Aug

MEDICAL LICENSURE COMMISSION
STATE OF ALABAMA
P.O. BOX 946
MONTGOMERY, ALABAMA 36102

APPLICATION FOR LICENSE TO PRACTICE MEDICINE/OSTEOPATHY

NAME IN FULL LYNN, SHERWOOD CHANG, JR
(Last Name) (First Name) (Middle Name)

MAILING ADDRESS 603 CHURCH ST

CITY MOBILE STATE ALABAMA ZIP 36602

COUNTY MOBILE TELEPHONE NUMBER (205) 433-3147

TYPE OF PRACTICE OB-GYN

DATE 15 AUG 93 SIGNED [signature]

ALABAMA OFFICE MAILING ADDRESS:

2451 Fillingim St.
Mobile, AL 36617-2293

Please attach license fee of $ 75.00
Make check payable to AL Medical Licensure Commission

(Rev. 08/93)

RENEWAL APPLICATION

For a certificate of registration to practice medicine in Alabama in 1994

Alabama Medical Licensure Commission • Post Office Box 887 • Montgomery, Alabama 36101-0887 • Phone (205) 242-4153

Name & Mailing Address

(Make address corrections in (4) below)

LICENSE #: 00017601 ISSUED: 8/19/1993

LYNN SHERWOOD CHANG JR
USAMC/DEPT OBGYN
2451 FILLINGIM STREET
MOBILE AL 36617-2238

- Every physician and osteopath licensed to practice medicine/osteopathy in the State of Alabama shall, on or before the 31st of December of each year, apply to this Commission for a Certificate of Registration which shall be effective during the calendar year.
- Renewal Fee: $100.00 - Failure to register and pay the annual registration fee within 30 days after registration becomes due will result in the automatic revocation of the current license without further notice or hearing as provided in §34-24-337, Code of Alabama (1975).

(Check a or b) For CME Certification

a) ✓ I hereby certify that I have met the annual minimum continuing education requirement of 12 hours of Category I continuing medical education during the calendar year ending December 31, 1993.

b) ✓ I certify that I am exempt from the minimum continuing medical education requirement for the following reason:

Check One Below If You Answered (b)

- ___ I do not reside in the State of Alabama and do not have a significant portion of my medical practice in Alabama.
- ✓ I received my initial license to practice medicine in Alabama after June 30th of this calendar year.
- ___ I reinstated my license to practice medicine in the State of Alabama after June 30th of this calendar year.
- ___ I am retired from the practice of medicine and have obtained a waiver from the Board of Medical Examiners.
- ___ I am a resident physician enrolled in a residency training program.

Within The Past Year:

	Yes	No
1. Have you been convicted of a felony or of any offense (felony/misdemeanor) involving the practice of medicine?	☐	☒
2. Has your certificate of qualification or license to practice medicine in any state been suspended, revoked, restricted, curtailed or voluntarily surrendered under threat of suspension or revocation?	☐	☒
3. Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practice?	☐	☒
4. Have you been denied a certificate of qualification or license to practice medicine in any state or has your application for a certificate of qualification or license to practice medicine been withdrawn under threat of denial?	☐	☒
5. Are you now or have you been addicted to the use of alcohol or controlled substances?	☐	☒
6. Have you been diagnosed and/or treated for a mental illness and/or serious physical illness?	☐	☒
7. Have you had a judgement rendered against you, or action settled relating to the performance of your professional service?	☐	☒
8. To your knowledge, are you the subject of an investigation by any licensing Board/Agency as of the date of this application?	☐	☒

I certify that all information on this form is correct ____________ [signature] 11-5-93

Signature Date

License Renewal for 1995
Deadline is December 31, 1994

State of Alabama
Medical Licensure Commission
205/242-4153

P.O. Box 887
Montgomery, Alabama 36101-0887

Complete **BOTH** sides including signature.
Be sure to correct or supply **ALL** information.
Return with $100.00 renewal fee.
Incomplete applications will be returned.
Failure to register and pay renewal fee will result in the automatic revocation of the current license to practice medicine or osteopathy.

SHERWOOD CHANG LYNN JR, M.D.
USAMC/DEPT OBGYN
2451 FILLINGIM STREET
MOBILE, AL 36617

Please make corrections or supply information: License # 00017601 Sex: M [X] F[ ]

Race: White [X] Black [ ] Am. Indian [ ] Oriental or Asian [ ] Other [ ] Social Security #

Office Address:

USAMC/DEPT OBGYN
2451 FILLINGIM STREET
City, State, Zip: MOBILE, AL 36617
County: Mobile
Business Phone: (205)471-7947
Fax Number: (205) 471-7740
Permission to publish in Roster: Yes [X] No [ ]

Home Address:

603 CHURCH ST
City, State, Zip: MOBILE, AL 36602
County: Mobile
Home Phone: (205)433-3147
(Will not be published)
Send official mail to (Business) or Home address (circle one)

Specialty: Primary: OB/GYN Board Certified: Yes [X] No [ ]

Secondary: ______ Board Certified: Yes [ ] No [X]

Form of Practice: [] Solo [] Partnership (2, 3 or 4) [X] Group (5 or more) If Group, give name: USAMC, Ob-GynDept.

Primary Hospital where you have staff privileges:

Name: UNIV SO AL MED CTR City/State: MOBILE , AL

Are you licensed in another state: Yes [X] No [X] Which ones: [X] Texas [NM] New Mexico [WV] West Virginia [ ] [ ]

CME Certification: (Check one)

[X] I hereby certify that I have met the annual minimum continuing education requirement of 12 hours of Category I continuing medical education during the calendar year ending December 31, 1994.

[] I certify that I am exempt from the minimum continuing medical education requirement for the following reason:

- [] I do not reside in the State of Alabama and do not have a significant portion of my medical practice in Alabama.
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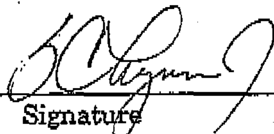
- [] I reinstated my license to practice medicine in the State of Alabama after June 30th of this calendar year.
- [] I am a resident physician enrolled in a residency training program.
- [] I am retired from the practice of medicine and have obtained a waiver from the Board of Medical Examiners.

Complete both sides including signature. Supply or correct all information. **OVER**

Within The Past Year:

		Yes	No
1.	Have you been convicted of a felony or of any offense (felony/misdemeanor) involving the practice of medicine?	☐	X
2.	Has your certificate of qualification or license to practice medicine in any state been suspended, revoked, restricted, curtailed or voluntarily surrendered under threat of suspension or revocation? *Am voluntarily surrendering WV License*	X	X
3.	Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practice?	☐	X
4.	Have you been denied a certificate of qualification or license to practice medicine in any state or has your application for a certificate of qualification or license to practice medicine been withdrawn under threat of denial?	☐	X
5.	Are you now or have you been addicted to the use of alcohol or controlled substances?	☐	X
6.	Have you been diagnosed and/or treated for a mental illness and/or serious physical illness?	☐	X
7.	Have you had a judgement rendered against you, or action settled relating to the performance of your professional service?	☐	X
8.	To your knowledge, are you the subject of an investigation by any licensing Board/Agency as of the date of this application?	☐	X

I certify that all information on this form is correct:



Signature

10 Oct 94

Date

- Complete both sides, including signature.
- Be sure to correct or supply all information.

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Medical Licensure Commission
P.O. Box 887
Montgomery, AL 36101-0887

DEADLINE — DECEMBER 31, 1994

License Renewal for 1996
Deadline is December 31, 1995

State of Alabama
Medical Licensure Commission

334/242-4153

P.O. Box 887
Montgomery, Alabama 36101-0887

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CAR-RT-SORTC010
164
26

Sherwood Chang Lynn Jr, M.D.
2451 Fillingim St
USAMC/DEPT OBGYN
Mobile, AL 36617 2238

Please make corrections or supply information: License **17601** DATE ISSUED: 08/19/93 Sex: M [X] F[ ]

Race: White [X] Black [ ] Am. Indian [ ] Oriental or Asian [ ] Other [ ] Social Security #

Office Address:

2451 FILLINGIM ST

USAMC/DEPT OBGYN

City, State, Zip: MOBILE, AL 36617 2238

(Alabama) County: Mobile

Business Phone: (334)471-7947

Fax Number: (334)471-7740

Permission to publish in Roster: Yes [X] No [ ]

Home Address:

603 CHURCH ST

City, State, Zip: MOBILE, AL 36602 1601

(Alabama) County: Mobile

Home Phone: (334)433-3147
(Will not be published)

Send official mail to: **Business** [X] address (check one)
Home [ ]

Specialty: Primary: OBSTETRICS & GYNECOLOGY Board Certified: Yes [X] No [ ]

Secondary: ______________________ Board Certified: Yes [ ] No [ ]

Form of Practice: [ ] Solo [ ] Partnership (2, 3, or 4) [X] Group (5 or more) If Group, give name below:

USA OB/GYN DEPT

Primary Hospital where you have staff privileges:

Name: USA MEDICAL CENTER City/State: MOBILE, AL

Are you licensed in another state: Yes [X] No [ ] Which ones: [TX] [NM] [WV] [ ] [ ]

CME Certification: (Check one)

[X] I hereby certify that I have met the annual minimum continuing education requirement of 12 hours of Category I continui medical education during the calendar year ending December 31, 1995.

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- [] I am retired from the practice of medicine and have obtained a waiver from the Board of Medical Examiners.

Complete both sides including signature. Supply or correct all information. **OVER**

DEADLINE IS DECEMBER 31, 1995

	Yes	No
1. Have you been convicted of a felony or of any offense (felony/misdemeanor) involving the practice of medicine within the past year?	☐	☒
2. Has your certificate of qualification or license to practice medicine in any state been suspended, revoked, restricted, curtailed or voluntarily surrendered under threat of suspension or revocation within the past year?	☒	☐
3. Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practice, within the past year?	☐	☒
4. Have you been denied a certificate of qualification or license to practice medicine in any state or has your application for a certificate of qualification or license to practice medicine been withdrawn under threat of denial within the past year?	☐	☒
5. Are you now or have you been addicted to the use of alcohol or controlled substances within the past year?	☐	☒
6. Have you been diagnosed and/or treated for a mental illness and/or serious physical illness?	☐	☒
7. Have you had a judgement rendered against you, or action settled relating to the performance of your professional service within the past year?	☐	☒
8. To your knowledge, are you the subject of an investigation by any licensing Board/Agency as of the date of this application within the past year?	☐	☒

IF YOU HAVE ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, PLEASE ATTACH A DETAILED EXPLANATION WITH YOUR APPLICATION UPON RETURNING IT TO THIS OFFICE.

I certify that all information on this form is correct.

[signature] 10-13-95

Signature Date

- Complete both sides, including signature.
- Be sure to correct or supply all information.

Incomplete applications will be returned.

Return with $100.00 renewal fee to:

Medical Licensure Commission
P.O. Box 887
Montgomery, AL 36101-0887

License Renewal for 1997
Deadline is December 31, 1996

State of Alabama
Medical Licensure Commission

334/242-4153

P.O. Box 887
Montgomery, Alabama 36101-0887

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SHERWOOD CHANG LYNN JR, M.D.
USAMC/DEPT OBGYN
2451 FILLINGIM ST
MOBILE AL 36617-2238

Please make corrections or supply information: License 17601 DATE-ISSUED: 08/19/93 Sex: M [X] F [ ]

Race: White [X] Black [ ] Am. Indian [ ] Oriental or Asian [ ] Other [ ] Social Security #: Enter SSAN#

Office Address:

2451 FILLINGIM ST

USAMC/DEPT OBGYN

City, State, Zip: MOBILE, AL 36617 2238

(Alabama) County: Mobile

Business Phone: (334)471-7947

Fax Number: (334)471-7740

Permission to publish in Roster: Yes [X] No [ ]

Home Address:

603 CHURCH ST

City, State, Zip: MOBILE, AL 36602 1601

(Alabama) County: Mobile

Home Phone: (334)433-3147
(Will not be published)

Send official mail to: **Business** [ ] address (check one)
Home [ ]

Speciality: Primary: OBSTETRICS & GYNECOLOGY Board Certified: Yes [X] No [ ]

Secondary: ______ Board Certified: Yes [ ] No [ ]

Form of Practice: [] Solo [] Partnership (2, 3, or 4) [X] Group (5 or more) If Group, give name below:

USA OB/GYN DEPT

Primary Hospital where you have staff privileges:

Name: USA MEDICAL CENTER City/State: MOBILE, AL

Are you licensed in another state: Yes [X] No [ ] Which ones: [TX] [NM] [WV] [ ] [ ]

CME Certification: (Check one)

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- [] I am retired from the practice of medicine and have obtained a waiver from the Board of Medical Examiners.

Complete both sides including signature. Supply or correct all information. **OVER**

DEADLINE IS DECEMBER 31, 1996

		YES	NO
1.	Have you been convicted of a felony or of any offense (felony/misdemeanor) involving the practice of medicine within the past year?	[ ]	[X]
2.	Has your certificate of qualification or license to practice medicine in any state been suspended, revoked, restricted, curtailed or voluntarily surrendered under threat of suspension or revocation within the past year? *See Addendum*	[ ]	[X]
3.	Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practice, within the past year?	[ ]	[X]
4.	Have you been denied a certificate of qualification or license to practice medicine in any state or has your application for a certificate of qualification or license to practice medicine been withdrawn under threat of denial within the past year?	[ ]	[X]
5.	Have you had a judgement rendered against you, or action settled relating to the performance of your professional service within the past year? *2 Cases settled in 1995*	[ ]	[X]
6.	To your knowledge, are you the subject of an investigation by any licensing Board/Agency as of the date of this application within the past year?	[ ]	[X]
7.	Within the past year, have you been diagnosed with or have you been treated for bi-polar disorder, schizophrenia, paranoia, or any other psychotic disorder?	[ ]	[X]
8.	Do you currently have any mental or physical condition or impairment (including, but not limited to, substance abuse, alcohol abuse, or mental, emotional, or nervous disorder or condition) which in any way currently affects, or if untreated could affect, your ability to practice in a competent and professional manner?	[ ]	[X]
9.	Within the past year, have you ever raised the issue of consumption of drugs or alcohol or the issue of a mental, emotional, nervous, or behavioral disorder or condition as a defense, mitigation, or explanation for your actions in the course of any administrative or judicial proceeding or investigation; any inquiry or other proceeding; or any proposed termination by an educational institution, employer, government agency, professional organization or licensing authority?	[ ]	[X]
10.	Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism?	[ ]	[X]
11.	Are you currently engaged in the illegal use of controlled dangerous substances?	[ ]	[X]
12.	If your answer to the preceding question is yes, are you currently participating in a supervised rehabilitation program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances?	[ ]	[X]
13.	Have you been, within the past year, convicted of driving under the influence (DUI) or have you been charged with DUI and been convicted of a lesser offense such as reckless driving?	[ ]	[X]
14.	Has your medical training or medical practice been interrupted or suspended for a period longer than 60 days for any reason other than a vacation?	[ ]	[X]

The term "currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the condition referred to may have an ongoing impact on one's functioning as a physician or an assistant to a physician, or within the past two years.

IF YOU HAVE ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, PLEASE ATTACH A DETAILED EXPLANATION WITH YOUR APPLICATION UPON RETURNING IT TO THIS OFFICE.

I certify that all information on this form is correct. ______________________ Signature   *22 Oct 96* Date

- **Complete both sides, including signature.**
- **Be sure to supply all information.**
- **Incomplete applications will be returned.**

Return with $100.00 renewal fee to:

Medical Licensure Commission
P.O. Box 887
Montgomery, AL 36101-0887

SERVICE PRINTING CO. (334) 269-0058

License Renewal for 1998
Deadline is December 31, 1997

State of Alabama
Medical Licensure Commission

334/242-4153

P.O. Box 887
Montgomery, Alabama 36101-0887

Complete **BOTH** sides including signature.
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**5-DIGIT 36617
SHERWOOD CHANG LYNN JR, M.D. 26
USAMC/DEPT OBGYN 147
2451 FILLINGIM ST 7896
MOBILE, AL 36617-2238

Please make corrections or supply information: License 17601 DATE-ISSUED: 8/19/93 Sex: M [X] F [_]
Race: White [X] Black [_] Am. Indian [_] Oriental or Asian [_] Other [_] Social Security #[redacted]

Office Address:
USAMC/DEPT OBGYN
2451 FILLINGIM ST
City, State, Zip: MOBILE, AL 36617 2238
(Alabama) County: Mobile
Business Phone: (334)471-~~7947~~ 7998
Fax Number: (334)471-7740
Permission to publish in Roster: Yes [X] No [_]

Home Address:
603 CHURCH ST
City, State, Zip: MOBILE, AL 36602 1601
(Alabama) County: Mobile
Home Phone: (334)433-3147
(Will not be published)
Send official mail to: **Business** [X] address (check one)
Home [ ]

Specialty: Primary: OBSTETRICS & GYNECOLOGY Board Certified: Yes [X] No [_]
Secondary: ________________ Board Certified: Yes [_] No [_]
Form of Practice: [] Solo [] Partnership (2, 3, or 4) [X] Group (5 or more) If Group, give name below:
USA OB/GYN DEPT

Primary Hospital where you have staff privileges:
Name: USA ~~MEDICAL CENTER~~ Children & Women's Hospital City/State: MOBILE, AL
Are you licensed in another state: Yes [X] No [_] which ones: [TX] [NM] [WV] [_] [_]

Primary Care Information:

1. Are you actively engaged in clinical practice? (Check one): Yes [X] No [ ]
2. Does your practice include the delivery of primary care medical services? (Primary care is defined as: "Basic or general health care focused on the point at which a patient ideally *first* seeks assistance from the medical care system, exclusive of emergency room care."): (Check one): Yes [X] No [ ]
3. Approximately how many hours per week do you practice the above-defined primary care services? __________

CME Certification: (Check one)

[X] I hereby certify that I have met the annual minimum continuing education requirement of 12 hours of Category I continuing medical education during the calendar year ending December 31, 1997.

[ ] I certify that I am exempt from the minimum continuing medical education requirements for the following reason:

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Complete both sides including signature. Supply or correct all information. **OVER**

DEADLINE IS DECEMBER 31, 1997

7896

		YES	NO
1.	Have you been convicted of a felony or of any offense (felony/misdemeanor) involving the practice of medicine within the past year?	[ ]	[x]
2.	Has your certificate of qualification or license to practice medicine in any state been suspended, revoked, restricted, curtailed or voluntarily surrendered under threat of suspension or revocation within the past year?	[ ]	[x]
3.	Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practice, within the past year?	[ ]	[x]
4.	Have you been denied a certificate of qualification or license to practice medicine in any state or has your application for a certificate of qualification or license to practice medicine been withdrawn under threat of denial within the past year?	[ ]	[x]
5.	Have you had a judgement rendered against you, or action settled relating to the performance of your professional service within the past year?	[ ]	[x]
6.	To your knowledge, are you the subject of an investigation by any licensing Board/Agency as of the date of this application within the past year?	[ ]	[x]
7.	Within the past year, have you been diagnosed with or have you been treated for bi-polar disorder, schizophrenia, paranoia, or any other psychotic disorder?	[ ]	[x]
8.	Do you currently have any mental or physical condition or impairment (including, but not limited to, substance abuse, alcohol abuse, or mental, emotional, or nervous disorder or condition) which in any way currently affects, or if untreated could affect, your ability to practice in a competent and professional manner?	[ ]	[x]
9.	Within the past year, have you ever raised the issue of consumption of drugs or alcohol or the issue of a mental, emotional, nervous, or behavioral disorder or condition as a defense, mitigation, or explanation for your actions in the course of any administrative or judicial proceeding or investigation; any inquiry or other proceeding; or any proposed termination by an educational institution, employer, government agency, professional organization or licensing authority?	[ ]	[x]
10.	Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism?	[ ]	[x]
11.	Are you currently engaged in the illegal use of controlled dangerous substances?	[ ]	[x]
12.	If your answer to the preceding question is yes, are you currently participating in a supervised rehabilitation program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances?	[ ]	[x]
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14.	Has your medical training or medical practice been interrupted or suspended for a period longer than 60 days for any reason other than a vacation?	[ ]	[x]

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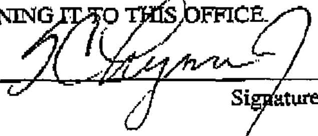
IF YOU HAVE ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, PLEASE ATTACH A DETAILED EXPLANATION WITH YOUR APPLICATION UPON RETURNING IT TO THIS OFFICE.

I certify that all information on this form is correct. 
Signature

10/22/97
Date

- **Complete both sides, including signature.**
- ***Be sure to supply all information.***
- **Incomplete applications will be returned.**

Return with $100.00 renewal fee to:

Medical Licensure Commission
P.O. Box 887
Montgomery, AL 36101-0887

License Renewal for 1999

Deadline is December 31, 1998

State of Alabama
Medical Licensure Commission

334/242-4153

P.O. Box 887
Montgomery, Alabama 36101-0887

***************************AUTO**3-DIGIT 366
SHERWOOD CHANG LYNN JR, M.D.
USAMC/DEPT OBGYN
2451 FILLINGIM ST
MOBILE AL 36617-2238

43
1
8137

Complete **BOTH** sides including signature.
Be sure to correct or supply **ALL** information.
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Please make corrections or supply information: License 17601 DATE-ISSUED: 8/19/93 Sex: M [X] F [ ]
Race: White [X] Black [ ] Am. Indian [ ] Oriental or Asian [ ] Other [ ] Social Security #

Office Address:
USAMC/DEPT OBGYN
2451 FILLINGIM ST
City, State, Zip: MOBILE, AL 36617 2238
(Alabama) County: Mobile
Business Phone: (334)471-7947
Fax Number: (334)471-7740

Home Address:
603 CHURCH ST
City, State, Zip: MOBILE, AL 36602 1601
(Alabama) County: Mobile
Home Phone: (334)433-3147
(Will not be published)

Permission to publish in Roster: Yes [X] No [ ]

Send official mail to: **Business** [ ] address (check one)
Home [ ]

Specialty: Primary: OBSTETRICS & GYNECOLOGY Board Certified: Yes [ ] No [ ]
Secondary: ______ Board Certified: Yes [ ] No [ ]

Form of Practice: [ ] Solo [ ] Partnership (2, 3, or 4) [X] Group (5 or more) If Group, give name below:
USA OB/GYN DEPT

Primary Hospital where you have staff privileges:
Name: USA CHILDRENS & WOMENS HOSP City/State: MOBILE, AL
Are you licensed in another state: Yes [X] No [ ] which ones: [TX] [NM] [WV] [ ] [ ]

Primary Care Information:

1. Are you actively engaged in clinical practice? (Check one): Yes [✓] No [ ]
2. Does your practice include the delivery of primary care medical services? (Primary care is defined as: "Basic or general health care focused on the point at which a patient ideally *first* seeks assistance from the medical care system, exclusive of emergency room care."): (Check one): Yes [✓] No [ ]
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DEADLINE IS DECEMBER 31, 1998

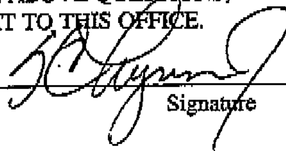
Complete both sides including signature. Supply or correct all information. **OVER**

License #17601 8137 LYNN, SHERWOOD CHANG JR

		YES	NO
1.	Have you been convicted of a felony or of any offense (felony/misdemeanor) involving the practice of medicine within the past year?	[ ]	[✓]
2.	Has your certificate of qualification or license to practice medicine in any state been suspended, revoked, restricted, curtailed or voluntarily surrendered under threat of suspension or revocation within the past year?	[ ]	[✓]
3.	Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practice, within the past year?	[ ]	[✓]
4.	Have you been denied a certificate of qualification or license to practice medicine in any state or has your application for a certificate of qualification or license to practice medicine been withdrawn under threat of denial within the past year?	[ ]	[✓]
5.	Have you had a judgement rendered against you, or action settled relating to the performance of your professional service within the past year?	[ ]	[✓]
6.	To your knowledge, are you the subject of an investigation by any licensing Board/Agency as of the date of this application within the past year?	[ ]	[✓]
7.	Within the past year, have you been diagnosed with or have you been treated for bi-polar disorder, schizophrenia, paranoia, or any other psychotic disorder?	[ ]	[✓]
8.	Do you currently have any mental or physical condition or impairment (including, but not limited to, substance abuse, alcohol abuse, or mental, emotional, or nervous disorder or condition) which in any way currently affects, or if untreated could affect, your ability to practice in a competent and professional manner?	[ ]	[✓]
9.	Within the past year, have you ever raised the issue of consumption of drugs or alcohol or the issue of a mental, emotional, nervous, or behavioral disorder or condition as a defense, mitigation, or explanation for your actions in the course of any administrative or judicial proceeding or investigation; any inquiry or other proceeding; or any proposed termination by an educational institution, employer, government agency, professional organization or licensing authority?	[ ]	[✓]
10.	Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism?	[ ]	[✓]
11.	Are you currently engaged in the illegal use of controlled dangerous substances?	[ ]	[✓]
12.	If your answer to the preceding question is yes, are you currently participating in a supervised rehabilitation program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances?	[ ]	[✓]
13.	Have you been, within the past year, convicted of driving under the influence (DUI) or have you been charged with DUI and been convicted of a lesser offense such as reckless driving?	[ ]	[✓]
14.	Has your medical training or medical practice been interrupted or suspended for a period longer than 60 days for any reason other than a vacation?	[ ]	[✓]

The term "currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the condition referred to may have an ongoing impact on one's functioning as a physician or an assistant to a physician, or within the past two years.

IF YOU HAVE ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, PLEASE ATTACH A DETAILED EXPLANATION WITH YOUR APPLICATION UPON RETURNING IT TO THIS OFFICE.

I certify that all information on this form is correct.  Signature   13 Oct 98 Date

- **Complete both sides, including signature.**
- **Be sure to supply all information.**
- **Incomplete applications will be returned.**

Return with $100.00 renewal fee to:

Medical Licensure Commission
P.O. Box 887
Montgomery, AL 36101-0887

License Renewal for 2000
Deadline is December 31, 1999

State of Alabama
Medical Licensure Commission

334/242-4153

P.O. Box 887
Montgomery, Alabama 36101-0887

Complete **BOTH** sides including signature.
Be sure to correct or supply **ALL** information.
Return with $100.00 renewal fee.
Incomplete applications will be returned.
Failure to register and pay renewal fee will result in the automatic revocation of the current license to practice medicine or osteopathy.

AUTO 3-DIGIT 366
SHERWOOD CHANG LYNN JR, M.D.
USAMC/DEPT OBGYN
2451 FILLINGIM ST
MOBILE, AL 36617-2238

36
1
8302

Please make corrections or supply information: License **17601** DATE-ISSUED: 8/19/93 Sex: M [X] F [_]
Race: White [X] Black [_] Am. Indian [_] Oriental or Asian [_] Other [_] Social Security # [redacted]
Enter SSAN#

Office Address:	**Home Address:**
USAMC/DEPT OBGYN	603 CHURCH ST
~~2451 FILLINGIM ST~~ 251 Cox St., Suite 100	
City, State, Zip: MOBILE, AL ~~36617-2238~~ 36604	City, State, Zip: MOBILE, AL 36602 1601
(Alabama) County: Mobile	(Alabama) County: Mobile
Business Phone: (334)~~471-7947~~ 415-1557	Home Phone: (334)433-3147
Fax Number: (334)~~471-7740~~ 415-1552	(Will not be published)
Permission to publish in Roster: Yes [X] No [_]	Send official mail to: **Business** [✓] address (check one) **Home** [ ]

Specialty: Primary: OBSTETRICS & GYNECOLOGY — Board Certified: Yes [✓] No [_]
Secondary: ______________________ — Board Certified: Yes [_] No [_]
Form of Practice: [ ] Solo [ ] Partnership (2, 3, or 4) [X] Group (5 or more) If Group, give name below:
USA OB/GYN DEPT

Primary Hospital where you have staff privileges:
Name: USA CHILDRENS & WOMENS HOSP City/State: MOBILE, AL
Are you licensed in another state: Yes [X] No [_] which ones: [TX] [__] [__] [__] [__]

Primary Care Information:

1. Are you actively engaged in clinical practice in the State of Alabama?
   Yes [X] Go to Question 2 No [ ] Do NOT answer questions 2 and 3 below. Skip to CME Certification questions.
2. Does your practice include the delivery of primary care medical services in Alabama? (Primary care is defined as: "Basic or general 'gatekeeper' health care focused on the point at which a patient ideally first seeks assistance from the medical care system, exclusive of an emergency care situation.")
   Yes [X] Go to Question 3 No [ ] Do NOT answer question 3 below. Skip to CME Certification questions.
3. Approximately how many hours per week do you practice the above-defined primary care services in Alabama? Only answer if you answered YES to questions 1 and 2 above.) Approximately 16 hours per week.

CME Certification: (Check one)

[X] I hereby certify that I have met the annual minimum continuing education requirement of 12 hours of Category I continuing medical education during the calendar year ending December 31, 1999.
[ ] I certify that I am exempt from the minimum continuing medical education requirements for the following reason:
[ ] I do not reside in the State of Alabama and do not have a significant portion of my medical practice in Alabama.
[ ] I received my initial license to practice medicine in Alabama after June 30th of this calendar year.
[ ] I reinstated my license to practice medicine in the State of Alabama after June 30th of this calendar year.
[ ] I am a resident physician enrolled in a residency training program.
[ ] I am retired from the practice of medicine and have obtained a waiver from the Board of Medical Examiners.

DEADLINE IS DECEMBER 31, 1999

Complete both sides including signature. Supply or correct all information. **OVER**

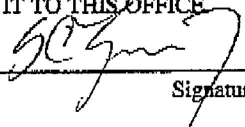
License #17601 8302 LYNN, SHERWOOD CHANG JR

RECEIVED OCT 1 9 1999

		YES	NO
1.	Have you been convicted of a felony or of any offense (felony/misdemeanor) involving the practice of medicine within the past year?	[ ]	[X]
2.	Has your certificate of qualification or license to practice medicine in any state been suspended, revoked, restricted, curtailed or voluntarily surrendered under threat of suspension or revocation within the past year?	[ ]	[X]
3.	Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practice, within the past year?	[ ]	[X]
4.	Have you been denied a certificate of qualification or license to practice medicine in any state or has your application for a certificate of qualification or license to practice medicine been withdrawn under threat of denial within the past year?	[ ]	[X]
5.	Have you had a judgement rendered against you, or action settled relating to the performance of your professional service within the past year?	[ ]	[X]
6.	To your knowledge, are you the subject of an investigation by any licensing Board/Agency as of the date of this application within the past year?	[ ]	[X]
7.	Within the past year, have you been diagnosed with or have you been treated for bi-polar disorder, schizophrenia, paranoia, or any other psychotic disorder?	[ ]	[X]
8.	Do you currently have any mental or physical condition or impairment (including, but not limited to, substance abuse, alcohol abuse, or mental, emotional, or nervous disorder or condition) which in any way currently affects, or if untreated could affect, your ability to practice in a competent and professional manner?	[ ]	[X]
9.	Within the past year, have you ever raised the issue of consumption of drugs or alcohol or the issue of a mental, emotional, nervous, or behavioral disorder or condition as a defense, mitigation, or explanation for your actions in the course of any administrative or judicial proceeding or investigation; any inquiry or other proceeding; or any proposed termination by an educational institution, employer, government agency, professional organization or licensing authority?	[ ]	[X]
10.	Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism?	[ ]	[X]
11.	Are you currently engaged in the illegal use of controlled dangerous substances?	[ ]	[X]
12.	If your answer to the preceding question is yes, are you currently participating in a supervised rehabilitation program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances?	[ ]	[ ]
13.	Have you been, within the past year, convicted of driving under the influence (DUI) or have you been charged with DUI and been convicted of a lesser offense such as reckless driving?	[ ]	[X]
14.	Has your medical training or medical practice been interrupted or suspended for a period longer than 60 days for any reason other than a vacation?	[ ]	[X]

The term "currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the condition referred to may have an ongoing impact on one's functioning as a physician or an assistant to a physician, or within the past two years.

IF YOU HAVE ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, PLEASE ATTACH A DETAILED EXPLANATION WITH YOUR APPLICATION UPON RETURNING IT TO THIS OFFICE.

I certify that all information on this form is correct.  ____________ Signature   10/19/99 Date

- **Complete both sides, including signature.**
- **Be sure to supply all information.**
- **Incomplete applications will be returned.**

Return with $100.00 renewal fee to:

Medical Licensure Commission
P.O. Box 887
Montgomery, AL 36101-0887

License Renewal for 2001
Deadline is December 31, 2000

State of Alabama RECEIVED OCT 24 2000
Medical Licensure Commission

334/242-4153

P.O. Box 887
Montgomery, Alabama 36101-0887

Complete **BOTH** sides including signature.
Be sure to correct or supply **ALL** information.
Return with $125.00 renewal fee.
Incomplete applications will be returned.
Failure to register and pay renewal fee will result in the automatic revocation of the current license to practice medicine or osteopathy.

*************************************AUTO**3-DIGIT 366
SHERWOOD CHANG LYNN JR, M.D. 39
251 COX ST STE 100 1
MOBILE, AL 36604-3302 8390

Please make corrections or supply information: License **17601** DATE-ISSUED: 8/19/93 Sex: M [X] F [_]
Race: White [X] Black [_] Am. Indian [_] Oriental or Asian [_] Other [_] Social Security # Enter SSAN#

Office Address:
SUITE 100
251 COX ST
City, State, Zip: MOBILE, AL 36604
(Alabama) County: Mobile
Business Phone: (334)415-1557
Fax Number: (334)415-1552
Permission to publish in Roster: Yes [X] No [_]

Home Address:
603 CHURCH ST
City, State, Zip: MOBILE, AL 36602 1601
(Alabama) County: Mobile
Home Phone: (334)433-3147
(Will not be published)
Send official mail to: **Business** [X] address (check one)
Home [ ]

Specialty: Primary: OBSTETRICS & GYNECOLOGY Board Certified: Yes [X] No [_]
Secondary: ________ ________________ Board Certified: Yes [_] No [_]
Form of Practice: [ ] Solo [ ] Partnership (2, 3, or 4) [X] Group (5 or more) If Group, give name below:
USA OB/GYN DEPT

Primary Hospital where you have staff privileges:
Name: USA CHILDRENS & WOMENS HOSP City/State: MOBILE, AL
Are you licensed in another state: Yes [X] No [_] which ones: [TX] [__] [__] [__] [__]

Primary Care Information:

1. Are you actively engaged in clinical practice in the State of Alabama?
   Yes [X] Go to Question 2 No [ ] Do NOT answer questions 2 and 3 below. Skip to CME Certification questions.
2. Does your practice include the delivery of primary care medical services in Alabama? (Primary care is defined as: "Basic or general 'gatekeeper' health care focused on the point at which a patient ideally first seeks assistance from the medical care system, exclusive of an emergency care situation.")
   Yes [X] Go to Question 3 No [ ] Do NOT answer question 3 below. Skip to CME Certification questions.
3. Approximately how many hours per week do you practice the above-defined primary care services in Alabama? Only answer if you answered YES to questions 1 and 2 above.) Approximately ___80___ hours per week.

CME Certification: (Check one)

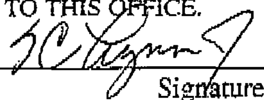
[X] I hereby certify that I have met the annual minimum continuing education requirement of 24 hours of Category I continuing medical education within the past two calendar years ending December 31, 2000.
[_] I certify that I am exempt from the minimum continuing medical education requirements for the following reason:
[ ] I do not reside in the State of Alabama and do not have a significant portion of my medical practice in Alabama.
[ ] I received my initial license to practice medicine in Alabama after June 30th of this calendar year.
[ ] I reinstated my license to practice medicine in the State of Alabama after June 30th of this calendar year.
[ ] I am a resident physician enrolled in a residency training program.
[ ] I am retired from the practice of medicine and have obtained a waiver from the Board of Medical Examiners.

DEADLINE IS DECEMBER 31, 2000
Complete both sides including signature. Supply or correct all information. **OVER**

		Yes	No
1.	Have you been convicted of a felony or of any offense (felony/misdemeanor) involving the practice of medicine within the past year?	[ ]	[X]
2.	Has your certificate of qualification or license to practice medicine in any state been suspended, revoked, restricted, curtailed or voluntarily surrendered under threat of suspension or revocation within the past year?	[ ]	[X]
3.	Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practice, within the past year?	[X]	[ ]
4.	Have you been denied a certificate of qualification or license to practice medicine in any state or has your application for a certificate of qualification or license to practice medicine been withdrawn under threat of denial within the past year?	[ ]	[X]
5.	Have you had a judgement rendered against you, or action settled relating to the performance of your professional service within the past year?	[ ]	[X]
6.	To your knowledge, are you the subject of an investigation by any licensing Board/Agency as of the date of this application within the past year?	[ ]	[X]
7.	Within the past year, have you been diagnosed with or have you been treated for bi-polar disorder, schizophrenia, paranoia, or any other psychotic disorder?	[ ]	[X]
8.	Do you currently have any mental or physical condition or impairment (including, but not limited to, substance abuse, alcohol abuse, or mental, emotional, or nervous disorder or condition) which in any way currently affects, or if untreated could affect, your ability to practice in a competent and professional manner?	[ ]	[X]
9.	Within the past year, have you ever raised the issue of consumption of drugs or alcohol or the issue of a mental, emotional, nervous, or behavioral disorder or condition as a defense, mitigation, or explanation for your actions in the course of any administrative or judicial proceeding or investigation; any inquiry or other proceeding; or any proposed termination by an educational institution, employer, government agency, professional organization or licensing authority?	[ ]	[X]
10.	Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism?	[ ]	[X]
11.	Are you currently engaged in the illegal use of controlled dangerous substances?	[ ]	[X]
12.	If your answer to the preceding question is yes, are you currently participating in a supervised rehabilitation program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances?	[ ]	[X]
13.	Have you been, within the past year, convicted of driving under the influence (DUI) or have you been charged with DUI and been convicted of a lesser offense such as reckless driving?	[ ]	[X]
14.	Has your medical training or medical practice been interrupted or suspended for a period longer than 60 days for any reason other than a vacation?	[ ]	[X]

The term "currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the condition referred to may have an ongoing impact on one's functioning as a physician or an assistant to a physician, or within the past two years.

IF YOU HAVE ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, PLEASE ATTACH A DETAILED EXPLANATION WITH YOUR APPLICATION UPON RETURNING IT TO THIS OFFICE.

I certify that all information on this form is correct.  23 Oct 2000

Signature Date

- **Complete both sides, including signature.**
- **Be sure to correct or supply all information.**
- **Incomplete applications will be returned.**

Return with $125.00 renewal fee to:

Medical Licensure Commission
P.O. Box 887
Montgomery, AL 36101-0887

SERVICE PRINTING CO. (334) 269-0058

License Renewal for 2002
Deadline is December 31, 2001

State of Alabama
Medical Licensure Commission

334/242-4153

P.O. Box 887
Montgomery, Alabama 36101-0887

SHERWOOD CHANG LYNN, M.D.
251 COX ST
SUITE 100
MOBILE, AL 36604

Complete **BOTH** sides including signature.
Be sure to correct or supply **ALL** information.
Return with $200.00 renewal fee.
Incomplete applications will be returned.
Failure to register and pay renewal fee will result in the automatic revocation of the current license to practice medicine or osteopathy.

Please make corrections or supply information: License: **MD . 00017601** Date-Issued: 08/19/1993 Sex: M [X] F [ ]
Race: White [X] Black [ ] American Indian [ ] Oriental or Asian [ ] Other [ ] Social Security# [redacted]

Office Address

251 COX ST
SUITE 100
MOBILE, AL 36604

(Alabama) County: Mobile

Business Phone: (~~334~~ 251) 415-1557

Fax Number: (~~334~~ 251) 415-1552

Permission to publish in Roster: Yes [X]

Home Address

603 CHURCH ST

MOBILE, AL 36602-1601

(Alabama) County: Mobile

Home Phone: (~~334~~ 251) 433-3147 (Will not be published)

Send official mail to: Business [X] address (check one)
Home [ ] address

Specialty: Primary: OBSTETRICS & GYNECOLOGY Board Certified: Yes [X] No [ ]
Secondary: Board Certified: Yes [ ] No [ ]
Form of Practice: [~~X~~] Solo [ ] Partnership (2, 3, or 4) [X] Group If Group give Group Name below: Univ. of South AL College of Medicine, Ob-Gyn Dept.

Primary Hospital where you have staff privileges:
Name: USA CHILDRENS & WOMENS HOSP City/State: MOBILE, AL

Are you licensed in another state: Yes [X] No [ ] Which ones: [TX] [ ] [ ] [ ] [ ]

Primary Care Information:

1. Are you actively engaged in clinical practice in the State of Alabama?
   Yes [X] Go to Question 2 No [ ] Do NOT answer questions 2 and 3 below. Skip to CME Certification questions.
2. Does your practice include the delivery of primary care medical services in Alabama? (Primary care is defined as: "Basic or general 'gatekeeper' health care focused on the point at such a patient ideally first seeks assistance from the medical care system, exclusive of an emergency care situation.")
   Yes [X] Go to Question 3 No [ ] Do NOT answer question 3 below. Skip to the CME Certification questions.
3. Approximately how many hours per week do you practice the above-defined primary care services in Alabama? Only answer if you Answered YES to questions 1 and 2 above. Approximately: **80** hours per week.

CME Certification: (Check one)

[✓] I hereby certify that I have met the annual minimum continuing education requirement of 24 hours of Category I continuing medical education within the past two calendar years ending December 31, 2001.
[ ] I certify that I am exempt from the minimum continuing medical education requirements for the following reason:
  [ ] I do not reside in the State of Alabama and do not have a significant portion of my medical practice in Alabama.
  [ ] I received my initial license to practice medicine in Alabama after June 30th of this calendar year.
  [ ] I reinstated my license to practice medicine in the State of Alabama after June 30th of this calendar year.
  [ ] I am a resident physician enrolled in a residency training program.
  [ ] I am retired from the practice of medicine and have obtained a waiver from the Board of Medical Examiners.

MD . 00017601 **DEADLINE IS DECEMBER 31, 2001** LYNN, SHERWOOD CHANG **OVER**

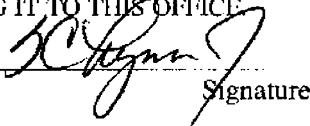
Complete both sides including signature. Supply or correct all information.

030149

		Yes	No
1.	Have you been convicted of a felony or of any offense (felony/misdemeanor) involving the practice of medicine within the past year?	[ ]	[X]
2.	Has your certificate of qualification or license to practice medicine in any state been suspended, revoked, restricted, curtailed or voluntarily surrendered under threat of suspension or revocation within the past year?	[ ]	[X]
3.	Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practice, within the past year?	[ ]	[X]
4.	Have you been denied a certificate of qualification or license to practice medicine in any state or has your application for a certificate of qualification or license to practice medicine been withdrawn under threat of denial within the past year?	[ ]	[X]
5.	Have you had a judgement rendered against you, or action settled relating to the performance of your professional service within the past year?	[ ]	[X]
6.	To your knowledge, are you the subject of an investigation by any licensing Board/Agency as of the date of this application within the past year?	[ ]	[X]
7.	Within the past year, have you been diagnosed with or have you been treated for bi-polar disorder, schizophrenia, paranoia, or any other psychotic disorder?	[ ]	[X]
8.	Do you currently have any mental or physical condition or impairment (including, but not limited to, substance abuse, alcohol abuse, or mental, emotional, or nervous disorder or condition) which in any way currently affects, or if untreated could affect, your ability to practice in a competent and professional manner?	[ ]	[X]
9.	Within the past year, have you ever raised the issue of consumption of drugs or alcohol or the issue of a mental, emotional, nervous, or behavioral disorder or condition as a defense, mitigation, or explanation for your actions in the course of any administrative or judicial proceeding or investigation; any inquiry or other proceeding; or any proposed termination by an educational institution, employer, government agency, professional organization or licensing authority?	[ ]	[X]
10.	Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism?	[ ]	[X]
11.	Are you currently engaged in the illegal use of controlled dangerous substances?	[ ]	[X]
12.	If your answer to the preceding question is yes, are you currently participating in a supervised rehabilitation program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances?	[ ]	[ ]
13.	Have you been, within the past year, convicted of driving under the influence (DUI) or have you been charged with DUI and been convicted of a lesser offense such as reckless driving?	[ ]	[X]
14.	Has your medical training or medical practice been interrupted or suspended for a period longer than 60 days for any reason other than a vacation?	[ ]	[X]

The term "currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the condition referred to may have an ongoing impact on one's functioning as a physician or an assistant to a physician, or within the past two years.

IF YOU HAVE ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, PLEASE ATTACH A DETAILED EXPLANATION WITH YOUR APPLICATION UPON RETURNING IT TO THIS OFFICE.

I certify that all information on this form is correct. 
Signature

11/15/01
Date

- **Complete both sides, including signature.**
- **Be sure to correct or supply all information.**
- **Incomplete applications will be returned.**

Return with $200.00 renewal fee to:

Medical Licensure Commission
P.O. Box 887
Montgomery, AL 36101-0887

License Renewal for 2003
Deadline is December 31, 2002

State of Alabama
Medical Licensure Commission

334/242-4153

P.O. Box 887
Montgomery, Alabama 36101-0887

SHERWOOD CHANG LYNN, M.D.
251 COX ST
SUITE 100
MOBILE, AL 36604

Complete **BOTH** sides including signature.
Be sure to correct or supply **ALL** information.
Return with $200.00 renewal fee.
Incomplete applications will be returned.
Failure to register and pay renewal fee will result in the automatic revocation of the current license to practice medicine or osteopathy.

Please make corrections or supply information: License: **MD . 00017601** Date-Issued: 08/19/1993 Sex: M [X] F [ ]

Race: White [X] Black [ ] American Indian [ ] Oriental or Asian [ ] Other [ ] Social Security# [redacted]

Office Address

251 COX ST
SUITE 100

City, State, Zip: MOBILE, AL 36604

(Alabama) County:

Business Phone: (251) 415-~~1557~~ 1563

Fax Number: (251) 415-1552

Permission to publish in Roster: Yes [X]

Home Address

603 CHURCH ST

City, State, Zip: MOBILE, AL 36602-1601

(Alabama) County:

Home Phone: (251) 433-3147 (Will not be published)

Send official mail to: Business [X] address (check one)
Home [ ]

Specialty: Primary: OBSTETRICS & GYNECOLOGY Board Certified: Yes [ ] No [ ]
Secondary: Board Certified: Yes [ ] No [ ]
Form of Practice: [ ] Solo [ ] Partnership (2, 3, or 4) [ ] Group If Group give Group Name below:

Primary Hospital where you have staff privileges:
Name: USA CHILDRENS & WOMENS HOSP City/State: MOBILE, Alabama
Are you licensed in another state: Yes [X] No [ ] Which ones: [TX] [ ] [ ] [ ] [ ]

Primary Care information:

1. Are you actively engaged in clinical practice in the State of Alabama?
   Yes [X] Go to Question 2 No [ ] Do NOT answer questions 2 and 3 below. Skip to CME Certification questions.
2. Does your practice include the delivery of primary care medical services in Alabama? (Primary care is defined as: "Basic or general 'gatekeeper' health care focused on the point at such a patient ideally first seeks assistance from the medical care system, exclusive of an emergency care situation.")
   Yes [X] Go to Question 3 No [ ] Do NOT answer question 3 below. Skip to the CME Certification questions.
3. Approximately how many hours per week do you practice the above-defined primary care services in Alabama? Only answer if you Answered YES to questions 1 and 2 above. Approximately: 80 hours per week.

CME Certification: (Check one)

[X] I hereby certify that I have met the annual minimum continuing education requirement of 24 hours of Category I continuing medical education within the past two calendar years ending December 31, 2002.
[ ] I certify that I am exempt from the minimum continuing medical education requirements for the following reason:
- [ ] I do not reside in the State of Alabama and do not have a significant portion of my medical practice in Alabama.
- [ ] I received my initial license to practice medicine in Alabama after June 30th of this calendar year.
- [ ] I reinstated my license to practice medicine in the State of Alabama after June 30th of this calendar year.
- [ ] I am a resident physician enrolled in a residency training program.
- [ ] I am retired from the practice of medicine and have obtained a waiver from the Board of Medical Examiners.

DEADLINE IS DECEMBER 31, 2002

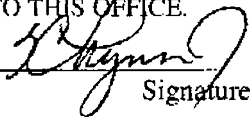
MD . 00017601 **LYNN, SHERWOOD CHANG**

Complete both sides including signature. Supply or correct all information. **OVER**

		Yes	No
1.	Have you been convicted of a felony or of any offense (felony/misdemeanor) involving the practice of medicine within the past year?	[ ]	[X]
2.	Has your certificate of qualification or license to practice medicine in any state been suspended, revoked, restricted, curtailed or voluntarily surrendered under threat of suspension or revocation within the past year?	[ ]	[X]
3.	Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practice, within the past year?	[ ]	[X]
4.	Have you been denied a certificate of qualification or license to practice medicine in any state or has your application for a certificate of qualification or license to practice medicine been withdrawn under threat of denial within the past year?	[ ]	[X]
5.	Have you had a judgement rendered against you, or action settled relating to the performance of your professional service within the past year?	[ ]	[X]
6.	To your knowledge, are you the subject of an investigation by any licensing Board/Agency as of the date of this application within the past year?	[ ]	[X]
7.	Within the past year, have you been diagnosed with or have you been treated for bi-polar disorder, schizophrenia, paranoia, or any other psychotic disorder?	[ ]	[X]
8.	Do you currently have any mental or physical condition or impairment (including, but not limited to, substance abuse, alcohol abuse, or mental, emotional, or nervous disorder or condition) which in any way currently affects, or if untreated could affect, your ability to practice in a competent and professional manner?	[ ]	[X]
9.	Within the past year, have you ever raised the issue of consumption of drugs or alcohol or the issue of a mental, emotional, nervous, or behavioral disorder or condition as a defense, mitigation, or explanation for your actions in the course of any administrative or judicial proceeding or investigation; any inquiry or other proceeding; or any proposed termination by an educational institution, employer, government agency, professional organization or licensing authority?	[ ]	[X]
10.	Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism?	[ ]	[X]
11.	Are you currently engaged in the illegal use of controlled dangerous substances?	[ ]	[X]
12.	If your answer to the preceding question is yes, are you currently participating in a supervised rehabilitation program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances?	~~[ ]~~	~~[ ]~~
13.	Have you been, within the past year, convicted of driving under the influence (DUI) or have you been charged with DUI and been convicted of a lesser offense such as reckless driving?	[ ]	[X]
14.	Has your medical training or medical practice been interrupted or suspended for a period longer than 60 days for any reason other than a vacation?	[ ]	[X]

The term "currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the condition referred to may have an ongoing impact on one's functioning as a physician or an assistant to a physician, or within the past two years.

IF YOU HAVE ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, PLEASE ATTACH A DETAILED EXPLANATION WITH YOUR APPLICATION UPON RETURNING IT TO THIS OFFICE.

I certify that all information on this form is correct. ______  Signature ______ 10/30/07 Date

- **Complete both sides, including signature.**
- **Be sure to correct or supply all information.**
- **Incomplete applications will be returned.**

Return with $200.00 renewal fee to:

Medical Licensure Commission
P.O. Box 887
Montgomery, AL 36101-0887

SERVICE PRINTING CO. (334) 269-0058

Medical Licensure Commission of the State of Alabama
PO Box 887
Montgomery, AL 36101

2004 Online Renewal Summary

Name: **Sherwood Chang Lynn Jr.**

License Number: **MD.17601**

Transaction Date: **2003-12-30***

Transaction Number: **null**

Registration Fee: **200**

Date of Birth: **1940-06-14**

* - This date reflects the date that the transaction was downloaded into the production system not the date the transaction was processed online.

Have you been convicted of a felony or of any offense (felony/misdemeanor) involving the practice of medicine within the past year? **N**

If yes, please explain:

Has your certificate of qualification or license to practice medicine in any state been suspended, revoked, restricted, curtailed or voluntarily surrendered under threat of suspension or revocation within the past year? **N**

If yes, please explain:

Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practice, within the past year? **N**

If yes, please explain:

Have you been denied a certificate of qualification or license to practice medicine in any state or has your application for a certificate of qualification or license to practice medicine been withdrawn under threat of denial within the past year? **N**

If yes, please explain:

Have you had a judgement rendered against you, or action settled relating to the performance of your professional service within the past year? **N**

If yes, please explain:

To your knowledge, are you the subject of an investigation, or has a formal complaint against your license been filed by any licensing Board/Agency as of the date of this application within the past year? **N**

If yes, please explain:

Within the past year, have you been diagnosed with or have you been treated for bi-polar disorder, schizophrenia, paranoia, or any other psychotic disorder? **N**

If yes, please explain:

Do you currently* have any mental or physical condition or impairment (including, but not limited to, substance abuse, alcohol abuse, or mental, emotional or nervous disorder or condition) which in any way currently affects, or if untreated could affect, your ability to practice in a competent and professional manner or, within the past year, have you applied for and/or have you received any payment or other compensation for any mental or physical condition? **N**

If yes, please explain:

Within the past year, have you ever raised the issue of consumption of drugs or alcohol or the issue of a mental, emotional, nervous, or behavioral disorder or condition as a defense, mitigation, or explanation for your actions in the course of any administrative or judicial proceeding or investigation; any inquiry or other proceeding; or any proposed termination by an educational institution, employer, government agency, professional organization or licensing authority? **N**

If yes, please explain:

Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism? **N**

If yes, please explain:

Are you currently* engaged in the illegal use of controlled dangerous substances? **N**

If yes, please explain:

If your answer to the preceding question is yes, are you currently* participating in a supervised rehabilitation program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances? **N**

If yes, please explain:

Have you been, within the past year, convicted of driving under the influence (DUI) or have you been charged with DUI and been convicted of a lesser offense such as reckless driving? **N**

If yes, please explain:

Has your medical training or medical practice been interrupted or suspended for a period longer than 60 days for any reason other than a vacation? **N**

If yes, please explain:

*Note: The term "currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the condition referred to may have an ongoing impact on one`s functioning as a physician or an assistant to a physician, or within the past two years.

Primary specialty:

Are you Board certified in your primary specialty? **Y**

Secondary specialty:

Are you Board certified in your secondary specialty? **N**

Practice Type:

Primary Hospital where you have privileges:

Are you licensed in another State: **Y**

Primary Care Information:

Are you actively engaged in clinical practice in the State of Alabama? **Y**

Does your practice include the delivery of primary care medical services in Alabama? (Primary care is defined as: "Basic or general `gatekeeper` health care focused on the point at such a patient ideally first seeks assistance from the medical care system, exclusive of an emergency care situation.") **Y**

Approximately how many hours per week do you practice the above-defined primary care services in Alabama? Only answer if you answered YES to questions 1 and 2 above. **60**

CME Certification: I hereby certify that I have met the annual minimum continuing education requirement of 24 hours of Category I continuing medical education within the past two Calendar Years ending December 31, 2004. **Y**

I certify that I am exempt from the minimum CME requirement. **N**

I am exempt from the CME requirement for the following reason: **null**

Practice Telephone: **(251) 415-1563**

Practice Address: **251 COX ST**

Home Telephone: **(251) 433-3147**

Home Address: **603 CHURCH ST**

Public Address: **Practice**

Mail Address: **Practice**

By agreeing with this data and submitting your credit information, you have signed this registration form attesting that the material has been supplied by you, the licensee, and that the information is correct. Knowingly providing false registration information to the Alabama Board of Medical Examiners may result in the loss of your license to practice medicine.

Medical Licensure Commission of the State of Alabama
PO Box 887
Montgomery, AL 36101

2005 Online Renewal Summary

Name: **Sherwood Chang Lynn Jr.**
Transaction Date: **2004-12-03***
Registration Fee: **200**

License Number: **MD.17601**
Transaction Number: **null**
Date of Birth: **1940-06-14**

* - This date reflects the date that the transaction was downloaded into the production system not the date the transaction was processed online.

Have you been convicted of a felony or of any offense (felony/misdemeanor) involving the practice of medicine within the past year? **N**

If yes, please explain:

Has your certificate of qualification or license to practice medicine in any state been suspended, revoked, restricted, curtailed or voluntarily surrendered under threat of suspension or revocation within the past year? **N**

If yes, please explain:

Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practice, within the past year? **N**

If yes, please explain:

Have you been denied a certificate of qualification or license to practice medicine in any state or has your application for a certificate of qualification or license to practice medicine been withdrawn under threat of denial within the past year? **N**

If yes, please explain:

Have you had a judgement rendered against you, or action settled relating to the performance of your professional service within the past year? **N**

If yes, please explain:

To your knowledge, are you the subject of an investigation, or has a formal complaint against your license been filed by any licensing Board/Agency as of the date of this application within the past year? **N**

If yes, please explain:

Within the past year, have you been diagnosed with or have you been treated for bi-polar disorder, schizophrenia, paranoia, or any other psychotic disorder? **N**

If yes, please explain:

Do you currently* have any mental or physical condition or impairment (including, but not limited to, substance abuse, alcohol abuse, or mental, emotional or nervous disorder or condition) which in any way currently affects, or if untreated could affect, your ability to practice in a competent and professional manner or, within the past year, have you applied for and/or have you received any payment or other compensation for any mental or physical condition? **N**

If yes, please explain:

Within the past year, have you ever raised the issue of consumption of drugs or alcohol or the issue of a mental, emotional, nervous, or behavioral disorder or condition as a defense, mitigation, or explanation for your actions in the course of any administrative or judicial proceeding or investigation; any inquiry or other proceeding; or any proposed termination by an educational institution, employer, government agency, professional organization or licensing authority? **N**

If yes, please explain:

Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism? **N**

If yes, please explain:

Are you currently* engaged in the illegal use of controlled dangerous substances? **N**

If yes, please explain:

If your answer to the preceding question is yes, are you currently* participating in a supervised rehabilitation program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances? **N**

If yes, please explain:

Have you been, within the past year, convicted of driving under the influence (DUI) or have you been charged with DUI and been convicted of a lesser offense such as reckless driving? **N**

If yes, please explain:

Has your medical training or medical practice been interrupted or suspended for a period longer than 60 days for any reason other than a vacation? **N**

If yes, please explain:

*Note: The term "currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the condition referred to may have an ongoing impact on one`s functioning as a physician or an assistant to a physician, or within the past two years.

Primary specialty:

Are you Board certified in your primary specialty? **Y**

Secondary specialty:

Are you Board certified in your secondary specialty? **N**

Practice Type:

Primary Hospital where you have privileges:

Are you licensed in another State: **Y**

Primary Care Information:

Are you actively engaged in clinical practice in the State of Alabama? **Y**

Does your practice include the delivery of primary care medical services in Alabama? (Primary care is defined as: "Basic or general `gatekeeper` health care focused on the point at such a patient ideally first seeks assistance from the medical care system, exclusive of an emergency care situation.") **Y**

Approximately how many hours per week do you practice the above-defined primary care services in Alabama? Only answer if you answered YES to questions 1 and 2 above. **70**

CME Certification: I hereby certify that I have met the annual minimum continuing education requirement of 12 hours of Category I continuing medical education for the Calendar Year 2004. **Y**

I certify that I am exempt from the minimum Continuing Medical Education requirement for the following reason: **N**

I am exempt from the Continuing Medical Education requirement for the following reason: (Reason Response) **null**

Practice Telephone: **(251) 415-1563**

Practice Address: **251 COX ST**

Home Telephone: **(251) 433-3147**

Home Address: **603 CHURCH ST**

Public Address: **Practice**

Mail Address: **Practice**

By agreeing with this data and submitting your credit information, you have signed this registration form attesting that the material has been supplied by you, the licensee, and that the information is correct. Knowingly providing false registration information to the Alabama Board of Medical Examiners may result in the loss of your license to practice medicine.

RENEW ONLINE AT http://renewal.albme.org Registration ID: 178086

2ND NOTICE

License Renewal for 2006
Deadline is December 31, 2005

State of Alabama
Medical Licensure Commission
334/242-4153
P.O. Box 887
Montgomery, Alabama 36101-0887

Complete **BOTH** sides including signature.
Be sure to correct or supply **ALL** information.
Return with $200.00 renewal fee.
Incomplete applications will be returned.
Failure to register and pay renewal fee will result in the automatic revocation of the current license to practice medicine or osteopathy.

32 25
2402
LYNN SHERWOOD CHANG JR, MD
251 COX ST STE 100
MOBILE, AL 36604-3302

Please make corrections or supply information: License: **MD . 00017601** Date-Issued: 08/19/1993 Sex: M [X] F [ ]

Race: White [X] Black [ ] American Indian [ ] Oriental or Asian [ ] Other [ ] Social Security

Office Address
251 COX ST
SUITE 100

City, State, Zip: MOBILE, AL 36604

(Alabama) County: Mobile

Business Phone: (251) 415-1583

Fax Number: (251) 415-1552

Home Address
603 CHURCH ST

City, State, Zip: MOBILE, AL 36602-1601

(Alabama) County: Mobile

Home Phone: (251) 433-3147 (Will not be published)

Permission to publish in Roster: Yes [✓]

Send official mail to: Business [ ] Home [ ] Address (Check One)

Specialty: Primary: OBSTETRICS & GYNECOLOGY Board Certified: Yes [X] No [ ]
Secondary: Board Certified: Yes [ ] No [ ]
Form of Practice: [ ] Solo [ ] Partnership (2, 3, or 4) [✓] Group If Group give Group Name below:

Primary Hospital where you have staff privileges:
Name: USA Children's and Women's Hos City/State: Mobile, AL
Are you licensed in another state: Yes [X] No [ ] Which ones: [TX] [ ] [ ] [ ] [ ]

Primary Care Information:

1. Are you actively engaged in clinical practice in the State of Alabama? **(Check One)**
   Yes [X] Go to Question 2 No [ ] Do NOT answer questions 2 and 3 below. Skip to CME Certification questions.
2. Does your practice include the delivery of primary care medical services in Alabama? (Primary care is defined as: "Basic or general 'gatekeeper' health care focused on the point at such a patient ideally first seeks assistance from the medical care system, exclusive of an emergency care situation.")
   Yes [X] Go to Question 3 No [ ] Do NOT answer question 3 below. Skip to the CME Certification questions.
3. Approximately how many hours per week do you practice the above-defined primary care services in Alabama? Only answer if you Answered YES to questions 1 and 2 above. Approximately: 80 hours per week.

CME Certification: (Check one)

(a) [✓] I hereby certify that I have met the annual minimum continuing education requirement of 12 hours of Category I continuing medical education for the calendar year 2005.

(b) [ ] I certify that I am exempt from the minimum continuing medical education requirement for the following reason **(Check One)**:

[ ] I do not reside in the State of Alabama and do not have a significant portion of my medical practice in the State of Alabama.
[ ] I was exempt from the CME requirement for the previous calendar year 2004 and I moved my residence to the State of Alabama during calendar year 2005.
[ ] I received my initial license to practice medicine in Alabama in the calendar year 2005.
[ ] I have obtained a retirement waiver from the Board of Medical Examiners, and I do not engage in the practice of medicine in any form.
[ ] I have obtained a waiver from the Board of Medical Examiners due to illness, disability or other hardship condition which existed in the calendar year 2005.
[ ] I am enrolled or was enrolled in a residency training program or clinical fellowship program during the calendar year 2005.

MD . 00017601

DEADLINE IS DECEMBER 31, 2005
LYNN, SHERWOOD CHANG JR

Complete both sides including signature. Supply or correct all information. *OVER*

		Yes	No
1.	Have you been convicted of a felony or of any offense (felony/misdemeanor) involving the practice of medicine within the past year?	[ ]	[✓]
2.	Has your certificate of qualification or license to practice medicine in any state been suspended, revoked, restricted, curtailed or voluntarily surrendered under threat of suspension or revocation within the past year?	[ ]	[✓]
3.	Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practice, within the past year?	[ ]	[✓]
4.	Have you been denied a certificate of qualification or license to practice medicine in any state or has your application for a certificate of qualification or license to practice medicine been withdrawn under threat of denial within the past year?	[ ]	[✓]
5.	Have you had a judgement rendered against you, or action settled relating to the performance of your professional service within the past year?	[ ]	[✓]
6.	To your knowledge, are you the subject of an investigation, or has a formal complaint against your license been filed by any licensing Board/Agency as of the date of this application within the past year?	[ ]	[✓]
7.	Within the past year, have you been diagnosed with or have you been treated for bi-polar disorder, schizophrenia, paranoia, or any other psychotic disorder?	[ ]	[✓]
8.	Do you currently have any mental or physical condition or impairment (including, but not limited to, substance abuse, alcohol abuse, or mental, emotional, or nervous disorder or condition) which in any way currently affects, or if untreated could affect, your ability to practice in a competent and professional manner or, within the past year, have you applied for and/or have you received any payment or other compensation for any mental or physical condition?	[ ]	[✓]
9.	Within the past year, have you ever raised the issue of consumption of drugs or alcohol or the issue of a mental, emotional, nervous, or behavioral disorder or condition as a defense, mitigation, or explanation for your actions in the course of any administrative or judicial proceeding or investigation; any inquiry or other proceeding; or any proposed termination by an educational institution, employer, government agency, professional organization or licensing authority?	[ ]	[✓]
10.	Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism?	[ ]	[✓]
11.	Are you currently engaged in the illegal use of controlled dangerous substances?	[ ]	[✓]
12.	If your answer to the preceding question is yes, are you currently participating in a supervised rehabilitation program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances?	[ ]	[ ]
13.	Have you been, within the past year, convicted of driving under the influence (DUI) or have you been charged with DUI and been convicted of a lesser offense such as reckless driving?	[ ]	[✓]
14.	Has your medical training or medical practice been interrupted or suspended for a period longer than 60 days for any reason other than a vacation?	[ ]	[✓]

The term "currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the condition referred to may have an ongoing impact on one's functioning as a physician or an assistant to a physician, or within the past two years.

IF YOU HAVE ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, PLEASE ATTACH A DETAILED EXPLANATION WITH YOUR APPLICATION UPON RETURNING IT TO THIS OFFICE.

I certify that all information on this form is correct.

Signature

12-13-05

Date

- **Complete both sides, including signature.**
- **Be sure to correct or supply all information.**
- **Incomplete applications will be returned.**

Return with $200.00 renewal fee to:

Medical Licensure Commission
P.O. Box 887
Montgomery, AL 36101-0887

SERVICE PRINTING CO. (334) 269-0058

Medical Licensure Commission of the State of Alabama
PO Box 887
Montgomery, AL 36101

2007 Online Renewal Summary

Name: **Sherwood Chang Lynn Jr.**

License Number: **MD.17601**

Transaction Date: **2006-12-06***

Transaction Number: **VPFF0CD4AD6A**

Registration Fee: **200**

Date of Birth: **1940-06-14**

* - This date reflects the date that the transaction was downloaded into the production system not the date the transaction was processed online.

Have you been charged with any offense (felony/ misdemeanor) within the past year? **no**

If yes, please explain:

Has your certificate of qualification or license to practice medicine in any state been suspended, revoked, restricted, curtailed or voluntarily surrendered under threat of suspension or revocation within the past year? **no**

If yes, please explain:

Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practice, within the past year? **no**

If yes, please explain:

Have you been denied a certificate of qualification or license to practice medicine in any state or has your application for a certificate of qualification or license to practice medicine been withdrawn under threat of denial within the past year? **no**

If yes, please explain:

Have you had a judgment rendered against you, or action settled relating to the performance of your professional service within the past year? **no**

If yes, please explain:

To your knowledge, are you the subject of an investigation, or has a formal complaint against your license been filed by any licensing Board/Agency as of the date of this application within the past year? **no**

If yes, please explain:

Within the past year, have you been diagnosed with or have you been treated for bi-polar disorder, schizophrenia, paranoia, or any other psychotic disorder? **no**

If yes, please explain:

Do you currently have any mental or physical condition or impairment (including, but not limited to, substance abuse, alcohol abuse, or mental, emotional, or nervous disorder or condition) which in any way currently affects, or if untreated could affect, your ability to practice in a competent and professional manner or, within the past year, have you applied for and/or have you received any payment or other compensation for any mental or physical condition? **no**

If yes, please explain:

Within the past year, have you raised the issue of consumption of drugs or alcohol or the issue of a mental, emotional, nervous, or behavioral disorder or condition as a defense, mitigation, or explanation for your actions in the course of any administrative or judicial proceeding or investigation; any inquiry or other proceeding; or any proposed termination by an educational institution, employer, government agency, professional organization or licensing authority? **no**

If yes, please explain:

Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism? **no**

If yes, please explain:

Have you engaged in the illegal use of controlled dangerous substances within the past twelve months? **no**

If yes, please explain:

If your answer to the preceding question is yes, are you currently participating in a supervised rehabilitation program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances? **n/a**

If yes, please explain:

Have you been, within the past year, convicted of driving under the influence (DUI) or have you been charged with DUI and been convicted of a lesser offense such as reckless driving? **no**

If yes, please explain:

Has your medical training or medical practice been interrupted or suspended for a period longer than 60 days for any reason other than a vacation? **no**

If yes, please explain:

Note: The term "currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough that the condition referred to may have an ongoing impact on one's functioning as a physician, or within the past two years. **null**

Primary specialty: **OBSTETRICS & GYNECOLOGY**

Are you Board certified in your primary specialty? **yes**

Secondary specialty:

Are you Board certified in your secondary specialty?

Practice Type: **Solo**

If Group, provide the Group Name:

Primary Hospital where you have privileges: (if any) **null**

Hospital Name: **U So Al Children's and Women's Hospital**

Hospital City: **Mobile**

Hospital State: **AL**

Are you licensed in another State: **yes**

TX

Are you actively engaged in clinical practice in the State of Alabama? **yes**

What is your principal county of practice in the State of Alabama? **Mobile**

(**indicate state if not in Alabama)

Other county(ies) of practice? Indicate state, if counties are not in Alabama). Click 'NONE' if you only practice in the indicated principal county. **null**

Other County1

Other State1

Other County 2

Other State 2

Do you have a current collaborative agreement with a nurse or practitioner or midwife? **No**

Does the nurse practitioner/midwife practice at a site other than your office?

Are you employed by the nurse practitioner/midwife or a corporation owned by the nurse practitioner/midwife?

Do you currently conduct office based surgery involving the administration of parenteral medication for analgesia/sedation, general anesthesia or major regional block anesthesia? **no**

PRIMARY CARE INFORMATION:Primary care is defined as: Basic or general health care focused on the point at which a patient ideally first seeks assistance from the medical care system, exclusive or an emergency situation. **null**

Does your practice include the delivery of primary care medical services in Alabama? **no**

Approximately how many hours per week do you practice the above defined primary care services in Alabama? NOTE: Enter the Average hours worked as a whole number. Do not enter ranges of hours or decimals. **0**

Approximately how many patient encounters (office, hospital, ER, etc.) per week do you have involving the above defined priary care services in Alabama? **0**

CME Certification: I hereby certify that I have met the annual minimum continuing education requirement of 12 hours of Category I continuing medical education for the calendar year 2006 and have supporting documentation if audited. **Y**

I certify that I am exempt from the minimum continuing medical education requirements for the following reason: **N**

Exempt Reason

Practice Telephone: **(251) 433-3147**

Practice Address: **603 Church Street**

Home Telephone: **(251) 433-3147**

Home Address: **603 CHURCH ST**

Public Address:

Mail Address:

By agreeing with this data and submitting your credit information, you have signed this registration form attesting that the material has been supplied by you, the licensee, and that the information is correct. Knowingly providing false registration information to the State of Alabama Medical Licensure Commission may result in the loss of your license to practice medicine. **null**

Medical Licensure Commission of the State of Alabama
PO Box 887
Montgomery, AL 36101

2008 Online Renewal Summary

Name: **Sherwood Chang Lynn Jr.**
Transaction Date: **2008-01-02***
Registration Fee: **300**

License Number: **MD.17601**
Transaction Number: **VSHF1E177ABF**
Date of Birth: **1940-06-14**

* - This date reflects the date that the transaction was downloaded into the production system not the date the transaction was processed online.

Have you been charged with any offense (felony/ misdemeanor) within the past year? **no**

If yes, please explain:

Has your certificate of qualification or license to practice medicine in any state been suspended, revoked, restricted, curtailed or voluntarily surrendered under threat of suspension or revocation within the past year? **no**

If yes, please explain:

Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practice, within the past year? **no**

If yes, please explain:

Have you been denied a certificate of qualification or license to practice medicine in any state or has your application for a certificate of qualification or license to practice medicine been withdrawn under threat of denial within the past year? **no**

If yes, please explain:

Have you had a judgment rendered against you, or action settled relating to the performance of your professional service within the past year? **no**

If yes, please explain:

To your knowledge, are you the subject of an investigation, or has a formal complaint against your license been filed by any licensing Board/Agency as of the date of this application within the past year? **no**

If yes, please explain:

Within the past year, have you been diagnosed with or have you been treated for bi-polar disorder, schizophrenia, paranoia, or any other psychotic disorder? **no**

If yes, please explain:

Do you currently have any mental or physical condition or impairment (including, but not limited to, substance abuse, alcohol abuse, or mental, emotional, or nervous disorder or condition) which in any way currently affects, or if untreated could affect, your ability to practice in a competent and professional manner or, within the past year, have you applied for and/or have you received any payment or other compensation for any mental or physical condition? **no**

If yes, please explain:

Within the past year, have you raised the issue of consumption of drugs or alcohol or the issue of a mental, emotional, nervous, or behavioral disorder or condition as a defense, mitigation, or explanation for your actions in the course of any administrative or judicial proceeding or investigation; any inquiry or other proceeding; or any proposed termination by an educational institution, employer, government agency, professional organization or licensing authority? **no**

If yes, please explain:

Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism? **no**

If yes, please explain:

Have you engaged in the illegal use of controlled dangerous substances within the past twelve months? **no**

If yes, please explain:

If your answer to the preceding question is yes, are you currently participating in a supervised rehabilitation program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances? **n/a**

If yes, please explain:

Have you been, within the past year, convicted of driving under the influence (DUI) or have you been charged with DUI and been convicted of a lesser offense such as reckless driving? **no**

If yes, please explain:

Has your medical training or medical practice been interrupted or suspended for a period longer than 60 days for any reason other than a vacation? **no**

If yes, please explain:

Note: The term "currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough that the condition referred to may have an ongoing impact on one's functioning as a physician, or within the past two years. **null**

Primary specialty: **Obstetrics & Gynecoloy**

Are you Board certified in your primary specialty? **Y**

Secondary specialty: **Other**

Are you Board certified in your secondary specialty?

Practice Type: **S**

If Group, provide the Group Name:

Primary Hospital where you have privileges: (if any) **null**

Hospital Name: **U So Al Children's and Women's Hospital**

Hospital City: **Mobile**

Hospital State:

Are you licensed in another State: **Y**

TX

Are you actively engaged in clinical practice in the State of Alabama? **N**

What is your principal county of practice in the State of Alabama?

(**indicate state if not in Alabama) **TX**

Other county(ies) of practice? Indicate state, if counties are not in Alabama). Click 'NONE' if you only practice in the indicated principal county. **null**

Other County1

Other State1

Other County 2

Other State 2

Do you have a current collaborative agreement with a nurse or practitioner or midwife? **N**

Do you currently conduct office based surgery involving the administration of parenteral medication for analgesia/sedation, general anesthesia or major regional block anesthesia?

PRIMARY CARE INFORMATION:Primary care is defined as: Basic or general health care focused on the point at which a patient ideally first seeks assistance from the medical care system, exclusive or an emergency situation. **null**

Does your practice include the delivery of primary care medical services in Alabama?

Approximately how many hours per week do you practice the above defined primary care services in Alabama? NOTE: Enter the Average hours worked as a whole number. Do not enter ranges of hours or decimals.

Approximately how many patient encounters (office, hospital, ER, etc.) per week do you have involving the above defined priary care services in Alabama?

CME Certification: I hereby certify that I have met the annual minimum continuing education requirement of 12 hours of Category I continuing medical education for the calendar year 2007 and have supporting documentation if audited. **yes**

I certify that I am exempt from the minimum continuing medical education requirements for the following reason:

Exempt Reason

Practice Telephone: **(251) 433-3147**

Practice Address: **603 Church Street**

Home Telephone: **(251) 433-3147**

Home Address: **603 Church St**

Public Address:

Mail Address:

By agreeing with this data and submitting your credit information, you have signed this registration form attesting that the material has been supplied by you, the licensee, and that the information is correct. Knowingly providing false registration information to the State of Alabama Medical Licensure Commission may result in the loss of your license to practice medicine. **null**