$518.00

#4768

Maryland Board of Physicians
P.O. Box 17314
Baltimore, Maryland 21297-0475
2008 Application for Renewal of Medical License
(410) 764-4705

For Bank Use Only
AC [X] NS [ ] Y [X] BL [ ]

1. MEDICAL LICENSE NUMBER: D22211 9

2. LAST NAME: ALEKANDER

FIRST NAME: HAROLD

MAIDEN NAME:

E-MAIL ADDRESS:

ADDRESS CHANGES: NON-PUBLIC AND PUBLIC

3a. Non-Public Address: This address is for Board use only and is **where your license will be mailed**. However, if no public address is listed, this address will also be made available to the public.

Name or Facility Name: INTEGRATED OB/GYN SERVICES

Street Address: 7610

PENNSYLVANIA AVE #305

City: FORESTVILLE State: MD Zip: 20747

Country USA

3b. Public Address: This address, usually your office, is available to the public and will be posted on the Internet. **If you do not designate a public address your non-public address will be posted on the Internet.**

Name or Facility Name: AS ABOVE

Street Address:

City: State: Zip:

Country

PERSONAL AND PROFESSIONAL INFORMATION

4. Do you give the Maryland Board of Physicians permission to report your date of birth to the Federation of State Medical Boards' Physician Data Center?

[X] Yes [ ] No

5a. Are you engaged in the direct care of patients in the State of Maryland? Answer yes if you saw one or more patients since July 1, 2006 or initial licensure or reinstatement in Maryland whichever is more recent.

[X] Yes [ ] No

If you answered no to 5a, please answer 5b.

5b. Did your practice include making decisions that had direct impact on patient care in Maryland (such as radiology, pathology, or medical director)?

[ ] Yes [ ] No

ONLINE RENEWAL IS AVAILABLE AT: http://www.mbp.state.md.us.

CHARACTER AND FITNESS QUESTIONS

6. The following questions pertain to the period since July 1, 2006. If this is your first renewal, these questions apply to the period commencing with the date of your initial licensure or reinstatement.

YES NO **SINCE JULY 1, 2006**

a. Has any licensing or disciplinary board of any jurisdiction (except this licensing board), or any entity of the armed services denied your application for licensure, reinstatement or renewal, or taken any action against your license, including but not limited to reprimand, suspension, revocation, a fine, or nonjudicial punishment, for an act that would be grounds for disciplinary action under Md. Code Ann. Health Occ. §14-404?

b. Have any complaints, investigations or charges been brought against you or are any currently pending in any jurisdiction by any licensing or disciplinary board (except this licensing board) or an entity of the armed services?

c. Has your application for a medical or health professional license been withdrawn for reasons that would be grounds for disciplinary action under Md. Code Ann. Health Occ. §14-404?

d. Has an investigation or charge been brought against you by a hospital, related institution, or alternative health care system that would be grounds for disciplinary action under Md. Code Ann. Health Occ. §14-404?

e. Have you had any denial of application for privileges, failure to renew your privileges or limitation, restriction, suspension, revocation or loss in privileges in a hospital, related health care facility, or alternative health care system that would be grounds for disciplinary action under Md. Code Ann. Health Occ. §14-404?

f. Have you had a plea of guilty, nolo contendere, conviction, or receipt of probation before judgment or other diversionary disposition of any criminal act, excluding traffic violations?

g. Have you had a plea of guilty, nolo contendere, conviction, or receipt of probation before judgment or other diversionary disposition for an alcohol or controlled dangerous substance offense, including but not limited to driving while under the influence of alcohol or controlled dangerous substances?

h. Are there any pending criminal charges against you in any court of law, excluding minor traffic violations?

.. Do you have a physical or mental condition that currently impairs your ability to practice medicine?

j. Has the use of drugs and/or alcohol resulted in an impairment of your ability to practice your profession?

k. Do you illegally use drug(s)?

l. Have you surrendered or allowed your license to lapse while under investigation by any licensing or disciplinary board of any jurisdiction or an entity of the armed services?

m. Have you been named as a defendant in a filing or settlement of a medical malpractice action?

n. Has your employment by any hospital, HMO, related health care or other institution, or military entity been terminated for any disciplinary reasons?

o. Have you voluntarily resigned from any hospital, HMO, or other health care facility or institution, or military entity while under investigation by that institution for disciplinary reasons?

p. Are you in default of a service obligation resulting from your receipt of state or federal funding for your medical education?

q. Have you failed to make arrangements to satisfy any state or federal loans that financed your medical education?

If you answered "YES" to any of question 6 (a) through (q), attach a separate page with a complete explanation of each occasion. Each attachment must have your name in print, signature, and date.

7. **CONTINUING MEDICAL EDUCATION** Choose one statement that applies to you.

☒ a. CME met. I have earned 50 credit hours of Category 1 continuing medical education during the two years prior to this renewal.

☐ b. First renewal and NPO. I am exempt from CME during the renewal period because this is my first renewal after initial medical licensure in Maryland and I have completed the Board's New Physician Orientation Program. The New Physician Orientation is for NEWLY licensed physicians only. If you were licensed prior to September 30, 2006 or reinstated, this does not apply to you. Please visit our website at www.mbp.state.md.us to complete the orientation.
Your license will not be renewed unless you have completed the orientation.

☐ c. First renewal after reinstatement. I am exempt from CME during the renewal period because this is my first renewal after reinstatement of my medical licensure in Maryland.

8. Ethnicity and Race (select all that apply)

☐ a. Hispanic or Latino ☐ b. American Indian or Alaska Native ☐ c. Asian ☒ d. Black or African American
☐ e. Native Hawaiian or other Pacific Islander ☐ f. White ☐ g. Other

9. Are you employed by the Federal Government? ☐ Yes ☒ No

10. Do you plan on ending your medical practice in the next 2 years? ☐ Yes ☒ No ☐ N/A

11. Current area of concentration:

Using the codes on the Code sheet, list which area(s) best describe your current area(s) of concentration.

Primary: 0 1 5 Secondary: ☐☐☐

12. SPECIALTY BOARD CERTIFICATION: Using the codes on the Code Sheet, list up to two (2) specialty areas only if certified by a recognized board of the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA).

Primary: 0 1 5 Secondary: ☐☐☐

13. **HEALTH CARE ALTERNATIVE DISPUTE RESOLUTIONS QUESTIONS**
The following questions pertain to the period since July 1, 2006. If this is your first renewal, these questions apply to the period commencing with the date of your initial licensure or reinstatement.

YES NO

a. Have you been the subject of professional discipline?

b. Have you, your partners or associates or anyone in your immediate family or household, been sued or had a claim filed against you or any of them for medical malpractice?

c. Have you testified as a medical witness in a judicial or administrative proceeding?

d. Have you been an arbitrator?

e. Are you currently an arbitrator?

f. Are you, or any member of your immediate family or household, currently a party in a medical malpractice case?

g. Is there any reason why you could not hear and decide impartially a health care malpractice claim solely on the basis of the law and the evidence presented?

ONLINE RENEWAL IS AVAILABLE AT: http://www.mbp.state.md.us.

PRACTICE INFORMATION

14. Do you currently practice medicine? [X] Yes [ ] No

15. If you are not currently in practice, are you? [ ] a. Retired, permanently not in practice

If retired, previous occupation: _____

[ ] b. Semi-retired, working outside the practice of medicine [ ] c. Temporarily not in practice

[ ] d. Inactive for other reasons [ ] e. Working full-time outside the practice of medicine

[X] f. Not applicable (Currently in practice)

If you answered question 15 *f*, indicating that you are currently in practice, please answer questions 16-33.
If you answered question 15 *a, b, c, d,* or *e*, please skip to question 32 and complete the Affirmation.

16. What percent of your average work day is spent in personally providing PRIMARY/PREVENTIVE CARE SERVICES in Maryland?

100 %

17. If all offices are located outside of Maryland, do you treat Maryland residents? [ ] Yes [ ] No [X] N/A

18. What is the total number of practice/office locations at which you personally work within Maryland? 01 (If none, enter 00)

19. PRIMARY PRACTICE/OFFICE LOCATION:

(Please print within boxes)

Organization Name: INTEGRATED OB/GYN SVCS

Street Address: 7610 PENNSYLVANIA AVE #305

Street2:

City: FORESTVILLE State: MD Zip Code: 20747

(Use postal abbreviations)

Employer Tax ID: [redacted] Jurisdiction: 16 (Jurisdiction codes on the Code Sheet)

(IF FEDERAL FACILITY WITHOUT TAX ID # ENTER N/A)

At this site, what is the average number of hours per week you are available for ALL PATIENT CARE? [ ] (IF NONE ENTER 00)

Setting: 01 Practice: 02 Primary Role: 01 Secondary Role: 02 Private / Public: 02

(See Setting, Practice, Role, and Private/Public codes on the Code Sheet)

20. This question is about the use of computers and other forms of information technology, such as hand-held computers, in diagnosing or treating your patients.

In your practice, are computers or other forms of information technology used:

YES	NO	
[ ]	[X]	A. To obtain information about treatment alternatives or recommended guidelines?
[ ]	[X]	B. To send prescriptions electronically to a pharmacy? If you answered **yes** to 20B, what percentage of prescriptions are submitted electronically? [ ] % (Please enter a whole number for the percentage. No decimals.)
[ ]	[X]	C. To generate reminders for you about preventative services needed for your patients?
[ ]	[X]	D. To access patient notes, medication lists, or problem lists?
[ ]	[X]	E. For clinical data and image exchanges **WITH OTHER PHYSICIANS**?
[ ]	[X]	F. For clinical data and image exchanges **WITH HOSPITALS AND LABORATORIES**?
[ ]	[X]	G. To communicate about clinical issues with patients by email?
[ ]	[X]	H. To obtain information on potential patient drug interactions with other drugs, allergies, and/or patient conditions?

I. If you admit patients to the hospital, does the hospital where most of your patients are treated have computerized systems to order tests and medications? [X] YES [ ] NO [ ] N/A

21. SECONDARY PRACTICE/OFFICE LOCATION:

Organization Name: N/A

Street Address

Street2

City: State: (Use postal abbreviations) Zip Code:

Employer Tax ID: Jurisdiction: (Use jurisdiction codes on the Code Sheet)

At this site, what is the average number of hours per week you are available for ALL PATIENT CARE? (If none, insert 00)

Setting: Practice: Primary Role: Secondary Role: Private/Public:

(See Setting, Practice, Role, and Private/Public codes on the Code Sheet)

22. Do you participate in the Maryland Medical Assistance (Medicaid) program? [X] Yes [ ] No [ ] Not Applicable

23. If you answered Yes to question 22, are you accepting new Maryland Medical Assistance patients? [X] Yes [ ] No

24. Do you participate in Medicare? [ ] Yes [X] No [ ] Not Applicable

25. If you answered YES to question 24, are you accepting new Medicare patients? [ ] Yes [ ] No

26. **National Provider Identifier** (NPI): If you have your NPI number, please enter it below. Otherwise, leave the NPI blank.

NPI: 1306807797

For more information about the NPI number, please contact the Centers for Medicare and Medicaid Services at 1-877-267-2323.

27. Do you offer a sliding fee scale based on ability to pay? (Utilize a standardized fee reduction schedule for low-income) [X] Yes [ ] No [ ] Not Applicable

28. Do you offer uncompensated (charity) care? [X] Yes [ ] No [ ] Not Applicable

29. If you answered Yes to question 28, report the number of hours you personally provide in uncompensated care in a month? 10

30. Is a Physician Assistant, Nurse Practitioner, or Nurse Midwife included as part of your practice (employee or on staff)? [ ] Yes [X] No

31. Workers' Compensation coverage: If you employ one or more persons, the Md. Code Ann. Health Occ. §1-202 requires that you verify that you are complying with the Workers' Compensation Law for your renewal to be issued.

I certify one of the following:

[ ] I do not practice in Maryland. [ ] Not Applicable:

[ ] I do not employ anyone in my practice in Maryland.

[X] I employ one or more persons in my Maryland practice and have the following Workers' Compensation coverage:

Policy Number: [redacted] Expiration Date: [redacted] MONTH DAY YEAR

Name of Insurance Carrier: [redacted]

32. Affirmation: Please read this section carefully before signing your name.

I certify that I have personally reviewed all responses to the items in this application and that the information I have given is true and correct to the best of my knowledge and that any false information provided as part of my application may be cause for the denial of my application.

I agree that the Maryland Board of Physicians (the Board) may request any information necessary to process my application for renewal from any person or agency, including but not limited to former and current employers, government agencies, the National Practitioners Data Bank, the Healthcare Integrity and Protection Data Bank, hospitals and other licensing bodies, and I agree that any person or agency may release to the Board the information requested. I also agree to sign any subsequent releases for information that may be requested by the Board.

I shall inform the Board, by certified mail, return receipt requested, within 30 days of:

(a) an action that would be grounds for disciplinary action under Md. Code Ann. Health Occ. 14-404, that occurred at any time during the application period;

(b) a change in any answer that was originally given in this application.

SIGNATURE: [signature] DATE: 8/1/08

LICENSE NUMBER: D22219

ONLINE RENEWAL IS AVAILABLE AT: http://www.mbp.state.md.us.

DO NOT MAIL THIS TO THE BOARD. RETAIN THIS APPLICATION FOR YOUR RECORDS.

Application for renewal of: **Physicians** 2010

1. **License Number D0022219** Dr. Harold O Alexander

2.	Individual National Provider Identifier NPI: 1306680779 ☐ I do not have an NPI This is the NPI entered in the field for Rendering NPI on a claim (10 digit number) [x] NPI Information

3. EMAIL ADDRESS: This is your email address on file. If it has changed, please edit below. If you do not have an email address please indicate by checking the checkbox below.

[redacted]

☐ I do not have an email address

Address Changes (Non-Public and Public):
You must submit a Public and Non-Public address. If either address has changed, please correct here.
Your address(es) on the online renewal application is current as of July 1, 2012 . If you requested any changes to your address(es) that are not reflected on this application, please make the change at this time. These changes will be updated in the main database.

4a. Non-Public Address: This address is for Board use only and is **where your license will be mailed**. However, if no public address is listed, this address will also be made available to the public.

Street	[redacted]
Street (2)	
Street (3)	
City	[redacted]
State	[redacted] If selecting a country other than USA or Canada, please choose "Foreign" as your state
ZipCode	[redacted]
Country	United States

4b. Public Address: This address, usually your office, is available to the public and will be posted on the Internet. If you do not designate a public address, your non-public address will be posted on the Internet.

☐ Check if Public Address is the same as your Non-Public address (the address above will be automatically entered below.)

Street	Integrated OB-GYN Services
Street (2)	7610 Pennsylvania Ave
Street (3)	Suite 305
City	Forestville
State	Maryland If selecting a country other than USA or Canada, please choose "Foreign" as your state
ZipCode	20747
Country	United States

5. Do you give the Maryland Board of Physicians permission to report your date of birth to the Federation of State Medical Boards' Physician Data Center? See instruction ◉ Yes ○ No

CHARACTER AND FITNESS (Question 6)

6. The following questions pertain to the period since July 1, 2010. If this is your first renewal, these questions apply to the period commencing with the date of your initial licensure or reinstatement. Check the box YES or NO next to each question. ***If you answer Yes, provide an explanation at the prompt.***
* All questions must be answered Yes or No.

Yes * No [redacted]

a. Has any licensing or disciplinary board of any jurisdiction (except this licensing board), or any entity of the armed services denied your application for licensure, reinstatement or renewal, or taken any action against your license, including but not limited to reprimand, suspension, revocation, a fine, or nonjudicial punishment, for an act that would be grounds for disciplinary action under Md. Code Ann. Health Occ. §14-404?

Yes [redacted] No

b. Have any complaints, investigations or charges been brought against you or are any currently pending in any jurisdiction by any licensing or disciplinary board (except this licensing board) or an entity of the armed services?

Yes [redacted] No

c. Has your application for a medical or health professional license been withdrawn for reasons that would be grounds for disciplinary action under Md. Code Ann. Health Occ. §14-404?

Yes [redacted] No

d. Has an investigation or charge been brought against you by a hospital, related institution, or alternative health care system that would be grounds for action under Md. Code Ann. Health Occ. §14-404?

Yes [redacted] No

e. Have you had any denial of application for privileges, failure to renew your privileges, or limitation, restriction, suspension, revocation or loss in privileges in a hospital, related health care facility, or alternative health care system that would be grounds for disciplinary action under Md. Code Ann. Health Occ. §14-404?

Yes [redacted] No

f. Have you had a plea of guilty, nolo contendere, conviction, or receipt of probation before judgment or other diversionary disposition of any criminal act, excluding traffic violations?

Yes [redacted] No

g. Have you had a plea of guilty, nolo contendere, conviction, or receipt of probation before judgment or other diversionary disposition for an alcohol or controlled dangerous substance offense, including but not limited to driving while under the influence of alcohol or controlled dangerous substances?

Yes [redacted] No

h. Are there any pending criminal charges against you in any court of law, excluding minor traffic violations?

Yes [redacted] No

i. Do you have a physical or mental condition that currently impairs your ability to practice medicine?

Yes [redacted] No

j. Has the use of drugs and/or alcohol resulted in an impairment of your ability to practice your profession?

Yes [redacted] No

k. Do you illegally use drugs?

Yes [redacted] No

l. Have you surrendered or allowed your license to lapse while under investigation by any licensing or disciplinary board of any jurisdiction or an entity of the armed services?

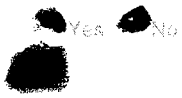
Yes [redacted] No

m. Have you been named as a defendant in a filing or settlement of a medical malpractice action?

[redacted]

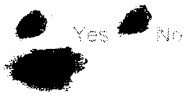
Yes [redacted] No

n. Has your employment by any hospital, HMO, related health care or other institution, or military entity been terminated for any diciplinary reasons?



o. Have you voluntarily resigned from any hospital, HMO, or other health care facility or institution, or military entity while under investigation by that institution for disciplinary reasons?

p. Are you in default of a service obligation resulting from your receipt of state or federal funding for your medical education?



q. Have you failed to make arrangements to satisfy any state or federal loans that financed your medical education?

CONTINUING MEDICAL EDUCATION (Question 7)

(◉) **a. CME met**. I have earned 50 credit hours of Category 1 continuing medical education during the two (2) years prior to this renewal.

( ) **b. First Renewal & NPO**. I am exempt from CME during the renewal period because this is my first renewal after initial medical licensure in Maryland and I have completed the Board's New Physician Orientation Program. The New Physician Orientation is for **NEWLY** licensed physicians only. If you were licensed prior to September 30, 2010 or reinstated, this does not apply to you. See New Physician Orientation Program web site. **Your license will not be renewed unless you have completed the orientation.**

( ) **c. First Renewal after reinstatement.** I am exempt from CME during the renewal period because this is my first renewal after reinstatement of my medical licensure in Maryland.

PERSONAL AND PROFESSIONAL INFORMATION (Questions 8-17)

8. Ethnicity and Race: (Select all that apply)

- [ ] Hispanic or Latino
- [ ] American Indian or Alaska native
- [ ] Asian
- [x] Black or African American
- [ ] Native Hawaiian or other Pacific Islander
- [ ] White
- [ ] Other

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9. Are you employed by the Federal Government?

( ) Yes (◉) No

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10. Please indicate if you are currently in: a) a residency program accredited by the Accreditation Council for Graduate Medical Education or an internship or residency program approved by the American Osteopathic Association; or b) a fellowship (subspecialty) training program accredited by the ACGME.

If you answer ***Yes*** to either a. or b. you will not be required to complete the Practice Information section (Questions 15-26) of this application.

a. In an accredited/approved internship or residency program?

( ) Yes (◉) No

b. In an accredited fellowship (subspecialty) training program?

( ) Yes (◉) No

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11. Which best describes your current area(s) of concentration:

Primary Concentration: Gynecology

Secondary Concentration: None

12. SPECIALTY BOARD CERTIFICATION: List up to two (2) specialty areas only if certified by a recognized board of the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA).

Primary Certification: Obstetrics & Gynecology

Secondary Certification: None

13. Please indicate below how the hours in your typical work week are allocated. The sum of these hours should reflect the number of hours in your typical work week. Definitions of these categories are listed below.

If you allocate **0 hours per week** to a. Patient Care Related Activities you will not be required to complete the Practice Information section (Questions 15-26) of this application.

Patient Care Related Activities include seeing patients, writing prescriptions, patient-related clinical activities (such as pathologic and radiologic assessments), maintaining patient records, obtaining and reviewing test results, arranging referrals, consulting with other providers about patients, talking with a patient's family members.

Research includes clinical, laboratory, and analytical research

Teaching includes teaching of medical undergraduate & graduate students and other graduate students.

Administration & Other: Administration includes practice management (billing, contract negotiations, personnel, regulatory activities) & management of institutions or programs (health departments, health insurance, hospitals, other health-related institutions or programs); Other

Use whole numbers. No fractional hours. If none enter 0.

a. Patient Care Related Activities	40	hours per week
b. Research	0	hours per week
c. Teaching	0	hours per week
d. Administration & Other	30	hours per week
Total Hours	70	hours per week

14. If you indicated in Question 13 that you are not engaged in patient care related activities, do you intend to resume patient care related activities in the next 2 years?

○ Yes ○ No

PRACTICE INFORMATION (Questions 15-26)

15. Do you plan to discontinue patient care related activities in the next two years?

○ Yes ◉ No

16. Please indicate below the number of practice/office locations at which you routinely deliver patient care for reimbursement.

a. Number of locations in Maryland (if none, enter 0) 1

b. Number of locations outside of Maryland (if none, enter 0) 0
If you have locations outside Maryland, please answer (c) below after you answer (b).

c. Do you routinely treat Maryland patients at your practice/office location(s) outside of Maryland?

○ Yes ○ No ○ Don't know

17. Please indicate below the number of hospitals at which you currently have admitting privileges.

a. Number of hospitals in Maryland (if none, enter 0) 0

b. Number of hospitals outside of Maryland (if none, enter 0) 0

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18. Primary Practice / Office Location Primary Practice / Office Location

Please answer all Primary Practice questions

a. Organization Name Harold O. Alexander, M.D.

b. Street Address 7610 Pennsylvania Avenue

c. Street2 Suite # 305
Enter suite or room number here. (Ex. Suite 101 or Room 101)

d. City Forestville

e. State Maryland

f. Zip Code 20747

g. Jurisdiction PRINCE GEORGE'S

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h. Employer Tax ID [redacted] What is Employer tax ID?
Enter "None" if you do not have an Employer tax ID

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i. Please select one of the following related to the NPI used for billing insurers:

- ○ **I use an Organizational NPI for billing. Please Enter >** Organizational NPI
- ◉ **I use my Individual NPI for billing.**
- ○ **I do not bill public or private insurers.**

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j. You indicated in Question 13a, **40** hours of Patient Care Related Activities during a typical work week.
How many of those Patient Care Related Activity hours in your typical work week are delivered at this practice/office location? 40 Hours
If none, enter 0.

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k. Setting Freestanding Physician Office

l. Private/Public Private-For profit

m. Practice Solo

Please answer the following regarding staffing at this practice/office location on a typical day. Definition of mid-level medical providers is listed below.
If none, enter 0; if you don't know the number, enter 999

Number of physicians (MDs, DOs, residents, fellows) including yourself at this location. 3

Number of mid-level medical providers at this location. 0
Mid-level medical providers: nurse practitioners, nurse midwives, nurse anesthetists and physician assistants.

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19. Secondary Practice / Office Location
No Secondary Location indicated from your response in Question 16.
If you have a secondary practice/office location and you've checked the box above, you will see a series of questions that must be completed.

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20. Information Technology (Primary Practice / Office Location)

Please answer all Primary Practice Information Technology questions

This question is about the use of computers and other forms of information technology, such as hand-held computers, in diagnosing or treating your patients at your primary office/practice location, which you listed in question 18.

(●) Yes ( ) No A. To obtain information about treatment alternatives or recommended guidelines?

( ) Yes (●) No B. To send prescriptions electronically to a pharmacy?

If you answered **Yes** to 20B, what percentage of prescriptions are submitted electronically? Use whole numbers. %

( ) Yes (●) No C. To generate reminders for you about preventive services needed for your patients?

(●) Yes ( ) No D. To access patient notes, medication lists, or problem lists?

( ) Yes (●) No E. For clinical data and image exchanges **WITH OTHER PHYSICIANS**?

(●) Yes ( ) No F. For clinical data and image exchanges **WITH HOSPITALS AND LABORATORIES**?

( ) Yes (●) No G. To communicate about clinical issues with patients by email?

(●) Yes ( ) No H. To obtain information on potential patient drug interactions with other drugs, allergies, and/or patient conditions?

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21. Does your primary office/practice location use electronic MEDICAL RECORDS (not including billing records)?

( ) Yes, all electronic (●) Yes, part paper and part electronic ( ) No ( ) Don't know

21a. If **No,** please indicate your most significant reason for not using electronic medical records.

Capital cost outlays | Risk of privacy breaches | Retiring soon
Overburdened staff | Lack of technology standards | Not my decision
Physician resistance to adoption | Intangible benefits

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22. Please indicate if you participate in the following private and public insurance programs, and whether you are currently accepting new public insurance program patients.

a. Participate in any PRIVATE insurance plan networks, including PPO, EPO, HMO, etc. (●) Yes ( ) No

b. Participate in the MARYLAND MEDICAL ASSISTANCE PROGRAM (in either the traditional program or a Managed Care Organization) (●) Yes ( ) No

b1. If **Yes**, are you accepting new Maryland Medical Assistance patients? ( ) Yes (●) No

c. Participate in the MEDICARE (in either the traditional program or a Medicare Advantage Plan)? ( ) Yes (●) No

c1. If **Yes**, are you accepting new Medicare patients? Yes No

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23. Do you offer a sliding fee scale based on ability to pay? (Utilize a standardized fee reduction schedule for low-income)

( ) Yes (●) No ( ) NA

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24. Please report the typical number of hours per week you personally provide care to patients on a charity basis (do not include bad debt).

5 hours per week. If none, enter 0

If you are practicing as an adult primary care specialist (internal medicine, family practice, general medicine), answer Q.25. Otherwise skip to Q.26.

25. Do you charge patients an annual fee for participating on your patient panel (sometime called direct, concierge, or retainer-based practice)?

○ Yes ○ No

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26. Workers Compensation

Workers Compensation coverage: If you employ one or more persons, the Md. Code Ann. Health Occ. §1-202 requires that you verify that you are complying with the Workers' Compensation Law for your renewal to be issued.

I hereby certify:

○ Not Applicable (Do not complete below)

○ I do not practice in Maryland.

○ I do not employ anyone in my practice in Maryland.

◉ I employ one or more persons in my Maryland practice and have the following Workers Compensation coverage.

If you are a Maryland employer you must provide the information requested below.

Insurance Company [redacted]

Policy Number [redacted]

Expiration Date [redacted] Enter as MM/DD/YYYY Enter as MM/DD/YYYY

PHYSICIANS EMERGENCY CONTACT INFORMATION

27. As part of Maryland's emergency preparedness efforts, the Department of Health and Mental Hygiene has identified the need for certain contact information for licensed physicians in Maryland who may be needed to respond to a catastrophic health emergency. (Public Safety Article, Sec. 14-3A-01 et seq. and Health General Article Section 18-901 et seq. sets forth the powers of the Governor and Secretary of the Department of Health and Mental Hygiene.

* Required Field

Please provide the phone number that should be used in the event of an actual emergency.

Daytime * [redacted]

Nighttime* [redacted]

Indicate by checking any box that applies whether you have any particular training and experience regarding the following specific agents:

☐ Chemical ☐ Biological ☐ Radiological

If you are interested in being contacted about training opportunities provided by the Board of Physicians, please visit the Maryland Professional Volunteer Corps website at https://mdresponds.dhmh.maryland.gov/.

Thank you for your assistance!

APPLICATION PACKET FOR EXEMPTION FROM LICENSE FEE

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28. CERTIFICATION AND AUTHORIZATION OF LICENSE APPLICATION

Please check the first 3 boxes to certify and affirm your renewal application.

- [x] a. I certify that I have personally reviewed all responses to the items in this application and that the information I have given is true and correct to the best of my knowledge and that any false information provided as part of my application may be cause for the denial of my application.
- [x] b. I agree that the Maryland Board of Physicians (the Board) may request any information necessary to process my application for renewal from any person or agency, including but not limited to former and current employers, government agencies, the National Practitioners Data Bank, the Healthcare Integrity and Protection Data Bank, hospitals and other licensing bodies, and I agree that any person or agency may release to the Board the information requested. I also agree to sign any subsequent releases for information that may be requested by the Board.
- [x] c. I shall inform the Board, by certified mail, return receipt requested, within 30 days of: (a) action that would be grounds for disciplinary action under Md. Code Ann. Health Occ. §14-404, that occurred at any time during the application period; (b) change in any answer that was originally given in this application.
- [x] d. Check Here if you wish to have the option of viewing your completed application online after you renew your license. Otherwise, your application will not be available online for your later viewing. If selected, viewing is available until 12/1/2012.

29. Please provide your electronic signature (type your name) below:

Name	Harold O. Alexander, M.D.
Today's Date	9/3/2010
Last four digits of Social Security Number:	[redacted]

30. Select a Payment Option here to complete your application.

Please note: Credit cards may be used for online payment only. If you or a 3rd party is sending in payment, it must be by check.

Your renewal fee is:

○ **Credit Card** ◉ **Send Check** ○ **3rd Party Check** **3rd Party Payer:**

PAYMENT

APPLICATION COMPLETION INFORMATION:

Date Application Started	9/3/2010
Date Application Submitted	9/3/2010
Confirmation Number	9824D0022219
Payment Method	Send Check
Amount Due	$512.00