrative Code.

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Florida Board of Medicine information which is material to my application for licensure.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind. I state that my answers and all statements made by me herein are true and correct.

Should I furnish any false information in this application, I hereby agree that such act constitutes cause for denial, suspension, or revocation of my license to practice medicine in the State of Florida. If there are any changes to my status or any change that would affect any of my answers to this application I must notify the board within 30 days.

I understand that my records are protected under federal and state regulations governing Confidentiality of Mental Health Patient Records and cannot be disclosed without my written consent unless otherwise provided in the regulations. I understand that my records are protected under federal and state regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it.

Donald W Ketterhagen

Print name

Signature

7-1-20

Date

July 15, 2020

Donald William Ketterhagen, M.D.
3130 Guadalupe Dr
Punta Gorda, FL 33950

Dear Dr. Ketterhagen:
File: 116164

Thank you for considering Florida for physician licensure. Your application for medical licensure has been received. The application is incomplete for the reasons set out in the attached deficiency notice. Please address these deficiencies as soon as possible to avoid delay in processing your application.

Information received by this office may require additional explanation or documentation to determine licensure eligibility. After all requested documentation is received, your application will be submitted for supervisory review. We will notify you if additional information is required.

Applicants with a history of malpractice, criminal activity, discipline, physical or mental impairment, unfavorable evaluations, or other matters that need explanation may require a personal appearance before the Board of Medicine Credentials Committee for determination of licensure eligibility. If your appearance is required, you will be notified in writing once your application is complete.

You can now follow the progress of your application through our website at: www.FLHealthSource.gov/mqa-services. If you are a returning user, select "Yes" and enter the user ID and password you selected during the registration process under Returning User. If you did not apply for licensure through this screen, select "No" and follow the prompts to create an account. You must have a valid email address to create your account.

Once you are logged in, you will be prompted to add your application to your account. Once you have successfully added your application, you will be directed to your dashboard. Under the "Additional Activities" section, select "Check Application Status" to review any open deficiencies, upload documents or print out instructional documents.

THIS IS IMPORTANT: Your application will remain incomplete until all deficiencies are completed. In addition, you are required to notify the Board office immediately in writing of any occurrence(s) that would in any way change or affect any answer given in the application or an answer provided in response to any of our direct questions to you.

If you have any questions, please contact me at AnnMarie.Bissoo@flhealth.gov, or call 850-617-1909.

Sincerely,

Ann-Marie Bissoo

Ann-Marie Bissoo
Regulatory Specialist II

Enclosure(s)

Dr Donald William Ketterhagen **Date: July 15, 2020**

REMINDER: Chapter 456.013(1)(a), Florida Statutes, provides that an incomplete application shall expire one year after initial filing with the department.

YOUR APPLICATION'S EXPIRATION DATE IS 07/08/2021.

APPLICATION SUBMITTED REMAINS DEFICIENT FOR LACK OF THE FOLLOWING:

Your paper application signed 7/1/2020 has been received. Your file is being reviewed.

If you have any questions, please contact me at AnnMarie.Bissoo@flhealth.gov, or call 850 617 1909. The Florida Board of Medicine has assigned **116164** as your **tracking number**. Please indicate this number if you leave a message, and try to ensure that other sources include it on their communications to us as well.

August 5, 2020

Donald William Ketterhagen, M.D.
3130 Guadalupe Dr
Punta Gorda, FL 33950

Dear Dr. Ketterhagen:

It has been determined that you will be required to make a personal appearance before the Credentials Committee for consideration of your application.

This letter is to advise that you are required to appear before the Credentials Committee of the Florida Board of Medicine upon completion of your application file to discuss your application for licensure.

You will receive a letter in the mail approximately 2 weeks prior to the meeting notifying you of the meeting location and time you are required to appear. If you move, please notify our office immediately of your new address. Address changes must be sent in writing and signed by you. Please mail your address change to the address listed below.

If you have any questions, please contact me at Karrell.Goldwire@flhealth.gov, call (850) 617-1907, or fax (850) 412-1279. Your tracking number in our database is 116164. Indicate your tracking number if you leave a message, and try to ensure that other sources include it on their communications to us as well.

Sincerely,

Karrell D. Goldwire

Karrell D. Goldwire
Regulatory Supervisor
Florida Board of Medicine

(http://dsps.wi.gov/)

Wisconsin Department of Safety and Professional Services

Credential/Licensing Search

Individual Search Results - Detail

Credential/License Summary for 19509

Name: KETTERHAGEN, DONALD W
Profession: MEDICINE AND SURGERY (20)
Credential/License Number: 19509-20
Location: WAUWATOSA WI
Credential/License Type: regular
Status: License is not current (Expired)
Eligible To Practice: Not Eligible to Practice

Credential/License current through: 1/1/1978
Granted date: 7/10/1975
Multi-state: N
Orders: NONE
Specialties: OBSTETRICS AND GYNECOLOGY
Other Names: NONE

Wis. Stat. § 227.51(2) When a licensee has made timely and sufficient application for the renewal of a license or a new license with reference to any activity of a continuing nature, the existing license does not expire until the application has been finally acted upon by the agency, and, if the application is denied or the terms of the new license are limited, until the last day for seeking review of the agency decision or a later date fixed by order of the reviewing court.

Requirement Code Description (https://dsps.wi.gov/Documents/LicenseRequirementAcronyms.pdf)

Return to Search Results (/IndividualLicense/SearchResults)

Consistent with The Joint Commission and NCQA standards for primary source verification. Data on this page is refreshed hourly.
Send questions or comments to dsps@wisconsin.gov (mailto:dsps@wisconsin.gov).

Department of Health

DONALD WILLIAM KETTERHAGEN

License Number: ME32448

Data As Of 8/12/2020

Profession	Medical Doctor
License	ME32448
License Status	NULL AND VOID/
License Expiration Date	1/31/2002
License Original Issue Date	04/07/1978
Address of Record	If further information is needed, please contact the Department of Health at (850) 488-0595.
Controlled Substance Prescriber (for the Treatment of Chronic Non-malignant Pain)	No
Discipline on File	No
Public Complaint	No

The information on this page is a secure, primary source for license verification provided by the Florida Department of Health, Division of Medical Quality Assurance. This website is maintained by Division staff and is updated immediately upon a change to our licensing and enforcement database.

Chair
Zachariah Zachariah, M.D.
Ft. Lauderdale, Florida

Members
Hector Vila, M.D.
Tampa, Florida
Vice-Chair

Luz Marina Pages, M.D.
Miami Beach, Florida

Scot N. Ackerman, M.D.
Jacksonville, Florida

Eleonor Pimentel, M.D.
Miami, Florida

David A. Diamond, M.D.
Winter Park, Florida

Vacant, Consumer Member

Robert London, M.D.
Maitland, Florida

Jorge J. Lopez, M.D.
Maitland, Florida

Andre M. Perez
Miami, Florida

Kevin Cairns, M.D.
Fort Lauderdale, Florida

Nicholas W. Romanello, Esq.
Melbourne, Florida

Sarvam TerKonda, M.D.
Jacksonville, Florida

Shailesh Gupta, M.D.
Coral Springs, Florida

Vacant, M.D.

Executive Director
Claudia Kemp, J.D.

September 1, 2020

Ettore Vulcano, MD
2110 44TH Drive, Apt. PHA
Long Island, New York 11101

Dear Dr. Vulcano:

This is in further reference to your application for licensure by endorsement.

Please be advised that you are required to make a personal appearance before the Credentials Committee of the Board of Medicine to discuss:

- Failure to meet section 458.313(1)(a) and 458.311(1)(f)3.c., Florida Statutes, postgraduate training

In addition, the Committee may inquire into any other issues relating to your application and eligibility for licensure.

Date:	Thursday, October 1, 2020
Time:	8:00 a.m. (Meeting starts at 8:00 a.m. Interview time may vary.)
Location:	The in-person meeting scheduled in Orlando, Florida is cancelled, and the meeting will be held by a web-based meeting platform or, if appropriate, a teleconference call.

The meeting information and directions for participating in the October 2020 meeting will be posted on the Florida Board of Medicine's website: https://flboardofmedicine.gov/meeting-information.

Additionally, the Committee's recommendation on your application for licensure will be presented to the full Board of Medicine on Friday, October 2, 2020 for final action. You are not required to attend the full board meeting.

Thank you for your continued cooperation. Should you have any questions regarding this matter, please feel free to contact me. *This is your first scheduled appearance.

Sincerely,

Angela Denson

Angela Denson
Regulatory Supervisor

Pursuant to the provisions of the Americans with Disabilities Act, any person requiring special accommodations to participate in this workshop/meeting is asked to advise the agency at least 10 days before the workshop/meeting by contacting: Rebecca.Hewett@flhealth.gov or call (850) 245-4137.

*** 456.013(3)(c) In considering applications for licensure, the board, or the department when there is no board, may require a personal appearance of the applicant. If the applicant is required to appear, the time period in which a licensure application must be granted or denied shall be tolled until such time as the applicant appears. However, if the applicant fails to appear before the board at either of the next two regularly scheduled board meetings, or fails to appear before the department within 30 days if there is no board, the application for licensure shall be denied.**

MEDICAL DOCTOR
APPLICATION FOR LICENSURE

016183

Apply for your license online at www.flboardofmedicine.gov

Choose your application type:

☒ Endorsement (1021) ☐ Examination (1024)

☐ Military Veterans Fee Waiver

If you were honorably discharged from the U.S. armed services within 60 months of your application you will qualify for a waiver of the application fee and the initial licensure fee. In order to qualify, please check the box above indicating that you are seeking a waiver and submit **a DD-214 or NGB-22 form as proof of honorable discharge.**

☐ I plan to dispense medicinal drugs in the State of Florida for a fee or other remuneration and hereby register as required by Section 465.0276, F.S. I understand that the fee for the Dispensing Practitioner is $100.00 in addition to the required initial license fee and will submit it along with the license fee.

1. PERSONAL INFORMATION

Name: VULCANO (Last/Surname) ETTORE (First) (Middle) **Date of Birth:** 03/22/1983 (MM/DD/YYYY)

Mailing Address: (The address where mail and your license should be sent)

2110 44th DRIVE (Street/ PO Box) APT PHA (Suite/Apt. No) LONG ISLAND CITY (City)

NY (State) 11101 (Zip) USA (Country) 443-600-2655 (Phone Number)

Physical Location: A Post Office Box is not acceptable. This address will be posted on the Department of Health's website. *If you do not have a current practice address, your mailing address will be used. When you obtain a practice address, you will be required to update your online practitioner profile.*

2110 44th DRIVE (Street/ P.O. Box) APT. PHA (Suite/Apt. No) LONG ISLAND CITY (City)

NY (State) 11101 (Zip) USA (Country) (Alternate Phone Number)

Email Address: ETTOREVULCANOMD@GMAIL.COM

Under Florida law, email addresses are public records. If you do not want your e-mail address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.

Equal Opportunity Data: We are required to ask that you furnish the following information as part of your voluntary compliance with Section 2, Uniform Guidelines on Employee Selection Procedure (1978) 43 CFR 38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

SEX: ☒ **Male** ☐ **Female** **RACE:** ☒ **White** ☐ **Black** ☐ **Asian/Pacific Islander** ☐ **Hispanic** ☐ **Other**

☒ Yes ☐ No **Availability for Disaster:** Will you be available to provide health care services in special needs shelters or to help staff disaster medical assistance teams during times of

2. MEDICAL EDUCATION HISTORY

Federal Credentials Verification Services (FCVS) is not a requirement for licensure. FCVS will primary source verify and provide a copy of the medical school transcript(s), medical school diploma, medical school verification, name change document(s), national examination score report, ECFMG certificate, ECFMG verification and postgraduate training verifications. For more information about FCVS, visit their web-site at www.fcvs.org/.

☒ Yes ☐ No Are you using the FCVS to verify your core credentials?

☒ Yes ☐ No Have you completed the equivalent of 2 academic years of preprofessional, postsecondary education including, courses in anatomy, biology and chemistry prior to entering medical school?

Medical Education:
List in chronological order all medical schools attended, whether completed or not. Submit on a separate sheet if needed.

Medical School Name and Address:	From: (mm/yy)	To: (mm/yy)	Date Degree Received:
UNIVERSITA' CAMPUS BIOMEDICO VIA A. DEL PORTILLO 21, 00128 ROME ITALY	09/2001	07/2007	7/19/2007

Fifth Pathway Certificate Holders:

If you answer "yes" to any of the following questions, you must request verifications to be sent directly to the Board office.

☐ Yes ☐ No Did you attend an international medical school and do not possess a valid ECFMG Certificate?

☐ Yes ☐ No Did you receive a bachelor's degree from an accredited United States college or University?

☐ Yes ☐ No Did you study at a medical school which is recognized by the World Health Organization?

☐ Yes ☐ No Did you complete all of the formal requirement of the International medical school, except the internship or social service requirements, and pass part I of the National board of Medical examination or the Education Commission for Foreign Medical Graduates Examination equivalent?

☐ Yes ☐ No Did you complete an academic year of supervised clinical training in a hospital affiliated with a medical school approved by the Council on Medical Education of the American Medical Association and upon completion passed part II of the National Board of Medical Examiners examination or the Education Commission for Foreign Medical Graduates examination Equivalent?

Postgraduate Training:

Provide the following documentation to support your postgraduate training:

☑ Post-Graduate Training Form

In the table below list, in chronological order, all postgraduate training from the date you graduated from medical school to the present. Start with your first program and end with your last or current program. List all programs you began, whether you completed or received credit for the training.

	Program Name and Full Mailing Address:	Specialty Area:	From: (mm/yy)	To: (mm/yy)	Did you receive credit? (Y/N)
1.	ORTHOPEDIC RESIDENCY VIA RAVASI 2, 21100 VARESE, ITALY	ORTHOPEDICS	07/2009	07/2014	Y
2.	FOOT ANKLE SURGERY 345 ST. PAUL PL. BALTIMORE, MD 21202	FOOT SURGERY FELLOWSHIP	08/2014	07/2015	Y
3.	LIMB LENGTHENING HOSPITAL FOR SPECIAL SURGERY 535 E 70 ST, NEW YORK, NY, 10021	LIMB LENGTHENING SURGERY	08/2015	07/2016	Y

Loan History:

☐ Yes ☒ No Are you currently in default on any health education loan or scholarship obligation? (If "yes", explain on a separate sheet providing accurate details.)

3. EXAMINATION HISTORY

State Board (prior to 1974), State Board (after 1974) & SPEX, LMCC & SPEX, NBME, FLEX, USMLE III, or Combination (prior to 2000)

Request that the score report be sent directly to the Board of Medicine. NOTE: If you took a state Board examination and are not currently licensed in three other states, you must also request your SPEX score be sent.

Exam taken: USMLE STEP 3 12/8/2010 Date passed: 12/8/2010
mm/dd/yy

4. LICENSURE HISTORY

Request verification of licensure status directly from the licensing entity or www.veridoc.org. Request international license verification(s) if you have practiced outside of the U.S. for at least two of the previous four years.

☒ Yes ☒ No Do you now hold or have you ever held a license to practice medicine or any other profession in any US State or territory, or foreign country? Please list in table below.

Jurisdiction	Profession	License number
NEW YORK STATE	PHYSICIAN	282624

If you answer "yes" to any of the questions in this section, you are required to send an explanation and supporting documentation.

☐ Yes ☒ No Have you had any application for a medical license or professional license denied by any state board or other governmental agency of any state, territory, or country?

☐ Yes ☒ No Are you currently under investigation in any jurisdiction for an act or offense that would constitute a violation of Section 458.331, Florida Statutes?

☐ Yes ☒ No Have you ever had any professional license or license to practice medicine revoked, suspended, placed on probation, or other disciplinary action taken in any state, territory or country?

5. PRACTICE/EMPLOYMENT HISTORY

List the year you legally first began to practice medicine, 2009 (yyyy). This would be the year you began practicing medicine and could be the date you began your postgraduate training.

☒ Yes ☐ No Have you practiced medicine in any jurisdiction for two of the last four years **or** completed a board approved post-graduate training program within the last two years?

☐ Yes ☐ No If your answer to the question above was "No," have you passed a board approved clinical competency exam within the last year? If yes, then submit supporting documentation.

List in chronological order all employment for the last four (4) years.

Name and address of practice or employment	Type of employment	From: mm/yy	To: mm/yy
MOUNT SINAI HEALTH SYSTEM 5 EAST 98 ST, NEW YORK, NY 10029	FULL TIME ORTHOPEDIC SURGEON	9/2016	CURRENT

☒ Yes ☐ No Do you currently hold staff privileges in any hospital, health institution, clinic or medical facility? List each facility below.

Name of facility
MOUNT SINAI HEALTH SYSTEM

If you answer "yes" to the following questions, you are required to send an explanation and supporting documentation.

☐ Yes ☒ No Have you ever had any staff privileges denied, suspended, revoked, modified, restricted, not renewed, or placed on probation, or have you been asked to resign or take a temporary leave of absence or were otherwise acted against by any facility?

☒ Yes ☐ No Do you currently, or have you had, responsibility for graduate medical education within the last 10 years?

In the table below, list all institutions where you have had responsibility for graduate medical education or faculty appointment(s) at any medical school.

Name of institution
ASSOCIATE PROFESSOR, ORTHOPEDIC SURGERY, ICAHN SCHOOL OF MEDICINE

☐ Yes ☒ No Are you certified by any specialty board recognized by the American Board of Medical Specialties or specialty board approved by the Florida Board of Medicine?

Board Name	Certification/ Specialty/Sub-Specialty	Date of Certification (mm/yy)

If you answer "yes" to any of the following questions, please explain on a separate sheet providing accurate details.

☐ Yes ☐ No Have you ever had any final disciplinary action taken against you by a specialty board or other similar national organization?

☐ Yes ☐ No Have you ever been denied or surrendered a DEA registration?

6. CRIMINAL HISTORY

If you answer "Yes" to the following question you are required to send the following items:

a. Self-explanation describing in detail the circumstances surrounding each offense, including dates, city and state, charges and final results.
b. Final Dispositions and Arrest Records for all offenses. The Clerk of the Court in the arresting jurisdiction will provide you with these documents. Unavailability of these documents must come in the form of a letter from the Clerk of the Court.
c. Completion of Sentence Documents. You may obtain documentation from the Department of Corrections. The report must include the start date, end date and that the conditions were met.

☐ Yes ☒ No Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to, a crime in any jurisdiction other than a minor traffic offense? You must include all misdemeanors and felonies, **even if adjudication was withheld. Driving under the influence (DUI) or driving while impaired (DWI) are not minor traffic offenses for purposes of this question.**

Yes ☒ I have been provided and read the statement from the Florida Department of Law Enforcement regarding the sharing, retention, privacy and right to challenge incorrect criminal history records and the "Privacy Statement" document from the Federal Bureau of Investigation.

7. MILITARY HISTORY

A. ☐ Yes ☒ No Have you ever been in the United States Military and/or Public Health Service?

B. ☐ Yes ☒ No Have you ever been disciplined by any branch of the United States Armed Services or Public Health Services? If you answered "yes" please provide a detailed explanation and supporting documentation

8. CRIMINAL AND MEDICAID/MEDICARE FRAUD QUESTIONS

Applicants for licensure, certification or registration and candidates for examination may be excluded from licensure, certification or registration if their felony conviction falls into certain timeframes as established in Section 456.0635(2), Florida Statutes. If you answer "Yes" to any of the following questions, please provide a written explanation for each question. Supporting documentation includes court dispositions or agency orders where applicable.

1. ☐ Yes ☒ No Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, F.S. (relating to social and economic assistance), Chapter 817, F.S. (relating to fraudulent practices), Chapter 893, F.S. (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction?

If you responded "No" to the question above, skip to question 2.

a. ☐ Yes ☐ No If "yes" to 1, for the felonies of the first or second degree, has it been more than 15 years from the date of the plea, sentence and completion of any subsequent probation?

b. ☐ Yes ☐ No If "Yes" to 1, for felonies of the third degree, has it been more than 10 years from the date of the plea, sentence and completion of any subsequent probation? (This question does not apply to felonies of the third degree under Section 893.13(6)(a), Florida Statutes)

c. ☐ Yes ☐ No If "Yes" to 1, for the felonies of the third degree under Section 893.13(6)(a), Florida Statutes, has it been more than 5 years from the date of the plea, sentence and completion of any subsequent probation?

d. ☐ Yes ☐ No If "Yes" to 1, have you successfully completed a drug court program that resulted in the plea for the felony offense being withdrawn or charges dismissed?

2. ☐ Yes ☒ No Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970 (relating to controlled substances) or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)?

If you responded "No" to the question above, skip to question 3.

a. ☐ Yes ☐ No If "Yes" to 2, has it been more than 15 years before the date of application since the sentence and any subsequent period of probation for such conviction or plea ended?

3. ☐ Yes ☒ No Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes?

If you responded "No" to the question above, skip to question 4.

a. ☐ Yes ☐ No If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years?

4. ☐ Yes ☒ No Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid Program?

If you responded "No" to the question above, skip to question 5.

a. ☐ Yes ☐ No Have you been in good standing with a state Medicaid program for the most recent five years?

b. ☐ Yes ☐ No Did the termination occur at least 20 years before the date of this application?

5. ☐ Yes ☒ No Are you currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities?

If you answer "Yes" to the questions below, you are required to send the following items:

- **A statement indicating the date of each incident and the number for each case.**
- **An explanation of details for each case and your involvement for each case.**
- **Submit the enclosed Exhibit 1 form.**
- **A copy of the complaint, judgments and/or settlements for each case.**
- **Submit a complete copy of the trial record(s) of each case, including the trial transcript, evidentiary exhibits and final judgment in electronic format.**

☒ Yes ☐ No Have you ever had a judgment entered against you for medical malpractice where the incident(s) of malpractice occurred after November 2, 2004?

☐ Yes ☒ No Within the last 10 years have you had any liability claim(s) or action(s) for damages for personal injury settled or finally adjudicated in an amount that exceeds $100,000.00?

10. FINANCIAL RESPONSIBILITY

The Financial Responsibility options are divided into two categories, coverage and exemptions. Check only one option of the ten provided as required by s. 458.320, Florida Statutes.

Category I: Financial Responsibility Coverage

☐1. I do not have hospital staff privileges, I do not perform surgery at an ambulatory surgical center and I have established an irrevocable letter or credit or an escrow account in an amount of $100,000/$300,000, in accord with Chapter 675, F. S., for a letter of credit and s. 625.52, F. S., for an escrow account.

☐2. I have hospital staff privileges or I perform surgery at an ambulatory surgical and I have established an irrevocable letter of credit or escrow account in an amount of $250,000/$750,000, in accord with Chapter 675, F. S., for a letter of credit and s. 625.52, F. S., for an escrow account.

☐3. I do not have hospital staff privileges, I do not perform surgery at an ambulatory surgical center and I have obtained and maintain professional liability coverage in an amount not less than $100,000 per claim, with a minimum annual aggregate of not less than $300,000 from an authorized insurer as defined under s. 624.09, F. S., from a surplus lines insurer as defined under s. 626.914(2), F. S., from a risk retention group as defined under s. 627.942, F. S., from the Joint Underwriting Association established under s. 627.351(4), F. S., or through a plan of self-insurance as provided in s. 627.357, F. S.

☒4. I have hospital staff privileges or I perform surgery at an ambulatory surgical and I have professional liability coverage in an amount not less than $250,000 per claim, with a minimum annual aggregate of not less than $750,000 from an authorized insurer as defined under s. 624.09, F. S., from a surplus lines insurer as defined under s. 626.914(2), F. S., from a risk retention group as defined under s. 627.942, F. S., from the Joint Underwriting Association established under s. 627.351(4), F. S., or through a plan of self-insurance as provided in s. 627.357, F. S.

☐5. I have elected not to carry medical malpractice insurance however, I agree to satisfy any adverse judgments up to the minimum amounts pursuant to s. 458.320(5)(g)1, F. S. I understand that I must either post notice in a sign prominently displayed in my reception area or provide a written statement to any person to whom medical services are being provided that I have decided not to carry medical malpractice insurance. I understand that such a sign or notice must contain the wording specified in s. 458.320(5)(g), F. S.

Category II: Financial Responsibility Exemptions

☐6. I practice medicine exclusively as an officer, employee, or agent of the federal government, the state, or its agencies or subdivisions.

☐7. I hold a limited license issued pursuant to s. 458.317, F. S., and practice only under the scope of the limited license.

☒8. I do not practice medicine in the State of Florida.

☐9. I meet all of the following criteria:

(a) I have held an active license to practice in this state or another state or some combination thereof for more than 15 years;

(b) I am retired or maintain part time practice of no more than 1000 patient contact hours per year;

(c) I have had no more than two claims resulting in an indemnity exceeding $25,000 within the previous five-year period;

(d) I have not been convicted of or pled guilty or nolo contendere to any criminal violation specified in Chapter 458, F. S. or the medical practice act in any other state; and

(e) I have not been subject, within the past ten years of practice, to license revocation, suspension, or probation for a period of three years or longer, or a fine of $500 or more for a violation of Chapter 458, F. S., or the medical practice act of another jurisdiction. A regulatory agency's acceptance of a relinquishment of license, stipulation, consent order, or other settlement offered in response to or in anticipation of filing of administrative charges against a license is construed as action against a license. I understand if I am claiming an exception under this section that I must either post notice in a sign prominently displayed in my reception area or provide a written statement to any person to whom medical services are being provided that I have decided not to carry medical malpractice insurance. See Section 458.320(5)(f), Florida Statutes, for specific notice requirements.

☒10. I practice only in conjunction with my teaching duties at an accredited medical school or its teaching hospitals. (Interns and residents do not qualify for this exemption).

If you select an exemption based on number 9, you must also complete the affidavit on the following page.

11. FLORIDA BIRTH RELATED NEUROLOGICAL COMPENSATION ASSOCIATION

You must choose one of the three options described below. Please be sure to view the information about each exemption at www.nica.com. Check only one.

☐	☒	☐	$250
$5,000 Participating	$250 Non-participating	$0 Exempt	Amount enclosed

If you choose "$0 Exempt" provide appropriate documentation to the Board of Medicine and to NICA.

I have read the explanatory information provided by NICA, and I choose the option above.

Signature 5/20/2020 Date

ETTORE VULCANO
Name
2110 44th DRIVE Apt PHA
Street Address
LONG ISLAND CITY NY 11101
City, State, Zip

If you are a participating or non-participating physician, or a physician claiming exemption, you must complete, sign and date this form and return it with your payment to this address.

Board of Medicine
4052 Bald Cypress Way, #C-03
Tallahassee, FL 32399-3253

If you are a physician claiming exemption, you must also send a copy of your completed, signed, and dated form with proof of your exemption to:

NICA
2360 Christopher Place
Tallahassee, FL 32308

If you have any questions about NICA or this form, please contact NICA at www.nica.com or (850) 488-8191.

12. STATEMENT OF APPLICANT

I state that these statements are true and correct. I recognize that providing false information may result in denial of licensure, disciplinary action against my license, or criminal penalties pursuant to Sections 456.067, 775.083, and 775.084, Florida Statutes. I state that I have read Chapters 456, 458 and 766.301-.316, Florida Statutes and Chapter 64B8, Florida Administrative Code.

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Florida Board of Medicine information which is material to my application for licensure.

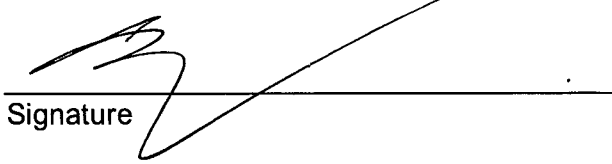
I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind. I state that my answers and all statements made by me herein are true and correct.

Should I furnish any false information in this application, I hereby agree that such act constitutes cause for denial, suspension, or revocation of my license to practice medicine in the State of Florida. If there are any changes to my status or any change that would affect any of my answers to this application I must notify the board within 30 days.

I understand that my records are protected under federal and state regulations governing Confidentiality of Mental Health Patient Records and cannot be disclosed without my written consent unless otherwise provided in the regulations. I understand that my records are protected under federal and state regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it.

ETTORE VULCANO

Print name



Signature

5/20/2020

Date

June 19, 2020

Ettore Vulcano, M.D.
2110 44th Drive
Apt- Pha
Long Island City, NY 11101

Dear Dr. Vulcano:
File: 126485

Thank you for considering Florida for physician licensure. Your application for medical licensure has been received. The application is incomplete for the reasons set out in the attached deficiency notice. Please address these deficiencies as soon as possible to avoid delay in processing your application.

Information received by this office may require additional explanation or documentation to determine licensure eligibility. After all requested documentation is received, your application will be submitted for supervisory review. We will notify you if additional information is required.

Applicants with a history of malpractice, criminal activity, discipline, physical or mental impairment, unfavorable evaluations, or other matters that need explanation may require a personal appearance before the Board of Medicine Credentials Committee for determination of licensure eligibility. If your appearance is required, you will be notified in writing once your application is complete.

You can now follow the progress of your application through our website at: www.FLHealthSource.gov/mqa-services. If you are a returning user, select “Yes” and enter the user ID and password you selected during the registration process under Returning User. If you did not apply for licensure through this screen, select “No” and follow the prompts to create an account. You must have a valid email address to create your account.

Once you are logged in, you will be prompted to add your application to your account. Once you have successfully added your application, you will be directed to your dashboard. Under the “Additional Activities” section, select “Check Application Status” to review any open deficiencies, upload documents or print out instructional documents.

THIS IS IMPORTANT: Your application will remain incomplete until all deficiencies are completed. In addition, you are required to notify the Board office immediately in writing of any occurrence(s) that would in any way change or affect any answer given in the application or an answer provided in response to any of our direct questions to you.

If you have any questions, please contact me at Vanessa.Valme@flhealth.gov, call 850-617-1918, or fax 850-412-1265.

Sincerely,

Vanessa Valme

Vanessa Valme
Regulatory Specialist II

Enclosure(s)

Ettore Vulcano, M.D **Date: June 19, 2020**

REMINDER: Chapter 456.013(1)(a), Florida Statutes, provides that an incomplete application shall expire one year after initial filing with the department.

YOUR APPLICATION'S EXPIRATION DATE IS **JUNE 9, 2021**

APPLICATION SUBMITTED REMAINS DEFICIENT FOR LACK OF THE FOLLOWING:

Chapter 458.311 Florida Statutes states that an international medical graduate must have completed an ACGME approved residency or fellowship program of at least two progressive years in one specialty area. However, to be acceptable, the fellowship experience and training must be counted toward regular or subspecialty certification by a board recognized and certified by the American Board of Medical Specialties. Provide proof that you meet this requirement.

An official verification of your medical license from the state of New York.

REGARDING THE INDICATED MALPRACTICE, please submit the following:

a. A statement indicating the date of each incident and the number for each case.

b. An explanation of details for reach case and your involvement for each case.

c. Submit a completed copy of the enclosed Exhibit 1 form.

d. Copy of complaint, judgements, and or settlements for each case.

Page 6 of the application was not submitted, completed and/or signed.

Enclosed is a financial responsibility form Please select one option.

Postgraduate training verification for 08/15-07/16.

If you have any questions, please contact me at Vanessa.Valme@flhealth.gov, call 850-617-1918, or fax 850-412-1265. The Florida Board of Medicine has assigned **126485** as your **tracking number**. Please indicate this number if you leave a message, and try to ensure that other sources include it on their communications to us as well.

Alls, Wendy

From: Ettore Vulcano <ettorevulcano@hotmail.com>
Sent: Sunday, August 16, 2020 6:04 PM
To: Alls, Wendy
Subject: no open investigation

Dear Ms. Alls,

this is to confirm that in regards to the pending malpractice case there is **no open investigation by any State board**.

Sincerely,

Ettore Vulcano, MD

Federation of STATE MEDICAL BOARDS

Federation Credentials Verification Service (FCVS)

400 Fuller Wiser Road, Suite 300, Euless, TX 76039
Tel: (817) 868-5000 Fax: (817) 868-5099

Verification of Graduate Medical Education

Institution: Mercy Medical Center

Attention: **FOOT & ANKLE ORTHOPAEDIC SURGERY**

Specialty: Orthopaedic Surgery/Foot and Ankle Orthopaedics

Affiliated University: _____

Address: Baltimore, MD

Verification For:

Name: Vulcano, Ettore

DOB: 03/22/1983

Individual's Name on Record (If different from above):_____

Program Participation:

Important:

Report Incomplete Training Levels (years) separate from those that were successfully completed.

If the training level (year) is currently in progress report the expected completion date in the "To" field.

Report Internships, Residencies and Fellowships separately.

Use one section per Department/Specialty. If the Department/Specialty is rotating or transitional, please provide a schedule of rotations.

Training Level: 6 (e.g., 1, 2, 3, etc.)
☐ Internship ☐ Residency ☐ Chief Residency ☒ Fellowship ☐ Research

Specialty/Subspecialty: ORTHOPAEDIC FOOT + ANKLE

From: 8/1/2014 **To:** 7/31/2015

Successfully Completed?: ☑ Yes ☐ No ☐ In Progress

Accredited by: ☑ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Training Level: _____ (e.g., 1, 2, 3, etc.)
☐ Internship ☐ Residency ☐ Chief Residency ☐ Fellowship ☐ Research

Specialty/Subspecialty: _____

From: / / **To:** / /

Successfully Completed?: ☐ Yes ☐ No ☐ In Progress

Accredited by: ☐ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Training Level: _____ (e.g., 1, 2, 3, etc.)
☐ Internship ☐ Residency ☐ Chief Residency ☐ Fellowship ☐ Research

Specialty/Subspecialty: _____

From: / / **To:** / /

Successfully Completed?: ☐ Yes ☐ No ☐ In Progress

Accredited by: ☐ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Unusual Circumstances:

Check the correct response. Omitted responses require written explanation.

If necessary, you may continue your explanation on a separate sheet of paper.

1. Did this individual ever take a leave of absence or break from his/her training? ☐ Yes ☒ No
2. Was this individual ever placed on probation? ☐ Yes ☒ No
3. Was this individual ever disciplined or placed under investigation? ☐ Yes ☒ No
4. Were any negative reports for behavioral reasons ever filed by instructors? ☐ Yes ☒ No
5. Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason? ☐ Yes ☒ No

Please explain any "Yes" response from above:

_____

_____

Certification:

Affix your institutional seal in this space. If no seal is available, you must have this form notarized.

Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct. The signature line must contain the original signature, or the electronic typed signature, of the program director **(M.D./D.O. only).**

Name: Clifford Jeng, M.D.

Signature:

Title of Signatory: Fellowship Director (e.g., Program Director)

Date of Signature: 11/11/15

Tel: _____ Fax: _____ E-Mail: _____

ELECTRONIC SEAL VERIFIED

HOSPITAL FOR SPECIAL SURGERY
NEW YORK-PRESBYTERIAN HOSPITAL
WEILL CORNELL MEDICAL COLLEGE

CERTIFIES THAT

Ettore Vulcano, M.D.

SERVED AS A

Fellow on the Limb Lengthening and Complex Reconstruction Service

from August 1, 2015 to July 31, 2016
AND PERFORMED ALL ASSIGNED DUTIES AND
RESPONSIBILITIES WITH ABILITY AND CREDIT TO HIMSELF
AND TO THE SATISFACTION OF THE UNDERSIGNED

Chair
Board of Trustees

Surgeon-in-Chief
Korein-Wilson Professor of Orthopaedic Surgery

President and Chief Executive Officer

Chief of Service

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Federation of STATE MEDICAL BOARDS

Federation Credentials Verification Service (FCVS)

400 Fuller Wiser Road, Suite 300, Euless, TX 76039
Tel: (817) 868-5000 Fax: (817) 868-5099

Verification of Graduate Medical Education

Institution: Hospital for Special Surgery

Attention: **Program Director**

Specialty: Orthopedic Surgery/Limb Lengthening and Reconstruction

Affiliated University: **Weill Cornell Medical College**

Verification For:

Name: Vulcano, Ettore

DOB: 03/22/1983

Individual's Name on Record (If different from above):_____

Program Participation:

Important:

Report Incomplete Training Levels (years) separate from those that were successfully completed.

If the training level (year) is currently in progress report the expected completion date in the "To" field.

Report Internships, Residencies and Fellowships separately.

Use one section per Department/Specialty. If the Department/Specialty is rotating or transitional, please provide a schedule of rotations.

Training Level: 6 (e.g., 1, 2, 3, etc.)
☐Internship ☐Residency ☐Chief Residency ☒Fellowship ☐Research

Specialty/Subspecialty: Orthopaedic Surgery / Limb Lengthening & Complex Reconstruction

From: 08/01/2015 **To:** 07/31/2016

Successfully Completed?: ☐Yes ☐No ☒In Progress

Accredited by: ☐ACGME ☐AOA ☐LCGME ☐RSC ☐CFPC ☐RCPSC ☐APPAP ☒None of these

Training Level: _____ (e.g., 1, 2, 3, etc.)
☐Internship ☐Residency ☐Chief Residency ☐Fellowship ☐Research

Specialty/Subspecialty: _____

From: / / **To:** / /

Successfully Completed?: ☐Yes ☐No ☐In Progress

Accredited by: ☐ACGME ☐AOA ☐LCGME ☐RSC ☐CFPC ☐RCPSC ☐APPAP ☐None of these

Training Level: _____ (e.g., 1, 2, 3, etc.)
☐Internship ☐Residency ☐Chief Residency ☐Fellowship ☐Research

Specialty/Subspecialty: _____

From: / / **To:** / /

Successfully Completed?: ☐Yes ☐No ☐In Progress

Accredited by: ☐ACGME ☐AOA ☐LCGME ☐RSC ☐CFPC ☐RCPSC ☐APPAP ☐None of these

Unusual Circumstances:

Check the correct response. Omitted responses require written explanation.

If necessary, you may continue your explanation on a separate sheet of paper.

1. Did this individual ever take a leave of absence or break from his/her training? ☐Yes ☑No
2. Was this individual ever placed on probation? ☐Yes ☑No
3. Was this individual ever disciplined or placed under investigation? ☐Yes ☑No
4. Were any negative reports for behavioral reasons ever filed by instructors? ☐Yes ☑No
5. Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason? ☐Yes ☑No

Please explain any "Yes" response from above:

_____

_____

Certification:

Affix your institutional seal in this space. If no seal is available, you must have this form notarized.

Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct. The signature line must contain the original signature, or the electronic typed signature, of the program director **(M.D./D.O. only)**.

Name: Austin Fragomen, MD

Signature: _____

Title of Signatory: Program Director (e.g., Program Director)

Date of Signature: 11/10/15

Tel: 212-606-1466 Fax: 212-606-1477 E-Mail: academictraining@hss.edu

ELECTRONIC SEAL VERIFIED

AMERICAN BOARD OF ORTHOPAEDIC SURGERY, INC.

Member Board of the American Board of Medical Specialties

400 SILVER CEDAR COURT
CHAPEL HILL, NORTH CAROLINA 27514

PHONE: 919/929-7103
FAX: 919/942-8988
www.abos.org

2013 - 2014

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December 10, 2014

Ms. Kathleen Kaufman
EVSP-ECFMG
3624 Market Street, 4th Floor
Philadelphia, Pennsylvania 19104-2685

Dear Ms. Kaufman:

The American Board of Orthopaedic Surgery (ABOS) has been asked to provide a letter to the ECFMG regarding a one year, nonstandard orthopaedic limb lengthening and complex reconstruction fellowship at the Hospital for Special Surgery in New York City beginning August 1, 2015, with an orientation from July 27-31, 2015, for fellowship candidate Dr. Ettore Vulcano of Italy.

The American Board of Orthopaedic Surgery confirms that limb lengthening and complex reconstruction is a recognized subspecialty of orthopaedic surgery.

The fellowship program has provided to us the program description, the rotation schedule, an executed GMEC verification statement, and a copy of the candidate's CV.

If you have any questions or concerns about this matter, please contact me directly.

Sincerely yours,

Shepard R. Hurwitz, MD
Executive Director

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Coral Springs, Florida

Vacant, M.D.

Executive Director
Claudia Kemp, J.D.

September 7, 2020

Tonya L. Corbin, MD
22614 King Richard Ct.
Beverly Hills, MI 48025

Dear Dr. Corbin

This is in further reference to your application for licensure by examination.

Please be advised that you are required to make a personal appearance before the Credentials Committee of the Board of Medicine to discuss:

- Failure to meet section 458.311(1)(h), Florida Statutes, examination

In addition, the Committee may inquire into any other issues relating to your application and eligibility for licensure.

Date:	Thursday, October 1, 2020
Time:	8:00 a.m. (Meeting starts at 8:00 a.m. Interview time may vary.)
Location:	The in-person meeting scheduled in Orlando, Florida is cancelled, and the meeting will be held by a web-based meeting platform or, if appropriate, a teleconference call.

The meeting information and directions for participating in the October 2020 meeting will be posted on the Florida Board of Medicine's website: https://flboardofmedicine.gov/meeting-information.

Additionally, the Committee's recommendation on your application for licensure will be presented to the full Board of Medicine on Friday, October 2, 2020 for final action. You are not required to attend the full board meeting.

Thank you for your continued cooperation. Should you have any questions regarding this matter, please feel free to contact me. *This is your first scheduled appearance.

Sincerely,

Karrell D. Goldwire

Karrell D. Goldwire
Regulatory Supervisor

Pursuant to the provisions of the Americans with Disabilities Act, any person requiring special accommodations to participate in this workshop/meeting is asked to advise the agency at least 10 days before the workshop/meeting by contacting: Rebecca.Hewett@flhealth.gov or call (850) 245-4137.

*** 456.013(3)(c) In considering applications for licensure, the board, or the department when there is no board, may require a personal appearance of the applicant. If the applicant is required to appear, the time period in which a licensure application must be granted or denied shall be tolled until such time as the applicant appears. However, if the applicant fails to appear before the board at either of the next two regularly scheduled board meetings, or fails to appear before the department within 30 days if there is no board, the application for licensure shall be denied.**

Application

Application Detail	
License Type:	**Medical Doctor**
Profession Number:	**1501 - Medical Doctor**
File Number:	**147442**
Application:	**Medical Doctor Endorsement Application**
Application Date:	**02/17/2020**
Suitability Question(s)	
Are you an osteopathic physician?	**No**
Application Questions	
Military Veteran Fee Waiver - I have been honorably discharged from a branch of the United States Armed Forces within the previous 60 months.	**No**
I am selecting NICA Non-Participating - (I understand that a $250.00 fee will be included if I select this option.)	**No**
I will qualify for "In Training" status at the approval of my licensure application.	**No**
I plan to dispense medicinal drugs in the State of Florida for a fee or other remuneration and hereby register as required by Section 465.0276,F.S. I understand that the fee for the Dispensing Practitioner is $100.00 over and above the required initial license fee and will submit it along with the license fee.	**No**
Military Veteran Spouse Fee Waiver - I am the spouse of a military veteran who has been honorably discharged from a branch of the United States Armed Forces within the previous 60 months.	**No**

License Attributes Selected	
Qualification	NICA Exempt

Federal Credentials Verification Services (FCVS)	
Are you using the FCVS to verify your core credentials?	No

Education History 1	
School Name:	Michigan State University College of Human Medicine
Street Address Line 1:	965 Fee Rd
Street Address Line 2:	N/A
City:	East Lansing
State:	MICHIGAN
Postal/Zip:	48224
Country:	UNITED STATES OF AMERICA
Date of Graduation (mm/dd/yyyy):	06/01/1992
Attended From (mm/dd/yyyy):	08/01/1988
Attended To (mm/dd/yyyy):	06/01/1989

Education History 2	
School Name:	Wayne State University School of Medicine
Street Address Line 1:	540 E. Canfield Ave
Street Address Line 2:	N/A
City:	Detroit
State:	MICHIGAN
Postal/Zip:	48201
Country:	UNITED STATES OF AMERICA
Date of Graduation (mm/dd/yyyy):	06/20/1992
Attended From (mm/dd/yyyy):	08/08/1989
Attended To (mm/dd/yyyy):	06/01/1992

Additional Education Questions	
Are you currently in default on any health education loan or scholarship obligation?	No

Have you completed the equivalent of 2 academic years of preprofessional, postsecondary education including, courses in anatomy, biology, and chemistry prior to entering medical school?	**Yes**

Fifth Pathway

Did you attend an international medical school and do not possess a valid ECFMG Certificate?	**No**
Did you receive a bachelor's degree from an accredited United States college or University?	**Yes**
Did you study at a medical school which is recognized by the World Health Organization?	**Yes**
Did you complete all of the formal requirement of the International medical school, except the internship or social service requirements, and pass part I of the National board of Medical examination or the Education Commission for Foreign Medical Graduates Examination equivalent?	**No**
Did you complete an academic year of supervised clinical training in a hospital affiliated with a medical school approved by the Council on Medical Education of the American Medical Association and upon completion passed part II of the National Board of Medical Examiners examination or the Education Commission for Foreign Medical Graduates examination Equivalent?	**No**

Postgraduate Training 1

Program Name:	**Internal Medicine Program/Detroit Medical Center**
Mailing Address:	**Graduate Medical Education Office** **Scott Hall Room 4374** **540 E. Canfield** **Detroit, MI 48201** **Phone: 313-577-0714**
Program City:	**Detroit**
Program State or Country:	**MICHIGAN**
Program Type:	**RESIDENCY**
Specialty Area:	**IM - INTERNAL MEDICINE**
Attended From (mm/dd/yyyy):	**07/01/1992**
Attended To (mm/dd/yyyy):	**06/30/1995**
Did you receive credit?	**Yes**

Postgraduate Training 2

Program Name:	**Henry Ford Health System**

Mailing Address:	**Office of Graduate Medical Education Department of Medical Education Henry Ford Hospital 2799 West Grand Boulevard Detroit, Michigan 48202-9888. Phone: (313) 916-1601 Email: GME@hfhs.org.**
Program City:	**Detroit**
Program State or Country:	**MICHIGAN**
Program Type:	**FELLOWSHIP**
Specialty Area:	**AI - ALLERGY AND IMMUNOLOGY**
Attended From (mm/dd/yyyy):	**08/01/1995**
Attended To (mm/dd/yyyy):	**08/01/1997**
Did you receive credit?	**Yes**

Exam History

Examination:	**USMLE/FOREIGN**
Date Passed (mm/dd/yyyy):	**N/A**

United States Military and/or Public Health

Have you ever been in the United States Military and/or Public Health Service?	**No**
Have you ever been disciplined by any branch of the United States Armed Services or Public Health Service?	**No**

Practice Employment 1

Place of Employment:	**AstraZeneca Pharmaceutical**
Address Line 1:	**1800 Concord Pike**
Address Line 2:	**N/A**
City:	**Wilmington**
State:	**DE**
Type of Employment:	**SR Medical Scientific Liaison**
Begin Date (mm/dd/yyyy):	**05/14/2018**
End Date (mm/dd/yyyy):	**01/02/2020**

If 'to present', enter today's date.

Practice Employment 2

Place of Employment:	**Lilly Pharmaceutical**
Address Line 1:	**Lilly USA 1500 South Harding S**
Address Line 2:	**N/A**

City:	**Indianapolis**
State:	**MI**
Type of Employment:	**Medical Scientific Liaison**
Begin Date (mm/dd/yyyy):	**09/08/2008**
End Date (mm/dd/yyyy):	**12/31/2017**

If 'to present', enter today's date.

Other State Licenses

Do you now hold or have you ever held a license to practice medicine or any other profession in any US State or territory, or foreign country?	**Yes**

Request verification of licensure status directly from the licensing entity or www.veridoc.org. Request international license verification(s) if you have practiced outside of the U.S. for at least two of the previous four years.

License Number:	**4351038024**
Profession:	**Medical Training License**
Jurisdiction - Country:	**UNITED STATES**
Jurisdiction - State:	**MICHIGAN**

Additional Employment Questions

Have you practiced medicine in any jurisdiction for two of the last four years or completed a board approved post-graduate training program within the last two years?	**No**
Have you passed a board approved clinical competency exam within the last year?	**No**

Graduate Education

Do you currently, or have you had, responsibility for graduate medical education within the last 10 years?	**Yes**

Initial Graduate Medical Education Responsibility and Faculty Appointments

List all institutions where you have had responsibility for graduate medical education or faculty appointment(s) at any medical school.

Name of Institution:	**WAYNE STATE UNIVERSITY SCHOOL OF MEDICIN**

Staff Privileges

Do you currently hold staff privileges in any hospital, health institution, clinic or medical facility?	**No**

Specialty Board Certifications

Are you certified by any specialty board recognized by the American Board of Medical Specialties or specialty board approved by the Florida Board of Medicine?	**No**

DEA

Have you ever been denied, or surrendered, a DEA registration?	**No**

Criminal History

Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to, a crime in any jurisdiction other than a minor traffic offense?	**No**

You must include all misdemeanors and felonies, even if adjudication was withheld. Driving under the influence (DUI) or driving while impaired (DWI) are not minor traffic offenses for purposes of this question.

Medicaid / Medicare

1. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, F.S. (relating to social and economic assistance), Chapter 817, F.S. (relating to fraudulent practices), Chapter 893, F.S. (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction?	**No**
2. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970 (relating to controlled substances) or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)?	**No**
3. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, F.S.?	**No**
4. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program?	**No**
5. Are you currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities?	**No**

Health History

In the last five years, have you been enrolled in, required to enter into, or participated in any drug and/or alcohol recovery program or impaired practitioner program for treatment of drug or alcohol abuse that occurred within the past five years?	**No**

In the last five years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental disorder or impairment?	**No**
During the last five years, have you been treated for or had a recurrence of a diagnosed mental disorder that has impaired your ability to practice medicine within the past five years?	**No**
During the last five years, have you been treated for or had a recurrence of a diagnosed physical disorder that has impaired your ability to practice medicine?	**No**
In the last five years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol/drug) disorder or, if you were previously in such a program, did you suffer a relapse within the last five years?	**No**
During the last five years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol/drug) disorder that impaired your ability to practice medicine within the last five years?	**No**

Electronic Fingerprinting

I have been provided and read the statement from the Florida Department of Law Enforcement regarding the sharing, retention, privacy and right to challenge incorrect criminal history records and the 'Privacy Statement' document from the Federal Bureau of Investigation.	**Yes**
Enter in today's date	**01/16/2020**

Medical Malpractice Question

Have you ever had a judgment entered against you for medical malpractice where the incident(s) of malpractice occurred after November 2, 2004?	**No**

Liability Claims

Within the last 10 years have you had any liability claim(s) or action(s) for damages for personal injury settled or finally adjudicated in an amount that exceeds $100,000.00?	**No**

Financial Responsibility/Exemption

Financial Responsibility	**5. NOT TO CARRY MEDICAL MALPRACTICE**

FDA Institution

Have you ever had any staff privileges denied, suspended, revoked, modified, restricted, not renewed or placed on probation, or have you been asked to resign or take a temporary leave of absence or were otherwise acted against by any facility?	**No**

FDA Licensing

Have you ever had any professional license or license to practice medicine revoked, suspended, placed on probation, or other disciplinary action taken in any state, territory or country?	**No**

FDANP Denied

Have you had any application for a medical license or professional license denied by any state board or other governmental agency of any state, territory, or country?	**No**

FDANP Investigation

Are you currently under investigation in any jurisdiction for an act or offense that would constitute a violation of Section 458.331, Florida Statutes?	**No**

Specialty Board Discipline History

Have you ever had any final disciplinary action taken against you by a specialty board or other similar national organization?	**No**

Year Began Practice

Year Began Practice:	**07/01/1992**

Availability for Disaster

Are you willing to provide health care services in special need shelters or to work with disaster medical teams during times of emergency or major disasters?	**Yes**

Attachments

Document Type: Letters of Reference File Name: Reference-Letter of Support Dr. Sharp.jpg

Document Type: Education Documents File Name: Wayne state.jpg

Document Type: Education Documents File Name: Residency.jpg

Document Type: Education Documents File Name: Fellowship.jpg

Document Type: Initial Application Supporting Documentation File Name: Florida medical Board Letter of Support.docx

Fees

NICA Fee -	**$-250.00**
Application	**$350.00**
Unlicensed Activity	**$5.00**
Initial License	**$350.00**
NICA Fee	**$250.00**
Total Amount Due:	**$705.00**

Attestation

I state that these statements are true and correct. I recognize that providing false information may result in denial of licensure, disciplinary action against my license, or criminal penalties pursuant to Sections 456.067, 775.083, and 775.084, Florida Statutes. I state that I have read Chapters 456, 458 and 766.301-.316, Florida Statutes and Chapter 64B8, Florida Administrative Code.

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Florida Board of Medicine information which is material to my application for licensure.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind. I state that my answers and all statements made by me herein are true and correct.

Should I furnish any false information in this application, I hereby agree that such act constitutes cause for denial, suspension, or revocation of my license to practice Medicine in the State of Florida. If there are any changes to my status or any change that would affect any of my answers to this application I must notify the board within 30 days.

I understand that my records are protected under federal and state regulations governing Confidentiality of Mental Health Patient Records and cannot be disclosed without my written consent unless otherwise provided in the regulations. I understand that my records are protected under federal and state regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it.

Attestation Answer: Yes

February 19, 2020

Dr Tonya L. Corbin , M.D.
22614 King Richard Ct.
Beverly Hills, MI 48025

Dear Dr. Corbin:
File: 147442

Thank you for considering Florida for physician licensure. Your application for medical licensure has been received. The application is incomplete for the reasons set out in the attached deficiency notice. Please address these deficiencies as soon as possible to avoid delay in processing your application.

Information received by this office may require additional explanation or documentation to determine licensure eligibility. After all requested documentation is received, your application will be submitted for supervisory review. We will notify you if additional information is required.

Applicants with a history of malpractice, criminal activity, discipline, physical or mental impairment, unfavorable evaluations, or other matters that need explanation may require a personal appearance before the Board of Medicine Credentials Committee for determination of licensure eligibility. If your appearance is required, you will be notified in writing once your application is complete.

You can now follow the progress of your application through our website at: www.FLHealthSource.gov/mqa-services. If you are a returning user, select "Yes" and enter the user ID and password you selected during the registration process under Returning User. If you did not apply for licensure through this screen, select "No" and follow the prompts to create an account. You must have a valid email address to create your account.

Once you are logged in, you will be prompted to add your application to your account. Once you have successfully added your application, you will be directed to your dashboard. Under the "Additional Activities" section, select "Check Application Status" to review any open deficiencies, upload documents or print out instructional documents.

THIS IS IMPORTANT: Your application will remain incomplete until all deficiencies are completed. In addition, you are required to notify the Board office immediately in writing of any occurrence(s) that would in any way change or affect any answer given in the application or an answer provided in response to any of our direct questions to you.

If you have any questions, please contact me at latayvia.alexander@flhealth.gov, call 850-901-6842, or fax (850) 412-1270.

Sincerely,

LRA

Latayvia Alexander

Dr. Tonya L. Corbin **Date: February 19, 2020**

REMINDER: Chapter 456.013(1)(a), Florida Statutes, provides that an incomplete application shall expire one year after initial filing with the department.

YOUR APPLICATION'S EXPIRATION DATE IS: **February 16, 2021**

APPLICATION SUBMITTED REMAINS DEFICIENT FOR LACK OF THE FOLLOWING:

- An official verification of your medical license from the state of Michigan has not been received
- The employment/non-employment section of your application was not completed. Submit your employment/non-employment activities to our office for 08/02/97-09/07/08, 01/01/18-05/13/18, and 01/03/20-present in MM/YYYY format no gaps.
- The inquiry you mailed to your medical school has not been received.
- Your Postgraduate Training Verification Forms from Detroit Medical Center 07/01/92-06/30/95 and Henry Ford Health System 08/01/95-08/01/97 have not been received.
- Please submit the National Practitioner Data Bank (NPDB) report to our office. You may contact the NPDB at 1-800-767-6732 to obtain this information.
- We await your USMLE exam scores, directly from the Federation of State Medical Boards, which must be requested by the applicant.
- Pursuant to Section 458.311, F.S., any person desiring to be licensed as a physician, who does not hold a valid license in any state, shall apply by examination. According to your application, you hold a training license in Michigan. Please clarify.

If you have any questions, please contact me at latayvia.alexander@flhealth.gov, or fax (850) 412-1270. The Florida Board of Medicine has assigned **147442** as your **tracking number**. Please indicate this number if you leave a message, and try to ensure that other sources include it on their communications to us as well.

Dr. Tonya L. Corbin **Date: February 26, 2020**

REMINDER: Chapter 456.013(1)(a), Florida Statutes, provides that an incomplete application shall expire one year after initial filing with the department.

YOUR APPLICATION'S EXPIRATION DATE IS: **February 16, 2021**

APPLICATION SUBMITTED REMAINS DEFICIENT FOR LACK OF THE FOLLOWING:

- The employment/non-employment section of your application was not completed. Submit your employment/non-employment activities to our office for 01/01/18-05/13/18, and 01/03/20-present in MM/YYYY format no gaps.
- Your Postgraduate Training Verification Forms from Henry Ford Health System 08/01/95-08/01/97 have not been received.
- Please submit the National Practitioner Data Bank (NPDB) report to our office. You may contact the NPDB at 1-800-767-6732 to obtain this information.
- We await your USMLE exam scores, directly from the Federation of State Medical Boards, which must be requested by the applicant.
- Pursuant to Section 458.311, F.S., any person desiring to be licensed as a physician, who does not hold a valid license in any state, shall apply by examination. According to your application, you hold a training license in Michigan. Please clarify.

If you have any questions, please contact me at latayvia.alexander@flhealth.gov, or fax (850) 412-1270. The Florida Board of Medicine has assigned **147442** as your **tracking number**. Please indicate this number if you leave a message, and try to ensure that other sources include it on their communications to us as well.

April 8, 2020

Dr. Tonya L. Corbin, M.D.
22614 King Richard Ct.
Beverly Hills, MI 48025

Dear Dr. Corbin:
File: 147442

Thank you for considering Florida for physician licensure. Your application for medical licensure has been received. The application is incomplete for the reasons set out in the attached deficiency notice. Please address these deficiencies as soon as possible to avoid delay in processing your application.

Information received by this office may require additional explanation or documentation to determine licensure eligibility. After all requested documentation is received, your application will be submitted for supervisory review. We will notify you if additional information is required.

Applicants with a history of malpractice, criminal activity, discipline, physical or mental impairment, unfavorable evaluations, or other matters that need explanation may require a personal appearance before the Board of Medicine Credentials Committee for determination of licensure eligibility. If your appearance is required, you will be notified in writing once your application is complete.

You can now follow the progress of your application through our website at: www.FLHealthSource.gov/mqa-services. If you are a returning user, select "Yes" and enter the user ID and password you selected during the registration process under Returning User. If you did not apply for licensure through this screen, select "No" and follow the prompts to create an account. You must have a valid email address to create your account.

Once you are logged in, you will be prompted to add your application to your account. Once you have successfully added your application, you will be directed to your dashboard. Under the "Additional Activities" section, select "Check Application Status" to review any open deficiencies, upload documents or print out instructional documents.

THIS IS IMPORTANT: Your application will remain incomplete until all deficiencies are completed. In addition, you are required to notify the Board office immediately in writing of any occurrence(s) that would in any way change or affect any answer given in the application or an answer provided in response to any of our direct questions to you.

If you have any questions, please contact me at latayvia.alexander@flhealth.gov, call 850-901-6842, or fax (850) 412-1270.

Sincerely,

LRA

Latayvia Alexander

Enclosure(s)

Dr. Tonya L. Corbin **Date: April 8, 2020**

REMINDER: Chapter 456.013(1)(a), Florida Statutes, provides that an incomplete application shall expire one year after initial filing with the department.

YOUR APPLICATION'S EXPIRATION DATE IS: **February 16, 2021**

APPLICATION SUBMITTED REMAINS DEFICIENT FOR LACK OF THE FOLLOWING:

- Insufficient money received. A payment of $250 is due. Please note that your application will not be reviewed until payment has been received. Mail payments to:
  Department of Health
  P.O. Box 6330
  Tallahassee, FL 32314-6330

- Job title at AstraZeneca Pharmaceutical from 05/2018 to 01/2020 and at Lilly Pharmaceutical from 09/2008 to 12/2017.

- Submit a statement explaining how you were able to practice at AstraZeneca Pharmaceutical without a Delaware license and at Lilly Pharmaceutical without a Michigan license.

- We have not received your Livescan results. If you have already had your electronic fingerprinting completed, please allow 24-72 hours for receipt of your results. You can find more information on this process, including how to find a provider in your area and your ORI number, by visiting the Background Screening Website at http://www.flhealthsource.gov/background-screening/. Should your Criminal Background Check disclose an arrest record(s), you will need to provide documentation related to each criminal event revealed in your background, if you have not already done so. You can find a detailed description of documents that will be required by visiting the FAQs on the Background Screening Website (Click on 'General FAQs'). Note: Criminal History will be reviewed by the Background Screening Unit, not the Board Office. Please email all criminal history documents to mqa.backgroundscreen@flhealth.gov. Any original certified documents must be mailed to the following address: Attn: Background Screening Unit Florida Department of Health 4052 Bald Cypress

Way, Bin BSU-01 Tallahassee, FL, 32399

If you have any questions, please contact me at latayvia.alexander@flhealth.gov, call 850-901-6842, or fax (850) 412-1270. The Florida Board of Medicine has assigned **147442** as your **tracking number**. Please indicate this number if you leave a message, and try to ensure that other sources include it on their communications to us as well.

Alexander, Latayvia R

From: Tonya Corbin <tonyalcorbin@msn.com>
Sent: Friday, February 28, 2020 2:08 PM
To: Alexander, Latayvia R
Subject: RE: File | 147442
Attachments: TLC-CV-2020-FB.docx

Good Afternoon Latayvia,

As a Follow up- to Florida License Inquiries

The employment/non-employment section of your application was not completed. Submit your employment/non-employment activities to our office for 01/01/18-05/13/18, and 01/03/20-present in MM/YYYY format no gaps. I will complete today and submit my CV as well

12-31-17 Retired from Lilly Pharmaceutical
Medical Scientific Liaison

12-10-18–5-13-18 Full-time Preceptorship
Dr. William Sharp
Internal Medicine
Providence, Providence Park Hospital
Reference Letter Provided in Initial Application Attachment

1-03-20 -Current Current Employer – AstraZeneca Pharmaceutical Company
Senior Medical Scientific Liaison

I will contact the USMLE Boards to send copies of past examination:

Kind Regards,
Tonya

From: Alexander, Latayvia R <Latayvia.Alexander@flhealth.gov>
Sent: Friday, February 28, 2020 10:41 AM
To: Tonya Corbin <tonyalcorbin@msn.com>
Subject: RE: File | 147442

Received.

From: Tonya Corbin <tonyalcorbin@msn.com>
Sent: Wednesday, February 26, 2020 12:03 PM
To: Alexander, Latayvia R <Latayvia.Alexander@flhealth.gov>
Subject: Re: File | 147442

Good Afternoon Latayvia,
As a follow up to the attachments below;

The employment/non-employment section of your application was not completed. Submit your employment/non-employment activities to our office for 01/01/18-05/13/18, and 01/03/20-present in MM/YYYY format no gaps. I will complete today and submit my CV as well

· Your Postgraduate Training Verification Forms from Henry Ford Health System 08/01/95-08/01/97 have not been received. I will request the Graduate office to resubmit by fax.

· Please submit the National Practitioner Data Bank (NPDB) report to our office. You may contact the NPDB at 1-800-767-6732 to obtain this information. I will complete today

· We await your USMLE exam scores, directly from the Federation of State Medical Boards, which must be requested by the applicant. I will request today

· Pursuant to Section 458.311, F.S., any person desiring to be licensed as a physician, who does not hold a valid license in any state, shall apply by examination. According to your application, you hold a training license in Michigan. Please clarify. I had a training license years 1992-1997 during my Internal Medicine Residency - Detroit Medical Center and During My Allergy and Immunology Fellowship Program - Henry Ford Health System.

Additionally,

I would like to request my Florida Board Licensing and regulation application to be **changed to License by Examination.**

Tonya L. Corbin

"iPhone. iTypos. iApologize."

From: Alexander, Latayvia R <Latayvia.Alexander@flhealth.gov>
Sent: Wednesday, February 26, 2020 11:46 AM
To: tonyalcorbin@msn.com <tonyalcorbin@msn.com>
Subject: File | 147442

Good morning,

See attachments.

Thanks,

LaTayvia R. Alexander, Regulatory Specialist II
Department of Health | Division of Medical Quality Assurance

Bureau of Health Care Practitioner Regulation | Board of Medicine
4052 Bald Cypress Way Bin C03
Tallahassee, FL 32399-1708
Phone 850-901-6842

Department's Mission: To protect, promote and improve the health of all people in Florida through integrated state, county and community efforts.
Department's Vision: To be the Healthiest State in the nation.
Department's Purpose: To protect the public through health care licensure, enforcement and information.
Department's Focus: To be the nation's leader in quality health care regulation.

Department's Values: (ICARE)
I nnovation: We search for creative solutions and manage resources wisely.
C ollaboration: We use teamwork to achieve common goals and solve problems.
A ccountability: We perform with integrity and respect.
R esponsiveness: We achieve our mission by serving our customers and engaging our partners.
E xcellence: We promote quality outcomes through learning and continuous performance improvement.

Florida has a very broad public records law. Most written communications to or from state officials regarding state business are public records available to the public and media upon request. Your e-mail communications may therefore be subject to public disclosure.
There have been changes to the license renewal process. Please visit www.flhealthsource.gov to learn more. For questions, contact the Florida Department of Health at (850) 410-3344 or by email at MQAReportCE@flhealth.gov.
How am I communicating? Please feel free to contact my supervisor at Karrell.Goldwire@flhealth.gov

From: Tonya Corbin
To: Alexander, Latayvia R
Subject: RE: Verification Form
Date: Thursday, April 9, 2020 6:09:23 AM
Attachments: Role of Medical Science Liaison.docx

Hi Ms. Alexander,

In response to one of the deficiencies listed below:

APPLICATION SUBMITTED REMAINS DEFICIENT FOR LACK OF THE FOLLOWING:

- Job title at AstraZeneca Pharmaceutical from 05/2018 to 01/2020 and at Lilly Pharmaceutical from 09/2008 to 12/2017.

- Submit a statement explaining how you were able to practice at AstraZeneca Pharmaceutical without a Delaware license and at Lilly Pharmaceutical without a Michigan license.

I have attached a detail explanation of the Role as a Science Medical Liaison:
These roles do not involve patient interaction or patient care. As a Medical Science Liaison responsibility you are trained to provide medical information on the product disease state and on the therapeutic product by the pharmaceutical company. Upon completion of an intense training, Science Medical Liaisons at the request of the Health Care Providers meet and interact only with Health Care Providers (Physicians, Physicians Assistants, Nurse Practitioners and Pharmacist) to reactively to answer any medical question pertaining the drugs disease stated and the pharmaceutical (AstraZeneca or Lilly) product.

The Medical Science Liaison role does not require a license. One has to educational training and graduated from Medical School, Pharmacy School and Physician Assistant US Programs.

Please let me know if this is sufficient in complete the deficiency stated upon. If any additional information is need please do not hesitate to inform me.

Kind Regards,
Tonya L. Corbin
2485337289

From: Alexander, Latayvia R <Latayvia.Alexander@flhealth.gov>
Sent: Wednesday, April 08, 2020 10:59 AM
To: Tonya Corbin <tonyalcorbin@msn.com>
Subject: RE: Verification Form
Importance: High

Good morning,

Thank you for your email. See attachments.

Thanks,

LaTayvia R. Alexander, Regulatory Specialist II
Department of Health | Division of Medical Quality Assurance
Bureau of Health Care Practitioner Regulation | Board of Medicine
4052 Bald Cypress Way Bin C03
Tallahassee, FL 32399-1708
Phone 850-901-6842

Department's Mission: To protect, promote and improve the health of all people in Florida through integrated state, county and community efforts.
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Department's Focus: To be the nation's leader in quality health care regulation.

Department's Values: (ICARE)
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How am I communicating? Please feel free to contact my supervisor at Karrell.Goldwire@flhealth.gov

From: Tonya Corbin <tonyalcorbin@msn.com>
Sent: Monday, March 30, 2020 2:29 PM
To: Alexander, Latayvia R <Latayvia.Alexander@flhealth.gov>
Subject: Re: Verification Form

Good Afternoon Latayvia,
I wanted to follow up and make sure all my paperwork is completed before April 1.

Kind Regards,
Tonya Corbin

Sent from my iPhone

On Feb 28, 2020, at 2:52 PM, Alexander, Latayvia R <Latayvia.Alexander@flhealth.gov> wrote:

Received.

Thanks,

LaTayvia R. Alexander, Regulatory Specialist II
Department of Health | Division of Medical Quality Assurance
Bureau of Health Care Practitioner Regulation | Board of Medicine
4052 Bald Cypress Way Bin C03
Tallahassee, FL 32399-1708
Phone 850-901-6842

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How am I communicating? Please feel free to contact my supervisor at Karrell.Goldwire@flhealth.gov

From: Miller, Emilie I. <emiller5@hfhs.org>
Sent: Friday, February 28, 2020 2:52 PM
To: Alexander, Latayvia R <Latayvia.Alexander@flhealth.gov>
Cc: Nageotte, Christian <CNAGEOT1@hfhs.org>; tonyalcorbin@msn.com
Subject: Verification Form

Good Afternoon,

Please see attached the verification form submitted 2/12/20 by Dr. Nageotte. Please let us know if you need anything else.

Thank you,

Emilie Miller
Medical Educati/on Coordinator I
Allergy, Endocrinology, Rheumatology, & Sleep Medicine
Henry Ford Health System

P: 313-916-4988
F:313-916-8065
3031 W. Grand Blvd., 8th Floor
Detroit, MI 48202
<image001.png>

CONFIDENTIALITY NOTICE: This email contains information from the sender that may be CONFIDENTIAL, LEGALLY PRIVILEGED, PROPRIETARY or otherwise protected from disclosure. This email is intended for use only by the person or entity to whom it is addressed. If you are not the intended recipient, any use, disclosure, copying, distribution, printing, or any action taken in reliance on the contents of this email, is strictly prohibited. If you received this email in error, please contact the sending party by reply email, delete the email from your computer system and shred any paper copies.

Note to Patients: There are a number of risks you should consider before using e-mail to communicate with us. See our Privacy & Security page on www.henryford.com for more detailed information as well as information concerning MyChart, our new patient portal. If you do not believe that our policy gives you the privacy and security protection you need, do not send e-mail or Internet communications to us.

DEAR: LaTayvia Alexander
Regulator Specialist II

April 10, 2020

Department of Health
P.O. Box 6330
Tallahassee FL. 32314-6330

File#
Tracking number: 147442 1501

04/20/2020 250.00
ID: 147442 Type: F
BT: 3014148
R#: 919029533

Tonya L. Corbin
22614 King Richard CT.
Beverly Hills, MI 48025

PAYMENT $ 250.00
For Insufficient Fund, Stated in Letter
(Email) SENT April 8, 2020
FROM

Tonya L Corbin
(TONYA L. CORBIN)

2020 APR 22 AM 11:06

Goldwire, Karrell

From: Nelson, Gloria J
Sent: Tuesday, July 21, 2020 8:58 AM
To: Goldwire, Karrell
Subject: USMLE
Attachments: Corbin, Tonya Lynn-TR-USMLE-2020-07-20-1.pdf

Please see the attachment.

Thank you.

~~UNEXAMINED RETURN~~ 36680411

POST-GRADUATE TRAINING VERIFICATION FORM

Please have this form completed by the Chairman/Director of the post-graduate training program you attended. Please note that if you are using FCVS, do not submit these items.

The form should be mailed or faxed to:

FLORIDA BOARD OF MEDICINE
4052 BALD CYPRESS WAY, BIN C-03
TALLAHASSEE, FLORIDA 32399-3253
(850) 412-1268 Facsimile

MEDICINE BOARD
2020 FEB 18 PM 2:19

Detroit Medical Center.
Name of School

Internal Medicine
Department

4201 St. Antoine.
Address

Detroit, Mi 48021.
City, State, Zip

1. Name of Resident: Tonya L. Corbin, MD.

2. Internship/Residency/Fellowship: From: 7/1/1992. To: 7/31/1995.

3. Matriculation Date: 7/1/1992.

4. Completion Date: 7/31/1995.

5. Specialty: Internal Medicine

6. Levels completed (check all that apply):

PGY I___ PGY II___ PGY III X PGY IV___ PGY V___

Signed: [signature]
Chairman or Program Director Only
(No stamped signatures please).

64B8-4.009, F.A.C. DH-MQA 1000
Revised 12/2018

2020-02-12 15:19

3466544 9

MEDICINE BOARD
2020 FEB 13 AM 8:59

POST-GRADUATE TRAINING VERIFICATION FORM

Please have this form completed by the Chairman/Director of the post-graduate training program you attended. Please note that if you are using FCVS, do not submit these items.

The form should be mailed or faxed to:

FLORIDA BOARD OF MEDICINE
4052 BALD CYPRESS WAY, BIN C-03
TALLAHASSEE, FLORIDA 32399-3253
(850) 412-1268 Facsimile

Henry Ford Hospital
Name of School

Allergy & Immunology
Department

2799 W. Grand Blvd
Address

Detroit, MI 48202
City, State, Zip

1. Name of Resident: Tonya L. Corbin

2. Internship/Residency/Fellowship: From: 9/1/1995 To: 8/31/1997

3. Matriculation Date: 9/1/1995

4. Completion Date: 8/31/1997

5. Specialty: Allergy & Immunology

6. Levels completed (check all that apply):

PGY I___ PGY II___ PGY III___ PGY IV ✓ PGY V ✓

Signed: Christopher P. Thom

Chairman or Program Director Only
(No stamped signatures please).

Chair
Zachariah Zachariah, M.D.
Ft. Lauderdale, Florida

Members
Hector Vila, M.D.
Tampa, Florida
Vice-Chair

Luz Marina Pages, M.D.
Miami Beach, Florida

Scot N. Ackerman, M.D.
Jacksonville, Florida

Eleonor Pimentel, M.D.
Miami, Florida

David A. Diamond, M.D.
Winter Park, Florida

Vacant, Consumer Member

Robert London, M.D.
Maitland, Florida

Jorge J. Lopez, M.D.
Maitland, Florida

Andre M. Perez
Miami, Florida

Kevin Cairns, M.D.
Fort Lauderdale, Florida

Nicholas W. Romanello, Esq.
Melbourne, Florida

Sarvam TerKonda, M.D.
Jacksonville, Florida

Shailesh Gupta, M.D.
Coral Springs, Florida

Vacant, M.D.

Executive Director
Claudia Kemp, J.D.

September 7, 2020

Khurshid Haque, MD
5935 Winterberry Place
Allentown, PA 18104

Dear Dr. Haque:

This is in further reference to your application for licensure by endorsement.

Please be advised that you are required to make a personal appearance before the Credentials Committee of the Board of Medicine to discuss:

- Failure to meet section 458.313(1)(b), Florida Statutes, examination

In addition, the Committee may inquire into any other issues relating to your application and eligibility for licensure.

Date:	Thursday, October 1, 2020
Time:	8:00 a.m. (Meeting starts at 8:00 a.m. Interview time may vary.)
Location:	The in-person meeting scheduled in Orlando, Florida is cancelled, and the meeting will be held by a web-based meeting platform or, if appropriate, a teleconference call.

The meeting information and directions for participating in the October 2020 meeting will be posted on the Florida Board of Medicine's website: https://flboardofmedicine.gov/meeting-information.

Additionally, the Committee's recommendation on your application for licensure will be presented to the full Board of Medicine on Friday, October 2, 2020 for final action. You are not required to attend the full board meeting.

Thank you for your continued cooperation. Should you have any questions regarding this matter, please feel free to contact me. *This is your first scheduled appearance.

Sincerely,

Karrell D. Goldwire

Karrell D. Goldwire
Regulatory Supervisor

Pursuant to the provisions of the Americans with Disabilities Act, any person requiring special accommodations to participate in this workshop/meeting is asked to advise the agency at least 10 days before the workshop/meeting by contacting: Rebecca.Hewett@flhealth.gov or call (850) 245-4137.

*** 456.013(3)(c) In considering applications for licensure, the board, or the department when there is no board, may require a personal appearance of the applicant. If the applicant is required to appear, the time period in which a licensure application must be granted or denied shall be tolled until such time as the applicant appears. However, if the applicant fails to appear before the board at either of the next two regularly scheduled board meetings, or fails to appear before the department within 30 days if there is no board, the application for licensure shall be denied.**

Application

Application Detail

License Type:	**Medical Doctor**
Profession Number:	**1501 - Medical Doctor**
File Number:	**148023**
Application:	**Medical Doctor Endorsement Application**
Application Date:	**03/17/2020**

Suitability Question(s)

Are you an osteopathic physician?	**No**

Application Questions

Military Veteran Fee Waiver - I have been honorably discharged from a branch of the United States Armed Forces within the previous 60 months.	**No**
I am selecting NICA Non-Participating - (I understand that a $250.00 fee will be included if I select this option.)	**No**
I will qualify for "In Training" status at the approval of my licensure application.	**No**
I plan to dispense medicinal drugs in the State of Florida for a fee or other remuneration and hereby register as required by Section 465.0276,F.S. I understand that the fee for the Dispensing Practitioner is $100.00 over and above the required initial license fee and will submit it along with the license fee.	**No**
Military Veteran Spouse Fee Waiver - I am the spouse of a military veteran who has been honorably discharged from a branch of the United States Armed Forces within the previous 60 months.	**No**

Street Address Line 1:	**19 lope de vega**
Street Address Line 2:	**N/A**
City:	**Santo Domingo**
State:	**N/A**
Postal/Zip:	**5**
Country:	**DOMINICAN REPUBLIC**
Date of Graduation (mm/dd/yyyy):	**01/30/1985**
Attended From (mm/dd/yyyy):	**05/01/1982**
Attended To (mm/dd/yyyy):	**01/30/1985**

Additional Education Questions

Are you currently in default on any health education loan or scholarship obligation?	**No**
Have you completed the equivalent of 2 academic years of preprofessional, postsecondary education including, courses in anatomy, biology, and chemistry prior to entering medical school?	**Yes**

Fifth Pathway

Did you attend an international medical school and do not possess a valid ECFMG Certificate?	**No**
Did you receive a bachelor's degree from an accredited United States college or University?	**No**
Did you study at a medical school which is recognized by the World Health Organization?	**Yes**
Did you complete all of the formal requirement of the International medical school, except the internship or social service requirements, and pass part I of the National board of Medical examination or the Education Commission for Foreign Medical Graduates Examination equivalent?	**Yes**
Did you complete an academic year of supervised clinical training in a hospital affiliated with a medical school approved by the Council on Medical Education of the American Medical Association and upon completion passed part II of the National Board of Medical Examiners examination or the Education Commission for Foreign Medical Graduates examination Equivalent?	**Yes**

Postgraduate Training 1

Program Name:	**Trenton Psychiatric Hospital**

Mailing Address:	**101 Sullivan Way, Trenton, NJ 08628**
Program City:	**Trenton**
Program State or Country:	**NEW JERSEY**
Program Type:	**RESIDENCY**
Specialty Area:	**PYN - PSYCHIATRY/NEUROLOGY**
Attended From (mm/dd/yyyy):	**07/01/1993**
Attended To (mm/dd/yyyy):	**07/01/1997**
Did you receive credit?	**Yes**

Postgraduate Training 2

Program Name:	**Child and Adolescent Psychiatry**
Mailing Address:	**1215 Lee St, Charlottesville, VA 22908**
Program City:	**Charlottesville**
Program State or Country:	**VIRGINIA**
Program Type:	**FELLOWSHIP**
Specialty Area:	**PYN - PSYCHIATRY AND NEUROLOGY**
Attended From (mm/dd/yyyy):	**07/01/1997**
Attended To (mm/dd/yyyy):	**07/01/1999**
Did you receive credit?	**Yes**

Exam History

Examination:	**USMLE/FOREIGN**
Date Passed (mm/dd/yyyy):	**01/22/1986**

United States Military and/or Public Health

Have you ever been in the United States Military and/or Public Health Service?	**No**
Have you ever been disciplined by any branch of the United States Armed Services or Public Health Service?	**No**

Practice Employment 1

Place of Employment:	**Child and Adolescent Psychiatrist**
Address Line 1:	**1 Chimney Point Dr.**
Address Line 2:	**N/A**
City:	**Ogdensburg**
State:	**NY**

Type of Employment:	**Child and Adolescent Psychiatrist**
Begin Date (mm/dd/yyyy):	**07/01/1999**
End Date (mm/dd/yyyy):	**07/01/2003**

If 'to present', enter today's date.

Practice Employment 2

Place of Employment:	**Claxton Hepburn Medical Center**
Address Line 1:	**214 King St**
Address Line 2:	**N/A**
City:	**Ogdensburg**
State:	**NY**
Type of Employment:	**Psychiatrist-Locum Tenens**
Begin Date (mm/dd/yyyy):	**10/01/2002**
End Date (mm/dd/yyyy):	**07/01/2003**

If 'to present', enter today's date.

Practice Employment 3

Place of Employment:	**Restigouche Hospital Centre**
Address Line 1:	**63 Gallant Dr**
Address Line 2:	**N/A**
City:	**Campbellton**
State:	**NB**
Type of Employment:	**Psychiatrist**
Begin Date (mm/dd/yyyy):	**09/01/2003**
End Date (mm/dd/yyyy):	**07/01/2019**

If 'to present', enter today's date.

Other State Licenses

Do you now hold or have you ever held a license to practice medicine or any other profession in any US State or territory, or foreign country? **Yes**

Request verification of licensure status directly from the licensing entity or www.veridoc.org. Request international license verification(s) if you have practiced outside of the U.S. for at least two of the previous four years.

License Number: **P08955**

Profession:	**Psychiatrist**
Jurisdiction - Country:	**UNITED STATES**
Jurisdiction - State:	**NEW YORK**

Additional Employment Questions

Have you practiced medicine in any jurisdiction for two of the last four years or completed a board approved post-graduate training program within the last two years?	**No**
Have you passed a board approved clinical competency exam within the last year?	**No**

Graduate Education

Do you currently, or have you had, responsibility for graduate medical education within the last 10 years?	**No**

Initial Graduate Medical Education Responsibility and Faculty Appointments

List all institutions where you have had responsibility for graduate medical education or faculty appointment(s) at any medical school.

Name of Institution: **N/A**

Staff Privileges

Do you currently hold staff privileges in any hospital, health institution, clinic or medical facility?	**No**

Specialty Board Certifications

Are you certified by any specialty board recognized by the American Board of Medical Specialties or specialty board approved by the Florida Board of Medicine?	**No**

DEA

Have you ever been denied, or surrendered, a DEA registration?	**No**

Criminal History

Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to, a crime in any jurisdiction other than a minor traffic offense?	**No**

You must include all misdemeanors and felonies, even if adjudication was withheld. Driving under the influence (DUI) or driving while impaired (DWI) are not minor traffic offenses for purposes of this question.

Medicaid / Medicare

1. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, F.S. (relating to social and economic assistance), Chapter 817, F.S. (relating to fraudulent practices), Chapter 893, F.S. (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction?	**No**
2. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970 (relating to controlled substances) or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)?	**No**
3. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, F.S.?	**No**
4. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program?	**No**
5. Are you currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities?	**No**

Health History

In the last five years, have you been enrolled in, required to enter into, or participated in any drug and/or alcohol recovery program or impaired practitioner program for treatment of drug or alcohol abuse that occurred within the past five years?	**No**
In the last five years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental disorder or impairment?	**No**
During the last five years, have you been treated for or had a recurrence of a diagnosed mental disorder that has impaired your ability to practice medicine within the past five years?	**No**
During the last five years, have you been treated for or had a recurrence of a diagnosed physical disorder that has impaired your ability to practice medicine?	**No**
In the last five years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol/drug) disorder or, if you were previously in such a program, did you suffer a relapse within the last five years?	**No**

During the last five years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol/drug) disorder that impaired your ability to practice medicine within the last five years?	**No**

Electronic Fingerprinting

I have been provided and read the statement from the Florida Department of Law Enforcement regarding the sharing, retention, privacy and right to challenge incorrect criminal history records and the 'Privacy Statement' document from the Federal Bureau of Investigation.	**Yes**
Enter in today's date	**03/17/2020**

Medical Malpractice Question

Have you ever had a judgment entered against you for medical malpractice where the incident(s) of malpractice occurred after November 2, 2004?	**No**

Liability Claims

Within the last 10 years have you had any liability claim(s) or action(s) for damages for personal injury settled or finally adjudicated in an amount that exceeds $100,000.00?	**No**

Financial Responsibility/Exemption

Financial Responsibility	**3. LIABILITY NOT LESS THAN $100,000**

FDA Institution

Have you ever had any staff privileges denied, suspended, revoked, modified, restricted, not renewed or placed on probation, or have you been asked to resign or take a temporary leave of absence or were otherwise acted against by any facility?	**No**

FDA Licensing

Have you ever had any professional license or license to practice medicine revoked, suspended, placed on probation, or other disciplinary action taken in any state, territory or country?	**No**

FDANP Denied

Have you had any application for a medical license or professional license denied by any state board or other governmental agency of any state, territory, or country?	**No**

FDANP Investigation

Are you currently under investigation in any jurisdiction for an act or offense that would constitute a violation of Section 458.331, Florida Statutes?	**No**

Specialty Board Discipline History

Have you ever had any final disciplinary action taken against you by a specialty board or other similar national organization?	**No**

Year Began Practice

Year Began Practice:	**07/01/1993**

Availability for Disaster

Are you willing to provide health care services in special need shelters or to work with disaster medical teams during times of emergency or major disasters?	**Yes**

Fees

Application	**$350.00**
Unlicensed Activity	**$5.00**
NICA Part. Phys. Fee	**$4750.00**
Initial License	**$350.00**
NICA Fee	**$250.00**
Total Amount Due:	**$5705.00**

Attestation

I state that these statements are true and correct. I recognize that providing false information may result in denial of licensure, disciplinary action against my license, or criminal penalties pursuant to Sections 456.067, 775.083, and 775.084, Florida Statutes. I state that I have read Chapters 456, 458 and 766.301-.316, Florida Statutes and Chapter 64B8, Florida Administrative Code.

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Florida Board of Medicine information which is material to my application for licensure.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind. I state that my answers and all statements made by me herein are true and correct.

Should I furnish any false information in this application, I hereby agree that such act constitutes cause for denial, suspension, or revocation of my license to practice Medicine in the State of Florida. If there are any changes to my status or any change that would affect any of my answers to this application I must notify the board within 30 days.

I understand that my records are protected under federal and state regulations governing Confidentiality of Mental Health Patient Records and cannot be disclosed without my written consent unless otherwise provided in the regulations. I understand that my records are protected under federal and state regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it.

Attestation Answer: Yes

March 24, 2020

Dr. Khurshid Haque
5935 Winterberry Place
Allentown, PA 18104

Dear Dr. Haque:
File: 148023

Thank you for considering Florida for physician licensure. Your application for medical licensure has been received. The application is incomplete for the reasons set out in the attached deficiency notice. Please address these deficiencies as soon as possible to avoid delay in processing your application.

Information received by this office may require additional explanation or documentation to determine licensure eligibility. After all requested documentation is received, your application will be submitted for supervisory review. We will notify you if additional information is required.

Applicants with a history of malpractice, criminal activity, discipline, physical or mental impairment, unfavorable evaluations, or other matters that need explanation may require a personal appearance before the Board of Medicine Credentials Committee for determination of licensure eligibility. If your appearance is required, you will be notified in writing once your application is complete.

You can now follow the progress of your application through our website at: www.FLHealthSource.gov/mqa-services. If you are a returning user, select "Yes" and enter the user ID and password you selected during the registration process under Returning User. If you did not apply for licensure through this screen, select "No" and follow the prompts to create an account. You must have a valid email address to create your account.

Once you are logged in, you will be prompted to add your application to your account. Once you have successfully added your application, you will be directed to your dashboard. Under the "Additional Activities" section, select "Check Application Status" to review any open deficiencies, upload documents or print out instructional documents.

THIS IS IMPORTANT: Your application will remain incomplete until all deficiencies are completed. In addition, you are required to notify the Board office immediately in writing of any occurrence(s) that would in any way change or affect any answer given in the application or an answer provided in response to any of our direct questions to you.

If you have any questions, please contact me at Deondra.McMillan@flhealth.gov, call 850-617-1914, or fax 850-412-1914.

Sincerely,

Deondra McMillan

Deondra McMillan
Regulatory Specialist II

Enclosure(s)

Dr. Khurshid Haque **Date: March 24, 2020**

REMINDER: Chapter 456.013(1)(a), Florida Statutes, provides that an incomplete application shall expire one year after initial filing with the department.

YOUR APPLICATION'S EXPIRATION DATE IS **03/17/2021.**

APPLICATION SUBMITTED REMAINS DEFICIENT FOR LACK OF THE FOLLOWING:

Your ECFMG status report, directly from the ECFMG, has not been received.

An official verification of your medical license from the state of New York has not been received.

The inquiry you mailed to your medical school has not been received.

Your Postgraduate Training Verification Forms from the following entities have not been received:

- Trenton Psychiatric Hospital (07/1993-07/1997)
- Child and Adolescent Psychiatry (07/1997-07/1999)

Your FCVS Profile has not been received. Please contact FCVS to check the status of your profile.

Please submit the National Practitioner Data Bank (NPDB) report to our office. You may contact the NPDB at 1-800-767-6732 to obtain this information.

We await your USMLE exam scores, direct from the Federation of State Medical Boards, which must be requested by the applicant.

Please provide me with a correct response to the following question:

Have you practiced medicine in any jurisdiction for two of the last four years or completed a board approved post-graduate training program within the last two years? Y/N

We have not received your Livescan results. If you have already had your electronic fingerprinting completed, please allow 24-72 hours for receipt of your results. You can find more information on this process, including how to find a provider in your area and your ORI number, by visiting the Background Screening Website at http://www.flhealthsource.gov/background-screening/. Should your Criminal Background Check disclose an arrest record(s), you will need to provide documentation related to each criminal event revealed in your background, if you have not already done so. You can find a detailed description of documents that will be required by visiting the FAQs on the Background Screening Website (Click on 'General FAQs'). Note: Criminal History will be reviewed by the Background Screening Unit, not the Board Office. Please email all criminal history documents to mqa.backgroundscreen@flhealth.gov. Any original certified documents must be mailed to the following address:

Attn: Background Screening Unit
Florida Department of Health
4052 Bald Cypress Way, Bin BSU-01
Tallahassee, FL, 32399

If you have any questions, please contact me at Deondra.McMillan@flhealth.gov, call 850-617-1914, or fax 850-412-1914. The Florida Board of Medicine has assigned **148023** as your **tracking number**. Please indicate this number if you leave a message, and try to ensure that other sources include it on their communications to us as well.

Goldwire, Karrell

From: khurshid haque <khurshidhaque@hotmail.com>
Sent: Thursday, June 18, 2020 7:14 PM
To: Goldwire, Karrell
Subject: Re: Appl for Florida Licensure, Dr. Khurshid Haque 148023
Attachments: SCN_0012.pdf

Hi Karrell Goldwire,

Subject: Application for Florida Licensure,
Dr. Khurshid Hauqe 148023

Thank you for your prompt response. Here is the response to your email.

- I went for a fingerprinting and photograph through the Livescan method today. Background screening has been submitted through a livescan service provider and should be received by the board within 24-72 hours of being processed.

- After completing residency and fellowship I worked on a limited permit in Ogdensburg, New York from 1999-2003. In New York State, the department of education issues a limited permit for a maximum of four years to physicians who have completed residency but not yet fully licensed.

In 2003, I was offered a job in New Brunswick, Canada, Where I worked as a psychiatrist on an unrestricted, full license from August, 2003 until July, 2019.

- Yes, I did practice in Canada for two of the last four years (2003-2019)

Attachments:

- Limited Permit issued by the New York State Education Department.
- Letter of Employment

I hope my file is completed now and you can move forward with the further process of my file.

Thanks,
Dr. Khurshid Haque

Phone: (610)-393-6020
File Number: 148 023
Application # 1502-1012948

From: Goldwire, Karrell <Karrell.Goldwire@flhealth.gov>
Sent: June 17, 2020 4:37 PM
To: khurshidhaque@hotmail.com <khurshidhaque@hotmail.com>
Subject: Appl for Florida Licensure, Dr. Khurshid Haque 148023

Good Afternoon Dr. Haque;

On behalf of Deondra McMillan, the below listed items are needed for the completion of your Florida licensure file:

- Background screening results from your fingerprinting process
- Exam scores directly from the scoring entity
- Verification of Postgraduate Training form directly from Trenton Psychiatric Hospital verifying your training from 07/1993 to 06/1997
- Statement explaining how you are able to practice from 07/1999 to 06/2003 without a New York license

Also, please provide me with a corrected YES/NO response to the following question of the application: "*Have you practiced medicine in any jurisdiction for two of the last four years or completed a board approved post-graduate training program within the last two years*?"

These items can be emailed directly to me as a PDF attachment. Once received I can move forward with the processing of your file.

If you have any questions, please let me know.

Thank You
Karrell D. Goldwire
Regulatory Supervisor / Consultant
Department of Health (DOH) / Division of Medical Quality Assurance (MQA)
Board of Medicine
4052 Bald Cypress Way, # C03 / Tallahassee, Fl. 32399-3256
Phone: (850) 617-1907 / Fax: (850) 412-1279
www.flboardofmedicine.gov
www.twitter.com/FLBoardofMed

Department's Mission: To protect, promote and improve the health of all people in Florida through integrated state, county and community efforts.
Department's Vision: To be the Healthiest State in the nation.
Department's Purpose: To protect the public through health care licensure, enforcement and information.
Department's Focus: To be the nation's leader in quality health care regulation.

Department's Values: (ICARE)
I nnovation: We search for creative solutions and manage resources wisely.
C ollaboration: We use teamwork to achieve common goals and solve problems.
A ccountability: We perform with integrity and respect.
R esponsiveness: We achieve our mission by serving our customers and engaging our partners.
E xcellence: We promote quality outcomes through learning and continuous performance improvement.

Florida has a very broad public records law. Most written communications to or from state officials regarding state business are public records available to the public and media upon request. Your e-mail communications may therefore be subject to public disclosure.

How am I communicating? Please feel free to contact my supervisor at Wendy.Alls@flhealth.gov

Goldwire, Karrell

From: LeBel, Sarah M (OMH) <Sarah.LeBel@omh.ny.gov>
Sent: Monday, June 22, 2020 10:56 AM
To: Goldwire, Karrell
Subject: Reference

To whom it may concern,

Dr. Khurshid U. Haque was employed By the St. Lawrence Psychiatric Center, 1 Chimney Point Drive, Ogdensburg, NY 13669, as an Assistant Psychiatrist from 7/12/1999 -7/12/2003.

Thank you
Sarah LeBel

Sarah LeBel
Office Assistant 2
Time Office/ Human Resources
St. Lawrence Psychiatric Center
1 Chimney Point Drive
Ogdnesburg, NY 13669
Phone 315-541-2188
Fax 315-541-2034
Sarah.lebel@omh.ny.gov

Feeling stressed by the COVID-19 pandemic? You are not alone. Call the NYS Emotional Support Helpline 7 days a week, 8am-10pm at 1-844-863-9314.

IMPORTANT NOTICE:
This e-mail is meant only for the use of the intended recipient. It may contain confidential information which is legally privileged or otherwise protected by law. If you received this e-mail in error or from someone who was not authorized to send it to you, you are strictly prohibited from reviewing, using, disseminating, distributing or copying the e-mail. PLEASE NOTIFY US IMMEDIATELY OF THE ERROR BY RETURN E-MAIL AND DELETE THIS MESSAGE FROM YOUR SYSTEM. Thank you for your cooperation.

State of New Jersey
DEPARTMENT OF HEALTH
DIVISION OF BEHAVIORAL HEALTH SERVICES
TRENTON PSYCHIATRIC HOSPITAL
PO BOX 7500
WEST TRENTON, NEW JERSEY 08628
(609) 633-1500

PHILIP D. MURPHY
Governor

SHEILA Y. OLIVER
Lt. Governor

JUDITH PERSICHILLI, RN, BSN, MA
Commissioner

DEBORAH HARTEL
Deputy Commissioner

CHRISTOPHER J. MORRISON
Assistant Commissioner

ROBYN WRAMAGE-CAPOROSO, MA, OT
Chief Executive Office

Ms. Karrell Goldwire
4052 Bald Cypress Way
Tallahassee FL, 32394

June 22, 2020

Dear Ms. Goldwire;

I can verify that Dr. Khurshid Haque was a resident in Psychiatry at Trenton Psychiatric Hospital from July 1, 1993 to June 30, 1997. (PGY1, PGY2, and PGY3)

Sincerely,

Intikhab Ahmad, MD
Clinical Director
Trenton Psychiatric Hospital
PO Box 7500
Sullivan Way
West Trenton, New Jersey 08628

RETURN 490023

THE NEW YORK STATE EDUCATION DEPARTMENT / 89 WASHINGTON AVENUE / ALBANY, NY 12234-1000

Office of the Professions
Division of Professional Licensing Services
Certifications & verifications Unit, 483 EBA, Education Building, Albany, NY 12234
Tel. (518) 474-3817 ext. 390
Fax (518) 486-2694
E-mail: oprau@mail.nysed.gov

MEDICINE BOARD
2020 JUN 29 AM 10:00

To Whom It May Concern:

In New York State, a permit is different than a license. The terminology "good standing" is only applied to a professional license.

The "good standing" of the permit holder would have to be verified with the supervisor listed on the permit or with the Institution at which the permit is issued.

If a license applicant has moral character issues on the application, a "permit" will not be issued without review.

If you have any questions, please contact us at (518) 474-3817, Extension 390.

Sandra Brandt

Certification & Verification Unit

THE STATE EDUCATION DEPARTMENT/THE UNIVERSITY OF THE STATE OF NEW YORK/ALBANY, NY 12234
Office of The Professions, Certification & Verification Unit, 89 Washington Ave, 4th Floor, Albany, NY 12234-1000
Tel. 518-474-3817
Fax 518-474-1449
E-mail: oprau@mail.nysed.gov
Internet: www.op.nysed.gov

6/24/2020

ST LAWRENCE SYCHIATRIC CENTER CLAXTON - HEPBURN MEDICAL CENTER

1 CHIMNEY POINT DRIVE

OGDENSBURG, NY 13669

To Whom It May Concern:

This is to notify you that **Limited Permit Number** P08955 for the practice of MEDICINE was issued on 09/12/2002 to KHURSHID HAQUE

To practice at:

ST LAWRENCE SYCHIATRIC CENTER CLAXTON - HEPBURN MEDICAL CENTER

This permit expire(s)(d) on 07/13/2003

ORIGINAL PERMIT 07/12/1999 EXPIRED 07/12/2001 RENEWED 07/13/2001 EXPIRED 07/12/2003

Sandra Barsallo

Education Credentials Specialist

Sandra Beth Barsallo

COLLEGE OF PHYSICIANS AND SURGEONS OF NEW BRUNSWICK

COLLÈGE DES MÉDECINS ET CHIRURGIENS DU NOUVEAU-BRUNSWICK

CERTIFICATE OF STANDING

Name: Khurshid Haque
Registration No: 02744
D.O.B.: 7/9/54
MD: Santo Domingo - 1985
MINC: CAMD-0120-0077
Specialty: Psychiatry, CPSNB, 2004

Registration History:

- Public Service Licence from 4/4/2003 to 6/14/2004
- Regular Licence from 6/15/2004 to 6/19/2009
- Regular Licence from 6/19/2009

This physician is licensed at this time.

There is no derogatory information on this file. Specifically, this physician has never been the subject of an allegation, complaint, investigation, nor inquiry for professional misconduct or unfitness to practise.

E Schollenberg

Ed Schollenberg, MD, LLB, FRCPC
Registrar

Issued to: Florida Board of Medicine
June 9, 2020

1 HAMPTON ROAD, SUITE 300
ROTHESAY, NEW BRUNSWICK E2E 5K8

1, CHEMIN HAMPTON, BUREAU 300
ROTHESAY (NOUVEAU-BRUNSWICK) E2E 5K8

info@cpsnb.org (506) 849-5050 1-800-667-4641 FAX: (506) 849-5069 www.cpsnb.org

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Ft. Lauderdale, Florida

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Vice-Chair

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Winter Park, Florida

Vacant, Consumer Member

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Maitland, Florida

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Shailesh Gupta, M.D.
Coral Springs, Florida

Vacant, M.D.

Executive Director
Claudia Kemp, J.D.

September 5, 2020

Hoon Dae Yu, MD
11445 Oyster Bay Circl
New Port Richey, FL 34654

Dear Dr. Yu:

This is in further reference to your application for licensure by endorsement.

Please be advised that you are required to make a personal appearance before the Credentials Committee of the Board of Medicine to discuss:

- **Action by Florida Medical Board**
- **Action by Connecticut Medical Board**
- **Action by Virginia Medical Board**
- **Criminal History**
- **Malpractice History**
- **Exclusion from Medicare, Medicaid and all other federal health care programs**

In addition, the Committee may inquire into any other issues relating to your application and eligibility for licensure.

Date:	Thursday, October 1, 2020
Time:	8:00 a.m. (Meeting starts at 8:00 a.m. Interview time may vary.)
Location:	The in-person meeting scheduled in Orlando, Florida is cancelled, and the meeting will be held by a web-based meeting platform or, if appropriate, a teleconference call.

The meeting information and directions for participating in the October 2020 meeting will be posted on the Florida Board of Medicine's website: https://flboardofmedicine.gov/meeting-information.

Additionally, the Committee's recommendation on your application for licensure will be presented to the full Board of Medicine on Friday, October 2, 2020 for final action. You are not required to attend the full board meeting.

Thank you for your continued cooperation. Should you have any questions regarding this matter, please feel free to contact me. *This is your first scheduled appearance.

Sincerely,

Karrell D. Goldwire

Karrell D. Goldwire
Regulatory Supervisor

Pursuant to the provisions of the Americans with Disabilities Act, any person requiring special accommodations to participate in this workshop/meeting is asked to advise the agency at least 10 days before the workshop/meeting by contacting: Rebecca.Hewett@flhealth.gov or call (850) 245-4137.

*** 456.013(3)(c) In considering applications for licensure, the board, or the department when there is no board, may require a personal appearance of the applicant. If the applicant is required to appear, the time period in which a licensure application must be granted or denied shall be tolled until such time as the applicant appears. However, if the applicant fails to appear before the board at either of the next two regularly scheduled board meetings, or fails to appear before the department within 30 days if there is no board, the application for licensure shall be denied.**

1501

MEDICAL DOCTOR
APPLICATION FOR LICENSURE F-137956
Apply for your license online at www.flboardofmedicine.gov

09/18/2019 350.00
ID: 137956 Type: F
BT: 3004636
R#: 919009752

Choose your application type:

☒ Endorsement (1021) ☐ Examination (1024)

☐ Military Veterans Fee Waiver

If you were honorably discharged from the U.S. armed services within 60 months of your application you will qualify for a waiver of the application fee and the initial licensure fee. In order to qualify, please check the box above indicating that you are seeking a waiver and submit **a DD-214 or NGB-22 form as proof of honorable discharge.**

☐ I plan to dispense medicinal drugs in the State of Florida for a fee or other remuneration and hereby register as required by Section 465.0276, F.S. I understand that the fee for the Dispensing Practitioner is $100.00 in addition to the required initial license fee and will submit it along with the license fee.

1. PERSONAL INFORMATION

Name: Yu (Last/Surname) Hoon (First) Dae (Middle) **Date of Birth:** 01/30/1971 (MM/DD/YYYY)

Mailing Address: (The address where mail and your license should be sent)

11445 Oyster Bay Circle (Street/ PO Box) _____ (Suite/Apt. No) New Port Richey (City)

Florida (State) 34654 (Zip) United States (Country) 301-237-7970 (Phone Number)

Physical Location: A Post Office Box is not acceptable. This address will be posted on the Department of Health's website. *If you do not have a current practice address, your mailing address will be used. When you obtain a practice address, you will be required to update your online practitioner profile.*

_____ (Street/ P.O. Box) _____ (Suite/Apt. No) _____ (City)

_____ (State) _____ (Zip) _____ (Country) _____ (Alternate Phone Number)

Email Address: hdyumd@gmail.com

Under Florida law, email addresses are public records. If you do not want your e-mail address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.

Equal Opportunity Data: We are required to ask that you furnish the following information as part of your voluntary compliance with Section 2, Uniform Guidelines on Employee Selection Procedure (1978) 43 CFR 38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

SEX: ☒ Male ☐ Female **RACE:** ☐ White ☐ Black ☒ Asian/Pacific Islander ☐ Hispanic ☐ Other

☑ Yes ☐ No **Availability for Disaster:** Will you be available to provide health care services in special needs shelters or to help staff disaster medical assistance teams during times of emergency or major disaster?

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2. MEDICAL EDUCATION HISTORY

Federal Credentials Verification Services (FCVS) is not a requirement for licensure. FCVS will primary source verify and provide a copy of the medical school transcript(s), medical school diploma, medical school verification, name change document(s), national examination score report, ECFMG certificate, ECFMG verification and postgraduate training verifications. For more information about FCVS, visit their web-site at www.fcvs.org/.

☒ Yes ☐ No Are you using the FCVS to verify your core credentials?

☒ Yes ☐ No Have you completed the equivalent of 2 academic years of preprofessional, postsecondary education including, courses in anatomy, biology and chemistry prior to entering medical school?

Medical Education:
List in chronological order all medical schools attended, whether completed or not. Submit on a separate sheet if needed.

Medical School Name and Address:	From: (mm/yy)	To: (mm/yy)	Date Degree Received:
Howard University College of Medicine; 520 W Street, NW, Washington, D.C.	08/95	12/01	M.D.

Fifth Pathway Certificate Holders: N/A

If you answer "yes" to any of the following questions, you must request verifications to be sent directly to the Board office.

☐ Yes ☐ No Did you attend an international medical school and do not possess a valid ECFMG Certificate?

☐ Yes ☐ No Did you receive a bachelor's degree from an accredited United States college or University?

☐ Yes ☐ No Did you study at a medical school which is recognized by the World Health Organization?

☐ Yes ☐ No Did you complete all of the formal requirement of the International medical school, except the internship or social service requirements, and pass part I of the National board of Medical examination or the Education Commission for Foreign Medical Graduates Examination equivalent?

☐ Yes ☐ No Did you complete an academic year of supervised clinical training in a hospital affiliated with a medical school approved by the Council on Medical Education of the American Medical Association and upon completion passed part II of the National Board of Medical Examiners examination or the Education Commission for Foreign Medical Graduates examination Equivalent?

Postgraduate Training:

Provide the following documentation to support your postgraduate training:

1) Post-Graduate Training Form

In the table below list, in chronological order, all postgraduate training from the date you graduated from medical school to the present. Start with your first program and end with your last or current program. List all programs you began, whether you completed or received credit for the training.

Program Name and Full Mailing Address:	Specialty Area:	From: (mm/yy)	To: (mm/yy)	Did you receive credit? (Y/N)
Howard University Hospital; 2041 Georgia Ave., NW, Washington, D.C.	Surgery/Internal Medicine	12/01	12/02	Y
Howard University Hospital; 2041 Georgia Ave., NW, Washington D.C.	Anesthesiology	12/02	05/03	Y
Western Pennsylvania Hospital; 4800 Friendship Ave., Pittsburgh, PA	Anesthesiology	05/03	12/05	Y

Loan History:

☐ Yes ☒ No Are you currently in default on any health education loan or scholarship obligation? (If "yes", explain on a separate sheet providing accurate details.)

3. EXAMINATION HISTORY

State Board (prior to 1974), State Board (after 1974) & SPEX, LMCC & SPEX, NBME, FLEX, USMLE III, or Combination (prior to 2000)

Request that the score report be sent directly to the Board of Medicine. NOTE: If you took a state Board examination and are not currently licensed in three other states, you must also request your SPEX score be sent.

Exam taken: USMLE Date passed: 11/16/06 mm/dd/yy

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4. LICENSURE HISTORY

Request verification of licensure status directly from the licensing entity or www.veridoc.org. Request international license verification(s) if you have practiced outside of the U.S. for at least two of the previous four years.

☒ Yes ☐ No Do you now hold or have you ever held a license to practice medicine or any other profession in any US State or territory, or foreign country? Please list in table below.

Jurisdiction	Profession	License number
Florida	Physician	ME100278
Virginia	Physician	0101242136

If you answer "yes" to any of the questions in this section, you are required to send an explanation and supporting documentation.

☒ Yes ☐ No Have you had any application for a medical license or professional license denied by any state board or other governmental agency of any state, territory, or country?

☐ Yes ☒ No Are you currently under investigation in any jurisdiction for an act or offense that would constitute a violation of Section 458.331, Florida Statutes?

☒ Yes ☐ No Have you ever had any professional license or license to practice medicine revoked, suspended, placed on probation, or other disciplinary action taken in any state, territory or country?

5. PRACTICE/EMPLOYMENT HISTORY

List the year you legally first began to practice medicine, 2001 (yyyy). This would be the year you began practicing medicine and could be the date you began your postgraduate training.

☐ Yes ☒ No Have you practiced medicine in any jurisdiction for two of the last four years **or** completed a board approved post-graduate training program within the last two years?

☐ Yes ☒ No If your answer to the question above was "No," have you passed a board approved clinical competency exam within the last year? If yes, then submit supporting documentation.

List in chronological order all employment for the last four (4) years.

Name and address of practice or employment	Type of employment	From: mm/yy	To: mm/yy
Physicians Rehabilitation: 6150 Diamond Centre Ct., Bldg 100, Fort Myers, FL	Physician - Locum Tenens	10/13	11/13

☐ Yes ☑ No Do you currently hold staff privileges in any hospital, health institution, clinic or medical facility? List each facility below.

Name of facility

If you answer "yes" to the following questions, you are required to send an explanation and supporting documentation.

☐ Yes ☒ No Have you ever had any staff privileges denied, suspended, revoked, modified, restricted, not renewed, or placed on probation, or have you been asked to resign or take a temporary leave of absence or were otherwise acted against by any facility?

☐ Yes ☒ No Do you currently, or have you had, responsibility for graduate medical education within the last 10 years?

In the table below, list all institutions where you have had responsibility for graduate medical education or faculty appointment(s) at any medical school.

Name of institution

☐ Yes ☑ No Are you certified by any specialty board recognized by the American Board of Medical Specialties or specialty board approved by the Florida Board of Medicine?

Board Name	Certification/ Specialty/Sub-Specialty	Date of Certification (mm/yy)

If you answer "yes" to any of the following questions, please explain on a separate sheet providing accurate details.

☐ Yes ☒ No Have you ever had any final disciplinary action taken against you by a specialty board or other similar national organization?

☐ Yes ☒ No Have you ever been denied or surrendered a DEA registration?

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6. CRIMINAL HISTORY

If you answer "Yes" to the following question you are required to send the following items:

a. Self-explanation describing in detail the circumstances surrounding each offense, including dates, city and state, charges and final results.
b. Final Dispositions and Arrest Records for all offenses. The Clerk of the Court in the arresting jurisdiction will provide you with these documents. Unavailability of these documents must come in the form of a letter from the Clerk of the Court.
c. Completion of Sentence Documents. You may obtain documentation from the Department of Corrections. The report must include the start date, end date and that the conditions were met.

☐ Yes ☒ No Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to, a crime in any jurisdiction other than a minor traffic offense? You must include all misdemeanors and felonies, **even if adjudication was withheld. Driving under the influence (DUI) or driving while impaired (DWI) are not minor traffic offenses for purposes of this question.**

Yes ☒ I have been provided and read the statement from the Florida Department of Law Enforcement regarding the sharing, retention, privacy and right to challenge incorrect criminal history records and the "Privacy Statement" document from the Federal Bureau of Investigation.

7. MILITARY HISTORY

A. ☒ Yes ☐ No Have you ever been in the United States Military and/or Public Health Service?

B. ☐ Yes ☒ No Have you ever been disciplined by any branch of the United States Armed Services or Public Health Services? If you answered "yes" please provide a detailed explanation and supporting documentation

8. CRIMINAL AND MEDICAID/MEDICARE FRAUD QUESTIONS

Applicants for licensure, certification or registration and candidates for examination may be excluded from licensure, certification or registration if their felony conviction falls into certain timeframes as established in Section 456.0635(2), Florida Statutes. If you answer "Yes" to any of the following questions, please provide a written explanation for each question. Supporting documentation includes court dispositions or agency orders where applicable.

1. ☐ Yes ☒ No Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, F.S. (relating to social and economic assistance), Chapter 817, F.S. (relating to fraudulent practices), Chapter 893, F.S. (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction?

If you responded "No" to the question above, skip to question 2.

a. ☐ Yes ☐ No If "yes" to 1, for the felonies of the first or second degree, has it been more than 15 years from the date of the plea, sentence and completion of any subsequent probation?

b. ☐ Yes ☐ No If "Yes" to 1, for felonies of the third degree, has it been more than 10 years from the date of the plea, sentence and completion of any subsequent probation? (This question does not apply to felonies of the third degree under Section 893.13(6)(a), Florida Statutes)

c. ☐ Yes ☐ No If "Yes" to 1, for the felonies of the third degree under Section 893.13(6)(a), Florida Statutes, has it been more than 5 years from the date of the plea, sentence and completion of any subsequent probation?

d. ☐ Yes ☐ No If "Yes" to 1, have you successfully completed a drug court program that resulted in the plea for the felony offense being withdrawn or charges dismissed?

2. ☐ Yes ☒ No Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970 (relating to controlled substances) or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)?

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If you responded "No" to the question above, skip to question 3.

a. ☐ Yes ☐ No If "Yes" to 2, has it been more than 15 years before the date of application since the sentence and any subsequent period of probation for such conviction or plea ended?

3. ☒ Yes ☐ No Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes?

If you responded "No" to the question above, skip to question 4.

a. ☐ Yes ☐ No If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years?

4. ☒ Yes ☐ No Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid Program?

If you responded "No" to the question above, skip to question 5.

a. ☐ Yes ☒ No Have you been in good standing with a state Medicaid program for the most recent five years?

b. ☐ Yes ☒ No Did the termination occur at least 20 years before the date of this application?

5. ☒ Yes ☐ No Are you currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities?

If you answer "Yes" to the questions below, you are required to send the following items:

- **A statement indicating the date of each incident and the number for each case.**
- **An explanation of details for each case and your involvement for each case.**
- **Submit the enclosed Exhibit 1 form.**
- **A copy of the complaint, judgments and/or settlements for each case.**
- **Submit a complete copy of the trial record(s) of each case, including the trial transcript, evidentiary exhibits and final judgment in electronic format.**

☐ Yes ☒ No Have you ever had a judgment entered against you for medical malpractice where the incident(s) of malpractice occurred after November 2, 2004?

☒ Yes ☐ No Within the last 10 years have you had any liability claim(s) or action(s) for damages for personal injury settled or finally adjudicated in an amount that exceeds $100,000.00?

10. FINANCIAL RESPONSIBILITY

The Financial Responsibility options are divided into two categories, coverage and exemptions. Check only one option of the ten provided as required by s. 458.320, Florida Statutes.

Category I: Financial Responsibility Coverage

☐1. I do not have hospital staff privileges, I do not perform surgery at an ambulatory surgical center and I have established an irrevocable letter or credit or an escrow account in an amount of $100,000/$300,000, in accord with Chapter 675, F. S., for a letter of credit and s. 625.52, F. S., for an escrow account.

☐2. I have hospital staff privileges or I perform surgery at an ambulatory surgical and I have established an irrevocable letter of credit or escrow account in an amount of $250,000/$750,000, in accord with Chapter 675, F. S., for a letter of credit and s. 625.52, F. S., for an escrow account.

☐3. I do not have hospital staff privileges, I do not perform surgery at an ambulatory surgical center and I have obtained and maintain professional liability coverage in an amount not less than $100,000 per claim, with a minimum annual aggregate of not less than $300,000 from an authorized insurer as defined under s. 624.09, F. S., from a surplus lines insurer as defined under s. 626.914(2), F. S., from a risk retention group as defined under s. 627.942, F. S., from the Joint Underwriting Association established under s. 627.351(4), F. S., or through a plan of self-insurance as provided in s. 627.357, F. S.

☐4. I have hospital staff privileges or I perform surgery at an ambulatory surgical and I have professional liability coverage in an amount not less than $250,000 per claim, with a minimum annual aggregate of not less than $750,000 from an authorized insurer as defined under s. 624.09, F. S., from a surplus lines insurer as defined under s. 626.914(2), F. S., from a risk retention group as defined under s. 627.942, F. S., from the Joint Underwriting Association established under s. 627.351(4), F. S., or through a plan of self-insurance as provided in s. 627.357, F. S.

☐5. I have elected not to carry medical malpractice insurance however, I agree to satisfy any adverse judgments up to the minimum amounts pursuant to s. 458.320(5)(g)1, F. S. I understand that I must either post notice in a sign prominently displayed in my reception area or provide a written statement to any person to whom medical services are being provided that I have decided not to carry medical malpractice insurance. I understand that such a sign or notice must contain the wording specified in s. 458.320(5)(g), F. S.

Category II: Financial Responsibility Exemptions

☐6. I practice medicine exclusively as an officer, employee, or agent of the federal government, the state, or its agencies or subdivisions.

☐7. I hold a limited license issued pursuant to s. 458.317, F. S., and practice only under the scope of the limited license.

☒8. I do not practice medicine in the State of Florida.

☐9. I meet all of the following criteria.

(a) I have held an active license to practice in this state or another state or some combination thereof for more than 15 years;

(b) I am retired or maintain part time practice of no more than 1000 patient contact hours per year;

(c) I have had no more than two claims resulting in an indemnity exceeding $25,000 within the previous five-year period;

(d) I have not been convicted of or pled guilty or nolo contendere to any criminal violation specified in Chapter 458, F. S. or the medical practice act in any other state; and

(e) I have not been subject, within the past ten years of practice, to license revocation, suspension, or probation for a period of three years or longer, or a fine of $500 or more for a violation of Chapter 458, F. S., or the medical practice act of another jurisdiction. A regulatory agency's acceptance of a relinquishment of license, stipulation, consent order, or other settlement offered in response to or in anticipation of filing of administrative charges against a license is construed as action against a license. I understand if I am claiming an exception under this section that I must either post notice in a sign prominently displayed in my reception area or provide a written statement to any person to whom medical services are being provided that I have decided not to carry medical malpractice insurance. See Section 458.320(5)(f), Florida Statutes, for specific notice requirements.

☐10. I practice only in conjunction with my teaching duties at an accredited medical school or its teaching hospitals. (Interns and residents do not qualify for this exemption).

If you select an exemption based on number 9, you must also complete the affidavit on the following page.

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11. FLORIDA BIRTH RELATED NEUROLOGICAL COMPENSATION ASSOCIATION

You must choose one of the three options described below. Please be sure to view the information about each exemption at www.nica.com. Check only one.

☐	☒	☐	
$5,000	$250	$0	$250.00
Participating	Non-participating	Exempt	Amount enclosed

If you choose "$0 Exempt" provide appropriate documentation to the Board of Medicine and to NICA.

I have read the explanatory information provided by NICA, and I choose the option above.

Signature 9/2/2019 Date

Hoon Dae Yu, MD
Name
11445 Oyster Bay Circle
Street Address
New Port Richey, FL 34654
City, State, Zip

If you are a participating or non-participating physician, or a physician claiming exemption, you must complete, sign and date this form and return it with your payment to this address.

Board of Medicine
4052 Bald Cypress Way, #C-03
Tallahassee, FL 32399-3253

If you are a physician claiming exemption, you must also send a copy of your completed, signed, and dated form with proof of your exemption to:

NICA
2360 Christopher Place
Tallahassee, FL 32308

If you have any questions about NICA or this form, please contact NICA at www.nica.com or (850) 488-8191.

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12. STATEMENT OF APPLICANT

I state that these statements are true and correct. I recognize that providing false information may result in denial of licensure, disciplinary action against my license, or criminal penalties pursuant to Sections 456.067, 775.083, and 775.084, Florida Statutes. I state that I have read Chapters 456, 458 and 766.301-.316, Florida Statutes and Chapter 64B8, Florida Administrative Code.

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Florida Board of Medicine information which is material to my application for licensure.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind. I state that my answers and all statements made by me herein are true and correct.

Should I furnish any false information in this application, I hereby agree that such act constitutes cause for denial, suspension, or revocation of my license to practice medicine in the State of Florida. If there are any changes to my status or any change that would affect any of my answers to this application I must notify the board within 30 days.

I understand that my records are protected under federal and state regulations governing Confidentiality of Mental Health Patient Records and cannot be disclosed without my written consent unless otherwise provided in the regulations. I understand that my records are protected under federal and state regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it.

Hoon Dae Yu, MD
Print name

Signature

9-2-2019
Date

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SPECIFIC POWER OF ATTORNEY

I, Hoon Yu,

do hereby authorize and direct Brittney Provatas, Healthcare Licensing Services, by this Specific Power of Attorney to carry out and execute certain duties pursuant to my request and necessary in Brittney Provatas, Healthcare Licensing Services 's reasonable judgment in connection with my pursuit of a license to practice medicine in the State of Florida ("Licensed State"). It is expressly understood and agreed that this Specific Power of Attorney authorizes Brittney Provatas, Healthcare Licensing Services to make inquiries as to the status of my application for a medical license in the Licensed State and provide additional information or clarification of any discrepancies on my behalf. This Specific Power of Attorney does not authorize Brittney Provatas, Healthcare Licensing Services to act on my behalf for any other purpose and shall expire on the date I am granted a license in the Licensed State, the date my application for a medical license is denied, or upon the **Florida Board of Medicine's** receipt of written notice from me of revocation of this Specific Power of Attorney. I hereby release Brittney Provatas, Healthcare Licensing Services and the Licensing State from any and all liability, damages, claims for damages, suits, actions and causes of action which may accrue as a result of Brittney Provatas, Healthcare Licensing Services acting on my behalf in connection with my pursuit of a medical license in the Licensed State.

PRINTED NAME OF APPLICANT

Yu Hoon

SIGNATURE OF APPLICANT

Hoon Yu

Being duly sworn, says that he/she is the person who executed the above application for a license to practice medicine and surgery in the State of Florida; and that all the statements herein contained are true in every respect.

Sworn and subscribed to me this 3 day of Sept, 2019

Suzann McDaniel
(Notary Public)

June 04, 2021
My Commission Expires

NOTARY SEAL MUST BE IMPRINTED HERE

SUEANN MCDANIEL
MY COMMISSION # GG 111070
EXPIRES: June 4, 2021
Bonded Thru Notary Public Underwriters

September 26, 2019

Hoon Dae Yu, M.D.
11445 Oyster Bay Circle
New Port Richey, FL 34654

Dear Dr. Yu:
File: 137956

Thank you for considering Florida for physician licensure. Your application for medical licensure has been received. The application is incomplete for the reasons set out in the attached deficiency notice. Please address these deficiencies as soon as possible to avoid delay in processing your application.

Information received by this office may require additional explanation or documentation to determine licensure eligibility. After all requested documentation is received, your application will be submitted for supervisory review. We will notify you if additional information is required.

Applicants with a history of malpractice, criminal activity, discipline, physical or mental impairment, unfavorable evaluations, or other matters that need explanation may require a personal appearance before the Board of Medicine Credentials Committee for determination of licensure eligibility. If your appearance is required, you will be notified in writing once your application is complete.

You can now follow the progress of your application through our website at: www.FLHealthSource.gov/mqa-services. If you are a returning user, select "Yes" and enter the user ID and password you selected during the registration process under Returning User. If you did not apply for licensure through this screen, select "No" and follow the prompts to create an account. You must have a valid email address to create your account.

Once you are logged in, you will be prompted to add your application to your account. Once you have successfully added your application, you will be directed to your dashboard. Under the "Additional Activities" section, select "Check Application Status" to review any open deficiencies, upload documents or print out instructional documents.

THIS IS IMPORTANT: Your application will remain incomplete until all deficiencies are completed. In addition, you are required to notify the Board office immediately in writing of any occurrence(s) that would in any way change or affect any answer given in the application or an answer provided in response to any of our direct questions to you.

If you have any questions, please contact me at AnnMarie.Bissoo@flhealth.gov, or call 850-617-1909.

Sincerely,

Ann-Marie Bissoo

Ann-Marie Bissoo
Regulatory Specialist II

Enclosure(s)

Dr. Hoon Dae Yu **Date: September 26, 2019**

REMINDER: Chapter 456.013(1)(a), Florida Statutes, provides that an incomplete application shall expire one year after initial filing with the department.

YOUR APPLICATION'S EXPIRATION DATE IS 09/17/2020.

APPLICATION SUBMITTED REMAINS DEFICIENT FOR LACK OF THE FOLLOWING:

1. Practice Location Address on Page 7 of the Application is needed. See attached page.

2. Your application list Training Dates as 12/01 to 5/03 at Howard University; whereas, verification from the entity list 7/10 to 6/04. Also, your application list training dates as 05/03 to 12/05 at Western Pennsylvania whereas verification from the entity list 7/04 to 12/05. Please explain the discrepancy.

3. Your criminal background screening requires further review by the Background Screening Unit, that may require you to provide additional information. If additional information is needed, you will receive a separate letter explaining what is needed to complete the processing of your background screening review. If you have any questions, please contact (850) 488-0595.

4. REGARDING MALPRACTICE, please submit the following:

   - A statement COMPOSED BY YOU saying how many malpractice cases you have been named in and a statement of the details of each case and your involvement.

   - For each case, you must obtain a copy of the complaint from the county court in which the case was filed and send a copy to our office.

   - FOR EACH CLOSED CASE, submit a copy of the disposition. If the case was dismissed, submit a copy of the terms of settlement, if applicable.

- FOR EACH PENDING CASE, have your attorney submit an original letter addressed to the Florida Board with the current litigation status.

- If a case went to arbitration only, submit a copy of the "Notice To File Suit" or the "Statement of Claim" and a certified copy of the Arbitration results.

- Please complete and submit the attached Exhibit 1 form for each case.

5. Please submit the National Practitioner Data Bank (NPDB) report to our office. You may contact the NPDB at 1-800-767-6732 to obtain this information.

If you have any questions, please contact me at AnnMarie.Bissoo@flhealth.gov, or call 850-617-1909. The Florida Board of Medicine has assigned **137956** as your **tracking number**. Please indicate this number if you leave a message, and try to ensure that other sources include it on their communications to us as well.

26 September 2019

Ann-Marie Bissoo

Regulatory Specialist II

Department of Health (DOH) / Division of Medical Quality Assurance (MQA)

Board of Medicine

4052 Bald Cypress Way, # C03 / Tallahassee, Fl. 32399-3256

Re: File 137956

Dear Ms. Bissoo:

I am writing you to clarify the differences in the dates of my residency training.

In the middle of my third year of medical school, I was diagnosed with a degenerative hip condition (avascular necrosis), which delayed my graduation by six months. As such, I began my internship in December, 2001.

I underwent two surgical procedures during my residency (2002, 2003), performed by Dr. Michael Mont (Sinai Hospital-Baltimore, MD), to address my hip condition. Also in 2003, the anesthesiology residency program at Howard University Hospital lost its accreditation, necessitating a transfer to the Western Pennsylvania Hospital/Allegheny General Hospital (Pittsburgh, PA) where I completed the remainder of my post-graduate training. Due to the extended recovery from both surgeries, my residency training was similarly extended by an additional six months, and I graduated in December, 2005.

I hope this adequately explains the chronology of my residency. Thank you.

Sincerely,

Hoon Dae Yu, M.D.

Bissoo, AnnMarie

From: bprovatas@hls-mail.com
Sent: Thursday, October 17, 2019 3:42 PM
To: Bissoo, AnnMarie
Cc: hdyumd@gmail.com
Subject: RE: Florida Board of Medicine-137956-Dr. Yu, Hoon Dae

Hi Ann Marie!

Dr. Yu's home address is 11445 Oyster Bay Circle, New Port Richey, FL 34654

From: Bissoo, AnnMarie <AnnMarie.Bissoo@flhealth.gov>
Sent: Tuesday, October 15, 2019 3:31 PM
To: bprovatas@hls-mail.com
Cc: hdyumd@gmail.com
Subject: RE: Florida Board of Medicine-137956-Dr. Yu, Hoon Dae

Thanks for the email.

Please provide me with Dr. Yu's home address if he does not have a practice location address.

Thanks,
Ann-Marie Bissoo

From: bprovatas@hls-mail.com <bprovatas@hls-mail.com>
Sent: Thursday, September 26, 2019 4:44 PM
To: Bissoo, AnnMarie <AnnMarie.Bissoo@flhealth.gov>
Cc: hdyumd@gmail.com
Subject: RE: Florida Board of Medicine-137956-Dr. Yu, Hoon Dae

Hi Ann!

Please see the attached

- NPDB Report
- Explanation from Doc about malpractice cases
- Court documents

I also see on the page 7 where you need the practice address that if you do not have a practice address your public address will be used. He does not have a practice address so I thought we could leave it blank. Do we need to re-write in his home address?

Dr. Yu, can you respond to Ann Marie and explain to her the differences in dates for your training programs?

Brittney Provatas

Licensing Consultant
Healthcare Licensing Services, Inc.
880 Munson Avenue, Suite F

Traverse City, MI 49686
Tel: 850-444-9814 ext. 133
Fax: 904-339-9075
Email: bprovatas@hls-mail.com

From: Bissoo, AnnMarie <AnnMarie.Bissoo@flhealth.gov>
Sent: Thursday, September 26, 2019 2:22 PM
To: bprovatas@hls-mail.com
Cc: hdyumd@gmail.com
Subject: Florida Board of Medicine-137956-Dr. Yu, Hoon Dae

Hi all,

Attached are the deficiency letters for Dr. Yu.

Regards,
Ann-Marie Bissoo
Regulatory Specialist II
Department of Health (DOH) / Division of Medical Quality Assurance (MQA)
Board of Medicine
4052 Bald Cypress Way, # C03 / Tallahassee, Fl. 32399-3256
Phone: (850) 617-1909
www.flboardofmedicine.gov
www.twitter.com/FLBoardofMed

Department's Mission: To protect, promote and improve the health of all people in Florida through integrated state, county and community efforts.
Department's Vision: To be the Healthiest State in the nation.
Department's Purpose: To protect the public through health care licensure, enforcement and information.
Department's Focus: To be the nation's leader in quality health care regulation.

Department's Values: (ICARE)
I nnovation: We search for creative solutions and manage resources wisely.
C ollaboration: We use teamwork to achieve common goals and solve problems.
A ccountability: We perform with integrity and respect.
R esponsiveness: We achieve our mission by serving our customers and engaging our partners.
E xcellence: We promote quality outcomes through learning and continuous performance improvement.

Florida has a very broad public records law. Most written communications to or from state officials regarding state business are public records available to the public and media upon request. Your e-mail communications may therefore be subject to public disclosure.

How am I communicating? Please feel free to contact my supervisor at Karrell.Goldwire@flhealth.gov.

December 5, 2019

Dr. Hoon Dae Yu
11445 Oyster Bay Circle
New Port Richey, FL 34654

Dear Dr. Yu:
File #: 137956

Thank you for considering Florida for physician licensure. Your application has been received and processed. However, the application is incomplete and remains deficient for the following:

1. Pending background screening review.

2. REGARDING MALPRACTICE, please submit the following:

- A statement COMPOSED BY YOU saying how many malpractice cases you have been named in and a statement of the details of each case and your involvement.
- For each case, you must obtain a copy of the complaint from the county court in which the case was filed and send a copy to our office.
- FOR EACH CLOSED CASE, submit a copy of the disposition. If the case was dismissed, submit a copy of the terms of settlement, if applicable.
- FOR EACH PENDING CASE, have your attorney submit an original letter addressed to the Florida Board with the current litigation status.
- If a case went to arbitration only, submit a copy of the "Notice To File Suit" or the "Statement of Claim" and a certified copy of the Arbitration results.
- Submit a completed copy of Exhibit 1 form for each case.

After all deficient items are received; your file will be submitted for a secondary review. You will be notified if additional information is required.

Section 456.013(1)(a), Florida Statutes, provides that an incomplete application shall expire one year after initial filing with the department. Your application will expire 9/17/2020.

If you have any questions, please contact me at AnnMarie.Bissoo@flhealth.gov, or call 850-617-1909.

Sincerely,

Ann-Marie Bissoo

Ann-Marie Bissoo
Regulatory Specialist II

Department of Health

HOON DAE YU

License Number: ME100278

Data As Of 8/28/2020

Profession	Medical Doctor
License	ME100278
License Status	REVOKED/
License Expiration Date	1/31/2014
License Original Issue Date	10/23/2007
Address of Record	If further information is needed, please contact the Department of Health at (850) 488-0595.
Controlled Substance Prescriber (for the Treatment of Chronic Non-malignant Pain)	Yes
Discipline on File	Yes
Public Complaint	Yes

The information on this page is a secure, primary source for license verification provided by the Florida Department of Health, Division of Medical Quality Assurance. This website is maintained by Division staff and is updated immediately upon a change to our licensing and enforcement database.

Chair
Zachariah Zachariah, M.D.
Ft. Lauderdale, Florida

Members
Hector Vila, M.D.
Tampa, Florida
Vice-Chair

Luz Marina Pages, M.D.
Miami Beach, Florida

Scot N. Ackerman, M.D.
Jacksonville, Florida

Eleonor Pimentel, M.D.
Miami, Florida

David A. Diamond, M.D.
Winter Park, Florida

Vacant, Consumer Member

Robert London, M.D.
Maitland, Florida

Jorge J. Lopez, M.D.
Maitland, Florida

Andre M. Perez
Miami, Florida

Kevin Cairns, M.D.
Fort Lauderdale, Florida

Nicholas W. Romanello, Esq.
Melbourne, Florida

Sarvam TerKonda, M.D.
Jacksonville, Florida

Shailesh Gupta, M.D.
Coral Springs, Florida

Vacant, M.D.

Executive Director
Claudia Kemp, J.D.

September 1, 2020

Joseph A. Greco, MD
142 Millstone Way
Canton, Georgia 30115

Dear Dr. Greco:

This is in further reference to your application for licensure by endorsement.

Please be advised that you are required to make a personal appearance before the Credentials Committee of the Board of Medicine to discuss:

- Tennessee State Board Action(s)

In addition, the Committee may inquire into any other issues relating to your application and eligibility for licensure.

Date:	Thursday, October 1, 2020
Time:	8:00 a.m. (Meeting starts at 8:00 a.m. Interview time may vary.)
Location:	The in-person meeting scheduled in Orlando, Florida is cancelled, and the meeting will be held by a web-based meeting platform or, if appropriate, a teleconference call.

The meeting information and directions for participating in the October 2020 meeting will be posted on the Florida Board of Medicine's website: https://flboardofmedicine.gov/meeting-information.

Additionally, the Committee's recommendation on your application for licensure will be presented to the full Board of Medicine on Friday, October 2, 2020 for final action. You are not required to attend the full board meeting.

Thank you for your continued cooperation. Should you have any questions regarding this matter, please feel free to contact me. *This is your first scheduled appearance.

Sincerely,

Angela Denson
Angela Denson
Regulatory Supervisor

Pursuant to the provisions of the Americans with Disabilities Act, any person requiring special accommodations to participate in this workshop/meeting is asked to advise the agency at least 10 days before the workshop/meeting by contacting: Rebecca.Hewett@flhealth.gov or call (850) 245-4137.

*** 456.013(3)(c) In considering applications for licensure, the board, or the department when there is no board, may require a personal appearance of the applicant. If the applicant is required to appear, the time period in which a licensure application must be granted or denied shall be tolled until such time as the applicant appears. However, if the applicant fails to appear before the board at either of the next two regularly scheduled board meetings, or fails to appear before the department within 30 days if there is no board, the application for licensure shall be denied.**

Chair
Zachariah Zachariah, M.D.
Ft. Lauderdale, Florida

Members
Hector Vila, M.D.
Tampa, Florida
Vice-Chair

Luz Marina Pages, M.D.
Miami Beach, Florida

Scot N. Ackerman, M.D.
Jacksonville, Florida

Eleonor Pimentel, M.D.
Miami, Florida

David A. Diamond, M.D.
Winter Park, Florida

Barbara Fonte
Cutler Bay, Florida

Robert London, M.D.
Maitland, Florida

Jorge J. Lopez, M.D.
Maitland, Florida

Andre M. Perez
Miami, Florida

Kevin Cairns, M.D.
Fort Lauderdale, Florida

Nicholas W. Romanello, Esq.
Melbourne, Florida

Sarvam TerKonda, M.D.
Jacksonville, Florida

Shailesh Gupta, M.D.
Coral Springs, Florida

Vacant, M.D.

Executive Director
Claudia Kemp, J.D.

August 18th, 2020

Joseph A. Greco, MD
142 Millstone Way
Canton, GA 30115

At the August 7th, 2020 full board meeting, the Board of Medicine accepted the recommendation of the Credentials Committee to table the application for licensure until the next credentials committee meeting.

If you have any additional questions or concerns, please do not hesitate to contact me at 850-617-1913 or e-mail me at Christina.Keelor@flhealth.gov .

Sincerely,

Christina Keelor

Christina Keelor
Administrative Assistant II

Tab 27 - Abhishek Mishra, MD – Examination
Issue(s): Health History

No action was required by the Credentials Committee. The license was issued administratively.

Tab 28 - Robert M. Frankle, MD – Endorsement
Issue(s): Action by Illinois Medical Board

The applicant was present. After discussion, a motion was made to approve the application for licensure. The motion was seconded, which carried 4/0.

Action Taken: The Committee voted to approve the application for licensure.

Tab 5 - Joseph A. Greco, MD – Endorsement
Issue(s): Tennessee State Board Action(s)

The applicant was not present. After discussion, a motion was made to table the application for licensure until the next credentials committee meeting. The motion was seconded, which carried 4/0.

Action Taken: The Committee voted to table the application for licensure until the next credentials committee meeting.

Tab 7 - Jose Guillermo Alvarez Fontes, MD – Endorsement
Issue(s): Failure to meet section 458.313(1)(a) and 458.311(1)(f)3.c., Florida Statutes, postgraduate training

The applicant was not present. After discussion, a motion was made to table the application for licensure until the next credentials committee meeting. The motion was seconded, which carried 4/0.

Action Taken: The Committee voted to table the application for licensure until the next credentials committee meeting.

Tab 8 - Daimis Vazquez Rosabal, MD – Endorsement
Issue(s): Failure to meet section 458.313(1)(a) and 458.311(1)(f)3.c., Florida Statutes, postgraduate training

The applicant was present. After discussion, a motion was made to allow Dr. Vazquez Rosabal to withdraw her application for licensure. The motion was seconded, which carried 4/0.

Action Taken: The Committee voted to allow withdrawal of the licensure application.

Tab 16 - Odelaisys Enriquez, MD – Endorsement
Issue(s): Failure to meet section 458.313(1)(a) and 458.311(1)(f)3.c., Florida Statutes, postgraduate training

The applicant was present. After discussion, a motion was made to allow Dr. Enriquez to withdraw her application for licensure. The motion was seconded, which carried 4/0.

Action Taken: The Committee voted to allow withdrawal of the licensure application.

INDIVIDUAL CONSIDERATIONS

Robert London, MD – To Interview Tabs 29-36

Tab 29 - Gorana Kuka Epstein, MD – Medical Faculty Certificate
Issue(s): To determine if your postgraduate training is equivalent to the 1-year residency requirement pursuant to section 458.3145(1)(d), Florida Statutes.

The applicant was not present. After discussion, a motion was made to allow Dr. Kuka Epstein to withdraw her application for licensure. The motion was seconded, which carried 4/0.

Action Taken: The Committee voted to allow withdrawal of the licensure application.

1501-
143651
CK

FILED
DEPARTMENT OF HEALTH
DEPUTY CLERK
CLERK: Amanda Morales
DATE: OCT 17 2019

STATE OF FLORIDA
BOARD OF MEDICINE

IN RE: THE APPLICATION FOR
LICENSURE OF

JOSEPH A. GRECO, M.D.

_____/

ORDER ALLOWING WITHDRAWAL OF APPLICATION

This matter came before the Credentials Committee of the Florida Board of Medicine at a duly-noticed public meeting on October 3, 2019, in Tampa, Florida, and the full Board of Medicine on October 4, 2019, in Tampa, Florida. The Applicant, Joseph A. Greco, M.D., did not appear before the Credentials Committee or the full Board.

Based on the material presented and the request by the Applicant to withdraw his application for licensure, the Credentials Committee recommended and the full Board approved Dr. Greco's request to withdraw his application for licensure.

It is therefore **ORDERED** that the application for licensure is **WITHDRAWN.**

This Order shall become effective upon filing with the Clerk of the Department of Health.

DONE AND ORDERED this 17th day of October, 2019.

BOARD OF MEDICINE

Claudia Kemp

Claudia Kemp, J.D., Executive Director
For Steven Rosenberg, M.D., Chair

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing has been furnished by U.S. Mail to **Joseph A. Greco, M.D.,** 22 Maria Place, Ponte Vedra Beach, FL 32082; and by email to **Donna McNulty**, Special Counsel, at Donna.McNulty@myfloridalegal.com, this 17th day of Oct-, 2019.

Anne Marcus
Deputy Agency Clerk

https://dohmqa31.imageapi.com/axiomproviewer/viewer/ViewDocument?documentId=40350048&aut... 6/8/2020

1601 F-143651

MEDICAL DOCTOR
APPLICATION FOR LICENSURE

Apply for your license online at www.flboardofmedicine.gov

05/07/2020 350.00
ID: 143651 Type: F
BT: 3014839
R#: 919031137

Choose your application type:

☒ Endorsement (1021) ☐ Examination (1024)

☐ Military Veterans Fee Waiver

If you were honorably discharged from the U.S. armed services within 60 months of your application you will qualify for a waiver of the application fee and the initial licensure fee. In order to qualify, please check the box above indicating that you are seeking a waiver and submit **a DD-214 or NGB-22 form as proof of honorable discharge.**

☐ I plan to dispense medicinal drugs in the State of Florida for a fee or other remuneration and hereby register as required by Section 465.0276, F.S. I understand that the fee for the Dispensing Practitioner is $100.00 in addition to the required initial license fee and will submit it along with the license fee.

1. PERSONAL INFORMATION

Name: GRECO (Last/Surname) JOSEPH (First) A (Middle) **Date of Birth:** 09/10/1976 (MM/DD/YYYY)

Mailing Address: (The address where mail and your license should be sent)

142 MILLSTONE WAY (Street/ PO Box) ____ (Suite/Apt. No) CANTON (City)

GEORGIA (State) 30115 (Zip) USA (Country) 615/775-8300 (Phone Number)

Physical Location: A Post Office Box is not acceptable. This address will be posted on the Department of Health's website. *If you do not have a current practice address, your mailing address will be used. When you obtain a practice address, you will be required to update your online practitioner profile.*

142 MILLSTONE WAY (Street/ P.O. Box) ____ (Suite/Apt. No) CANTON (City)

GEORGIA (State) 30115 (Zip) USA (Country) ____ (Alternate Phone Number)

Email Address: JAG3MD@GMAIL.COM

Under Florida law, email addresses are public records. If you do not want your e-mail address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.

Equal Opportunity Data: We are required to ask that you furnish the following information as part of your voluntary compliance with Section 2, Uniform Guidelines on Employee Selection Procedure (1978) 43 CFR 38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

SEX: ☒ Male ☐ Female **RACE:** ☒ White ☐ Black ☐ Asian/Pacific Islander ☐ Hispanic ☐ Other

☒ Yes ☐ No **Availability for Disaster:** Will you be available to provide health care services in special needs shelters or to help staff disaster medical assistance teams during times of

2. MEDICAL EDUCATION HISTORY

Federal Credentials Verification Services (FCVS) is not a requirement for licensure. FCVS will primary source verify and provide a copy of the medical school transcript(s), medical school diploma, medical school verification, name change document(s), national examination score report, ECFMG certificate, ECFMG verification and postgraduate training verifications. For more information about FCVS, visit their web-site at www.fcvs.org/.

☐ Yes ☒ No Are you using the FCVS to verify your core credentials?

☒ Yes ☐ No Have you completed the equivalent of 2 academic years of preprofessional, postsecondary education including, courses in anatomy, biology and chemistry prior to entering medical school?

Medical Education:
List in chronological order all medical schools attended, whether completed or not. Submit on a separate sheet if needed.

Medical School Name and Address:	From: (mm/yy)	To: (mm/yy)	Date Degree Received:
MEDICAL COLLEGE OF GEORGIA	08/1998	05/2002	05/01/2002

Fifth Pathway Certificate Holders: N/A

If you answer "yes" to any of the following questions, you must request verifications to be sent directly to the Board office.

☐ Yes ☒ No Did you attend an international medical school and do not possess a valid ECFMG Certificate?

☐ Yes ☐ No Did you receive a bachelor's degree from an accredited United States college or University?

☐ Yes ☐ No Did you study at a medical school which is recognized by the World Health Organization?

☐ Yes ☐ No Did you complete all of the formal requirement of the International medical school, except the internship or social service requirements, and pass part I of the National board of Medical examination or the Education Commission for Foreign Medical Graduates Examination equivalent?

☐ Yes ☐ No Did you complete an academic year of supervised clinical training in a hospital affiliated with a medical school approved by the Council on Medical Education of the American Medical Association and upon completion passed part II of the National Board of Medical Examiners examination or the Education Commission for Foreign Medical Graduates examination Equivalent?

Postgraduate Training:

Provide the following documentation to support your postgraduate training:

☒ Post-Graduate Training Form PREVIOUSLY PROVIDED

In the table below list, in chronological order, all postgraduate training from the date you graduated from medical school to the present. Start with your first program and end with your last or current program. List all programs you began, whether you completed or received credit for the training.

Program Name and Full Mailing Address:	Specialty Area:	From: (mm/yy)	To: (mm/yy)	Did you receive credit? (Y/N)
VANDERBILT UNIV. DEPT. OF SURG + D4303	GENERAL SURGERY	07/2002	06/2009	Y
VANDERBILT UNIV DEPT OF 1161 21ST. AVE SOUTH	PLASTIC SURGERY	07/2009	06/2011	Y
D4207 MEDICAL CENTR N. NASHVILLE, TN 37232				

Loan History:

☐ Yes ☒ No Are you currently in default on any health education loan or scholarship obligation? (If "yes", explain on a separate sheet providing accurate details.)

3. EXAMINATION HISTORY

State Board (prior to 1974), State Board (after 1974) & SPEX, LMCC & SPEX, NBME, FLEX, USMLE III, or Combination (prior to 2000)

Request that the score report be sent directly to the Board of Medicine. NOTE: If you took a state Board examination and are not currently licensed in three other states, you must also request your SPEX score be sent.

Exam taken: USMLE III Date passed: 5/2003 (mm/dd/yy)

4. LICENSURE HISTORY

Request verification of licensure status directly from the licensing entity or www.veridoc.org. Request international license verification(s) if you have practiced outside of the U.S. for at least two of the previous four years.

☒ Yes ☐ No Do you now hold or have you ever held a license to practice medicine or any other profession in any US State or territory, or foreign country? Please list in table below.

Jurisdiction	Profession	License number
STATE OF GEORGIA	PHYSICIAN	66041 - ACTIVE
COMPOSITE MEDICAL BOARD		SENT VIA VERIDOC
STATE OF TENNESSEE	PHYSICIAN	M39961 - INACTIVE
TN. HEALTH RELATED BOARDS		

If you answer "yes" to any of the questions in this section, you are required to send an explanation and supporting documentation.

☐ Yes ☒ No Have you had any application for a medical license or professional license denied by any state board or other governmental agency of any state, territory, or country?

☐ Yes ☒ No Are you currently under investigation in any jurisdiction for an act or offense that would constitute a violation of Section 458.331, Florida Statutes?

☒ Yes ☐ No Have you ever had any professional license or license to practice medicine revoked, suspended, placed on probation, or other disciplinary action taken in any state, territory or country?

5. PRACTICE/EMPLOYMENT HISTORY

List the year you legally first began to practice medicine, 2002 2011 (yyyy). This would be the year you began practicing medicine and could be the date you began your postgraduate training.

☒ Yes ☐ No Have you practiced medicine in any jurisdiction for two of the last four years **or** completed a board approved post-graduate training program within the last two years?

☐ Yes ☐ No If your answer to the question above was "No," have you passed a board approved clinical competency exam within the last year? If yes, then submit supporting documentation.

List in chronological order all employment for the last four (4) years.

Name and address of practice or employment	Type of employment	From: mm/yy	To: mm/yy

☐ Yes ☐ No Do you currently hold staff privileges in any hospital, health institution, clinic or medical facility? List each facility below.

Name of facility

If you answer "yes" to the following questions, you are required to send an explanation and supporting documentation.

☐ Yes ☐ No Have you ever had any staff privileges denied, suspended, revoked, modified, restricted, not renewed, or placed on probation, or have you been asked to resign or take a temporary leave of absence or were otherwise acted against by any facility?

☐ Yes ☐ No Do you currently, or have you had, responsibility for graduate medical education within the last 10 years?

In the table below, list all institutions where you have had responsibility for graduate medical education or faculty appointment(s) at any medical school.

Name of institution

☐ Yes ☐ No Are you certified by any specialty board recognized by the American Board of Medical Specialties or specialty board approved by the Florida Board of Medicine?

Board Name	Certification/ Specialty/Sub-Specialty	Date of Certification (mm/yy)

If you answer "yes" to any of the following questions, please explain on a separate sheet providing accurate details.

☐ Yes ☐ No Have you ever had any final disciplinary action taken against you by a specialty board or other similar national organization?

☐ Yes ☐ No Have you ever been denied or surrendered a DEA registration?

6. CRIMINAL HISTORY

If you answer "Yes" to the following question you are required to send the following items:

a. Self-explanation describing in detail the circumstances surrounding each offense, including dates, city and state, charges and final results.
b. Final Dispositions and Arrest Records for all offenses. The Clerk of the Court in the arresting jurisdiction will provide you with these documents. Unavailability of these documents must come in the form of a letter from the Clerk of the Court.
c. Completion of Sentence Documents. You may obtain documentation from the Department of Corrections. The report must include the start date, end date and that the conditions were met.

☐ Yes ☒ No Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to, a crime in any jurisdiction other than a minor traffic offense? You must include all misdemeanors and felonies, **even if adjudication was withheld. Driving under the influence (DUI) or driving while impaired (DWI) are not minor traffic offenses for purposes of this question.**

Yes ☒ I have been provided and read the statement from the Florida Department of Law Enforcement regarding the sharing, retention, privacy and right to challenge incorrect criminal history records and the "Privacy Statement" document from the Federal Bureau of Investigation.

7. MILITARY HISTORY

A. ☐ Yes ☒ No Have you ever been in the United States Military and/or Public Health Service?

B. ☐ Yes ☒ No Have you ever been disciplined by any branch of the United States Armed Services or Public Health Services? If you answered "yes" please provide a detailed explanation and supporting documentation

8. CRIMINAL AND MEDICAID/MEDICARE FRAUD QUESTIONS

Applicants for licensure, certification or registration and candidates for examination may be excluded from licensure, certification or registration if their felony conviction falls into certain timeframes as established in Section 456.0635(2), Florida Statutes. If you answer "Yes" to any of the following questions, please provide a written explanation for each question. Supporting documentation includes court dispositions or agency orders where applicable.

1. ☐ Yes ☒ No Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, F.S. (relating to social and economic assistance), Chapter 817, F.S. (relating to fraudulent practices), Chapter 893, F.S. (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction?

If you responded "No" to the question above, skip to question 2.

a. ☐ Yes ☐ No If "yes" to 1, for the felonies of the first or second degree, has it been more than 15 years from the date of the plea, sentence and completion of any subsequent probation?

b. ☐ Yes ☐ No If "Yes" to 1, for felonies of the third degree, has it been more than 10 years from the date of the plea, sentence and completion of any subsequent probation? (This question does not apply to felonies of the third degree under Section 893.13(6)(a), Florida Statutes)

c. ☐ Yes ☐ No If "Yes" to 1, for the felonies of the third degree under Section 893.13(6)(a), Florida Statutes, has it been more than 5 years from the date of the plea, sentence and completion of any subsequent probation?

d. ☐ Yes ☐ No If "Yes" to 1, have you successfully completed a drug court program that resulted in the plea for the felony offense being withdrawn or charges dismissed?

2. ☐ Yes ☒ No Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970 (relating to controlled substances) or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)?

If you responded "No" to the question above, skip to question 3.

a. ☐ Yes ☐ No If "Yes" to 2, has it been more than 15 years before the date of application since the sentence and any subsequent period of probation for such conviction or plea ended?

3. ☐ Yes ☒ No Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes?

If you responded "No" to the question above, skip to question 4.

a. ☐ Yes ☐ No If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years?

4. ☐ Yes ☒ No Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid Program?

If you responded "No" to the question above, skip to question 5.

a. ☐ Yes ☐ No Have you been in good standing with a state Medicaid program for the most recent five years?

b. ☐ Yes ☐ No Did the termination occur at least 20 years before the date of this application?

5. ☐ Yes ☒ No Are you currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities?

If you answer "Yes" to the questions below, you are required to send the following items:

- **A statement indicating the date of each incident and the number for each case.**
- **An explanation of details for each case and your involvement for each case.**
- **Submit the enclosed Exhibit 1 form.**
- **A copy of the complaint, judgments and/or settlements for each case.**
- **Submit a complete copy of the trial record(s) of each case, including the trial transcript, evidentiary exhibits and final judgment in electronic format.**

☐ Yes ☒ No Have you ever had a judgment entered against you for medical malpractice where the incident(s) of malpractice occurred after November 2, 2004?

☐ Yes ☒ No Within the last 10 years have you had any liability claim(s) or action(s) for damages for personal injury settled or finally adjudicated in an amount that exceeds $100,000.00?

10. FINANCIAL RESPONSIBILITY

The Financial Responsibility options are divided into two categories, coverage and exemptions. Check only one option of the ten provided as required by s. 458.320, Florida Statutes.

Category I: Financial Responsibility Coverage

☐1. I do not have hospital staff privileges, I do not perform surgery at an ambulatory surgical center and I have established an irrevocable letter or credit or an escrow account in an amount of $100,000/$300,000, in accord with Chapter 675, F. S., for a letter of credit and s. 625.52, F. S., for an escrow account.

☐2. I have hospital staff privileges or I perform surgery at an ambulatory surgical and I have established an irrevocable letter of credit or escrow account in an amount of $250,000/$750,000, in accord with Chapter 675, F. S., for a letter of credit and s. 625.52, F. S., for an escrow account.

☐3. I do not have hospital staff privileges, I do not perform surgery at an ambulatory surgical center and I have obtained and maintain professional liability coverage in an amount not less than $100,000 per claim, with a minimum annual aggregate of not less than $300,000 from an authorized insurer as defined under s. 624.09, F. S., from a surplus lines insurer as defined under s. 626.914(2), F. S., from a risk retention group as defined under s. 627.942, F. S., from the Joint Underwriting Association established under s. 627.351(4), F. S., or through a plan of self-insurance as provided in s. 627.357, F. S.

☒4. I have hospital staff privileges or I perform surgery at an ambulatory surgical and I have professional liability coverage in an amount not less than $250,000 per claim, with a minimum annual aggregate of not less than $750,000 from an authorized insurer as defined under s. 624.09, F. S., from a surplus lines insurer as defined under s. 626.914(2), F. S., from a risk retention group as defined under s. 627.942, F. S., from the Joint Underwriting Association established under s. 627.351(4), F. S., or through a plan of self-insurance as provided in s. 627.357, F. S.

☐5. I have elected not to carry medical malpractice insurance however, I agree to satisfy any adverse judgments up to the minimum amounts pursuant to s. 458.320(5)(g)1, F. S. I understand that I must either post notice in a sign prominently displayed in my reception area or provide a written statement to any person to whom medical services are being provided that I have decided not to carry medical malpractice insurance. I understand that such a sign or notice must contain the wording specified in s. 458.320(5)(g), F. S.

Category II: Financial Responsibility Exemptions

☐6. I practice medicine exclusively as an officer, employee, or agent of the federal government, the state, or its agencies or subdivisions.

☐7. I hold a limited license issued pursuant to s. 458.317, F. S., and practice only under the scope of the limited license.

☐8. I do not practice medicine in the State of Florida.

☐9. I meet all of the following criteria:

(a) I have held an active license to practice in this state or another state or some combination thereof for more than 15 years;

(b) I am retired or maintain part time practice of no more than 1000 patient contact hours per year;

(c) I have had no more than two claims resulting in an indemnity exceeding $25,000 within the previous five-year period;

(d) I have not been convicted of or pled guilty or nolo contendere to any criminal violation specified in Chapter 458, F. S. or the medical practice act in any other state; and

(e) I have not been subject, within the past ten years of practice, to license revocation, suspension, or probation for a period of three years or longer, or a fine of $500 or more for a violation of Chapter 458, F. S., or the medical practice act of another jurisdiction. A regulatory agency's acceptance of a relinquishment of license, stipulation, consent order, or other settlement offered in response to or in anticipation of filing of administrative charges against a license is construed as action against a license. I understand if I am claiming an exception under this section that I must either post notice in a sign prominently displayed in my reception area or provide a written statement to any person to whom medical services are being provided that I have decided not to carry medical malpractice insurance. See Section 458.320(5)(f), Florida Statutes, for specific notice requirements.

☐10. I practice only in conjunction with my teaching duties at an accredited medical school or its teaching hospitals. (Interns and residents do not qualify for this exemption).

If you select an exemption based on number 9, you must also complete the affidavit on the following page.

BOARD OF MEDICINE
Financial Responsibility Affidavit of Exemption

This affidavit is only required if you are claiming an Exemption based on number 9 on the preceding page.

I,_____, do hereby certify and attest that I meet all of the following criteria:

(a) I have held an active license to practice in this state or another state or some combination thereof for more than 15 years;
(b) I am retired or maintain part time practice of no more than 1000 patient contact hours per year;
(c) I have had no more than two claims resulting in an indemnity exceeding $25,000 within the previous five-year period;
(d) I have not been convicted of or pled guilty or nolo contendere to any criminal violation specified in Chapter 458, F. S. or the medical practice act in any other state; and
(e) I have not been subject, within the past ten years of practice, to license revocation, suspension, or probation for a period of three years or longer, or a fine of $500 or more for a violation of Chapter 458, F. S., or the medical practice act of another jurisdiction. A regulatory agency's acceptance of a relinquishment of license, stipulation, consent order, or other settlement offered in response to or in anticipation of filing of administrative charges against a license is construed as action against a license. I understand if I am claiming an exception under this section that I must either post notice in a sign prominently displayed in my reception area or provide a written statement to any person to whom medical services are being provided that I have decided not to carry medical malpractice insurance. See Section 458.320(5) (f), F.S., for specific notice requirements.

Dated: _____ Signature:_____

STATE OF _____
COUNTY OF _____

Sworn to (or affirmed) and subscribed before me this_____day of_____, by

_____

_____
(Signature of Notary Public - State of Florida)

(Print, Type, or Stamp Commissioned Name of Notary Public)

Personally Known_____OR Produced Identification _____

Type of Identification Produced_____

11. FLORIDA BIRTH RELATED NEUROLOGICAL COMPENSATION ASSOCIATION

You must choose one of the three options described below. Please be sure to view the information about each exemption at www.nica.com. Check only one.

☐	☒	☐	
$5,000	$250	$0	PROVIDED IN PREVIOUS APPLICATION
Participating	Non-participating	Exempt	Amount enclosed

If you choose "$0 Exempt" provide appropriate documentation to the Board of Medicine and to NICA.

I have read the explanatory information provided by NICA, and I choose the option above.

Signature 4/29/2020 Date

JOSEPH GRECO
Name
142 MILESTONE WAY
Street Address
CANTON, GA 30115
City, State, Zip

If you are a participating or non-participating physician, or a physician claiming exemption, you must complete, sign and date this form and return it with your payment to this address.

Board of Medicine
4052 Bald Cypress Way, #C-03
Tallahassee, FL 32399-3253

If you are a physician claiming exemption, you must also send a copy of your completed, signed, and dated form with proof of your exemption to:

NICA
2360 Christopher Place
Tallahassee, FL 32308

If you have any questions about NICA or this form, please contact NICA at www.nica.com or (850) 488-8191.

12. STATEMENT OF APPLICANT

I state that these statements are true and correct. I recognize that providing false information may result in denial of licensure, disciplinary action against my license, or criminal penalties pursuant to Sections 456.067, 775.083, and 775.084, Florida Statutes. I state that I have read Chapters 456, 458 and 766.301-.316, Florida Statutes and Chapter 64B8, Florida Administrative Code.

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Florida Board of Medicine information which is material to my application for licensure.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind. I state that my answers and all statements made by me herein are true and correct.

Should I furnish any false information in this application, I hereby agree that such act constitutes cause for denial, suspension, or revocation of my license to practice medicine in the State of Florida. If there are any changes to my status or any change that would affect any of my answers to this application I must notify the board within 30 days.

I understand that my records are protected under federal and state regulations governing Confidentiality of Mental Health Patient Records and cannot be disclosed without my written consent unless otherwise provided in the regulations. I understand that my records are protected under federal and state regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it.

JOSEPH A. GRECO

Print name

Signature

4/29/20

Date

Mission:
To protect, promote & improve the health of all people in Florida through integrated state, county & community efforts.

Florida HEALTH

Ron DeSantis
Governor

Scott A. Rivkees, MD
State Surgeon General

Vision: To be the **Healthiest State** in the Nation

May 8, 2020

Joseph A Greco, M.D.
142 Millstone Way
Canton, GA 30115

Dear Dr. Greco:
File: 143651

Thank you for considering Florida for physician licensure. Your application for medical licensure has been received. The application is incomplete for the reasons set out in the attached deficiency notice. Please address these deficiencies as soon as possible to avoid delay in processing your application.

Information received by this office may require additional explanation or documentation to determine licensure eligibility. After all requested documentation is received, your application will be submitted for supervisory review. We will notify you if additional information is required.

Applicants with a history of malpractice, criminal activity, discipline, physical or mental impairment, unfavorable evaluations, or other matters that need explanation may require a personal appearance before the Board of Medicine Credentials Committee for determination of licensure eligibility. If your appearance is required, you will be notified in writing once your application is complete.

You can now follow the progress of your application through our website at: www.FLHealthSource.gov/mqa-services. If you are a returning user, select "Yes" and enter the user ID and password you selected during the registration process under Returning User. If you did not apply for licensure through this screen, select "No" and follow the prompts to create an account. You must have a valid email address to create your account.

Once you are logged in, you will be prompted to add your application to your account. Once you have successfully added your application, you will be directed to your dashboard. Under the "Additional Activities" section, select "Check Application Status" to review any open deficiencies, upload documents or print out instructional documents.

THIS IS IMPORTANT: Your application will remain incomplete until all deficiencies are completed. In addition, you are required to notify the Board office immediately in writing of any occurrence(s) that would in any way change or affect any answer given in the application or an answer provided in response to any of our direct questions to you.

If you have any questions, please contact me at cheryl.smiley@flhealth.gov, call (850) 617-1917, or fax (850) 412-1278.

Sincerely,

Cheryl Smiley
Regulatory Specialist II

Enclosure(s)

Florida Department of Health
Division of Medical Quality Assurance • Bureau of HCPR
4052 Bald Cypress Way, Bin C03 • Tallahassee, FL 32399-3253
PHONE: (850)245-4131 • FAX : (850) 488-0596

PHAB Accredited Health Department
Public Health Accreditation Board

Joseph A Greco III, MD
142 Millstone Way
Canton, Georgia 30115
jag3md@gmail.com ~ 615/775*8300

April 29, 2020

Florida Medical Board
Department of Health
PO Box 6330
Tallahassee, Florida 32314-6330
To Whom It May Concern:

Ms. Wendy Alls asked me to include the enclosed documentation with my new application. I applied for my license in March of 2018 but did not see it to completion for personal reasons. Ms. Alls indicated that all of my verification information (Medical School, Residency, USMLE, Livescan) would be sufficient except for new NPDB (enclosed) and state medical license (submitted request to Veridoc).

Additionally, I have enclosed my application fee and two (2) document that Ms. Alls said you would make sure were given to the Chairman of the Board, Dr. Zachariah: a letter addressed to him and a copy of the letter I sent to the board last year regarding a state of Tennessee Reprimand.

Thank you so much for your help with my application process. Please let me know if you have any questions and what further information you need from me if any.

Sincerely,

Joe Greco

THE AMERICAN BOARD OF SURGERY

July 13, 2020

Re: Joseph A. Greco, M.D.

Thank you for your recent inquiry to the American Board of Surgery (ABS) regarding the certification status of the above named surgeon. The specific status of this surgeon with the ABS is listed below.

Surgery	**Current Status: Certified** **Not Meeting CC Requirements**	**Certificate #054992** **Initial Certification Date: January 26, 2010** **Expiration Date: December 31, 2020**

Please inform us immediately if your information differs from what we have supplied above. If you have questions regarding this information, please contact the ABS office.

Jo Buyske, M.D.
President and CEO

FLORIDA | Board of Medicine

Ron DeSantis
Governor

Scott A. Rivkees, MD
State Surgeon General

Chair
Zachariah Zachariah, M.D.
Ft. Lauderdale, Florida

Members
Hector Vila, M.D.
Tampa, Florida
Vice-Chair

Luz Marina Pages, M.D.
Miami Beach, Florida

Scot N. Ackerman, M.D.
Jacksonville, Florida

Eleonor Pimentel, M.D.
Miami, Florida

David A. Diamond, M.D.
Winter Park, Florida

Vacant, Consumer Member

Robert London, M.D.
Maitland, Florida

Jorge J. Lopez, M.D.
Maitland, Florida

Andre M. Perez
Miami, Florida

Kevin Cairns, M.D.
Fort Lauderdale, Florida

Nicholas W. Romanello, Esq.
Melbourne, Florida

Sarvam TerKonda, M.D.
Jacksonville, Florida

Shailesh Gupta, M.D.
Coral Springs, Florida

Vacant, M.D.

Executive Director
Claudia Kemp, J.D.

September 7, 2020

Jesus Andres Montano, MD
3633 SW 24 Avenue
Creek Club Apartments #9
Miami, Florida 33142

Dear Dr. Montano:

This is in further reference to your application for licensure by examination.

Please be advised that you are required to make a personal appearance before the Credentials Committee of the Board of Medicine to discuss:

- Failure to meet section 458.311(1)(f)3.c., Florida Statutes, postgraduate training

In addition, the Committee may inquire into any other issues relating to your application and eligibility for licensure.

Date:	Thursday, October 1, 2020
Time:	8:00 a.m. (Meeting starts at 8:00 a.m. Interview time may vary.)
Location:	The in-person meeting scheduled in Orlando, Florida is cancelled, and the meeting will be held by a web-based meeting platform or, if appropriate, a teleconference call.

The meeting information and directions for participating in the October 2020 meeting will be posted on the Florida Board of Medicine's website: https://flboardofmedicine.gov/meeting-information.

Additionally, the Committee's recommendation on your application for licensure will be presented to the full Board of Medicine on Friday, October 2, 2020 for final action. You are not required to attend the full board meeting.

Thank you for your continued cooperation. Should you have any questions regarding this matter, please feel free to contact me. *This is your first scheduled appearance.

Sincerely,

Angela Denson

Angela Denson
Regulatory Supervisor

Pursuant to the provisions of the Americans with Disabilities Act, any person requiring special accommodations to participate in this workshop/meeting is asked to advise the agency at least 10 days before the workshop/meeting by contacting: Rebecca.Hewett@flhealth.gov or call (850) 245-4137.

*** 456.013(3)(c) In considering applications for licensure, the board, or the department when there is no board, may require a personal appearance of the applicant. If the applicant is required to appear, the time period in which a licensure application must be granted or denied shall be tolled until such time as the applicant appears. However, if the applicant fails to appear before the board at either of the next two regularly scheduled board meetings, or fails to appear before the department within 30 days if there is no board, the application for licensure shall be denied.**

4052 Bald Cypress Way, Bin C-03
Tallahassee, Florida 32399-3253
Phone: 850/245-4131
Fax: 850/488-0596 or 850/412-1268
https://www.FLBoardofMedicine.gov

Florida HEALTH

Application

Application Detail

License Type:	**Medical Doctor**
Profession Number:	**1501 - Medical Doctor**
File Number:	**149791**
Application:	**Medical Doctor by Exam Application**
Application Date:	**07/01/2020**

Suitability Question(s)

Have you passed all parts of a United States national examination (NBME, FLEX, or USMLE)? OR Are you licensed on the basis of a state board examination and currently hold a license in at least one other jurisdiction of the United States or Canada, have practiced pursuant to such licensure for a period of at least 10 years, and have received a passing score on the Special Purpose Examination of the Federation of State Medical Boards of the United States (SPEX)? OR Were you licensed prior to 1974 on the basis of a state board examination, are currently licensed in at least three other jurisdictions of the United States or Canada, and have practiced pursuant to such licensure for a period of at least 20 years	**Yes**

Application Questions

Military Veteran Fee Waiver - I have been honorably discharged from a branch of the United States Armed Forces within the previous 60 months.	**No**
I am selecting NICA Non-Participating - (I understand that a $250.00 fee will be included if I select this option.)	**Yes**

Address:	**3633 NW 24 AVE** **Creek Club Apartments** **Apt. 9** **MIAMI-DADE** **MIAMI, FL** **33142** **US**
Phone Number:	**786-337-2253**

License Attributes Selected

Qualification	**Dispensing Practitioner**

Federal Credentials Verification Services (FCVS)

Are you using the FCVS to verify your core credentials?	**Yes**

Education History

School Name:	**PONTIFICIA UNIVERSIDAD JAVERIANA**
Street Address Line 1:	**Cra. 7 #No. 40 - 62, Bogotá, Colombia**
Street Address Line 2:	**N/A**
City:	**Bogotá**
State:	**N/A**
Postal/Zip:	**110231**
Country:	**COLUMBIA**
Date of Graduation (mm/dd/yyyy):	**07/24/2014**
Attended From (mm/dd/yyyy):	**01/14/2008**
Attended To (mm/dd/yyyy):	**05/31/2014**

Additional Education Questions

Are you currently in default on any health education loan or scholarship obligation?	**No**
Have you completed the equivalent of 2 academic years of preprofessional, postsecondary education including, courses in anatomy, biology, and chemistry prior to entering medical school?	**Yes**

Fifth Pathway

Did you attend an international medical school and do not possess a valid ECFMG Certificate?	**No**
Did you receive a bachelor's degree from an accredited United States college or University?	**No**
Did you study at a medical school which is recognized by the World Health Organization?	**Yes**
Did you complete all of the formal requirement of the International medical school, except the internship or social service requirements, and pass part I of the National board of Medical examination or the Education Commission for Foreign Medical Graduates Examination equivalent?	**Yes**
Did you complete an academic year of supervised clinical training in a hospital affiliated with a medical school approved by the Council on Medical Education of the American Medical Association and upon completion passed part II of the National Board of Medical Examiners examination or the Education Commission for Foreign Medical Graduates examination Equivalent?	**Yes**

Postgraduate Training

Program Name:	**General**
Mailing Address:	**1611 NW 12th Ave, Miami, FL 33136**
Program City:	**Miami**
Program State or Country:	**UNITED STATES**
Program Type:	**RESIDENCY**
Specialty Area:	**GS - SURGERY**
Attended From (mm/dd/yyyy):	**06/24/2017**
Attended To (mm/dd/yyyy):	**06/23/2019**
Did you receive credit?	**Yes**

Exam History

Examination:	**USMLE/FOREIGN**
Date Passed (mm/dd/yyyy):	**07/25/2019**

United States Military and/or Public Health

Have you ever been in the United States Military and/or Public Health Service?	**No**
Have you ever been disciplined by any branch of the United States Armed Services or Public Health Service?	**No**

Practice Employment

Place of Employment:	**Jackson Memorial Hospital**
Address Line 1:	**1611 NW 12th Ave, Miami, FL 33**
Address Line 2:	**N/A**
City:	**Miami**
State:	**FL**
Begin Date (mm/dd/yyyy):	**06/24/2017**
End Date (mm/dd/yyyy):	**06/23/2019**

If 'to present', enter today's date.

Other State License

Do you now hold or have you ever held a license to practice medicine or any other profession in any US State or territory?	**No**

Request verification of licensure status directly from the licensing entity or www.veridoc.org. Request international license verification(s) if you have practiced outside of the U.S. for at least two of the previous four years.

Additional Employment Questions

Have you practiced medicine in any jurisdiction for two of the last four years or completed a board approved post-graduate training program within the last two years?	**Yes**

Graduate Education

Do you currently, or have you had, responsibility for graduate medical education within the last 10 years?	**Yes**

Initial Graduate Medical Education Responsibility and Faculty Appointments 1

List all institutions where you have had responsibility for graduate medical education or faculty appointment(s) at any medical school.

Name of Institution: **JACKSON MEMORIAL HOSPITAL**

Initial Graduate Medical Education Responsibility and Faculty Appointments 2

List all institutions where you have had responsibility for graduate medical education or faculty appointment(s) at any medical school.

Name of Institution: **VETERAN AFFAIRS**

Initial Graduate Medical Education Responsibility and Faculty Appointments 3

List all institutions where you have had responsibility for graduate medical education or faculty appointment(s) at any medical school.

Name of Institution: **UNIVERSITY OF MIAMI SCHOOL OF MEDICINE**

Staff Privileges

Do you currently hold staff privileges in any hospital, health institution, clinic or medical facility?	**No**

Specialty Board Certifications

Are you certified by any specialty board recognized by the American Board of Medical Specialties or specialty board approved by the Florida Board of Medicine?	**No**

DEA

Have you ever been denied, or surrendered, a DEA registration?	**No**

Criminal History

Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to, a crime in any jurisdiction other than a minor traffic offense?	**No**

You must include all misdemeanors and felonies, even if adjudication was withheld. Driving under the influence (DUI) or driving while impaired (DWI) are not minor traffic offenses for purposes of this question.

Medicaid / Medicare

1. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, F.S. (relating to social and economic assistance), Chapter 817, F.S. (relating to fraudulent practices), Chapter 893, F.S. (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction?	**No**
2. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970 (relating to controlled substances) or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)?	**No**
3. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, F.S.?	**No**
4. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program?	**No**
5. Are you currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities?	**No**

Health History

In the last five years, have you been enrolled in, required to enter into, or participated in any drug and/or alcohol recovery program or impaired practitioner program for treatment of drug or alcohol abuse that occurred within the past five years?	**No**
In the last five years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental disorder or impairment?	**No**
During the last five years, have you been treated for or had a recurrence of a diagnosed mental disorder that has impaired your ability to practice medicine within the past five years?	**No**
During the last five years, have you been treated for or had a recurrence of a diagnosed physical disorder that has impaired your ability to practice medicine?	**No**
In the last five years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol/drug) disorder or, if you were previously in such a program, did you suffer a relapse within the last five years?	**No**
During the last five years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol/drug) disorder that impaired your ability to practice medicine within the last five years?	**No**

Electronic Fingerprinting

I have been provided and read the statement from the Florida Department of Law Enforcement regarding the sharing, retention, privacy and right to challenge incorrect criminal history records and the 'Privacy Statement' document from the Federal Bureau of Investigation.	**Yes**
Enter in today's date	**07/01/2020**

Medical Malpractice Question

Have you ever had a judgment entered against you for medical malpractice where the incident(s) of malpractice occurred after November 2, 2004?	**No**

Liability Claims

Within the last 10 years have you had any liability claim(s) or action(s) for damages for personal injury settled or finally adjudicated in an amount that exceeds $100,000.00?	**No**

Financial Responsibility/Exemption

Financial Responsibility	**3. LIABILITY NOT LESS THAN $100,000**

FDA Licensing

Have you ever had any professional license or license to practice medicine revoked, suspended, placed on probation, or other disciplinary action taken in any state, territory or country?	**No**

FDA Institution

Have you ever had any staff privileges denied, suspended, revoked, modified, restricted, not renewed or placed on probation, or have you been asked to resign or take a temporary leave of absence or were otherwise acted against by any facility?	**No**

FDANP Denied

Have you had any application for a medical license or professional license denied by any state board or other governmental agency of any state, territory, or country?	**No**

FDANP Investigation

Are you currently under investigation in any jurisdiction for an act or offense that would constitute a violation of Section 458.331, Florida Statutes?	**No**

Specialty Board Discipline History

Have you ever had any final disciplinary action taken against you by a specialty board or other similar national organization?	**No**

Year Began Practice

Year Began Practice:	**06/23/2017**

Availability for Disaster

Are you willing to provide health care services in special need shelters or to work with disaster medical teams during times of emergency or major disasters?	**Yes**

Attachments

Document Type: Miscellaneous Documents File Name: SSN.pdf

Fees

Application Fee	**$350.00**
Unlicensed Activity	**$5.00**
Dispensing Fee	**$100.00**
Initial License	**$350.00**
NICA Fee	**$250.00**
Total Amount Due:	**$1055.00**

Attestation

I state that these statements are true and correct. I recognize that providing false information may result in denial of licensure, disciplinary action against my license, or criminal penalties pursuant to Sections 456.067, 775.083, and 775.084, Florida Statutes. I state that I have read Chapters 456, 458 and 766.301-.316, Florida Statutes and Chapter 64B8, Florida Administrative Code.

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Florida Board of Medicine information which is material to my application for licensure.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind. I state that my answers and all statements made by me herein are true and correct.

Should I furnish any false information in this application, I hereby agree that such act constitutes cause for denial, suspension, or revocation of my license to practice Medicine in the State of Florida. If there are any changes to my status or any change that would affect any of my answers to this application I must notify the board within 30 days.

I understand that my records are protected under federal and state regulations governing Confidentiality of Mental Health Patient Records and cannot be disclosed without my written consent unless otherwise provided in the regulations. I understand that my records are protected under federal and state regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it.

Attestation Answer: Yes

July 14, 2020

Jesus Andres Montano , M.D.
3633 Nw 24 Ave
Creek Club Apartments
Apt. 9
Miami, FL 33142

Dear Dr. Montano:
File: 149791

Thank you for considering Florida for physician licensure. Your application for medical licensure has been received. The application is incomplete for the reasons set out in the attached deficiency notice. Please address these deficiencies as soon as possible to avoid delay in processing your application.

Information received by this office may require additional explanation or documentation to determine licensure eligibility. After all requested documentation is received, your application will be submitted for supervisory review. We will notify you if additional information is required.

Applicants with a history of malpractice, criminal activity, discipline, physical or mental impairment, unfavorable evaluations, or other matters that need explanation may require a personal appearance before the Board of Medicine Credentials Committee for determination of licensure eligibility. If your appearance is required, you will be notified in writing once your application is complete.

You can now follow the progress of your application through our website at: www.FLHealthSource.gov/mqa-services. If you are a returning user, select “Yes” and enter the user ID and password you selected during the registration process under Returning User. If you did not apply for licensure through this screen, select “No” and follow the prompts to create an account. You must have a valid email address to create your account.

Once you are logged in, you will be prompted to add your application to your account. Once you have successfully added your application, you will be directed to your dashboard. Under the “Additional Activities” section, select “Check Application Status” to review any open deficiencies, upload documents or print out instructional documents.

THIS IS IMPORTANT: Your application will remain incomplete until all deficiencies are completed. In addition, you are required to notify the Board office immediately in writing of any occurrence(s) that would in any way change or affect any answer given in the application or an answer provided in response to any of our direct questions to you.

If you have any questions, please contact me at Hazel.Myles@flhealth.gov, call (850) 617-1915, or fax (850) 412-1277.

Sincerely,

Hazel Myles
Regulatory Specialist II

Enclosure(s)

Myles, Hazel

From: JESUS MONTANO <andresmontano1711@gmail.com>
Sent: Tuesday, July 21, 2020 8:02 AM
To: Myles, Hazel
Cc: JESUS MONTANO
Subject: Unrestricted Florida Medical License Application
Attachments: PGY-1 Jackson Contract.pdf; Jackson Diploma.pdf; PGY-2 Jackson Contract.pdf

Good morning Ms. Myles

I hope this email finds you well,

My name is Jesus A. Montano, applicant for the unrestricted Florida Medical License with File #149791; you can also locate my file from my previous Resident Registration #25777. I am writing you because I have a particular type of case and I would like to request to make an appearance before the Credentials Committee of the Florida Board of Medicine as recommended by Ms. Gloria Nelson from The Florida Board of Medicine to explain in detail my case. I started working at Jackson Memorial Hospital back in June 24, 2017 in the Department of Surgery and subsequently continued my medical education in the area of Physical Medicine and Rehabilitation back in 2018. I had an unfortunate familiar calamity at the end of the second year of my residency program last year, my mom suffered Influenza Pneumonia leading her to a long stay in ICU and causing severe physical deconditioning with fecal and urinary incontinence. I was the only one who could have taken care of her so I decided to travel back to my Country of Birth Colombia under a Family Leave of absence. Unfortunately, it was longer than I expected so I reached a mutual resignation agreement with my program director Dr. Andrew Sherman, Program Director from the Physical Medicine and Rehabilitation program at Jackson Memorial Hospital where I completed 22 months of training, with resignation dated as April 8, 2019. This is the main reason I am currently writing because I would like to practice in Miami so I was wondering if I could be considered for approval of an unrestricted medical license.

Should you need any further information, please do not hesitate to contact to Mr. Roberto Campos-Marquetti, Director of Employee/Labor Relations and Workforce Compliance with the Jackson Health System's Human Resources to the following email address: Robert.CamposMarqu@jhsmiami.org.

Attach you can find my Jackson Diploma and PGY-1 and PGY-2 Post-graduate Training contracts. I also recently emailed Mr. Roberto Campos-Marquetti to obtain my Post-graduate Training Verification forms that I filled out and sent for signature but I haven't gotten a response yet. As soon as he sends me these files, I will upload them into the MQA FBOM System.

Thank you in advance for your time and consideration,

Have a blessed day and stay safe,
Jesus A. Montano.

POST-GRADUATE TRAINING VERIFICATION FORM

Please have this form completed by the Chairman/Director of the post-graduate training program you attended. Please note that if you are using FCVS, do not submit these items.

The form should be mailed or faxed to:

FLORIDA BOARD OF MEDICINE
4052 BALD CYPRESS WAY, BIN C-03
TALLAHASSEE, FLORIDA 32399-3253
(850) 412-1268 Facsimile

University of Miami/Jackson Health System
Name of School

General Surgery
Department

1611 NW 12th Avenue
Address

Miami, FL 33136
City, State, Zip

1. Name of Resident: Jesus Andres Montano Saavedra

2. Internship/Residency/Fellowship: From: 06/24/2017 To: 06/23/2018

3. Matriculation Date: 06/24/2017

4. Completion Date: 06/23/2018

5. Specialty: General Surgery

6. Levels completed (check all that apply):

PGY I X PGY II ___ PGY III ___ PGY IV ___ PGY V ___

Signed: _____
Chairman or Program Director Only
(No stamped signatures please).

POST-GRADUATE TRAINING VERIFICATION FORM

Please have this form completed by the Chairman/Director of the post-graduate training program you attended. Please note that if you are using FCVS, do not submit these items.

The form should be mailed or faxed to:

FLORIDA BOARD OF MEDICINE
4052 BALD CYPRESS WAY, BIN C-03
TALLAHASSEE, FLORIDA 32399-3253
(850) 412-1268 Facsimile

Jackson Memorial Hospital
Name of School

Physical Medicine and Rehabilitation
Department

1611 NW 12th Ave
Address

Miami, FL, 33136
City, State, Zip

1. Name of Resident: JESUS ANDRES MONTANO SAAVEDRA

2. Internship/Residency/Fellowship: From: 08/20/2018 To: 03/08/2019

3. Matriculation Date: 08/20/2018

4. Completion Date: 03/08/2019

5. Specialty: Physical Medicine and Rehabilitation

6. Levels completed (check all that apply): — Not completed

PGY I___ PGY II X PGY III___ PGY IV___ PGY V___

Signed: _____
Chairman or Program Director Only
(No stamped signatures please).

Department of Health

JESUS ANDRES MONTANO

License Number: TRN25777

Data As Of 9/7/2020

Profession	Resident Registration
License	TRN25777
License Status	NULL AND VOID/
License Expiration Date	6/30/2019
License Original Issue Date	08/02/2017
Address of Record	If further information is needed, please contact the Department of Health at (850) 488-0595.
Controlled Substance Prescriber (for the Treatment of Chronic Non-malignant Pain)	No
Discipline on File	No
Public Complaint	No

The information on this page is a secure, primary source for license verification provided by the Florida Department of Health, Division of Medical Quality Assurance. This website is maintained by Division staff and is updated immediately upon a change to our licensing and enforcement database.

Chair
Zachariah Zachariah, M.D.
Ft. Lauderdale, Florida

Members
Hector Vila, M.D.
Tampa, Florida
Vice-Chair

Luz Marina Pages, M.D.
Miami Beach, Florida

Scot N. Ackerman, M.D.
Jacksonville, Florida

Eleonor Pimentel, M.D.
Miami, Florida

David A. Diamond, M.D.
Winter Park, Florida

Vacant, Consumer Member

Robert London, M.D.
Maitland, Florida

Jorge J. Lopez, M.D.
Maitland, Florida

Andre M. Perez
Miami, Florida

Kevin Cairns, M.D.
Fort Lauderdale, Florida

Nicholas W. Romanello, Esq.
Melbourne, Florida

Sarvam TerKonda, M.D.
Jacksonville, Florida

Shailesh Gupta, M.D.
Coral Springs, Florida

Vacant, M.D.

Executive Director
Claudia Kemp, J.D.

September 5, 2020

Jad Dughayli, MD
24171 Penn Street
Dearborn, MI 48124

Dear Dr. Dughayli:

This is in further reference to your application for licensure by endorsement.

Please be advised that you are required to make a personal appearance before the Credentials Committee of the Board of Medicine to discuss:

- **Failure to meet section 458.313(1)(a) and 458.311(1)(f)3.c., Florida Statutes, postgraduate training**

In addition, the Committee may inquire into any other issues relating to your application and eligibility for licensure.

Date:	Thursday, October 1, 2020
Time:	8:00 a.m. (Meeting starts at 8:00 a.m. Interview time may vary.)
Location:	The in-person meeting scheduled in Orlando, Florida is cancelled, and the meeting will be held by a web-based meeting platform or, if appropriate, a teleconference call.

The meeting information and directions for participating in the October 2020 meeting will be posted on the Florida Board of Medicine's website: https://flboardofmedicine.gov/meeting-information.

Additionally, the Committee's recommendation on your application for licensure will be presented to the full Board of Medicine on Friday, October 2, 2020 for final action. You are not required to attend the full board meeting.

Thank you for your continued cooperation. Should you have any questions regarding this matter, please feel free to contact me. *This is your first scheduled appearance.

Sincerely,

Karrell D. Goldwire

Karrell D. Goldwire
Regulatory Supervisor

Pursuant to the provisions of the Americans with Disabilities Act, any person requiring special accommodations to participate in this workshop/meeting is asked to advise the agency at least 10 days before the workshop/meeting by contacting: Rebecca.Hewett@flhealth.gov or call (850) 245-4137.

*** 456.013(3)(c) In considering applications for licensure, the board, or the department when there is no board, may require a personal appearance of the applicant. If the applicant is required to appear, the time period in which a licensure application must be granted or denied shall be tolled until such time as the applicant appears. However, if the applicant fails to appear before the board at either of the next two regularly scheduled board meetings, or fails to appear before the department within 30 days if there is no board, the application for licensure shall be denied.**

Application

Application Detail

License Type:	**Medical Doctor**
Profession Number:	**1501 - Medical Doctor**
File Number:	**149603**
Application:	**Medical Doctor Endorsement Application**
Application Date:	**06/17/2020**

Suitability Question(s)

Are you an osteopathic physician?	**No**

Application Questions

Military Veteran Fee Waiver - I have been honorably discharged from a branch of the United States Armed Forces within the previous 60 months.	**No**
I am selecting NICA Non-Participating - (I understand that a $250.00 fee will be included if I select this option.)	**No**
I will qualify for "In Training" status at the approval of my licensure application.	**Yes**
I plan to dispense medicinal drugs in the State of Florida for a fee or other remuneration and hereby register as required by Section 465.0276,F.S. I understand that the fee for the Dispensing Practitioner is $100.00 over and above the required initial license fee and will submit it along with the license fee.	**Yes**
Military Veteran Spouse Fee Waiver - I am the spouse of a military veteran who has been honorably discharged from a branch of the United States Armed Forces within the previous 60 months.	**No**

Education History

School Name:	**UNIVERSITY OF SINT EUSTATIUS**
Street Address Line 1:	**4953 Presidents Way, Ste A**
Street Address Line 2:	**N/A**
City:	**Tucker**
State:	**GEORGIA**
Postal/Zip:	**30084**
Country:	**UNITED STATES OF AMERICA**
Date of Graduation (mm/dd/yyyy):	**06/03/2013**
Attended From (mm/dd/yyyy):	**01/12/2009**
Attended To (mm/dd/yyyy):	**06/03/2013**

Additional Education Questions

Are you currently in default on any health education loan or scholarship obligation?	**No**
Have you completed the equivalent of 2 academic years of preprofessional, postsecondary education including, courses in anatomy, biology, and chemistry prior to entering medical school?	**Yes**

Fifth Pathway

Did you attend an international medical school and do not possess a valid ECFMG Certificate?	**No**
Did you receive a bachelor's degree from an accredited United States college or University?	**No**
Did you study at a medical school which is recognized by the World Health Organization?	**Yes**
Did you complete all of the formal requirement of the International medical school, except the internship or social service requirements, and pass part I of the National board of Medical examination or the Education Commission for Foreign Medical Graduates Examination equivalent?	**Yes**
Did you complete an academic year of supervised clinical training in a hospital affiliated with a medical school approved by the Council on Medical Education of the American Medical Association and upon completion passed part II of the National Board of Medical Examiners examination or the Education Commission for Foreign Medical Graduates examination Equivalent?	**Yes**

Postgraduate Training 1

Program Name:	**american university of beirut**
Mailing Address:	**P.O. Box: 11-0236,Riad el Saleh, Beirut 1107 2020**
Program City:	**Beirut**
Program State or Country:	**LEBANON**
Program Type:	**RESIDENCY**
Specialty Area:	**AN - ANESTHESIOLOGY**
Attended From (mm/dd/yyyy):	**06/16/2014**
Attended To (mm/dd/yyyy):	**06/17/2018**
Did you receive credit?	**No**

Postgraduate Training 2

Program Name:	**State university of new york at Buffalo**
Mailing Address:	**77 Goodell Street, Suite 550,**
Program City:	**Buffalo**
Program State or Country:	**UNITED STATES**
Program Type:	**FELLOWSHIP**
Specialty Area:	**AN - PEDIATRIC ANESTHESIOLOGY**
Attended From (mm/dd/yyyy):	**07/01/2018**
Attended To (mm/dd/yyyy):	**07/01/2019**
Did you receive credit?	**No**

Exam History

Examination:	**USMLE/US/CANADA**
Date Passed (mm/dd/yyyy):	**09/03/2019**

United States Military and/or Public Health

Have you ever been in the United States Military and/or Public Health Service?	**No**
Have you ever been disciplined by any branch of the United States Armed Services or Public Health Service?	**No**

Practice Employment

Place of Employment:	**Great Lakes Anesthesiology**
Address Line 1:	**1001 Main St, Buffalo, NY 1420**
Address Line 2:	**N/A**

City: **Buffalo**

State: **NY**

Type of Employment: **full time anesthesiologist**

Begin Date (mm/dd/yyyy): **07/01/2019**

End Date (mm/dd/yyyy): **06/17/2020**

If 'to present', enter today's date.

Other State Licenses

Do you now hold or have you ever held a license to practice medicine or any other profession in any US State or territory, or foreign country? **Yes**

Request verification of licensure status directly from the licensing entity or www.veridoc.org. Request international license verification(s) if you have practiced outside of the U.S. for at least two of the previous four years.

License Number: **301692**

Profession: **medicine and surgery**

Jurisdiction - Country: **UNITED STATES**

Jurisdiction - State: **NEW YORK**

Additional Employment Questions

Have you practiced medicine in any jurisdiction for two of the last four years or completed a board approved post-graduate training program within the last two years? **Yes**

Graduate Education

Do you currently, or have you had, responsibility for graduate medical education within the last 10 years? **No**

Initial Graduate Medical Education Responsibility and Faculty Appointments

List all institutions where you have had responsibility for graduate medical education or faculty appointment(s) at any medical school.

Name of Institution: **N/A**

Staff Privileges 1

Do you currently hold staff privileges in any hospital, health institution, clinic or medical facility? **Yes**

The facilities listed are Florida facilities. If your privileges are for a facility in another state, select "Out of State".

Name of Facility: **OUT OF STATE**

Out of State Facility: **Olean General Hospital**

Staff Privileges 2

Do you currently hold staff privileges in any hospital, health institution, clinic or medical facility?	**Yes**

The facilities listed are Florida facilities. If your privileges are for a facility in another state, select "Out of State".

Name of Facility:	**OUT OF STATE**
Out of State Facility:	**Oishei Children Hospital**

Specialty Board Certifications

Are you certified by any specialty board recognized by the American Board of Medical Specialties or specialty board approved by the Florida Board of Medicine?	**No**

DEA

Have you ever been denied, or surrendered, a DEA registration?	**No**

Criminal History

Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to, a crime in any jurisdiction other than a minor traffic offense?	**No**

You must include all misdemeanors and felonies, even if adjudication was withheld. Driving under the influence (DUI) or driving while impaired (DWI) are not minor traffic offenses for purposes of this question.

Medicaid / Medicare

1. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, F.S. (relating to social and economic assistance), Chapter 817, F.S. (relating to fraudulent practices), Chapter 893, F.S. (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction?	**No**
2. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970 (relating to controlled substances) or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)?	**No**
3. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, F.S.?	**No**
4. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program?	**No**

5. Are you currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities?	**No**

Health History

In the last five years, have you been enrolled in, required to enter into, or participated in any drug and/or alcohol recovery program or impaired practitioner program for treatment of drug or alcohol abuse that occurred within the past five years?	**No**
In the last five years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental disorder or impairment?	**No**
During the last five years, have you been treated for or had a recurrence of a diagnosed mental disorder that has impaired your ability to practice medicine within the past five years?	**No**
During the last five years, have you been treated for or had a recurrence of a diagnosed physical disorder that has impaired your ability to practice medicine?	**No**
In the last five years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol/drug) disorder or, if you were previously in such a program, did you suffer a relapse within the last five years?	**No**
During the last five years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol/drug) disorder that impaired your ability to practice medicine within the last five years?	**No**

Electronic Fingerprinting

I have been provided and read the statement from the Florida Department of Law Enforcement regarding the sharing, retention, privacy and right to challenge incorrect criminal history records and the 'Privacy Statement' document from the Federal Bureau of Investigation.	**Yes**
Enter in today's date	**06/17/2020**

Medical Malpractice Question

Have you ever had a judgment entered against you for medical malpractice where the incident(s) of malpractice occurred after November 2, 2004?	**No**

Liability Claims

Within the last 10 years have you had any liability claim(s) or action(s) for damages for personal injury settled or finally adjudicated in an amount that exceeds $100,000.00?	**No**

Financial Responsibility/Exemption

Financial Responsibility	**4. LIABILITY NOT LESS THAN $250,000**

FDA Institution

Have you ever had any staff privileges denied, suspended, revoked, modified, restricted, not renewed or placed on probation, or have you been asked to resign or take a temporary leave of absence or were otherwise acted against by any facility?	**No**

FDA Licensing

Have you ever had any professional license or license to practice medicine revoked, suspended, placed on probation, or other disciplinary action taken in any state, territory or country?	**No**

FDANP Denied

Have you had any application for a medical license or professional license denied by any state board or other governmental agency of any state, territory, or country?	**No**

FDANP Investigation

Are you currently under investigation in any jurisdiction for an act or offense that would constitute a violation of Section 458.331, Florida Statutes?	**No**

Specialty Board Discipline History

Have you ever had any final disciplinary action taken against you by a specialty board or other similar national organization?	**No**

Year Began Practice

Year Began Practice:	**07/01/2020**

Availability for Disaster

Are you willing to provide health care services in special need shelters or to work with disaster medical teams during times of emergency or major disasters?	**Yes**

Attachments

Document Type: Certificate File Name: 2029 passport.pdf

Document Type: Initial Application Supporting Documentation File Name: sint eustatius diploma.pdf

Document Type: Initial Application Supporting Documentation File Name: aubmc diploma residency.pdf

Document Type: Initial Application Supporting Documentation File Name: NYS licenses.pdf

Document Type: Initial Application Supporting Documentation File Name: pediatric anesthesia fellowship certificate.pdf

Fees

Initial License -	**$-350.00**
NICA Fee -	**$-250.00**
Application	**$350.00**
Initial License TRNG	**$200.00**
Unlicensed Activity	**$5.00**
Dispensing	**$100.00**
NICA Part. Phys. Fee	**$4750.00**
Initial License	**$350.00**
NICA Fee	**$250.00**
Total Amount Due:	**$5405.00**

Attestation

I state that these statements are true and correct. I recognize that providing false information may result in denial of licensure, disciplinary action against my license, or criminal penalties pursuant to Sections 456.067, 775.083, and 775.084, Florida Statutes. I state that I have read Chapters 456, 458 and 766.301-.316, Florida Statutes and Chapter 64B8, Florida Administrative Code.

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Florida Board of Medicine information which is material to my application for licensure.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind. I state that my answers and all statements made by me herein are true and correct.

Should I furnish any false information in this application, I hereby agree that such act constitutes cause for denial, suspension, or revocation of my license to practice Medicine in the State of Florida. If there are any changes to my status or any change that would affect any of my answers to this application I must notify the board within 30 days.

I understand that my records are protected under federal and state regulations governing Confidentiality of Mental Health Patient Records and cannot be disclosed without my written consent unless otherwise provided in the regulations. I understand that my records are protected under federal and state regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it.

Attestation Answer: Yes

June 22, 2020

Jad Dughayli, M.D.
24171 Penn St
Dearborn, MI 48124

Dear Dr. Dughayli:
File: 149603

Thank you for considering Florida for physician licensure. Your application for medical licensure has been received. The application is incomplete for the reasons set out in the attached deficiency notice. Please address these deficiencies as soon as possible to avoid delay in processing your application.

Information received by this office may require additional explanation or documentation to determine licensure eligibility. After all requested documentation is received, your application will be submitted for supervisory review. We will notify you if additional information is required.

Applicants with a history of malpractice, criminal activity, discipline, physical or mental impairment, unfavorable evaluations, or other matters that need explanation may require a personal appearance before the Board of Medicine Credentials Committee for determination of licensure eligibility. If your appearance is required, you will be notified in writing once your application is complete.

You can now follow the progress of your application through our website at: www.FLHealthSource.gov/mqa-services. If you are a returning user, select "Yes" and enter the user ID and password you selected during the registration process under Returning User. If you did not apply for licensure through this screen, select "No" and follow the prompts to create an account. You must have a valid email address to create your account.

Once you are logged in, you will be prompted to add your application to your account. Once you have successfully added your application, you will be directed to your dashboard. Under the "Additional Activities" section, select "Check Application Status" to review any open deficiencies, upload documents or print out instructional documents.

THIS IS IMPORTANT: Your application will remain incomplete until all deficiencies are completed. In addition, you are required to notify the Board office immediately in writing of any occurrence(s) that would in any way change or affect any answer given in the application or an answer provided in response to any of our direct questions to you.

If you have any questions, please contact me at carmelette.gilley@flhealth.gov, call (850) 617-1906, or fax (850) 412-1284.

Sincerely,

Carmen Gilley

Carmen Gilley
Regulatory Specialist II

Enclosure(s)

Jad Dughayli **Date: June 22, 2020**

REMINDER: Chapter 456.013(1)(a), Florida Statutes, provides that an incomplete application shall expire one year after initial filing with the department.

YOUR APPLICATION'S EXPIRATION DATE IS JUNE 21, 2021

APPLICATION SUBMITTED REMAINS DEFICIENT FOR LACK OF THE FOLLOWING:

Your ECFMG status report, directly from the ECFMG, has not been received.

An official verification of your medical license from the state of NY has not been received

The inquiry you mailed to your medical school has not been received.

Your Postgraduate Training Verification Form for year18-19 have not been received.

Your application reflects you trained at State University of New York at Buffalo from 07/18 to 07/19. Chapter 458.311 Florida Statutes states that an international medical graduate must have completed an ACGME approved residency or fellowship program of at least two progressive years in one specialty area. However, to be acceptable, the fellowship experience and training must be counted toward regular or subspecialty certification by a board recognized and certified by the American Board of Medical Specialties. It appears that you do not meet this requirement, please notify the board of your intensions.

Your FCVS Profile has not been received. Please contact FCVS to check the status of your profile.

Please submit the National Practitioner Data Bank (NPDB) report to our office. You may contact the NPDB at 1-800-767-6732 to obtain this information.

We await your FLEX/USMLE/SPEX/National Board exam scores, direct from the Federation of State Medical Boards, which must be requested by the applicant.

We have not received your Livescan results. If you have already had your electronic fingerprinting completed, please allow 24-72 hours for receipt of your results. You can find more information on this process, including how to find a provider in your area and your ORI number, by visiting the Background Screening Website at http://www.flhealthsource.gov/background-screening/. Should your Criminal Background Check disclose an arrest record(s), you will need to provide documentation related to each criminal event revealed in your background, if you have not already done so. You can find a detailed description of documents that will be required by visiting the FAQs on the Background Screening Website (Click on 'General FAQs'). Note: Criminal History

will be reviewed by the Background Screening Unit, not the Board Office. Please email all criminal history documents to mqa.backgroundscreen@flhealth.gov. Any original certified documents must be mailed to the following address: Attn: Background Screening Unit Florida Department of Health 4052 Bald Cypress Way, Bin BSU-01 Tallahassee, FL, 32399

If you have any questions, please contact me at carmelette.gilley@flhealth.gov, call (850) 617-1906, or fax (850) 412-1284. The Florida Board of Medicine has assigned **149603** as your **tracking number**. Please indicate this number if you leave a message, and try to ensure that other sources include it on their communications to us as well.

NYSED.gov

OP OFFICE OF THE PROFESSIONS

Office of the Professions

Verification Searches

The information furnished at this web site is from the Office of Professions' official database and is updated daily, Monday through Friday. The Office of Professions considers this information to be a secure, primary source for license verification.

License Information *

07/17/2020

Name : DUGHAYLI JAD MOHAMAD
Address : DEARBORN MI
Profession : MEDICINE
License No: 301692
Date of Licensure : 10/22/2019
Additional Qualification :
Status : REGISTERED
Registered through last day of : 09/21
Medical School: UNIV OF SINT EUSTATIUS **Degree Date :** 06/03/2013

(Use your browser's back key to return to licensee list.)

* Use of this online verification service signifies that you have read and agree to the terms and conditions of use. See HELP glossary for further explanations of terms used on this page.

Note: The Board of Regents does not discipline *physicians(medicine), physician assistants,* or *specialist assistants.* The status of individuals in these professions may be impacted by information provided by the NYS Department of Health. To search for the latest discipline actions against individuals in these professions, please check the New York State Department of Health's Office of Professional Medical Conduct homepage.

Further information on physicians may be found on the following external sites (The State Education Department is not responsible for the accuracy or completeness of information located on external Internet addresses.):

American Board of Medical Specialties

American Medical Association:
- For the general public: AMA Physician Select, On-line Doctor Finder
- For organizations that verify physician credentials: AMA Physician Profiles

American Osteopathic Association, AOA-Net

Association of State Medical Board Executive Directors-(A.I.M."DOCFINDER")

New York State Department of Health Physician Profiles

The following sites provide additional information concerning the medical profession:

CLEAR (Council on Licensure, Enforcement and Regulation)

Federation of State Medical Boards

July 16, 2020 | 2:26 pm

Information on Novel Coronavirus

Coronavirus is still active in New York. We have to be smart. Wear a mask and maintain 6 feet distance in public.

Department of Health

GET THE FACTS >

Professional Misconduct and Physician Discipline

New Physician Search

Physician Records

Search Results - 0 documents found

On: 7/17/2020 9:33 AM

You searched for: Last Name: DUGHAYLI First Name: JAD MOHAMAD Middle Name: ----------

License: 301692 Type: ----------

Effective Date From: ---------- Effective Date To: ----------

Update Date From: ---------- Update Date To: ----------

*** If there is a list of name(s) above, click on each name to see the disciplinary information.**
If there is no list of names, there is no public disciplinary action that matches what you entered for the search.

Reminder: This database contains public disciplinary actions for 1990 and later.

Return to Professional Misconduct and Professional Discipline
Return to Welcome Page

Send questions or comments to:
opmc@health.ny.gov

Home Page / From the Commissioner / Directory Services / Vital Records /
Info for Consumers / Info for Providers / Info for Researchers /
Public Health Forum / What's New / HELP! / Search our Web Site

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Questions or comments: nhinfo@health.ny.gov Revised: March 2017

Department of Health

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Howard Zucker, Commissioner

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Coral Springs, Florida

Vacant, M.D.

Executive Director
Claudia Kemp, J.D.

September 1, 2020

Osvanny Nodal, MD
2123 West Dr. Martin Luther King Jr. BLVD
Tampa, FL 33607

Dear Dr. Nodal:

This is in further reference to your application for licensure by endorsement.

Please be advised that you are required to make a personal appearance before the Credentials Committee of the Board of Medicine to discuss:

- **Failure to meet section 458.313(1)(a) and 458.311(1)(f)3.c., Florida Statutes, postgraduate training**

In addition, the Committee may inquire into any other issues relating to your application and eligibility for licensure.

Date:	Thursday, October 1, 2020
Time:	8:00 a.m. (Meeting starts at 8:00 a.m. Interview time may vary.)
Location:	The in-person meeting scheduled in Orlando, Florida is cancelled, and the meeting will be held by a web-based meeting platform or, if appropriate, a teleconference call.

The meeting information and directions for participating in the October 2020 meeting will be posted on the Florida Board of Medicine's website: https://flboardofmedicine.gov/meeting-information.

Additionally, the Committee's recommendation on your application for licensure will be presented to the full Board of Medicine on Friday, October 2, 2020 for final action. You are not required to attend the full board meeting.

Thank you for your continued cooperation. Should you have any questions regarding this matter, please feel free to contact me. *This is your first scheduled appearance.

Sincerely,

Karrell D. Goldwire

Karrell D. Goldwire
Regulatory Supervisor

Pursuant to the provisions of the Americans with Disabilities Act, any person requiring special accommodations to participate in this workshop/meeting is asked to advise the agency at least 10 days before the workshop/meeting by contacting: Rebecca.Hewett@flhealth.gov or call (850) 245-4137.

*** 456.013(3)(c) In considering applications for licensure, the board, or the department when there is no board, may require a personal appearance of the applicant. If the applicant is required to appear, the time period in which a licensure application must be granted or denied shall be tolled until such time as the applicant appears. However, if the applicant fails to appear before the board at either of the next two regularly scheduled board meetings, or fails to appear before the department within 30 days if there is no board, the application for licensure shall be denied.**

1601 F-137363

MEDICAL DOCTOR
APPLICATION FOR LICENSURE
Apply for your license online at www.flboardofmedicine.gov

05/04/2020 955.00
ID: 137363 Type: F
BT: 3014697
R#: 919030821

Choose your application type:

☒ Endorsement (1021) ☐ Examination (1024)

☐ Military Veterans Fee Waiver

If you were honorably discharged from the U.S. armed services within 60 months of your application you will qualify for a waiver of the application fee and the initial licensure fee. In order to qualify, please check the box above indicating that you are seeking a waiver and submit **a DD-214 or NGB-22 form as proof of honorable discharge.**

☐ I plan to dispense medicinal drugs in the State of Florida for a fee or other remuneration and hereby register as required by Section 465.0276, F.S. I understand that the fee for the Dispensing Practitioner is $100.00 in addition to the required initial license fee and will submit it along with the license fee.

1. PERSONAL INFORMATION

Name: Nodal (Last/Surname) Osvanny (First) (Middle) **Date of Birth:** 06/19/1975 (MM/DD/YYYY)

Mailing Address: (The address where mail and your license should be sent)

2123 W Dr Martin Luther King Jr Blvd (Street/ PO Box) | 101 (Suite/Apt. No) | Tampa (City)

FL (State) | 33607 (Zip) | Hillsborough (Country) | 813-488-4801 (Phone Number)

Physical Location: A Post Office Box is not acceptable. This address will be posted on the Department of Health's website. *If you do not have a current practice address, your mailing address will be used. When you obtain a practice address, you will be required to update your online practitioner profile.*

2123 W Dr Martin Luther King Jr Blvd (Street/ P.O. Box) | 101 (Suite/Apt. No) | Tampa (City)

FL (State) | 33607 (Zip) | Hillsborough (Country) | 813-235-5068 (Alternate Phone Number)

Email Address: nodalmed@gmail.com

Under Florida law, email addresses are public records. If you do not want your e-mail address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.

Equal Opportunity Data: We are required to ask that you furnish the following information as part of your voluntary compliance with Section 2, Uniform Guidelines on Employee Selection Procedure (1978) 43 CFR 38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

SEX: ☒ Male ☐ Female **RACE:** ☒ White ☐ Black ☐ Asian/Pacific Islander ☒ Hispanic ☐ Other

☒ Yes ☐ No **Availability for Disaster:** Will you be available to provide health care services in special needs shelters or to help staff disaster medical assistance teams during times of emergency or major disaster?

2. MEDICAL EDUCATION HISTORY

Federal Credentials Verification Services (FCVS) is not a requirement for licensure. FCVS will primary source verify and provide a copy of the medical school transcript(s), medical school diploma, medical school verification, name change document(s), national examination score report, ECFMG certificate, ECFMG verification and postgraduate training verifications. For more information about FCVS, visit their web-site at www.fcvs.org/.

☒ Yes ☐ No Are you using the FCVS to verify your core credentials?

☒ Yes ☐ No Have you completed the equivalent of 2 academic years of preprofessional, postsecondary education including, courses in anatomy, biology and chemistry prior to entering medical school?

Medical Education:
List in chronological order all medical schools attended, whether completed or not. Submit on a separate sheet if needed.

Medical School Name and Address:	From: (mm/yy)	To: (mm/yy)	Date Degree Received:
Facultad de Ciencias Medicas de Ciego de Avila Dr Jose Assef Yara Circunvalacion y carretera Moron Ciego de Avila, Cuba, 55100	09/01/1995	10/30/2000	
Central America Health Sciences University Mile 13 1/2 Philip Goldson Highway, Boom Cut Off Rd, Ladyville, Belize	05/05/2007	10/03/2008	10/03/2008

Fifth Pathway Certificate Holders: N/A

If you answer "yes" to any of the following questions, you must request verifications to be sent directly to the Board office.

☐ Yes ☐ No Did you attend an international medical school and do not possess a valid ECFMG Certificate?

☐ Yes ☐ No Did you receive a bachelor's degree from an accredited United States college or University?

☐ Yes ☐ No Did you study at a medical school which is recognized by the World Health Organization?

☐ Yes ☐ No Did you complete all of the formal requirement of the International medical school, except the internship or social service requirements, and pass part I of the National board of Medical examination or the Education Commission for Foreign Medical Graduates Examination equivalent?

☐ Yes ☐ No Did you complete an academic year of supervised clinical training in a hospital affiliated with a medical school approved by the Council on Medical Education of the American Medical Association and upon completion passed part II of the National Board of Medical Examiners examination or the Education Commission for Foreign Medical Graduates examination Equivalent?

2. MEDICAL EDUCATION HISTORY

Federal Credentials Verification Services (FCVS) is not a requirement for licensure. FCVS will primary source verify and provide a copy of the medical school transcript(s), medical school diploma, medical school verification, name change document(s), national examination score report, ECFMG certificate, ECFMG verification and postgraduate training verifications. For more information about FCVS, visit their web-site at www.fcvs.org/.

☒ Yes ☐ No Are you using the FCVS to verify your core credentials?

☒ Yes ☐ No Have you completed the equivalent of 2 academic years of preprofessional, postsecondary education including, courses in anatomy, biology and chemistry prior to entering medical school?

Medical Education:
List in chronological order all medical schools attended, whether completed or not. Submit on a separate sheet if needed.

Medical School Name and Address:	From: (mm/yy)	To: (mm/yy)	Date Degree Received:
Facultad de Ciencias Medicas de Ciego de Avila Dr Jose Assef Yara	09/01/1995	10/30/2000	
Central America Health Sciences University	05/05/2007	10/03/2008	10/03/2008

Fifth Pathway Certificate Holders:

If you answer "yes" to any of the following questions, you must request verifications to be sent directly to the Board office.

☐ Yes ☐ No Did you attend an international medical school and do not possess a valid ECFMG Certificate?

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☐ Yes ☐ No Did you study at a medical school which is recognized by the World Health Organization?

☐ Yes ☐ No Did you complete all of the formal requirement of the International medical school, except the internship or social service requirements, and pass part I of the National board of Medical examination or the Education Commission for Foreign Medical Graduates Examination equivalent?

☐ Yes ☐ No Did you complete an academic year of supervised clinical training in a hospital affiliated with a medical school approved by the Council on Medical Education of the American Medical Association and upon completion passed part II of the National Board of Medical Examiners examination or the Education Commission for Foreign Medical Graduates examination Equivalent?

Postgraduate Training:

Provide the following documentation to support your postgraduate training:

☑ Post-Graduate Training Form

In the table below list, in chronological order, all postgraduate training from the date you graduated from medical school to the present. Start with your first program and end with your last or current program. List all programs you began, whether you completed or received credit for the training.

Program Name and Full Mailing Address:	Specialty Area:	From: (mm/yy)	To: (mm/yy)	Did you receive credit? (Y/N)
Hospital Dr. Cayetano Coll y Toste Carretera 129 Km 1 Avenida San Luis Arecibo, Puerto Rico 00613	Internship , Family Medicine	07/01/2013	06/30/2014	N

Loan History:

☐ Yes ☒ No Are you currently in default on any health education loan or scholarship obligation? (If "yes", explain on a separate sheet providing accurate details.)

3. EXAMINATION HISTORY

State Board (prior to 1974), State Board (after 1974) & SPEX, LMCC & SPEX, NBME, FLEX, USMLE III, or Combination (prior to 2000)

Request that the score report be sent directly to the Board of Medicine. NOTE: If you took a state Board examination and are not currently licensed in three other states, you must also request your SPEX score be sent.

Exam taken: USMLE III Date passed: 09/25/2014
mm/dd/yy

Postgraduate Training:

Provide the following documentation to support your postgraduate training:

☐ Post-Graduate Training Form

In the table below list, in chronological order, all postgraduate training from the date you graduated from medical school to the present. Start with your first program and end with your last or current program. List all programs you began, whether you completed or received credit for the training.

Program Name and Full Mailing Address:	Specialty Area:	From: (mm/yy)	To: (mm/yy)	Did you receive credit? (Y/N)
Hospital Cayetano Coll y Toste Arecibo , Puerto Rico	Internship , Family Medicine	07/01/2013	06/30/2014	N

Loan History:

☐ Yes ☒ No Are you currently in default on any health education loan or scholarship obligation? (If "yes", explain on a separate sheet providing accurate details.)

3. EXAMINATION HISTORY

State Board (prior to 1974), State Board (after 1974) & SPEX, LMCC & SPEX, NBME, FLEX, USMLE III, or Combination (prior to 2000)

Request that the score report be sent directly to the Board of Medicine. NOTE: If you took a state Board examination and are not currently licensed in three other states, you must also request your SPEX score be sent.

Exam taken:_____ Date passed: _____
mm/dd/yy

4. LICENSURE HISTORY

Request verification of licensure status directly from the licensing entity or www.veridoc.org. Request international license verification(s) if you have practiced outside of the U.S. for at least two of the previous four years.

☒ Yes ☐ No Do you now hold or have you ever held a license to practice medicine or any other profession in any US State or territory, or foreign country? Please list in table below.

Jurisdiction	Profession	License number
Florida	Medical Doctor	ACN 693
Puerto Rico	Medical Doctor	18942

If you answer "yes" to any of the questions in this section, you are required to send an explanation and supporting documentation.

☐ Yes ☒ No Have you had any application for a medical license or professional license denied by any state board or other governmental agency of any state, territory, or country?

☐ Yes ☒ No Are you currently under investigation in any jurisdiction for an act or offense that would constitute a violation of Section 458.331, Florida Statutes?

☐ Yes ☒ No Have you ever had any professional license or license to practice medicine revoked, suspended, placed on probation, or other disciplinary action taken in any state, territory or country?

5. PRACTICE/EMPLOYMENT HISTORY

List the year you legally first began to practice medicine, 2013 (yyyy). This would be the year you began practicing medicine and could be the date you began your postgraduate training.

☒ Yes ☐ No Have you practiced medicine in any jurisdiction for two of the last four years **or** completed a board approved post-graduate training program within the last two years?

☐ Yes ☐ No If your answer to the question above was "No," have you passed a board approved clinical competency exam within the last year? If yes, then submit supporting documentation.

List in chronological order all employment for the last four (4) years.

Name and address of practice or employment	Type of employment	From: mm/yy	To: mm/yy
Tampa Family Medical Center 8313 W Hillsborough Ave Tampa FL 33615	Medical Doctor	08/2015	09/2016
Hess spinal and Medical Centers 4505 Town N Country Blvd Tampa Fl 33615	Medical Doctor	09/2016	05/2017
Nodal Medical Center LLC 2123 West Dr Martin Luther King Jr Blvd Suite 101 Tampa Fl 33607	Medical Doctor	05/2017	Present

☐ Yes ☒ No Do you currently hold staff privileges in any hospital, health institution, clinic or medical facility? List each facility below.

Name of facility

If you answer "yes" to the following questions, you are required to send an explanation and supporting documentation.

☐ Yes ☒ No Have you ever had any staff privileges denied, suspended, revoked, modified, restricted, not renewed, or placed on probation, or have you been asked to resign or take a temporary leave of absence or were otherwise acted against by any facility?

☐ Yes ☒ No Do you currently, or have you had, responsibility for graduate medical education within the last 10 years?

In the table below, list all institutions where you have had responsibility for graduate medical education or faculty appointment(s) at any medical school.

Name of institution

☐ Yes ☒ No Are you certified by any specialty board recognized by the American Board of Medical Specialties or specialty board approved by the Florida Board of Medicine?

Board Name	Certification/ Specialty/Sub-Specialty	Date of Certification (mm/yy)

If you answer "yes" to any of the following questions, please explain on a separate sheet providing accurate details.

☐ Yes ☒ No Have you ever had any final disciplinary action taken against you by a specialty board or other similar national organization?

☐ Yes ☒ No Have you ever been denied or surrendered a DEA registration?

6. CRIMINAL HISTORY

If you answer "Yes" to the following question you are required to send the following items:

a. Self-explanation describing in detail the circumstances surrounding each offense, including dates, city and state, charges and final results.
b. Final Dispositions and Arrest Records for all offenses. The Clerk of the Court in the arresting jurisdiction will provide you with these documents. Unavailability of these documents must come in the form of a letter from the Clerk of the Court.
c. Completion of Sentence Documents. You may obtain documentation from the Department of Corrections. The report must include the start date, end date and that the conditions were met.

☐Yes ☒ No Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to, a crime in any jurisdiction other than a minor traffic offense? You must include all misdemeanors and felonies, **even if adjudication was withheld. Driving under the influence (DUI) or driving while impaired (DWI) are not minor traffic offenses for purposes of this question.**

Yes ☒ I have been provided and read the statement from the Florida Department of Law Enforcement regarding the sharing, retention, privacy and right to challenge incorrect criminal history records and the "Privacy Statement" document from the Federal Bureau of Investigation.

7. MILITARY HISTORY

A. ☐Yes ☒ No Have you ever been in the United States Military and/or Public Health Service?

B. ☐Yes ☒ No Have you ever been disciplined by any branch of the United States Armed Services or Public Health Services? If you answered "yes" please provide a detailed explanation and supporting documentation

8. CRIMINAL AND MEDICAID/MEDICARE FRAUD QUESTIONS

Applicants for licensure, certification or registration and candidates for examination may be excluded from licensure, certification or registration if their felony conviction falls into certain timeframes as established in Section 456.0635(2), Florida Statutes. If you answer "Yes" to any of the following questions, please provide a written explanation for each question. Supporting documentation includes court dispositions or agency orders where applicable.

1. ☐ Yes ☒ No Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, F.S. (relating to social and economic assistance), Chapter 817, F.S. (relating to fraudulent practices), Chapter 893, F.S. (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction?

If you responded "No" to the question above, skip to question 2.

a. ☐ Yes ☐ No If "yes" to 1, for the felonies of the first or second degree, has it been more than 15 years from the date of the plea, sentence and completion of any subsequent probation?

b. ☐ Yes ☐ No If "Yes" to 1, for felonies of the third degree, has it been more than 10 years from the date of the plea, sentence and completion of any subsequent probation? (This question does not apply to felonies of the third degree under Section 893.13(6)(a), Florida Statutes)

c. ☐ Yes ☐ No If "Yes" to 1, for the felonies of the third degree under Section 893.13(6)(a), Florida Statutes, has it been more than 5 years from the date of the plea, sentence and completion of any subsequent probation?

d. ☐ Yes ☐ No If "Yes" to 1, have you successfully completed a drug court program that resulted in the plea for the felony offense being withdrawn or charges dismissed?

2. ☐ Yes ☒ No Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970 (relating to controlled substances) or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)?

If you responded "No" to the question above, skip to question 3.

a. ☐ Yes ☐ No If "Yes" to 2, has it been more than 15 years before the date of application since the sentence and any subsequent period of probation for such conviction or plea ended?

3. ☐ Yes ☒ No Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes?

If you responded "No" to the question above, skip to question 4.

a. ☐ Yes ☐ No If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years?

4. ☐ Yes ☒ No Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid Program?

If you responded "No" to the question above, skip to question 5.

a. ☐ Yes ☐ No Have you been in good standing with a state Medicaid program for the most recent five years?

b. ☐ Yes ☐ No Did the termination occur at least 20 years before the date of this application?

5. ☐ Yes ☒ No Are you currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities?

If you answer "Yes" to the questions below, you are required to send the following items:

- **A statement indicating the date of each incident and the number for each case.**
- **An explanation of details for each case and your involvement for each case.**
- **Submit the enclosed Exhibit 1 form.**
- **A copy of the complaint, judgments and/or settlements for each case.**
- **Submit a complete copy of the trial record(s) of each case, including the trial transcript, evidentiary exhibits and final judgment in electronic format.**

☐ Yes ☒ No Have you ever had a judgment entered against you for medical malpractice where the incident(s) of malpractice occurred after November 2, 2004?

☐ Yes ☒ No Within the last 10 years have you had any liability claim(s) or action(s) for damages for personal injury settled or finally adjudicated in an amount that exceeds $100,000.00?

10. FINANCIAL RESPONSIBILITY

The Financial Responsibility options are divided into two categories, coverage and exemptions. Check only one option of the ten provided as required by s. 458.320, Florida Statutes.

Category I: Financial Responsibility Coverage

☐1. I do not have hospital staff privileges, I do not perform surgery at an ambulatory surgical center and I have established an irrevocable letter or credit or an escrow account in an amount of $100,000/$300,000, in accord with Chapter 675, F. S., for a letter of credit and s. 625.52, F. S., for an escrow account.

☐2. I have hospital staff privileges or I perform surgery at an ambulatory surgical and I have established an irrevocable letter of credit or escrow account in an amount of $250,000/$750,000, in accord with Chapter 675, F. S., for a letter of credit and s. 625.52, F. S., for an escrow account.

☒3. I do not have hospital staff privileges, I do not perform surgery at an ambulatory surgical center and I have obtained and maintain professional liability coverage in an amount not less than $100,000 per claim, with a minimum annual aggregate of not less than $300,000 from an authorized insurer as defined under s. 624.09, F. S., from a surplus lines insurer as defined under s. 626.914(2), F. S., from a risk retention group as defined under s. 627.942, F. S., from the Joint Underwriting Association established under s. 627.351(4), F. S., or through a plan of self-insurance as provided in s. 627.357, F. S.

☐4. I have hospital staff privileges or I perform surgery at an ambulatory surgical and I have professional liability coverage in an amount not less than $250,000 per claim, with a minimum annual aggregate of not less than $750,000 from an authorized insurer as defined under s. 624.09, F. S., from a surplus lines insurer as defined under s. 626.914(2), F. S., from a risk retention group as defined under s. 627.942, F. S., from the Joint Underwriting Association established under s. 627.351(4), F. S., or through a plan of self-insurance as provided in s. 627.357, F. S.

☐5. I have elected not to carry medical malpractice insurance however, I agree to satisfy any adverse judgments up to the minimum amounts pursuant to s. 458.320(5)(g)1, F. S. I understand that I must either post notice in a sign prominently displayed in my reception area or provide a written statement to any person to whom medical services are being provided that I have decided not to carry medical malpractice insurance. I understand that such a sign or notice must contain the wording specified in s. 458.320(5)(g), F. S.

Category II: Financial Responsibility Exemptions

☐6. I practice medicine exclusively as an officer, employee, or agent of the federal government, the state, or its agencies or subdivisions.

☐7. I hold a limited license issued pursuant to s. 458.317, F. S., and practice only under the scope of the limited license.

☐8. I do not practice medicine in the State of Florida.

☐9. I meet all of the following criteria:

(a) I have held an active license to practice in this state or another state or some combination thereof for more than 15 years;

(b) I am retired or maintain part time practice of no more than 1000 patient contact hours per year;

(c) I have had no more than two claims resulting in an indemnity exceeding $25,000 within the previous five-year period;

(d) I have not been convicted of or pled guilty or nolo contendere to any criminal violation specified in Chapter 458, F. S. or the medical practice act in any other state; and

(e) I have not been subject, within the past ten years of practice, to license revocation, suspension, or probation for a period of three years or longer, or a fine of $500 or more for a violation of Chapter 458, F. S., or the medical practice act of another jurisdiction. A regulatory agency's acceptance of a relinquishment of license, stipulation, consent order, or other settlement offered in response to or in anticipation of filing of administrative charges against a license is construed as action against a license. I understand if I am claiming an exception under this section that I must either post notice in a sign prominently displayed in my reception area or provide a written statement to any person to whom medical services are being provided that I have decided not to carry medical malpractice insurance. See Section 458.320(5)(f), Florida Statutes, for specific notice requirements.

☐10. I practice only in conjunction with my teaching duties at an accredited medical school or its teaching hospitals. (Interns and residents do not qualify for this exemption).

If you select an exemption based on number 9, you must also complete the affidavit on the following page.

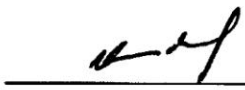
11. FLORIDA BIRTH RELATED NEUROLOGICAL COMPENSATION ASSOCIATION

You must choose one of the three options described below. Please be sure to view the information about each exemption at www.nica.com. Check only one.

☐	☒	☐	250.00
$5,000 Participating	$250 Non-participating	$0 Exempt	Amount enclosed

If you choose "$0 Exempt" provide appropriate documentation to the Board of Medicine and to NICA.

I have read the explanatory information provided by NICA, and I choose the option above.



Signature

04/27/2020
Date

Osvanny Nodal
Name

2123 W Dr Martin Luther King Jr Blvd , Suite 101
Street Address

Tampa FL 33607
City, State, Zip

If you are a participating or non-participating physician, or a physician claiming exemption, you must complete, sign and date this form and return it with your payment to this address.

Board of Medicine
4052 Bald Cypress Way, #C-03
Tallahassee, FL 32399-3253

If you are a physician claiming exemption, you must also send a copy of your completed, signed, and dated form with proof of your exemption to:

NICA
2360 Christopher Place
Tallahassee, FL 32308

If you have any questions about NICA or this form, please contact NICA at www.nica.com or (850) 488-8191.

12. STATEMENT OF APPLICANT

I state that these statements are true and correct. I recognize that providing false information may result in denial of licensure, disciplinary action against my license, or criminal penalties pursuant to Sections 456.067, 775.083, and 775.084, Florida Statutes. I state that I have read Chapters 456, 458 and 766.301-.316, Florida Statutes and Chapter 64B8, Florida Administrative Code.

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Florida Board of Medicine information which is material to my application for licensure.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind. I state that my answers and all statements made by me herein are true and correct.

Should I furnish any false information in this application, I hereby agree that such act constitutes cause for denial, suspension, or revocation of my license to practice medicine in the State of Florida. If there are any changes to my status or any change that would affect any of my answers to this application I must notify the board within 30 days.

I understand that my records are protected under federal and state regulations governing Confidentiality of Mental Health Patient Records and cannot be disclosed without my written consent unless otherwise provided in the regulations. I understand that my records are protected under federal and state regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it.

Osvanny Nodal

Print name

Signature

04/27/2020

Date

May 6, 2020

Osvanny Nodal, M.D.
2123 W. Dr.martin Luther King
Jr Blvd, Apt 101
Tampa, FL 33607

Dear Dr. Nodal:
File: 137363

Thank you for considering Florida for physician licensure. Your application for medical licensure has been received. The application is incomplete for the reasons set out in the attached deficiency notice. Please address these deficiencies as soon as possible to avoid delay in processing your application.

Information received by this office may require additional explanation or documentation to determine licensure eligibility. After all requested documentation is received, your application will be submitted for supervisory review. We will notify you if additional information is required.

Applicants with a history of malpractice, criminal activity, discipline, physical or mental impairment, unfavorable evaluations, or other matters that need explanation may require a personal appearance before the Board of Medicine Credentials Committee for determination of licensure eligibility. If your appearance is required, you will be notified in writing once your application is complete.

You can now follow the progress of your application through our website at: www.FLHealthSource.gov/mqa-services. If you are a returning user, select "Yes" and enter the user ID and password you selected during the registration process under Returning User. If you did not apply for licensure through this screen, select "No" and follow the prompts to create an account. You must have a valid email address to create your account.

Once you are logged in, you will be prompted to add your application to your account. Once you have successfully added your application, you will be directed to your dashboard. Under the "Additional Activities" section, select "Check Application Status" to review any open deficiencies, upload documents or print out instructional documents.

THIS IS IMPORTANT: Your application will remain incomplete until all deficiencies are completed. In addition, you are required to notify the Board office immediately in writing of any occurrence(s) that would in any way change or affect any answer given in the application or an answer provided in response to any of our direct questions to you.

If you have any questions, please contact me at carmelette.gilley@flhealth.gov, call (850) 617-1906, or fax (850) 412-1284.

Sincerely,

Carmen Gilley

Carmen Gilley
Regulatory Specialist II

Enclosure(s)

Osvanny Nodal **Date: May 6, 2020**

REMINDER: Chapter 456.013(1)(a), Florida Statutes, provides that an incomplete application shall expire one year after initial filing with the department.

YOUR APPLICATION'S EXPIRATION DATE IS MAY 3, 2021

APPLICATION SUBMITTED REMAINS DEFICIENT FOR LACK OF THE FOLLOWING:

An official verification of your medical license from the state of PR has not been received

Pages 8 & 9 are incomplete on the application. Please answer the questions (addresses) on each page and submit this information to our office.

Your FCVS Profile has not been received. Please contact FCVS to check the status of your profile.

If you have any questions, please contact me at carmelette.gilley@flhealth.gov, call (850) 617-1906, or fax (850) 412-1284. The Florida Board of Medicine has assigned **137363** as your **tracking number**. Please indicate this number if you leave a message, and try to ensure that other sources include it on their communications to us as well.

Gilley, Carmelette D

From: Nodal Medical Center <nodalmed@gmail.com>
Sent: Thursday, May 7, 2020 2:10 PM
To: Gilley, Carmelette D
Subject: Re: FLORIDA DEF LETTERS-F137363
Attachments: New two pages.pdf

I'm so sorry, so many details . Here goes again.

On Thu, May 7, 2020 at 1:53 PM Gilley, Carmelette D <Carmelette.Gilley@flhealth.gov> wrote:

> Did you received credit for training on page nine. Please type Y/N on the this page. Thank you.
>
> Sincerely,
>
> *Carmen Gilley*
>
> Regulatory Specialist II
> Department of Health (DOH) | Division of Medical Quality Assurance (MQA)
> Board Office
> Phone: 850-617-1906 | Fax: 850-412-1284
>
> 4052 Bald Cypress Way, # C03 | Tallahassee, FL 32399-3256
>
> New Website: www.flboardofmedicine.gov
>
> Twitter: www.twitter.com/FLBoardofMed
>
> There have been changes to the license renewal process. Please visit www.CEAtRenewal.com to learn more.
>
> Mission: To protect, promote and improve the health of all people in Florida through integrated state, county, and community efforts.
>
> Vision: To be the **Healthiest State** in the Nation.
>
> Purpose: To protect the public through health care licensure, enforcement and information.
>
> Focus: To be the nation's leader in quality health care regulation.
>
> Values: I.C.A.R.E. (Innovation, Collaboration, Accountability, Responsiveness, Excellence)
>
> PLEASE NOTE: Florida has a very broad public records law. Most written communications to or from State officials regarding State business are public records available to the public and media upon request. Your email communications may therefore be subject to public disclosure.

From: Nodal Medical Center [mailto:nodalmed@gmail.com]
Sent: Thursday, May 7, 2020 1:46 PM
To: Gilley, Carmelette D <Carmelette.Gilley@flhealth.gov>
Subject: Re: FLORIDA DEF LETTERS-F137363

Hi Carmen,

I'm sorry for the inconvenience, Attached are the pages with the missing information.

Thank you for your time ,

Dr Nodal.

On Thu, May 7, 2020 at 12:51 PM Gilley, Carmelette D <Carmelette.Gilley@flhealth.gov> wrote:

> Please provide the address to your medical school and PGT program on the application.
>
> Sincerely,
>
> *Carmen Gilley*
>
> Regulatory Specialist II
> Department of Health (DOH) | Division of Medical Quality Assurance (MQA)
> Board Office
> Phone: 850-617-1906 | Fax: 850-412-1284
>
> 4052 Bald Cypress Way, # C03 | Tallahassee, FL 32399-3256
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From: Nodal Medical Center [mailto:nodalmed@gmail.com]
Sent: Thursday, May 7, 2020 12:36 PM
To: Gilley, Carmelette D <Carmelette.Gilley@flhealth.gov>
Subject: Re: FLORIDA DEF LETTERS-F137363

Thank You , attached are the 2 pages .

Osvanny Nodal

On Thu, May 7, 2020 at 12:26 PM Gilley, Carmelette D <Carmelette.Gilley@flhealth.gov> wrote:

Hi Dr. Nodal,

It appears it's not been uploaded at this time. You may email it to me as an attached document.

Sincerely,

Carmen Gilley

Regulatory Specialist II
Department of Health (DOH) | Division of Medical Quality Assurance (MQA)
Board Office
Phone: 850-617-1906 | Fax: 850-412-1284

4052 Bald Cypress Way, # C03 | Tallahassee, FL 32399-3256

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From: Nodal Medical Center [mailto:nodalmed@gmail.com]
Sent: Thursday, May 7, 2020 8:31 AM
To: Gilley, Carmelette D <Carmelette.Gilley@flhealth.gov>
Subject: Re: FLORIDA DEF LETTERS-F137363

Good Morning , I just uploaded page 8 and 9 from the application , on page 8 I did not fill the part for Fifth Pathway Holder because I am not fifth pathway holder . Please let me Know if I still need to fill it out .

Thank You , Osvanny Nodal .

On Wed, May 6, 2020 at 9:56 AM Gilley, Carmelette D <Carmelette.Gilley@flhealth.gov> wrote:

> Hi Dr. Nodal,
>
> Please see the attached letters. Thank you and have a great day.
>
> Sincerely,
>
> *Carmen Gilley*
>
> Regulatory Specialist II
> Department of Health (DOH) | Division of Medical Quality Assurance (MQA)
> Board Office
> Phone: 850-617-1906 | Fax: 850-412-1284
>
> 4052 Bald Cypress Way, # C03 | Tallahassee, FL 32399-3256
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--

Nodal Medical Center LLC

2123 W. Dr Martin Luther King Jr Blvd

suite 101, Tampa Fl, 33607

Main Phone: 813-488-4801

Fax: 813-405-4506

CONFIDENTIALITY NOTICE: The contents of this email message and any attachments are intended solely for the addressee(s) and may contain confidential and/or privileged information and may be legally protected from disclosure. If you are not the intended recipient of this message or their agent, or if this message has been addressed to you in error, please immediately alert the sender by reply email and then delete this message and any attachments. If you are not the intended recipient, you are hereby notified that any use, dissemination, copying, or storage of this message or its attachments is strictly prohibited.

--

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--

Nodal Medical Center LLC
2123 W. Dr Martin Luther King Jr Blvd
suite 101, Tampa Fl, 33607
Main Phone: 813-488-4801
Fax: 813-405-4506

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May 14, 2020

Osvanny Nodal, M.D.
2123 W Dr Martin Luther King Jr. Bl
Tampa, FL ates 33607

Dear Dr. Nodal:
File: 149105

Thank you for considering Florida for physician licensure. Your application for medical licensure has been received. The application is incomplete for the reasons set out in the attached deficiency notice. Please address these deficiencies as soon as possible to avoid delay in processing your application.

Information received by this office may require additional explanation or documentation to determine licensure eligibility. After all requested documentation is received, your application will be submitted for supervisory review. We will notify you if additional information is required.

Applicants with a history of malpractice, criminal activity, discipline, physical or mental impairment, unfavorable evaluations, or other matters that need explanation may require a personal appearance before the Board of Medicine Credentials Committee for determination of licensure eligibility. If your appearance is required, you will be notified in writing once your application is complete.

You can now follow the progress of your application through our website at: www.FLHealthSource.gov/mqa-services. If you are a returning user, select "Yes" and enter the user ID and password you selected during the registration process under Returning User. If you did not apply for licensure through this screen, select "No" and follow the prompts to create an account. You must have a valid email address to create your account.

Once you are logged in, you will be prompted to add your application to your account. Once you have successfully added your application, you will be directed to your dashboard. Under the "Additional Activities" section, select "Check Application Status" to review any open deficiencies, upload documents or print out instructional documents.

THIS IS IMPORTANT: Your application will remain incomplete until all deficiencies are completed. In addition, you are required to notify the Board office immediately in writing of any occurrence(s) that would in any way change or affect any answer given in the application or an answer provided in response to any of our direct questions to you.

If you have any questions, please contact me at carmelette.gilley@flhealth.gov, call (850) 617-1906, or fax (850) 412-1284.

Sincerely,

Carmen Gilley

Carmen Gilley
Regulatory Specialist II

Enclosure(s)

Osvanny Nodal **Date: May 14, 2020**

REMINDER: Chapter 456.013(1)(a), Florida Statutes, provides that an incomplete application shall expire one year after initial filing with the department.

YOUR APPLICATION'S EXPIRATION DATE IS MAY 3, 2021

APPLICATION SUBMITTED REMAINS DEFICIENT FOR LACK OF THE FOLLOWING:

An official verification of your medical license from the state of PR has not been received.

Your FCVS Profile has not been received. Please contact FCVS to check the status of your profile.

If you have any questions, please contact me at carmelette.gilley@flhealth.gov, call (850) 617-1906, or fax (850) 412-1284. The Florida Board of Medicine has assigned **149105** as your **tracking number**. Please indicate this number if you leave a message, and try to ensure that other sources include it on their communications to us as well.

Gilley, Carmelette D

From: Gilley, Carmelette D
Sent: Thursday, May 14, 2020 4:44 PM
To: Nodal Medical Center
Subject: OLD FILE NUMBER 137363-NEW FILE NUMBER -149105

Hi Dr. Nodal,

You were allowed to withdraw your application at the June 8, 2018 board meeting. Your application number was 137363 was withdrawn and your new file number is 149105. Thank you and have great day.

Sincerely,
Carmen Gilley
Regulatory Specialist II
Department of Health (DOH) | Division of Medical Quality Assurance (MQA)
Board Office
Phone: 850-617-1906 | Fax: 850-412-1284
4052 Bald Cypress Way, # C03 | Tallahassee, FL 32399-3256
New Website: www.flboardofmedicine.gov
Twitter: www.twitter.com/FLBoardofMed

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MEDICINE BOARD
2020 JUL -1 AM 10:44

GOBIERNO DE PUERTO RICO
Government of Puerto Rico

DEPARTAMENTO DE SALUD
Department of Health

JUNTA DE LICENCIAMIENTO Y DISCIPLINA MEDICA DE PUERTO RICO
Puerto Rico Medical Discipline and Licensure Board

LICENSE VERIFICATION
"GOOD STANDING"

Name:	OSVANNY NODAL
Social Security:	XXX-XX-1633
Board:	P.R. MEDICAL DISCIPLINE AND LICENSURE BOARD
License Type:	REGULAR LICENSE
Registry Number:	188799
Expiration Date:	JUNE 17, 2023
License Number:	18942
License Expedition Date:	NOVEMBER 14, 2014
License Status:	ACTIVE

Restrictions or Comments:

We hereby certify that this Physician has met all requirements established in Law 11, as amended in June 23, 1976. The license should be recertified on or before its expedition date:

In San Juan, Puerto Rico on Tuesday, June 23, 2020.

BOARD OF LICENSING AND MEDICAL DISCIPLINES OF PUERTO RICO

President or Director
Puerto Rico Medical Discipline and Licensure Board

FLORIDA BOARD OF MEDICINE , DEPARTMENT OF HEALTH , DIVISION OF MEDICAL QUALITY ASSURANCE
4052 BALD CYPRESS WAY # C03
TALLAHASSEE FL 32399-3256

20200623202306179784O9

This Licensure Verification is valid for one (1) year.

ESTE DOCUMENTO NO ES TRANSFERIBLE / THIS DOCUMENT IS NOT TRANSFERABLE

37292

Department of Health

OSVANNY NODAL

License Number: ACN693

Data As Of 8/25/2020

Profession	Area of Critical Need Medical Doctor
License	ACN693
License Status	CLEAR/ACTIVE
License Expiration Date	1/31/2022
License Original Issue Date	08/11/2015
Address of Record	2123 W. MLK JR. BLVD STE.#101 NODAL MEDICAL CENTER, LLC TAMPA, FL 33607
Controlled Substance Prescriber (for the Treatment of Chronic Non-malignant Pain)	Yes
Discipline on File	No
Public Complaint	No

The information on this page is a secure, primary source for license verification provided by the Florida Department of Health, Division of Medical Quality Assurance. This website is maintained by Division staff and is updated immediately upon a change to our licensing and enforcement database.

Chair
Zachariah Zachariah, M.D.
Ft. Lauderdale, Florida

Members
Hector Vila, M.D.
Tampa, Florida
Vice-Chair

Luz Marina Pages, M.D.
Miami Beach, Florida

Scot N. Ackerman, M.D.
Jacksonville, Florida

Eleonor Pimentel, M.D.
Miami, Florida

David A. Diamond, M.D.
Winter Park, Florida

Vacant, Consumer Member

Robert London, M.D.
Maitland, Florida

Jorge J. Lopez, M.D.
Maitland, Florida

Andre M. Perez
Miami, Florida

Kevin Cairns, M.D.
Fort Lauderdale, Florida

Nicholas W. Romanello, Esq.
Melbourne, Florida

Sarvam TerKonda, M.D.
Jacksonville, Florida

Shailesh Gupta, M.D.
Coral Springs, Florida

Vacant, M.D.

Executive Director
Claudia Kemp, J.D.

September 5, 2020

Rajpaul Singh, MD
16537 Spring Park Drive
Clermont, FL 34711

Dear Dr. Singh:

This is in further reference to your application for licensure by endorsement.

Please be advised that you are required to make a personal appearance before the Credentials Committee of the Board of Medicine to discuss:

- **Action by Florida Medical Board**
- **Action by New York Medical Board**
- **Action by Indiana Medical Board**
- **Criminal History**
- **Voluntary surrender of DEA registration**

In addition, the Committee may inquire into any other issues relating to your application and eligibility for licensure.

Date:	Thursday, October 1, 2020
Time:	8:00 a.m. (Meeting starts at 8:00 a.m. Interview time may vary.)
Location:	The in-person meeting scheduled in Orlando, Florida is cancelled, and the meeting will be held by a web-based meeting platform or, if appropriate, a teleconference call.

The meeting information and directions for participating in the October 2020 meeting will be posted on the Florida Board of Medicine's website: https://flboardofmedicine.gov/meeting-information.

Additionally, the Committee's recommendation on your application for licensure will be presented to the full Board of Medicine on Friday, October 2, 2020 for final action. You are not required to attend the full board meeting.

Thank you for your continued cooperation. Should you have any questions regarding this matter, please feel free to contact me. *This is your first scheduled appearance.

Sincerely,

Karrell D. Goldwire

Karrell D. Goldwire
Regulatory Supervisor

Pursuant to the provisions of the Americans with Disabilities Act, any person requiring special accommodations to participate in this workshop/meeting is asked to advise the agency at least 10 days before the workshop/meeting by contacting: Rebecca.Hewett@flhealth.gov or call (850) 245-4137.

*** 456.013(3)(c) In considering applications for licensure, the board, or the department when there is no board, may require a personal appearance of the applicant. If the applicant is required to appear, the time period in which a licensure application must be granted or denied shall be tolled until such time as the applicant appears. However, if the applicant fails to appear before the board at either of the next two regularly scheduled board meetings, or fails to appear before the department within 30 days if there is no board, the application for licensure shall be denied.**

Application

Application Detail

License Type:	**Medical Doctor**
Profession Number:	**1501 - Medical Doctor**
File Number:	**148683**
Application:	**Medical Doctor Endorsement Application**
Application Date:	**04/20/2020**

Suitability Question(s)

Are you an osteopathic physician?	**No**

Application Questions

Military Veteran Fee Waiver - I have been honorably discharged from a branch of the United States Armed Forces within the previous 60 months.	**No**
I am selecting NICA Non-Participating - (I understand that a $250.00 fee will be included if I select this option.)	**Yes**
I will qualify for "In Training" status at the approval of my licensure application.	**Yes**
I plan to dispense medicinal drugs in the State of Florida for a fee or other remuneration and hereby register as required by Section 465.0276,F.S. I understand that the fee for the Dispensing Practitioner is $100.00 over and above the required initial license fee and will submit it along with the license fee.	**Yes**
Military Veteran Spouse Fee Waiver - I am the spouse of a military veteran who has been honorably discharged from a branch of the United States Armed Forces within the previous 60 months.	**No**

School Name:	**UNIVERSITY OF HAVANA**
Street Address Line 1:	**G and 23 Vedado**
Street Address Line 2:	**N/A**
City:	**Havana**
State:	**N/A**
Postal/Zip:	**cuba**
Country:	**CUBA**
Date of Graduation (mm/dd/yyyy):	**08/20/1983**
Attended From (mm/dd/yyyy):	**09/01/1977**
Attended To (mm/dd/yyyy):	**07/30/1983**

Additional Education Questions

Are you currently in default on any health education loan or scholarship obligation?	**No**
Have you completed the equivalent of 2 academic years of preprofessional, postsecondary education including, courses in anatomy, biology, and chemistry prior to entering medical school?	**Yes**

Fifth Pathway

Did you attend an international medical school and do not possess a valid ECFMG Certificate?	**No**
Did you receive a bachelor's degree from an accredited United States college or University?	**No**
Did you study at a medical school which is recognized by the World Health Organization?	**Yes**
Did you complete all of the formal requirement of the International medical school, except the internship or social service requirements, and pass part I of the National board of Medical examination or the Education Commission for Foreign Medical Graduates Examination equivalent?	**Yes**
Did you complete an academic year of supervised clinical training in a hospital affiliated with a medical school approved by the Council on Medical Education of the American Medical Association and upon completion passed part II of the National Board of Medical Examiners examination or the Education Commission for Foreign Medical Graduates examination Equivalent?	**Yes**

Postgraduate Training 1

Program Name:	**SUNY Downstate/ Kings County Hospital**
Mailing Address:	**450 Clarkson Ave, Brooklyn NY 11023**
Program City:	**Brooklyn**
Program State or Country:	**NEW YORK**
Program Type:	**RESIDENCY**
Specialty Area:	**N - CHILD NEUROLOGY**
Attended From (mm/dd/yyyy):	**07/01/1994**
Attended To (mm/dd/yyyy):	**06/30/1997**
Did you receive credit?	**Yes**

Postgraduate Training 2

Program Name:	**SUNY Downstate/ Kings County Hospital**
Mailing Address:	**450 Clarkson Ave, Brooklyn NY 11023**
Program City:	**Brooklyn**
Program State or Country:	**NEW YORK**
Program Type:	**RESIDENCY**
Specialty Area:	**PD - PEDIATRICS**
Attended From (mm/dd/yyyy):	**07/01/1997**
Attended To (mm/dd/yyyy):	**06/30/1998**
Did you receive credit?	**Yes**

Postgraduate Training 3

Program Name:	**SUNY Downstate/ Kings County Hospital**
Mailing Address:	**450 Clarkson Ave, Brooklyn NY 11023**
Program City:	**Brooklyn**
Program State or Country:	**NEW YORK**
Program Type:	**FELLOWSHIP**
Specialty Area:	**N - CLINICAL NEUROPHYSIOLOGY**
Attended From (mm/dd/yyyy):	**07/01/1998**
Attended To (mm/dd/yyyy):	**06/30/1999**
Did you receive credit?	**Yes**

Exam History

Examination:	**USMLE/FOREIGN**
Date Passed (mm/dd/yyyy):	**12/29/1993**

United States Military and/or Public Health

Have you ever been in the United States Military and/or Public Health Service?	**No**
Have you ever been disciplined by any branch of the United States Armed Services or Public Health Service?	**No**

Practice Employment 1

Place of Employment:	**Weight Loss Center**
Address Line 1:	**200 Motor Pkwy, Suite C14**
Address Line 2:	**N/A**
City:	**Hauppauge**
State:	**NY**
Type of Employment:	**Physician**
Begin Date (mm/dd/yyyy):	**04/01/2018**
End Date (mm/dd/yyyy):	**03/15/2019**

If 'to present', enter today's date.

Practice Employment 2

Place of Employment:	**AMDO Medical**
Address Line 1:	**11605 Myrtle Ave**
Address Line 2:	**N/A**
City:	**Richmond Hill**
State:	**NY**
Type of Employment:	**Physician**
Begin Date (mm/dd/yyyy):	**04/01/2019**
End Date (mm/dd/yyyy):	**06/30/2019**

If 'to present', enter today's date.

Practice Employment 3

Place of Employment:	**Queens lifestyle Changes**
Address Line 1:	**195-03 Hillside Ave**
Address Line 2:	**N/A**
City:	**hollis**

State: **NY**

Type of Employment: **Physician / Owner**

Begin Date (mm/dd/yyyy): **07/01/2019**

End Date (mm/dd/yyyy): **04/20/2020**

If 'to present', enter today's date.

Other State Licenses

Do you now hold or have you ever held a license to practice medicine or any other profession in any US State or territory, or foreign country? **Yes**

Request verification of licensure status directly from the licensing entity or www.veridoc.org. Request international license verification(s) if you have practiced outside of the U.S. for at least two of the previous four years.

License Number: **212722**

Profession: **Medicine**

Jurisdiction - Country: **UNITED STATES**

Jurisdiction - State: **NEW YORK**

Additional Employment Questions

Have you practiced medicine in any jurisdiction for two of the last four years or completed a board approved post-graduate training program within the last two years? **Yes**

Graduate Education

Do you currently, or have you had, responsibility for graduate medical education within the last 10 years? **Yes**

Initial Graduate Medical Education Responsibility and Faculty Appointments

List all institutions where you have had responsibility for graduate medical education or faculty appointment(s) at any medical school.

Name of Institution: **SUNY DOWNSTATE MEDICAL CENTER**

Staff Privileges

Do you currently hold staff privileges in any hospital, health institution, clinic or medical facility? **No**

Specialty Board Certifications

Are you certified by any specialty board recognized by the American Board of Medical Specialties or specialty board approved by the Florida Board of Medicine? **No**

DEA

Have you ever been denied, or surrendered, a DEA registration? **Yes**

Description:	**I voluntarily surrendered my DEA in both New York and Florida when my medical license was suspended in 02/15/ 2015**

Criminal History

Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to, a crime in any jurisdiction other than a minor traffic offense?	**Yes**

You must include all misdemeanors and felonies, even if adjudication was withheld. Driving under the influence (DUI) or driving while impaired (DWI) are not minor traffic offenses for purposes of this question.

Offense:	**Falsifying business records**
Date of Offense:	**06/12/2014**
State or Jurisdiction:	**New York**
Under Appeal:	**No**
Applicant Statement:	**A rouge technician working with me doing NCV test cut / copied and pasted old records unknown to me. he then threw me under the bus stating that I told him to do so , which was a blatant lie. He ruined my character , reputation and life. I had to plead guilty to avoid jail time.**

Medicaid / Medicare

1. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, F.S. (relating to social and economic assistance), Chapter 817, F.S. (relating to fraudulent practices), Chapter 893, F.S. (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction?	**No**
2. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970 (relating to controlled substances) or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)?	**No**
3. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, F.S.?	**No**
4. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program?	**No**
5. Are you currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities?	**No**

Health History

In the last five years, have you been enrolled in, required to enter into, or participated in any drug and/or alcohol recovery program or impaired practitioner program for treatment of drug or alcohol abuse that occurred within the past five years?	**No**
In the last five years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental disorder or impairment?	**No**
During the last five years, have you been treated for or had a recurrence of a diagnosed mental disorder that has impaired your ability to practice medicine within the past five years?	**No**
During the last five years, have you been treated for or had a recurrence of a diagnosed physical disorder that has impaired your ability to practice medicine?	**No**
In the last five years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol/drug) disorder or, if you were previously in such a program, did you suffer a relapse within the last five years?	**No**
During the last five years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol/drug) disorder that impaired your ability to practice medicine within the last five years?	**No**

Electronic Fingerprinting

I have been provided and read the statement from the Florida Department of Law Enforcement regarding the sharing, retention, privacy and right to challenge incorrect criminal history records and the 'Privacy Statement' document from the Federal Bureau of Investigation.	**Yes**
Enter in today's date	**04/20/2020**

Medical Malpractice Question

Have you ever had a judgment entered against you for medical malpractice where the incident(s) of malpractice occurred after November 2, 2004?	**Yes**
Description:	**In May 2009 , I was part of a malpractice suit, wherein the neuroradiologist missed a faint shadow of what ended up as a bone tumor at T12. She was referred to me by the PCPwith this MRI after the patient complained of back pain. I diagnosed her with a pinched nerve at L5-S1, after doing an EMG/NCV test on her. She improved . She moved to Georgia and was lost to follow-up. My insurance carrier settled the case for $100,000, against my will.**

Liability Claims

Within the last 10 years have you had any liability claim(s) or action(s) for damages for personal injury settled or finally adjudicated in an amount that exceeds $100,000.00?	**No**

Financial Responsibility/Exemption

Financial Responsibility	**3. LIABILITY NOT LESS THAN $100,000**

FDA Institution

Have you ever had any staff privileges denied, suspended, revoked, modified, restricted, not renewed or placed on probation, or have you been asked to resign or take a temporary leave of absence or were otherwise acted against by any facility?	**No**

FDA Licensing

Have you ever had any professional license or license to practice medicine revoked, suspended, placed on probation, or other disciplinary action taken in any state, territory or country?	**Yes**
Name of Agency:	**Florida Medical Board**
Discipline Date:	**10/07/2016**
Action Description:	**SUSPENDED**
Appeal Status:	**Yes**
Explanation:	**I have completed all board orders from the state of Florida. On June,27th 2018 I have been cleared for re-application for a new license. (Letter from Towanda Burnett) compliance officer.**

FDANP Denied

Have you had any application for a medical license or professional license denied by any state board or other governmental agency of any state, territory, or country?	**No**

FDANP Investigation

Are you currently under investigation in any jurisdiction for an act or offense that would constitute a violation of Section 458.331, Florida Statutes?	**No**

Specialty Board Discipline History

Have you ever had any final disciplinary action taken against you by a specialty board or other similar national organization?	**No**

Year Began Practice

Year Began Practice:	**10/01/1983**

Availability for Disaster

Are you willing to provide health care services in special need shelters or to work with disaster medical teams during times of emergency or major disasters?	**Yes**

Attachments

Document Type: Criminal History Documents File Name: Scan(court documents).pdf

Fees

Initial License -	**$-350.00**
NICA Fee -	**$-250.00**
Application	**$350.00**
Initial License TRNG	**$200.00**
Unlicensed Activity	**$5.00**
Dispensing	**$100.00**
Initial License	**$350.00**
NICA Fee	**$250.00**
Total Amount Due:	**$655.00**

Attestation

I state that these statements are true and correct. I recognize that providing false information may result in denial of licensure, disciplinary action against my license, or criminal penalties pursuant to Sections 456.067, 775.083, and 775.084, Florida Statutes. I state that I have read Chapters 456, 458 and 766.301-.316, Florida Statutes and Chapter 64B8, Florida Administrative Code.

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Florida Board of Medicine information which is material to my application for licensure.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind. I state that my answers and all statements made by me herein are true and correct.

Should I furnish any false information in this application, I hereby agree that such act constitutes cause for denial, suspension, or revocation of my license to practice Medicine in the State of Florida. If there are any changes to my status or any change that would affect any of my answers to this application I must notify the board within 30 days.

I understand that my records are protected under federal and state regulations governing Confidentiality of Mental Health Patient Records and cannot be disclosed without my written consent unless otherwise provided in the regulations. I understand that my records are protected under federal and state regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it.

Attestation Answer: Yes

April 27, 2020

Dr. Rajpaul Singh
16537 Spring Park Drive
Clermont, FL 34711

Dear Dr. Singh:
File: 148683

Thank you for considering Florida for physician licensure. Your application for medical licensure has been received. The application is incomplete for the reasons set out in the attached deficiency notice. Please address these deficiencies as soon as possible to avoid delay in processing your application.

Information received by this office may require additional explanation or documentation to determine licensure eligibility. After all requested documentation is received, your application will be submitted for supervisory review. We will notify you if additional information is required.

Applicants with a history of malpractice, criminal activity, discipline, physical or mental impairment, unfavorable evaluations, or other matters that need explanation may require a personal appearance before the Board of Medicine Credentials Committee for determination of licensure eligibility. If your appearance is required, you will be notified in writing once your application is complete.

You can now follow the progress of your application through our website at: www.FLHealthSource.gov/mqa-services. If you are a returning user, select "Yes" and enter the user ID and password you selected during the registration process under Returning User. If you did not apply for licensure through this screen, select "No" and follow the prompts to create an account. You must have a valid email address to create your account.

Once you are logged in, you will be prompted to add your application to your account. Once you have successfully added your application, you will be directed to your dashboard. Under the "Additional Activities" section, select "Check Application Status" to review any open deficiencies, upload documents or print out instructional documents.

THIS IS IMPORTANT: Your application will remain incomplete until all deficiencies are completed. In addition, you are required to notify the Board office immediately in writing of any occurrence(s) that would in any way change or affect any answer given in the application or an answer provided in response to any of our direct questions to you.

If you have any questions, please contact me at Deondra.McMillan@flhealth.gov, call 850-617-1914, or fax 850-412-1914.

Sincerely,

Deondra McMillan

Deondra McMillan
Regulatory Specialist II

Enclosure(s)

Dr. Rajpaul Singh **Date: April 27, 2020**

REMINDER: Chapter 456.013(1)(a), Florida Statutes, provides that an incomplete application shall expire one year after initial filing with the department.

YOUR APPLICATION'S EXPIRATION DATE IS **04/19/2021.**

APPLICATION SUBMITTED REMAINS DEFICIENT FOR LACK OF THE FOLLOWING:

Your ECFMG status report, directly from the ECFMG, has not been received.

An official verification of your medical license from the state of New York has not been received.

Please provide non-employment / employment activities from August 1983 to July 1994 and June 1999 to April 2018 in a PDF document and submit it by email to Deondra.McMillan@flhealth.gov.

REGARDING MALPRACTICE, please submit the following:

A statement COMPOSED BY YOU saying how many malpractice cases you have been named in and a statement of the details of each case and your involvement.

For each case, you must obtain a copy of the complaint from the county court in which the case was filed and send a copy to our office.

FOR EACH CLOSED CASE, submit a copy of the disposition. If the case was dismissed, submit a copy of the terms of settlement, if applicable.

FOR EACH PENDING CASE, have your attorney submit an original letter addressed to the Florida Board with the current litigation status.

If a case went to arbitration only, submit a copy of the "Notice To File Suit" or the "Statement of Claim" and a certified copy of the Arbitration results.

The inquiry you mailed to your medical school has not been received.

Your Postgraduate Training Verification Form from SUNY Downstate/ Kings County Hospital (07/1994-06/1999) has not been received.

Please submit the National Practitioner Data Bank (NPDB) report to our office. You may contact the NPDB at 1-800-767-6732 to obtain this information.

We have not received your Livescan results. If you have already had your electronic fingerprinting completed, please allow 24-72 hours for receipt of your results. You can find more information on this process, including how to find a provider in your area and your ORI number, by visiting the Background Screening Website at http://www.flhealthsource.gov/background-screening/. Should your Criminal Background Check disclose an arrest record(s), you will need to provide documentation related to each criminal event revealed in your background, if you have not already done so. You can find a detailed description of documents that will be required by visiting the FAQs on the Background Screening Website (Click on 'General FAQs'). Note: Criminal History will be reviewed by the Background Screening Unit, not the Board Office. Please email all criminal history documents to mqa.backgroundscreen@flhealth.gov. Any original certified documents must be mailed to the following address:

Attn: Background Screening Unit
Florida Department of Health
4052 Bald Cypress Way, Bin BSU-01
Tallahassee, FL, 32399

We await your USMLE exam scores, direct from the Federation of State Medical Boards, which must be requested by the applicant.

If you have any questions, please contact me at Deondra.McMillan@flhealth.gov, call 850-617-1914, or fax 850-412-1914. The Florida Board of Medicine has assigned **148683** as your **tracking number**. Please indicate this number if you leave a message, and try to ensure that other sources include it on their communications to us as well.

Goldwire, Karrell

From: Rajpaul Singh <rajpaul.md@gmail.com>
Sent: Thursday, July 23, 2020 5:15 PM
To: Goldwire, Karrell
Subject: RE: malpractice after 2004 and Denial of renewal from Indiana.

Yes , I am sorry . It was a settlement. Not a judgement. Do I need to do anything else? Thanks. Dr. Singh.

From: Goldwire, Karrell <Karrell.Goldwire@flhealth.gov>
Sent: Thursday, July 23, 2020 5:13 PM
To: Rajpaul Singh <rajpaul.md@gmail.com>
Subject: RE: malpractice after 2004 and Denial of renewal from Indiana.

Thank you for your response Dr. Singh. Please review your NPDB report. It appears your malpractice cases ended in a Settlement as opposed to a judgement. Please state the question and review your response if need be.

From: Rajpaul Singh <rajpaul.md@gmail.com>
Sent: Wednesday, July 22, 2020 4:53 PM
To: Goldwire, Karrell <Karrell.Goldwire@flhealth.gov>
Cc: McMillan, Deondra D <Deondra.McMillan@flhealth.gov>
Subject: malpractice after 2004 and Denial of renewal from Indiana.

Hi Karrell,

I had just arrived in Florida on Monday, when you sent me your email . So my apologies for not getting back to you promptly because all this info I have on file in New York , some dating back over 10 years, so I had to get my son to retrieve these files from my home. Anyhow, with regards to your first question about a judgement on a malpractice claim after 2004 . The answer is yes . I have included the pertinent documentation. The carrier settled for $100,000 on my behalf. I disagreed with this and wanted to go to trial' since I was not at fault. The radiologist missed the shadow? Tumor. The patient was lost to follow up. She moved to Georgia and 2 years later complained again of back pain. With regards to renewal in Indiana, both attorneys representing me suggest not to appeal until my suspension was over in New York. I concurred. I had never worked in Indiana .I had to report the suspension. They called me before the board. I attended the meeting to be in compliance. They took no action against me , since I never worked in the state of Indiana. They did not put it in writing , but at the medical board meeting they told me to reapply after I would have cleared up things with the state of New York. I am not desirous of working any longer in a cold place (winter).I have had over 26 years in New York and I am looking to work in a warmer place , as I am 65 years old. I have included the documents for your review. Your understanding and help is sincerely appreciated. Thanks. Dr. Singh.

July 30, 2020

Dr. Rajpaul Singh
16537 Spring Park Drive
Clermont, FL 34711

Dear Dr. Singh:

It has been determined that you will be required to make a personal appearance before the Credentials Committee for consideration of your application.

This letter is to advise that you are required to appear before the Credentials Committee of the Florida Board of Medicine upon completion of your application file to discuss your application for licensure.

You will receive a letter in the mail approximately 2 weeks prior to the meeting notifying you of the meeting location and time you are required to appear. If you move, please notify our office immediately of your new address. Address changes must be sent in writing and signed by you. Please mail your address change to the address listed below.

If you have any questions, please contact me at Karrell.Goldwire@flhealth.gov, call (850) 617-1907, or fax (850) 412-1279. Your tracking number in our database is 148683. Indicate your tracking number if you leave a message, and try to ensure that other sources include it on their communications to us as well.

Sincerely,

Karrell D. Goldwire

Karrell D. Goldwire
Regulatory Supervisor
Florida Board of Medicine

Florida Department of Health
Board of Medicine
4052 Bald Cypress Way, Bin C03
Tallahassee, Florida 32399-3253
(850) 245-4131
(850) 488-0596 -fax

Post-Graduate Training Evaluation Form

The physician listed in #1 submitted an application for licensure and is under investigation by this authority. Please complete items 3 through 7 of this form and return directly to the Board of Medicine. Thank You!

To: Kings County Hospital
School
Pediatric Neurology
Department
450 Clarkson Avenue
Address
Brooklyn, NY 11203
City, State, Zip

1. Name: Rajpaul Singh, MD SS#: 589-96-6502
2. Internship/Residency/Fellowship Pediatric Neurology Resident From: 07/94 - 06/97

3 Please verify: If yes, explain on a separate sheet providing accurate details.
a. Matriculation Date 7/1/94 Completion Date 6/30/97 Specialty Pediatric Neurology
b. Levels completed: PGY I ✓ PGY II ✓ PGY III ✓ PGY IV ___ PGY V ___
c. Did this individual take any type of break or leave of absence for any reason? Yes ___ No ✓
d. Was this individual ever dropped, suspended, placed on probation, asked to resign or expelled? Yes ___ No ✓
e. Was attendance for a period other than the established timeframe or was he/she required to repeat any training? Yes ___ No ✓
f. Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason? Yes ___ No ✓

4. Professional Character: Evaluate compared to a physician or similar experience.

	Poor	Fair	Good	Superior	Don't Know
a. Basic Medical Knowledge			✓		
b. Diagnostic/Clinical Ability			✓		
c. Teaching Ability			✓		
d. Research Potential					✓
e. Fitness for Clinical Practice			✓		

5. Personal Character:

a. Motivation			✓		
b. Initiative			✓		
c. Responsibility			✓		
d. Integrity			✓		
e. Appearance			✓		
f. Knowledge of English			✓		

6. Professional Relationship With:

a. Teaching Staff			✓		
b. Colleagues			✓		
c. Nursing Staff			✓		
d. Patients			✓		

7. Overall Evaluation: If item C or D is checked, provide a written explanation on a separate sheet.
a. ___ Recommended as an outstanding applicant
b. ✓ Recommended as qualified and competent
c. ___ Recommended with some reservation
d. ___ Cannot Recommend

Signed: [signature]
Chairman or Program Director Only No **stamped** signatures please.

DH-MQA 1009 07/06

Chris

Florida Department of Health
Board of Medicine
4052 Bald Cypress Way, Bin C03
Tallahassee, Florida 32399-3253
(850) 245-4131
(850) 488-0596 -fax

Post-Graduate Training Evaluation Form

The physician listed in #1 submitted an application for licensure and is under investigation by this authority. Please complete items 3 through 7 of this form and return directly to the Board of Medicine. Thank You!

To: SUNY Downstate Medical Center
School
Pediatric Residency
Department
450 Clarkson Avenue
Address
Brooklyn, NY 11203
City, State, Zip

1. Name: Rajpaul Singh, MD SS#: 589-96-6502
2. Internship/Residency/Fellowship Pediatric Residency From: 07/1997 - 06/1998

3 Please verify: If yes, explain on a separate sheet providing accurate details.
a. Matriculation Date 7/92 Completion Date 6/98 Specialty Peds
b. Levels completed: PGY I PGY II PGY III PGY IV PGY V
c. Did this individual take any type of break or leave of absence for any reason? Yes No
d. Was this individual ever dropped, suspended, placed on probation, asked to resign or expelled? Yes No
e. Was attendance for a period other than the established timeframe or was he/she required to repeat any training? Yes No
f. Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason? Yes No

2000 DEC -4 PM 2:56 MEDICINE BOARD

4. Professional Character: Evaluate compared to a physician or similar experience.

	Poor	Fair	Good	Superior	Don't Know
a. Basic Medical Knowledge					
b. Diagnostic/Clinical Ability					
c. Teaching Ability					
d. Research Potential					
e. Fitness for Clinical Practice					
5. Personal Character:					
a. Motivation					
b. Initiative					
c. Responsibility					
d. Integrity					
e. Appearance					
f. Knowledge of English					
6. Professional Relationship With:					
a. Teaching Staff					
b. Colleagues					
c. Nursing Staff					
d. Patients					

7. Overall Evaluation: If item C or D is checked, provide a written explanation on a separate sheet.
a. ____ Recommended as an outstanding applicant
b. X Recommended as qualified and competent → Only did one year of residency
c. ____ Recommended with some reservation
d. ____ Cannot Recommend

Signed: [signature] M.D.
Chairman or Program Director Only No **stamped** signatures please.

DII-MQA form 0174

https://dohmqa31.imageapi.com/axiomproviewer/viewer/ViewDocument?documentId=11021605&aut... 6/6/2020

Florida Department of Health
Board of Medicine
4052 Bald Cypress Way, Bin C03
Tallahassee, Florida 32399-3253
(850) 245-4131
(850) 488-0596 -fax

Post-Graduate Training Evaluation Form

The physician listed in #1 submitted an application for licensure and is under investigation by this authority. Please complete items 3 through 7 of this form and return directly to the Board of Medicine. Thank You!

To: SUNY Downstate Medical Center
School
Clinical Neurophysiology Fellowship
Department
450 Clarkson Avenue
Address
Brooklyn, NY 11203
City, State, Zip

1. Name: Rajpaul Singh, MD SS#: 589-96-6502
2. Internship/Residency/Fellowship Clinical Neurophysiology Fellowship From: 07/1998 - 06/1999

3 Please verify: If yes, explain on a separate sheet providing accurate details.
a. Matriculation Date _____ Completion Date ✓ Specialty CLINICAL NEUROPHYSIOLOGY
b. Levels completed: PGY I ___ PGY II ___ PGY III ___ PGY IV ___ PGY V ___ PGY VI ✓
c. Did this individual take any type of break or leave of absence for any reason? Yes ___ No ✓
d. Was this individual ever dropped, suspended, placed on probation, asked to resign or expelled? Yes ___ No ✓
e. Was attendance for a period other than the established timeframe or was he/she required to repeat any training? Yes ___ No ✓
f. Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason? Yes ___ No ✓

4. Professional Character: Evaluate compared to a physician or similar experience.

	Poor	Fair	Good	Superior	Don't Know
a. Basic Medical Knowledge			✓		
b. Diagnostic/Clinical Ability			✓		
c. Teaching Ability			✓		
d. Research Potential			✓		
e. Fitness for Clinical Practice			✓		

5. Personal Character:

a. Motivation			✓		
b. Initiative			✓		
c. Responsibility			✓		
d. Integrity			✓		
e. Appearance			✓		
f. Knowledge of English			✓		

6. Professional Relationship With:

a. Teaching Staff			✓		
b. Colleagues			✓		
c. Nursing Staff			✓		
d. Patients			✓		

7. Overall Evaluation: If item C or D is checked, provide a written explanation on a separate sheet.
a. ___ Recommended as an outstanding applicant
b. ✓ Recommended as qualified and competent
c. ___ Recommended with some reservation
d. ___ Cannot Recommend

Signed: Geetha Ghori MD PROGRAM DIRECTOR CLINICAL NEUROPHYS

Chairman or Program Director Only No stamped signatures please.

State of Indiana

DEMOGRAPHIC INFORMATION

Name: Rajpaul Singh

ADDRESS INFORMATION

City/State/Zip: Hollis NY 11423
County: Queens

LICENSE INFORMATION

Lic #:	01047354A	Profession:	Medical Licensing Board	Type:	Physician	Secondary:	
Status:	Expired	Issued:	7/24/1997	Expiration:	10/31/2015		
Method:	Endorsement						

DISCIPLINE INFORMATION

RELATED LICENSES

No Related Licenses

SPECIALTY INFORMATION

Specialty: Neurology - Child Neurology (CHN)

DOCUMENTS

No Public Documents Available

THE UNIVERSITY OF THE STATE OF NEW YORK
THE STATE EDUCATION DEPARTMENT
DIVISION OF PROFESSIONAL LICENSING SERVICES
89 WASHINGTON AVENUE
ALBANY, NEW YORK 12234

This is to certify that according to the records of the Division of Professional Licensing Services, New York State Education Department Albany, New York, SINGH RAJPAUL
was issued license/certificate number 212722 for the practice of MEDICINE on 12/08/1998.

Our records also indicate the following information:
Date of birth: 09/22/1955
School attended: UNIVERSITY OF HAVANA
Date of graduation: 08/20/83
Degree earned: MD

Program was acceptable in accordance with the NYS Regulations of the Commissioner of Education. Requirements met at the time of licensure.

Basis of licensure:

DATE	COMP1	COMP2	FLEX	
12/93	00079	00080		OOSPA*

*EXANS TAKEN IN PENNSYLVANIA

EXMS TAKEN=01

A license is valid during the life of the holder unless revoked, annulled or suspended by the Board of Regents. A licensee must register periodically with this Department to practice in this state.

Currently Registered: YES Reg period ends: 08/31/21
Address: 195-03 HILLSIDE AVE HOLLIS NY 11423-0000

Disciplinary information: *See attached

Comments:

I, Sandra Barsallo, Education Credentials Specialist, Division of Professional Licensing Services of the New York State Education Department, do hereby state that as Education Credentials Specialist of said Division, I have legal custody of the official records of the Division of Professional Licensing Services and to the best of my knowledge, the aforesaid information is true and correct.

SEAL

Sandra Barsallo 06/22/20
Education Credentials Specialist

Department of Health

RAJPAUL SINGH

License Number: ME103728

Data As Of 8/19/2020

Profession	Medical Doctor
License	ME103728
License Status	NULL AND VOID/
License Expiration Date	1/31/2015
License Original Issue Date	02/12/2009
Address of Record	If further information is needed, please contact the Department of Health at (850) 488-0595.
Controlled Substance Prescriber (for the Treatment of Chronic Non-malignant Pain)	Yes
Discipline on File	Yes
Public Complaint	Yes

The information on this page is a secure, primary source for license verification provided by the Florida Department of Health, Division of Medical Quality Assurance. This website is maintained by Division staff and is updated immediately upon a change to our licensing and enforcement database.

FLORIDA | Board of Medicine

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Shailesh Gupta, M.D.
Coral Springs, Florida

Vacant, M.D.

Executive Director
Claudia Kemp, J.D.

September 9, 2020

Donald Collier Proctor, Jr., MD
2208 E. Ocean Oaks Ln
Vero Beach, FL 32963

Dear Dr. Proctor, Jr.:

This is in further reference to your application for licensure by examination.

Please be advised that you are required to make a personal appearance before the Credentials Committee of the Board of Medicine to discuss:

- Pursuant to section 456.0635(2)(e), Florida Statutes, currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities.

In addition, the Committee may inquire into any other issues relating to your application and eligibility for licensure.

Date:	Thursday, October 1, 2020
Time:	8:00 a.m. (Meeting starts at 8:00 a.m. Interview time may vary.)
Location:	The in-person meeting scheduled in Orlando, Florida is cancelled, and the meeting will be held by a web-based meeting platform or, if appropriate, a teleconference call.

The meeting information and directions for participating in the October 2020 meeting will be posted on the Florida Board of Medicine's website: https://flboardofmedicine.gov/meeting-information.

Additionally, the Committee's recommendation on your application for licensure will be presented to the full Board of Medicine on Friday, October 2, 2020 for final action. You are not required to attend the full board meeting.

Thank you for your continued cooperation. Should you have any questions regarding this matter, please feel free to contact me. *This is your first scheduled appearance.

Sincerely,

Wendy Alls

Wendy Alls
Program Operations Administrator

cc: Mark Thomas, Esquire

Pursuant to the provisions of the Americans with Disabilities Act, any person requiring special accommodations to participate in this workshop/meeting is asked to advise the agency at least 10 days before the workshop/meeting by contacting: Rebecca.Hewett@flhealth.gov or call (850) 245-4137.

*** 456.013(3)(c) In considering applications for licensure, the board, or the department when there is no board, may require a personal appearance of the applicant. If the applicant is required to appear, the time period in which a licensure application must be granted or denied shall be tolled until such time as the applicant appears. However, if the applicant fails to appear before the board at either of the next two regularly scheduled board meetings, or fails to appear before the department within 30 days if there is no board, the application for licensure shall be denied.**

4052 Bald Cypress Way, Bin C-03
Tallahassee, Florida 32399-3253
Phone: 850/245-4131
Fax: 850/488-0596 or 850/412-1268
https://www.FLBoardofMedicine.gov

Florida HEALTH

000705

MEDICAL DOCTOR
APPLICATION FOR LICENSURE
Apply for your license online at www.flboardofmedicine.gov

Choose your application type:

☐ Endorsement (1021) ☑ Examination (1024)

☐ Military Veterans Fee Waiver

If you were honorably discharged from the U.S. armed services within 60 months of your application you will qualify for a waiver of the application fee and the initial licensure fee. In order to qualify, please check the box above indicating that you are seeking a waiver and submit **a DD-214 or NGB-22 form as proof of honorable discharge.**

☐ I plan to dispense medicinal drugs in the State of Florida for a fee or other remuneration and hereby register as required by Section 465.0276, F.S. I understand that the fee for the Dispensing Practitioner is $100.00 in addition to the required initial license fee and will submit it along with the license fee.

1. PERSONAL INFORMATION

Name: Proctor (Last/Surname) Donald Jr (First) Collier (Middle) **Date of Birth:** 05/31/1965 (MM/DD/YYYY)

Mailing Address: (The address where mail and your license should be sent)

2208 E. Ocean Oaks Ln (Street/ PO Box) ____ (Suite/Apt. No) Vero Beach (City)

FL (State) 32963 (Zip) USA (Country) 772-234-3706/772-559-3706 (Phone Number)

Physical Location: A Post Office Box is not acceptable. This address will be posted on the Department of Health's website. *If you do not have a current practice address, your mailing address will be used. When you obtain a practice address, you will be required to update your online practitioner profile.*

2208 E. Ocean Oaks Ln (Street/ P.O. Box) ____ (Suite/Apt. No) VeroBeach (City)

FL (State) 32963 (Zip) USA (Country) 772-234-3706 (Alternate Phone Number)

Email Address: dcpjrmd@gmail.com

Under Florida law, email addresses are public records. If you do not want your e-mail address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.

Equal Opportunity Data: We are required to ask that you furnish the following information as part of your voluntary compliance with Section 2, Uniform Guidelines on Employee Selection Procedure (1978) 43 CFR 38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

SEX: ☑ Male ☐ Female **RACE:** ☑ White ☐ Black ☐ Asian/Pacific Islander ☐ Hispanic ☐ Other

☑ Yes ☐ No **Availability for Disaster:** Will you be available to provide health care services in special needs shelters or to help staff disaster medical assistance teams during times of emergency or major disaster?

2. MEDICAL EDUCATION HISTORY

Federal Credentials Verification Services (FCVS) is not a requirement for licensure. FCVS will primary source verify and provide a copy of the medical school transcript(s), medical school diploma, medical school verification, name change document(s), national examination score report, ECFMG certificate, ECFMG verification and postgraduate training verifications. For more information about FCVS, visit their web-site at www.fcvs.org/.

☑ Yes ☐ No Are you using the FCVS to verify your core credentials?

☑ Yes ☐ No Have you completed the equivalent of 2 academic years of preprofessional, postsecondary education including, courses in anatomy, biology and chemistry prior to entering medical school?

Medical Education:
List in chronological order all medical schools attended, whether completed or not. Submit on a separate sheet if needed.

Medical School Name and Address:	From: (mm/yy)	To: (mm/yy)	Date Degree Received:
USF Morsani College of Medicine 12901 Bruce B Downs Blvd Tampa, FL 33612	08/87	05/91	05/24/1991 MD

Fifth Pathway Certificate Holders: N/A

If you answer "yes" to any of the following questions, you must request verifications to be sent directly to the Board office.

☐ Yes ☐ No Did you attend an international medical school and do not possess a valid ECFMG Certificate?

☐ Yes ☐ No Did you receive a bachelor's degree from an accredited United States college or University?

☐ Yes ☐ No Did you study at a medical school which is recognized by the World Health Organization?

☐ Yes ☐ No Did you complete all of the formal requirement of the International medical school, except the internship or social service requirements, and pass part I of the National board of Medical examination or the Education Commission for Foreign Medical Graduates Examination equivalent?

☐ Yes ☐ No Did you complete an academic year of supervised clinical training in a hospital affiliated with a medical school approved by the Council on Medical Education of the American Medical Association and upon completion passed part II of the National Board of Medical Examiners examination or the Education Commission for Foreign Medical Graduates examination Equivalent?

Postgraduate Training:

Provide the following documentation to support your postgraduate training:

☑ Post-Graduate Training Form

In the table below list, in chronological order, all postgraduate training from the date you graduated from medical school to the present. Start with your first program and end with your last or current program. List all programs you began, whether you completed or received credit for the training.

Program Name and Full Mailing Address:	Specialty Area:	From: (mm/yy)	To: (mm/yy)	Did you receive credit? (Y/N)
UF Dept of Surgery 1600 SW Archer Rd Gainesville, FL 32610	Basic Surgery Resident	07/91	06/92	Y
UF Dept of Otolaryngology 1345 Center Dr Box 100264 Gainesville, FL 32610	Otolaryngology-Head and Neck Surgery	07/92	06/96	Y
American Academy of Facial Plastic and Reconstructive Surgery 310 S Henry St Alexandria, VA 22314	Facial Plastic and Reconstructive Surgery	07/96	06/97	Y

Loan History:

☐ Yes ☑ No Are you currently in default on any health education loan or scholarship obligation? (If "yes", explain on a separate sheet providing accurate details.)

3. EXAMINATION HISTORY

State Board (prior to 1974), State Board (after 1974) & SPEX, LMCC & SPEX, NBME, FLEX, USMLE III, or Combination (prior to 2000)

Request that the score report be sent directly to the Board of Medicine. NOTE: If you took a state Board examination and are not currently licensed in three other states, you must also request your SPEX score be sent.

Exam taken: NBME Date passed: 07/01/1992 mm/dd/yy

4. LICENSURE HISTORY

Request verification of licensure status directly from the licensing entity or www.veridoc.org. Request international license verification(s) if you have practiced outside of the U.S. for at least two of the previous four years.

☑ Yes ☐ No Do you now hold or have you ever held a license to practice medicine or any other profession in any US State or territory, or foreign country? Please list in table below.

Jurisdiction	Profession	License number
Florida	MD	ME 0064734

If you answer "yes" to any of the questions in this section, you are required to send an explanation and supporting documentation.

☐ Yes ☑ No Have you had any application for a medical license or professional license denied by any state board or other governmental agency of any state, territory, or country?

☐ Yes ☑ No Are you currently under investigation in any jurisdiction for an act or offense that would constitute a violation of Section 458.331, Florida Statutes?

☐ Yes ☑ No Have you ever had any professional license or license to practice medicine revoked, suspended, placed on probation, or other disciplinary action taken in any state, territory or country?

5. PRACTICE/EMPLOYMENT HISTORY

List the year you legally first began to practice medicine, 1993 (yyyy). This would be the year you began practicing medicine and could be the date you began your postgraduate training.

☐ Yes ☑ No Have you practiced medicine in any jurisdiction for two of the last four years **or** completed a board approved post-graduate training program within the last two years?

☐ Yes ☑ No If your answer to the question above was "No," have you passed a board approved clinical competency exam within the last year? If yes, then submit supporting documentation.

List in chronological order all employment for the last four (4) years.

Name and address of practice or employment	Type of employment	From: mm/yy	To: mm/yy
Self 2208 E. Ocean Oaks Ln Vero Beach, FL 32963	Self Semi-retired	2/16	10/16
Proctor Construction Company 2050 US#1 #200 Vero Beach, FL 32960	part time Consulting	11/16	Present 7/20

☐ Yes ☑ No Do you currently hold staff privileges in any hospital, health institution, clinic or medical facility? List each facility below.

Name of facility

If you answer "yes" to the following questions, you are required to send an explanation and supporting documentation.

☐ Yes ☑ No Have you ever had any staff privileges denied, suspended, revoked, modified, restricted, not renewed, or placed on probation, or have you been asked to resign or take a temporary leave of absence or were otherwise acted against by any facility?

☐ Yes ☑ No Do you currently, or have you had, responsibility for graduate medical education within the last 10 years?

In the table below, list all institutions where you have had responsibility for graduate medical education or faculty appointment(s) at any medical school.

Name of institution

☑ Yes ☐ No Are you certified by any specialty board recognized by the American Board of Medical Specialties or specialty board approved by the Florida Board of Medicine?

Board Name	Certification/ Specialty/Sub-Specialty	Date of Certification (mm/yy)
American Board of Otolaryngology - Head and Neck Surgery	Otolaryngology - Head and Neck Surgery	04/97

If you answer "yes" to any of the following questions, please explain on a separate sheet providing accurate details.

☑ Yes ☐ No Have you ever had any final disciplinary action taken against you by a specialty board or other similar national organization? See Attachment A from American Board of Facial Plastic Surgery

☑ Yes ☐ No Have you ever been denied or surrendered a DEA registration? See Attachment from NPDB B

6. CRIMINAL HISTORY

If you answer "Yes" to the following question you are required to send the following items:

a. Self-explanation describing in detail the circumstances surrounding each offense, including dates, city and state, charges and final results.
b. Final Dispositions and Arrest Records for all offenses. The Clerk of the Court in the arresting jurisdiction will provide you with these documents. Unavailability of these documents must come in the form of a letter from the Clerk of the Court.
c. Completion of Sentence Documents. You may obtain documentation from the Department of Corrections. The report must include the start date, end date and that the conditions were met.

☐ Yes ☑ No Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to, a crime in any jurisdiction other than a minor traffic offense? You must include all misdemeanors and felonies, **even if adjudication was withheld. Driving under the influence (DUI) or driving while impaired (DWI) are not minor traffic offenses for purposes of this question.**

Yes ☑ I have been provided and read the statement from the Florida Department of Law Enforcement regarding the sharing, retention, privacy and right to challenge incorrect criminal history records and the "Privacy Statement" document from the Federal Bureau of Investigation.

7. MILITARY HISTORY

A. ☐ Yes ☑ No Have you ever been in the United States Military and/or Public Health Service?

B. ☐ Yes ☑ No Have you ever been disciplined by any branch of the United States Armed Services or Public Health Services? If you answered "yes" please provide a detailed explanation and supporting documentation

8. CRIMINAL AND MEDICAID/MEDICARE FRAUD QUESTIONS

Applicants for licensure, certification or registration and candidates for examination may be excluded from licensure, certification or registration if their felony conviction falls into certain timeframes as established in Section 456.0635(2), Florida Statutes. If you answer "Yes" to any of the following questions, please provide a written explanation for each question. Supporting documentation includes court dispositions or agency orders where applicable.

1. ☐ Yes ☑ No Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, F.S. (relating to social and economic assistance), Chapter 817, F.S. (relating to fraudulent practices), Chapter 893, F.S. (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction?

If you responded "No" to the question above, skip to question 2.

a. ☐ Yes ☐ No If "yes" to 1, for the felonies of the first or second degree, has it been more than 15 years from the date of the plea, sentence and completion of any subsequent probation?

b. ☐ Yes ☐ No If "Yes" to 1, for felonies of the third degree, has it been more than 10 years from the date of the plea, sentence and completion of any subsequent probation? (This question does not apply to felonies of the third degree under Section 893.13(6)(a), Florida Statutes)

c. ☐ Yes ☐ No If "Yes" to 1, for the felonies of the third degree under Section 893.13(6)(a), Florida Statutes, has it been more than 5 years from the date of the plea, sentence and completion of any subsequent probation?

d. ☐ Yes ☐ No If "Yes" to 1, have you successfully completed a drug court program that resulted in the plea for the felony offense being withdrawn or charges dismissed?

2. ☐ Yes ☑ No Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970 (relating to controlled substances) or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)?

If you responded "No" to the question above, skip to question 3.

a. ☐ Yes ☐ No If "Yes" to 2, has it been more than 15 years before the date of application since the sentence and any subsequent period of probation for such conviction or plea ended?

3. ☐ Yes ☑ No Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes?

If you responded "No" to the question above, skip to question 4.

a. ☐ Yes ☐ No If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years?

4. ☐ Yes ☑ No Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid Program?

If you responded "No" to the question above, skip to question 5.

a. ☐ Yes ☐ No Have you been in good standing with a state Medicaid program for the most recent five years?

b. ☐ Yes ☐ No Did the termination occur at least 20 years before the date of this application?

5. ☑ Yes ☐ No Are you currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities? See Attachment From OIG C

If you answer "Yes" to the questions below, you are required to send the following items:

- **A statement indicating the date of each incident and the number for each case.**
- **An explanation of details for each case and your involvement for each case.**
- **Submit the enclosed Exhibit 1 form.**
- **A copy of the complaint, judgments and/or settlements for each case.**
- **Submit a complete copy of the trial record(s) of each case, including the trial transcript, evidentiary exhibits and final judgment in electronic format.**

☐ Yes ☑ No Have you ever had a judgment entered against you for medical malpractice where the incident(s) of malpractice occurred after November 2, 2004?

☐ Yes ☑ No Within the last 10 years have you had any liability claim(s) or action(s) for damages for personal injury settled or finally adjudicated in an amount that exceeds $100,000.00?

10. FINANCIAL RESPONSIBILITY

The Financial Responsibility options are divided into two categories, coverage and exemptions. Check only one option of the ten provided as required by s. 458.320, Florida Statutes.

Category I: Financial Responsibility Coverage

☐1. I do not have hospital staff privileges, I do not perform surgery at an ambulatory surgical center and I have established an irrevocable letter or credit or an escrow account in an amount of $100,000/$300,000, in accord with Chapter 675, F. S., for a letter of credit and s. 625.52, F. S., for an escrow account.

☐2. I have hospital staff privileges or I perform surgery at an ambulatory surgical and I have established an irrevocable letter of credit or escrow account in an amount of $250,000/$750,000, in accord with Chapter 675, F. S., for a letter of credit and s. 625.52, F. S., for an escrow account.

☐3. I do not have hospital staff privileges, I do not perform surgery at an ambulatory surgical center and I have obtained and maintain professional liability coverage in an amount not less than $100,000 per claim, with a minimum annual aggregate of not less than $300,000 from an authorized insurer as defined under s. 624.09, F. S., from a surplus lines insurer as defined under s. 626.914(2), F. S., from a risk retention group as defined under s. 627.942, F. S., from the Joint Underwriting Association established under s. 627.351(4), F. S., or through a plan of self-insurance as provided in s. 627.357, F. S.

☐4. I have hospital staff privileges or I perform surgery at an ambulatory surgical and I have professional liability coverage in an amount not less than $250,000 per claim, with a minimum annual aggregate of not less than $750,000 from an authorized insurer as defined under s. 624.09, F. S., from a surplus lines insurer as defined under s. 626.914(2), F. S., from a risk retention group as defined under s. 627.942, F. S., from the Joint Underwriting Association established under s. 627.351(4), F. S., or through a plan of self-insurance as provided in s. 627.357, F. S.

☑5. I have elected not to carry medical malpractice insurance however, I agree to satisfy any adverse judgments up to the minimum amounts pursuant to s. 458.320(5)(g)1, F. S. I understand that I must either post notice in a sign prominently displayed in my reception area or provide a written statement to any person to whom medical services are being provided that I have decided not to carry medical malpractice insurance. I understand that such a sign or notice must contain the wording specified in s. 458.320(5)(g), F. S.

Category II: Financial Responsibility Exemptions

☐6. I practice medicine exclusively as an officer, employee, or agent of the federal government, the state, or its agencies or subdivisions.

☐7. I hold a limited license issued pursuant to s. 458.317, F. S., and practice only under the scope of the limited license.

☐8. I do not practice medicine in the State of Florida.

☐9. I meet all of the following criteria:

(a) I have held an active license to practice in this state or another state or some combination thereof for more than 15 years;

(b) I am retired or maintain part time practice of no more than 1000 patient contact hours per year;

(c) I have had no more than two claims resulting in an indemnity exceeding $25,000 within the previous five-year period;

(d) I have not been convicted of or pled guilty or nolo contendere to any criminal violation specified in Chapter 458, F. S. or the medical practice act in any other state; and

(e) I have not been subject, within the past ten years of practice, to license revocation, suspension, or probation for a period of three years or longer, or a fine of $500 or more for a violation of Chapter 458, F. S., or the medical practice act of another jurisdiction. A regulatory agency's acceptance of a relinquishment of license, stipulation, consent order, or other settlement offered in response to or in anticipation of filing of administrative charges against a license is construed as action against a license. I understand if I am claiming an exception under this section that I must either post notice in a sign prominently displayed in my reception area or provide a written statement to any person to whom medical services are being provided that I have decided not to carry medical malpractice insurance. See Section 458.320(5)(f), Florida Statutes, for specific notice requirements.

☐10. I practice only in conjunction with my teaching duties at an accredited medical school or its teaching hospitals. (Interns and residents do not qualify for this exemption).

If you select an exemption based on number 9, you must also complete the affidavit on the following page.

N/A

BOARD OF MEDICINE
Financial Responsibility Affidavit of Exemption

This affidavit is only required if you are claiming an Exemption based on number 9 on the preceding page.

I,_____, do hereby certify and attest that I meet all of the following criteria:

(a) I have held an active license to practice in this state or another state or some combination thereof for more than 15 years;
(b) I am retired or maintain part time practice of no more than 1000 patient contact hours per year;
(c) I have had no more than two claims resulting in an indemnity exceeding $25,000 within the previous five-year period;
(d) I have not been convicted of or pled guilty or nolo contendere to any criminal violation specified in Chapter 458, F. S. or the medical practice act in any other state; and
(e) I have not been subject, within the past ten years of practice, to license revocation, suspension, or probation for a period of three years or longer, or a fine of $500 or more for a violation of Chapter 458, F. S., or the medical practice act of another jurisdiction. A regulatory agency's acceptance of a relinquishment of license, stipulation, consent order, or other settlement offered in response to or in anticipation of filing of administrative charges against a license is construed as action against a license. I understand if I am claiming an exception under this section that I must either post notice in a sign prominently displayed in my reception area or provide a written statement to any person to whom medical services are being provided that I have decided not to carry medical malpractice insurance. See Section 458.320(5) (f), F.S., for specific notice requirements.

Dated: _____ Signature:_____

STATE OF _____
COUNTY OF _____

Sworn to (or affirmed) and subscribed before me this_____day of_____, by

_____

_____
(Signature of Notary Public - State of Florida)

(Print, Type, or Stamp Commissioned Name of Notary Public)

Personally Known_____OR Produced Identification _____

Type of Identification Produced_____

11. FLORIDA BIRTH RELATED NEUROLOGICAL COMPENSATION ASSOCIATION

You must choose one of the three options described below. Please be sure to view the information about each exemption at www.nica.com. Check only one.

☐	☑	☐	$250.00
$5,000 Participating	$250 Non-participating	$0 Exempt	Amount enclosed

If you choose "$0 Exempt" provide appropriate documentation to the Board of Medicine and to NICA.

I have read the explanatory information provided by NICA, and I choose the option above.

Signature 7/1/2020 Date

Donald Collier Proctor, Jr MD
Name
2208 E. Ocean Oaks Ln
Street Address
Vero Beach, FL 32963
City, State, Zip

If you are a participating or non-participating physician, or a physician claiming exemption, you must complete, sign and date this form and return it with your payment to this address.

Board of Medicine
4052 Bald Cypress Way, #C-03
Tallahassee, FL 32399-3253

If you are a physician claiming exemption, you must also send a copy of your completed, signed, and dated form with proof of your exemption to:

NICA
2360 Christopher Place
Tallahassee, FL 32308

If you have any questions about NICA or this form, please contact NICA at www.nica.com or (850) 488-8191.

12. STATEMENT OF APPLICANT

I state that these statements are true and correct. I recognize that providing false information may result in denial of licensure, disciplinary action against my license, or criminal penalties pursuant to Sections 456.067, 775.083, and 775.084, Florida Statutes. I state that I have read Chapters 456, 458 and 766.301-.316, Florida Statutes and Chapter 64B8, Florida Administrative Code.

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Florida Board of Medicine information which is material to my application for licensure.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind. I state that my answers and all statements made by me herein are true and correct.

Should I furnish any false information in this application, I hereby agree that such act constitutes cause for denial, suspension, or revocation of my license to practice medicine in the State of Florida. If there are any changes to my status or any change that would affect any of my answers to this application I must notify the board within 30 days.

I understand that my records are protected under federal and state regulations governing Confidentiality of Mental Health Patient Records and cannot be disclosed without my written consent unless otherwise provided in the regulations. I understand that my records are protected under federal and state regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it.

Donald Collier Proctor Jr.

Print name

Signature

07/01/2020

Date

N/A

EXHIBIT 1–REPORT ON PROFESSIONAL LIABILITY CLAIMS AND ACTIONS

Include information relating to liability actions occurring within the previous 10 years. The actions are required to be reported under section 456.039(1)(b) F. S. You must submit a completed form for each occurrence. If you are an allopathic, osteopathic, or podiatric physician, to satisfy this reporting requirement you may submit copies of reports previously submitted under the requirements of s. 456.049 F. S. instead of this exhibit.

Date of occurrence: / /____ Date reported to licensee: / /____ Date claim reported to insurer or self-insurer / /_____

Injured person's name: (last, first, middle initial)_____

Street Address:_____

City:_____ State:_____ Zip Code: _____
Age:_____ Sex: _____

Date of suit, if filed: / /____

List all defendants with their health care provider license number involved in this claim:
1._____ 2._____
3._____ 4._____

Date of final claim disposition:_____/_____/_____

Date and amount of judgment or settlement, if any: _____

Was there an itemized verdict? [ ] Yes [ ] No (If "YES", attach copy of settlement verdict)

Indemnity paid on behalf of this defendant: $_____
Loss adjustment expense paid to defense counsel: $_____
All other loss adjustment expense paid: $_____

The date and reason for final disposition, if no judgment or settlement: _____

Name of institution at which the injury occurred: _____

Location of injury occurrence:

[ ] Patient's Room [ ] Physical Therapy Dept. [ ] Radiology [ ] Labor & Delivery Room
[ ] Operating Suite [ ] Nursery [ ] Emergency Room
[ ] Recovery Room [ ] Critical Care Unit [ ] Other [ ] Special Procedure Room

Final diagnosis for which treatment was sought or rendered: _____
_____

Describe misdiagnosis made, if any, of the patient's actual condition. _____
_____

Describe the operation, diagnostic, or treatment procedure causing the injury. Use nomenclature and/or descriptions of the procedures used. Include method of anesthesia, or name of drug used for treatment, with detail of administration. _____
_____

Describe the principal injury giving rise to the claim. Use nomenclature and/or descriptions of the injury. Include type of adverse effect from drugs where applicable. _____
_____

Safety management steps taken by the licensee to make similar occurrences less likely: _____
_____

I represent that these statements are true and correct pursuant to s. 837.06, Florida Statutes. I recognize that providing any false statements made in writing with the intent to mislead the Department staff in the performance of their official duties, shall be punishable as provided in s. 775.082 and 775.083, Florida Statutes.

Signature of physician: _____

July 17, 2020

Donald Collier Proctor Jr, M.D.
2208 E. Ocean Oaks Ln
Vero Beach, FL 32963

Dear Dr. Proctor:
File: 149942

Thank you for considering Florida for physician licensure. Your application for medical licensure has been received. The application is incomplete for the reasons set out in the attached deficiency notice. Please address these deficiencies as soon as possible to avoid delay in processing your application.

Information received by this office may require additional explanation or documentation to determine licensure eligibility. After all requested documentation is received, your application will be submitted for supervisory review. We will notify you if additional information is required.

Applicants with a history of malpractice, criminal activity, discipline, physical or mental impairment, unfavorable evaluations, or other matters that need explanation may require a personal appearance before the Board of Medicine Credentials Committee for determination of licensure eligibility. If your appearance is required, you will be notified in writing once your application is complete.

You can now follow the progress of your application through our website at: www.FLHealthSource.gov/mqa-services. If you are a returning user, select "Yes" and enter the user ID and password you selected during the registration process under Returning User. If you did not apply for licensure through this screen, select "No" and follow the prompts to create an account. You must have a valid email address to create your account.

Once you are logged in, you will be prompted to add your application to your account. Once you have successfully added your application, you will be directed to your dashboard. Under the "Additional Activities" section, select "Check Application Status" to review any open deficiencies, upload documents or print out instructional documents.

THIS IS IMPORTANT: Your application will remain incomplete until all deficiencies are completed. In addition, you are required to notify the Board office immediately in writing of any occurrence(s) that would in any way change or affect any answer given in the application or an answer provided in response to any of our direct questions to you.

If you have any questions, please contact me at Vanessa.Valme@flhealth.gov, call 850-617-1918, or fax 850-412-1265.

Sincerely,

Vanessa Valme

Vanessa Valme
Regulatory Specialist II

Enclosure(s)

Federation of STATE MEDICAL BOARDS

Federation Credentials Verification Service (FCVS)

400 Fuller Wiser Road, Suite 300, Euless, TX 76039
Tel: (817) 868-5000 Fax: (817) 868-5099

Verification of Graduate Medical Education

Institution: University of Florida College of Medicine

Attention: **Verification of Training/Joan Wysocki**

Specialty: Surgery-General

Affiliated University: _____

Address: Gainesville, FL

RECEIVED
SEP 16 2016
By _____

Verification For:

Name: Proctor, Donald Collier Jr

DOB: 05/31/1965

Individual's Name on Record (If different from above): _____

Program Participation:

Important: Report Incomplete Training Levels (years) separate from those that were successfully completed.

If the training level (year) is currently in progress report the expected completion date in the "To" field.

Report Internships, Residencies and Fellowships separately.

Use one section per Department/Specialty. If the Department/Specialty is rotating or transitional, please provide a schedule of rotations.

Training Level: 1 (e.g., 1, 2, 3, etc.)
☒ Internship ☐ Residency ☐ Chief Residency ☐ Fellowship ☐ Research

Specialty/Subspecialty: General Surgery

From: 7/1/1991 **To:** 6/30/1992

Successfully Completed?: ☒ Yes ☐ No ☐ In Progress

Accredited by: ☒ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Training Level: _____ (e.g., 1, 2, 3, etc.)
☐ Internship ☐ Residency ☐ Chief Residency ☐ Fellowship ☐ Research

Specialty/Subspecialty: _____

From: / / **To:** / /

Successfully Completed?: ☐ Yes ☐ No ☐ In Progress

Accredited by: ☐ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Training Level: _____ (e.g., 1, 2, 3, etc.)
☐ Internship ☐ Residency ☐ Chief Residency ☐ Fellowship ☐ Research

Specialty/Subspecialty: _____

From: / / **To:** / /

Successfully Completed?: ☐ Yes ☐ No ☐ In Progress

Accredited by: ☐ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Unusual Circumstances:

Check the correct response. Omitted responses require written explanation.

If necessary, you may continue your explanation on a separate sheet of paper.

SEAL VERIFIED

1. Did this individual ever take a leave of absence or break from his/her training? ☐ Yes ☒ No
2. Was this individual ever placed on probation? ☐ Yes ☒ No
3. Was this individual ever disciplined or placed under investigation? ☐ Yes ☒ No
4. Were any negative reports for behavioral reasons ever filed by instructors? ☐ Yes ☒ No
5. Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason? ☐ Yes ☒ No

Please explain any "Yes" response from above:

Certification:

Affix your institutional seal in this space. If no seal is available, you must have this form notarized

Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct. The signature line must contain the original signature, or the electronic typed signature, of the program director **(M.D./D.O. only)**.

Name: George Sarosi, MD **Signature:** _____

Title of Signatory (e.g., Program Director): Program Director **Date of Signature:** 9/15/16

Tel: 352-265-0916 Fax: 352-265-3292 E-Mail: George.Sarosi@surgery.ufl.edu

Federation of STATE MEDICAL BOARDS

Federation Credentials Verification Service (FCVS)

400 Fuller Wiser Road, Suite 300, Euless, TX 76039
Tel: (817) 868-5000 Fax: (817) 868-5099

Verification of Graduate Medical Education

Institution: University of Florida Health Science Center

Attention: **Program Director**

Specialty: Otolaryngology

Affiliated University: **University of Florida**

Address: Gainesville, FL

Verification For:

Name: Proctor, Donald Collier Jr

DOB: 05/31/1965

Individual's Name on Record (If different from above): _____

Program Participation:

Important:

Report Incomplete Training Levels (years) separate from those that were successfully completed.

If the training level (year) is currently in progress report the expected completion date in the "To" field.

Report Internships, Residencies and Fellowships separately.

Use one section per Department/Specialty. If the Department/Specialty is rotating or transitional, please provide a schedule of rotations.

Training Level: 2-5 (e.g., 1, 2, 3, etc.)
☐ Internship ☒ Residency ☐ Chief Residency ☐ Fellowship ☐ Research

Specialty/Subspecialty: Otolaryngology

From: 07/01/1992 **To:** 06/30/1996

Successfully Completed?: ☒ Yes ☐ No ☐ In Progress

Accredited by: ☒ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Training Level: _____ (e.g., 1, 2, 3, etc.)
☐ Internship ☐ Residency ☐ Chief Residency ☐ Fellowship ☐ Research

Specialty/Subspecialty: _____

From: / / **To:** / /

Successfully Completed?: ☐ Yes ☐ No ☐ In Progress

Accredited by: ☐ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Training Level: _____ (e.g., 1, 2, 3, etc.)
☐ Internship ☐ Residency ☐ Chief Residency ☐ Fellowship ☐ Research

Specialty/Subspecialty: _____

From: / / **To:** / /

Successfully Completed?: ☐ Yes ☐ No ☐ In Progress

Accredited by: ☐ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Unusual Circumstances:

Check the correct response. Omitted responses require written explanation.

If necessary, you may continue your explanation on a separate sheet of paper.

1. Did this individual ever take a leave of absence or break from his/her training? ☐ Yes ☒ No
2. Was this individual ever placed on probation? ☐ Yes ☒ No
3. Was this individual ever disciplined or placed under investigation? ☐ Yes ☒ No
4. Were any negative reports for behavioral reasons ever filed by instructors? ☐ Yes ☒ No
5. Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason? ☐ Yes ☒ No

Please explain any "Yes" response from above:

_____

_____

Certification:

Affix your institutional seal in this space. If no seal is available, you must have this form notarized

Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct. The signature line must contain the original signature, or the electronic typed signature, of the program director **(M.D./D.O. only)**.

Name: William O. Collins, MD

Signature: William O. Collins, MD

Title of Signatory: Program Director

Date of Signature: 8/4/2016

Tel: 352-273-5199 Fax: 352-392-6781 E-Mail: william.collins@ent.ufl.edu

ELECTRONIC SEAL VERIFIED

Valme, Vanessa

From: Alls, Wendy
Sent: Tuesday, August 25, 2020 2:13 PM
To: Valme, Vanessa
Subject: FW: Postgraduate Fellowship Certificate

Please upload.

From: Don Proctor <dcpjrmd@gmail.com>
Sent: Tuesday, August 25, 2020 9:45 AM
To: Alls, Wendy <Wendy.Alls@flhealth.gov>
Subject: Fwd: Postgraduate Fellowship Certificate

File no.149942

Dear Ms. Alls
Attached is my postgraduate certificate certifying my postgraduate training in advanced facial plastic and reconstructive surgery. This training took place immediately after the completion of my residency training. The application indicated that I needed to document all training, education and time in practice. Thank you again.

Respectfully,

Donald C Proctor Jr MD

---------- Forwarded message ---------
From: **Allison Proctor** <allisondonald3@gmail.com>
Date: Tue, Aug 25, 2020 at 9:18 AM
Subject: Postgraduate Fellowship Certificate
To: <dcpjrmd@gmail.com>

Educational and Research Found

American Acad

of

Facial Plastic and Reconstru

certifies that

Donald Collier Proctor,

has completed an approved Postgraduate

Advanced Facial Plastic and Reconstr

July 1, 1996 - June 30, 199

Date of Fellowship

December 1, 1997

Date Issued

President

Education Vi

Department of Health

DONALD COLLIER PROCTOR JR

License Number: ME64734

Data As Of 8/26/2020

Profession	Medical Doctor
License	ME64734
License Status	NULL AND VOID/
License Expiration Date	1/31/2016
License Original Issue Date	08/06/1993
Address of Record	If further information is needed, please contact the Department of Health at (850) 488-0595.
Controlled Substance Prescriber (for the Treatment of Chronic Non-malignant Pain)	No
Discipline on File	No
Public Complaint	No

The information on this page is a secure, primary source for license verification provided by the Florida Department of Health, Division of Medical Quality Assurance. This website is maintained by Division staff and is updated immediately upon a change to our licensing and enforcement database.

FLORIDA | Board *of* Medicine

Ron DeSantis
Governor

Scott A. Rivkees, MD
State Surgeon General

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Zachariah Zachariah, M.D.
Ft. Lauderdale, Florida

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Vacant, Consumer Member

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Shailesh Gupta, M.D.
Coral Springs, Florida

Vacant, M.D.

Executive Director
Claudia Kemp, J.D.

September 9, 2020

Bruno Hochhegger, MD
Rua Goncalo de Carvalho 471
Porto Alegre ZZ 900050230

Dear Dr. Hocchegger:

This is in further reference to your application for a Medical Faculty Certificate.

Please be advised that your application will be presented as an individual item to the Credentials Committee of the Board of Medicine to discuss:

- **Lack of a U.S. social security number pursuant to section 456.013(1)(a), Florida Statutes**
- **To determine if postgraduate training is equivalent to the 1-year residency requirement pursuant to section 458.3145(1)(d), Florida Statutes**

In addition, the Committee may inquire into any other issues relating to your application and eligibility for licensure.

Date:	Thursday, October 1, 2020
Time:	8:00 a.m. (Meeting starts at 8:00 a.m. Interview time may vary.)
Location:	The in-person meeting scheduled in Orlando, Florida is cancelled, and the meeting will be held by a web-based meeting platform or, if appropriate, a teleconference call.

The meeting information and directions for participating in the October 2020 meeting will be posted on the Florida Board of Medicine's website: https://flboardofmedicine.gov/meeting-information.

Additionally, the Committee's recommendation on your application for licensure will be presented to the full Board of Medicine on Friday, October 2, 2020 for final action. You are not required to attend the full board meeting.

Thank you for your continued cooperation. Should you have any questions regarding this matter, please feel free to contact me. This is your first scheduled appearance.

Sincerely,

Karrell D. Goldwire

Karrell D. Goldwire
Regulatory Supervisor

Pursuant to the provisions of the Americans with Disabilities Act, any person requiring special accommodations to participate in this workshop/meeting is asked to advise the agency at least 10 days before the workshop/meeting by contacting: Rebecca.Hewett@flhealth.gov or call (850) 245-4137.

*** 456.013(3)(c) In considering applications for licensure, the board, or the department when there is no board, may require a personal appearance of the applicant. If the applicant is required to appear, the time period in which a licensure application must be granted or denied shall be tolled until such time as the applicant appears. However, if the applicant fails to appear before the board at either of the next two regularly scheduled board meetings, or fails to appear before the department within 30 days if there is no board, the application for licensure shall be denied.**

4052 Bald Cypress Way, Bin C-03
Tallahassee, Florida 32399-3253
Phone: 850/245-4131
Fax: 850/488-0596 or 850/412-1268
https://www.FLBoardofMedicine.gov

Florida HEALTH

DocuSign Envelope ID: 8119FF23-CC7F-43B3-BB71-E84316F39180

UF | UNIVERSITY of FLORIDA

Dean, College of Medicine

P.O. Box 100215
Gainesville, FL 32610-0215
352-273-7500 (Tel)
352-273-8309 (Fax)

November 14, 2019

Claudia Kemp, J.D.
Executive Director
Florida Board of Medicine
4052 Bald Cypress Way
Tallahassee, FL 32399-1753

Re: Medical Faculty Certificate for Dr. Bruno Hochhegger

Dear Ms. Kemp:

This letter is to request approval to grant a Medical Faculty Certificate for Dr. Bruno Hochhegger. Dr. Hochhegger has been offered and accepted a full-time faculty appointment to teach in a program of medicine in the Department of Radiology at the University of Florida, College of Medicine in Gainesville, Florida.

Dr. Hochhegger, who was born on July 21, 1982 in Sao Luiz Gonzaga, Brazil, graduated from Universidade Federal De Santa Maria, and has been licensed in Porto Alegre, Brazil (478/2009).

I have been advised that Dr. Hochhegger's Medical Faculty Certificate application and other documents already are on file with the Florida Board of Medicine and that any other required documents have been requested and will be forthcoming.

Your approval of this request is appreciated. Should you have any questions, please let me know.

Sincerely,

A Tyndall

Joseph A. Tyndall, M.D., M.P.H.
Interim Dean, College of Medicine

Application

Application Detail

License Type:	**Medical Doctor Medical Faculty Certifica**
Profession Number:	**1508 - Medical Faculty Certificate**
File Number:	**816**
Application:	**Initial Medical Faculty Certificate Application**
Application Date:	**12/22/2019**

Suitability Question(s)

Have you graduated from an accredited medical school on the World Health Organization school list?	**Yes**
Do you hold a valid current license to practice medicine in another jurisdiction?	**Yes**
Have you been offered and accepted a full-time faculty appointment to teach in a program of medicine at:The University of FloridaThe University of MiamiThe University of South Florida Department of HealthThe Florida State UniversityThe International UniversityThe University of Central Florida orThe Mayo Medical School at the Mayo Clinic in Jacksonville, Florida?	**Yes**
Will you only be practicing medicine in conjunction with a full time faculty position at an accredited medical school in the State of Florida and its affiliated clinical facilities or teaching hospitals?	**Yes**

Application Questions

Military Veteran Fee Waiver - I have been honorably discharged from a branch of the United States Armed Forces within the previous 60 months.	**No**

	US
Phone Number:	352-265-0291

License Attributes Selected

Qualification	NICA Part. Physician

Federal Credentials Verification Services (FCVS)

Are you using the FCVS to verify your core credentials? No

Education History 1

School Name:	UNIVERSIDADE FEDERAL DE SANTA MARIA (UFSM)
Street Address Line 1:	CCS, PRÉDIO 26, 3º ANDAR, SALA 1353
Street Address Line 2:	N/A
City:	santa Maria
State:	Foreign School/Program
Postal/Zip:	97105900
Country:	BRAZIL
Date of Graduation (mm/dd/yyyy):	07/14/2006
Attended From (mm/dd/yyyy):	07/01/2000
Attended To (mm/dd/yyyy):	07/12/2006

Education History 2

School Name:	UNIVERSIDADE FEDERAL DE SANTA MARIA (UFSM)
Street Address Line 1:	Salesian Sisters School - INSA e Mazzarelo
Street Address Line 2:	3149, R. José Bonifácio
City:	São Luiz Gonzaga
State:	Foreign School/Program
Postal/Zip:	97800-000
Country:	BRAZIL
Date of Graduation (mm/dd/yyyy):	12/13/1996
Attended From (mm/dd/yyyy):	03/01/1989
Attended To (mm/dd/yyyy):	12/10/1996

Education History 3

School Name:	UNIVERSIDADE FEDERAL DE SANTA MARIA (UFSM)

Street Address Line 1:	**RIACHUELO School - HIGH SCHOOL**
Street Address Line 2:	**Rua Cruz e Souza, 150**
City:	**Santa Maria**
State:	**Foreign School/Program**
Postal/Zip:	**97110-220**
Country:	**BRAZIL**
Date of Graduation (mm/dd/yyyy):	**02/10/2000**
Attended From (mm/dd/yyyy):	**02/10/1997**
Attended To (mm/dd/yyyy):	**02/10/2000**

Additional Education Questions

Are you currently in default on any health education loan or scholarship obligation?	**No**

Graduate Education

Do you currently, or have you had, responsibility for graduate medication education within the last 10 years?	**Yes**
Name of Institution:	**PONTIFICIA UNIVERSIDADE CATOLICA DO RIO GRANDE DO SUL (PUCRS)**

Post Graduate Education 1

Program Name:	**Medical Residency in Radiology Santa casa Mercy Hospital**
Program Address - Line 1	**Av. Independência, 75 - Independência,**
City	**Porto Alegre**
Program State or Country:	**BRAZIL**
Program Zip:	**90035-072**
Program Type:	**RESIDENCY**
Specialty Area:	**DR - DIAGNOSTIC RADIOLOGY**
Attended From (mm/dd/yyyy):	**02/01/2007**
Attended To (mm/dd/yyyy):	**01/31/2010**
Did you receive credit?	**Yes**

Post Graduate Education 2

Program Name:	**Post graduation program in Medicine (radiology)**
Program Address - Line 1	**R. Prof. Rodolpho Paulo Rocco, 255 - Ilha do, Fundão - RJ,**

City	**Rio de Janeiro**
Program State or Country:	**BRAZIL**
Program Zip:	**21941-590**
Program Type:	**OTHER PROGRAM**
Specialty Area:	**DIAGNOSTIC IMAGING**
Attended From (mm/dd/yyyy):	**02/01/2010**
Attended To (mm/dd/yyyy):	**10/11/2011**
Did you receive credit?	**Yes**

Post Graduate Education 3

Program Name:	**Post Graduation Program in Pneumological Sciences-PhD**
Program Address - Line 1	**Rua Ramiro Barcelos, 2400 2º Andar**
City	**Porto Alegre**
Program State or Country:	**BRAZIL**
Program Zip:	**90035003**
Program Type:	**OTHER PROGRAM**
Specialty Area:	**DR - RADIOLOGY**
Attended From (mm/dd/yyyy):	**02/02/2010**
Attended To (mm/dd/yyyy):	**03/24/2011**
Did you receive credit?	**Yes**

Post Graduate Education 4

Program Name:	**Thoracic Imaging Radiology**
Program Address - Line 1	**Pc Dom Feliciano, 135 - Centro Histórico -**
City	**Porto Alegre,**
Program State or Country:	**BRAZIL**
Program Zip:	**90020-160**
Program Type:	**FELLOWSHIP**
Specialty Area:	**DR - DIAGNOSTIC RADIOLOGY**
Attended From (mm/dd/yyyy):	**10/11/2011**
Attended To (mm/dd/yyyy):	**10/11/2012**

Did you receive credit?	**Yes**

Medical School Teacher

Please select the Employing University or Affiliation from the list :	**University of Florida**

Other State License 1

Do you now hold or have you ever held a license to practice medicine or any other profession in any US State or territory, or foreign country?	**Yes**

Request verification of licensure status directly from the licensing entity or www.veridoc.org. Request international license verification(s) if you have practiced outside of the U.S. for at least two of the previous four years.

License Number:	**CREMERS 30427**
Type:	**FULL**
Jurisdiction - Country:	**BRAZIL**

Other State License 2

Do you now hold or have you ever held a license to practice medicine or any other profession in any US State or territory, or foreign country?	**Yes**

Request verification of licensure status directly from the licensing entity or www.veridoc.org. Request international license verification(s) if you have practiced outside of the U.S. for at least two of the previous four years.

License Number:	**7056588**
Type:	**FULL**
Jurisdiction - Country:	**UNITED KINGDOM**

Year Began Practice

Year Began Practice:	**07/17/2006**

Practice Employment 1

Place of Employment:	**Federal University of Health Sciences of Porto Alegre**
Address Line 1:	**R. Sarmento Leite, 245**
Address Line 2:	**N/A**
City:	**Porto alegre**
State:	**rs**
Type of Employment:	**Assistant Professor**
Begin Date (mm/dd/yyyy):	**05/24/2011**
End Date (mm/dd/yyyy):	**12/26/2019**

If 'to present', enter Today's date.

Practice Employment 2

Place of Employment:	**Pntificia University Catholic of Rio Grande do Sul**
Address Line 1:	**Av. Ipiranga, 6681**
Address Line 2:	**N/A**
City:	**Porto Alegre**
State:	**RS**
Type of Employment:	**Assistant Professor**
Begin Date (mm/dd/yyyy):	**03/01/2012**
End Date (mm/dd/yyyy):	**12/26/2019**

If 'to present', enter Today's date.

Staff Privileges

Do you currently hold staff privileges in any hospital, health institution, clinic or medical facility?	**No**

Specialty Board Certifications 1

Are you certified by any specialty board recognized by the American Board of Medical Specialties or specialty board approved by the Florida Board of Medicine?	**No**

Specialty Board Certifications 2

Are you certified by any specialty board recognized by the American Board of Medical Specialties or specialty board approved by the Florida Board of Medicine?	**No**

Initial DEA Questions

Have you ever been warned or called before the Drug Enforcement Agency (DEA)?	**No**

Health History

In the last five years, have you been enrolled in, required to enter into, or participated in any drug and/or alcohol recovery program or impaired practitioner program for treatment of drug or alcohol abuse that occurred within the past five years?	**No**
In the last five years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental disorder or impairment?	**No**
During the last five years, have you been treated for or had a recurrence of a diagnosed mental disorder that has impaired your ability to practice medicine within the past five years?	**No**

During the last five years, have you been treated for or had a recurrence of a diagnosed physical disorder that has impaired your ability to practice medicine?	**No**
In the last five years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol/drug) disorder or, if you were previously in such a program, did you suffer a relapse within the last five years?	**No**
During the last five years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol/drug) disorder that impaired your ability to practice medicine within the last five years?	**No**

Initial Criminal History

Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to any crime in any jurisdiction other than a minor traffic offense?	**No**

You must include all misdemeanors and felonies even if adjudication was withheld by the court so that you would not have a record of conviction. Driving under the influence or driving while impaired is not a minor traffic offense for purposes of this question.

United States Military and/or Public Health

Have you ever been in the United States Military and/or Public Health Service?	**No**
Have you ever been disciplined by any branch of the United States Armed Services or Public Health Service?	**No**

Medicaid / Medicare

1. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, F.S. (relating to social and economic assistance), Chapter 817, F.S. (relating to fraudulent practices), Chapter 893, F.S. (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction?	**No**
2. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970 (relating to controlled substances) or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)?	**No**
3. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, F.S.?	**No**
4. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program?	**No**

5. Are you currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities?	**No**

Electronic Fingerprinting

I have been provided and read the statement from the Florida Department of Law Enforcement regarding the sharing, retention, privacy and right to challenge incorrect criminal history records and the 'Privacy Statement' document from the Federal Bureau of Investigation.	**Yes**
Enter in today's date	**12/26/2019**

Medical Malpractice Question

Have you ever had a judgment entered against you for medical malpractice where the incident(s) of malpractice occurred after November 2, 2004?	**No**

Liability Claims

Within the last 10 years have you had any liability claim(s) or action(s) for damages for personal injury settled or finally adjudicated in an amount that exceeds $100,000.00?	**No**

Financial Responsibility/Exemption

Financial Exemption	**5. NOT TO CARRY MEDICAL MALPRACTICE**

FDA Licensing

Have you ever had any professional license or license to practice medicine revoked, suspended, placed on probation, received a citation, or other disciplinary action taken in any state, territory or country?	**No**

FDA Institution

Have you ever had any staff privileges denied, suspended, revoked, modified, restricted, not renewed or placed on probation, or have you been asked to resign or take a temporary leave of absence or were otherwise acted against by any facility?	**No**

FDA Entity

Have you ever been asked, or allowed to resign from any facility instead of disciplinary action or during any pending investigations into your practice?	**No**

FDA Restrict

Have you ever had any staff privileges restricted or not renewed by any facility instead of disciplinary action?	**No**

FDANP Denied

Have you had any application for a medical license or professional license denied by any state board or other governmental agency of any state, territory, or country?	**No**

FDANP Notified

Have you ever been notified, invited or required to appear before any licensing agency for a hearing on a complaint of any nature including, but not limited to, a charge or violation of the Medical Practice Act, involving unprofessional or unethical conduct?	**No**

FDANP - Investigation

Are you currently under investigation in any jurisdiction for an act or offense that would constitute a violation of Section 458.331, Florida Statutes?	**No**

FDANP - Pending

Have you ever been allowed to withdraw an application for medical licensure or professional license for any reason or during a pending investigation in any jurisdiction in lieu of your license being denied?	**No**

Specialty Board Discipline History

Have you ever had any final disciplinary action taken against you by a specialty board or other similar national organization?	**No**

Availability for Disaster

As a Florida licensed physician, are you willing to provide health care services in special needs shelters or to work with disaster medical assistance teams during times of emergency or major disaster?	**Yes**

Attachments

Document Type: Certificate	File Name: MFC Letter Hochhegger, Bruno 11-14-19 (2).pdf
Document Type: Certificate	File Name: Brazilian Board of medicine.pdf
Document Type: Certificate	File Name: Phd Certificate.pdf
Document Type: Certificate	File Name: Medical residency certificate.pdf
Document Type: Certificate	File Name: UFRJ Radiology.pdf
Document Type: Certificate	File Name: 20190820104716039-mesclado (1).pdf
Document Type: Certificate	File Name: 20190820104825562-mesclado.pdf
Document Type: Certificate	File Name: Fellowship.pdf

Fees

NICA Fee	**$250.00**

Application Fee	**$350.00**
Unlicensed Activity	**$5.00**
Initial License	**$350.00**
NICA Part. Phys. Fee	**$4750.00**
Total Amount Due:	**$5705.00**

Attestation

Checking the box below will acknowledge this application is correct and was submitted by you (the applicant) and not a third party. You also agree to comply with all requirements for licensure and renewal.

I state that these statements are true and correct. I recognize that providing false information may result in denial of licensure, disciplinary action against my license, or criminal penalties pursuant to Sections 456.067, 775.083, and 775.084, Florida Statutes. I state that I have read Chapters 456, 458 and 766.301-.316, Florida Statutes and Chapter 64B8, Florida Administrative Code.

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Florida Board of Medicine information which is material to my application for licensure.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind. I state that my answers and all statements made by me herein are true and correct.
Should I furnish any false information in this application, I hereby agree that such act constitutes cause for denial, suspension, or revocation of my license to practice Medicine in the State of Florida. If there are any changes to my status or any change that would affect any of my answers to this application I must notify the board within 30 days.

I understand that my records are protected under federal and state regulations governing Confidentiality of Mental Health Patient Records and cannot be disclosed without my written consent unless otherwise provided in the regulations. I understand that my records are protected under federal and state regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it.

Attestation Answer: Yes

January 13, 2020

Bruno Hochhegger, M.D.
Rua Goncalo De Carvalho 471
Porto Alegre, Brazil 900050230

Dear Dr. Hochhegger:
File: 816

Your application for medical licensure has been received and processed. Upon initial review, your application remains incomplete for the following deficiencies:

1. Copy of your National Practitioner Data Bank (NPDB) report and the Healthcare Integrity Protection Data Bank (HIPDB). You may contact NPDB at 1-800-767-6732.

2. Copy of postgraduate training certificate verifying internship, from: **Medical Residency in Radiology Santa Casa Mercy 02/01/2007-01/31/2010, Post-Graduation Program in Medicine (Radiology) 02/01/2010-10/11/2011, Post-Graduation Program in Pneumological Sciences-PhD 02/02/2010-03/24/2011, and Thoracic Imaging Radiology 10/11/2011-10/11/2012.**

3. The medical degree verification has not been received. The verification must come directly to the Florida Board.

4. The official license verification from Brazil and United Kingdom has not been received. The verification must come directly to the Florida Board.

5. It appears that your file may be required to be presented before the Credentials Committee to discuss your lack of one (1) year of ACGME approved postgraduate training pursuant to Section 458.3145(1)(d), Florida Statues.

6. No U.S. Social Security Number.

7. We have not received your Livescan results. If you have already had your electronic fingerprinting completed, please allow 24 – 72 hours for receipt of your results. Should your Criminal Background Check disclose an arrest record(s), you will need to provide

documentation related to each criminal event revealed in your background, if you have not already done so. You can find a detailed description of documents that will be required by visiting the FAQs on the Background Screening Website at http://www.flhealthsource.gov/background-screening/ (Click on FAQs)

Note: Criminal History will be reviewed by the Background Screening Unit, not the Board Office. Please email all criminal history documents to mqa.backgroundscreen@flhealth.gov. Any original certified documents must be mailed to the following address:

Attn: Background Screening Unit
Florida Department of Health
4052 Bald Cypress Way, Bin BSU-01
Tallahassee, FL 32399

Please be advised that previous malpractice, criminal charges, discipline, addictions/impairments, unfavorable evaluations, etc. may require you to appear before the Credentials Committee for determination of eligibility for licensure. If your appearance is required, you will be notified in writing once your file is complete. Any information received by this office may require additional explanation and/or documentation to be requested in order to further determine licensure eligibility. After all requested documentation is received, your file will be submitted for a standard supervisory review. Should additional information be required, you will be notified. Once your file is determined complete, it will be presented to the Board for consideration at the next scheduled meeting.

As documentation is received in our office, an updated list of deficiencies will be mailed to you. Your application will remain incomplete until all deficiencies are completed. In addition, notify the Board office immediately in writing of any occurrence(s) that would in any way change or affect any answer given in the application or an answer provided in response to any of our direct questions to you.

After all deficient items are received; your file will be submitted for a secondary review. You will be notified if additional information is required.

Section 456.013(1)(a), Florida Statues provides that an incomplete application shall expire one year after initial filing with the department. Your application will expire .

If you have any questions, please contact me at latayvia.alexander@flhealth.gov, call 850-901-6842, or fax (850) 412-1282.

Sincerely,

Latayvia Alexander
Paralegal Specialist

Enclosure(s)

March 26, 2020

Bruno Hochhegger, M.D.
Rua Goncalo De Carvalho 471
Porto Alegre, Brazil 900050230

Dear Dr. Hochhegger:
File: 816

Your application for medical licensure has been received and processed. Upon initial review, your application remains incomplete for the following deficiencies:

1. Copy of your National Practitioner Data Bank (NPDB) report and the Healthcare Integrity Protection Data Bank (HIPDB). You may contact NPDB at 1-800-767-6732.

2. It appears that your file may be required to be presented before the Credentials Committee to discuss your lack of one (1) year of ACGME approved postgraduate training pursuant to Section 458.3145(1)(d), Florida Statues.

3. No U.S. Social Security Number.

4. We have not received your Livescan results. If you have already had your electronic fingerprinting completed, please allow 24 – 72 hours for receipt of your results. Should your Criminal Background Check disclose an arrest record(s), you will need to provide documentation related to each criminal event revealed in your background, if you have not already done so. You can find a detailed description of documents that will be required by visiting the FAQs on the Background Screening Website at http://www.flhealthsource.gov/background-screening/ (Click on FAQs)

   Note: Criminal History will be reviewed by the Background Screening Unit, not the Board Office. Please email all criminal history documents to mqa.backgroundscreen@flhealth.gov. Any original certified documents must be mailed to the following address:

   Attn: Background Screening Unit
   Florida Department of Health
   4052 Bald Cypress Way, Bin BSU-01
   Tallahassee, FL 32399

Please be advised that previous malpractice, criminal charges, discipline, addictions/impairments, unfavorable evaluations, etc. may require you to appear before the Credentials Committee for determination of eligibility for licensure. If your appearance is required, you will be notified in writing once your file is complete. Any information received by this office may require additional explanation and/or documentation to be requested in order to further determine licensure eligibility. After all requested documentation is received, your file will be submitted for a standard supervisory review. Should additional information be required, you will be notified. Once your file is determined complete, it will be presented to the Board for consideration at the next scheduled meeting.

As documentation is received in our office, an updated list of deficiencies will be mailed to you. Your application will remain incomplete until all deficiencies are completed. In addition, notify the Board office immediately in writing of any occurrence(s) that would in any way change or affect any answer given in the application or an answer provided in response to any of our direct questions to you.

After all deficient items are received; your file will be submitted for a secondary review. You will be notified if additional information is required.

Section 456.013(1)(a), Florida Statues provides that an incomplete application shall expire one year after initial filing with the department. Your application will expire December 21, 2021.

If you have any questions, please contact me at latayvia.alexander@flhealth.gov, call 850-901-6842, or fax (850) 412-1270.

Sincerely,

LRA

Latayvia Alexander

Enclosure(s)

Goldwire, Karrell

From: Alls, Wendy
Sent: Tuesday, September 8, 2020 6:20 PM
To: Goldwire, Karrell
Subject: FW: Certification about Prof. Bruno Hochhegger
Attachments: doc 2.pdf

From: Prog Pos-Grad Pneumologia <ppgpneu@ufrgs.br>
Sent: Tuesday, September 8, 2020 6:17 PM
To: Alls, Wendy <Wendy.Alls@flhealth.gov>
Subject: Certification about Prof. Bruno Hochhegger

Dear

We certify that Professor Bruno Hochhegger obtained his doctorade degree in our institution in 2010.

Attached is the copy of the legal document.

Regards,

Paulo de Tarso Roth Dalcin
MD, Full Professor, Faculdade de Medicina, Universidade Federal do Rio Grande do Sul.

Coordinator of Programa de Pós-Graduação em Ciências Pneumológicas.

Address: Hospital de Clínicas de Porto Alegre, Serviço de Pneumologia, Rua Ramiro Barcelos, 2350, CEP 90035-903, Bairro Rio Branco, Porto Alegre, RS, Brazil.
Phone: +55 51 3359-8241
Mobile Phone: +55 51 9964-6612
e-mail: pdalcin@terra.com.br

Telefone: +55 (51) 3308 - 5602
ppgpneu@ufrgs.br

TRADUZCA
TRADUÇÕES JURAMENTADAS
traduzca.com
+55 51 3222.2277

FEDERATIVE REPUBLIC OF BRAZIL
ALEX CARDOSO CUNHA
PUBLIC SWORN TRANSLATOR AND COMMERCIAL INTERPRETER – Enrollment 057/2010
Rua Marquês do Pombal, 783/501 – CEP 90.540-001 – Porto Alegre/RS/Brazil
Tel.: 55 51 3222-2277 – Cell.: 55 51 99212-7939 – E-mail: juramentados@traduzca.com.br

Duly commissioned by the Board of Trade, Industry and Services of the State of Rio Grande do Sul, Brazil, and qualified according to legislation in force, I, Alex Cardoso Cunha, hereby certify that the document described below was presented to me for translation from Portuguese into English
Book Nº 8 - Translation nº: 0469/2019
This document is a Diploma issued by the Universidade Federal do Rio Grande do Sul (Federal University of Rio Grande do Sul) – UFRGS, in Brazil.
[*Coat of arms of the Federative Republic of Brazil*]. [*Seal of the Federative Republic of Brazil*]. Federative Republic of Brazil. Ministry of Education. **Universidade Federal do Rio Grande do Sul**. The President of the Universidade Federal do Rio Grande do Sul, in exercise of his powers and in view of the completion of the doctoral degree program of the Department of Postgraduate Studies in Pneumological Sciences, at the School of Medicine, on Sept 09, 2010, hereby confers the title of **Doctor of Pneumological Sciences**, on **Bruno Hochhegger**, a Brazilian, born on Jul 21, 1982, in São Luiz Gonzaga, Rio Grande do Sul, granting him this diploma so that he may enjoy all the rights and legal prerogatives appertaining thereto. Porto Alegre, Mar 24, 2011. [*Illegible signature*]. Mauro Antonio Czepielewski. Director. [*Illegible signature*]. Graduate. [*Illegible signature*]. Carlos Alexandre Netto. President.
[*Overleaf*]
Universidade Federal do Rio Grande do Sul. Vice President's Office for Postgraduate Studies. Program accredited through Directive No. 524, of the Minister of Education, dated Apr 29, 2008, published in the Federal Official Gazette on Apr 30, 2008, No. 82, Section 1, page 16. Diploma registered under No. 1144, page 191-v, of Book PG 29, in accordance with Article 48, Paragraph 1, of Law No. 9394, dated Dec 21, 1996. Filing No.: 23078.007215/11-43. Porto Alegre, Mar 24, 2011. [*Illegible signature*]. Zaira Brasbiel de Azevedo, Director of the Division of Postgraduate Certificates and Diplomas. [*Illegible signature*]. Aldo Bolten Lucion, Vice President for Postgraduate Studies. No. 48998.
In witness whereof I declare that there was nothing else in the original document presented to me and it was fully and faithfully translated by me on this public instrument of translation on November 8th, 2019, in Porto Alegre, Rio Grande do Sul, Brazil. This translation has legal force in Brazil and all foreign countries.

Ayrton B. Carvalho - Tabelião
Eugênio Cunha Ayr. Neto
Escr. Aut. 017A90

1º TABELIONATO DE NOTAS DE PORTO ALEGRE - RS
RUA GAL. ANDRADE NEVES, 159 - CENTRO - PORTO ALEGRE - RS - FONE:(51) 3079-5300
BEL. AYRTON BERNARDES CARVALHO - TABELIÃO
Reconheço por SEMELHANÇA a firma de Alex Cardoso Cunha, indicada com a seta de uso deste tabelionato, e a qual confere com a ficha padrão aqui depositada.
EMITIDO NA INTERNET

Rec. Firma: R$ 5,00 + Selo digital: R$ 1,40
0450.01.1900008.02240

1º Tabelionato

Alex Cardoso Cunha
Tradutor Público Juramentado
CPF 727.552.960-20
Junta Comercial do RS

CONSELHO NACIONAL DE JUSTIÇA

BRASIL
APOSTILLE
(Convention de La Haye du 5 octobre 1961)

1. País: (Country / Pays):	REPÚBLICA FEDERATIVA DO BRASIL

Este documento público
(This public document / Le présent acte public)

2. Foi assinado por: (Has been signed by / A été signé par)	ALEX CARDOSO CUNHA
3. Na qualidade de: (Acting in the capacity of / Agissant en qualité de)	TRADUTOR PÚBLICO
4. Tem o selo / carimbo de: (Bears the seal / stamp of / Est revêtu du sceau / timbre de)	MATRÍCULA JUCERGS Nº 057

Certificado
(Certified / Attesté)

5. Em: (At / À)	Porto Alegre	6. No dia: (The / Le)	14/05/2020
7. Por: (By / Par):	EUGÊNIO CIMADOR NETO		
8. Nº: (Nº/ Sous nº)	11873067		
9. Selo / Carimbo: (Seal / Stamp / Sceau / Timbre)	BRASIL APOSTILA APOSTILLE CONVENÇÃO DE HAIA DE 1961 - CONVENTION DE LA HAYE DE 1961 CNJ	10. Firma: (Signature)	Assinatura Eletrônica Electronic Signature Signature Électronique

Tipo de documento:
(Type of document / Type d'acte) TRADUÇÃO PÚBLICA JURAMENTADA

Nome do titular:
(Name of holder of document/ Nom du titulaire) BRUNO HOCHHEGGER

Esta Apostila certifica apenas a assinatura, a capacidade do signatário e, quando apropriado, o selo ou carimbo constantes no documento público. Ela não certifica o conteúdo do documento para o qual foi emitida.

This Apostille certifies only the signature, the capacity of the person signing it and where appropriate, the seal or stamp which the public document bears. It does not certify the content of the document for which it was issued.

Cette Apostille ne certifie que la signature, la qualité en laquelle le signataire de l'acte a agi, et, le cas échéant, les sceau ou le timbre dont cet acte public est revêtu. Elle ne certifie pas le contenu de l'acte pour lequel elle a été émise.

A autenticidade desta Apostila e de sua assinatura eletrônica, bem como o documento público subjacente, podem ser verificadas em:

The authenticity of this Apostille and its electronic signature, along with the underlying public document, may be verified at:

L'authenticité de cette Apostille, de la signature électronique, ainsi que de l'acte public sous-jacent peut être vérifiée sur:

www.cnj.jus.br/apostila/conferencia

A presente Apostila foi firmada com assinatura eletrônica, conforme a Lei nº 11.419/2006.

This Apostille was electronically signed in accordance with Law nº 11.419/2006.

Cette Apostille a été signée par une signature électronique, d'après la Loi nº 11.419/2006.

Dúvidas a respeito desta Apostila entrar em contato com a Ouvidoria do CNJ:

Any questions about this Apostille may be directed to the Ombudsman of the CNJ:

Veuillez contacter l'Ombudsman de la CNJ pour toute question relative à cette Apostille:

55 61 2326-4607

ouvidoria@cnj.jus.br

Por favor, utilize este QR Code para checar a autenticidade desta Apostila e de sua assinatura eletrônica. Uma cópia do documento público subjacente também está disponível na mesma página.

Please use this QR Code to check the authenticity of this Apostille and its electronic signature. A copy of the underlying public document is also accessible from the same page.

Veuillez utiliser ce Code QR pour vérifier l'authenticité de cette Apostille et de sa signature électronique. Une copie de l'acte public sous-jacent est également disponible sur la même page.

Código (Code):
11873067
CRC:
2BA3C1E1

20.0.00371529-1
A5960828

1º TABELIONATO DE NOTAS DE PORTO ALEGRE - RS
RUA GAL. ANDRADE NEVES, 159 - CENTRO - PORTO ALEGRE - RS - FONE:(51) 3079-5300
BEL. AYRTON BERNARDES CARVALHO - TABELIÃO

Ayrton B. Carvalho - Tabelião
Eugênio Cimador Neto
ESCR. AUTORIZADO

Etiqueta afixada conforme dispõe o artigo 9º do Provimento 62/2017 do CNJ. Apostila emitida mediante solicitação do portador do documento, conforme dispõe o artigo 9º do Provimento 62/2017 do CNJ.
Porto Alegre, 14 de maio de 2020

Emolumento: R$ 48,40 + Selo digital: R$ 3,30
0450.04.1800007.23525

República Federativa do Brasil
Ministério da Educação
UNIVERSIDADE FEDERAL DO RIO GRANDE DO SUL

O Reitor da Universidade Federal do Rio Grande do Sul, no uso de suas atribuições, tendo em vista a conclusão do curso de doutorado do Programa de Pós-Graduação em Ciências Pneumológicas, da Faculdade de Medicina, em 9 de setembro de 2010, confere o título de

Doutor em Ciências Pneumológicas

a

Bruno Hochhegger

nacionalidade brasileira, nascido a 21 de julho de 1982, em São Luiz Gonzaga, Rio Grande do Sul, e outorga-lhe o presente diploma a fim de que possa gozar de todos os direitos e prerrogativas legais.

Porto Alegre, 24 de março de 2011.

Mauro Antônio Czepielewski
Diretor

Diplomado

Carlos Alexandre Netto
Reitor

CASA DA MOEDA DO BRASIL

UNIVERSIDADE FEDERAL DO RIO GRANDE DO SUL
PRÓ-REITORIA DE PÓS-GRADUAÇÃO

Curso reconhecido pela Portaria nº. 524, do Ministro de Estado da Educação, de 29/04/2008, publicado do D.O.U., 30/04/2008, nº. 82, Seção 1, p. 16. Diploma registrado sob o nº. 1144, fl. 191-v, do Livro PG 29, de acordo com artigo 48, parágrafo 1°, da Lei 9394, de 21 de dezembro de 1996.
Processo nº. 23078.007215/11-43.

Porto Alegre, 24 de março de 2011.

Zaira Brasbiel de Azevedo
Diretora da Divisão de Diplomas e Certificados

Aldo Bolten Lucion
Pró-Reitor de Pós-Graduação

Nº 048998

General Medical Council

Bruno HOCHHEGGER

GMC reference no: 7056588

Results of search on: 09 Sep 2020 at 14:41 BST
The details shown are valid at the date and time of the search only.

Not Registered - Administrative Reason

GP This doctor is not on the GP Register

SR This doctor is not on the Specialist Register

This doctor is not subject to revalidation

Only doctors holding full registration with a licence to practise are subject to revalidation.

Primary medical qualification	Medico 2006 Universidade Federal Santa Maria
Full registration date	09 Nov 2009
Gender	Male

Further information

This person is not on the Medical Register and may not practise as a doctor in the UK.

Doctor's history

Registration and licensing history (since 20 October 2005)

From	To	Status
10 Jan 2013	Present	Not Registered - Administrative Reason
16 Nov 2009	10 Jan 2013	Registered with a licence to practise
09 Nov 2009	16 Nov 2009	Registered

Please note:

All doctors who were registered before 20 October 2005 have their registration 'From' date set to 20 October 2005.

This is the date when the register went online.

If you need to know whether the doctor was registered before 20 October 2005 please contact us.

TRADUZCA

TRADUÇÕES JURAMENTADAS

traduzca.com
+55 51 3222.2277

FEDERATIVE REPUBLIC OF BRAZIL
ALEX CARDOSO CUNHA
PUBLIC SWORN TRANSLATOR AND COMMERCIAL INTERPRETER – Enrollment 057/2010
Rua Marquês do Pombal, 783/501 – CEP 90.540-001 – Porto Alegre/RS/Brazil
Tel.: 55 51 3222-2277 – Cell.: 55 51 99212-7939 – E-mail: juramentados@traduzca.com.br

Duly commissioned by the Board of Trade, Industry and Services of the State of Rio Grande do Sul, Brazil, and qualified according to legislation in force, I, Alex Cardoso Cunha, hereby certify that the document described below was presented to me for translation from Portuguese into English
Book Nº 8 - Translation nº: 0600/2019.
This document is a Certificate of Good Standing, issued by Conselho Regional de Medicina do Estado do Rio Grande do Sul (Regional Medical Board of the State of Rio Grande do Sul) – CREMERS, in Brazil.
[*Header*: Nov 25, 2019. CREMERS – Regional Medical Board of the State of Rio Grande do Sul]. [*Coat of Arms of the Federative Republic of Brazil:* CREMERS]. **Regional Medical Board of the State of Rio Grande do Sul. Certificate of Good Standing.** The Regional Medical Board of the State of Rio Grande do Sul, in use of its attributions conferred by Law 3,268/57 and Decree 44,045/58, hereby certifies that Doctor **Bruno Hochhegger**, a Medical Doctor graduated by Universidade Federal de Santa Maria on Jul 12, 2006, registered at this Board under No. 30427, since Jul 21, 2006, with a registration of **Specialist in Radiology and Diagnostic Imaging** (RQE 31220) is in good standing with this Board regarding its annual fees, up to Mar 31, 2020. Finally, I certify that there are no records of a final court decision against him. This certificate's authenticity can be verified by entering the code 191125163300349929 at www.cremers.org.br/certidao.php. Certificate issued through Cremers Portal on Nov 25, 2019 – 04:33 PM. This document is valid for 90 days, as of its date of issue. [*Footer with printing details*].
In witness whereof I declare that there was nothing else in the original document presented to me and it was fully and faithfully translated by me on this public instrument of translation on November 29th, 2019, in Porto Alegre, Rio Grande do Sul, Brazil. This translation has legal force in Brazil and all foreign countries.

Alex Cardoso Cunha
Tradutor Público Juramentado
CPF 727.552.960-20
Junta Comercial do RS

CREMERS

Conselho Regional de Medicina do Estado do RS

Certidão de Regularidade

O Conselho Regional de Medicina do Estado do RS, no uso das atribuições que lhe confere a Lei 3.268/57 e o Decreto 44.045/58, Certifica que o(a) Dr(a). **BRUNO HOCHHEGGER**, Médico(a) diplomado(a) pelo(a) **UNIVERSIDADE FEDERAL DE SANTA MARIA** em **12/07/2006**, inscrito(a) neste Conselho sob número **30427**, desde **21/07/2006** , possuindo registro de especialista em **RADIOLOGIA E DIAGNOSTICO POR IMAGEM (RQE 31220),** encontra-se quite com as anuidades deste Conselho até **31/03/2020.** Certifica, ainda, que não há registro de condenação a penalidade com trânsito em julgado. -.

A verificação de autenticidade da presente certidão pode ser feita informando o código **191125163300349929** na página www.cremers.org.br/certidao.php.

Certidão emitida pelo Portal Cremers em 25/11/2019 - 16:33.

Este documento é válido por 90 dias, contados a partir da data de emissão.

Chair
Zachariah Zachariah, M.D.
Ft. Lauderdale, Florida

Members
Hector Vila, M.D.
Tampa, Florida
Vice-Chair

Luz Marina Pages, M.D.
Miami Beach, Florida

Scot N. Ackerman, M.D.
Jacksonville, Florida

Eleonor Pimentel, M.D.
Miami, Florida

David A. Diamond, M.D.
Winter Park, Florida

Vacant, Consumer Member

Robert London, M.D.
Maitland, Florida

Jorge J. Lopez, M.D.
Maitland, Florida

Andre M. Perez
Miami, Florida

Kevin Cairns, M.D.
Fort Lauderdale, Florida

Nicholas W. Romanello, Esq.
Melbourne, Florida

Sarvam TerKonda, M.D.
Jacksonville, Florida

Shailesh Gupta, M.D.
Coral Springs, Florida

Vacant, M.D.

Executive Director
Claudia Kemp, J.D.

September 9, 2020

Ashraf Kamal Abdelhemid, MD
7940 Frant Beach Road
Apt #2006
Panama City Beach, FL 32407

Dear Dr. Abdelhemid:

This is in further reference to your Conditional Licensure.

Please be advised that your letter will be presented as an individual item to the Credentials Committee of the Board of Medicine to discuss:

- **Request for Reconsideration**

The Committee may inquire into any other issues relating to your application and eligibility for licensure. Your appearance is not required but if you choose to appear the date, time and location of the meeting are listed below.

Date:	Thursday, October 1, 2020
Time:	8:00 a.m. (Meeting starts at 8:00 a.m. Interview time may vary.)
Location:	The in-person meeting scheduled in Orlando, Florida is cancelled, and the meeting will be held by a web-based meeting platform or, if appropriate, a teleconference call.

The meeting information and directions for participating in the October 2020 meeting will be posted on the Florida Board of Medicine's website: https://flboardofmedicine.gov/meeting-information.

Additionally, the Committee's recommendation on your application for licensure will be presented to the full Board of Medicine on Friday, October 2, 2020 for final action. You are not required to attend the full board meeting.

Thank you for your continued cooperation. Should you have any questions regarding this matter, please feel free to contact me.

Sincerely,

Wendy Alls

Wendy Alls
Program Operations Administrator

cc: Allen Grossman, Esquire

Pursuant to the provisions of the Americans with Disabilities Act, any person requiring special accommodations to participate in this workshop/meeting is asked to advise the agency at least 10 days before the workshop/meeting by contacting: Rebecca.Hewett@flhealth.gov or call (850) 245-4137.

1501-
f.145551
L#144094
CK

STATE OF FLORIDA
BOARD OF MEDICINE

FILED
DEPARTMENT OF HEALTH
DEPUTY CLERK
CLERK ANGEL SANDERS
DATE FEB 2 7 2020

IN RE: THE APPLICATION FOR
LICENSURE OF

ASHRAF KAMAL ABDELHEMID, M.D.
_____/

NOTICE OF INTENT TO APPROVE LICENSURE WITH CONDITIONS

This matter came before the Credentials Committee of the Florida Board of Medicine at a duly-noticed public meeting on February 6, 2020, in Lake Buena Vista, Florida, and the full Board of Medicine on February 7, 2020, in Lake Buena Vista, Florida. The Applicant, Ashraf Kamal Abdelhemid, M.D., was present at the Credentials Committee meeting and was represented by Allen Grossman, Esq.

The application file demonstrates that Dr. Abdelhemid has not submitted evidence of meeting the training requirement of Section 458.313(1)(a), and Section 458.311(1)(f)3.c., Florida Statutes, which requires him to have completed an approved residency or fellowship of at least two years in one specialty area and that to be acceptable, it must be counted toward regular or subspecialty certification by a board recognized and certified by the American Board of Specialties.

The application file reveals, however, that Dr. Abdelhemid has met the criteria for competence by other means. In 1995, Dr. Abdelhemid received a medical degree from Cairo University Faculty of Medicine, Egypt, followed by a Master's Degree in Pediatrics in 1999 and a clinical Ph.D. in Pediatrics in 2007. He completed four years of Pediatrics Residency at New Children University Hospital in Cairo, Egypt, in 2001. For the last 15 years, Dr. Abdelhemid has served as a Neonatologist and Pediatrician at New Dar Elshifa Hospital in Kuwait, which is a

Canadian Diamond Accredited Hospital affiliated with the U.S. Army in Kuwait. In addition, he has been serving as a Senior Registrar, Neonatologist, and Senior Pediatric Consultant providing services to the U.S. Army community in Kuwait for the last 15 years. He has been licensed to practice medicine in Egypt since 1997 and in Kuwait since 2004. Dr. Abdelhemid has held a valid certificate from the ECFMG since 2016 and has passed all parts of the USMLE. In 2018, Dr. Abdelhemid enrolled in a three-year ACGME-accredited postgraduate training program in Pediatric Infectious Disease at SUNY Health Sciences Center in Brooklyn, New York. The American Board of Pediatrics granted him one year of credit for his General Pediatric training in Egypt. In July 2020, Dr. Abdelhemid will have completed PGY II and will have two years of approved postgraduate training.

Section 458.313(7), Florida Statutes, allows the Board to enter an order certifying an applicant for licensure with restrictions when the Board determines that an applicant for licensure by endorsement has failed to meet each of the appropriate licensing requirements.

It is therefore **ORDERED** that the application for licensure be **approved under the following condition:**

> Dr. Abdelhemid shall successfully complete the fellowship training program in Pediatric Infectious Disease at SUNY Health Sciences Center in Brooklyn, New York.

This Order does not constitute disciplinary action against the license that has been approved herein. The terms of this Order are considered conditions for licensure.

This Order shall become effective upon filing with the Clerk of the Department of Health.

DONE AND ORDERED this 26th day of February, 2020.

BOARD OF MEDICINE

Claudia Kemp

Claudia Kemp, J.D., Executive Director
For Zachariah P. Zachariah, M.D., Chair

NOTICE OF RIGHT TO HEARING

This notice constitutes final agency action if no request for a hearing is received by the Board on or before the twenty-first day after the applicant's receipt of the notice. The applicant may request a hearing by filing an appropriate petition with the Executive Director of the Board at 4052 Bald Cypress Way, Bin #C-03, Tallahassee, Florida 32399-3253. The applicant may petition for a hearing involving disputed issues of material fact before an administrative law judge pursuant to Section 120.57 (1), Florida Statutes, or for a hearing not involving disputed issues of material fact pursuant to Section 120.57 (2), Florida Statutes.

A petition for a hearing involving disputed issues of material fact must contain information required by Rule 28-106.201, Florida Administrative Code, ***including a statement of all disputed issues of material fact.*** The Board may refer a petition to the Division of Administrative Hearings for assignment of an administrative law judge only if the petition is in substantial compliance with the rule requirements. A petition for a proceeding not involving disputed issues of material fact must contain information required by Rule 28.106.301, Florida Administrative Code, including a concise statement of the ultimate facts alleged, as well as the rules and statutes which entitle petitioner to relief.

In accordance with Section 120.573, Florida Statutes, mediation is not available.

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing has been furnished by **Certified Mail** to **Ashraf Kamal Abdelhemid, M.D.,** 7904 Front Beach Road, Suite 2006, Panama City Beach, FL 32407; and **Allen Grossman, Esq.,** Grossman, Furlow & Bayó, L.L.C., 2022-2 Raymond Diehl Road, Tallahassee, FL 32308; and by email to **Donna McNulty**, Special Counsel, at Donna.McNulty@myfloridalegal.com, this 27th day of Feb., 2020.

Brigel Sanders

Deputy Agency Clerk

ASHRAF KAMAL ABDELHEMID
7904 FRONT BEACH RD.
SUITE 2006
PANAMA CITY BEACH, FL 32407

Certified Article Number
9414 7266 9904 2140 1098 77
SENDER'S RECORD

ASHRAF KAMAL ABDELHEMID
C/O ALLEN GROSSMAN, ESQ.
2022-2 RAYMOND DIEHL RD.
TALLAHASSEE, FL 32308

Represented by Monica Felder Rodriguez, Esquire.

The applicant was present and sworn in by the court reporter. After discussion, a motion was made to approve the application for licensure with the condition that Dr. Patel practice at the University of Miami Miller School of Medicine for two (2) years. The motion was seconded, which carried 3/0.

Later in the meeting, Dr. Patel and Monica Felder Rodriguez, Esquire reappeared before the Credentials Committee. After discussion, motion was made to reconsider the condition and approve the application for licensure with the condition that Dr. Patel practice at the University of Miami Miller School of Medicine for two (2) years. Upon proof that Dr. Patel has successfully passed the Special Purpose Examination (SPEX), the condition will be lifted. The motion was seconded, which carried 3/0.

Action Taken: The Committee voted to reconsider and approve the application for licensure with the condition that Dr. Patel practice at the University of Miami Miller School of Medicine for two (2) years. Upon proof that Dr. Patel has successfully passed the Special Purpose Examination (SPEX), the condition will be lifted.

Tab 4 - Imran Sajan, MD – Endorsement
Issue(s): Health History

Accompanied by Alexandria Polles, MD, Medical Director, Professionals Resource Network.

The applicant was present and sworn in by the court reporter. After discussion, a motion was made to approve the application for licensure. The motion was seconded, which carried 3/0.

Action Taken: The Committee voted to approve the application for licensure.

Tab 5 - Ashraf Kamal Abdelhemid, MD – Endorsement
Issue(s): Failure to meet section 458.313(1)(a) and 458.311(1)(f)3.c., Florida Statutes, postgraduate training

Represented by Allen Grossman, Esquire.

The applicant was present and sworn in by the court reporter. After discussion, a motion was made to approve the application for licensure with the condition that Dr. Abdelhemid successfully complete the fellowship training in pediatric infectious disease at SUNY Health Sciences Center in Brooklyn, New York. The motion was seconded, which carried 3/0.

Action Taken: The Committee voted to approve the application for licensure with the condition that Dr. Abdelhemid successfully complete the fellowship training in pediatric infectious disease at SUNY Health Sciences Center in Brooklyn, New York.

Tab 6 - Miryam Shuman, MD – Endorsement
Issue(s): Failure to meet Section 458.311(1)(f)3.c, F.S., Postgraduate Training

The applicant was present and sworn in by the court reporter. After discussion, a motion was made to allow Dr. Shuman to withdraw her application for licensure. The motion was seconded, which carried 3/0.

Action Taken: The Committee voted to allow withdrawal of the licensure application.

Tab 7 - Gabriel Fernando Ramirez, MD – Endorsement
Issue(s):

- Action by Colorado Medical Board
- Action by California Medical Board
- Action by Illinois Medical Board
- Action by Kansas Medical Board
- Action by Kentucky Medical Board
- Criminal History

FLORIDA | Board *of* Medicine

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Governor

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State Surgeon General

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Miami, Florida

David A. Diamond, M.D.
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Brigitte Goersch
Satellite Beach, Florida

Robert London, M.D.
Maitland, Florida

Jorge J. Lopez, M.D.
Maitland, Florida

Andre M. Perez
Miami, Florida

Kevin Cairns, M.D.
Fort Lauderdale, Florida

Nicholas W. Romanello, Esq.
Melbourne, Florida

Sarvam TerKonda, M.D.
Jacksonville, Florida

Shailesh Gupta, M.D.
Coral Springs, Florida

Vacant, M.D.

Executive Director
Claudia Kemp, J.D.

January 5, 2020

Ashraf Kamal Abdelhemid, MD
7904 Front Beach Road
Suite 2006
Panama City Beach, Florida 32407

Dear Dr. Abdelhemid:

This is in further reference to your application for licensure by endorsement.

Please be advised that you are required to make a personal appearance before the Credentials Committee of the Board of Medicine to discuss:

- **Failure to meet section 458.313(1)(a) and 458.311(1)(f)3.c., Florida Statutes, postgraduate training**

In addition, the Committee may inquire into any other issues relating to your application and eligibility for licensure.

Date:	Thursday, February 6, 2020
Time:	8:00 a.m.
Location:	Florida Board of Medicine/Credentials Committee Meeting Holiday Inn at Disney Springs 1805 Hotel Plaza Boulevard Lake Buena Vista, Florida 32830 (877) 410-6667

The meeting room will be posted in the lobby of the hotel. Subject to availability, a block of rooms is available for the public attending the Department of Health – Florida Board of Medicine's meeting.

Additionally, the Committee's recommendation on your application for licensure will be presented to the full Board of Medicine on Friday, February 7, 2020 for final action. You are not required to attend the full board meeting.

Thank you for your continued cooperation. Should you have any questions regarding this matter, please feel free to contact me. *This is your first scheduled appearance.

Sincerely,

Wendy Alls

Wendy Alls
Program Operations Administrator

Pursuant to the provisions of the Americans with Disabilities Act, any person requiring special accommodations to participate in this workshop/meeting is asked to advise the agency at least 10 days before the workshop/meeting by contacting: Rebecca.Hewett@flhealth.gov or call (850) 245-4137.

*** 456.013(3)(c) In considering applications for licensure, the board, or the department when there is no board, may require a personal appearance of the applicant. If the applicant is required to appear, the time period in which a licensure application must be granted or denied shall be tolled until such time as the applicant appears. However, if the applicant fails to appear before the board at either of the next two regularly scheduled board meetings, or fails to appear before the department within 30 days if there is no board, the application for licensure shall be denied.**

4052 Bald Cypress Way, Bin C-03
Tallahassee, Florida 32399-3253
Phone: 850/245-4131
Fax: 850/488-0596 or 850/412-1268
https://www.FLBoardofMedicine.gov

Florida HEALTH

From: Robert London [mailto:rlondon10.bom@gmail.com]
Sent: Wednesday, December 25, 2019 9:31 AM
To: Alls, Wendy <Wendy.Alls@flhealth.gov>
Subject: Re: Advisements (statutory requirements)

Wendy,

Please schedule these applicants for personal appearances.

Thank you.

RAL

On Tue, Dec 24, 2019 at 4:01 PM Alls, Wendy <Wendy.Alls@flhealth.gov> wrote:

Good afternoon Dr. London,

Listed below are the names of applicants and the statutes that have not been met. Please confirm a **personal appearance** is required for the following:

Ashraf Kamal Abdelhemid, MD – Licensure by Endorsement

- Failure to meet section 458.313(1)(a) and 458.311(1)(f)3.c., Florida Statutes, postgraduate training

1501 F-138700

MEDICAL DOCTOR
APPLICATION FOR LICENSURE
Apply for your license online at www.flboardofmedicine.gov

10/16/2019 250.00
ID: 138700 Type: F
BT: 3005982
R#: 919012408

Choose your application type:

☒ Endorsement (1021) ☐ Examination (1024)

☐ Military Veterans Fee Waiver

If you were honorably discharged from the U.S. armed services within 60 months of your application you will qualify for a waiver of the application fee and the initial licensure fee. In order to qualify, please check the box above indicating that you are seeking a waiver and submit **a DD-214 or NGB-22 form as proof of honorable discharge.**

☐ I plan to dispense medicinal drugs in the State of Florida for a fee or other remuneration and hereby register as required by Section 465.0276, F.S. I understand that the fee for the Dispensing Practitioner is $100.00 in addition to the required initial license fee and will submit it along with the license fee.

1. PERSONAL INFORMATION

Name: **Abdelhemid** (Last/Surname) **Ashraf** (First) **Kamal** (Middle) **Date of Birth:** **06/12/1972** (MM/DD/YYYY)

Mailing Address: (The address where mail and your license should be sent)

7940 Front Beach Rd (Street/ PO Box) **#2006** (Suite/Apt. No) **Panama City Beach** (City)

FL (State) **32407** (Zip) **USA** (Country) **(850) 730-8585** (Phone Number)

Physical Location: A Post Office Box is not acceptable. This address will be posted on the Department of Health's website. *If you do not have a current practice address, your mailing address will be used. When you obtain a practice address, you will be required to update your online practitioner profile.*

7940 Front Beach Rd (Street/ P.O. Box) **#2006** (Suite/Apt. No) **Panama City Beach** (City)

FL (State) **32407** (Zip) **USA** (Country) **(850) 730-8585** (Alternate Phone Number)

Email Address: **ashrafkamal1972@yahoo.com**

Under Florida law, email addresses are public records. If you do not want your e-mail address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.

Equal Opportunity Data: We are required to ask that you furnish the following information as part of your voluntary compliance with Section 2, Uniform Guidelines on Employee Selection Procedure (1978) 43 CFR 38296 (August 25, 1978). This information is gathered for statistical,and reporting purposes only and does not in any way affect your candidacy for licensure.

SEX: ☐ **Male** ☐ **Female** **RACE:** ☐ **White** ☐ **Black** ☐ **Asian/Pacific Islander** ☐ **Hispanic** ☒ **Other**

☒ Yes ☐ No **Availability for Disaster:** Will you be available to provide health care services in special needs shelters or to help staff disaster medical assistance teams during times of emergency or major disaster?

2. MEDICAL EDUCATION HISTORY

Federal Credentials Verification Services (FCVS) is not a requirement for licensure. FCVS will primary source verify and provide a copy of the medical school transcript(s), medical school diploma, medical school verification, name change document(s), national examination score report, ECFMG certificate, ECFMG verification and postgraduate training verifications. For more information about FCVS, visit their web-site at www.fcvs.org/.

☒ Yes ☐ No Are you using the FCVS to verify your core credentials?

☒ Yes ☐ No Have you completed the equivalent of 2 academic years of preprofessional, postsecondary education including, courses in anatomy, biology and chemistry prior to entering medical school?

Medical Education:
List in chronological order all medical schools attended, whether completed or not. Submit on a separate sheet if needed.

Medical School Name and Address:	From: (mm/yy)	To: (mm/yy)	Date Degree Received:
Cairo University Faculty of Medicine	**11/89**	**12/95**	**12/95**
Elsaraya_st.Elmanial_,_Cairo_11562			

Tel : +202 2368 2030 Website http://medicine.cu.edu.eg

Fifth Pathway Certificate Holders: N/A

If you answer "yes" to any of the following questions, you must request verifications to be sent directly to the Board office.

☐ Yes ☐ No Did you attend an international medical school and do not possess a valid ECFMG Certificate?

☐ Yes ☐ No Did you receive a bachelor's degree from an accredited United States college or University?

☐ Yes ☐ No Did you study at a medical school which is recognized by the World Health Organization?

☐ Yes ☐ No Did you complete all of the formal requirement of the International medical school, except the internship or social service requirements, and pass part I of the National board of Medical examination or the Education Commission for Foreign Medical Graduates Examination equivalent?

☐ Yes ☐ No Did you complete an academic year of supervised clinical training in a hospital affiliated with a medical school approved by the Council on Medical Education of the American Medical Association and upon completion passed part II of the National Board of Medical Examiners examination or the Education Commission for Foreign Medical Graduates examination Equivalent?

Not Fifth pathway certificate holders

Postgraduate Training:

Provide the following documentation to support your postgraduate training:

☐ Post-Graduate Training Form

In the table below list, in chronological order, all postgraduate training from the date you graduated from medical school to the present. Start with your first program and end with your last or current program. List all programs you began, whether you completed or received credit for the training.

Program Name and Full Mailing Address:	Specialty Area:	From: (mm/yy)	To: (mm/yy)	Did you receive credit? (Y/N)
SUNY Health Science Center at Brooklyn Program Affiliated with SUNY Health Science Center at Brooklyn Brooklyn, NY, United States	Pediatric Infectious Diseases (ACGME 3353511036)	07/19	07/22	Y
New Children University Hospital Cairo, Egypt	Pediatrics	09/97	02/01	N
Pediatric Hematology Clinic Cairo, Egypt	Pediatric Hematology	04/01	04/04	N

SEE ATTACHED ADDITIONAL PAGE

Loan History:

☐ Yes ☒ No Are you currently in default on any health education loan or scholarship obligation? (If "yes", explain on a separate sheet providing accurate details.)

3. EXAMINATION HISTORY

State Board (prior to 1974), State Board (after 1974) & SPEX, LMCC & SPEX, NBME, FLEX, USMLE III, or Combination (prior to 2000)

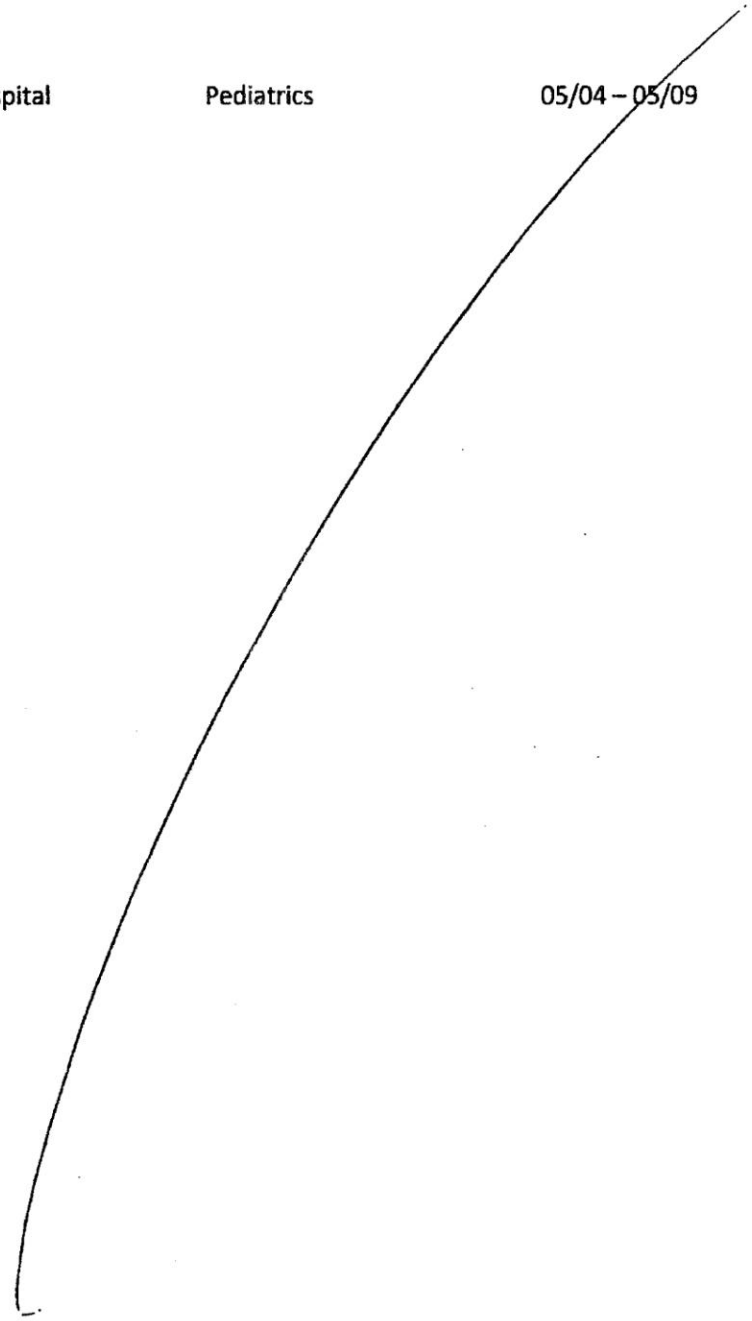
Request that the score report be sent directly to the Board of Medicine. NOTE: If you took a state Board examination and are not currently licensed in three other states, you must also request your SPEX score be sent.

Exam taken:_____ Date passed: _____
mm/dd/yy

Usmie step 1 Dec 27,2012
Usmie step 2 Ck Dec 22,2014
Usmie step 2 Cs April 1, 2016
ECFMG Certificate Aug 29,2016
USMLE Step 3 June 17, 2019

Additional Postgraduate Training:

New Dar Al Shifa Hospital Kuwait City, Kuwait	Pediatrics	05/04 – 05/09	N



4. LICENSURE HISTORY

Request verification of licensure status directly from the licensing entity or www.veridoc.org. Request international license verification(s) if you have practiced outside of the U.S. for at least two of the previous four years.

☒ Yes ☐ No Do you now hold or have you ever held a license to practice medicine or any other profession in any US State or territory, or foreign country? Please list in table below.

Jurisdiction	Profession	License number
Kuwait	**Medical Doctor, Pediatrics**	**131422 (issued 8/16/09)**
Egypt	**Medical Doctor**	**n/a**

If you answer "yes" to any of the questions in this section, you are required to send an explanation and supporting documentation.

☐ Yes ☒ No Have you had any application for a medical license or professional license denied by any state board or other governmental agency of any state, territory, or country?

☐ Yes ☒ No Are you currently under investigation in any jurisdiction for an act or offense that would constitute a violation of Section 458.331, Florida Statutes?

☐ Yes ☒ No Have you ever had any professional license or license to practice medicine revoked, suspended, placed on probation, or other disciplinary action taken in any state, territory or country?

5. PRACTICE/EMPLOYMENT HISTORY

List the year you legally first began to practice medicine, **1996** (yyyy). This would be the year you began practicing medicine and could be the date you began your postgraduate training.

☒ Yes ☐ No Have you practiced medicine in any jurisdiction for two of the last four years **or** completed a board approved post-graduate training program within the last two years?

☐ Yes ☒ No If your answer to the question above was "No," have you passed a board approved clinical competency exam within the last year? If yes, then submit supporting documentation.

List in chronological order all employment for the last four (4) years.

Name and address of practice or employment	Type of employment	From: mm/yy	To: mm/yy
New Dar Al Shifa Hospital Kuwait City, Kuwait	**Pediatrician**	**05/04**	**06/19**
Suny Downstate Medical Center 450 Clarkson Ave, Brooklyn, NY 11203	**Pediatric ID Fellow**	**07/19**	**Current**

☒ Yes ☐ No Do you currently hold staff privileges in any hospital, health institution, clinic or medical facility? List each facility below.

Name of facility
SUNY Downstate Health Sciences University 450 Clarkson Ave, Brooklyn, NY 11203
Beni Suef University, Faculty otMedicine - Beni Suef, Egypt - 2007-present
Beni Suef University Faculty of Medicine - Beni Suef, Egypt - 2001-2004
New Dar Al Shifa Hospital, Kuwait City, Kuwait

If you answer "yes" to the following questions, you are required to send an explanation and supporting documentation.

☐ Yes ☒ No Have you ever had any staff privileges denied, suspended, revoked, modified, restricted, not renewed, or placed on probation, or have you been asked to resign or take a temporary leave of absence or were otherwise acted against by any facility?

☒ Yes ☐ No Do you currently, or have you had, responsibility for graduate medical education within the last 10 years?

In the table below, list all institutions where you have had responsibility for graduate medical education or faculty appointment(s) at any medical school.

Name of institution
Clinical Asst Instructor SUNY Downstate Health Sciences University 450 Clarkson Ave, Brooklyn, NY 11203
Lecturer in Pediatrics - Beni Suef University, Faculty otMedicine - Beni Suef, Egypt - 2007-present
Clinical Instructor in Pediatrics - Beni Suef University Faculty of Medicine - Beni Suef, Egypt - 2001-2004

☐ Yes ☒ No Are you certified by any specialty board recognized by the American Board of Medical Specialties or specialty board approved by the Florida Board of Medicine?

Board Name	Certification/ Specialty/Sub-Specialty	Date of Certification (mm/yy)

If you answer "yes" to any of the following questions, please explain on a separate sheet providing accurate details.

☐ Yes ☒ No Have you ever had any final disciplinary action taken against you by a specialty board or other similar national organization?

☐ Yes ☒ No Have you ever been denied or surrendered a DEA registration?

6. CRIMINAL HISTORY

If you answer "Yes" to the following question you are required to send the following items:

a. Self-explanation describing in detail the circumstances surrounding each offense, including dates, city and state, charges and final results.
b. Final Dispositions and Arrest Records for all offenses. The Clerk of the Court in the arresting jurisdiction will provide you with these documents. Unavailability of these documents must come in the form of a letter from the Clerk of the Court.
c. Completion of Sentence Documents. You may obtain documentation from the Department of Corrections. The report must include the start date, end date and that the conditions were met.

☐ Yes ☒ No Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to, a crime in any jurisdiction other than a minor traffic offense? You must include all misdemeanors and felonies, **even if adjudication was withheld. Driving under the influence (DUI) or driving while impaired (DWI) are not minor traffic offenses for purposes of this question.**

Yes ☒ I have been provided and read the statement from the Florida Department of Law Enforcement regarding the sharing, retention, privacy and right to challenge incorrect criminal history records and the "Privacy Statement" document from the Federal Bureau of Investigation.

7. MILITARY HISTORY

A. ☐ Yes ☒ No Have you ever been in the United States Military and/or Public Health Service?

B. ☐ Yes ☒ No Have you ever been disciplined by any branch of the United States Armed Services or Public Health Services? If you answered "yes" please provide a detailed explanation and supporting documentation

8. CRIMINAL AND MEDICAID/MEDICARE FRAUD QUESTIONS

Applicants for licensure, certification or registration and candidates for examination may be excluded from licensure, certification or registration if their felony conviction falls into certain timeframes as established in Section 456.0635(2), Florida Statutes. If you answer "Yes" to any of the following questions, please provide a written explanation for each question. Supporting documentation includes court dispositions or agency orders where applicable.

1. ☐ Yes ☒ No Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, F.S. (relating to social and economic assistance), Chapter 817, F.S. (relating to fraudulent practices), Chapter 893, F.S. (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction?

If you responded "No" to the question above, skip to question 2.

a. ☐ Yes ☐ No If "yes" to 1, for the felonies of the first or second degree, has it been more than 15 years from the date of the plea, sentence and completion of any subsequent probation?

b. ☐ Yes ☐ No If "Yes" to 1, for felonies of the third degree, has it been more than 10 years from the date of the plea, sentence and completion of any subsequent probation? (This question does not apply to felonies of the third degree under Section 893.13(6)(a), Florida Statutes)

c. ☐ Yes ☐ No If "Yes" to 1, for the felonies of the third degree under Section 893.13(6)(a), Florida Statutes, has it been more than 5 years from the date of the plea, sentence and completion of any subsequent probation?

d. ☐ Yes ☐ No If "Yes" to 1, have you successfully completed a drug court program that resulted in the plea for the felony offense being withdrawn or charges dismissed?

2. ☐ Yes ☒ No Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970 (relating to controlled substances) or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)?

If you responded "No" to the question above, skip to question 3.

a. ☐ Yes ☐ No If "Yes" to 2, has it been more than 15 years before the date of application since the sentence and any subsequent period of probation for such conviction or plea ended?

3. ☐ Yes ☒ No Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes?

If you responded "No" to the question above, skip to question 4.

a. ☐ Yes ☐ No If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years?

4. ☐ Yes ☒ No Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid Program?

If you responded "No" to the question above, skip to question 5.

a. ☐ Yes ☐ No Have you been in good standing with a state Medicaid program for the most recent five years?

b. ☐ Yes ☐ No Did the termination occur at least 20 years before the date of this application?

5. ☐ Yes ☒ No Are you currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities?

If you answer "Yes" to the questions below, you are required to send the following items:

- **A statement indicating the date of each incident and the number for each case.**
- **An explanation of details for each case and your involvement for each case.**
- **Submit the enclosed Exhibit 1 form.**
- **A copy of the complaint, judgments and/or settlements for each case.**
- **Submit a complete copy of the trial record(s) of each case, including the trial transcript, evidentiary exhibits and final judgment in electronic format.**

☐ Yes ☒ No Have you ever had a judgment entered against you for medical malpractice where the incident(s) of malpractice occurred after November 2, 2004?

☐ Yes ☒ No Within the last 10 years have you had any liability claim(s) or action(s) for damages for personal injury settled or finally adjudicated in an amount that exceeds $100,000.00?

10. FINANCIAL RESPONSIBILITY

The Financial Responsibility options are divided into two categories, coverage and exemptions. Check only one option of the ten provided as required by s. 458.320, Florida Statutes.

Category I: Financial Responsibility Coverage

☐1. I do not have hospital staff privileges, I do not perform surgery at an ambulatory surgical center and I have established an irrevocable letter or credit or an escrow account in an amount of $100,000/$300,000, in accord with Chapter 675, F. S., for a letter of credit and s. 625.52, F. S., for an escrow account.

☐2. I have hospital staff privileges or I perform surgery at an ambulatory surgical and I have established an irrevocable letter of credit or escrow account in an amount of $250,000/$750,000, in accord with Chapter 675, F. S., for a letter of credit and s. 625.52, F. S., for an escrow account.

☐3. I do not have hospital staff privileges, I do not perform surgery at an ambulatory surgical center and I have obtained and maintain professional liability coverage in an amount not less than $100,000 per claim, with a minimum annual aggregate of not less than $300,000 from an authorized insurer as defined under s. 624.09, F. S., from a surplus lines insurer as defined under s. 626.914(2), F. S., from a risk retention group as defined under s. 627.942, F. S., from the Joint Underwriting Association established under s. 627.351(4), F. S., or through a plan of self-insurance as provided in s. 627.357, F. S.

☐4. I have hospital staff privileges or I perform surgery at an ambulatory surgical and I have professional liability coverage in an amount not less than $250,000 per claim, with a minimum annual aggregate of not less than $750,000 from an authorized insurer as defined under s. 624.09, F. S., from a surplus lines insurer as defined under s. 626.914(2), F. S., from a risk retention group as defined under s. 627.942, F. S., from the Joint Underwriting Association established under s. 627.351(4), F. S., or through a plan of self-insurance as provided in s. 627.357, F. S.

☐5. I have elected not to carry medical malpractice insurance however, I agree to satisfy any adverse judgments up to the minimum amounts pursuant to s. 458.320(5)(g)1, F. S. I understand that I must either post notice in a sign prominently displayed in my reception area or provide a written statement to any person to whom medical services are being provided that I have decided not to carry medical malpractice insurance. I understand that such a sign or notice must contain the wording specified in s. 458.320(5)(g), F. S.

Category II: Financial Responsibility Exemptions

☐6. I practice medicine exclusively as an officer, employee, or agent of the federal government, the state, or its agencies or subdivisions.

☐7. I hold a limited license issued pursuant to s. 458.317, F. S., and practice only under the scope of the limited license.

☒8. I do not practice medicine in the State of Florida.

☐9. I meet all of the following criteria:

(a) I have held an active license to practice in this state or another state or some combination thereof for more than 15 years;

(b) I am retired or maintain part time practice of no more than 1000 patient contact hours per year;

(c) I have had no more than two claims resulting in an indemnity exceeding $25,000 within the previous five-year period;

(d) I have not been convicted of or pled guilty or nolo contendere to any criminal violation specified in Chapter 458, F. S. or the medical practice act in any other state; and

(e) I have not been subject, within the past ten years of practice, to license revocation, suspension, or probation for a period of three years or longer, or a fine of $500 or more for a violation of Chapter 458, F. S., or the medical practice act of another jurisdiction. A regulatory agency's acceptance of a relinquishment of license, stipulation, consent order, or other settlement offered in response to or in anticipation of filing of administrative charges against a license is construed as action against a license. I understand if I am claiming an exception under this section that I must either post notice in a sign prominently displayed in my reception area or provide a written statement to any person to whom medical services are being provided that I have decided not to carry medical malpractice insurance. See Section 458.320(5)(f), Florida Statutes, for specific notice requirements.

☐10. I practice only in conjunction with my teaching duties at an accredited medical school or its teaching hospitals. (Interns and residents do not qualify for this exemption).

If you select an exemption based on number 9, you must also complete the affidavit on the following page.

12. STATEMENT OF APPLICANT

I state that these statements are true and correct. I recognize that providing false information may result in denial of licensure, disciplinary action against my license, or criminal penalties pursuant to Sections 456.067, 775.083, and 775.084, Florida Statutes. I state that I have read Chapters 456, 458 and 766.301-.316, Florida Statutes and Chapter 64B8, Florida Administrative Code.

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Florida Board of Medicine information which is material to my application for licensure.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind. I state that my answers and all statements made by me herein are true and correct.

Should I furnish any false information in this application, I hereby agree that such act constitutes cause for denial, suspension, or revocation of my license to practice medicine in the State of Florida. If there are any changes to my status or any change that would affect any of my answers to this application I must notify the board within 30 days.

I understand that my records are protected under federal and state regulations governing Confidentiality of Mental Health Patient Records and cannot be disclosed without my written consent unless otherwise provided in the regulations. I understand that my records are protected under federal and state regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it.

ashraf kamal abdelhemid
Print name

Ashraf Abdelhemid **10/11/2019**
Signature Date

EXHIBIT 1 – REPORT ON PROFESSIONAL LIABILITY CLAIMS AND ACTIONS N/A

Include information relating to liability actions occurring within the previous 10 years. The actions are required to be reported under section 456.039(1)(b) F. S. You must submit a completed form for each occurrence. If you are an allopathic, osteopathic, or podiatric physician, to satisfy this reporting requirement you may submit copies of reports previously submitted under the requirements of s. 456.049 F. S. instead of this exhibit.

Date of occurrence: / /____ Date reported to licensee: / /____ Date claim reported to insurer or self-insurer / /_____

Injured person's name: (last, first, middle initial)_____

Street Address:_____

City:_____ State:_____ Zip Code: _____
Age:_____ Sex: _____

Date of suit, if filed: / /____

List all defendants with their health care provider license number involved in this claim:
1 _____ 2._____
3._____ 4._____

Date of final claim disposition:_____/_____/_____

Date and amount of judgment or settlement, if any: _____

Was there an itemized verdict? [ ] Yes [ ] No (If "YES", attach copy of settlement verdict)

Indemnity paid on behalf of this defendant: $_____
Loss adjustment expense paid to defense counsel: $_____
All other loss adjustment expense paid: $_____

The date and reason for final disposition, if no judgment or settlement: _____

Name of institution at which the injury occurred: _____

Location of injury occurrence:

[ ] Patient's Room [ ] Physical Therapy Dept. [ ] Radiology [ ] Labor & Delivery Room
[ ] Operating Suite [ ] Nursery [ ] Emergency Room
[ ] Recovery Room [ ] Critical Care Unit [ ] Other [ ] Special Procedure Room

Final diagnosis for which treatment was sought or rendered: _____
_____

Describe misdiagnosis made, if any, of the patient's actual condition. _____
_____

Describe the operation, diagnostic, or treatment procedure causing the injury. Use nomenclature and/or descriptions of the procedures used. Include method of anesthesia, or name of drug used for treatment, with detail of administration. _____
_____

Describe the principal injury giving rise to the claim. Use nomenclature and/or descriptions of the injury. Include type of adverse effect from drugs where applicable. _____
_____

Safety management steps taken by the licensee to make similar occurrences less likely: _____
_____

I represent that these statements are true and correct pursuant to s. 837.06, Florida Statutes. I recognize that providing any false statements made in writing with the intent to mislead the Department staff in the performance of their official duties, shall be punishable as provided in s. 775.082 and 775.083, Florida Statutes.

Signature of physician: _____

FCVS | FEDERATION CREDENTIALS VERIFICATION SERVICE

Applicant Reported Unusual Circumstances

Federation of STATE MEDICAL BOARDS

Medical School

Medical Professional Name: Abdelhemid, Ashraf Kamal

University of Cairo

Unusual Circumstances

Did you have any interruption(s) or extension(s) in your medical education?	**No**
Were you ever placed on probation?	**No**
Were you ever disciplined or placed under investigation?	**No**
Were any negative reports for behavioral reasons ever filed by instructors?	**No**
Were any limitations or special requirements imposed on you because of academic performance, incompetence, disciplinary problems or for any other reason?	**No**

End of Applicant Reported Unusual Circumstances report for: Abdelhemid, Ashraf Kamal

© 1996 FEDERATION OF STATE MEDICAL BOARDS

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Postgraduate Training

fsmb

Postgraduate Training

Accreditation ID: **3353511036**

Institution: **SUNY Health Science Center at Brooklyn Program**

Location: Brooklyn, NY
UNITED STATES

Credentials Analysis Information for Postgraduate Training

There is no Omission/Discrepancy/Miscellaneous information identified.

1501 F-138700

MEDICAL DOCTOR
APPLICATION FOR LICENSURE
Apply for your license online at www.flboardofmedicine.gov

10/16/2019 250.00
ID: 138700 Type: F
BT: 3005982
R#: 919012408

Choose your application type:

☒ Endorsement (1021) ☐ Examination (1024)

☐ Military Veterans Fee Waiver

If you were honorably discharged from the U.S. armed services within 60 months of your application you will qualify for a waiver of the application fee and the initial licensure fee. In order to qualify, please check the box above indicating that you are seeking a waiver and submit **a DD-214 or NGB-22 form as proof of honorable discharge.**

☐ I plan to dispense medicinal drugs in the State of Florida for a fee or other remuneration and hereby register as required by Section 465.0276, F.S. I understand that the fee for the Dispensing Practitioner is $100.00 in addition to the required initial license fee and will submit it along with the license fee.

1. PERSONAL INFORMATION

Name: Abdelhemid (Last/Surname) Ashraf (First) Kamal (Middle) **Date of Birth:** 06/12/1972 (MM/DD/YYYY)

Mailing Address: (The address where mail and your license should be sent)

7940 Front Beach Rd (Street/ PO Box) #2006 (Suite/Apt. No) Panama City Beach (City)

FL (State) 32407 (Zip) USA (Country) (850) 730-8585 (Phone Number)

Physical Location: A Post Office Box is not acceptable. This address will be posted on the Department of Health's website. *If you do not have a current practice address, your mailing address will be used. When you obtain a practice address, you will be required to update your online practitioner profile.*

7940 Front Beach Rd (Street/ P.O. Box) #2006 (Suite/Apt. No) Panama City Beach (City)

FL (State) 32407 (Zip) USA (Country) (850) 730-8585 (Alternate Phone Number)

Email Address: ashrafkamal1972@yahoo.com

Under Florida law, email addresses are public records. If you do not want your e-mail address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.

Equal Opportunity Data: We are required to ask that you furnish the following information as part of your voluntary compliance with Section 2, Uniform Guidelines on Employee Selection Procedure (1978) 43 CFR 38296 (August 25, 1978). This information is gathered for statistical,and reporting purposes only and does not in any way affect your candidacy for licensure.

SEX: ☐ Male ☐ Female **RACE:** ☐ White ☐ Black ☐ Asian/Pacific Islander ☐ Hispanic ☒ Other

☒ Yes ☐ No **Availability for Disaster:** Will you be available to provide health care services in special needs shelters or to help staff disaster medical assistance teams during times of emergency or major disaster?

2. MEDICAL EDUCATION HISTORY

Federal Credentials Verification Services (FCVS) is not a requirement for licensure. FCVS will primary source verify and provide a copy of the medical school transcript(s), medical school diploma, medical school verification, name change document(s), national examination score report, ECFMG certificate, ECFMG verification and postgraduate training verifications. For more information about FCVS, visit their web-site at www.fcvs.org/.

☒ Yes ☐ No Are you using the FCVS to verify your core credentials?

☒ Yes ☐ No Have you completed the equivalent of 2 academic years of preprofessional, postsecondary education including, courses in anatomy, biology and chemistry prior to entering medical school?

Medical Education:
List in chronological order all medical schools attended, whether completed or not. Submit on a separate sheet if needed.

Medical School Name and Address:	From: (mm/yy)	To: (mm/yy)	Date Degree Received:
Cairo University Faculty of Medicine	**11/89**	**12/95**	**12/95**
Elsaraya_st.Elmanial_,_Cairo_11562			

Tel : +202 2368 2030 Website http://medicine.cu.edu.eg

Fifth Pathway Certificate Holders: N/A

If you answer "yes" to any of the following questions, you must request verifications to be sent directly to the Board office.

☐ Yes ☐ No Did you attend an international medical school and do not possess a valid ECFMG Certificate?

☐ Yes ☐ No Did you receive a bachelor's degree from an accredited United States college or University?

☐ Yes ☐ No Did you study at a medical school which is recognized by the World Health Organization?

☐ Yes ☐ No Did you complete all of the formal requirement of the International medical school, except the internship or social service requirements, and pass part I of the National board of Medical examination or the Education Commission for Foreign Medical Graduates Examination equivalent?

☐ Yes ☐ No Did you complete an academic year of supervised clinical training in a hospital affiliated with a medical school approved by the Council on Medical Education of the American Medical Association and upon completion passed part II of the National Board of Medical Examiners examination or the Education Commission for Foreign Medical Graduates examination Equivalent?

Not Fifth pathway certificate holders

Postgraduate Training:

Provide the following documentation to support your postgraduate training:

☐ Post-Graduate Training Form

In the table below list, in chronological order, all postgraduate training from the date you graduated from medical school to the present. Start with your first program and end with your last or current program. List all programs you began, whether you completed or received credit for the training.

Program Name and Full Mailing Address:	Specialty Area:	From: (mm/yy)	To: (mm/yy)	Did you receive credit? (Y/N)
SUNY Health Science Center at Brooklyn Program Affiliated with SUNY Health Science Center at Brooklyn Brooklyn, NY, United States	Pediatric Infectious Diseases (ACGME 3353511038)	07/19	07/22	Y
New Children University Hospital Cairo, Egypt	Pediatrics	09/97	02/01	N
Pediatric Hematology Clinic Cairo, Egypt	Pediatric Hematology	04/01	04/04	N

SEE ATTACHED ADDITIONAL PAGE

Loan History:

☐ Yes ☒ No Are you currently in default on any health education loan or scholarship obligation? (If "yes", explain on a separate sheet providing accurate details.)

3. EXAMINATION HISTORY

State Board (prior to 1974), State Board (after 1974) & SPEX, LMCC & SPEX, NBME, FLEX, USMLE III, or Combination (prior to 2000)

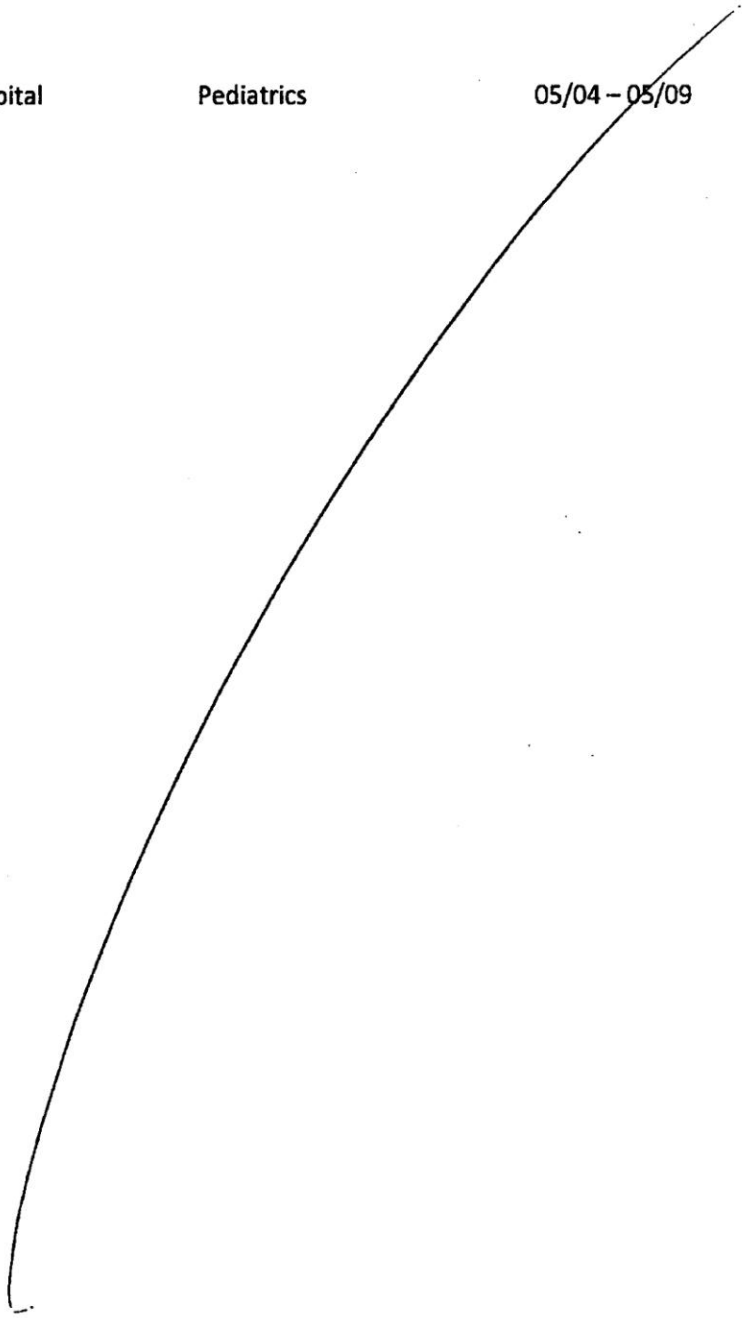
Request that the score report be sent directly to the Board of Medicine. NOTE: If you took a state Board examination and are not currently licensed in three other states, you must also request your SPEX score be sent.

Exam taken:_____ Date passed: _____
mm/dd/yy

Usmie step 1 Dec 27,2012
Usmie step 2 Ck Dec 22,2014
Usmie step 2 Cs April 1, 2016
ECFMG Certificate Aug 29,2016
USMLE Step 3 June 17, 2019

Additional Postgraduate Training:

New Dar Al Shifa Hospital Kuwait City, Kuwait	Pediatrics	05/04 – 05/09	N



4. LICENSURE HISTORY

Request verification of licensure status directly from the licensing entity or www.veridoc.org. Request international license verification(s) if you have practiced outside of the U.S. for at least two of the previous four years.

☒ Yes ☐ No Do you now hold or have you ever held a license to practice medicine or any other profession in any US State or territory, or foreign country? Please list in table below.

Jurisdiction	Profession	License number
Kuwait	**Medical Doctor, Pediatrics**	**131422 (issued 8/16/09)**
Egypt	**Medical Doctor**	**n/a**

If you answer "yes" to any of the questions in this section, you are required to send an explanation and supporting documentation.

☐ Yes ☒ No Have you had any application for a medical license or professional license denied by any state board or other governmental agency of any state, territory, or country?

☐ Yes ☒ No Are you currently under investigation in any jurisdiction for an act or offense that would constitute a violation of Section 458.331, Florida Statutes?

☐ Yes ☒ No Have you ever had any professional license or license to practice medicine revoked, suspended, placed on probation, or other disciplinary action taken in any state, territory or country?

5. PRACTICE/EMPLOYMENT HISTORY

List the year you legally first began to practice medicine, **1996** (yyyy). This would be the year you began practicing medicine and could be the date you began your postgraduate training.

☒ Yes ☐ No Have you practiced medicine in any jurisdiction for two of the last four years **or** completed a board approved post-graduate training program within the last two years?

☐ Yes ☒ No If your answer to the question above was "No," have you passed a board approved clinical competency exam within the last year? If yes, then submit supporting documentation.

List in chronological order all employment for the last four (4) years.

Name and address of practice or employment	Type of employment	From: mm/yy	To: mm/yy
New Dar Al Shifa Hospital Kuwait City, Kuwait	**Pediatrician**	**05/04**	**06/19**
Suny Downstate Medical Center 450 Clarkson Ave, Brooklyn, NY 11203	**Pediatric ID Fellow**	**07/19**	**Current**

☒ Yes ☐ No Do you currently hold staff privileges in any hospital, health institution, clinic or medical facility? List each facility below.

Name of facility
SUNY Downstate Health Sciences University 450 Clarkson Ave, Brooklyn, NY 11203
Beni Suef University, Faculty otMedicine - Beni Suef, Egypt - 2007-present
Beni Suef University Faculty of Medicine - Beni Suef, Egypt - 2001-2004
New Dar Al Shifa Hospital, Kuwait City, Kuwait

If you answer "yes" to the following questions, you are required to send an explanation and supporting documentation.

☐ Yes ☒ No Have you ever had any staff privileges denied, suspended, revoked, modified, restricted, not renewed, or placed on probation, or have you been asked to resign or take a temporary leave of absence or were otherwise acted against by any facility?

☒ Yes ☐ No Do you currently, or have you had, responsibility for graduate medical education within the last 10 years?

In the table below, list all institutions where you have had responsibility for graduate medical education or faculty appointment(s) at any medical school.

Name of institution
Clinical Asst Instructor SUNY Downstate Health Sciences University 450 Clarkson Ave, Brooklyn, NY 11203
Lecturer in Pediatrics - Beni Suef University, Faculty otMedicine - Beni Suef, Egypt - 2007-present
Clinical Instructor in Pediatrics - Beni Suef University Faculty of Medicine - Beni Suef, Egypt - 2001-2004

☐ Yes ☒ No Are you certified by any specialty board recognized by the American Board of Medical Specialties or specialty board approved by the Florida Board of Medicine?

Board Name	Certification/ Specialty/Sub-Specialty	Date of Certification (mm/yy)

If you answer "yes" to any of the following questions, please explain on a separate sheet providing accurate details.

☐ Yes ☒ No Have you ever had any final disciplinary action taken against you by a specialty board or other similar national organization?

☐ Yes ☒ No Have you ever been denied or surrendered a DEA registration?

6. CRIMINAL HISTORY

If you answer "Yes" to the following question you are required to send the following items:

a. Self-explanation describing in detail the circumstances surrounding each offense, including dates, city and state, charges and final results.
b. Final Dispositions and Arrest Records for all offenses. The Clerk of the Court in the arresting jurisdiction will provide you with these documents. Unavailability of these documents must come in the form of a letter from the Clerk of the Court.
c. Completion of Sentence Documents. You may obtain documentation from the Department of Corrections. The report must include the start date, end date and that the conditions were met.

☐ Yes ☒ No Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to, a crime in any jurisdiction other than a minor traffic offense? You must include all misdemeanors and felonies, **even if adjudication was withheld. Driving under the influence (DUI) or driving while impaired (DWI) are not minor traffic offenses for purposes of this question.**

Yes ☒ I have been provided and read the statement from the Florida Department of Law Enforcement regarding the sharing, retention, privacy and right to challenge incorrect criminal history records and the "Privacy Statement" document from the Federal Bureau of Investigation.

7. MILITARY HISTORY

A. ☐ Yes ☒ No Have you ever been in the United States Military and/or Public Health Service?

B. ☐ Yes ☒ No Have you ever been disciplined by any branch of the United States Armed Services or Public Health Services? If you answered "yes" please provide a detailed explanation and supporting documentation

8. CRIMINAL AND MEDICAID/MEDICARE FRAUD QUESTIONS

Applicants for licensure, certification or registration and candidates for examination may be excluded from licensure, certification or registration if their felony conviction falls into certain timeframes as established in Section 456.0635(2), Florida Statutes. If you answer "Yes" to any of the following questions, please provide a written explanation for each question. Supporting documentation includes court dispositions or agency orders where applicable.

1. ☐ Yes ☒ No Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, F.S. (relating to social and economic assistance), Chapter 817, F.S. (relating to fraudulent practices), Chapter 893, F.S. (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction?

If you responded "No" to the question above, skip to question 2.

a. ☐ Yes ☐ No If "yes" to 1, for the felonies of the first or second degree, has it been more than 15 years from the date of the plea, sentence and completion of any subsequent probation?

b. ☐ Yes ☐ No If "Yes" to 1, for felonies of the third degree, has it been more than 10 years from the date of the plea, sentence and completion of any subsequent probation? (This question does not apply to felonies of the third degree under Section 893.13(6)(a), Florida Statutes)

c. ☐ Yes ☐ No If "Yes" to 1, for the felonies of the third degree under Section 893.13(6)(a), Florida Statutes, has it been more than 5 years from the date of the plea, sentence and completion of any subsequent probation?

d. ☐ Yes ☐ No If "Yes" to 1, have you successfully completed a drug court program that resulted in the plea for the felony offense being withdrawn or charges dismissed?

2. ☐ Yes ☒ No Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970 (relating to controlled substances) or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)?

If you responded "No" to the question above, skip to question 3.

a. ☐ Yes ☐ No If "Yes" to 2, has it been more than 15 years before the date of application since the sentence and any subsequent period of probation for such conviction or plea ended?

3. ☐ Yes ☒ No Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes?

If you responded "No" to the question above, skip to question 4.

a. ☐ Yes ☐ No If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years?

4. ☐ Yes ☒ No Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid Program?

If you responded "No" to the question above, skip to question 5.

a. ☐ Yes ☐ No Have you been in good standing with a state Medicaid program for the most recent five years?

b. ☐ Yes ☐ No Did the termination occur at least 20 years before the date of this application?

5. ☐ Yes ☒ No Are you currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities?

If you answer "Yes" to the questions below, you are required to send the following items:

- **A statement indicating the date of each incident and the number for each case.**
- **An explanation of details for each case and your involvement for each case.**
- **Submit the enclosed Exhibit 1 form.**
- **A copy of the complaint, judgments and/or settlements for each case.**
- **Submit a complete copy of the trial record(s) of each case, including the trial transcript, evidentiary exhibits and final judgment in electronic format.**

☐ Yes ☒ No Have you ever had a judgment entered against you for medical malpractice where the incident(s) of malpractice occurred after November 2, 2004?

☐ Yes ☒ No Within the last 10 years have you had any liability claim(s) or action(s) for damages for personal injury settled or finally adjudicated in an amount that exceeds $100,000.00?

CONFIDENTIAL AND EXEMPT FROM PUBLIC RECORDS DISCLOSURE*

9. HEALTH HISTORY

If you answer "Yes" to any of the questions in this section, you are required to send the following items:

- A self-explanation providing accurate details that include name of all physicians, therapists, counselors, hospitals, institutions, and/or clinics where you received treatment and dates of treatment.
- A report directed to the Florida Board of Medicine from each treatment provider about your treatment, medications, and dates of treatment. If applicable, include all DSM III R/DSM IV/DSM IV-TR Axis I and II diagnosis(es) code(s), and admission and discharge summary(s).

A. ☐ Yes ☒ No In the last five years, have you been enrolled in, required to enter into, or participated in any drug or alcohol recovery program or impaired practitioner program for treatment of drug or alcohol abuse that occurred within the past five years?

B. ☐ Yes ☒ No In the last five years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental disorder or impairment?

C. ☐ Yes ☒ No During the last five years, have you been treated for or had a recurrence of a diagnosed mental disorder that has impaired your ability to practice medicine within the past five years?

D. ☐ Yes ☒ No During the last five years, have you been treated for or had a recurrence of a diagnosed physical disorder that has impaired your ability to practice medicine?

E. ☐ Yes ☒ No In the last five years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol/drug) disorder or, if you were previously in such a program, did you suffer a relapse within the last five years?

F. ☐ Yes ☒ No During the last five years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol/drug) disorder that has impaired your ability to practice medicine within the past five years?

Name: Abdelhemid (Last) Ashraf (First) Kamal (Middle)

Social Security Number: 379-23-0457

Social Security Information - * Under the Federal Privacy Act, disclosure of Social Security numbers is voluntary unless specifically required by federal statute. In this instance, Social Security numbers are mandatory pursuant to Title 42 United States Code, Sections 653 and 654; and Section 456.013(1), 409.2577 and 409.2598, Florida Statutes. Social Security numbers are used to allow efficient screening of applicants and licensees by a Title IV-D child support agency to ensure compliance with child support obligations. Social Security numbers must also be recorded on all professional and occupational license applications and will be used for license identification pursuant to the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Welfare Reform Act. 104 Pub.L. Section 317) Clarification of the SSA process may be reviewed at **www.ssa.gov** or by calling 1-800-772-1213.

10. FINANCIAL RESPONSIBILITY

The Financial Responsibility options are divided into two categories, coverage and exemptions. Check only one option of the ten provided as required by s. 458.320, Florida Statutes.

Category I: Financial Responsibility Coverage

☐1. I do not have hospital staff privileges, I do not perform surgery at an ambulatory surgical center and I have established an irrevocable letter or credit or an escrow account in an amount of $100,000/$300,000, in accord with Chapter 675, F. S., for a letter of credit and s. 625.52, F. S., for an escrow account.

☐2. I have hospital staff privileges or I perform surgery at an ambulatory surgical and I have established an irrevocable letter of credit or escrow account in an amount of $250,000/$750,000, in accord with Chapter 675, F. S., for a letter of credit and s. 625.52, F. S., for an escrow account.

☐3. I do not have hospital staff privileges, I do not perform surgery at an ambulatory surgical center and I have obtained and maintain professional liability coverage in an amount not less than $100,000 per claim, with a minimum annual aggregate of not less than $300,000 from an authorized insurer as defined under s. 624.09, F. S., from a surplus lines insurer as defined under s. 626.914(2), F. S., from a risk retention group as defined under s. 627.942, F. S., from the Joint Underwriting Association established under s. 627.351(4), F. S., or through a plan of self-insurance as provided in s. 627.357, F. S.

☐4. I have hospital staff privileges or I perform surgery at an ambulatory surgical and I have professional liability coverage in an amount not less than $250,000 per claim, with a minimum annual aggregate of not less than $750,000 from an authorized insurer as defined under s. 624.09, F. S., from a surplus lines insurer as defined under s. 626.914(2), F. S., from a risk retention group as defined under s. 627.942, F. S., from the Joint Underwriting Association established under s. 627.351(4), F. S., or through a plan of self-insurance as provided in s. 627.357, F. S.

☐5. I have elected not to carry medical malpractice insurance however, I agree to satisfy any adverse judgments up to the minimum amounts pursuant to s. 458.320(5)(g)1, F. S. I understand that I must either post notice in a sign prominently displayed in my reception area or provide a written statement to any person to whom medical services are being provided that I have decided not to carry medical malpractice insurance. I understand that such a sign or notice must contain the wording specified in s. 458.320(5)(g), F. S.

Category II: Financial Responsibility Exemptions

☐6. I practice medicine exclusively as an officer, employee, or agent of the federal government, the state, or its agencies or subdivisions.

☐7. I hold a limited license issued pursuant to s. 458.317, F. S., and practice only under the scope of the limited license.

☒8. I do not practice medicine in the State of Florida.

☐9. I meet all of the following criteria:

(a) I have held an active license to practice in this state or another state or some combination thereof for more than 15 years;

(b) I am retired or maintain part time practice of no more than 1000 patient contact hours per year;

(c) I have had no more than two claims resulting in an indemnity exceeding $25,000 within the previous five-year period;

(d) I have not been convicted of or pled guilty or nolo contendere to any criminal violation specified in Chapter 458, F. S. or the medical practice act in any other state; and

(e) I have not been subject, within the past ten years of practice, to license revocation, suspension, or probation for a period of three years or longer, or a fine of $500 or more for a violation of Chapter 458, F. S., or the medical practice act of another jurisdiction. A regulatory agency's acceptance of a relinquishment of license, stipulation, consent order, or other settlement offered in response to or in anticipation of filing of administrative charges against a license is construed as action against a license. I understand if I am claiming an exception under this section that I must either post notice in a sign prominently displayed in my reception area or provide a written statement to any person to whom medical services are being provided that I have decided not to carry medical malpractice insurance. See Section 458.320(5)(f), Florida Statutes, for specific notice requirements.

☐10. I practice only in conjunction with my teaching duties at an accredited medical school or its teaching hospitals. (Interns and residents do not qualify for this exemption).

If you select an exemption based on number 9, you must also complete the affidavit on the following page.

12. STATEMENT OF APPLICANT

I state that these statements are true and correct. I recognize that providing false information may result in denial of licensure, disciplinary action against my license, or criminal penalties pursuant to Sections 456.067, 775.083, and 775.084, Florida Statutes. I state that I have read Chapters 456, 458 and 766.301-.316, Florida Statutes and Chapter 64B8, Florida Administrative Code.

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Florida Board of Medicine information which is material to my application for licensure.

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ashraf kamal abdelhemid
Print name

Ashraf Abdelhemid **10/11/2019**
Signature Date

EXHIBIT 1 – REPORT ON PROFESSIONAL LIABILITY CLAIMS AND ACTIONS N/A

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Date of occurrence: / /____ Date reported to licensee: / /____ Date claim reported to insurer or self-insurer / /_____

Injured person's name: (last, first, middle initial)_____

Street Address:_____

City:_____ State:_____ Zip Code: _____
Age:_____ Sex: _____

Date of suit, if filed: / /____

List all defendants with their health care provider license number involved in this claim:
1._____ 2._____
3._____ 4._____

Date of final claim disposition:_____/_____/_____

Date and amount of judgment or settlement, if any: _____

Was there an itemized verdict? [ ] Yes [ ] No (If "YES", attach copy of settlement verdict)

Indemnity paid on behalf of this defendant: $_____
Loss adjustment expense paid to defense counsel: $_____
All other loss adjustment expense paid: $_____

The date and reason for final disposition, if no judgment or settlement: _____

Name of institution at which the injury occurred: _____

Location of injury occurrence:

[ ] Patient's Room [ ] Physical Therapy Dept. [ ] Radiology [ ] Labor & Delivery Room
[ ] Operating Suite [ ] Nursery [ ] Emergency Room
[ ] Recovery Room [ ] Critical Care Unit [ ] Other [ ] Special Procedure Room

Final diagnosis for which treatment was sought or rendered: _____
_____

Describe misdiagnosis made, if any, of the patient's actual condition. _____
_____

Describe the operation, diagnostic, or treatment procedure causing the injury. Use nomenclature and/or descriptions of the procedures used. Include method of anesthesia, or name of drug used for treatment, with detail of administration. _____
_____

Describe the principal injury giving rise to the claim. Use nomenclature and/or descriptions of the injury. Include type of adverse effect from drugs where applicable. _____
_____

Safety management steps taken by the licensee to make similar occurrences less likely: _____
_____

I represent that these statements are true and correct pursuant to s. 837.06, Florida Statutes. I recognize that providing any false statements made in writing with the intent to mislead the Department staff in the performance of their official duties, shall be punishable as provided in s. 775.082 and 775.083, Florida Statutes.

Signature of physician: _____

as they participate in the care of children with common acute or chronic medical problems, as well as rare or multisystem disorders. A full range of didactic conferences in both ambulatory and inpatient settings supplements interactive teaching rounds at the bedside. Trainees develop skills in medical problem solving, technical procedures, communication of medical information, critical appraisal of the medical literature, and teaching students and peers. The spirit of inquiry receives further support through active research. In addition, as part of a multidisciplinary health-care system, trainees become adept in their professional role as advocates for the health and welfare of children and their families.

The Pediatrics Residency Program consists of 36 months divided into 18 months floor activities, 6 months NICU , 3 months Intermediates Care , 3 months Gastroenterology and dehydrations unit and 6 month in Pediatrics Emergency unit. By the completion of the three-year residency program, residents are expected to have a thorough understanding of the normal and pathological states of infancy, childhood, and adolescence; and to have developed a sensitivity for the psychological and social needs of patients and their families. Graduates are fully prepared to enter either community-based practice.

Mar, 1999: Workshop on the neonatal care that held in Cairo and organized by JSI project /Egypt in collaborations with George Washington University.

April, 2000: workshop for training of trainer for Neonatal department, Cairo University organized JSI/EGYPT in collaborations with George Washington University.

April, 2001 : Assistant lecturer in Pediatric Department, Elkasar Elanni School of Medicine, Cairo University, Egypt **(Attending Physician).**

The job descriptions of the Clinical Instructor in Elkasar Elanni School of Medicine includes demonstrations and teaching clinical symptoms and signs to fifth grade medical student, teaching the fifth grade medical student pediatrics curriculum, attending the general and special Pediatrics outpatient clinics and decisions making with the residents.

April, 2001- May,2004 : Pediatrics Hematology subspecialty, Pediatric Hematology Clinic, Cairo University is one of the largest Hematology clinic in the middle east, more than 5000 patients attend to the clinic, the clinic hold 5 days a week ,two days for new cases ,two days for chronic hemolytic anemia ,one day for bleeding tendency and every Thursday for blood transfusions.

May,2002-Nov,2002: Rotation in Pediatric Intensive Care Unit (PICU) where care was giving to critical ill pediatric patient mainly with type I or type II Respiratory failure or multisystem organ failures.

.

May ,2004 -Oct , 2009 : registrar of neonatology in New Dar Elshifa Hospital , Kuwait.

New Dar Elshifa Hospital one of the biggest private hospital in Kuwait, we have 500 deliveries monthly and running NICU with 8 conventional ventilator , two high frequency ventilator SLE 6000 and one nitric oxide ventilator.

New Dar alshifa one of biggest hospital in Kuwait with average 450-500 deliveries per month ,and 60 to 80 NICU admission .NDASH is Canadian accredited hospital.

I got experience on all neonatal procedures and maneuvers including resuscitations of extreme low birth weight babies 24- 25 weeks of life with weight of 600 gram.

MAY, 2006 : Neonatal Resuscitation Program.

Register in American academy of pediatrics/American heart association as neonatal resuscitator.

May,2009 : observer ship of neonatology

Regional Neonatal Intensive Care
Sparrow Hospital,, Lansing, Michigan
Division of Neonatology
Michigan State University, East Lansing, MI 48823

Oct ,2009- Jan, 2011: Senior registrar of neonatology ,
New Dar Elshifa Hospital , Kuwait.

Jan, 2011- Feb , 2015: Neonatal specialist , New Dar Elshifa Hospital , Kuwait.

Mar, 2015 – Jul., 2019 : Pediatric consultant , New Dar Elshifa Hospital , Kuwait.

Researches Experience

May,2003: Measurement of podocyte antigen in urine using DNA probing for early detection of microalbuminuria in type I DM.
Under supervision of Dr David Kurnt Prof. of Pediatric genetic University of Michigan , Ann Arbor ,Michigan USA

Oral presentations:

- **18th Annual Congress Meeting of the European Society of Pediatrics Hematology and Immunology,** June 17th 2001,KKL Lucerne/Switzerland. Soluble transferrin receptors and its index in Hematological populations.

- **Master degree thesis**

New Children University Hospital, Cairo University, Nov. 10 th, 1999: Measurement of beta-glucocerebrosidase and chitotriosidase activity in lipid storage diseases.

- **PH. D. Thesis**

- **N .Mustafa, L.Ragab, L.Fateh and A.abdelhemid** (Gaucher disease, correlations between beta-glucocerebrocidase ,chitotrichidase and severity score Index).

The Gazette of the Egyptians Pediatrics associations, jan.2000, Vol.48,73-89.

- **L.Ragab, A.Elbashlawy and A.Abdelhemid** (soluble transferrin receptors, serum ferritin and sTFR/sF Index in hematological populations).

Pediatric research, June 2001.

LICENSURE

March 1997: Unrestricted license to practice medicine in Egypt.
2004: Unrestricted license to practice medicine in kuwait
2013: United State Medical License Exam Step II (USMLE).
2013 : BLS , ALS and PALS

OTHER ACCOMPLISHMENTS

1991-1995: Member of the Student Union, Cairo University, Egypt.
1995-2001: Member of the American Studies Library, Cairo, Egypt.
1997 till now: Member of the Egyptian Medical Syndicate.

Reference

SAID OMAR, MD, FAAP

Professor and Director
Regional Neonatal Intensive Care
Sparrow Hospital,, Lansing, Michigan
Division of Neonatology
Department of Pediatrics and Human Development
College of Human Medicine
Michigan State University, East Lansing, MI 48823
Telephone 517-364-2670
Fax 517-364-3994
e-mail: omar@msu.edu
said.omar@ht.msu.edu

L.Ragab. M.D. , Professor of Pediatric Hematology, Elkasar Elanni School of Medicine, Cairo University.

Office:23 Talat Harb st., Cairo , Egypt Tel:202 392 0774
(KIDS HOSPITAL),23rd Elphorate st., Mohandsin, Cairo
Tel:202 336 3917 Email: Lragab@yahoo.com

Ibrahim ouidat,M.D. , Consultant of Neonatology ,French board of Neonatology .

NEW DAR ELSHIFA HOSPITAL

Tel : 965 6038582

iouiadat@hotmail.com

Ayaz ahmed sheth , specialist of neonatology

MRCPCH

Email: ayazsheth@yahoo.com

Memorandum

Date: 18 Feb 2019

To: Florida Board of Medicine

From: Gerald Pleasents

Subject: Recommedation Letter

It is my privilege as an US Army Contractor Representative in State of Kuwait, to write an individual recommedation letter for Dr. Ashraf Kamal Abdelhemid, as a Senior Pediatric Consultant in Kuwait. We found Dr. Abdelhemid to be very hard working and conscientious individual. He took very good care of our children who were assigned to him, and he made sure that all the work up was done perfectly, where he actively participated.

Dr. Abdelhemid has excellent clinical skills and displays them with mature mannerisms. Dr. Abdelhemid has provided medical services for the American Community in Kuwait over the last decade sincerely and thoroughly. Dr. Abdelhemid works in a Canadian Diamond Accrediated Hospital, Dar Al Shifa affiliated with the US Army in Kuwait. Dar Al Shifa provides excellent care for their patients over the last 20 years.

Dr. Abdelhemid is very humble and gets along with his community in Kuwait. It is therefore without reservations that I, Gerald Pleasents, a US Army Contractor Respresentative, recommends Dr. Abdelhemid in this application for a Medical License in Florida that if he should seek it. We are sure that Dr. Abdelhemid will be valuable to the Florida Citizens and future pediatric patients. Please do not hesitate to contact me for further information.

Sincerely yours,

Gerald Pleasents
LOC Manager
URS Incorp.
Camp Arifjan, Kuwait
Cell: +965-9407-4611
Email: gerald.pleasents@aecom.com

October 23, 2019

Ashraf Kamal Abdelhemid , M.D.
7940 Frant Beach Rd
Apt#2006
Panama City Beach, FL 32407

Dear Dr. Abdelhemid:
File: 145551

Thank you for considering Florida for physician licensure. Your application for medical licensure has been received. The application is incomplete for the reasons set out in the attached deficiency notice. Please address these deficiencies as soon as possible to avoid delay in processing your application.

Information received by this office may require additional explanation or documentation to determine licensure eligibility. After all requested documentation is received, your application will be submitted for supervisory review. We will notify you if additional information is required.

Applicants with a history of malpractice, criminal activity, discipline, physical or mental impairment, unfavorable evaluations, or other matters that need explanation may require a personal appearance before the Board of Medicine Credentials Committee for determination of licensure eligibility. If your appearance is required, you will be notified in writing once your application is complete.

You can now follow the progress of your application through our website at: www.FLHealthSource.gov/mqa-services. If you are a returning user, select "Yes" and enter the user ID and password you selected during the registration process under Returning User. If you did not apply for licensure through this screen, select "No" and follow the prompts to create an account. You must have a valid email address to create your account.

Once you are logged in, you will be prompted to add your application to your account. Once you have successfully added your application, you will be directed to your dashboard. Under the "Additional Activities" section, select "Check Application Status" to review any open deficiencies, upload documents or print out instructional documents.

THIS IS IMPORTANT: Your application will remain incomplete until all deficiencies are completed. In addition, you are required to notify the Board office immediately in writing of any occurrence(s) that would in any way change or affect any answer given in the application or an answer provided in response to any of our direct questions to you.

If you have any questions, please contact me at Hazel.Myles@flhealth.gov, call (850) 617-1915, or fax (850) 412-1277.

Sincerely,

Hazel Myles
Regulatory Specialist II

Enclosure(s)

Ashraf Kamal Abdelhemid, M.D. **Date: October 23, 2019**

REMINDER: Chapter 456.013(1)(a), Florida Statutes, provides that an incomplete application shall expire one year after initial filing with the department.

YOUR APPLICATION'S EXPIRATION DATE IS October 17, 2020.

APPLICATION SUBMITTED REMAINS DEFICIENT FOR LACK OF THE FOLLOWING:

Official verification of your medical licenses from the medical boards of **Kuwait and Egypt** have not been received. You will need to contact them and request that they send verification of your license directly to the Florida Board of Medicine. Please be advised that Florida requires primary source verification, therefore, the verification will not be accepted if it's not submitted by the entity. Also, verification is required of all licenses regardless of the status.

Please submit the National Practitioner Data Bank (NPDB) report to our office. You may contact the NPDB at 1-800-767-6732 to obtain this information.

If you have any questions, please contact me at Hazel.Myles@flhealth.gov , call (850) 617-1915, or fax (850) 412-1277. The Florida Board of Medicine has assigned **145551** as your **tracking number**. Please indicate this number if you leave a message, and try to ensure that other sources include it on their communications to us as well.

Myles, Hazel

From: Myles, Hazel
Sent: Wednesday, October 30, 2019 2:23 PM
To: Allen Grossman
Cc: ashraf abdelhemid
Subject: RE: Deficiencies for Dr. Abdelhemid

Good afternoon and thank you for your email.

Per Wendy if the license verifications over 6 months since our office have received them. We will need an updated verification.

If I could be of any assistance, or if you should have any questions please feel free to call or respond to this email.

Thanks

Hazel Myles
Regulatory Specialist II
MQA Board Medicine
Phone:(850)617-1915
Fax:(850)412-1277
Email:Hazel.Myles@flhealth.gov

New Website: www.flboardofmedicine.gov
Twitter: www.twitter.com/FLBoardofMed

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Sent: Wednesday, October 30, 2019 1:03 PM
To: Myles, Hazel <Hazel.Myles@flhealth.gov>
Cc: ashraf abdelhemid <ashrafkamal1972@yahoo.com>
Subject: Deficiencies for Dr. Abdelhemid

Hazel,

We will get a new NPDB self-inquiry report. Verifications of licensure from Egypt and Kuwait were sent to the Board for Dr. Abdelhemid's previous application. They are a pain to get, so hopefully you can still use them.

Please confirm. Thank you.

Allen R. Grossman
Grossman Furlow and Bayo, LLC
2022 Raymond Diehl Road, Suite 2
Tallahassee, Florida 32308
(850) 385-1314
(850) 385-4240 (fax)

Sent from my cell phone

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Myles, Hazel

From: Myles, Hazel
Sent: Wednesday, October 30, 2019 2:26 PM
To: 'ashraf abdelhemid'; Allen Grossman
Subject: RE: Deficiencies for Dr. Abdelhemid

Thank you.

If I could be of any assistance, or if you should have any questions please feel free to call or respond to this email.

Thanks

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MQA Board Medicine
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New Website: www.flboardofmedicine.gov
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To: Myles, Hazel <Hazel.Myles@flhealth.gov>; Allen Grossman <a.grossman@gfblawfirm.com>
Subject: Re: Deficiencies for Dr. Abdelhemid

good afternoon

attached the NPDB i just received as PDF
thanks

Abdelhemid , Ashraf MD

On Wednesday, October 30, 2019, 01:02:42 PM EDT, Allen Grossman <a.grossman@gfblawfirm.com> wrote:

Hazel,

We will get a new NPDB self-inquiry report. Verifications of licensure from Egypt and Kuwait were sent to the Board for Dr. Abdelhemid's previous application. They are a pain to get, so hopefully you can still use them.

Please confirm. Thank you.

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Myles, Hazel

From: Myles, Hazel
Sent: Thursday, October 31, 2019 9:42 AM
To: ashraf abdelhemid
Subject: RE: Deficiencies for Dr. Abdelhemid

4052 Bald Cypress Way
Bin# C03
Tallahassee, FL 32399

If I could be of any assistance, or if you should have any questions please feel free to call or respond to this email.

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From: ashraf abdelhemid <ashrafkamal1972@yahoo.com>
Sent: Wednesday, October 30, 2019 7:08 PM
To: Myles, Hazel <Hazel.Myles@flhealth.gov>
Subject: Re: Deficiencies for Dr. Abdelhemid

Good morning
Can you give the mail address so the medical license authorities in KUWAIT and Egypt can send the copies of the license.
Thanks

Dr Ashraf K abdelhemid, M.D.

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Thank you.

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Myles, Hazel

From: ashraf abdelhemid <ashrafkamal1972@yahoo.com>
Sent: Thursday, October 31, 2019 3:52 AM
To: secretary@kma.org.kw; kma@kma.org.kw
Cc: Myles, Hazel
Subject: Dr Ashraf Kamal Abdelhemid . KMA good standing letter (Florida Board of Medicine Assign Number 145551)
Attachments: 12885.pdf

Dear Ms Salma,
Kuwait Medical Association medical secretary

as per my phone call today , requesting new good standing certificate , part of requirement need by Florida department of health.
The old certificate had more than one year , issued in Aug 1st and need , need to be renewed.
please send the new one by email to

Hazel Myles
Regulatory Specialist II
MQA Board Medicine
Florida Department of Health
email : hazel.myles@flhealth.gov

and keep my in the loop , CC me copy of the certificate

appreciate your help

N.B. attached to email the old certificate sent last year to Florida department of health

Abdelhemid , Ashraf MD

On Wednesday, August 1, 2018, 04:39:10 AM EDT, <secretary@kma.org.kw> wrote:

Dear Lamya . Mollay
Florida Department of Health
Division of Medical Quality Assurance* Bureau of HCPR
In Response to your email and Dr/ Ashraf Kamal Abdelhemid Request.We submitted good standing letter from Kuwait Medical Association , As attached file

Thanks Kuwait Medical Association

Myles, Hazel

From: Myles, Hazel
Sent: Tuesday, November 5, 2019 9:02 AM
To: ashraf abdelhemid
Cc: Allen Grossman
Subject: RE: Rapid response from KMA (KUWAIT MEDICAL ASSOCIATION) # 145551

Hello

I have received the Kuwait License verification and updated your application.

If I could be of any assistance, or if you should have any questions please feel free to call or respond to this email.

Thanks

Hazel Myles
Regulatory Specialist II
MQA Board Medicine
Phone:(850)617-1915
Fax:(850)412-1277
Email:Hazel.Myles@flhealth.gov

New Website: www.flboardofmedicine.gov
Twitter: www.twitter.com/FLBoardofMed

Attention Health Care Practitioners: There have been changes to the license renewal process. To learn more about CE/CME@Renewal visit www.flhealthsource.com. For questions, contact the Florida Department of Health toll-free at (855) 410-3344 or email us at MQAReportCE@flhealth.gov.

Mission: To protect, promote and improve the health of all people in Florida through integrated state, county, and community efforts.

Vision: To be the **Healthiest State** in the Nation.
Purpose: To protect the public through health care licensure, enforcement and information.
Focus: To be the nation's leader in quality health care regulation.
Values: I.C.A.R.E. (Innovation, Collaboration, Accountability, Responsiveness, Excellence)

Please Note: Florida has a very broad public records law. Most written communications to or from state officials regarding state business are public records available to the public and media upon request. Your e-mail communications may therefore be subject to public disclosure.

From: ashraf abdelhemid <ashrafkamal1972@yahoo.com>
Sent: Tuesday, November 5, 2019 6:09 AM
To: Myles, Hazel <Hazel.Myles@flhealth.gov>
Cc: Allen Grossman <a.grossman@gfblawfirm.com>
Subject: Rapid response from KMA (KUWAIT MEDICAL ASSOCIATION)

Dear Ms Hazel,

Good morning , we get rapid response from Kuwait medical association , they sent email today under name of Dr . ashraf contain the good standing letter. date of issue Nov 5th , 2019.
this letter similar to which they submitted by KMA On Wednesday, August 1, 2018, received by Ms Lamya . Mollay.

Regarding to NPDB soft copy sent to you. and the sealed letter will be available with Mr grossman this week.

Regarding to Egyptian medical licence document , i requested from the authorities in Egypt to sent direct to Florida board of medicine under the address you provided to me , i hope rapid response from them, i will fellow with them and doing my best.

finally, Mr Grossman , we need to request the board of medicine in Florida , like other medical board authorities in usa and all over the world to accept verification of 3rd party, ecfmgepic.org .

ecfmgepic can do all this work and verification , and accepted allover the world and in usa.

FYI if i want to apply to job in UK/ IRELAND ONCE i had epic portfolio i can submit my document in easy way.

Ms Hazel, thanks for your patient and care , it is very hard to do all process again after i moved to NYC

best wishes

Abdelhemid , Ashraf MD

Myles, Hazel

From: secretary <secretary@kma.org.kw>
Sent: Tuesday, November 5, 2019 3:51 AM
To: Myles, Hazel
Cc: ashraf abdelhemid
Subject: dr. ashraf
Attachments: dr. ashraf.pdf

Follow Up Flag: Follow up
Flag Status: Flagged

Myles, Hazel

From: Myles, Hazel
Sent: Tuesday, November 5, 2019 9:02 AM
To: ashraf abdelhemid
Cc: Allen Grossman
Subject: RE: Rapid response from KMA (KUWAIT MEDICAL ASSOCIATION) # 145551

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Sent: Tuesday, November 5, 2019 6:09 AM
To: Myles, Hazel <Hazel.Myles@flhealth.gov>
Cc: Allen Grossman <a.grossman@gfblawfirm.com>
Subject: Rapid response from KMA (KUWAIT MEDICAL ASSOCIATION)

Dear Ms Hazel,

Chair
Zachariah Zachariah, M.D.
Ft. Lauderdale, Florida

Members
Hector Vila, M.D.
Tampa, Florida
Vice-Chair

Luz Marina Pages, M.D.
Miami Beach, Florida

Scot N. Ackerman, M.D.
Jacksonville, Florida

Eleonor Pimentel, M.D.
Miami, Florida

David A. Diamond, M.D.
Winter Park, Florida

Vacant, Consumer Member

Robert London, M.D.
Maitland, Florida

Jorge J. Lopez, M.D.
Maitland, Florida

Andre M. Perez
Miami, Florida

Kevin Cairns, M.D.
Fort Lauderdale, Florida

Nicholas W. Romanello, Esq.
Melbourne, Florida

Sarvam TerKonda, M.D.
Jacksonville, Florida

Shailesh Gupta, M.D.
Coral Springs, Florida

Vacant, M.D.

Executive Director
Claudia Kemp, J.D.

September 9, 2020

Vinayak Bapat, MD
2900 Thomas Avenue South
Apt 2429
Minneapolis, MN 55416

Dear Dr. Bapat:

This is in further reference to your certification for approval of licensure with conditions.

Please be advised that your Notice of Intent to Approve Licensure with Conditions will be presented as an individual item to the Credentials Committee of the Board of Medicine to discuss:

- **Request for reconsideration**

The Committee may inquire into any other issues relating to your application and eligibility for licensure. Your appearance is not required but if you choose to appear the date, time and location of the meeting are listed below.

Date:	Thursday, October 1, 2020
Time:	8:00 a.m. (Meeting starts at 8:00 a.m. Interview time may vary.)
Location:	The in-person meeting scheduled in Orlando, Florida is cancelled, and the meeting will be held by a web-based meeting platform or, if appropriate, a teleconference call.

The meeting information and directions for participating in the October 2020 meeting will be posted on the Florida Board of Medicine's website: https://flboardofmedicine.gov/meeting-information.

Additionally, the Committee's recommendation on your application for licensure will be presented to the full Board of Medicine on Friday, October 2, 2020 for final action. You are not required to attend the full board meeting.

Thank you for your continued cooperation. Should you have any questions regarding this matter, please feel free to contact me.

Sincerely,

Wendy Alls

Wendy Alls
Program Operations Administrator

Pursuant to the provisions of the Americans with Disabilities Act, any person requiring special accommodations to participate in this workshop/meeting is asked to advise the agency at least 10 days before the workshop/meeting by contacting: Rebecca.Hewett@flhealth.gov or call (850) 245-4137.

1501-141890 CK

FILED
DEPARTMENT OF HEALTH
DEPUTY CLERK
CLERK: *Amanda Morales*
DATE: OCT 2 1 2019

STATE OF FLORIDA
BOARD OF MEDICINE

IN RE: THE APPLICATION FOR
LICENSURE OF

VINAYAK N. BAPAT, M.D.
_____/

NOTICE OF INTENT TO APPROVE LICENSURE WITH CONDITIONS

This matter came before the Credentials Committee of the Florida Board of Medicine at a duly-noticed public meeting on October 3, 2019, in Tampa, Florida, and the full Board of Medicine on October 4, 2019, in Tampa, Florida. The Applicant, Vinayak N. Bapat, M.D., was present at the Credentials Committee meeting.

The application file demonstrates that Dr. Bapat has not submitted evidence of meeting the training requirement of Section 458.313(1)(a), and Section 458.311(1)(f)3.c., Florida Statutes, which requires him to have completed an approved residency or fellowship of at least two years in one specialty area and that to be acceptable, it must be counted toward regular or subspecialty certification by a board recognized and certified by the American Board of Specialties. Further, the application file demonstrates that Dr. Bapat does not meet the examination requirement of Section 458.313(1)(b), Florida Statutes, and that he does not hold an active, valid certificate from the Education Commission for Foreign Medical Graduates (ECFMG) as required by Sections 458.313(1)(a) and 458.311(1)(f)3.b., Florida Statutes.

The application file reveals, however, that Dr. Bapat has met the criteria for competence by other means. In 1993, Dr. Bapat received a medical degree from Seth GS Medical College, Mumbai, India. From March 1992 to July 1998, Dr. Bapat completed residency training in Surgery and in Cardiothoracic Surgery at King Edward Memorial Hospital and University of

Mumbai, India. From January through December 1999, Dr. Bapat completed fellowship training in Cardiovascular Surgery at the University of Toronto, Canada, and from February 2000 through August 2007, he completed a residency and fellowship in Cardiothoracic Surgery in the United Kingdom. From October 2007 to October 2017, Dr. Bapat practiced medicine in London, United Kingdom. Since September 2015 he has held an academic appointment as Professor of Cardiothoracic Surgery at the Guys and St. Thomas' Hospital & Kings College, London, and since May 2017, he has held an academic appointment as Assistant Professor of Cardiothoracic Surgery at Columbia University Medical Center in New York. Dr. Bapat holds licenses to practice medicine in New York, United Kingdom, and India. In addition, Dr. Bapat has given numerous lectures both nationally and internationally and has published extensively in his area of practice.

Section 458.313(7), Florida Statutes, allows the Board to enter an order certifying an applicant for licensure with restrictions when the Board determines that an applicant for licensure by endorsement has failed to meet each of the appropriate licensing requirements.

It is therefore **ORDERED** that the application for licensure be **approved under the following condition:**

Dr. Bapat shall work for six (6) months under the indirect supervision of a Board-approved Florida-licensed allopathic physician who is certified by the American Board of Thoracic Surgery. The terms of indirect supervision are set forth in Rule 64B8-4.025, Florida Administrative Code.

This Order does not constitute disciplinary action against the license that has been approved herein. The terms of this Order are considered conditions for licensure.

This Order shall become effective upon filing with the Clerk of the Department of Health.

DONE AND ORDERED this 17th day of October, 2019.

BOARD OF MEDICINE

Claudia Kemp, J.D., Executive Director
For Steven Rosenberg, M.D., Chair

NOTICE OF RIGHT TO HEARING

This notice constitutes final agency action if no request for a hearing is received by the Board on or before the twenty-first day after the applicant's receipt of the notice. The applicant may request a hearing by filing an appropriate petition with the Executive Director of the Board at 4052 Bald Cypress Way, Bin #C-03, Tallahassee, Florida 32399-3253. The applicant may petition for a hearing involving disputed issues of material fact before an administrative law judge pursuant to Section 120.57 (1), Florida Statutes, or for a hearing not involving disputed issues of material fact pursuant to Section 120.57 (2), Florida Statutes.

A petition for a hearing involving disputed issues of material fact must contain information required by Rule 28-106.201, Florida Administrative Code, ***including a statement of all disputed issues of material fact.*** The Board may refer a petition to the Division of Administrative Hearings for assignment of an administrative law judge only if the petition is in substantial compliance with the rule requirements. A petition for a proceeding not involving disputed issues of material fact must contain information required by Rule 28.106.301, Florida Administrative Code, including a concise statement of the ultimate facts alleged, as well as the rules and statutes which entitle petitioner to relief.

In accordance with Section 120.573, Florida Statutes, mediation is not available.

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing has been furnished by **Certified Mail** to **Vinayak N. Bapat, M.D.,** 60 West 66th Street, Apt. 26A, New York, NY 10023; and by email to **Donna McNulty**, Special Counsel, at Donna.McNulty@myfloridalegal.com, this 21st day of Oct., 2019.

Certified Article Number
9414 7266 9904 2140 1221 11
SENDER'S RECORD

Vinayak N. Bapat, M.D.
60 West 66th Street
Apt. 26A
New York, NY 10023

Deputy Agency Clerk

Tab 2 - William George Martin, MD – Endorsement
Issue(s):

- Action by Michigan Medical Board
- Action by Pennsylvania Medical Board
- Action by South Carolina Medical Board
- Action by Ohio Medical Board
- Staff Privileges
- Criminal History
- Health History

Represented by Allen Grossman, Esquire.

The applicant was present and sworn in by the court reporter. After discussion, a motion was made to approve the application for licensure. The motion was seconded, which carried 5/0.

Action Taken: The Committee voted to approve the application for licensure.

Tab 3 - Luis A. Roman Marrero, MD – Endorsement
Issue(s): Failure to meet Section 458.313(1)(b), F.S., Examination

The applicant was present and sworn in by the court reporter. After discussion, a motion was made to approve the application for licensure with the condition that Dr. Roman Marrero successfully pass the Special Purpose Examination (SPEX) or certification examination in internal medicine within twelve (12) months and the license will issue. The motion was seconded, which carried 5/0.

Action Taken: The Committee voted to approve the application for licensure with the condition that Dr. Roman Marrero successfully pass the Special Purpose Examination (SPEX) or certification examination in internal medicine within twelve (12) months and the license will issue.

Tab 4 - Su Zhan, MD – Endorsement
Issue(s): Action by New York State Board of Medicine

The applicant was present and sworn in by the court reporter. After discussion, a motion was made to approve the application for licensure. The motion was seconded, which carried 5/0.

Action Taken: The Committee voted to approve the application for licensure.

Tab 5 - Vinayak N. Bapat, MD – Endorsement
Issue(s):

- Failure to meet Sections 458.313(1)(a) and 458.311(1)(f) 3.b., F.S., ECFMG Certification
- Failure to meet Sections 458.313(1)(a) and 458.311(1)(f) 3.c., F.S., Postgraduate Training
- Failure to meet Section 458.313(1)(b), F.S., Examination

The applicant was present and sworn in by the court reporter. After discussion, a motion was made to approve the application for licensure with the condition of indirect supervision for six (6) months by a Florida licensed physician who is certified by the American Board of Thoracic Surgery. The terms of indirect supervision are set forth in Rule 64B8-4.025, Florida Administrative Code. The motion was seconded, which carried 5/0.

Action Taken: The Committee voted to approve the application for licensure with the condition of indirect supervision for six (6) months by a Florida licensed physician who is certified by the American Board of Thoracic Surgery.

FLORIDA | Board *of* Medicine

Ron DeSantis
Governor

Scott A. Rivkees, MD
State Surgeon General

Chair
Steven Rosenberg, M.D.
Palm Beach, Florida

Members
Hector Vila, M.D.
Tampa, Florida
Vice Chair

Scot N. Ackerman, M.D.
Jacksonville, Florida

Magdalena Averhoff, M.D.
Miami, Florida

David A. Diamond, M.D.
Winter Park, Florida

Brigitte Goersch
Satellite Beach, Florida

Robert London, M.D.
Maitland, Florida

Jorge J. Lopez, M.D.
Maitland, Florida

Andre M. Perez
Miami, Florida

Kevin Cairns, M.D.
Fort Lauderdale, Florida

Nicholas W. Romanello, Esq.
Melbourne, Florida

Sarvam TerKonda, M.D.
Jacksonville, Florida

Zachariah Zachariah, M.D.
Ft. Lauderdale, Florida

Shailesh Gupta, M.D.
Coral Springs, Florida

Vacant, M.D.

Executive Director
Claudia Kemp, J.D.

August 27, 2019

Vinayak N. Bapat, M.D.
60 West 66th Street
Apt 26A
New York NY 10023

Dear Dr. Bapat:

This is in further reference to your application for licensure by Endorsement.

Please be advised that you are required to make a personal appearance before the Credentials Committee of the Board of Medicine to discuss:

- **Failure to meet Sections 458.313(1)(a) and 458.311(1)(f) 3.b., F.S., ECFMG Certification**
- **Failure to meet Sections 458.313(1)(a) and 458.311(1)(f) 3.c., F.S., Postgraduate Training**
- **Failure to meet Section 458.313(1)(b), F.S., Examination**

In addition, the Committee may inquire into any other issues relating to your application and eligibility for licensure.

Date:	Thursday, October 3, 2019
Time:	8:00 a.m.
Location:	Florida Board of Medicine/Credentials Committee Meeting Embassy Suites by Hilton Tampa USF Near Busch Gardens 3705 Spectrum Boulevard Tampa, Florida 33612 (813) 977-7066

The meeting room will be posted in the lobby of the hotel. Subject to availability, a block of rooms is available for the public attending the Department of Health – Florida Board of Medicine's meeting.

Additionally, the Committee's recommendation on your application for licensure will be presented to the full Board of Medicine on Friday, October 4, 2019 for final action. You are not required to attend the full board meeting.

Thank you for your continued cooperation. Should you have any questions regarding this matter, please feel free to contact me. This is your first scheduled appearance.

Sincerely,

Wendy Alls

Wendy Alls
Program Operations Administrator

Pursuant to the provisions of the Americans with Disabilities Act, any person requiring special accommodations to participate in this workshop/meeting is asked to advise the agency at least 10 days before the workshop/meeting by contacting: Rebecca.Hewett@flhealth.gov or call (850) 245-4137.

*** 456.013(3)(c) In considering applications for licensure, the board, or the department when there is no board, may require a personal appearance of the applicant. If the applicant is required to appear, the time period in which a licensure application must be granted or denied shall be tolled until such time as the applicant appears. However, if the applicant fails to appear before the board at either of the next two regularly scheduled board meetings or fails to appear before the department within 30 days if there is no board, the application for licensure shall be denied.**

4052 Bald Cypress Way, Bin C-03
Tallahassee, Florida 32399-3253
Phone: 850/245-4131
Fax: 850/488-0596 or 850/412-1268
https://www.FLBoardofMedicine.gov

Florida HEALTH

Application

Application Detail

License Type:	**Medical Doctor**
Profession Number:	**1501 - Medical Doctor**
File Number:	**141890**
Application:	**Medical Doctor Endorsement Application**
Application Date:	**02/04/2019**

Suitability Question(s)

Are you an osteopathic physician?	**No**

Application Questions

Military Veteran Fee Waiver - I have been honorably discharged from a branch of the United States Armed Forces within the previous 60 months.	**No**
I am selecting NICA Non-Participating - (I understand that a $250.00 fee will be included if I select this option.)	**Yes**
I will qualify for "In Training" status at the approval of my licensure application.	**No**
I plan to dispense medicinal drugs in the State of Florida for a fee or other remuneration and hereby register as required by Section 465.0276,F.S. I understand that the fee for the Dispensing Practitioner is $100.00 over and above the required initial license fee and will submit it along with the license fee.	**No**
I completed a board approved post-graduate training program within the last two years or have practiced medicine in another jurisdiction for two of the last four years.	**No**

School Name:	**OTHER**
Street Address Line 1:	**M.G. Road**
Street Address Line 2:	**Fort**
City:	**Mumbai**
State:	**N/A**
Postal/Zip:	**400032**
Country:	**INDIA**
Date of Graduation (mm/dd/yyyy):	**02/28/1992**
Attended From (mm/dd/yyyy):	**08/20/1986**
Attended To (mm/dd/yyyy):	**02/28/1992**

Education History 2

School Name:	**OTHER**
Street Address Line 1:	**M.G. Road**
Street Address Line 2:	**Fort**
City:	**Mumbai**
State:	**N/A**
Postal/Zip:	**400032**
Country:	**INDIA**
Date of Graduation (mm/dd/yyyy):	**06/30/1995**
Attended From (mm/dd/yyyy):	**03/01/1992**
Attended To (mm/dd/yyyy):	**06/30/1995**

Education History 3

School Name:	**OTHER**
Street Address Line 1:	**M.G. Road**
Street Address Line 2:	**Fort**
City:	**Mumbai**
State:	**N/A**
Postal/Zip:	**400032**
Country:	**INDIA**
Date of Graduation (mm/dd/yyyy):	**07/31/1998**

Attended From (mm/dd/yyyy):	**07/01/1995**
Attended To (mm/dd/yyyy):	**07/31/1998**

Education History 4

School Name:	**OTHER**
Street Address Line 1:	**Nicolson Street**
Street Address Line 2:	**N/A**
City:	**Edinborough**
State:	**N/A**
Postal/Zip:	**EH89DW**
Country:	**UNITED KINGDOM**
Date of Graduation (mm/dd/yyyy):	**10/31/2005**
Attended From (mm/dd/yyyy):	**02/01/2000**
Attended To (mm/dd/yyyy):	**10/31/2005**

Additional Education Questions

Are you currently in default on any health education loan or scholarship obligation?	**No**
Have you completed the equivalent of 2 academic years of preprofessional, postsecondary education including, courses in anatomy, biology, and chemistry prior to entering medical school?	**No**

Fifth Pathway

Did you attend an international medical school and do not possess a valid ECFMG Certificate?	**Yes**
Did you receive a bachelor's degree from an accredited United States college or University?	**No**
Did you study at a medical school which is recognized by the World Health Organization?	**Yes**
Did you complete all of the formal requirement of the International medical school, except the internship or social service requirements, and pass part I of the National board of Medical examination or the Education Commission for Foreign Medical Graduates Examination equivalent?	**Yes**

Did you complete an academic year of supervised clinical training in a hospital affiliated with a medical school approved by the Council on Medical Education of the American Medical Association and upon completion passed part II of the National Board of Medical Examiners examination or the Education Commission for Foreign Medical Graduates examination Equivalent?	**No**

Postgraduate Training 1

Program Name:	**King Edward Memorial Hospital - University of Mumbai**
Mailing Address:	**M.G. Road Fort**
Program City:	**Mumbai**
Program State or Country:	**INDIA**
Program Type:	**INTERNSHIP**
Specialty Area:	**GS - SURGERY**
Attended From (mm/dd/yyyy):	**02/01/1991**
Attended To (mm/dd/yyyy):	**02/28/1992**
Did you receive credit?	**Yes**

Postgraduate Training 2

Program Name:	**King Edward Memorial Hospital - University of Mumbai**
Mailing Address:	**M.G. Road Fort**
Program City:	**Mumbai**
Program State or Country:	**INDIA**
Program Type:	**RESIDENCY**
Specialty Area:	**GS - SURGERY**
Attended From (mm/dd/yyyy):	**03/01/1992**
Attended To (mm/dd/yyyy):	**06/30/1995**
Did you receive credit?	**Yes**

Postgraduate Training 3

Program Name:	**King Edward Memorial Hospital - University of Mumbai**
Mailing Address:	**M.G. Road Fort**

Program City:	**Mumbai**
Program State or Country:	**INDIA**
Program Type:	**RESIDENCY**
Specialty Area:	**CARDIAC SURGERY**
Attended From (mm/dd/yyyy):	**07/01/1995**
Attended To (mm/dd/yyyy):	**07/31/1998**
Did you receive credit?	**Yes**

Postgraduate Training 4

Program Name:	**Toronto General Hospital - University of Toronto**
Mailing Address:	**200 Elizabeth Street**
Program City:	**Toronto**
Program State or Country:	**CANADA**
Program Type:	**FELLOWSHIP**
Specialty Area:	**CARDIAC SURGERY**
Attended From (mm/dd/yyyy):	**01/01/1999**
Attended To (mm/dd/yyyy):	**12/31/1999**
Did you receive credit?	**Yes**

Postgraduate Training 5

Program Name:	**Southampton General Hospital**
Mailing Address:	**Tremona Road**
Program City:	**Southampton Hampshire**
Program State or Country:	**UNITED KINGDOM**
Program Type:	**FELLOWSHIP**
Specialty Area:	**CARDIAC SURGERY**
Attended From (mm/dd/yyyy):	**02/01/2000**
Attended To (mm/dd/yyyy):	**06/30/2007**
Did you receive credit?	**Yes**

Postgraduate Training 6

Program Name:	**Guys and St. Thomas' Hospital NHS Foundation Trust**
Mailing Address:	**157-169 Walworth Road**

Program City:	**London**
Program State or Country:	**UNITED KINGDOM**
Program Type:	**RESIDENCY**
Specialty Area:	**CARDIAC SURGERY**
Attended From (mm/dd/yyyy):	**07/01/2000**
Attended To (mm/dd/yyyy):	**08/30/2007**
Did you receive credit?	**Yes**

Exam History

Examination:	**FLEX/Foreign**
Date Passed (mm/dd/yyyy):	**N/A**

United States Military and/or Public Health

Have you ever been in the United States Military and/or Public Health Service?	**No**
Have you ever been disciplined by any branch of the United States Armed Services or Public Health Service?	**No**

Other State Licenses

Do you now hold or have you ever held a license to practice medicine or any other profession in any US State or territory, or foreign country?	**Yes**

Request verification of licensure status directly from the licensing entity or www.veridoc.org. Request international license verification(s) if you have practiced outside of the U.S. for at least two of the previous four years.

License Number:	**286960-1**
Profession:	**MD**
Jurisdiction - Country:	**UNITED STATES**
Jurisdiction - State:	**NEW YORK**

Additional Employment Questions

Have you practiced medicine in another jurisdiction for two of the last four years or completed a board approved post-graduate training program within the last two years?	**No**
Have you passed a board approved clinical competency exam within the last year?	**No**

Graduate Education

Do you currently, or have you had, responsibility for graduate medical education within the last 10 years?	**No**

Initial Graduate Medical Education Responsibility and Faculty Appointments

List all institutions where you have had responsibility for graduate medical education or faculty appointment(s) at any medical school.

Name of Institution: **NEW YORK PRESBYTERIAN HOSPITAL**

Staff Privileges

Do you currently hold staff privileges in any hospital, health institution, clinic or medical facility? **Yes**

The facilities listed are Florida facilities. If your privileges are for a facility in another state, select "Out of State".

Name of Facility: **OUT OF STATE**

Out of State Facility: **New York Presbyterian Hospital**

Specialty Board Certifications

Are you certified by any specialty board recognized by the American Board of Medical Specialties or specialty board approved by the Florida Board of Medicine? **No**

DEA

Have you ever been denied, or surrendered, a DEA registration? **No**

Criminal History

Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to, a crime in any jurisdiction other than a minor traffic offense? **No**

You must include all misdemeanors and felonies, even if adjudication was withheld. Driving under the influence (DUI) or driving while impaired (DWI) are not minor traffic offenses for purposes of this question.

Medicaid / Medicare

1. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, F.S. (relating to social and economic assistance), Chapter 817, F.S. (relating to fraudulent practices), Chapter 893, F.S. (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction? **No**

2. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970 (relating to controlled substances) or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)? **No**

3. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, F.S.? **No**

4. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program?	**No**
5. Are you currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities?	**No**

Health History

In the last five years, have you been enrolled in, required to enter into, or participated in any drug and/or alcohol recovery program or impaired practitioner program for treatment of drug or alcohol abuse that occurred within the past five years?	**No**
In the last five years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental disorder or impairment?	**No**
During the last five years, have you been treated for or had a recurrence of a diagnosed mental disorder that has impaired your ability to practice medicine within the past five years?	**No**
During the last five years, have you been treated for or had a recurrence of a diagnosed physical disorder that has impaired your ability to practice medicine?	**No**
In the last five years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol/drug) disorder or, if you were previously in such a program, did you suffer a relapse within the last five years?	**No**
During the last five years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol/drug) disorder that impaired your ability to practice medicine within the last five years?	**No**

Electronic Fingerprinting

I have been provided and read the statement from the Florida Department of Law Enforcement regarding the sharing, retention, privacy and right to challenge incorrect criminal history records and the 'Privacy Statement' document from the Federal Bureau of Investigation.	**Yes**
Enter in today's date	**02/03/2019**

Medical Malpractice Question

Have you ever had a judgment entered against you for medical malpractice where the incident(s) of malpractice occurred after November 2, 2004?	**No**

Liability Claims

Within the last 10 years have you had any liability claim(s) or action(s) for damages for personal injury settled or finally adjudicated in an amount that exceeds $100,000.00?	**No**

Financial Responsibility/Exemption

Financial Responsibility	**4. LIABILITY NOT LESS THAN $250,000**

FDA Institution

Have you ever had any staff privileges denied, suspended, revoked, modified, restricted, not renewed or placed on probation, or have you been asked to resign or take a temporary leave of absence or were otherwise acted against by any facility?	**No**

FDA Licensing

Have you ever had any professional license or license to practice medicine revoked, suspended, placed on probation, received a citation, or other disciplinary action taken in any state, territory or country?	**No**

FDANP Denied

Have you had any application for a medical license or professional license denied by any state board or other governmental agency of any state, territory, or country?	**No**

FDANP Investigation

Are you currently under investigation in any jurisdiction for an act or offense that would constitute a violation of Section 458.331, Florida Statutes?	**No**

Specialty Board Discipline History

Have you ever had any final disciplinary action taken against you by a specialty board or other similar national organization?	**No**

Year Began Practice

Year Began Practice:	**02/01/2000**

Availability for Disaster

Are you willing to provide health care services in special need shelters or to work with disaster medical teams during times of emergency or major disasters?	**No**

Attachments

Document Type: Insurance File Name: Malpractice Insurance.pdf

Document Type: Initial Application Supporting Documentation File Name: Driver's License - Bapat.pdf

Fees

4. LICENSURE HISTORY

Request verification of licensure status directly from the licensing entity or www.veridoc.org. Request international license verification(s) if you have practiced outside of the U.S. for at least two of the previous four years.

☐ Yes ☐ No Do you now hold or have you ever held a license to practice medicine or any other profession in any US State or territory, or foreign country? Please list in table below.

Jurisdiction	Profession	License number

If you answer "yes" to any of the questions in this section, you are required to send an explanation and supporting documentation.

☐ Yes ☐ No Have you had any application for a medical license or professional license denied by any state board or other governmental agency of any state, territory, or country?

☐ Yes ☐ No Are you currently under investigation in any jurisdiction for an act or offense that would constitute a violation of Section 458.331, Florida Statutes?

☐ Yes ☐ No Have you ever had any professional license or license to practice medicine revoked, suspended, placed on probation, or other disciplinary action taken in any state, territory or country?

5. PRACTICE/EMPLOYMENT HISTORY

List the year you legally first began to practice medicine, 1992 (yyyy). This would be the year you began practicing medicine and could be the date you began your postgraduate training.

☒ Yes ☐ No Have you practiced medicine in any jurisdiction for two of the last four years **or** completed a board approved post-graduate training program within the last two years?

☐ Yes ☐ No If your answer to the question above was "No," have you passed a board approved clinical competency exam within the last year? If yes, then submit supporting documentation.

List in chronological order all employment for the last four (4) years.

Name and address of practice or employment	Type of employment	From: mm/yy	To: mm/yy
Division of Cardiothoracic Surgery Columbia University Medical Center 177 Fort Washington Avenue, New York, NY 10032	Asst. Professor	05/17	to date

Application	**$350.00**
Unlicensed Activity	**$5.00**
NICA Fee	**$250.00**
Initial License	**$350.00**
Total Amount Due:	**$955.00**

Attestation

I state that these statements are true and correct. I recognize that providing false information may result in denial of licensure, disciplinary action against my license, or criminal penalties pursuant to Sections 456.067, 775.083, and 775.084, Florida Statutes. I state that I have read Chapters 456, 458 and 766.301-.316, Florida Statutes and Chapter 64B8, Florida Administrative Code.

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Florida Board of Medicine information which is material to my application for licensure.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind. I state that my answers and all statements made by me herein are true and correct.

Should I furnish any false information in this application, I hereby agree that such act constitutes cause for denial, suspension, or revocation of my license to practice Medicine in the State of Florida. If there are any changes to my status or any change that would affect any of my answers to this application I must notify the board within 30 days.

I understand that my records are protected under federal and state regulations governing Confidentiality of Mental Health Patient Records and cannot be disclosed without my written consent unless otherwise provided in the regulations. I understand that my records are protected under federal and state regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it.

Attestation Answer: Yes

3528315

EBAPKS
141890

THE UNIVERSITY OF THE STATE OF NEW YORK
THE STATE EDUCATION DEPARTMENT
DIVISION OF PROFESSIONAL LICENSING SERVICES
89 WASHINGTON AVENUE
ALBANY, NEW YORK 12234

MEDICINE BOARD
19 APR 11 AM 9:10

This is to certify that according to the records of the Division of Professional Licensing Services, New York State Education Department Albany, New York, BAPAT, VINAYAK NILKANTH
was issued license/certificate number 286960 for the practice of MEDICINE on 11/17/2016.

Our records also indicate the following information:
Date of birth: 08/30/1968
School attended: UNIVERSITY OF BOMBAY
Date of graduation: 03/22/93
Degree earned: MBBS

Program was acceptable in accordance with the NYS Regulations of the Commissioner of Education. Requirements met at the time of licensure.

Basis of licensure:
ENDORSEMENT OF UNITED KINGDOM LICENSE #5203830 ISSUED ON 9/26/2002.

ORIGINAL

A license is valid during the life of the holder unless revoked, annulled or suspended by the Board of Regents. A licensee must register periodically with this Department to practice in this state.

Currently Registered: YES Reg period ends: 07/31/20
Address: 60 WEST 66TH STREET APT 26A
NEW YORK NY 10023-0000
Disciplinary information: No charges have been preferred against this licensee
Comments:

I, Audrey Bell, Education Program Assistant 1, Division of Professional Licensing Services of the New York State Education Department, do hereby state that as Education Program Assistant 1 of said Division, I have legal custody of the official records of the Division of Professional Licensing Services and to the best of my knowledge, the aforesaid information is true and correct.

SEAL

Audrey Bell 04/05/19
Education Program Assistant 1

Chair
Zachariah Zachariah, M.D.
Ft. Lauderdale, Florida

Members
Hector Vila, M.D.
Tampa, Florida
Vice-Chair

Luz Marina Pages, M.D.
Miami Beach, Florida

Scot N. Ackerman, M.D.
Jacksonville, Florida

Eleonor Pimentel, M.D.
Miami, Florida

David A. Diamond, M.D.
Winter Park, Florida

Vacant, Consumer Member

Robert London, M.D.
Maitland, Florida

Jorge J. Lopez, M.D.
Maitland, Florida

Andre M. Perez
Miami, Florida

Kevin Cairns, M.D.
Fort Lauderdale, Florida

Nicholas W. Romanello, Esq.
Melbourne, Florida

Sarvam TerKonda, M.D.
Jacksonville, Florida

Shailesh Gupta, M.D.
Coral Springs, Florida

Vacant, M.D.

Executive Director
Claudia Kemp, J.D.

September 9, 2020

Broderick Carlton Jones, MD
1831 NW 57th Street
Miami, FL 33142

Dear Dr. Jones:

This is in further reference to your certification for approval of licensure with conditions.

Please be advised that your Notice of Intent to Approve Licensure with Conditions will be presented as an individual item to the Credentials Committee of the Board of Medicine to discuss:

- **Request for extension of time to take USMLE**

The Committee may inquire into any other issues relating to your application and eligibility for licensure. Your appearance is not required but if you choose to appear the date, time and location of the meeting are listed below.

Date:	Thursday, October 1, 2020
Time:	8:00 a.m. (Meeting starts at 8:00 a.m. Interview time may vary.)
Location:	The in-person meeting scheduled in Orlando, Florida is cancelled, and the meeting will be held by a web-based meeting platform or, if appropriate, a teleconference call.

The meeting information and directions for participating in the October 2020 meeting will be posted on the Florida Board of Medicine's website: https://flboardofmedicine.gov/meeting-information.

Additionally, the Committee's recommendation on your application for licensure will be presented to the full Board of Medicine on Friday, October 2, 2020 for final action. You are not required to attend the full board meeting.

Thank you for your continued cooperation. Should you have any questions regarding this matter, please feel free to contact me.

Sincerely,

Wendy Alls

Wendy Alls
Program Operations Administrator

Pursuant to the provisions of the Americans with Disabilities Act, any person requiring special accommodations to participate in this workshop/meeting is asked to advise the agency at least 10 days before the workshop/meeting by contacting: Rebecca.Hewett@flhealth.gov or call (850) 245-4137.

1501-70396 CK

FILED
DEPARTMENT OF HEALTH
DEPUTY CLERK
CLERK: Amanda Morales
DATE: DEC 20 2019

STATE OF FLORIDA
BOARD OF MEDICINE

IN RE: THE APPLICATION FOR
LICENSURE OF

BRODERICK C. JONES, M.D.
_____/

NOTICE OF INTENT TO APPROVE LICENSURE WITH CONDITIONS

This matter came before the Credentials Committee of the Florida Board of Medicine at a duly-noticed public meeting on December 5, 2019, in Altamonte Springs, Florida, and the full Board of Medicine on December 6, 2019, in Altamonte Springs, Florida. The Applicant, Broderick C. Jones, M.D., was present at the Credentials Committee meeting.

Pursuant to Sections 458.331(2), and 456.072(2), Florida Statutes, the Board may refuse to certify an applicant for licensure, restrict the practice of the licensee, or impose a penalty. Dr. Jones's application file demonstrates that he has failed to submit a passing score on Step 3 of the licensure examination of the United States Medical Licensing Examination (USMLE), as required by Section 458.311(1)(h), Florida Statutes.

It is therefore **ORDERED** that the application for licensure by examination be **approved under the following conditions** that must be completed prior to licensure:

Dr. Jones shall successfully pass Step 3 of the USMLE within twelve (12) months of the issuance of this Order.

This Order does not constitute disciplinary action against the license that has been approved herein. The terms of this Order are considered conditions for licensure that must be satisfied prior to the issuance of the license.

This Order shall become effective upon filing with the Clerk of the Department of Health.

DONE AND ORDERED this 19th day of December, 2019.

BOARD OF MEDICINE

Crystal A. Kemp for
Claudia Kemp, J.D., Executive Director
For Steven Rosenberg, M.D., Chair

NOTICE OF RIGHT TO HEARING

This notice constitutes final agency action if no request for a hearing is received by the Board on or before the twenty-first day after the applicant's receipt of the notice. The applicant may request a hearing by filing an appropriate petition with the Executive Director of the Board at 4052 Bald Cypress Way, Bin #C-03, Tallahassee, Florida 32399-3253. The applicant may petition for a hearing involving disputed issues of material fact before an administrative law judge pursuant to Section 120.57 (1), Florida Statutes, or for a hearing not involving disputed issues of material fact pursuant to Section 120.57 (2), Florida Statutes.

A petition for a hearing involving disputed issues of material fact must contain information required by Rule 28-106.201, Florida Administrative Code, ***including a statement of all disputed issues of material fact.*** The Board may refer a petition to the Division of Administrative Hearings for assignment of an administrative law judge only if the petition is in substantial compliance with the rule requirements. A petition for a proceeding not involving disputed issues of material fact must contain information required by Rule 28.106.301, Florida Administrative Code, including a concise statement of the ultimate facts alleged, as well as the rules and statutes which entitle petitioner to relief.

In accordance with Section 120.573, Florida Statutes, mediation is not available.

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing has been furnished by **Certified Mail and U.S. Mail** to **Broderick C. Jones, M.D.,** 1831 NW 57th Street, Miami, FL 33142; and by email to Donna C. McNulty, Special Counsel, at Donna.McNulty@myfloridalegal.com, this 20th day of Dec., 2019.

Anne Manns

Deputy Agency Clerk

Certified Article Number

9414 7266 9904 2140 1233 78

SENDER'S RECORD

Broderick C. Jones, M.D.
1831 NW 57th Street
Miami, FL 33142

MEMORANDUM

DATE: December 19, 2019

TO: Mark Whitten, J.D. Bureau Chief
Bureau of Health Care Practitioner Regulation

FROM: Claudia J. Kemp
Executive Director, Board of Medicine

SUBJECT: Delegation of Authority

This is to advise you that while I am out of the office the following days the following Program Operations Administrator is delegated to serve as Acting Executive Director for the Board of Medicine.

Crystal Sanford	Program Operations Administrator	(850) 245-4132

Thursday-Friday, December 19-20,2019
Monday, December 23, 2019
Thursday-Friday, December 26-27, 2019

CK/cg
cc:
Sylvia Sanders
Staff, Board of Medicine
Board and Council Chairs

Tab 27 - Benedict Oladipo Olusola, MD – Examination
Issue(s):

- Texas Medical Board Action
- Florida Medical Board Action
- Surrender of DEA registration
- Termination of Contract

The applicant was present and sworn in by the court reporter. After discussion, a motion was made to allow Dr. Olusola to withdraw his application for licensure. The motion was seconded, which carried 5/0.

Action Taken: The Committee voted to allow withdrawal of the licensure application.

Tab 28 - William Lindsey Fontenot, MD – Endorsement
Issue(s):

- Criminal History
- Health History
- Tennessee Medical Board Action
- Texas Medical Board Action
- Illinois Medical Board Action
- Exclusion or Debarment Action

The applicant was present and sworn in by the court reporter. After discussion, a motion was made to approve the application for licensure. The motion was seconded, which carried 5/0.

Action Taken: The Committee voted to approve the application for licensure.

Tab 36 - Lisa Sanders, MD – Reactivation
Issue(s):

- Inactive license for more than two (2) consecutive biennial licensure cycles
- Failure to practice for two (2) of the previous four (4) years

The licensee was present and sworn in by the court reporter. After discussion, a motion was made to approve the request for reactivation. The motion was seconded, which carried 5/0.

Action Taken: The Committee voted to approve the request for reactivation.

Scot N. Ackerman, MD – To Interview Tabs 29-36

Tab 29 - Broderick Carlton Jones, MD – Examination
Issue(s): Failure to meet Section 458.311(1)(h), F.S., Examination

The applicant was present and sworn in by the court reporter. After discussion, a motion was made to approve the application for licensure with the condition that Dr. Jones successfully pass the United States Medical Licensing Examination (USMLE) Step III within twelve (12) months and the license will issue. The motion was seconded, which carried 5/0.

Action Taken: The Committee voted to approve the application for licensure with the condition that Dr. Jones successfully pass the United States Medical Licensing Examination (USMLE) Step III within twelve (12) months and the license will issue.

FLORIDA | Board *of* Medicine

Ron DeSantis
Governor

Scott A. Rivkees, MD
State Surgeon General

Chair
Steven Rosenberg, M.D.
Palm Beach, Florida

Members
Hector Vila, M.D.
Tampa, Florida
Vice Chair

Magdalena Averhoff, M.D.
Miami, Florida

Steven Falcone, M.D.
Coral Springs, Florida

Brigitte Goersch
Satellite Beach, Florida

Robert London, M.D.
Maitland, Florida

Jorge J. Lopez, M.D.
Maitland, Florida

James W. Orr, Jr., M.D.
Fort Myers, Florida

Andre M. Perez
Miami, Florida

Seela Ramesh, M.D.
Orlando, Florida

Nicholas W. Romanello, Esq.
Melbourne, Florida

Merle P. Stringer, M.D.
Panama City, Florida

Sarvam TerKonda, M.D.
Jacksonville, Florida

Zachariah Zachariah, M.D.
Ft. Lauderdale, Florida

Shailesh Gupta, M.D.
Coral Springs, Florida

Vacant, M.D.

Executive Director
Claudia Kemp, J.D.

October 31, 2019

Broderick Carlton Jones, MD
1831 NW 57th Street
Miami, Florida 33142

Dear Jones:

This is in further reference to your application for licensure by Examination.

Please be advised that you are required to make a personal appearance before the Credentials Committee of the Board of Medicine to discuss:

- **Failure to meet Section 458.311(1)(h), F.S., Examination**

In addition, the Committee may inquire into any other issues relating to your application and eligibility for licensure.

Date:	Thursday, December 5, 2019
Time:	8:00 a.m.
Location:	Florida Board of Medicine/Credentials Committee Meeting Hilton Orlando – Altamonte Sprints 350 Northlake Boulevard Altamonte Springs, Florida 32701 (407) 830-1985

The meeting room will be posted in the lobby of the hotel. Subject to availability, a block of rooms is available for the public attending the Department of Health – Florida Board of Medicine's meeting.

Additionally, the Committee's recommendation on your application for licensure will be presented to the full Board of Medicine on Friday, December 6, 2019 for final action. You are not required to attend the full board meeting.

Thank you for your continued cooperation. Should you have any questions regarding this matter, please feel free to contact me. *This is your first scheduled appearance.

Sincerely,

Wendy Alls

Wendy Alls
Program Operations Administrator

Pursuant to the provisions of the Americans with Disabilities Act, any person requiring special accommodations to participate in this workshop/meeting is asked to advise the agency at least 10 days before the workshop/meeting by contacting: Rebecca.Hewett@flhealth.gov or call (850) 245-4137.

*** 456.013(3)(c) In considering applications for licensure, the board, or the department when there is no board, may require a personal appearance of the applicant. If the applicant is required to appear, the time period in which a licensure application must be granted or denied shall be tolled until such time as the applicant appears. However, if the applicant fails to appear before the board at either of the next two regularly scheduled board meetings, or fails to appear before the department within 30 days if there is no board, the application for licensure shall be denied.**

4052 Bald Cypress Way, Bin C-03
Tallahassee, Florida 32399-3253
Phone: 850/245-4131
Fax: 850/488-0596 or 850/412-1268
https://www.FLBoardofMedicine.gov

Florida HEALTH

Denson, Angela

From: Alls, Wendy
Sent: Thursday, October 31, 2019 1:23 PM
To: Keelor, Christina C; Denson, Angela
Subject: FW: Advisements (statutory requirements)

From: Robert London [mailto:rlondon10.bom@gmail.com]
Sent: Thursday, October 31, 2019 12:36 PM
To: Alls, Wendy <Wendy.Alls@flhealth.gov>
Subject: Re: Advisements (statutory requirements)

Please schedule for personal appearance.

Thank you.

RAL

On Thu, Oct 31, 2019 at 12:14 PM Alls, Wendy <Wendy.Alls@flhealth.gov> wrote:

> Good afternoon Dr. London,
>
> Listed below is the name of the applicant and statute that has not been met. Please confirm a **personal appearance** is required for the following:
>
> **Broderick Carlton Jones, MD – Licensure by Examination**
>
> - Failure to meet section 458.311(1)(h), Florida Statutes, examination
>
> Thank you.
>
> Wendy V. Alls
> Program Operations Administrator
> Department of Health (DOH) | Division of Medical Quality Assurance(MQA)
> Board of Medicine
> Phone: 850-245-4135 | Fax: 850-412-1282
> 4052 Bald Cypress, Way, # C03 | Tallahassee, FL 32399-3256
> New website: www.flboardofmedicine.gov
> Twitter: www.twitter.com/FLBoardofMed
>
> How is my customer service? Feel free to contact my supervisor at Claudia.Kemp2@flhealth.gov.
>
> Mission: To protect, promote and improve the health of all people in Florida through integrated state, county, and community efforts.

1501 F- 70396

MEDICAL DOCTOR
APPLICATION FOR LICENSURE
Apply for your license online at www.flboardofmedicine.gov

05/06/2019 955.00
ID: 70396 Type: F
BT: 3016885
R#: 918035260

Choose your application type:

☐ Endorsement (1021) ☑ Examination (1024)

☐ Military Veterans Fee Waiver

If you were honorably discharged from the U.S. armed services within 60 months of your application you will qualify for a waiver of the application fee and the initial licensure fee. In order to qualify, please check the box above indicating that you are seeking a waiver and submit **a DD-214 or NGB-22 form as proof of honorable discharge.**

☐ I plan to dispense medicinal drugs in the State of Florida for a fee or other remuneration and hereby register as required by Section 465.0276, F.S. I understand that the fee for the Dispensing Practitioner is $100.00 in addition to the required initial license fee and will submit it along with the license fee.

1. PERSONAL INFORMATION

Name: Jones (Last/Surname) Broderick (First) Carlton (Middle) **Date of Birth:** 11·25·1957 (MM/DD/YYYY)

Mailing Address: (The address where mail and your license should be sent)

1831 NW 57th st (Street/ PO Box) – (Suite/Apt. No) Miami (City)

FL (State) 33142 (Zip) United States (Country) 305 333 4733 (Phone Number)

Physical Location: A Post Office Box is not acceptable. This address will be posted on the Department of Health's website. *If you do not have a current practice address, your mailing address will be used. When you obtain a practice address, you will be required to update your online practitioner profile.*

Street/ P.O. Box Suite/Apt. No City

State Zip Country Alternate Phone Number

Email Address: blue7drops@yahoo.com

Under Florida law, email addresses are public records. If you do not want your e-mail address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.

Equal Opportunity Data: We are required to ask that you furnish the following information as part of your voluntary compliance with Section 2, Uniform Guidelines on Employee Selection Procedure (1978) 43 CFR 38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

SEX: ☑ Male ☐ Female **RACE:** ☐ White ☐ Black ☑ Asian/Pacific Islander ☐ Hispanic ☐ Other

☑ Yes ☐ No **Availability for Disaster:** Will you be available to provide health care services in special needs shelters or to help staff disaster medical assistance teams during times of emergency or major disaster?

B. Jones

2. MEDICAL EDUCATION HISTORY

Federal Credentials Verification Services (FCVS) is not a requirement for licensure. FCVS will primary source verify and provide a copy of the medical school transcript(s), medical school diploma, medical school verification, name change document(s), national examination score report, ECFMG certificate, ECFMG verification and postgraduate training verifications. For more information about FCVS, visit their web-site at www.fcvs.org/.

☐ Yes ☑ No Are you using the FCVS to verify your core credentials?

☑ Yes ☐ No Have you completed the equivalent of 2 academic years of preprofessional, postsecondary education including, courses in anatomy, biology and chemistry prior to entering medical school?

Medical Education:
List in chronological order all medical schools attended, whether completed or not. Submit on a separate sheet if needed.

Medical School Name and Address:	From: (mm/yy)	To: (mm/yy)	Date Degree Received:
University of Miami Miller School of Medicine	08/87	05/92	MD

Fifth Pathway Certificate Holders:

If you answer "yes" to any of the following questions, you must request verifications to be sent directly to the Board office.

☐ Yes ☑ No Did you attend an international medical school and do not possess a valid ECFMG Certificate?

☐ Yes ☐ No Did you receive a bachelor's degree from an accredited United States college or University?

☐ Yes ☐ No Did you study at a medical school which is recognized by the World Health Organization?

☐ Yes ☐ No Did you complete all of the formal requirement of the International medical school, except the internship or social service requirements, and pass part I of the National board of Medical examination or the Education Commission for Foreign Medical Graduates Examination equivalent?

☐ Yes ☐ No Did you complete an academic year of supervised clinical training in a hospital affiliated with a medical school approved by the Council on Medical Education of the American Medical Association and upon completion passed part II of the National Board of Medical Examiners examination or the Education Commission for Foreign Medical Graduates examination Equivalent?

B. Jones

Postgraduate Training:

Provide the following documentation to support your postgraduate training:

☑ Post-Graduate Training Form

In the table below list, in chronological order, all postgraduate training from the date you graduated from medical school to the present. Start with your first program and end with your last or current program. List all programs you began, whether you completed or received credit for the training.

	Program Name and Full Mailing Address:	Specialty Area:	From: (mm/yy)	To: (mm/yy)	Did you receive credit? (Y/N)
1)	University of Miami Miller School of Medicine	Pathology	7/92	8/97	Yes
	Office of Student Affairs 1600 NW 10th Ave Rm 2101B	Location code R-128 Miami, FL 33136			
2)	Morehouse School of Medicine Residency Program Family Medicine 720 Westview Drive Atlanta, GA 30310	Family Medicine	7/99	4/2000	No

Loan History:

☐ Yes ☑ No Are you currently in default on any health education loan or scholarship obligation? (If "yes", explain on a separate sheet providing accurate details.)

3. EXAMINATION HISTORY

State Board (prior to 1974), State Board (after 1974) & SPEX, LMCC & SPEX, NBME, FLEX, USMLE III, or Combination (prior to 2000)

Request that the score report be sent directly to the Board of Medicine. NOTE: If you took a state Board examination and are not currently licensed in three other states, you must also request your SPEX score be sent.

Exam taken: USMLE pt 3
Need permission to take USMLE pt 3

Date passed: — (mm/dd/yy)

B. Jones

4. LICENSURE HISTORY

Request verification of licensure status directly from the licensing entity or www.veridoc.org. Request international license verification(s) if you have practiced outside of the U.S. for at least two of the previous four years.

☐ Yes ☑ No Do you now hold or have you ever held a license to practice medicine or any other profession in any US State or territory, or foreign country? Please list in table below.

Jurisdiction	Profession	License number

If you answer "yes" to any of the questions in this section, you are required to send an explanation and supporting documentation.

☐ Yes ☑ No Have you had any application for a medical license or professional license denied by any state board or other governmental agency of any state, territory, or country?

☐ Yes ☑ No Are you currently under investigation in any jurisdiction for an act or offense that would constitute a violation of Section 458.331, Florida Statutes?

☐ Yes ☑ No Have you ever had any professional license or license to practice medicine revoked, suspended, placed on probation, or other disciplinary action taken in any state, territory or country?

5. PRACTICE/EMPLOYMENT HISTORY

List the year you legally first began to practice medicine, (N/A) (yyyy). This would be the year you began practicing medicine and could be the date you began your postgraduate training.

☐ Yes ☑ No Have you practiced medicine in another jurisdiction for two of the last four years **or** completed a board approved post-graduate training program within the last two years?

☐ Yes ☑ No If your answer to the question above was "No," have you passed a board approved clinical competency exam within the last year? If yes, then submit supporting documentation.

List in chronological order all employment for the last four (4) years.

Name and address of practice or employment	Type of employment	From: mm/yy	To: mm/yy
Nova Southeastern University - College of Medical Science - HPD	Professor	12/2000	Current
Dept of Pathology and College of Allopathic Medicine 3200 S. University Drive			
Fort-Lauderdale, FL 33328-2018			

B. Jones

☐ Yes ☑ No Do you currently hold staff privileges in any hospital, health institution, clinic or medical facility? List each facility below.

Name of facility

If you answer "yes" to the following questions, you are required to send an explanation and supporting documentation.

☐ Yes ☑ No Have you ever had any staff privileges denied, suspended, revoked, modified, restricted, not renewed, or placed on probation, or have you been asked to resign or take a temporary leave of absence or were otherwise acted against by any facility?

☐ Yes ☐ No Do you currently, or have you had, responsibility for graduate medical education within the last 10 years?

In the table below, list all institutions where you have had responsibility for graduate medical education or faculty appointment(s) at any medical school.

Name of institution

☐ Yes ☑ No Are you certified by any specialty board recognized by the American Board of Medical Specialties or specialty board approved by the Florida Board of Medicine?

Board Name	Certification/ Specialty/Sub-Specialty	Date of Certification (mm/yy)

If you answer "yes" to any of the following questions, please explain on a separate sheet providing accurate details.

☐ Yes ☑ No Have you ever had any final disciplinary action taken against you by a specialty board or other similar national organization?

☐ Yes ☑ No Have you ever been denied or surrendered a DEA registration?

B. Jones

6. CRIMINAL HISTORY

If you answer "Yes" to the following question you are required to send the following items:

a. Self-explanation describing in detail the circumstances surrounding each offense, including dates, city and state, charges and final results.
b. Final Dispositions and Arrest Records for all offenses. The Clerk of the Court in the arresting jurisdiction will provide you with these documents. Unavailability of these documents must come in the form of a letter from the Clerk of the Court.
c. Completion of Sentence Documents. You may obtain documentation from the Department of Corrections. The report must include the start date, end date and that the conditions were met.

☐ Yes ☑ No Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to, a crime in any jurisdiction other than a minor traffic offense? You must include all misdemeanors and felonies, **even if adjudication was withheld. Driving under the influence (DUI) or driving while impaired (DWI) are not minor traffic offenses for purposes of this question.**

☐ Yes ☐ No I have been provided and read the statement from the Florida Department of Law Enforcement regarding the sharing, retention, privacy and right to challenge incorrect criminal history records and the "Privacy Statement" document from the Federal Bureau of Investigation.

7. MILITARY HISTORY

A. ☐ Yes ☑ No Have you ever been in the United States Military and/or Public Health Service?

B. ☐ Yes ☑ No Have you ever been disciplined by any branch of the United States Armed Services or Public Health Services? If you answered "yes" please provide a detailed explanation and supporting documentation

8. CRIMINAL AND MEDICAID/MEDICARE FRAUD QUESTIONS

Applicants for licensure, certification or registration and candidates for examination may be excluded from licensure, certification or registration if their felony conviction falls into certain timeframes as established in Section 456.0635(2), Florida Statutes. If you answer "Yes" to any of the following questions, please provide a written explanation for each question. Supporting documentation includes court dispositions or agency orders where applicable.

1. ☐ Yes ☑ No Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, F.S. (relating to social and economic assistance), Chapter 817, F.S. (relating to fraudulent practices), Chapter 893, F.S. (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction?

If you responded "No" to the question above, skip to question 2.

a. ☐ Yes ☐ No If "yes" to 1, for the felonies of the first or second degree, has it been more than 15 years from the date of the plea, sentence and completion of any subsequent probation?

b. ☐ Yes ☐ No If "Yes" to 1, for felonies of the third degree, has it been more than 10 years from the date of the plea, sentence and completion of any subsequent probation? (This question does not apply to felonies of the third degree under Section 893.13(6)(a), Florida Statutes)

c. ☐ Yes ☐ No If "Yes" to **1**, for the felonies of the third degree under Section 893.13(6)(a), Florida Statutes, has it been more than 5 years from the date of the plea, sentence and completion of any subsequent probation?

d. ☐ Yes ☐ No If "Yes" to **1**, have you successfully completed a drug court program that resulted in the plea for the felony offense being withdrawn or charges dismissed?

2. ☐ Yes ☑ No Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970 (relating to controlled substances) or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)?

B. Jones

If you responded "No" to the question above, skip to question 3.

a. ☐ Yes ☐ No If "Yes" to 2, has it been more than 15 years before the date of application since the sentence and any subsequent period of probation for such conviction or plea ended?

3. ☐ Yes ☑ No Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes?

If you responded "No" to the question above, skip to question 4.

a. ☐ Yes ☐ No If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years?

4. ☐ Yes ☑ No Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid Program?

If you responded "No" to the question above, skip to question 5.

a. ☐ Yes ☐ No Have you been in good standing with a state Medicaid program for the most recent five years?

b. ☐ Yes ☐ No Did the termination occur at least 20 years before the date of this application?

5. ☐ Yes ☑ No Are you currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities?

If you answer "Yes" to the questions below, you are required to send the following items:

- **A statement indicating the date of each incident and the number for each case.**
- **An explanation of details for each case and your involvement for each case.**
- **Submit the enclosed Exhibit 1 form.**
- **A copy of the complaint, judgments and/or settlements for each case.**
- **Submit a complete copy of the trial record(s) of each case, including the trial transcript, evidentiary exhibits and final judgment in electronic format.**

☐ Yes ☑ No Have you ever had a judgment entered against you for medical malpractice where the incident(s) of malpractice occurred after November 2, 2004?

☐ Yes ☑ No Within the last 10 years have you had any liability claim(s) or action(s) for damages for personal injury settled or finally adjudicated in an amount that exceeds $100,000.00?

B. Jones

10. FINANCIAL RESPONSIBILITY

The Financial Responsibility options are divided into two categories, coverage and exemptions. Check only one option of the ten provided as required by s. 458.320, Florida Statutes.

Category I: Financial Responsibility Coverage

☐1. I do not have hospital staff privileges, I do not perform surgery at an ambulatory surgical center and I have established an irrevocable letter or credit or an escrow account in an amount of $100,000/$300,000, in accord with Chapter 675, F. S., for a letter of credit and s. 625.52, F. S., for an escrow account.

☐2. I have hospital staff privileges or I perform surgery at an ambulatory surgical and I have established an irrevocable letter of credit or escrow account in an amount of $250,000/$750,000, in accord with Chapter 675, F. S., for a letter of credit and s. 625.52, F. S., for an escrow account.

☐3. I do not have hospital staff privileges, I do not perform surgery at an ambulatory surgical center and I have obtained and maintain professional liability coverage in an amount not less than $100,000 per claim, with a minimum annual aggregate of not less than $300,000 from an authorized insurer as defined under s. 624.09, F. S., from a surplus lines insurer as defined under s. 626.914(2), F. S., from a risk retention group as defined under s. 627.942, F. S., from the Joint Underwriting Association established under s. 627.351(4), F. S., or through a plan of self-insurance as provided in s. 627.357, F. S.

☐4. I have hospital staff privileges or I perform surgery at an ambulatory surgical and I have professional liability coverage in an amount not less than $250,000 per claim, with a minimum annual aggregate of not less than $750,000 from an authorized insurer as defined under s. 624.09, F. S., from a surplus lines insurer as defined under s. 626.914(2), F. S., from a risk retention group as defined under s. 627.942, F. S., from the Joint Underwriting Association established under s. 627.351(4), F. S., or through a plan of self-insurance as provided in s. 627.357, F. S.

☐5. I have elected not to carry medical malpractice insurance however, I agree to satisfy any adverse judgments up to the minimum amounts pursuant to s. 458.320(5)(g)1, F. S. I understand that I must either post notice in a sign prominently displayed in my reception area or provide a written statement to any person to whom medical services are being provided that I have decided not to carry medical malpractice insurance. I understand that such a sign or notice must contain the wording specified in s. 458.320(5)(g), F. S.

Category II: Financial Responsibility Exemptions

☐6. I practice medicine exclusively as an officer, employee, or agent of the federal government, the state, or its agencies or subdivisions.

☐7. I hold a limited license issued pursuant to s. 458.317, F. S., and practice only under the scope of the limited license.

☑8. I do not practice medicine in the State of Florida.

☐9. I meet all of the following criteria:

(a) I have held an active license to practice in this state or another state or some combination thereof for more than 15 years;

(b) I am retired or maintain part time practice of no more than 1000 patient contact hours per year;

(c) I have had no more than two claims resulting in an indemnity exceeding $25,000 within the previous five-year period;

(d) I have not been convicted of or pled guilty or nolo contendere to any criminal violation specified in Chapter 458, F. S. or the medical practice act in any other state; and

(e) I have not been subject, within the past ten years of practice, to license revocation, suspension, or probation for a period of three years or longer, or a fine of $500 or more for a violation of Chapter 458, F. S., or the medical practice act of another jurisdiction. A regulatory agency's acceptance of a relinquishment of license, stipulation, consent order, or other settlement offered in response to or in anticipation of filing of administrative charges against a license is construed as action against a license. I understand if I am claiming an exception under this section that I must either post notice in a sign prominently displayed in my reception area or provide a written statement to any person to whom medical services are being provided that I have decided not to carry medical malpractice insurance. See Section 458.320(5)(f), Florida Statutes, for specific notice requirements.

☐10. I practice only in conjunction with my teaching duties at an accredited medical school or its teaching hospitals. (Interns and residents do not qualify for this exemption).

If you select an exemption based on number 9, you must also complete the affidavit on the following page.

B. Jones

BOARD OF MEDICINE
Financial Responsibility Affidavit of Exemption (N/A) pg

This affidavit is only required if you are claiming an Exemption based on number 9 on the preceding page.

I,_____, do hereby certify and attest that I meet all of the following criteria:

(a) I have held an active license to practice in this state or another state or some combination thereof for more than 15 years;
(b) I am retired or maintain part time practice of no more than 1000 patient contact hours per year;
(c) I have had no more than two claims resulting in an indemnity exceeding $25,000 within the previous five-year period;
(d) I have not been convicted of or pled guilty or nolo contendere to any criminal violation specified in Chapter 458, F. S. or the medical practice act in any other state; and
(e) I have not been subject, within the past ten years of practice, to license revocation, suspension, or probation for a period of three years or longer, or a fine of $500 or more for a violation of Chapter 458, F. S., or the medical practice act of another jurisdiction. A regulatory agency's acceptance of a relinquishment of license, stipulation, consent order, or other settlement offered in response to or in anticipation of filing of administrative charges against a license is construed as action against a license. I understand if I am claiming an exception under this section that I must either post notice in a sign prominently displayed in my reception area or provide a written statement to any person to whom medical services are being provided that I have decided not to carry medical malpractice insurance. See Section 458.320(5) (f), F.S., for specific notice requirements.

Dated: _____ Signature:_____

STATE OF _____
COUNTY OF _____

Sworn to (or affirmed) and subscribed before me this_____day of_____, by

_____

_____
(Signature of Notary Public - State of Florida)

(Print, Type, or Stamp Commissioned Name of Notary Public)

Personally Known_____OR Produced Identification _____

Type of Identification Produced_____

B. Jones

11. FLORIDA BIRTH RELATED NEUROLOGICAL COMPENSATION ASSOCIATION

You must choose one of the three options described below. Please be sure to view the information about each exemption at www.nica.com. Check only one.

☐ $5,000 Participating	☑ $250 Non-participating	☐ $0 Exempt	$250.00 Amount enclosed

If you choose "$0 Exempt" provide appropriate documentation to the Board of Medicine and to NICA.

I have read the explanatory information provided by NICA, and I choose the option above.

Brodenck C Jones 5 2 19
Signature Date

Brodenck Jones
Name
1837 NW 57th St Miami FL
Street Address
33142
City, State, Zip

If you are a participating or non-participating physician, or a physician claiming exemption, you must complete, sign and date this form and return it with your payment to this address.

Board of Medicine
4052 Bald Cypress Way, #C-03
Tallahassee, FL 32399-3253

If you are a physician claiming exemption, you must also send a copy of your completed, signed, and dated form with proof of your exemption to:

NICA
2360 Christopher Place
Tallahassee, FL 32308

If you have any questions about NICA or this form, please contact NICA at www.nica.com or (850) 488-8191.

12. STATEMENT OF APPLICANT

I state that these statements are true and correct. I recognize that providing false information may result in denial of licensure, disciplinary action against my license, or criminal penalties pursuant to Sections 456.067, 775.083, and 775.084, Florida Statutes. I state that I have read Chapters 456, 458 and 766.301-.316, Florida Statutes and Chapter 64B8, Florida Administrative Code.

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Florida Board of Medicine information which is material to my application for licensure.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind. I state that my answers and all statements made by me herein are true and correct.

Should I furnish any false information in this application, I hereby agree that such act constitutes cause for denial, suspension, or revocation of my license to practice medicine in the State of Florida. If there are any changes to my status or any change that would affect any of my answers to this application I must notify the board within 30 days.

I understand that my records are protected under federal and state regulations governing Confidentiality of Mental Health Patient Records and cannot be disclosed without my written consent unless otherwise provided in the regulations. I understand that my records are protected under federal and state regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it.

Broderick Carlton Jones

Print name

Broderick C Jones 5 1 19

Signature Date

B. Jones

EXHIBIT 1 – REPORT ON PROFESSIONAL LIABILITY CLAIMS AND ACTIONS (N/A)

Include information relating to liability actions occurring within the previous 10 years. The actions are required to be reported under section 456.039(1)(b) F. S. You must submit a completed form for each occurrence. If you are an allopathic, osteopathic, or podiatric physician, to satisfy this reporting requirement you may submit copies of reports previously submitted under the requirements of s. 456.049 F. S. instead of this exhibit.

Date of occurrence: / /____ Date reported to licensee: / /____ Date claim reported to insurer or self-insurer / /_____

Injured person's name: (last, first, middle initial)_____

Street Address:_____

City:_____ State:_____ Zip Code: _____
Age:_____ Sex: _____

Date of suit, if filed: / /____

List all defendants with their health care provider license number involved in this claim:
1 _____ 2._____
3._____ 4._____

Date of final claim disposition:_____/_____/_____

Date and amount of judgment or settlement, if any: _____

Was there an itemized verdict? [ ] Yes [ ] No (If "YES", attach copy of settlement verdict)

Indemnity paid on behalf of this defendant: $_____
Loss adjustment expense paid to defense counsel: $_____
All other loss adjustment expense paid: $_____

The date and reason for final disposition, if no judgment or settlement: _____

Name of institution at which the injury occurred: _____

Location of injury occurrence:

[ ] Patient's Room [ ] Physical Therapy Dept. [ ] Radiology [ ] Labor & Delivery Room
[ ] Operating Suite [ ] Nursery [ ] Emergency Room
[ ] Recovery Room [ ] Critical Care Unit [ ] Other [ ] Special Procedure Room

Final diagnosis for which treatment was sought or rendered: _____
_____

Describe misdiagnosis made, if any, of the patient's actual condition. _____
_____

Describe the operation, diagnostic, or treatment procedure causing the injury. Use nomenclature and/or descriptions of the procedures used. Include method of anesthesia, or name of drug used for treatment, with detail of administration. _____
_____

Describe the principal injury giving rise to the claim. Use nomenclature and/or descriptions of the injury. Include type of adverse effect from drugs where applicable. _____
_____

Safety management steps taken by the licensee to make similar occurrences less likely: _____
_____

I represent that these statements are true and correct pursuant to s. 837.06, Florida Statutes. I recognize that providing any false statements made in writing with the intent to mislead the Department staff in the performance of their official duties, shall be punishable as provided in s. 775.082 and 775.083, Florida Statutes.

Signature of physician: _____

May 10, 2019

Broderick Carlton Jones
1831 Nw 57th St
Miami, FL 33142

Dear Dr. Jones:
File: 70396

Thank you for considering Florida for physician licensure. Your application for medical licensure has been received. The application is incomplete for the reasons set out in the attached deficiency notice. Please address these deficiencies as soon as possible to avoid delay in processing your application.

Information received by this office may require additional explanation or documentation to determine licensure eligibility. After all requested documentation is received, your application will be submitted for supervisory review. We will notify you if additional information is required.

Applicants with a history of malpractice, criminal activity, discipline, physical or mental impairment, unfavorable evaluations, or other matters that need explanation may require a personal appearance before the Board of Medicine Credentials Committee for determination of licensure eligibility. If your appearance is required, you will be notified in writing once your application is complete.

You can now follow the progress of your application through our website at: www.FLHealthSource.gov/mqa-services. If you are a returning user, select "Yes" and enter the user ID and password you selected during the registration process under Returning User. If you did not apply for licensure through this screen, select "No" and follow the prompts to create an account. You must have a valid email address to create your account.

Once you are logged in, you will be prompted to add your application to your account. Once you have successfully added your application, you will be directed to your dashboard. Under the "Additional Activities" section, select "Check Application Status" to review any open deficiencies, upload documents or print out instructional documents.

THIS IS IMPORTANT: Your application will remain incomplete until all deficiencies are completed. In addition, you are required to notify the Board office immediately in writing of any occurrence(s) that would in any way change or affect any answer given in the application or an answer provided in response to any of our direct questions to you.

If you have any questions, please contact me at serena.mylescrossley@flhealth.gov, call 850-901-6408.

Sincerely,

Serena Myles-Crossley
Regulatory Specialist II

Enclosure(s)

Broderick Carlton Jones **Date: May 10, 2019**

REMINDER: Chapter 456.013(1)(a), Florida Statutes, provides that an incomplete application shall expire one year after initial filing with the department.

YOUR APPLICATION'S EXPIRATION DATE IS **05/06/2020**

APPLICATION SUBMITTED REMAINS DEFICIENT FOR LACK OF THE FOLLOWING:

You did not complete number 6 under the criminal history (sharing, retention, privacy statement) portion of the application. Please complete the question and submit this information to our office.

The inquiry you mailed to your medical school has not been received from University of Miami.

Your Postgraduate Training Verification Forms have not been received from University of Miami School of Medicine 07/92- 08/97 and Morehouse School of medicine 07/99-04/00.

Please submit the National Practitioner Data Bank (NPDB) report to our office. You may contact the NPDB at 1-800-767-6732 to obtain this information.

We have not received your Livescan results. If you have already had your electronic fingerprinting completed, please allow 24 – 72 hours for receipt of your results. Should your Criminal Background Check disclose an arrest record(s), you will need to provide documentation related to each criminal event revealed in your background, if you have not already done so. You can find a detailed description of documents that will be required by visiting the FAQs on the Background Screening Website at http://www.flhealthsource.gov/background-screening/ (Click on FAQs)
Note: Criminal History will be reviewed by the Background Screening Unit, not the Board Office. Please email all criminal history documents to mqa.backgroundscreen@flhealth.gov. Any original certified documents must be mailed to the following address:

Attn: Background Screening Unit
Florida Department of Health
4052 Bald Cypress Way, Bin BSU-01
Tallahassee, FL 32399

We await your USMLE scores, direct from the Federation of State Medical Boards, which must be requested by the applicant.

If you have any questions, please contact me at serena.mylescrossley@flhealth.gov, call 850-901-6408. The Florida Board of Medicine has assigned **70396** as your **tracking number**. Please indicate this number if you leave a message, and try to ensure that other sources include it on their communications to us as well.

Denson, Angela

From: Santana, Natasha A <Natasha.Santana@jhsmiami.org>
Sent: Thursday, September 26, 2019 10:18 AM
To: Denson, Angela
Cc: BRODERICK C. JONES
Subject: Dr. Broderick Jones's Revised Verification Letter
Attachments: Jones Revised Verification Letter.pdf

Good morning Mrs. Denson,

I apologize for the confusion. Please use the attached letter to serve as the verification document for Dr. Jones's Pathology Residency.

Thank you very much,

Natasha Santana, BHSA
Physician Staffing Specialist II
House Staff Office

Jackson Memorial Hospital
East Tower, 1st Floor 1004
1611 N.W. 12 Ave
Miami, FL 33136-1096
Phone: 305-355-1122
Fax: 305-355-1123
Natasha.Santana@jhsmiami.org

Jackson
MEMORIAL HOSPITAL
Jackson Health System

PUBLIC HEALTH TRUST

September 23, 2019

To Whom It May Concern:

Re: Broderick Jones, MD

The large volume of inquiries concerning former House Staff Physicians necessitates our giving a form reply. Through this office only dates and positions will be verified.

PHYSICIAN'S NAME: Broderick Jones, MD

POSITION HELD: Intern/Resident

DATES ATTENDED: June 24, 1992 – June 23, 1993 (Internship)
July 1, 1993 – June 30, 1996 (Resident)

SPECIALTY/SUBSPECIALTY: Pathology

Remarks: Any additional information must be obtained by writing to the respective department(s).

If we can be of any further assistance to you, please write.

Sincerely,

Natasha Santana
Physician Services

Jackson Health System
1611 NW 12th Avenue
East Tower, 1st Floor, Room 1004
Miami, FL 33136
Phone: (305)355-1122
Fax: (305)355-1123

POST-GRADUATE TRAINING VERIFICATION FORM

Please have this form completed by the Chairman/Director of the post-graduate training program you attended. Please note that if you are using FCVS, do not submit these items.

The form should be mailed or faxed to:

FLORIDA BOARD OF MEDICINE
4052 BALD CYPRESS WAY, BIN C-03
TALLAHASSEE, FLORIDA 32399-3253
(850) 412-1268 Facsimile

Morehouse School of Medicine
Name of School

Internal Medicine
Department

720 Westview Drive SW
Address

Atlanta, GA 30310
City, State, Zip

1. Name of Resident: Broderick Jones

2. Internship/Residency/Fellowship: From: July 1, 1998 To: he was dismissed from the program

3. Matriculation Date: _____

4. Completion Date: He was dismissed from the residency program

5. Specialty: _____

6. Levels completed (check all that apply):

PGY I X PGY II___ PGY III___ PGY IV___ PGY V___

Signed: _____
Chairman or Program Director Only
(No stamped signatures please).
CHINEDU IVONYE MD

Denson, Angela

From: BRODERICK JONES! <blue7drops@yahoo.com>
Sent: Wednesday, October 30, 2019 1:40 PM
To: Denson, Angela
Subject: Fwd: Broderick Jones, MD #70396 - Florida Licensure Application

Hello Ms. Denson,
Sorry about the error in the last correspondence that read, "... significant new issue burden on my family", it should read, "....significant burden on my family".
Thanks again and it was a pleasure hearing from you. If there is anything else that I can do please let me know!
Sincerely,
Broderick

Sent from my iPhone

Begin forwarded message:

> **From:** BRODERICK JONES! <blue7drops@yahoo.com>
> **Date:** October 29, 2019 at 11:43:33 PM EDT
> **To:** "Denson, Angela" <Angela.Denson@flhealth.gov>
> **Subject: Re: Broderick Jones, MD #70396 - Florida Licensure Application**
>
> significant new issue burden on my family.

Chair
Zachariah Zachariah, M.D.
Ft. Lauderdale, Florida

Members
Hector Vila, M.D.
Tampa, Florida
Vice-Chair

Luz Marina Pages, M.D.
Miami Beach, Florida

Scot N. Ackerman, M.D.
Jacksonville, Florida

Eleonor Pimentel, M.D.
Miami, Florida

David A. Diamond, M.D.
Winter Park, Florida

Vacant, Consumer Member

Robert London, M.D.
Maitland, Florida

Jorge J. Lopez, M.D.
Maitland, Florida

Andre M. Perez
Miami, Florida

Kevin Cairns, M.D.
Fort Lauderdale, Florida

Nicholas W. Romanello, Esq.
Melbourne, Florida

Sarvam TerKonda, M.D.
Jacksonville, Florida

Shailesh Gupta, M.D.
Coral Springs, Florida

Vacant, M.D.

Executive Director
Claudia Kemp, J.D.

September 9, 2020

Armando A.Wiscovitch, MD
PO Box 7122
Ponce, PR 00732

Dear Dr. Wiscovitch:

This is in further reference to your certification for approval of licensure with conditions.

Please be advised that your Notice of Intent to Approve Licensure with Conditions will be presented as an individual item to the Credentials Committee of the Board of Medicine to discuss:

- **Request for extension of time to satisfy condition**

The Committee may inquire into any other issues relating to your application and eligibility for licensure. Your appearance is not required but if you choose to appear the date, time and location of the meeting are listed below.

Date:	Thursday, October 1, 2020
Time:	8:00 a.m. (Meeting starts at 8:00 a.m. Interview time may vary.)
Location:	The in-person meeting scheduled in Orlando, Florida is cancelled, and the meeting will be held by a web-based meeting platform or, if appropriate, a teleconference call.

The meeting information and directions for participating in the October 2020 meeting will be posted on the Florida Board of Medicine's website: https://flboardofmedicine.gov/meeting-information.

Additionally, the Committee's recommendation on your application for licensure will be presented to the full Board of Medicine on Friday, October 2, 2020 for final action. You are not required to attend the full board meeting.

Thank you for your continued cooperation. Should you have any questions regarding this matter, please feel free to contact me.

Sincerely,

Wendy Alls

Wendy Alls
Program Operations Administrator

cc: Allen Grossman, Esquire

Pursuant to the provisions of the Americans with Disabilities Act, any person requiring special accommodations to participate in this workshop/meeting is asked to advise the agency at least 10 days before the workshop/meeting by contacting: Rebecca.Hewett@flhealth.gov or call (850) 245-4137.

File # 139892
BCS

FILED
DEPARTMENT OF HEALTH
DEPUTY CLERK
CLERK Angel Sanders
DATE APR 2 4 2019

STATE OF FLORIDA
BOARD OF MEDICINE

IN RE: THE APPLICATION FOR
LICENSURE OF

ARMANDO A. WISCOVITCH, M.D.
_____/

NOTICE OF INTENT TO APPROVE LICENSURE WITH CONDITIONS

This matter came before the Credentials Committee of the Florida Board of Medicine at a duly-noticed public meeting on April 4, 2019, in West Palm Beach, Florida, and the full Board of Medicine on April 5, 2019, in West Palm Beach, Florida. The Applicant, Armando A. Wiscovitch, M.D., was present at the Credentials Committee meeting and was represented by Allen Grossman, Esq.

The application file demonstrates that Dr. Wiscovitch does not meet the examination requirement of Section 458.313(1)(b), Florida Statutes, and that he does not hold an active, valid certificate from the Education Commission for Foreign Medical Graduates (ECFMG) as required by Sections 458.313(1)(a) and 458.311(1)(f)3.b., Florida Statutes.

The application file reveals, however, that Dr. Wiscovitch has met the criteria for competence by other means. In 1980, Dr. Wiscovitch received a medical degree from the Universidad Central de Este, Dominican Republic. He then moved to Florida where he worked as a house physician and a medical assistant before going to Puerto Rico to complete a year of internship training. Upon completion of the Puerto Rico licensing examination and receiving a medical license in Puerto Rico, Dr. Wiscovitch practiced medicine as a hospital emergency physician for five years. Thereafter, from July 1990 through June 1993, Dr. Wiscovitch successfully completed three years of ACGME-accredited residency in Internal Medicine in

Puerto Rico. Following his residency training, he received recognition in Puerto Rico as an Internal Medicine specialist, where he has practiced medicine for thirty years. Dr. Wiscovitch has served in the Puerto Rico State Guard since 1991 and currently holds the rank of Colonel as the Surgeon for the Puerto Rico State Guard.

Section 458.313(7), Florida Statutes, allows the Board to enter an order certifying an applicant for licensure with restrictions when the Board determines that an applicant for licensure by endorsement has failed to meet each of the appropriate licensing requirements.

It is therefore **ORDERED** that the application for licensure be **approved under the following condition:**

Dr. Wiscovitch shall work for six (6) months under the indirect supervision of a Board-approved Florida-licensed allopathic physician who is certified by the American Board of Internal Medicine. The terms of indirect supervision are set forth in Rule 64B8-4.025, Florida Administrative Code.

This Order does not constitute disciplinary action against the license that has been approved herein. The terms of this Order are considered conditions for licensure.

This Order shall become effective upon filing with the Clerk of the Department of Health.

DONE AND ORDERED this 22nd day of April, 2019.

BOARD OF MEDICINE

Claudia Kemp

Claudia Kemp, J.D., Executive Director
For Steven Rosenberg, M.D., Chair

NOTICE OF RIGHT TO HEARING

This notice constitutes final agency action if no request for a hearing is received by the Board on or before the twenty-first day after the applicant's receipt of the notice. The applicant may request a hearing by filing an appropriate petition with the Executive Director of the Board at 4052 Bald Cypress Way, Bin #C-03, Tallahassee, Florida 32399-3253. The applicant may petition for a hearing involving disputed issues of material fact before an administrative law judge pursuant to Section 120.57 (1), Florida Statutes, or for a hearing not involving disputed issues of material fact pursuant to Section 120.57 (2), Florida Statutes.

A petition for a hearing involving disputed issues of material fact must contain information required by Rule 28-106.201, Florida Administrative Code, ***including a statement of all disputed issues of material fact.*** The Board may refer a petition to the Division of Administrative Hearings for assignment of an administrative law judge only if the petition is in substantial compliance with the rule requirements. A petition for a proceeding not involving disputed issues of material fact must contain information required by Rule 28.106.301, Florida Administrative Code, including a concise statement of the ultimate facts alleged, as well as the rules and statutes which entitle petitioner to relief.

In accordance with Section 120.573, Florida Statutes, mediation is not available.

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing has been furnished by **Certified Mail** to **Armando A. Wiscovitch, M.D.,** P.O. Box 7122, Ponce, PR 00732; and **Allen Grossman, Esq.,** Grossman, Furlow & Bayó, L.L.C., 2022-2 Raymond Diehl Road, Tallahassee, FL 32308; and by email to **Donna McNulty**, Special Counsel, at Donna.McNulty@myfloridalegal.com, this 24 day of April, 2019.

Armando A. Wiscovitch, M.D.
P.O. Box 7122
Ponce, PR 00732

Certified Article Number
9414 7266 9904 2140 1164 31
SENDER'S RECORD

Angel Sanders

Deputy Agency Clerk

Armando A. Wiscovitch, M.D.
c/o Allen Grossman, Esq.
2022-2 Raymond Diehl Rd.
Tallahassee, FL 32308

Certified Article Number
9414 7266 9904 2140 1164 24
SENDER'S RECORD

Tab 2 - Erika Lynn Garbrecht, MD – Intern/Resident/Fellow Registration
Issue:

- Health History
- Action by New Mexico Medical Board

Accompanied by Martha Brown, MD, Associate Medical Director, Professionals Resource Network.

The applicant was present and sworn in by the court reporter. After discussion, a motion was made to approve the application for licensure. The motion was seconded, which carried 6/0.

Action Taken: The Committee voted to approve the application for licensure.

Tab 3 - Gary Wayne Greer, MD – Endorsement
Issue: Request to withdraw application for licensure

The applicant was not present. After discussion, a motion was made to allow Dr. Greer to withdraw his application for licensure. The motion was seconded, which carried 6/0.

Action Taken: The Committee voted to allow withdrawal of the licensure application.

Tab 4 - Carla Jeannette Osigian Probst, MD – Endorsement
Issue: Failure to meet section 458.313(1)(a) and 458.311(1)(f)3.c., Florida Statutes, postgraduate training

Represented by Monica Felder Rodriguez, Esquire.

The applicant was present and sworn in by the court reporter. After discussion, a motion was made to approve the application for licensure with the condition that Dr Osigian Probst remain at one of Florida's medical universities for one (1) year. The motion was seconded, which carried 6/0.

Action Taken: The Committee voted to approve the application for licensure with the condition that Dr. Osigian Probst remain at one of Florida's medical universities for one (1) year.

Tab 5 - Armando A. Wiscovitch, MD – Endorsement
Issue:

- Failure to meet section 458.313(1)(a) and 458.311(1)(f)3.b., Florida Statutes, ECFMG certification
- Failure to meet section 458.313(1)(b), Florida Statutes, examination

Represented by Allen Grossman, Esquire.

The applicant was present and sworn in by the court reporter. After discussion, a motion was made to approve the application for licensure with the condition of indirect supervision for six (6) months by a Florida licensed physician who is certified by the American Board of Internal Medicine. The terms of indirect supervision are set forth in Rule 64B8-4.025, Florida Administrative Code. The motion was seconded, which carried 6/0.

Action Taken: The Committee voted to approve the application for licensure with the condition of indirect supervision for six (6) months by a Florida licensed physician who is certified by the American Board of Internal Medicine.

Tab 6 - Osama KH.M. Haddad, MD – Endorsement
Issue: Failure to meet section 458.313(1)(a) and 458.311(1)(f)3.c., Florida Statutes, postgraduate training.

The applicant was present and sworn in by the court reporter. After discussion, a motion was made to approve the application for licensure with the condition that Dr. Haddad continue to practice in a Florida postgraduate training institution for one (1) year. The motion was seconded, which carried 6/0.

Action Taken: The Committee voted to approve the application for licensure with the condition that Dr. Haddad continue to practice in a Florida postgraduate training institution for one (1) year.

FLORIDA | Board *of* Medicine

Ron DeSantis
Governor

Chair
Steven Rosenberg, M.D.
Palm Beach, Florida

Members
Hector Vila, M.D.
Tampa, Florida
Vice Chair

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Coral Springs, Florida

Brigitte Goersch
Satellite Beach, Florida

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Jorge J. Lopez, M.D.
Maitland, Florida

James W. Orr, Jr., M.D.
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Andre M. Perez
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Seela Ramesh, M.D.
Orlando, Florida

Nicholas W. Romanello, Esq.
Melbourne, Florida

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Panama City, Florida

Sarvam TerKonda, M.D.
Jacksonville, Florida

Enrique Ginzburg, MD
Miami, Florida

Vacant, MD

Executive Director
Claudia Kemp, J.D.

March 4, 2019

Armando A. Wiscovitch, MD
PO Box 7122
Ponce, PR 00732

Dear Dr. Wiscovitch:

This is in further reference to your application for licensure by Endorsement.

Please be advised that you are required to make a personal appearance before the Credentials Committee of the Board of Medicine to discuss:

- **Failure to meet section 458.313(1)(a) and 458.311(1)(f)3.b., Florida Statutes, ECFMG certification.**
- **Failure to meet section 458.313(1)(b), Florida Statutes, examination.**

In addition, the Committee may inquire into any other issues relating to your application and eligibility for licensure.

Date:	Thursday, April 4, 2019
Time:	8:00 a.m.
Location:	Florida Board of Medicine/Credentials Committee Meeting Embassy Suites by Hilton West Palm Beach Central 1601 Belvedere Road West Palm Beach, FL 33406 (561) 689-6400

The meeting room will be posted in the lobby of the hotel. Subject to availability, a block of rooms is available for the public attending the Department of Health – Florida Board of Medicine's meeting.

Additionally, the Committee's recommendation on your application for licensure will be presented to the full Board of Medicine on Friday, April 5, 2019 for final action. You are not required to attend the full board meeting.

Thank you for your continued cooperation. Should you have any questions regarding this matter, please feel free to contact me. *This is your first scheduled appearance.

Sincerely,

Wendy Alls

Wendy Alls
Program Operations Administrator

Allen Grossman, Esquire

Pursuant to the provisions of the Americans with Disabilities Act, any person requiring special accommodations to participate in this workshop/meeting is asked to advise the agency at least 10 days before the workshop/meeting by contacting: Rebecca.Hewett@flhealth.gov or call (850) 245-4137.

*** 456.013(3)(c) In considering applications for licensure, the board, or the department when there is no board, may require a personal appearance of the applicant. If the applicant is required to appear, the time period in which a licensure application must be granted or denied shall be tolled until such time as the applicant appears. However, if the applicant fails to appear before the board at either of the next two regularly scheduled board meetings, or fails to appear before the department within 30 days if there is no board, the application for licensure shall be denied.**

4052 Bald Cypress Way, Bin C-03
Tallahassee, Florida 32399-3253
Phone: 850/245-4131
Fax: 850/488-0596 or 850/412-1268
https://www.FLBoardofMedicine.gov

Florida HEALTH

1501 F139892

MEDICAL DOCTOR
APPLICATION FOR LICENSURE

Apply for your license online at www.flboardofmedicine.gov

09/06/2018 955.00
ID: 139892 Type: F
BT: 3004169
R#: 918008543

Choose your application type:

☒ Endorsement (1021) ☐ Examination (1024)

☐ Military Veterans Fee Waiver

If you were honorably discharged from the U.S. armed services within 60 months of your application you will qualify for a waiver of the application fee and the initial licensure fee. In order to qualify, please check the box above indicating that you are seeking a waiver and submit **a DD-214 or NGB-22 form as proof of honorable discharge.**

☐ I plan to dispense medicinal drugs in the State of Florida for a fee or other remuneration and hereby register as required by Section 465.0276, F.S. I understand that the fee for the Dispensing Practitioner is $100.00 in addition to the required initial license fee and will submit it along with the license fee.

1. PERSONAL INFORMATION

Name: Wiscovitch, Armando A **Date of Birth:** 04/29/1947
Last/Surname First Middle MM/DD/YYYY

Mailing Address: (The address where mail and your license should be sent)

PO Box 7122 Ponce
Street/ PO Box Suite/Apt. No City

PR 00732 USA 787-613-1613
State Zip Country Phone Number

Physical Location: A Post Office Box is not acceptable. This address will be posted on the Department of Health's website. *If you do not have a current practice address, your mailing address will be used. When you obtain a practice address, you will be required to update your online practitioner profile.*

2525 Ruberté St Suite 101 Ponce
Street/ P.O. Box Suite/Apt. No City

PR 00728 USA 787-259-5990
State Zip Country Alternate Phone Number

Email Address: drwiscov@yahoo.com

Under Florida law, email addresses are public records. If you do not want your e-mail address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.

Equal Opportunity Data: We are required to ask that you furnish the following information as part of your voluntary compliance with Section 2, Uniform Guidelines on Employee Selection Procedure (1978) 43 CFR 38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

SEX: ☒ **Male** ☐ **Female** **RACE:** ☒ **White** ☐ **Black** ☐ **Asian/Pacific Islander** ☐ **Hispanic** ☐ **Other**

☒ Yes ☐ No **Availability for Disaster:** Will you be available to provide health care services in special needs shelters or to help staff disaster medical assistance teams during times of emergency or major disaster?

Armando Wiscovitch F139892 3458253

F139892

Postgraduate Training:

MEDICINE BOARD

2018 NOV 14 AM 9:56

Provide the following documentation to support your postgraduate training:

✓ Post-Graduate Training Form

In the table below list, in chronological order, all postgraduate training from the date you graduated from medical school to the present. Start with your first program and end with your last or current program. List all programs you began, whether you completed or received credit for the training.

Program Name and Full Mailing Address:	Specialty Area:	From: (mm/yy)	To: (mm/yy)	Did you receive credit? (Y/N)
Hosp Episcopal San Lucas Ave Tito Castro #917 Ponce PR 00716	Internal Medicine	07/90	06/93	Y

Loan History:

☐ Yes ☒ No Are you currently in default on any health education loan or scholarship obligation? (If "yes", explain on a separate sheet providing accurate details.)

3. EXAMINATION HISTORY

State Board (prior to 1974), State Board (after 1974) & SPEX, LMCC & SPEX, NBME, FLEX, USMLE III, or Combination (prior to 2000)

Request that the score report be sent directly to the Board of Medicine. NOTE: If you took a state Board examination and are not currently licensed in three other states, you must also request your SPEX score be sent.

Exam taken: Flex (1975) Date passed: Not passed
mm/dd/yy

DR. ARMANDO WISCOVITCH
Director Médico

HOSPITAL METROPOLITANO DR. PILA PONCE

Tel:787•848•5600 Ext. 3102, 3103, 3120 | Fax: 787•848•4617

Postgraduate Training:

Provide the following documentation to support your postgraduate training:

☑ Post-Graduate Training Form

In the table below list, in chronological order, all postgraduate training from the date you graduated from medical school to the present. Start with your first program and end with your last or current program. List all programs you began, whether you completed or received credit for the training.

Program Name and Full Mailing Address:	Specialty Area:	From: (mm/yy)	To: (mm/yy)	Did you receive credit? (Y/N)
Hosp Episcopal San Lucas Ave Tito Castro #917 Ponce PR 00716	Internal Medicine	07/90	06/93	Y

Loan History:

☐ Yes ☒ No Are you currently in default on any health education loan or scholarship obligation? (If "yes", explain on a separate sheet providing accurate details.)

3. EXAMINATION HISTORY

State Board (prior to 1974), State Board (after 1974) & SPEX, LMCC & SPEX, NBME, FLEX, USMLE III, or Combination (prior to 2000)

Request that the score report be sent directly to the Board of Medicine. NOTE: If you took a state Board examination and are not currently licensed in three other states, you must also request your SPEX score be sent.

Exam taken:_____ Date passed: _____
mm/dd/yy

DR. ARMANDO WISCOVITCH
Director Médico

HOSPITAL METROPOLITANO DR. PILA PONCE

Tel:787•848•5600 Ext. 3102, 3103, 3120 | Fax: 787•848•4617

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4. LICENSURE HISTORY

Request verification of licensure status directly from the licensing entity or www.veridoc.org. Request international license verification(s) if you have practiced outside of the U.S. for at least two of the previous four years.

☑ Yes ☐ No Do you now hold or have you ever held a license to practice medicine or any other profession in any US State or territory, or foreign country? Please list in table below.

Jurisdiction	Profession	License number
State of Michigan	Physician	4301079001
Puerto Rico	Physician, Internal Med	9858

If you answer "yes" to any of the questions in this section, you are required to send an explanation and supporting documentation.

☐ Yes ☒ No Have you had any application for a medical license or professional license denied by any state board or other governmental agency of any state, territory, or country?

☐ Yes ☒ No Are you currently under investigation in any jurisdiction for an act or offense that would constitute a violation of Section 458.331, Florida Statutes?

☐ Yes ☒ No Have you ever had any professional license or license to practice medicine revoked, suspended, placed on probation, or other disciplinary action taken in any state, territory or country?

5. PRACTICE/EMPLOYMENT HISTORY

List the year you legally first began to practice medicine, 1990 (yyyy). This would be the year you began practicing medicine and could be the date you began your postgraduate training.

☒ Yes ☒ No — Have you practiced medicine in another jurisdiction for two of the last four years or completed a board approved post-graduate training program within the last two years?

☐ Yes ☒ No If your answer to the question above was "No," have you passed a board approved clinical competency exam within the last year? If yes, then submit supporting documentation.

List in chronological order all employment for the last four (4) years.

Name and address of practice or employment	Type of employment	From: mm/yy	To: mm/yy
Metropolitan Dr Pila Hosp. Blvd Luis A Ferré, Ponce PR	Medical Director	06/10	Present
Medical Office 2525 Ruberté Ave Suite 101 Ponce PR	Internal Medicine Practice	07/94	Present

4. LICENSURE HISTORY

Request verification of licensure status directly from the licensing entity or www.veridoc.org. Request international license verification(s) if you have practiced outside of the U.S. for at least two of the previous four years.

☒ Yes ☐ No Do you now hold or have you ever held a license to practice medicine or any other profession in any US State or territory, or foreign country? Please list in table below.

Jurisdiction	Profession	License number
State of Michigan	Physician	4301079001
Puerto Rico	Physician, Internal Med	9858

If you answer "yes" to any of the questions in this section, you are required to send an explanation and supporting documentation.

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☐ Yes ☒ No Are you currently under investigation in any jurisdiction for an act or offense that would constitute a violation of Section 458.331, Florida Statutes?

☐ Yes ☒ No Have you ever had any professional license or license to practice medicine revoked, suspended, placed on probation, or other disciplinary action taken in any state, territory or country?

5. PRACTICE/EMPLOYMENT HISTORY

List the year you legally first began to practice medicine, 1990 (yyyy). This would be the year you began practicing medicine and could be the date you began your postgraduate training.

☐ Yes ☒ No Have you practiced medicine in another jurisdiction for two of the last four years **or** completed a board approved post-graduate training program within the last two years?

☐ Yes ☒ No If your answer to the question above was "No," have you passed a board approved clinical competency exam within the last year? If yes, then submit supporting documentation.

List in chronological order all employment for the last four (4) years.

Name and address of practice or employment	Type of employment	From: mm/yy	To: mm/yy
Metropolitan Dr Pila Hosp. Blvd Luis A Ferré, Ponce PR	Medical Director	06/10	Present
Medical Office 2525 Ruberté Ave Suite 101 Ponce PR	Internal Medicine Practice	07/94	Present

☒ Yes ☐ No Do you currently hold staff privileges in any hospital, health institution, clinic or medical facility? List each facility below.

Name of facility
Metropolitan Dr Pila Hospital
Damas Hospital
San Cristobal Hospital

If you answer "yes" to the following questions, you are required to send an explanation and supporting documentation.

☐ Yes ☒ No Have you ever had any staff privileges denied, suspended, revoked, modified, restricted, not renewed, or placed on probation, or have you been asked to resign or take a temporary leave of absence or were otherwise acted against by any facility?

☐ Yes ☒ No Do you currently, or have you had, responsibility for graduate medical education within the last 10 years?

In the table below, list all institutions where you have had responsibility for graduate medical education or faculty appointment(s) at any medical school.

Name of institution

☐ Yes ☒ No Are you certified by any specialty board recognized by the American Board of Medical Specialties or specialty board approved by the Florida Board of Medicine?

Board Name	Certification/ Specialty/Sub-Specialty	Date of Certification (mm/yy)

If you answer "yes" to any of the following questions, please explain on a separate sheet providing accurate details.

☐ Yes ☒ No Have you ever had any final disciplinary action taken against you by a specialty board or other similar national organization?

☐ Yes ☒ No Have you ever been denied or surrendered a DEA registration?

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6. CRIMINAL HISTORY

If you answer "Yes" to the following question you are required to send the following items:

a. Self-explanation describing in detail the circumstances surrounding each offense, including dates, city and state, charges and final results.
b. Final Dispositions and Arrest Records for all offenses. The Clerk of the Court in the arresting jurisdiction will provide you with these documents. Unavailability of these documents must come in the form of a letter from the Clerk of the Court.
c. Completion of Sentence Documents. You may obtain documentation from the Department of Corrections. The report must include the start date, end date and that the conditions were met.

☐ Yes ☒ No Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to, a crime in any jurisdiction other than a minor traffic offense? You must include all misdemeanors and felonies, **even if adjudication was withheld. Driving under the influence (DUI) or driving while impaired (DWI) are not minor traffic offenses for purposes of this question.**

☒ Yes ☐ No I have been provided and read the statement from the Florida Department of Law Enforcement regarding the sharing, retention, privacy and right to challenge incorrect criminal history records and the "Privacy Statement" document from the Federal Bureau of Investigation.

7. MILITARY HISTORY

A. ☒ Yes ☐ No Have you ever been in the United States Military and/or Public Health Service?

B. ☐ Yes ☒ No Have you ever been disciplined by any branch of the United States Armed Services or Public Health Services? If you answered "yes" please provide a detailed explanation and supporting documentation

8. CRIMINAL AND MEDICAID/MEDICARE FRAUD QUESTIONS

Applicants for licensure, certification or registration and candidates for examination may be excluded from licensure, certification or registration if their felony conviction falls into certain timeframes as established in Section 456.0635(2), Florida Statutes. If you answer "Yes" to any of the following questions, please provide a written explanation for each question. Supporting documentation includes court dispositions or agency orders where applicable.

1. ☐ Yes ☒ No Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, F.S. (relating to social and economic assistance), Chapter 817, F.S. (relating to fraudulent practices), Chapter 893, F.S. (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction?

If you responded "No" to the question above, skip to question 2.

a. ☐ Yes ☐ No If "yes" to 1, for the felonies of the first or second degree, has it been more than 15 years from the date of the plea, sentence and completion of any subsequent probation?

b. ☐ Yes ☐ No If "Yes" to 1, for felonies of the third degree, has it been more than 10 years from the date of the plea, sentence and completion of any subsequent probation? (This question does not apply to felonies of the third degree under Section 893.13(6)(a), Florida Statutes)

c. ☐ Yes ☐ No If "Yes" to 1, for the felonies of the third degree under Section 893.13(6)(a), Florida Statutes, has it been more than 5 years from the date of the plea, sentence and completion of any subsequent probation?

d. ☐ Yes ☐ No If "Yes" to 1, have you successfully completed a drug court program that resulted in the plea for the felony offense being withdrawn or charges dismissed?

2. ☐ Yes ☒ No Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970 (relating to controlled substances) or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)?

6. CRIMINAL HISTORY

If you answer "Yes" to the following question you are required to send the following items:

a. Self-explanation describing in detail the circumstances surrounding each offense, including dates, city and state, charges and final results.
b. Final Dispositions and Arrest Records for all offenses. The Clerk of the Court in the arresting jurisdiction will provide you with these documents. Unavailability of these documents must come in the form of a letter from the Clerk of the Court.
c. Completion of Sentence Documents. You may obtain documentation from the Department of Corrections. The report must include the start date, end date and that the conditions were met.

☐Yes ☒No Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to, a crime in any jurisdiction other than a minor traffic offense? You must include all misdemeanors and felonies, **even if adjudication was withheld. Driving under the influence (DUI) or driving while impaired (DWI) are not minor traffic offenses for purposes of this question.**

☐Yes ☒No I have been provided and read the statement from the Florida Department of Law Enforcement regarding the sharing, retention, privacy and right to challenge incorrect criminal history records and the "Privacy Statement" document from the Federal Bureau of Investigation.

7. MILITARY HISTORY

A. ☒Yes ☐ No Have you ever been in the United States Military and/or Public Health Service?

B. ☐Yes ☒No Have you ever been disciplined by any branch of the United States Armed Services or Public Health Services? If you answered "yes" please provide a detailed explanation and supporting documentation

8. CRIMINAL AND MEDICAID/MEDICARE FRAUD QUESTIONS

Applicants for licensure, certification or registration and candidates for examination may be excluded from licensure, certification or registration if their felony conviction falls into certain timeframes as established in Section 456.0635(2), Florida Statutes. If you answer "Yes" to any of the following questions, please provide a written explanation for each question. Supporting documentation includes court dispositions or agency orders where applicable.

1. ☐ Yes ☒No Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, F.S. (relating to social and economic assistance), Chapter 817, F.S. (relating to fraudulent practices), Chapter 893, F.S. (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction?

If you responded "No" to the question above, skip to question 2.

a. ☐ Yes ☐ No If "yes" to 1, for the felonies of the first or second degree, has it been more than 15 years from the date of the plea, sentence and completion of any subsequent probation?

b. ☐ Yes ☐ No If "Yes" to 1, for felonies of the third degree, has it been more than 10 years from the date of the plea, sentence and completion of any subsequent probation? (This question does not apply to felonies of the third degree under Section 893.13(6)(a), Florida Statutes)

c. ☐ Yes ☐ No If "Yes" to 1, for the felonies of the third degree under Section 893.13(6)(a), Florida Statutes, has it been more than 5 years from the date of the plea, sentence and completion of any subsequent probation?

d. ☐ Yes ☐ No If "Yes" to 1, have you successfully completed a drug court program that resulted in the plea for the felony offense being withdrawn or charges dismissed?

2. ☐ Yes ☒No Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970 (relating to controlled substances) or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)?

If you responded "No" to the question above, skip to question 3.

a. ☐ Yes ☐ No If "Yes" to 2, has it been more than 15 years before the date of application since the sentence and any subsequent period of probation for such conviction or plea ended?

3. ☐ Yes ☒ No Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes?

If you responded "No" to the question above, skip to question 4.

a. ☐ Yes ☐ No If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years?

4. ☐ Yes ☒ No Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid Program?

If you responded "No" to the question above, skip to question 5.

a. ☐ Yes ☐ No Have you been in good standing with a state Medicaid program for the most recent five years?

b. ☐ Yes ☐ No Did the termination occur at least 20 years before the date of this application?

5. ☐ Yes ☒ No Are you currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities?

If you answer "Yes" to the questions below, you are required to send the following items:

- **A statement indicating the date of each incident and the number for each case.**
- **An explanation of details for each case and your involvement for each case.**
- **Submit the enclosed Exhibit 1 form.**
- **A copy of the complaint, judgments and/or settlements for each case.**
- **Submit a complete copy of the trial record(s) of each case, including the trial transcript, evidentiary exhibits and final judgment in electronic format.**

☐ Yes ☒ No Have you ever had a judgment entered against you for medical malpractice where the incident(s) of malpractice occurred after November 2, 2004?

☐ Yes ☒ No Within the last 10 years have you had any liability claim(s) or action(s) for damages for personal injury settled or finally adjudicated in an amount that exceeds $100,000.00?

10. FINANCIAL RESPONSIBILITY

The Financial Responsibility options are divided into two categories, coverage and exemptions. Check only one option of the ten provided as required by s. 458.320, Florida Statutes.

Category I: Financial Responsibility Coverage

☐1. I do not have hospital staff privileges, I do not perform surgery at an ambulatory surgical center and I have established an irrevocable letter or credit or an escrow account in an amount of $100,000/$300,000, in accord with Chapter 675, F. S., for a letter of credit and s. 625.52, F. S., for an escrow account.

☐2. I have hospital staff privileges or I perform surgery at an ambulatory surgical and I have established an irrevocable letter of credit or escrow account in an amount of $250,000/$750,000, in accord with Chapter 675, F. S., for a letter of credit and s. 625.52, F. S., for an escrow account.

☐3. I do not have hospital staff privileges, I do not perform surgery at an ambulatory surgical center and I have obtained and maintain professional liability coverage in an amount not less than $100,000 per claim, with a minimum annual aggregate of not less than $300,000 from an authorized insurer as defined under s. 624.09, F. S., from a surplus lines insurer as defined under s. 626.914(2), F. S., from a risk retention group as defined under s. 627.942, F. S., from the Joint Underwriting Association established under s. 627.351(4), F. S., or through a plan of self-insurance as provided in s. 627.357, F. S.

☐4. I have hospital staff privileges or I perform surgery at an ambulatory surgical and I have professional liability coverage in an amount not less than $250,000 per claim, with a minimum annual aggregate of not less than $750,000 from an authorized insurer as defined under s. 624.09, F. S., from a surplus lines insurer as defined under s. 626.914(2), F. S., from a risk retention group as defined under s. 627.942, F. S., from the Joint Underwriting Association established under s. 627.351(4), F. S., or through a plan of self-insurance as provided in s. 627.357, F. S.

☐5. I have elected not to carry medical malpractice insurance however, I agree to satisfy any adverse judgments up to the minimum amounts pursuant to s. 458.320(5)(g)1, F. S. I understand that I must either post notice in a sign prominently displayed in my reception area or provide a written statement to any person to whom medical services are being provided that I have decided not to carry medical malpractice insurance. I understand that such a sign or notice must contain the wording specified in s. 458.320(5)(g), F. S.

Category II: Financial Responsibility Exemptions

☐6. I practice medicine exclusively as an officer, employee, or agent of the federal government, the state, or its agencies or subdivisions.

☐7. I hold a limited license issued pursuant to s. 458.317, F. S., and practice only under the scope of the limited license.

☒8. I do not practice medicine in the State of Florida.

☐9. I meet all of the following criteria:

(a) I have held an active license to practice in this state or another state or some combination thereof for more than 15 years;

(b) I am retired or maintain part time practice of no more than 1000 patient contact hours per year;

(c) I have had no more than two claims resulting in an indemnity exceeding $25,000 within the previous five-year period;

(d) I have not been convicted of or pled guilty or nolo contendere to any criminal violation specified in Chapter 458, F. S. or the medical practice act in any other state; and

(e) I have not been subject, within the past ten years of practice, to license revocation, suspension, or probation for a period of three years or longer, or a fine of $500 or more for a violation of Chapter 458, F. S., or the medical practice act of another jurisdiction. A regulatory agency's acceptance of a relinquishment of license, stipulation, consent order, or other settlement offered in response to or in anticipation of filing of administrative charges against a license is construed as action against a license. I understand if I am claiming an exception under this section that I must either post notice in a sign prominently displayed in my reception area or provide a written statement to any person to whom medical services are being provided that I have decided not to carry medical malpractice insurance. See Section 458.320(5)(f), Florida Statutes, for specific notice requirements.

☐10. I practice only in conjunction with my teaching duties at an accredited medical school or its teaching hospitals. (Interns and residents do not qualify for this exemption).

If you select an exemption based on number 9, you must also complete the affidavit on the following page.

11. FLORIDA BIRTH RELATED NEUROLOGICAL COMPENSATION ASSOCIATION

You must choose one of the three options described below. Please be sure to view the information about each exemption at www.nica.com. Check only one.

☐	☑	☐	$250.00
$5,000 Participating	$250 Non-participating	$0 Exempt	Amount enclosed

If you choose "$0 Exempt" provide appropriate documentation to the Board of Medicine and to NICA.

I have read the explanatory information provided by NICA, and I choose the option above.

Signature 7/11/18 Date

Armando A Wiscovitch
Name
2525 Ruberté Ave Suite 101
Street Address
Ponce PR 00728
City, State, Zip

If you are a participating or non-participating physician, or a physician claiming exemption, you must complete, sign and date this form and return it with your payment to this address..

Board of Medicine
4052 Bald Cypress Way, #C-03
Tallahassee, FL 32399-3253

If you are a physician claiming exemption, you must also send a copy of your completed, signed, and dated form with proof of your exemption to:

NICA
2360 Christopher Place
Tallahassee, FL 32308

If you have any questions about NICA or this form, please contact NICA at www.nica.com or (850) 488-8191.

12. STATEMENT OF APPLICANT

I state that these statements are true and correct. I recognize that providing false information may result in denial of licensure, disciplinary action against my license, or criminal penalties pursuant to Sections 456.067, 775.083, and 775.084, Florida Statutes. I state that I have read Chapters 456, 458 and 766.301-.316, Florida Statutes and Chapter 64B8, Florida Administrative Code.

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Florida Board of Medicine information which is material to my application for licensure.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind. I state that my answers and all statements made by me herein are true and correct.

Should I furnish any false information in this application, I hereby agree that such act constitutes cause for denial, suspension, or revocation of my license to practice medicine in the State of Florida. If there are any changes to my status or any change that would affect any of my answers to this application I must notify the board within 30 days.

I understand that my records are protected under federal and state regulations governing Confidentiality of Mental Health Patient Records and cannot be disclosed without my written consent unless otherwise provided in the regulations. I understand that my records are protected under federal and state regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it.

Armando A Wiscovitch

Print name

Signature

7/11/18

Date

September 10, 2018

Armando A Wiscovitch , M.D.
Po Box 7122
Ponce, PR 00732

Dear Dr. Wiscovitch:
File: 139892

Thank you for considering Florida for physician licensure. Your application for medical licensure has been received. The application is incomplete for the reasons set out in the attached deficiency notice. Please address these deficiencies as soon as possible to avoid delay in processing your application.

Information received by this office may require additional explanation or documentation to determine licensure eligibility. After all requested documentation is received, your application will be submitted for supervisory review. We will notify you if additional information is required.

Applicants with a history of malpractice, criminal activity, discipline, physical or mental impairment, unfavorable evaluations, or other matters that need explanation may require a personal appearance before the Board of Medicine Credentials Committee for determination of licensure eligibility. If your appearance is required, you will be notified in writing once your application is complete.

You can now follow the progress of your application through our website at: www.FLHealthSource.gov/mqa-services. If you are a returning user, select "Yes" and enter the user ID and password you selected during the registration process under Returning User. If you did not apply for licensure through this screen, select "No" and follow the prompts to create an account. You must have a valid email address to create your account.

Once you are logged in, you will be prompted to add your application to your account. Once you have successfully added your application, you will be directed to your dashboard. Under the "Additional Activities" section, select "Check Application Status" to review any open deficiencies, upload documents or print out instructional documents.

THIS IS IMPORTANT: Your application will remain incomplete until all deficiencies are completed. In addition, you are required to notify the Board office immediately in writing of any occurrence(s) that would in any way change or affect any answer given in the application or an answer provided in response to any of our direct questions to you.

If you have any questions, please contact me at carmelette.gilley@flhealth.gov, call (850) 617-1906, or fax (850) 412-1284.

Sincerely,

Carmen Gilley

Carmen Gilley
Regulatory Specialist II

Enclosure(s)

Armando A Wiscovitch **Date: September 10, 2018**

REMINDER: Chapter 456.013(1)(a), Florida Statutes, provides that an incomplete application shall expire one year after initial filing with the department.

YOUR APPLICATION'S EXPIRATION DATE IS SEPTEMBER 05, 2019

APPLICATION SUBMITTED REMAINS DEFICIENT FOR LACK OF THE FOLLOWING:

1. Your ECFMG status report, directly from the ECFMG, has not been received.

2. An official verification of your medical license from the states of MI & PR has not been received.

3. The inquiry you mailed to your medical school has not been received.

4. Your Postgraduate Training Verification Forms for years 90-93 have not been received.

5. Please submit the National Practitioner Data Bank (NPDB) report to our office. You may contact the NPDB at 1-800-767-6732 to obtain this information.

6. Your application is incomplete. Please complete the highlighted section(s) on pages 9, 10 & 12 and return the enclosed pages to our office.

7. We have not received your Livescan results. If you have already had your electronic fingerprinting completed, please allow 24 – 72 hours for receipt of your results. Should your Criminal Background Check disclose an arrest record(s), you will need to provide documentation related to each criminal event revealed in your background, if you have not already done so. You can find a detailed description of documents that will be required by visiting the FAQs on the Background Screening Website at http://www.flhealthsource.gov/background-screening/ (Click on FAQs)

   Note: Criminal History will be reviewed by the Background Screening Unit, not the Board Office. Please email all criminal history documents to mqa.backgroundscreen@flhealth.gov. Any original certified documents must be mailed to the following address:

Attn: Background Screening Unit

Florida Department of Health
4052 Bald Cypress Way, Bin BSU-01
Tallahassee, FL 32399

8. We await your FLEX/USMLE/SPEX/National Board exam scores, direct from the Federation of State Medical Boards, which must be requested by the applicant.

If you have any questions, please contact me at carmelette.gilley@flhealth.gov, call (850) 617-1906, or fax (850) 412-1284. The Florida Board of Medicine has assigned **139892** as your **tracking number**. Please indicate this number if you leave a message, and try to ensure that other sources include it on their communications to us as well.

Universidad Central del Este

Fundada el 15 de Octubre de 1970
SAN PEDRO DE MACORIS, REPUBLICA DOMINICANA

El Consejo Universitario en virtud de las disposiciones legales vigentes:

Por cuanto: **Armando A. Wiscovitch Vélez**

ha cursado en la

Facultad de Ciencias Médicas *de esta Universidad los estudios requeridos y ha sido aprobado en los exámenes correspondientes.*

Por tanto, ha venido en otorgarle y le otorga el título de

Doctor en Medicina

Y para que sea notorio y constante le expide el presente Diploma, firmado y sellado en San Pedro de Macoris, República Dominicana, hoy dia 22 *de Agosto del año* 1980.

EL RECTOR
Dr. José E. Hazim Frappier

EL DECANO DE LA FACULTAD
Dr. Juan A. Silva S.

REGISTRADO BAJO EL No. 503 FOLIO 28
DEL LIBRO DE GRADOS Y TITULOS
El Secretario de la Universidad
Lic. Ricardo S. Noboa M.

We certify this document as a true copy of the original granted Armando. Wiscovich Velez , graduates on August 22, 1980 and received Degree Doctor of Medicine with Diploma registered under number 503 in Folio 28 of the Record Book of Title.

Lic. Piedad Licelott Noboa
General Secretary and Registrar

Medical Degree Verification Form

FLORIDA BOARD OF MEDICINE
4052 BALD CYPRESS WAY, BIN # C03
TALLAHASSEE, FL 32399-3253
FAX (850) 412-1268

Applicant completes number 1 through 3. Please note that if you are using FCVS, do not submit this item.

1. TO: Universidad Central del Este
Name of medical school

Francisco Alberto Caamaño Ave.
Street address

SPM-21000, Republica Dominica
City - State - Zip - Country

2. Name: Armando Antonio Wiscovitch Velez

3. Date of Birth: April 29, 1947

4. Type of Degree: Doctor of Medicine Date Degree Received: August 22,1980

Authenticate by signature and school seal.

Verified by

Rosanna Matos Rodriguez
Name

Verifications Department Director
Title

SEAL

POST-GRADUATE TRAINING VERIFICATION FORM

Please have this form completed by the Chairman/Director of the post-graduate training program you attended. Please note that if you are using FCVS, do not submit these items.

The form should be mailed or faxed to:

FLORIDA BOARD OF MEDICINE
4052 BALD CYPRESS WAY, BIN C-03
TALLAHASSEE, FLORIDA 32399-3253
(850) 412-1268 Facsimile

Hospital Episcopal San Lucas / Ponce Health Sciences University
Name of School Program

Internal Medicine
Department

Ave Tito Castro #917
Address

Ponce, PR 00716
City, State, Zip

1. Name of Resident: Armando Wiscovitch, MD

2. Internship/Residency/Fellowship: From: July 1, 1990 To: June 30, 93

3. Matriculation Date: July 1, 1990

4. Completion Date: June 30, 1993

5. Specialty: Internal Medicine

6. Levels completed (check all that apply):

PGY I ✓ PGY II ✓ PGY III ✓ PGY IV ___ PGY V ___

Signed: [signature] MD
Chairman or Program Director Only
(No stamped signatures please).

LICENSING AND REGULATORY AFFAIRS
CUSTOMER DRIVEN. BUSINESS MINDED.

Verify a License or Registration

Name and Address

Name: ARMANDO A WISCOVITCH
Address: Ponce, PR 007327122

Profession and License/Registration Information

Profession: Medicine
Type: Medical Doctor
Permanent ID #
4301079001
Status
Active
Issue Date
08/31/2001
Expiration Date
01/31/2022

Complaints and Disciplinary Action

Open Formal Complaints: None
Disciplinary Action: None

Back to Search (/VAL/License/Search)

Disclaimer: Licensing and registration records are made available on this website by LARA to provide immediate access to information for the convenience of interested persons. This information is updated once a day. All users have the responsibility to determine whether information obtained from this site is still accurate, current, and complete. LARA assumes no responsibility for any errors or omissions, or for the use of information obtained from this site.

The Disciplinary Action section shows if a licensee/registrant currently has an open formal complaint and a listing of any final disciplinary action after January 1, 2005. The date of compliance may not be listed for disciplinary actions occurring prior to January 1, 2005.

Disciplinary documents are posted to the Documents section as required by Section 333.16216(6) of the Public Health Code. Final administrative disciplinary action is subject to judicial review.

NOTE: EMS PERSONNEL ARE NOT LICENSED BY LARA BUREAU OF PROFESSIONAL LICENSING. PLEASE VISIT THE DHHS PERSONNEL LICENSURE AND EDUCATION REQUIREMENTS PAGE (http://www.michigan.gov/mdhhs/0,5885,7-339-73970_5093_28508-47472--,00.html) TO VERIFY A LICENSE FOR EMS PERSONNEL.

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

RICK SNYDER
GOVERNOR

SHELLY EDGERTON
DIRECTOR

VERIFICATION OF LICENSURE
MICHIGAN BOARD OF MEDICINE
VERIFICATION OF LICENSURE AS OF 10/17/2018

EMAILED: carmelette.gilley@flhealth.gov

NAME: **Armando A Wiscovitch** **BIRTHDATE:** XX/XX/1947

ADDRESS: PO Box 7122
Ponce PR 00732-7122

TYPE: **Medical Doctor** **ORIGINAL DATE:** 08/31/2001

LICENSE NUMBER: 4301079001 **STATUS:** Active **EXPIRATION DATE:** 01/31/2019
OBTAINED BY: Examination

EXAM DATE	EXAM TYPE	EXAM RESULTS

DISCIPLINARY ACTION NONE

OPEN FORMAL COMPLAINTS NONE

D- Gage

Dawn Gage, Licensing Manager
Bureau of Professional Licensing
Licensing Division
(517) 335-0918

LARA is an equal opportunity employer.
Auxiliary aids, services and other reasonable accommodations are available upon request to individuals with disabilities.

Chair
Zachariah Zachariah, M.D.
Ft. Lauderdale, Florida

Members
Hector Vila, M.D.
Tampa, Florida
Vice-Chair

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Miami, Florida

David A. Diamond, M.D.
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Maitland, Florida

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Nicholas W. Romanello, Esq.
Melbourne, Florida

Sarvam TerKonda, M.D.
Jacksonville, Florida

Shailesh Gupta, M.D.
Coral Springs, Florida

Vacant, M.D.

Executive Director
Claudia Kemp, J.D.

September 9, 2020

Adel Ricardo Vargas Rodriguez, MD
2430 S Atlantic Ave
Suite C
Daytona Beach Shores, FL 32118

Dear Dr. Vargas Rodriguez:

This is in further reference to your certification for approval of licensure with conditions.

Please be advised that your Notice of Intent to Approve Licensure with Conditions will be presented as an individual item to the Credentials Committee of the Board of Medicine to discuss:

- **Request for extension of time to satisfy condition**

The Committee may inquire into any other issues relating to your application and eligibility for licensure. Your appearance is not required but if you choose to appear the date, time and location of the meeting are listed below.

Date:	Thursday, October 1, 2020
Time:	8:00 a.m. (Meeting starts at 8:00 a.m. Interview time may vary.)
Location:	The in-person meeting scheduled in Orlando, Florida is cancelled, and the meeting will be held by a web-based meeting platform or, if appropriate, a teleconference call.

The meeting information and directions for participating in the October 2020 meeting will be posted on the Florida Board of Medicine's website: https://flboardofmedicine.gov/meeting-information.

Additionally, the Committee's recommendation on your application for licensure will be presented to the full Board of Medicine on Friday, October 2, 2020 for final action. You are not required to attend the full board meeting.

Thank you for your continued cooperation. Should you have any questions regarding this matter, please feel free to contact me.

Sincerely,

Wendy Alls

Wendy Alls
Program Operations Administrator

Pursuant to the provisions of the Americans with Disabilities Act, any person requiring special accommodations to participate in this workshop/meeting is asked to advise the agency at least 10 days before the workshop/meeting by contacting: Rebecca.Hewett@flhealth.gov or call (850) 245-4137.

1501
#142449
CR

FILED
DEPARTMENT OF HEALTH
DEPUTY CLERK
CLERK: Angel Sanders
DATE: JUL 02 2019

STATE OF FLORIDA
BOARD OF MEDICINE

IN RE: THE APPLICATION FOR
LICENSURE OF

ADEL RICARDO VARGAS RODRIGUEZ, M.D.
_____/

NOTICE OF INTENT TO APPROVE LICENSURE WITH CONDITIONS

This matter came before the Credentials Committee of the Florida Board of Medicine at a duly-noticed public meeting on June 6, 2019, in Miami, Florida, and the full Board of Medicine on June 7, 2019, in Miami, Florida. The Applicant, Adel Ricardo Vargas Rodriguez, M.D., was present at the Credentials Committee meeting.

The application file demonstrates that Dr. Vargas Rodriguez does not meet the examination requirement of Section 458.313(1)(b), Florida Statutes, and that he does not hold an active, valid certificate from the Education Commission for Foreign Medical Graduates (ECFMG) as required by Sections 458.313(1)(a) and 458.311(1)(f)3.b., Florida Statutes.

The application file reveals, however, that Dr. Vargas Rodriguez has met the criteria for competence by other means. In 1986, Dr. Vargas Rodriguez received a medical degree from the Universidad Central del Este, Dominican Republic. He completed a Rotating Internship from July 1, 19990 through June 30, 1991 at Hospital Oncologico, and obtained a medical license in Puerto Rico in 1991. From July 1992 through June 1995, Dr. Vargas Rodriguez successfully completed an ACGME-accredited Pediatric Residency at Hospital Regional de Caguas, Puerto Rico, followed by a Neonatal and Perinatal Fellowship at Hospital Regional de Caguas, Puerto Rico, from July 1995 through June 1997. For twenty-two years, Dr. Vargas Rodriguez has practiced medicine in the Neonatal Intensive Care Units in different hospitals for evaluation and

treatment of neonatal and pediatric patients. Since 2010, Dr. Vargas Rodriguez has been an Assistant Professor at the San Juan Bautista School of Medicine in Pediatrics and Neonatology.

Section 458.313(7), Florida Statutes, allows the Board to enter an order certifying an applicant for licensure with restrictions when the Board determines that an applicant for licensure by endorsement has failed to meet each of the appropriate licensing requirements.

It is therefore **ORDERED** that the application for licensure be **approved under the following conditions:**

1. Dr. Vargas Rodriguez shall successfully pass the Special Purpose Exam (SPEX) of the National Board of Medical Examiners within twelve (12) months and then the medical license will issue.
2. At the time the license is issued, Dr. Vargas Rodriguez shall work for six (6) months under the indirect supervision of a Board-approved Florida-licensed allopathic physician who is certified by the American Board of Pediatrics. Dr. Vargas Rodriguez has twelve (12) months from the date the license is issued to obtain a supervisor, and the rest of the terms of indirect supervision are set forth in Rule 64B8-4.025, Florida Administrative Code.

This Order does not constitute disciplinary action against the license that has been approved herein. The terms of this Order are considered conditions for licensure.

This Order shall become effective upon filing with the Clerk of the Department of Health.

DONE AND ORDERED this 1ST day of July, 2019.

BOARD OF MEDICINE

Claudia Kemp

Claudia Kemp, J.D., Executive Director
For Steven Rosenberg, M.D., Chair

NOTICE OF RIGHT TO HEARING

This notice constitutes final agency action if no request for a hearing is received by the Board on or before the twenty-first day after the applicant's receipt of the notice. The applicant may request a hearing by filing an appropriate petition with the Executive Director of the Board at 4052 Bald Cypress Way, Bin #C-03, Tallahassee, Florida 32399-3253. The applicant may petition for a hearing involving disputed issues of material fact before an administrative law judge pursuant to Section 120.57 (1), Florida Statutes, or for a hearing not involving disputed issues of material fact pursuant to Section 120.57 (2), Florida Statutes.

A petition for a hearing involving disputed issues of material fact must contain information required by Rule 28-106.201, Florida Administrative Code, ***including a statement of all disputed issues of material fact.*** The Board may refer a petition to the Division of Administrative Hearings for assignment of an administrative law judge only if the petition is in substantial compliance with the rule requirements. A petition for a proceeding not involving disputed issues of material fact must contain information required by Rule 28.106.301, Florida Administrative Code, including a concise statement of the ultimate facts alleged, as well as the rules and statutes which entitle petitioner to relief.

In accordance with Section 120.573, Florida Statutes, mediation is not available.

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing has been furnished by **Certified Mail** to **Adel Ricardo Vargas Rodriguez, M.D.,** 2430 S. Atlantic Avenue, Suite C, Daytona Beach Shores, FL 32118; and by email to **Donna McNulty**, Special Counsel, at Donna.McNulty@myfloridalegal.com, this 2ND day of July, 2019.

ADEL RICARDO VARGAS RODRIGUEZ, M
2430 SOUTH ATLANTIC AVE
SUITE C
DAYTONA BEACH SHORES, FL 32118

Certified Article Number
9414 7266 9904 2140 1187 63
SENDER'S RECORD

Angel Sanders

Deputy Agency Clerk

Tab 9 - Adel Ricardo Vargas Rodriguez, MD – Endorsement
Issue(s):

- Failure to meet section 458.313(1)(a) and 458.311(1)(f)3.b., Florida Statutes, ECFMG certification
- Failure to meet section 458.313(1)(b), Florida Statutes, examination

The applicant was present and sworn in by the court reporter. After discussion, a motion was made and seconded to approve the application for licensure with the condition that the applicant successfully pass the Special Purpose Examination (SPEX) and the license will issue, immediately followed by indirect supervision for six (6) months by a Florida licensed physician certified by the American Board of Pediatrics. Dr. Vargas Rodriguez will obtain a supervisor within twelve (12) months after the license is issued and the remaining terms of supervision are set forth in Rule 64B8-4.025, Florida Administrative Code.

Action Taken: The Committee voted to approve the application for licensure with conditions.

Tab 10 - Roberto Jose Garcia Ramirez, MD – Endorsement
Issue(s): Failure to meet section 458.313(1)(b), Florida Statutes, examination

The applicant was present and sworn in by the court reporter. After discussion, a motion was made and seconded to approve the application for licensure with the condition that the applicant successfully pass the Special Purpose Examination (SPEX) and the license will issue, immediately followed by indirect supervision for six (6) months by a Florida licensed physician certified by the American Board of Internal Medicine. Dr. Garcia Ramirez will obtain a supervisor within twelve (12) months after the license is issued and the remaining terms of supervision are set forth in Rule 64B8-4.025, Florida Administrative Code.

Action Taken: The Committee voted to approve the application for licensure with conditions.

Magdalena Averhoff, MD – To Interview Tabs 11-22

Tab 11 - Paul M. Glat, MD – Endorsement
Issue(s): Malpractice History

The applicant was present and sworn in by the court reporter. After discussion, a motion was made to approve the application for licensure. The motion was seconded, which carried 5/0.

Action Taken: The Committee voted to approve the application for licensure.

Tab 12 - Andrew Duerr, MD – Endorsement
Issue(s): Action by Alabama Medical Board

The applicant was present and sworn in by the court reporter. After discussion, a motion was made to approve the application for licensure. The motion was seconded, which carried 5/0.

Action Taken: The Committee voted to approve the application for licensure.

Tab 13 - Edward Byung Lee, MD – Endorsement
Issue(s): Malpractice History

The applicant was present and sworn in by the court reporter. After discussion, a motion was made to approve the application for licensure. The motion was seconded, which carried 5/0.

Action Taken: The Committee voted to approve the application for licensure.

Tab 14 - Olivia Ho, MD – Endorsement
Issue(s): Failure to meet section 458.313(1)(b), Florida Statutes, examination

The applicant was present and sworn in by the court reporter. After discussion, a motion was made to approve the application for licensure with the condition of indirect supervision for six (6) months by a Florida licensed physician who is certified by the American Board of Plastic Surgery. The terms of indirect supervision are set forth in Rule 64B8-4.025, Florida Administrative Code. The motion was seconded, which carried 5/0.

FLORIDA | Board *of* Medicine

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Governor

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Palm Beach, Florida

Members
Hector Vila, M.D.
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Vice Chair

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Satellite Beach, Florida

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Maitland, Florida

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Orlando, Florida

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Panama City, Florida

Sarvam TerKonda, M.D.
Jacksonville, Florida

Vacant, MD

Vacant, MD

Executive Director
Claudia Kemp, J.D.

May 10, 2019

Adel Ricardo Vargas Rodriguez, MD
2430 S. Atlantic Avenue, Suite C
Daytona Beach Shores, FL 32118

Dear Dr. Vargas Rodriguez:

This is in further reference to your application for licensure by Endorsement.

Please be advised that you are required to make a personal appearance before the Credentials Committee of the Board of Medicine to discuss:

- **Failure to meet section 458.313(1)(a) and 458.311(1)(f)3.b., Florida Statutes, ECFMG certification.**
- **Failure to meet section 458.313(1)(b), Florida Statutes, examination.**

In addition, the Committee may inquire into any other issues relating to your application and eligibility for licensure.

Date:	Thursday, June 6, 2019
Time:	8:00 a.m.
Location:	Florida Board of Medicine/Credentials Committee Meeting Hilton Miami Airport Blue Lagoon 5101 Blue Lagoon Drive Miami, FL 33126 (305) 262-1000

The meeting room will be posted in the lobby of the hotel. Subject to availability, a block of rooms is available for the public attending the Department of Health – Florida Board of Medicine's meeting.

Additionally, the Committee's recommendation on your application for licensure will be presented to the full Board of Medicine on Friday, June 7, 2019 for final action. You are not required to attend the full board meeting.

Thank you for your continued cooperation. Should you have any questions regarding this matter, please feel free to contact me. *This is your first scheduled appearance.

Sincerely,

Wendy Alls

Wendy Alls
Program Operations Administrator

Pursuant to the provisions of the Americans with Disabilities Act, any person requiring special accommodations to participate in this workshop/meeting is asked to advise the agency at least 10 days before the workshop/meeting by contacting: Rebecca.Hewett@flhealth.gov or call (850) 245-4137.

*** 456.013(3)(c) In considering applications for licensure, the board, or the department when there is no board, may require a personal appearance of the applicant. If the applicant is required to appear, the time period in which a licensure application must be granted or denied shall be tolled until such time as the applicant appears. However, if the applicant fails to appear before the board at either of the next two regularly scheduled board meetings, or fails to appear before the department within 30 days if there is no board, the application for licensure shall be denied.**

4052 Bald Cypress Way, Bin C-03
Tallahassee, Florida 32399-3253
Phone: 850/245-4131
Fax: 850/488-0596 or 850/412-1268
https://www.FLBoardofMedicine.gov

Florida HEALTH

150 F-142449

EDICAL DOCTOR
APPLICATION FOR LICENSURE
Apply for your license online at www.flboardofmedicine.gov

03/04/2019 1,055.00
ID: 142449 Type: F
BT: 3012815
R#: 918025949

Choose your application type:

☑ Endorsement (1021) ☐ Examination (1024)

☐ Military Veterans Fee Waiver

If you were honorably discharged from the U.S. armed services within 60 months of your application you will qualify for a waiver of the application fee and the initial licensure fee. In order to qualify, please check the box above indicating that you are seeking a waiver and submit **a DD-214 or NGB-22 form as proof of honorable discharge.**

☑ I plan to dispense medicinal drugs in the State of Florida for a fee or other remuneration and hereby register as required by Section 465.0276, F.S. I understand that the fee for the Dispensing Practitioner is $100.00 in addition to the required initial license fee and will submit it along with the license fee.

1. PERSONAL INFORMATION

Name: Vargas Rodriguez (Last/Surname) Adel (First) Ricardo (Middle) **Date of Birth:** 04/17/1963 (MM/DD/YYYY)

Mailing Address: (The address where mail and your license should be sent)

2430 s Atlantic Ave, (Street/ PO Box) C (Suite/Apt. No) Daytona Beach Shores (City)

Florida (State) 32118 (Zip) USA (Country) 386-281-3137 (Phone Number)

Physical Location: A Post Office Box is not acceptable. This address will be posted on the Department of Health's website. *If you do not have a current practice address, your mailing address will be used. When you obtain a practice address, you will be required to update your online practitioner profile.*

111 calle 1, Paseo las Vistas (Street/ P.O. Box) (Suite/Apt. No) San Juan (City)

Puerto Rico (State) 00096 (Zip) USA (Country) (787)612-0813 (Alternate Phone Number)

Email Address: Nathaly.Encarnacion@licenciasmedica.com

Under Florida law, email addresses are public records. If you do not want your e-mail address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.

Equal Opportunity Data: We are required to ask that you furnish the following information as part of your voluntary compliance with Section 2, Uniform Guidelines on Employee Selection Procedure (1978) 43 CFR 38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

SEX: ☑ Male ☐ Female **RACE:** ☐ White ☐ Black ☐ Asian/Pacific Islander ☑ Hispanic ☐ Other

☑ Yes ☐ No **Availability for Disaster:** Will you be available to provide health care services in special needs shelters or to help staff disaster medical assistance teams during times of emergency or major disaster?

A.U.

2. MEDICAL EDUCATION HISTORY

Federal Credentials Verification Services (FCVS) is not a requirement for licensure. FCVS will primary source verify and provide a copy of the medical school transcript(s), medical school diploma, medical school verification, name change document(s), national examination score report, ECFMG certificate, ECFMG verification and postgraduate training verifications. For more information about FCVS, visit their web-site at www.fcvs.org/.

☐ Yes ☑ No Are you using the FCVS to verify your core credentials?

☑ Yes ☐ No Have you completed the equivalent of 2 academic years of preprofessional, postsecondary education including, courses in anatomy, biology and chemistry prior to entering medical school?

Medical Education:
List in chronological order all medical schools attended, whether completed or not. Submit on a separate sheet if needed.

Medical School Name and Address:	From: (mm/yy)	To: (mm/yy)	Date Degree Received:
Univercidad Central del Este Ave Francisco Alberto Caamano Deno, San Pedro de Macoris, Dominican Republic	02/82	02/86	02/24/1988

Fifth Pathway Certificate Holders:

If you answer "yes" to any of the following questions, you must request verifications to be sent directly to the Board office.

☐ Yes ☐ No Did you attend an international medical school and do not possess a valid ECFMG Certificate?

☐ Yes ☐ No Did you receive a bachelor's degree from an accredited United States college or University?

☐ Yes ☐ No Did you study at a medical school which is recognized by the World Health Organization?

☐ Yes ☐ No Did you complete all of the formal requirement of the International medical school, except the internship or social service requirements, and pass part I of the National board of Medical examination or the Education Commission for Foreign Medical Graduates Examination equivalent?

N/A

☐ Yes ☐ No Did you complete an academic year of supervised clinical training in a hospital affiliated with a medical school approved by the Council on Medical Education of the American Medical Association and upon completion passed part II of the National Board of Medical Examiners examination or the Education Commission for Foreign Medical Graduates examination Equivalent?

AU.

Postgraduate Training:

Provide the following documentation to support your postgraduate training:

☐ Post-Graduate Training Form

In the table below list, in chronological order, all postgraduate training from the date you graduated from medical school to the present. Start with your first program and end with your last or current program. List all programs you began, whether you completed or received credit for the training.

Program Name and Full Mailing Address:	Specialty Area:	From: (mm/yy)	To: (mm/yy)	Did you receive credit? (Y/N)
Caguas Regional Hospital Carretera 172, Caguas, PR 00725	Pediatrics	07/92	06/95	Y
Caguas Regional Hospital Carretera 172, Caguas, PR 00725	Fellow Neonatology and Perinatal Medicine	07/95	06/97	Y

Loan History:

☐ Yes ☑ No Are you currently in default on any health education loan or scholarship obligation? (If "yes", explain on a separate sheet providing accurate details.)

3. EXAMINATION HISTORY

State Board (prior to 1974), State Board (after 1974) & SPEX, LMCC & SPEX, NBME, FLEX, USMLE III, or Combination (prior to 2000)

Request that the score report be sent directly to the Board of Medicine. NOTE: If you took a state Board examination and are not currently licensed in three other states, you must also request your SPEX score be sent.

Exam taken: Note: Letter will be addressed to the board. Date passed: _____ mm/dd/yy

A.U.

4. LICENSURE HISTORY

Request verification of licensure status directly from the licensing entity or www.veridoc.org. Request international license verification(s) if you have practiced outside of the U.S. for at least two of the previous four years.

☑ Yes ☐ No Do you now hold or have you ever held a license to practice medicine or any other profession in any US State or territory, or foreign country? Please list in table below.

Jurisdiction	Profession	License number
Puerto Rico	Pediatrics	10491

If you answer "yes" to any of the questions in this section, you are required to send an explanation and supporting documentation.

☐ Yes ☑ No Have you had any application for a medical license or professional license denied by any state board or other governmental agency of any state, territory, or country?

☐ Yes ☑ No Are you currently under investigation in any jurisdiction for an act or offense that would constitute a violation of Section 458.331, Florida Statutes?

☐ Yes ☑ No Have you ever had any professional license or license to practice medicine revoked, suspended, placed on probation, or other disciplinary action taken in any state, territory or country?

5. PRACTICE/EMPLOYMENT HISTORY

List the year you legally first began to practice medicine, 1991 (yyyy). This would be the year you began practicing medicine and could be the date you began your postgraduate training.

☑ Yes ☐ No Have you practiced medicine in another jurisdiction for two of the last four years or completed a board approved post-graduate training program within the last two years?

☐ Yes ☐ No If your answer to the question above was "No," have you passed a board approved clinical competency exam within the last year? If yes, then submit supporting documentation.

List in chronological order all employment for the last four (4) years.

Name and address of practice or employment	Type of employment	From: mm/yy	To: mm/yy
Hospital Pavia Arecibo Carretera 129, Km 1.0 Av. San Luis, Arecibo, 00613, Puerto Rico	Neonatologist	11/95	Present
Hospital Hima 100 Luis Munoz Marin Avenue, Caguas, 00725, Puerto Rico	Neonatologist	07/96	Present
Hospital Ryder Sector Cuesta Los Jobos, Humacao, 00791, Puerto Rico	Pediatrics Director/ Neonatologist	08/97	Present
Hospital Manati Medical Center Calle Hernandez Carrion, Manati, 00674, Puerto Rico	Neonatologist	07/04	Present

AII

☐ Yes ☑ No Do you currently hold staff privileges in any hospital, health institution, clinic or medical facility? List each facility below.

Name of facility
N/A

If you answer "yes" to the following questions, you are required to send an explanation and supporting documentation.

☐ Yes ☑ No Have you ever had any staff privileges denied, suspended, revoked, modified, restricted, not renewed, or placed on probation, or have you been asked to resign or take a temporary leave of absence or were otherwise acted against by any facility?

☐ Yes ☑ No Do you currently, or have you had, responsibility for graduate medical education within the last 10 years?

In the table below, list all institutions where you have had responsibility for graduate medical education or faculty appointment(s) at any medical school.

Name of institution
N/A

☐ Yes ☑ No Are you certified by any specialty board recognized by the American Board of Medical Specialties or specialty board approved by the Florida Board of Medicine?

Board Name	Certification/ Specialty/Sub-Specialty	Date of Certification (mm/yy)
	N/A	

If you answer "yes" to any of the following questions, please explain on a separate sheet providing accurate details.

☐ Yes ☑ No Have you ever had any final disciplinary action taken against you by a specialty board or other similar national organization?

☐ Yes ☑ No Have you ever been denied or surrendered a DEA registration?

A.U.

6. CRIMINAL HISTORY

If you answer "Yes" to the following question you are required to send the following items:

a. Self-explanation describing in detail the circumstances surrounding each offense, including dates, city and state, charges and final results.
b. Final Dispositions and Arrest Records for all offenses. The Clerk of the Court in the arresting jurisdiction will provide you with these documents. Unavailability of these documents must come in the form of a letter from the Clerk of the Court.
c. Completion of Sentence Documents. You may obtain documentation from the Department of Corrections. The report must include the start date, end date and that the conditions were met.

☐ Yes ☑ No Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to, a crime in any jurisdiction other than a minor traffic offense? You must include all misdemeanors and felonies, **even if adjudication was withheld. Driving under the influence (DUI) or driving while impaired (DWI) are not minor traffic offenses for purposes of this question.**

☑ Yes ☐ No I have been provided and read the statement from the Florida Department of Law Enforcement regarding the sharing, retention, privacy and right to challenge incorrect criminal history records and the "Privacy Statement" document from the Federal Bureau of Investigation.

7. MILITARY HISTORY

A. ☐ Yes ☑ No Have you ever been in the United States Military and/or Public Health Service?

B. ☐ Yes ☑ No Have you ever been disciplined by any branch of the United States Armed Services or Public Health Services? If you answered "yes" please provide a detailed explanation and supporting documentation

8. CRIMINAL AND MEDICAID/MEDICARE FRAUD QUESTIONS

Applicants for licensure, certification or registration and candidates for examination may be excluded from licensure, certification or registration if their felony conviction falls into certain timeframes as established in Section 456.0635(2), Florida Statutes. If you answer "Yes" to any of the following questions, please provide a written explanation for each question. Supporting documentation includes court dispositions or agency orders where applicable.

1. ☐ Yes ☑ No Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, F.S. (relating to social and economic assistance), Chapter 817, F.S. (relating to fraudulent practices), Chapter 893, F.S. (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction?

If you responded "No" to the question above, skip to question 2.

a. ☐ Yes ☐ No If "yes" to 1, for the felonies of the first or second degree, has it been more than 15 years from the date of the plea, sentence and completion of any subsequent probation?

b. ☐ Yes ☐ No If "Yes" to 1, for felonies of the third degree, has it been more than 10 years from the date of the plea, sentence and completion of any subsequent probation? (This question does not apply to felonies of the third degree under Section 893.13(6)(a), Florida Statutes)

c. ☐ Yes ☐ No If "Yes" to 1, for the felonies of the third degree under Section 893.13(6)(a), Florida Statutes, has it been more than 5 years from the date of the plea, sentence and completion of any subsequent probation?

d. ☐ Yes ☐ No If "Yes" to 1, have you successfully completed a drug court program that resulted in the plea for the felony offense being withdrawn or charges dismissed?

2. ☐ Yes ☑ No Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970 (relating to controlled substances) or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)?

A.V.

If you responded "No" to the question above, skip to question 3.

a. ☐ Yes ☐ No If "Yes" to 2, has it been more than 15 years before the date of application since the sentence and any subsequent period of probation for such conviction or plea ended?

3. ☐ Yes ☑ No Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes?

If you responded "No" to the question above, skip to question 4.

a. ☐ Yes ☐ No If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years?

4. ☐ Yes ☑ No Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid Program?

If you responded "No" to the question above, skip to question 5.

a. ☐ Yes ☐ No Have you been in good standing with a state Medicaid program for the most recent five years?

b. ☐ Yes ☐ No Did the termination occur at least 20 years before the date of this application?

5. ☐ Yes ☑ No Are you currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities?

If you answer "Yes" to the questions below, you are required to send the following items:

- **A statement indicating the date of each incident and the number for each case.**
- **An explanation of details for each case and your involvement for each case.**
- **Submit the enclosed Exhibit 1 form.**
- **A copy of the complaint, judgments and/or settlements for each case.**
- **Submit a complete copy of the trial record(s) of each case, including the trial transcript, evidentiary exhibits and final judgment in electronic format.**

☐ Yes ☑ No Have you ever had a judgment entered against you for medical malpractice where the incident(s) of malpractice occurred after November 2, 2004?

☐ Yes ☑ No Within the last 10 years have you had any liability claim(s) or action(s) for damages for personal injury settled or finally adjudicated in an amount that exceeds $100,000.00?

A.V.

10. FINANCIAL RESPONSIBILITY

The Financial Responsibility options are divided into two categories, coverage and exemptions. Check only one option of the ten provided as required by s. 458.320, Florida Statutes.

Category I: Financial Responsibility Coverage

☐1. I do not have hospital staff privileges, I do not perform surgery at an ambulatory surgical center and I have established an irrevocable letter or credit or an escrow account in an amount of $100,000/$300,000, in accord with Chapter 675, F. S., for a letter of credit and s. 625.52, F. S., for an escrow account.

☐2. I have hospital staff privileges or I perform surgery at an ambulatory surgical and I have established an irrevocable letter of credit or escrow account in an amount of $250,000/$750,000, in accord with Chapter 675, F. S., for a letter of credit and s. 625.52, F. S., for an escrow account.

☐3. I do not have hospital staff privileges, I do not perform surgery at an ambulatory surgical center and I have obtained and maintain professional liability coverage in an amount not less than $100,000 per claim, with a minimum annual aggregate of not less than $300,000 from an authorized insurer as defined under s. 624.09, F. S., from a surplus lines insurer as defined under s. 626.914(2), F. S., from a risk retention group as defined under s. 627.942, F. S., from the Joint Underwriting Association established under s. 627.351(4), F. S., or through a plan of self-insurance as provided in s. 627.357, F. S.

☐4. I have hospital staff privileges or I perform surgery at an ambulatory surgical and I have professional liability coverage in an amount not less than $250,000 per claim, with a minimum annual aggregate of not less than $750,000 from an authorized insurer as defined under s. 624.09, F. S., from a surplus lines insurer as defined under s. 626.914(2), F. S., from a risk retention group as defined under s. 627.942, F. S., from the Joint Underwriting Association established under s. 627.351(4), F. S., or through a plan of self-insurance as provided in s. 627.357, F. S.

☑5. I have elected not to carry medical malpractice insurance however, I agree to satisfy any adverse judgments up to the minimum amounts pursuant to s. 458.320(5)(g)1, F. S. I understand that I must either post notice in a sign prominently displayed in my reception area or provide a written statement to any person to whom medical services are being provided that I have decided not to carry medical malpractice insurance. I understand that such a sign or notice must contain the wording specified in s. 458.320(5)(g), F. S.

Category II: Financial Responsibility Exemptions

☐6. I practice medicine exclusively as an officer, employee, or agent of the federal government, the state, or its agencies or subdivisions.

☐7. I hold a limited license issued pursuant to s. 458.317, F. S., and practice only under the scope of the limited license.

☐8. I do not practice medicine in the State of Florida.

☐9. I meet all of the following criteria:

(a) I have held an active license to practice in this state or another state or some combination thereof for more than 15 years;

(b) I am retired or maintain part time practice of no more than 1000 patient contact hours per year;

(c) I have had no more than two claims resulting in an indemnity exceeding $25,000 within the previous five-year period;

(d) I have not been convicted of or pled guilty or nolo contendere to any criminal violation specified in Chapter 458, F. S. or the medical practice act in any other state; and

(e) I have not been subject, within the past ten years of practice, to license revocation, suspension, or probation for a period of three years or longer, or a fine of $500 or more for a violation of Chapter 458, F. S., or the medical practice act of another jurisdiction. A regulatory agency's acceptance of a relinquishment of license, stipulation, consent order, or other settlement offered in response to or in anticipation of filing of administrative charges against a license is construed as action against a license. I understand if I am claiming an exception under this section that I must either post notice in a sign prominently displayed in my reception area or provide a written statement to any person to whom medical services are being provided that I have decided not to carry medical malpractice insurance. See Section 458.320(5)(f), Florida Statutes, for specific notice requirements.

☐10. I practice only in conjunction with my teaching duties at an accredited medical school or its teaching hospitals. (Interns and residents do not qualify for this exemption).

If you select an exemption based on number 9, you must also complete the affidavit on the following page.

A.U.

11. FLORIDA BIRTH RELATED NEUROLOGICAL CO PENSATION ASSOCIATION

You must choose one of the three options described below. Please be sure to view the information about each exemption at www.nica.com. Check only one.

☐ $5,000 Participating	☑ $250 Non-participating	☐ $0 Exempt	$250 Amount enclosed

If you choose "$0 Exempt" provide appropriate documentation to the Board of Medicine and to NICA.

I have read the explanatory information provided by NICA, and I choose the option above.

Signature 1-23-15 Date

Adel Ricardo Vargas Rodriguez
Name
P O Box 8940
Street Address
Humacao, PR 00792
City, State, Zip

If you are a participating or non-participating physician, or a physician claiming exemption, you must complete, sign and date this form and return it with your payment to this address.

Board of Medicine
4052 Bald Cypress Way, #C-03
Tallahassee, FL 32399-3253

If you are a physician claiming exemption, you must also send a copy of your completed, signed, and dated form with proof of your exemption to:

NICA
2360 Christopher Place
Tallahassee, FL 32308

If you have any questions about NICA or this form, please contact NICA at www.nica.com or (850) 488-8191.

12. STATE ENT OF APPLICANT

I state that these statements are true and correct. I recognize that providing false information may result in denial of licensure, disciplinary action against my license, or criminal penalties pursuant to Sections 456.067, 775.083, and 775.084, Florida Statutes. I state that I have read Chapters 456, 458 and 766.301-.316, Florida Statutes and Chapter 64B8, Florida Administrative Code.

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Florida Board of Medicine information which is material to my application for licensure.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind. I state that my answers and all statements made by me herein are true and correct.

Should I furnish any false information in this application, I hereby agree that such act constitutes cause for denial, suspension, or revocation of my license to practice medicine in the State of Florida. If there are any changes to my status or any change that would affect any of my answers to this application I must notify the board within 30 days.

I understand that my records are protected under federal and state regulations governing Confidentiality of Mental Health Patient Records and cannot be disclosed without my written consent unless otherwise provided in the regulations. I understand that my records are protected under federal and state regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it.

Adel Ricardo Vargas Rodriguez
Print name

Signature

1-23-19
Date

FLORIDA SPECIFIC POWER OF ATTORNEY

I, Adel Vargas Rodriguez, the undersigned being of sound mind and body, whose address is: 151 Calle 1, Paseo Las Vistas San Juan PR do hereby grant a limited and specific power of attorney to LILIA WALDERO, of THE MEDICAL LICENSE FACTORY, whose address is 210 S. Beach Street, Suite 202, Daytona Beach, Florida, 32114:

Power Granted. Said attorney-in-fact shall have full power and authority to undertake and perform only the following acts on my behalf: To make any decisions reasonably necessary regarding or in any way relating to my application for a medical license in Florida. This authority shall include such incidental acts as are reasonably required to carry out and perform the specific authority granted herein.

My attorney-in-fact agrees to accept this appointment subject to its terms and conditions, and agrees to act and perform in said fiduciary capacity consistent with my best interests, as my attorney-in-fact in her discretion deems advisable.

Authority to Delegate. My attorney-in-fact shall have the right by written instrument to delegate any or all of the foregoing powers involving discretionary decision-making to any person or persons whom my attorney-in-fact may select, but such delegation may be amended or revoked by any agent (including any successor) named by me who is acting under this power of attorney at the time of reference.

AU.

Right to Compensation. My attorney-in-fact shall be entitled to reasonable compensation for services rendered as agent under this Florida Specific Power of Attorney.

Choice of Law. THIS FLORIDA SPECIFIC POWER OF ATTORNEY WILL BE GOVERNED BY THE LAWS OF THE STATE OF FLORIDA WITHOUT REGARD FOR CONFLICTS OF LAWS PRINCIPLES. IT WAS EXECUTED IN THE STATE OF FLORIDA AND IS INTENDED TO BE VALID IN ALL JURISDICTIONS OF THE UNITED STATES OF AMERICA AND ALL FOREIGN NATIONS.

I am fully informed as to all the contents of this form and understand the full import of this grant of powers to my attorney-in-fact.

This Florida Specific Power of Attorney is effective upon execution. This Florida Specific Power of Attorney may be revoked by me at any time, and shall automatically be revoked upon my death, provided that any person relying on this Florida Specific Power of Attorney shall have full rights to accept and rely upon the authority of my attorney-in-fact until in receipt of actual notice of revocation.

Signed this 29th day of January, 2019.

Principal

596 09 9058
Social Security Number

STATEMENT OF WITNESS

On the date written above, the principal declared to me in my presence that this instrument is his Florida Specific Power of Attorney and that he or she had willingly signed or directed another to sign for him or her, and that he or she executed it as his or her free and voluntary act for the purposes therein expressed.

[Signature of Witness #1]
Angel J Tower Sloan [Printed or typed name of Witness #1]
861 Pinecrest St [Address of Witness #1, Line 1]
Daytona Beach FL 32117. [Address of Witness #2, Line 2]

[Signature of Witness #2]
Stephanie Aponte. [Printed or typed name of Witness #2]
3656 Rockson St [Address of Witness #2, Line 1]
Port Orange FL 32129. [Address of Witness #2, Line 2]

A Note About Selecting Witnesses: The agent (attorney-in-fact) may not also serve as a witness. Each witness must be present at the time that principal signs the Power of Attorney in front of the notary. Each witness must be a mentally competent adult. Witnesses should ideally reside close by, so that they will be easily accessible in the event they are one day needed to affirm this document's validity.

CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC

STATE OF Florida
COUNTY OF Volusia

This document was acknowledged before me on Jan 28, 2019, by Adel Vargas Rodriguez [name of principal], who produced the following identification: Licnse.

[Notary Seal, if any]:

NATHALY ENCARNACION
Notary Public, State of Florida
Commission No. GG241117
Commission Expires 07/23/22

(Signature of Notarial Officer)

Notary Public for the State of Florida

My commission expires:
07/23/22

ACKNOWLEDGMENT OF AGENT

BY ACCEPTING OR ACTING UNDER THE APPOINTMENT, THE AGENT ASSUMES THE FIDUCIARY AND OTHER LEGAL RESPONSIBILITIES OF AN AGENT.

LILIA WALDERO

March 6, 2019

Adel Ricardo Vargas Rodriguez, MD
2430 S Atlantic Ave.
Suite C
Daytona Beach Shores, FL United States 32118

Dear Dr. Vargas Rodriguez:
File: 142449

Thank you for considering Florida for physician licensure. Your application for medical licensure has been received. The application is incomplete for the reasons set out in the attached deficiency notice. Please address these deficiencies as soon as possible to avoid delay in processing your application.

Information received by this office may require additional explanation or documentation to determine licensure eligibility. After all requested documentation is received, your application will be submitted for supervisory review. We will notify you if additional information is required.

Applicants with a history of malpractice, criminal activity, discipline, physical or mental impairment, unfavorable evaluations, or other matters that need explanation may require a personal appearance before the Board of Medicine Credentials Committee for determination of licensure eligibility. If your appearance is required, you will be notified in writing once your application is complete.

You can now follow the progress of your application through our website at: www.FLHealthSource.gov/mqa-services. If you are a returning user, select "Yes" and enter the user ID and password you selected during the registration process under Returning User. If you did not apply for licensure through this screen, select "No" and follow the prompts to create an account. You must have a valid email address to create your account.

Once you are logged in, you will be prompted to add your application to your account. Once you have successfully added your application, you will be directed to your dashboard. Under the "Additional Activities" section, select "Check Application Status" to review any open deficiencies, upload documents or print out instructional documents.

THIS IS IMPORTANT: Your application will remain incomplete until all deficiencies are completed. In addition, you are required to notify the Board office immediately in writing of any occurrence(s) that would in any way change or affect any answer given in the application or an answer provided in response to any of our direct questions to you.

If you have any questions, please contact me at Gale.Stith@flhealth.gov, call 850-617-1918, or fax (850) 412-1265.

Sincerely,

Gale Stith
Regulatory Specialist I

Enclosure(s)

Dr. Adel Ricardo Vargas Rodriguez **Date: March 6, 2019**

REMINDER: Chapter 456.013(1)(a), Florida Statutes, provides that an incomplete application shall expire one year after initial filing with the department.

YOUR APPLICATION'S EXPIRATION DATE IS 03/03/2020.

APPLICATION SUBMITTED REMAINS DEFICIENT FOR LACK OF THE FOLLOWING:

There was not a letter included with application.

There was only a CV in Spanish submitted with the application.

Does not have valid ECFMG Status Report. An official verification of your medical license from the state of Puerto Rico.

Your Postgraduate Training Verification Forms have not been received from:
Caguas Regional Hospital 7/92-6/97.

The inquiry you mailed to your medical school has not been received.

Please submit the National Practitioner Data Bank (NPDB) report to our office. You may contact the NPDB at 1-800-767-6732 to obtain this information.

Does not meet requirement. We await your FLEX/USMLE/SPEX/National Board exam scores, direct from the Federation of State Medical Boards, which must be requested by the applicant.

We have not received your Livescan results. If you have already had your electronic fingerprinting completed, please allow 24 – 72 hours for receipt of your results. Should your Criminal Background Check disclose an arrest record(s), you will need to provide documentation related to each criminal event revealed in your background, if you have not already done so. You can find a detailed description of documents that will be required by visiting the FAQs on the Background Screening Website at http://www.flhealthsource.gov/background-screening/ (Click on FAQs)
Note: Criminal History will be reviewed by the Background Screening Unit, not the Board Office. Please email all criminal history documents to mqa.backgroundscreen@flhealth.gov. Any original certified documents must be mailed to the following address:
Attn: Background Screening Unit
Florida Department of Health
4052 Bald Cypress Way, Bin BSU-01
Tallahassee, FL 32399

If you have any questions, please contact me at Gale.Stith@flhealth.gov, call 850-617-1918, or fax (850) 412-1265. The Florida Board of Medicine has assigned **142449** as your **tracking number**. Please indicate this number if you leave a message, and try to ensure that other sources include it on their communications to us as well.

Stith, Gale R

From: Stith, Gale R
Sent: Monday, April 15, 2019 10:19 AM
To: Angel Tovar
Subject: RE: Vargas (142449)

I will need to review the file for completeness.

Thanks,

Gale Rambaran Stith, MSW
Regulatory Specialist I
Department of Health (DOH) | Division of Medical Quality Assurance (MQA)
Board of Medicine
Phone: 850-617-1918 | Fax: 850-412-1265
4052 Bald Cypress Way, # C03 | Tallahassee, FL 32399-3256

From: Angel Tovar <angel.tovar@licenciasmedica.com>
Sent: Monday, April 15, 2019 10:14 AM
To: Stith, Gale R <Gale.Stith@flhealth.gov>
Subject: Vargas (142449)

Good morning Gale,

I hope all is well. Here is Dr. Vargas letter to the board.

I believe this makes his file complete can you please confirm,

Than you.

Angel Tovar (Account Manager)
2430 s. Atlantic Ave, Suite C, Daytona Beach Shores, Fl 32118
Endorsement, ACN, Health Practice Documentation
Telephone:(386) 281-3137
angel.tovar@licenciasmedica.com
www.licenciasmedica.com
www.medicalicensefactory.com

Universidad Central del Este

Fundada el 15 de Octubre de 1970
SAN PEDRO DE MACORIS, REPUBLICA DOMINICANA

El Consejo Universitario en virtud de las disposiciones legales vigentes:

Por cuanto: Adel Ricardo Vargas Rodríguez

ha cursado en la

Facultad de Ciencias Médicas

de esta Universidad los estudios requeridos y ha sido aprobado en los exámenes correspondientes.

Por tanto, ha venido en otorgarle y le otorga el título de

Doctor en Medicina

Y para que sea notorio y constante le expide el presente Diploma, firmado y sellado en San Pedro de Macorís, República Dominicana, hoy día 24 de Febrero del año 1986.

EL RECTOR

EL DECANO DE LA FACULTAD

We certify this document as a true copy of the original granted Adel Ricardo Vargas Rodriguez, graduates on February 24,1986 and received Degree Doctor of Medicine with Diploma registered under number 4542 in Folio 131 of the Record Book of Title.

Lic. Piedad Licelott Noboa
General Secretary and Registrar

Medical Degree Verification Form

FLORIDA BOARD OF MEDICINE
4052 BALD CYPRESS WAY, BIN # C03
TALLAHASSEE, FL 32399-3253
FAX (850) 412-1268

Applicant completes number 1 through 3. Please note that if you are using FCVS, do not submit this item.

1. TO: Univercidad Central del Este
Name of medical school
Ave Francisco Alberto Caamano Deno,
Street address
San Pedro de Macoris Dominican Republic
City - State - Zip - Country

2. Name: Adel Ricardo Vargas Rodriguez

3. Date of Birth: 04/17/1963

4. Type of Degree: Doctor of Medicine Date Degree Received: February 24. 1986

Authenticate by signature and school seal.

SEAL

Verified by

Lic. Piedad Licelott Noboa Mejia
Name

Registrar
Title

POST-GRADUATE TRAINING VERIFICATION FORM

Please have this form completed by the Chairman/Director of the post-graduate training program you attended. Please note that if you are using FCVS, do not submit these items.

The form should be mailed or faxed to:

FLORIDA BOARD OF MEDICINE
4052 BALD CYPRESS WAY, BIN C-03
TALLAHASSEE, FLORIDA 32399-3253
(850) 412-1268 Facsimile

Ciges P.R. Centro del Cancer / Hospital Oncologico
Name of School

Medical Education / Medical Rotational Internship Year
Department

P.O. Box 191811
Address

San Juan P.R. 00919-1811
City, State, Zip

1. Name of Resident: Adel A. Dargan Rodriguez M.D.
2. Internship/Residency/Fellowship: From: July-1-1990 To: June-30-1991
3. Matriculation Date: July-1-1990
4. Completion Date: June-30-1991
5. Specialty: General Medicine

RECIBIDO
MAY 2 0 2019
EDUCACION MEDICA

6. Levels completed (check all that apply):

PGY I PGY II PGY III PGY IV PGY V

Signed:
Chairman or Program Director Only
(No stamped signatures please).

RECIBIDO
MAY 2 0 2019
EDUCACION MEDICA

Hospital Oncológico [illegible]

[illegible]

Certify that

Abel R. Vargas Rodriguez, MD

has faithfully and satisfactorily performed the duties of

Transitional Internship

from July 1, 1990 *to* June 30, 1991

in witness whereof, this certificate is awarded at San Juan, P.R.

this 30 *day of* June *19* 91 .

ADMINISTRATOR

MEDICAL EDUCATION DIRECTOR

MEDICAL HOSPITAL DIRECTOR

Scanned by CamScanner

POST-GRADUATE TRAINING VERIFICATION FORM

Please have this form completed by the Chairman/Director of the post-graduate training program you attended. Please note that if you are using FCVS, do not submit these items.

The form should be mailed or faxed to:

FLORIDA BOARD OF MEDICINE
4052 BALD CYPRESS WAY, BIN C-03
TALLAHASSEE, FLORIDA 32399-3253
(850) 412-1268 Facsimile

San Juan Bautista School of Medicine
Name of School

Graduate Medical Education
Department

POBox 4968
Address

Caguas PR 00726-4968
City, State, Zip

1. Name of Resident: Adel R Vargas Rodriguez

2. Internship/Residency/Fellowship: From: 07-1-92 To: 6-30-95

3. Matriculation Date: 07-01-92

4. Completion Date: 06-30-95

5. Specialty: Pediatrics

6. Levels completed (check all that apply):

File# 142449

PGY I ✓ PGY II ✓ PGY III ✓ PGY IV ___ PGY V ___

Signed: [signature]
Chairman or Program Director Only
(No stamped signatures please).

POST-GRADUATE TRAINING VERIFICATION FORM

Please have this form completed by the Chairman/Director of the post-graduate training program you attended. Please note that if you are using FCVS, do not submit these items.

The form should be mailed or faxed to:

FLORIDA BOARD OF MEDICINE
4052 BALD CYPRESS WAY, BIN C-03
TALLAHASSEE, FLORIDA 32399-3253
(850) 412-1268 Facsimile

San Juan Bautista School of Medicine
Name of School

Graduate Medical Education
Department

PO Box 4968
Address

Caguas PR 00726-4968
City, State, Zip

1. Name of Resident: Adel R Vargas Rodriguez

2. Internship/Residency/Fellowship: From: 07-01-95 To: 06-30-97

3. Matriculation Date: 07-01-95

4. Completion Date: 06-30-97

5. Specialty: Fellow Neonatology and Perinatal Medicine

6. Levels completed (check all that apply):

File # 142449

PGY I___ PGY II___ PGY III___ PGY IV ✓ PGY V ✓

Signed: [signature]
Chairman or Program Director Only
(No stamped signatures please).

LICENSE WITH CONDITIONS REPORT
APPROVED SUPERVISOR AND PRACTICE PLAN BETWEEN 07/03/2020-08/25/2020

PROFESSION	NAME	LICENSE NUMBER	ORIGINAL LICENSE DATE	APPOVED SUPERVISOR & AREA OF PRACTICE	CONDITION	DATE OF TEMPORARY APPROVAL
1501	Armando James Collazo, MD	ME 146327	July 7th, 2020	Chris Grevengood, MD In Naples, FL	Indirect Supervision	July 6th, 2020
1501	Diego Jose Lopes De Lima, MD	ME 146444	July 14, 2020	Harvey Montijo, MD Center for Bone and Joint Surgery in Wellington, FL	Indirect Supervision	July 14th, 2020
1501	Pradeep K. Narotam, MD	ME 146515	July 17th, 2020	Carrie Shulman, MD The Florida Center for Minimally Invasive Neurosurgery in Largo, FL.	Indirect Supervision	July 16th, 2020
1501	Carmen Brito, MD	ME 141649	July 5th, 2019	Rodger Rothenberger, MD Sunset Point Medical Associates in Clearwater, FL	Indirect Supervision	August 12th, 2020
1501	Miguel A. Pereira Robert, MD	ME 146967	August 24th, 2020	Alfonso J. Henriquez, MD Soma Medical Center in Port St. Lucie, FL	Indirect Supervision	August 22nd, 2020
1501	Roberto Lucero, MD	ME 146971	August 24th, 2020	Jessica Rosario (Vigil), MD Family Physicians Group in Orlando, FL	Indirect Supervision	August 22nd, 2020