9/10/70
347 Bostwick, NE apt. 103
Grand Rapids, Mich
49503

THE STATE MEDICAL BOARD, STATE OF OHIO

Application for Examination for Certificate to Practice Medicine

FORM I.

I hereby make application for a license to practice Medicine and Surgery in the State of Ohio, and submit the following statement regarding my preliminary and medical education.

1. Name Thomas William Michaelis (Full Name) 2. Place of birth Oklahoma City, Oklahoma

Date of birth December 23, 1944

3. Intended Ohio residence Toledo (City) Lucas (County)

4. Where certificate is to be sent 2711 Grantwood, Toledo, Ohio 43613 (48)

The Applicant Must Give Full Answers to the Following:

5. **PRELIMINARY EDUCATION.**
(Name and location of Institution Attended and Degree Received) (Period and Date of Study)

The University of Michigan, Ann Arbor, Michigan B.S. 1962-1966

Received Ohio Medical Student's Certificate No. 36787, from Ohio Medical Board, 1966 (Date)

6. **MEDICAL EDUCATION.**
~~Was~~ Will be granted a diploma by The Ohio State University College of Medicine (Name of Medical College), located at Columbus, State of Ohio, on the 12th day of June, 1970

7. Time of practice (Give Places and Dates)

8. Has any license entitling you to practice in any foreign country or in any state or territory of the United States been suspended or revoked? no (Answer Yes or No)

If so, specify: (State or Country) (Charge) (Date)

Have you ever been or are you now addicted to narcotic or other drugs? no (Yes or No)

Have you ever found it necessary to surrender your narcotic license? (Yes or No)

Have you ever been charged with a violation of a Federal Law, State Law or a municipal ordinance other than a traffic violation? no (Yes or No)

If so, give full particulars: (Offense) (Place) (Disposition)

(Date of Disposition)

9. **PHYSICAL DESCRIPTION OF APPLICANT.**

Race Caucasian Native of USA Complexion Fair

Color of hair Brown Color of eyes Blue Height 5'9"

~~Stout~~ ~~Medium~~ Thin Weight 140 Marks Lump behind right ear

(Cross out words not answering description.) 1" scar on left index finger

*AFFIDAVIT

STATE OF OHIO
COUNTY OF FRANKLIN } ss.

On this 3rd day of April, 1970, personally appeared before me Helen L. Evans within and for the County and State aforesaid Thomas William Michaelis, who being duly sworn says that he is the person referred to in the foregoing application for certificate to practice medicine in the State of Ohio; that the statements herein contained are strictly true in every respect, that he is the person named on the accompanying diploma, and is the lawful possessor of the same, and that he **has read and understands this Affidavit.**

Thomas W. Michaelis
Signature of Applicant.

Signed and sworn to before me this 3rd day of April, 1970

(SEAL)

Helen L. Evans
Official designation of officer administering oath.

My Commission expires on August 7th, 1974

HELEN L. EVANS
NOTARY PUBLIC, FRANKLIN COUNTY, OHIO
MY COMMISSION EXPIRES AUG. 7, 1974

* Must be sworn to before an officer authorized to administer oaths.

Preliminary Educational Requirement

From the General Code of Ohio

Sec. 4731.09. *** The state medical board shall appoint an entrance examiner who shall not be directly or indirectly connected with a medical college and who shall determine the sufficiency of the preliminary education of an applicant for admission to the examination. The minimum requirement shall be two years of collegiate work in an approved college of arts and sciences in addition to high school graduation. Provided, however, that students already matriculated and enrolled in their professional colleges shall not be required to have the two years of college work but shall comply only with the preliminary requirements as existing and in effect at the time of their enrollment in their said colleges. In the absence of the foregoing qualifications, the entrance examiner may examine the applicant to overcome deficiencies. When the entrance examiner finds the preliminary education of the applicant sufficient, he shall issue a certificate of preliminary examination upon the payment to the state medical board of a fee of three dollars. Such certificate shall be attested by the secretary.

The applicant must also produce a diploma from a medical institution in the United States in good standing as defined by the board at the time the diploma was issued *** or a diploma or license approved by the board which conferred the full right to practice all branches of medicine or surgery in a foreign country. However, a person holding a diploma approved by the board which does not confer on him the full right to practice all branches of medicine or surgery in a foreign country may in the discretion of the board be admitted to the examination upon completion of a course of training approved by the board consisting of not less than twelve months of residency or internship in a hospital in the United States.

Sec. 4731.11. At the time of his application the applicant shall present such diploma or license with his affidavit that he is the person named therein and is the lawful possessor thereof, stating his age, residence, the college or colleges at which he obtained his medical education, the time spent in each, the time spent in the study of medicine *** and such other facts as the state medical board requires. If engaged in the practice of medicine or surgery *** the affidavit shall state the period during which and the place where he has been so engaged.

Sec. 4731.12. *** The state medical board shall admit to the examination an applicant holding the credentials set forth in section 4731.09 Revised Code.

Certificate of Preliminary and Medical Education

This certificate must be properly made out and signed by the president, dean or secretary of the medical school of which the applicant is a graduate.

It is hereby certified that Thomas William Michaelis

holding Ohio Medical Certificate No. 36787

as evidence of preliminary education on

the 12th day of June, 1970 will receive ~~received~~ from

The Ohio State University College of Medicine

a diploma conferring on him the degree of doctor of medicine and that he previously studied medicine

at least 4 full years, including 4 regular courses of lectures as follows:

MONTH	YEAR		MONTH	YEAR	NAME OF INSTITUTION
September 26	1966	to	June 3	1967	The Ohio State University College of Medicir
September 25	1967	to	June 8	1968	The Ohio State University College of Medicir
July 1 (One month off)	1968	to	June 30	1969	The Ohio State University College of Medicir
July 1 (One month off)	1969	to	June 12	1970	The Ohio State University College of Medicir
	1	to		1	

Dated at Columbus, Ohio

March 25, 1970

(Seal of College)

Richard L. Meiling

Richard L. Meiling, M.D.
Dean

Certificate of Good Moral Character

(Signed by not less than two registered physicians in good standing.)

This certifies that we have been personally acquainted with Dr. Thomas W. Michaelis

for (1 1/2) (____) years, that we know him

to be of good moral character, and hereby recommend him to the State Medical Board of the State of Ohio as entirely worthy to be licensed to practice medicine in the State of Ohio, pursuant to law.

Stanley E. Bolenzenk M.D.

P. O. Address 410 W. 10th Avenue Columbus, Ohio

Graduate (in the year 1955) of University of Maryland

* Certificate No. 30009 State of Ohio

John H. Holzapfel M.D.

P. O. Address 410 W 10th Avenue Columbus, Ohio

Graduate (in the year 1944) of Univ. of Michigan

* Certificate No. 14284 State of Michigan

* Physicians signing should give number of their certificate from this Board.
Parties signing certificate must be registered physicians.

Ohio State University, 1970

FOR USE OF SECRETARY ONLY

State Certificate No. 32590

Issued 8/4/70

Application for Examination for Certificate to Practice Medicine, by The State Medical Board, State of Ohio

123-46 M.O. 100

MICHAELIS, Thomas William, M. D.

Filed 4/30, 19 70

Receipt No. Fee 100

Examination No. 00193 Date 6/70

Approved / Rejected / Withdrawn

RECEIVED
APR 30 1970
STATE MEDICAL BOARD

The following facts are stated for the information of those desiring to practice medicine or surgery in the State of Ohio.

1. No person can lawfully practice medicine in the State of Ohio unless licensed to do so by the State Medical Board.

2. Certificates entitling the holder to practice medicine and surgery in Ohio are issued only after examination by the Board, except in the following case:

> Sec. 4731.29. *** When a physician or surgeon licensed by the licensing department of another state, a territory or the District of Columbia or a diplomate of the national board of medical examiners wishes to remove to this state to practice his profession, the state medical board may, in its discretion, issue to him a certificate to practice medicine or surgery in Ohio without requiring the applicant to submit to examination, provided he meets the requirements for entrance as set forth in section 4731.09 and section 4731.12. Application shall be made on a form prescribed by the board.

3. Examinations will be held in June and December of each year.

4. Completed applications must be filed with the Secretary of the Board by the first day of the month preceding the month set for the examination which the applicant desires to enter.

5. The fee must accompany each application. Personal checks not accepted. Send certified check, draft or money order. This fee shall not be refundable.

6. Only graduates in medicine from colleges recognized by the State Medical Board are admitted to the examinations.

7. The examination is written and must be in the English language. It includes Anatomy, Physiology, Pathology, Chemistry, Materia Medica and Therapeutics, the Principles and Practice of Medicine, Diagnosis, Surgery, Obstetrics.

8. The applicant's diploma must in every case accompany his application papers. After certifying the diploma the Secretary will return it.

9. All correspondence should be addressed to The State Medical Board, Wyandotte Building, 21 W. Broad Street, Columbus, Ohio 43215.

10. Applicants must be at least 21 years of age and **citizens of the United States.**

ARE YOU (check one) Active ☐ Inactive ☐ **IN THE MEDICAL PROFESSION.**

IF ACTIVE, CHECK YOUR PRESENT FIELD OF PRACTICE.

- ☐ 1. Private
- ☐ 2. Individual
- ☐ 3. Governmental
- ☐ 4. Armed Service
- ☐ 5. Academic
- ☐ 6. Industrial
- ☐ 7. In Training
- ☐ 8. Other

Date of Birth Month Dec. Day 12 Year 44

FEDERAL IDENTIFICATION NUMBER

Redacted

(social security)

INDICATE YOUR MEDICAL SPECIALTY

- ☐ 1. Administrative Medicine
- ☐ 2. Allergy
- ☐ 3. Anesthesiology
- ☐ 4. Aviation Medicine
- ☐ 5. Cardiovascular Disease
- ☐ 6. Child Psychiatry
- ☐ 7. Colon and Rectal Surgery
- ☐ 8. Dermatology
- ☐ 9. Diagnostic Roentgenology
- ☐ 10. Forenic Pathology
- ☐ 11. Gastroenterology
- ☐ 12. General Practice
- ☐ 13. General Preventive Medicine
- ☐ 14. General Surgery
- ☐ 15. Internal Medicine
- ☐ 16. Neurological Surgery
- ☐ 17. Neurology
- ☐ 18. Obstetrics and Gynecology
- ☐ 19. Occupational Medicine
- ☐ 20. Ophthalmology
- ☐ 21. Orthopedic Surgery
- ☐ 22. Otolaryngology
- ☐ 23. Pathology
- ☐ 24. Pediatrics
- ☐ 25. Pediatric Allergy
- ☐ 26. Pediatric Cardiology
- ☐ 27. Physical Medicine and Rehabilitation
- ☐ 28. Plastic Surgery
- ☐ 29. Psychiatry
- ☐ 30. Public Health
- ☐ 31. Pulmonary Diseases
- ☐ 32. Radiology
- ☐ 33. Therapeutic Radiology
- ☐ 34. Thoracic Surgery
- ☐ 35. Urology
- ☐ 36. Unspecified (not in practice)
- ☐ 37. Other (specify)

Please sign the receipt below and return at once to: Secretary of the State Medical Board
21 W. Broad Street
Columbus, Ohio 43215

_____ O., Sept. 14 19 70

Received of The State Medical Board, Certificate No. 32590

bearing my name Thomas William Michaels

P. O. Address 347 Bostwick NE apt 105

Grand Rapids, Michigan, ~~Ohio~~

ZIP: 49503

MICHAELIS, THOMAS W.

32590

ISSUED 8-4-70

EXAM

STATE OF OHIO STATE MEDICAL BOARD

65 SOUTH FRONT ST., SUITE 510 COLUMBUS, OHIO 43215

I CERTIFY, UNDER PENALTY OF THE LOSS OF MY RIGHT TO PRACTICE MEDICINE AND SURGERY IN THE STATE OF OHIO, THAT I HAVE COMPLETED DURING THE LAST BIENNIUM THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE OHIO STATE MEDICAL ASSN AND APPROVED BY THE STATE MEDICAL BOARD AND HEREBY MAKE APPLICATION FOR RENEWAL.

Thomas W. Michaelis 10/9/84
(SIGNATURE OF APPLICANT) (DATE)

APPLICATION FOR BIENNIAL LICENSE RENEWAL TO PRACTICE AS A
DOCTOR OF MEDICINE

IDENTIFICATION NUMBER
35-03-2590

1 THOMAS WILLIAM MICHAELIS
3900 SUNFOREST CT
TOLEDO OH 43623

OP-0345-F

MD & DO SPECIALTY CODES
SPECIALTY CODES CURRENTLY ON RECORD → 39
IF NECESSARY TO CORRECT, ENTER ALL SPECIALTY CODE NUMBERS → [ ] [ ] [ ]
(SEE LIST ON ENCLOSED CARD) (LIMIT OF 3)

AMOUNT DUE $100.00 DATE DUE 11/15/84

INSTRUCTIONS
1. DO NOT FOLD OR STAPLE THIS CARD.
2. REVERSE SIDE MUST BE COMPLETED.
3. MAKE CHECK OR MONEY ORDER PAYABLE TO: TREASURER, STATE OF OHIO
4. PUT IDENTIFICATION NUMBER ON CHECK.
5. MARK CORRECT SPECIALTY CODE(S) BELOW.
6. SEND PAYMENT (DO NOT SEND CASH) AND THIS APPLICATION IN ENCLOSED ENVELOPE TO: TREASURER, STATE OF OHIO BOX 2438 COLUMBUS, OHIO 43216

REPORT ANY CHANGE OF ADDRESS OF RECORD
(PLEASE PRINT)
LAST NAME FIRST NAME INITIAL
STREET ADDRESS
CITY STATE ZIP CODE
COUNTY

TO RECEIVE YOUR RENEWAL CARD BY DECEMBER 31ST, RETURN THIS APPLICATION AND FEE BY DUE DATE.

THE ADDRESS SHOWN ON THE FRONT OF THIS CARD WILL BE MAINTAINED AS YOUR ADDRESS OF RECORD WITH THE BOARD.

PRINCIPAL PRACTICE ADDRESS — IF DIFFERENT FROM THAT SHOWN ON FRONT
(PLEASE PRINT)

LAST NAME FIRST NAME INITIAL
STREET ADDRESS
CITY STATE ZIP CODE

SOCIAL SECURITY NUMBER Redacted

SECTION 4731.281, OHIO REVISED CODE REQUIRES THAT A RESPONSE BE GIVEN TO THE FOLLOWING QUESTION. PLEASE MARK THE CORRECT BOX.

SINCE YOU LAST RENEWED YOUR OHIO MEDICAL LICENSE, HAVE YOU BEEN CONVICTED OF OR PLEAD NOLO CONTENDERE TO:

YES	NO	
☐	☑	a.) a felony,
☐	☑	b.) a misdemeanor committed in the course of your practice, or
☐	☑	c.) a federal or state law regulating the possession, distribution or use of any drug?

AT ANY TIME SINCE THE LAST RENEWAL OF YOUR CERTIFICATE HAVE YOU:

YES	NO		YES	NO	
☐	☑	1). Been addicted to or dependent upon alcohol or any chemical substance?	☐	☑	3). Surrendered or consented to limitation of your license to practice medicine, or state or federal privileges to prescribe controlled substances?
☐	☑	2). Had any disciplinary action taken or initiated against you by a state licensing agency?	☐	☑	4). Had any hospital privileges suspended or revoked?

J345-B

STATE MEDICAL BOARD OF OHIO

65 SOUTH FRONT ST., SUITE 510 COLUMBUS, OHIO 43215

I CERTIFY, UNDER PENALTY OF THE LOSS OF MY RIGHT TO PRACTICE MEDICINE AND SURGERY IN THE STATE OF OHIO, THAT I HAVE COMPLETED DURING THE LAST BIENNIUM THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE OHIO STATE MEDICAL ASSN AND APPROVED BY THE STATE MEDICAL BOARD AND HEREBY MAKE APPLICATION FOR RENEWAL.

Thomas W. Michaelis 10/15/86

(SIGNATURE OF APPLICANT) (DATE)

INSTRUCTIONS

1. DO NOT FOLD OR STAPLE THIS CARD.
2. REVERSE SIDE MUST BE COMPLETED.
3. MAKE CHECK OR MONEY ORDER PAYABLE TO: TREASURER, STATE OF OHIO
4. PUT IDENTIFICATION NUMBER ON CHECK.
5. MARK CORRECT SPECIALTY CODE(S) BELOW.
6. SEND PAYMENT (DO NOT SEND CASH) AND THIS APPLICATION IN ENCLOSED ENVELOPE TO:

TREASURER, STATE OF OHIO
BOX 2438 COLUMBUS, OHIO 43216

APPLICATION FOR BIENNIAL LICENSE RENEWAL TO PRACTICE AS A
DOCTOR OF MEDICINE

IDENTIFICATION NUMBER
35-03-2590

1 THOMAS WILLIAM MICHAELIS
3900 SUNFOREST CT
TOLEDO OH 43623

REPORT ANY CHANGE OF ADDRESS OF RECORD
(PLEASE PRINT)

LAST NAME FIRST NAME INITIAL

STREET ADDRESS

CITY STATE ZIP CODE

COUNTY

MD & DO SPECIALTY CODES
ENTER ALL SPECIALTY CODES → 39
(SEE LIST ON ENCLOSED CARD) (LIMIT OF 3)

AMOUNT DUE $100.00 DATE DUE 11/15/86

EDM-14946

TO RECEIVE YOUR RENEWAL CARD BY DECEMBER 31ST, RETURN THIS APPLICATION AND FEE BY NOVEMBER 15

THE ADDRESS SHOWN ON THE FRONT OF THIS CARD WILL BE MAINTAINED AS YOUR ADDRESS OF RECORD WITH THE BOARD.

PRINCIPAL PRACTICE ADDRESS – IF DIFFERENT FROM THAT SHOWN ON FRONT
(PLEASE PRINT)

Michaelis, Thomas W
LAST NAME FIRST NAME INITIAL

3900 Sunforest Ct.
STREET ADDRESS

Toledo, Ohio 43623
CITY STATE ZIP CODE

Lucas

SOCIAL SECURITY NUMBER Redacted

SECTION 4731.281, OHIO REVISED CODE REQUIRES THAT A RESPONSE BE GIVEN TO THE FOLLOWING QUESTION. PLEASE MARK THE CORRECT BOX.

SINCE YOU LAST RENEWED YOUR OHIO MEDICAL LICENSE, HAVE YOU BEEN FOUND GUILTY OR PLEAD GUILTY OR NO CONTEST TO:

YES	NO	
☐	☑	a.) a felony.
☐	☑	b.) a misdemeanor committed in the course of your practice, or
☐	☑	c.) a federal or state law regulating the possession, distribution or use of any drug?

AT ANY TIME SINCE THE LAST RENEWAL OF YOUR CERTIFICATE HAVE YOU:

YES	NO	
☐	☑	1.) Been addicted to or dependent upon alcohol or any chemical substance?
☐	☑	2.) Had any disciplinary action taken or initiated against you by a state licensing agency?
☐	☑	3.) Surrendered or consented to limitation upon license to practice medicine, or state or federal privileges to prescribe controlled substances?
☐	☑	4.) Had any hospital privileges suspended or revoked?

EDM-14946-B

STATE MEDICAL BOARD OF OHIO

I CERTIFY, UNDER PENALTY OF THE LOSS OF MY RIGHT TO PRACTICE MEDICINE AND SURGERY IN THE STATE OF OHIO, THAT I HAVE COMPLETED DURING THE LAST BIENNIUM THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE OHIO STATE MEDICAL ASSN AND APPROVED BY THE STATE MEDICAL BOARD AND HEREBY MAKE APPLICATION FOR RENEWAL.

Thomas W. Michaelis
(SIGNAURE OF APPLICANT) 9/23/88

INSTRUCTIONS

1. DO NOT FOLD OR STAPLE THIS CARD.
2. REVERSE SIDE MUST BE COMPLETED.
3. MAKE CHECK OR MONEY ORDER PAYABLE TO: TREASURER, STATE OF OHIO
4. PUT IDENTIFICATION NUMBER ON CHECK.
5. UPDATE SPECIALTY IF NEEDED.
6. SEND PAYMENT (DO NOT SEND CASH) AND THIS APPLICATION IN ENCLOSED ENVELOPE TO: TREASURER, STATE OF OHIO BOX 2438, COLUMBUS, OHIO 43216

APPLICATION FOR BIENNIAL LICENSE RENEWAL TO PRACTICE AS A; DOCTOR OF MEDICINE

IDENTIFICATION NUMBER 35-03-2590

1 THOMAS WILLIAM MICHAELIS
3900 SUNFOREST CT
TOLEDO OH 43623

QT-00223-OF

MD & DO SPECIALTY CODES

SPECIALTY CODES CURRENTLY ON RECORD
IF NECESSARY TO CORRECT, ENTER ALL SPECIALTY CODE NUMBERS
(SEE LIFE ON ENCLOSED CARD) (LIMIT OF 3)

39

AMOUNT DUE	DATE DUE
$100.00	11/01/88

REPORT ANY CHANGE OF ADDRESS OF RECORD

(PLEASE PRINT)

LAST NAME FIRST NAME INITIAL

STREET ADDRESS

CITY STATE ZIP CODE

COUNTY

TO RECEIVE YOUR RENEWAL CARD BY DECEMBER 31ST, RETURN THIS APPLICATION AND FEE BY NOVEMBER 1.

THE ADDRESS SHOWN ON THE FRONT OF THIS CARD WILL BE MAINTAINED AS YOUR ADDRESS OF RECORD WITH THE BOARD.

PRINCIPAL PRACTICE ADDRESS—IF DIFFERENT FROM THAT SHOWN ON FRONT
(PLEASE PRINT)

LAST NAME FIRST NAME INITIAL

STREET ADDRESS

CITY STATE ZIP CODE

SECTION 4731.281, OHIO REVISED CODE REQUIRES THAT A RESPONSE BE GIVEN TO THE FOLLOWING QUESTION. PLEASE MARK THE CORRECT BOX.

SINCE YOU LAST RENEWED YOUR OHIO MEDICAL LICENSE, HAVE YOU BEEN FOUND GUILTY OR PLEAD GUILTY OR NO CONTEST TO:

YES	NO	
☐	☒	a.) a felony
☐	☒	b.) a federal or state law regulating the possession, distribution or use of any drug?

SOCIAL SECURITY NUMBER Redacted

AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION FOR RENEWAL OF YOUR CERTIFICATION HAVE YOU:

YES	NO	
☐	☒	1.) Been addicted to or dependent upon alcohol or any chemical substance? You may answer no to this question if you have successfully completed treatment at a program approved by this Board and have subsequently adhered to all statutory requirements as contained in Section 4731.224, O.R.C., and related provisions; or are currently enrolled in a Board approved program.
☐	☒	2.) Had any disciplinary action taken or initiated against you by a state licensing agency?
☐	☒	3.) Surrendered or consented to limitation upon a license to practice medicine or state or federal privileges to prescribe controlled substances?
☐	☒	4.) Had any clinical privileges suspended or revoked for other than failure to maintain records or attend staff meetings.

QT-00224-OB

DETACH HERE AND REMIT THIS PORTION WITH FEE

STATE MEDICAL BOARD OF OHIO

77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 43266 - 0315

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED DURING THE LAST BIENNIUM THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE OHIO STATE MEDICAL ASSOCIATION AND APPROVED BY THE STATE MEDICAL BOARD. AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.

X Thomas W. Michaelis 10/9/90

(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER:	AMOUNT DUE	DATE DUE
35-03-2590	$160.00	11/01/90

THOMAS WILLIAM MICHAELIS, M.D.
3740 WEST SYLVANIA
SUITE 103
TOLEDO OH 43623

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

39 OBSTETRICS & GYNECOLOGY

[X] SPECIALTY CODE(S) CORRECT AS LISTED

IF THE SPECIALTY CODE(S) ARE IN ERROR, ENTER ALL SPECIALTY CODE NUMBERS. CODE1 CODE2 CODE3

CHANGE OF ADDRESS

STREET

STREET

CITY STATE ZIP CODE

COUNTY

:969696962: 0935032590 :0000016000:

PRINCIPAL PRACTICE ADDRESS - IF DIFFERENT FROM THE ADDRESS SHOWN ON FRONT:

Street

Street

City State Zip Code

County

HAVE YOU BEEN FOUND GUILTY OF, OR PLEAD GUILTY OR NO CONTEST TO :

	YES	NO
A.) A felony		X
B.) A federal or state law regulating the possession, distribution or use of any drug?		X

AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION FOR RENEWAL OF YOUR CERTIFICATE HAVE YOU :

	YES	NO
1.) Been addicted to or dependent upon alcohol or any chemical substance? You may answer "no" to this question if you have successfully completed treatment at a program approved by this board and have subsequently adhered to all statutory requirements as contained in section 4731.224, O.R.C., and related provisions, or you are currently enrolled in a board approved program. Any questions concerning approval can be directed to the board offices.		X
2.) Had any disciplinary action taken or initiated against you by any state licensing board?		X
3.) Surrendered, or consented to limitation upon: a) A license to practice medicine; OR b) State or federal privileges to prescribe controlled substances?		X
4.) Had any clinical privileges suspended or revoked for reasons other than failure to maintain records or attend staff meetings?		X

SOCIAL SECURITY NUMBER (Optional for purposes of identification)

Redacted

DETACH HERE AND REMIT THIS PORTION WITH FEE

STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 43266 - 0315

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED DURING THE LAST BIENNIUM THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE OHIO STATE MEDICAL ASSOCIATION AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.

X Thomas W. Michaelis 10/16/92
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35032590	$160.00	07/01/92

THOMAS WILLIAM MICHAELIS,M.D.
6206 MEYERS DR
CINCINNATI OH 45215

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

39 OBSTETRICS & GYNECOLOGY

☐ SPECIALTY CODE(S) CORRECT AS LISTED

IF THE SPECIALTY CODE(S) ARE IN ERROR, ENTER ALL SPECIALTY CODE NUMBERS. CODE1 CODE2 CODE3

CHANGE OF ADDRESS

7855 Brint Rd.
STREET
STREET
Sylvania OH 43560
CITY STATE ZIP CODE
Lucas
COUNTY

:96969696 2: 0935032590 :0000016000:

PRINCIPAL PRACTICE ADDRESS - IF DIFFERENT FROM THE ADDRESS SHOWN ON FRONT:

Street
Street
City State Zip Code
County

HAVE YOU BEEN FOUND GUILTY OF, OR PLED GUILTY OR NO CONTEST TO :

YES NO
☒ ☐ A.) A felony or misdemeanor.
☐ ☒ B.) A federal or state law regulating the possession, distribution or use of any drug?

AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION FOR RENEWAL OF YOUR CERTIFICATE HAVE YOU :

YES NO
☐ ☒ 1.) Been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse? You may answer "no" to this question if you have successfully completed treatment at a program approved by this board and have subsequently adhered to all statutory requirements as contained in section 4731.224, O.R.C., and related provisions, or you are currently enrolled in a board approved program. Any questions concerning approval can be directed to the board offices.
☐ ☒ 2.) Had a license denied by or had any disciplinary action taken or initiated against you by any state licensing board other than the State Medical Board of Ohio?
☒ ☐ 3.) Surrendered, or consented to limitation upon a license to practice medicine; OR b) State or federal privileges to prescribe controlled substances? Ohio – Reinstated
☒ ☐ 4.) Had any clinical privileges suspended, limited or revoked for reasons other than failure to maintain records or attend staff meetings?

Redacted

(Optional for purposes of identification)

DETACH HERE AND REMIT THIS PORTION WITH FEE

STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 43266 - 0315

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 1992-1994 BIENNIUM THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE: OHIO STATE MEDICAL ASSOCIATION AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.

X Thomas W. Michaelis MD 4/21/94
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-03-2590	$250.00	05/01/94

THOMAS WILLIAM MICHAELIS,M.D.
61 W VERNON
PHOENIX AZ 54003

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

OBG OBSTETRICS & GYNECOLOGY

X SPECIALTY CODE(S) CORRECT AS LISTED

IF CORRECTIONS ARE NECESSARY, PLEASE ENTER ALL SPECIALTY CODES. CODE1 CODE2 CODE3

REPORT ANY CHANGE OF ADDRESS

STREET: 832 E. Country Gables Dr.
STREET:
CITY: Phoenix STATE: AZ ZIP CODE: 85022
COUNTY: MARICOPA

⑆969696962⑆ 0935032590⑈ ⑈0000025000⑈

PRINCIPAL PRACTICE ADDRESS - IF DIFFERENT FROM THE ADDRESS SHOWN ON FRONT:
Street: 832 E. Country Gables Dr
City: Phoenix State: AZ Zip Code: 85016
County: MARICOPA

ATTEST TIME SINCE SIGNING YOUR LAST APPLICATION FOR RENEWAL OF YOUR CERTIFICATE HAVE YOU :

1.) Been found guilty of, or pled guilty or no contest to a felony or misdemeanor. YES [ ] NO [X]

2.) Been found guilty of, or pled guilty or no contest to a federal or state law regulating the possession, distribution or use of any drug? YES [ ] NO [X]

3.) Been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from drug or alcohol dependency or abuse? You may answer "no" to this question if you have successfully completed treatment at a program approved by this board and have subsequently adhered to all statutory requirements as contained in sections 4731.224 and 4731.25 O.R.C., and related provisions, or you are currently enrolled in a board approved program. Any questions concerning approval can be directed to the board offices. YES [ ] NO [X]

4.) Had malpractice insurance cancelled or limited for other than failure to pay premiums? YES [ ] NO [X]

5.) Had any disciplinary action taken or initiated against you by any state licensing board other than the State Medical Board of Ohio? YES [ ] NO [X]

6.) Surrendered, or consented to limitation upon: a) A license to practice medicine; OR b) State or federal privileges to prescribe controlled substances? YES [ ] NO [X]

7.) Had any clinical privileges suspended, restricted or revoked for reasons other than failure to maintain records or attend staff meetings? YES [ ] NO [X]

8.) After January 14, 1993, referred a patient, or participated in an arrangement or scheme for referral of a patient, for clinical laboratory services to a person or facility in which either you or a member of your immediate family has an ownership or investment interest, or any compensation arrangement? YES [ ] NO [X]

SOCIAL SECURITY NUMBER (Optional for purposes of identification) Redacted

FAX 33-00
DATE 05/01/94
AMOUNT 250.00
BATCHDATE 04/27/94
ACCOUNT # 935032590

DETACH HERE AND RETURN THIS PORTION WITH FEE

STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 43266 - 0315

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 1994-1996 BIENNIUM THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE OHIO STATE MEDICAL ASSOCIATION AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.

X Thomas W. Michaelis 4/8/96
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-03-2590	$250.00	05/01/96

THOMAS WILLIAM MICHAELIS,M.D.
832 E COUNTRY GABLES DR
PHOENIX AZ 85022

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

OBG OBSTETRICS & GYNECOLOGY

[X] SPECIALTY CODE(S) CORRECT AS LISTED

IF CORRECTIONS ARE NECESSARY, PLEASE ENTER ALL SPECIALTY CODES. CODE1 CODE2 cODE3

REPORT ANY CHANGE OF ADDRESS

STREET
STREET
CITY STATE ZIP CODE
Maricopa
COUNTY

⑆96969696 2⑆ 0935032590⑈ ⑈0000025000⑈

PRINCIPAL PRACTICE ADDRESS - IF DIFFERENT FROM THE ADDRESS SHOWN ON FRONT:
Phoenix Indian Medical Center
Street: 4212 N. 16 th St.
Street:
City: Phoenix State: AZ Zip Code: 85016
County: Maricopa

AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION FOR RENEWAL OF YOUR CERTIFICATE HAVE YOU:

YES NO 1.) Been found guilty of, or pled guilty or no contest to a felony or misdemeanor.

YES NO 2.) Been found guilty of, or pled guilty or no contest to a federal or state law regulating the possession, distribution or use of any drug?

YES NO 3.) Been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse? You may answer "no" to this question if you have successfully completed treatment at a program approved by this board and have subsequently adhered to all statutory requirements as contained in sections 4731.224 and 4731.25 O.R.C., and related provisions, or you are currently enrolled in a board approved program. Any questions concerning approval can be directed to the board offices.

AMOUNT BATCH DATE 935032590 ACCOUNT #

YES NO 4.) Had malpractice insurance cancelled or limited for other than failure to pay premiums?

YES NO 5.) Had any disciplinary action taken or initiated against you by any state licensing board other than the State Medical Board of Ohio?

YES NO 6.) Surrendered, or consented to limitation upon: a) A license to practice medicine; OR b) State or federal privileges to prescribe controlled substances?

YES NO 7.) Had any clinical privileges suspended, restricted or revoked for reasons other than failure to maintain records or attend staff meetings?

YES NO 8.) Referred a patient, or participated in an arrangement or scheme for referral of a patient, for clinical laboratory services to a person or facility in which either you or a member of your immediate family has an ownership or investment interest, or any compensation [redacted]

SOCIAL SECURITY NUMBER [redacted]
(Optional for purposes of identification)

Redacted

DETACH HERE AND REMIT THIS PORTION WITH FEE

STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 43266 - 0315

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 1996-1998 BIENNIUM THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE OHIO STATE MEDICAL ASSOCIATION AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.

X Thomas W. Michaelis 4/13/98
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-03-2590-M	$243.00	05/01/98

THOMAS WILLIAM MICHAELIS,M.D.
600 W GROVE PKWY #1105
TEMPE AZ 85283

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

OBG OBSTETRICS & GYNECOLOGY

☑ SPECIALTY CODE(S) CORRECT AS LISTED

IF CORRECTIONS ARE NECESSARY, PLEASE ENTER ALL SPECIALTY CODES. CODE1 CODE2 CODE3

REPORT ANY CHANGE OF ADDRESS

6131 N. 16th St. Apt A-201
STREET
STREET
Phoenix AZ 85016
CITY STATE ZIP CODE
MARICOPA
COUNTY

:96969696 2: 0935032590 :00000 24300:

PRINCIPAL PRACTICE ADDRESS - IF DIFFERENT FROM THE ADDRESS SHOWN ON FRONT:
4312 N. 16th St.
Street
Street
Phoenix AZ 85016
City State Zip Code
MARICOPA
County

AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION FOR RENEWAL OF YOUR CERTIFICATE HAVE YOU :

YES NO ☒ 1.) Been found guilty of, or pled guilty or no contest to a felony or misdemeanor.

YES NO ☒ 2.) Been found guilty of, or pled guilty or no contest to a federal or state law regulating the possession, distribution or use of any drug?

YES NO ☒ 3.) Been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse? You may answer "no" to this question if you have successfully completed treatment at a program approved by this board and have subsequently adhered to all statutory requirements as contained in sections 4731.224 and 4731.25 O.R.C., and related provisions, or you are currently enrolled in a board approved program. Any questions concerning approval can be directed to the board offices.

YES NO ☒ 4.) Had malpractice insurance cancelled or limited for other than failure to pay premiums?

YES NO ☒ 5.) Had any disciplinary action taken or initiated against you by any state licensing board other than the State Medical Board of Ohio?

YES NO ☒ 6.) Surrendered, or consented to limitation upon: a) A license to practice medicine; OR b) State or federal privileges to prescribe controlled substances?

YES NO ☒ 7.) Had any clinical privileges suspended, restricted or revoked for reasons other than failure to maintain records or attend staff meetings?

YES NO ☒ 8.) Referred a patient, or participated in an arrangement or scheme for referral of a patient, for clinical laboratory services to a person or facility in which either you or a member of your immediate family has an ownership or investment interest, or any compensation arrangement?

SOCIAL SECURITY NUMBER
(Optional for purposes of identification)
Redacted

DETACH HERE AND REMIT THIS PORTION WITH FEE

STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 43266 - 0315

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 1998-2000 REGISTRATION PERIOD THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE **OHIO STATE MEDICAL ASSOCIATION** AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.

X Thomas W. Michaelis MD 2/20/00
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-03-2590-M	$305.00	04/01/2000

THOMAS WILLIAM MICHAELIS,M.D.
6131 N 16TH STREET
~~APT A-201~~
PHOENIX AZ 85016

I wish to apply for Emeritus status: ☐

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

OBG OBSTETRICS & GYNECOLOGY

☑ SPECIALTY CODE(S) CORRECT AS LISTED

IF CORRECTIONS ARE NECESSARY, PLEASE ENTER ALL SPECIALTY CODES. CODE1 CODE2 CODE3

REPORT ANY CHANGE OF ADDRESS

STREET same
STREET APT-C-204
CITY STATE ZIP CODE
COUNTY

:96969696 2: 0935032590 :0000030500:

PRINCIPAL PRACTICE ADDRESS - IF DIFFERENT FROM THE ADDRESS SHOWN ON FRONT: THIS ADDRESS MUST BE ENTERED AT EACH RENEWAL

Street: 4202 N. 16th St. Phoenix
Street: Indian Medical Center
City: Phoenix State: AZ Zip Code: 85016
County: Maricopa

AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION FOR RENEWAL OF YOUR CERTIFICATE HAVE YOU:

YES ☐ NO ☒ 1.) Been found guilty of, or pled guilty or no contest to, or received treatment in lieu of conviction of, a felony or misdemeanor?

YES ☐ NO ☒ 2.) Been found guilty of, or pled guilty or no contest to a federal or state law regulating the possession, distribution or use of any drug?

YES ☐ NO ☒ 3.) Been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse? You may answer "no" to this question if you have successfully completed treatment at a program approved by this board and have subsequently adhered to all statutory requirements as contained in sections 4731.224 and 4731.25 O.R.C., and related provisions, or you are currently enrolled in a board approved program. Any questions concerning approval can be directed to the board offices.

YES ☐ NO ☒ 4.) Had malpractice insurance cancelled or limited for other than failure to pay premiums?

YES ☐ NO ☒ 5.) Been notified by any board, bureau, department, agency, or other body including those in Ohio, other than this board, of any investigation concerning you, or any charges, allegations or complaints filed against you?

YES ☐ NO ☒ 6.) Surrendered, or consented to limitation in any jurisdiction: a) A license to practice medicine;OR b) State or federal privileges to prescribe controlled substances?

YES ☐ NO ☒ 7.) Had any clinical privileges or other authority to practice suspended,restricted or revoked for reasons other than failure to maintain records or attend staff meetings?

AMOUNT 305.00 BATCHDATE 0202900
YES ☐ NO ☒
925032590
ACCOUNT #

SOCIAL SECURITY NUMBER
(Optional for purposes of identification)
Redacted

DETACH HERE AND REMIT THIS PORTION WITH FEE

STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 43215 - 6127

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 2000 - 2002 REGISTRATION PERIOD THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE

OHIO STATE MEDICAL ASSOCIATION

AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.

X Thomas W. Michaelis 3/24/02
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE	$50 Late Fee Due After
35-03-2590-M	$305.00	04/04/02	07/01/02

THOMAS WILLIAM MICHAELIS,M.D.
6131 N 16TH STREET
APT C-204
PHOENIX AZ 85016

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

OBG OBSTETRICS & GYNECOLOGY

TM SPECIALTY CODE(S) CORRECT AS LISTED

IF CORRECTIONS ARE NECESSARY, PLEASE ENTER ALL SPECIALTY CODES. CODE1 CODE2 CODE3

RESIDENCE ADDRESS-THIS MUST BE ENTERED AT EACH RENEWAL.

6131 N. 16th St C-204
STREET
STREET
Phoenix AZ 85016
CITY STATE ZIP CODE
Maricopa
COUNTY

0935032590 30500

AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION FOR RENEWAL OF YOUR CERTIFICATE:

1.) Have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony? YES [ ] NO [X]

2.) Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse? **You may answer "NO" to this question** if you have successfully completed treatment at, or are currently enrolled in, a program approved by this Board and have adhered to all statutory requirements during and subsequent to treatment. You must answer "YES" if you have ever relapsed. Any questions concerning program approval or concerning this question can be directed to the board offices. YES [ ] NO [X]

3.) Have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio? YES [ ] NO [X]

4.) Has any board, bureau, department, agency, or other body, including those in Ohio, **other than this board**, filed any charges, allegations or complaints against you? YES [ ] NO [X]

5.) Have you surrendered, or consented to limitation of, or to reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction? You may answer "NO" to this question if the only such surrender or consent was given to this board. YES [ ] NO [X]

6.) Have you had any clinical privileges or other similar institutional authority suspended, restricted or revoked for reasons **other than failure to maintain records on a timely basis or to attend staff meetings?** YES [ ] NO [X]

PRINCIPAL PRACTICE ADDRESS - THIS ADDRESS MUST BE ENTERED AT EACH RENEWAL.

[X] Check this Box if you have NO principal Practice address.

Street
Street
City State Zip Code
County

REQUIRED
SOCIAL SECURITY NUMBER
Redacted

03282002 711700
0053 027
032590
I SE 0000030500

DETACH HERE AND REMIT THIS PORTION WITH FEE

STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 43215 - 6127

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED DURING THE 2002 - 2004 CME PERIOD THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE

OHIO STATE MEDICAL ASSOCIATION

AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.

X Thomas W. Michaelis MD 3/24/04
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE	$50 Late Fee Due After
35-03-2590-M	$305.00	04/01/04	07/01/04

THOMAS WILLIAM MICHAELIS,M.D.
~~5679 MONROE ST~~
~~#1105~~
~~SYLVANIA OH 43560~~

new home address →

MD & DO SPECIALTY CODES CURRENTLY ON RECORD
OBG OBSTETRICS & GYNECOLOGY

☒ SPECIALTY CODE(S) CORRECT AS LISTED

IF CORRECTIONS ARE NECESSARY, PLEASE ENTER ALL SPECIALTY CODES. CODE1 CODE2 CODE3

RESIDENCE ADDRESS-THIS MUST BE ENTERED AT EACH RENEWAL

3416 Middlesex Drive
STREET
Apt - D
STREET
Toledo OH 43606
CITY STATE ZIP CODE
Lucas
COUNTY

0935032590 30500

APPLICATION FOR RENEWAL OF YOUR CERTIFICATE:

YES NO ☒ 1.) Have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a felony or misdemeanor?

YES NO ☒ 2.) Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse? **You may answer "NO" to this question** if you have successfully completed treatment at, or are currently enrolled in, a program approved by this Board and have adhered to all statutory requirements during and subsequent to treatment. You must answer "YES" if you have ever relapsed. Any questions concerning program approval or concerning this question can be directed to the board offices.

YES NO ☒ 3.) Have any malpractice awards or settlements been paid by you or on your behalf for acts occurring in any state other than Ohio?

YES NO ☒ 4.) Has any board, bureau, department, agency, or other body, including those in Ohio, **other than this board**, filed any charges, allegations or complaints against you?

YES NO ☒ 5.) Have you surrendered, or consented to limitation of, or to suspension, reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction? You may answer "NO" to this question if the only such surrender or consent was given to this board.

YES NO ☒ 6.) Have you had any clinical privileges or other similar institutional authority suspended, restricted or revoked for reasons **other than failure to maintain records on a timely basis or to attend staff meetings?**

PRINCIPAL PRACTICE ADDRESS - THIS ADDRESS MUST BE ENTERED AT EACH RENEWAL.

☐ Check this Box if you have NO principal Practice address.

1160 Sylvania Ave.
Street
Street
Toledo OH 43612
City State Zip Code
Lucas
County

[redacted] SOCIAL SECURITY NUMBER

Redacted

03262004 711709
0043 022
032590
1 SE 000030500

Date Posted: 5/25/2006 12:09:36 AM

Please review all information you have provided. Click on the "Review" button to change any information given or click on the "I Agree" button to verify that all information posted below is correct and to proceed to payment options.

Please note that knowingly providing false information may result in denial of registration.

Address Information

BUSINESS ADDRESS	1160 SYLVANIA AVE. TOLEDO, OH 43612 Lucas County 419-478-6801
CREDENTIAL MAIL ADDRESS	3416 MIDDLESEX DRIVE APT D TOLEDO, OH 43606 Lucas County 419-297-1927
MAIN	3416 MIDDLESEX DRIVE APT D TOLEDO, OH 43606 Lucas County 419-297-1927

License Information

License Number	35.032590
License Name	THOMAS MICHAELIS
Email Address	

Fees

Relicensure Fee	$305.00
	========
Total Fees	**$305.00**

Specialty Codes

1. Please select one specialty from the field below
   ..... OBSTETRICS & GYNECOLOGY
2. Please select one specialty from the field below, if applicable.
   ..... *{not Answered}*
3. Please select one specialty from the field below, if applicable.
   ..... *{not Answered}*

CME-Physicians

1. Have you met the above CME requirements for your license?
   ..... YES

Discipline

1. Have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?
   ..... NO
2. Have you surrendered, consented to limitation of, or to suspension, reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction other than Ohio?
   ..... NO
3. Have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?
   ..... NO
4. Has any board, bureau, department, agency, or any other body, including those in Ohio **other than this board,** filed any charges, allegations or complaints against you?
   ..... NO
5. Have you had any clinical privileges or other similar institutional authority suspended, restricted or revoked for reasons **other than failure to maintain records on a timely basis or to attend staff meetings?**
   ..... NO
6. Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse?
   ..... NO

Social Security Number

1.

. . . . . Redacted

Nurse Collaboration Info

1. Are you currently in a collaboration agreement with any Clinical Nurse Specialists, Certified Nurse-Midwives or Certified Nurse Practitioners?

. . . . . NO

2. List the name/names and type of licensure for each nurse with whom you are collaborating. **For example: Jane Doe, CNP; Mary Smith, CNS.**

. . . . . *{not Answered}*

I understand that submitting a false, fraudulent, or forged statement or document or omitting a material fact in obtaining licensure may be grounds for disciplinary action against my license.

Under penalty of law, I hereby swear or affirm that the information I have provided in the application is complete and correct, and that I have complied with all criteria for applying on line.

Date Posted: 3/30/2008 11:56:21 AM

Please review all information you have provided. Click on the "Review" button to change any information given or click on the "I Agree" button to verify that all information posted below is correct and to proceed to payment options.

Please note that knowingly providing false information may result in denial of registration.

License Information

License Number	35.032590
License Name	THOMAS MICHAELIS
Email Address	tom44tom@buckeye-express.com

Fees

Relicensure Fee	$305.00
Total Fees	**$305.00**

Specialty Codes

1. Please select one specialty from the field below
   ..... OBSTETRICS & GYNECOLOGY
2. Please select one specialty from the field below, if applicable.
   ..... *{not Answered}*
3. Please select one specialty from the field below, if applicable.
   ..... *{not Answered}*

CME-Physicians

1. Have you met the above CME requirements for your license?
   ..... YES

Discipline

1. Have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?
   ..... NO
2. Have you surrendered, consented to limitation of, or to suspension,

reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction other than Ohio?

. . . . . NO

3. Have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?

. . . . . NO

4. Has any board, bureau, department, agency, or any other body, including those in Ohio **other than this board,** filed any charges, allegations or complaints against you?

. . . . . NO

5. Have you had any clinical privileges or other similar institutional authority suspended, restricted or revoked for reasons **other than failure to maintain records on a timely basis or to attend staff meetings?**

. . . . . NO

6. Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse?

. . . . . NO

Social Security Number

1.

. . . . . Redacted

Nurse Collaboration Info

1. Are you currently in a collaboration agreement with any Clinical Nurse Specialists, Certified Nurse-Midwives or Certified Nurse Practitioners?

. . . . . NO

2. List the name/names and type of licensure for each nurse with whom you are collaborating. **For example: Jane Doe, CNP; Mary Smith, CNS.**

. . . . . *{not Answered}*

I understand that submitting a false, fraudulent, or forged statement or document or omitting a material fact in obtaining licensure may be grounds for disciplinary action against my license.

Under penalty of law, I hereby swear or affirm that the information I have provided in the application is complete and correct, and that I have complied with all criteria for applying on line.

Date Posted: 5/14/2010 2:30:55 PM

Please review all information you have provided. Click on the "Review" button to change any information given or click on the "I Agree" button to verify that all information posted below is correct and to proceed to payment options.

Please note that knowingly providing false information may result in denial of registration.

License Information

License Number	35.032590
License Name	THOMAS MICHAELIS

Fees

Relicensure Fee	$305.00
Total Fees	**$305.00**

Specialty Codes

1. Please select one specialty from the field below
   ..... OBSTETRICS & GYNECOLOGY
2. Please select one specialty from the field below, if applicable.
   ..... *{not Answered}*
3. Please select one specialty from the field below, if applicable.
   ..... *{not Answered}*

CME-Physicians

1. Have you met the above CME requirements for your license?
   ..... YES

Discipline

1. Have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?
   ..... NO
2. Have you surrendered, consented to limitation of, or to suspension, reprimand or probation concerning, a license to practice any

healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction other than Ohio?

. . . . . NO

3. Have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?

. . . . . NO

4. Has any board, bureau, department, agency, or any other body, including those in Ohio **other than this board,** filed any charges, allegations or complaints against you?

. . . . . NO

5. Have you had any clinical privileges or other similar institutional authority suspended, restricted, revoked or placed on probation for reasons **other than failure to maintain records on a timely basis or to attend staff meetings?**

. . . . . NO

6. Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse?

. . . . . NO

Social Security Number

1.

. . . . . Redacted

Nurse Collaboration Info

1. Are you currently in a collaboration agreement with any Clinical Nurse Specialists, Certified Nurse-Midwives or Certified Nurse Practitioners?

. . . . . NO

2. List the name/names and type of licensure for each nurse with whom you are collaborating. **For example: Jane Doe, CNP; Mary Smith, CNS.**

. . . . . *{not Answered}*

I understand that submitting a false, fraudulent, or forged

statement or document or omitting a material fact in obtaining licensure may be grounds for disciplinary action against my license.

Under penalty of law, I hereby swear or affirm that the information I have provided in the application is complete and correct, and that I have complied with all criteria for applying on line.

Date Posted: 6/15/2012 2:54:22 PM

Please review all information you have provided. Click on the "Review" button to change any information given or click on the "I Agree" button to verify that all information posted below is correct and to proceed to payment options.

Please note that knowingly providing false information may result in denial of registration.

License Information

License Number	35.032590
License Name	THOMAS MICHAELIS

Fees

Relicensure Fee	$305.00
Total Fees	**$305.00**

Medical Board Correspondence Email

1. **Did you provide a Credential email address? Please note this information is a public record.**

   ..... YES

Specialty Codes

1. Please select one specialty from the field below

   ..... OBSTETRICS & GYNECOLOGY

2. Please select one specialty from the field below, if applicable.

   ..... *{not Answered}*

3. Please select one specialty from the field below, if applicable.

   ..... *{not Answered}*

CME-Physicians

1. Have you met the above CME requirements for your license?

   ..... YES

Discipline

1. Have you been found guilty of, or pled guilty or no contest to, or

received treatment or intervention in lieu of conviction of, a misdemeanor or felony?

. . . . . NO

2. Have you surrendered, consented to limitation of, or to suspension, reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction other than Ohio?

. . . . . NO

3. Have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?

. . . . . NO

4. Has any board, bureau, department, agency, or any other body, including those in Ohio **other than this board,** filed any charges, allegations or complaints against you?

. . . . . NO

5. Have you had any clinical privileges or other similar institutional authority suspended, restricted, revoked or placed on probation for reasons **other than failure to maintain records on a timely basis or to attend staff meetings?**

. . . . . NO

6. Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse?

. . . . . NO

Social Security Number

1.

. . . . . Redacted

Nurse Collaboration Info

1. Are you currently in a collaboration agreement with any Clinical Nurse Specialists, Certified Nurse-Midwives or Certified Nurse Practitioners?

. . . . . NO

2. List the name/names and type of licensure for each nurse with whom you are collaborating. **For example: Jane Doe, CNP; Mary Smith, CNS.**

. . . . . *{not Answered}*

Ohio Employment

1. Do you practice in Ohio?

. . . . . YES

Ohio Workforce Questions

1. "Clinical" - direct patient care

. 25-29

2. "Research" - study of a treatment, procedure or medication done in a medical setting or for a medical purpose

. 0

3. "Administration" - activities related generally to patient care other than direct contact with a patient (e.g. recordkeeping, clerical tasks, chart review, prior authorizations with insurers, claims, billing issues, etc.)

. 1-4

4. "Education" - preceptor, mentor, etc.

. 1-4

5. "Volunteering" - providing medical and medical-related services at no cost

. 0

6. "Other" - medical professional activities not included in above categories

. 0

Clinical - Practice setting

1. Enter the number of hours per week spent in "Office/Clinic/Ambulatory care" (out-patient care).

. 25-29

2. Enter the number of hours per week spent in "Hospital (in-patient care)".

. 0

3. Enter the number of hours per week spent in "Emergency Room".

. 0

4. Enter the number of hours per week spent in "Urgent Care".

..... 0

5. Enter the number of hours per week spent in "Other".

..... 0

Workforce Counties

1. Enter the first zip code:

..... 43612

2. Enter the first county:

..... Lucas

3. Enter the second zip code:

..... 43205

4. Enter the second county:

..... Franklin

5. Enter the third zip code:

..... 44223

6. Enter the third county:

..... Summit

7. Do you have more than one practice location?

..... YES

Workforce Practice Address

1. Please list all practice locations. Include street address, city, state and zip. Example "123 E Main St, Suite 2, Anywhere, OH 55555;" Separate multiply addresses with a semicolon.

..... 1160 W. Sylvania Ave., Toledo, OH 43612; 1243 E. Broad St., Columbus, OH 43205; 2127 State Rd., Cuyahoga Falls, OH 44223; 222 S. Elizabeth St., Lima, OH 45801; 4818 Indianola Ave., Columbus, OH 43214

Practice Arrangement (size)

1. Solo practitioner

..... NO

2. Single-specialty Group

..... 2-5

3. Multi-specialty Group

..... N/A

4. Employee of a clinical facility or hospital? (Clinical facility is an urgent care, industrial clinic or similar entity)

..... YES

Workforce Language Question

1. Do practitioners or staff in your practice communicate in sign language or in a language other than spoken English?

..... NO

ABMS Certified

1. Are you certified by an ABMS Board?

..... YES

ABMS Specialty

1. Choose specialty from the dropdown list.

..... Obstetrics and Gynecology

2. Choose specialty from the dropdown list.

..... *{not Answered}*

3. Choose specialty from the dropdown list.

..... *{not Answered}*

I understand that submitting a false, fraudulent, or forged statement or document or omitting a material fact in obtaining licensure may be grounds for disciplinary action against my license.

Under penalty of law, I hereby swear or affirm that the information I have provided in the application is complete and correct, and that I have complied with all criteria for applying on line.