ON LOG
→ WEM
2-9-03

D.C. Board of Medicine
Complaint/Adverse Information
Triage Form

PLEASE ATTACH THIS FORM TO THE COMPLAINT or OTHER DOCUMENT OF ADVERSE INFORMATION
(Please print except initials)

Mailed to WEM 3-4-03

Licensee/Applicant: HAROLD O. ALEXANDER, MD

Recommendation of the Chairperson:

1. Summary Suspension (imminent danger to public health and safety) ___

2. Investigate ___ Mailed 3-5-03

Please specify issues for investigation: _____

_____

3. Request reply from physician ___

4. Request opinion from Attorney Advisor ___

5. Refer to Board for recommended closing ___

6. Refer to Board for recommended NOI ___

7. Other ___

BOM to start investigation 7-28-03

Please Specify: Explanation in 5E Details etc

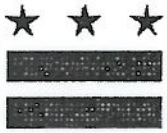
_____

Chairperson or Designee's Initials: JM

2/25/03
Date

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health

D.C. Board of Medicine



March 4, 2003

Harold O. Alexander, M.D.
[redacted]

Re: D.C. Medical License Renewal

Dear Dr. Alexander:

The D.C. Board of Medicine (the "Board") has received your renewal application (copy enclosed), and noted the malpractice suit(s). This letter is to request additional information regarding the suit(s). The Board requires the following information regarding each suit reported:

- The plaintiff;
- The venue;
- The specific allegation;
- The circumstances of your involvement; and
- The status, including the amount of any settlement.

Please forward the requested information by mail or fax to James R. Granger, Jr, Executive Director, at the address/fax number shown in the footer of this letter within thirty days of the date of this letter.

Thank you for your prompt attention to this matter.

Sincerely,

William E. Matory, M.D.
Chairperson
D.C. Board of Medicine

Enclosure as specified above.

WEM/jg

396759-12

District of Columbia — Department of Health
HEALTH OCCUPATION LICENSE RENEWAL FORM

DCMDREN01

GENERAL INSTRUCTIONS: The information printed in Section 1 of this form shows the current information on record for your license. Complete all sections of this form, where applicable, including the fee calculation. If more space is needed to fully answer questions, attach additional sheets. [illegible] or misleading statements will be cause for disciplinary action and may be cause for criminal prosecution. Mail the form, the required fee, and supporting documents to: **Promissor/DC DOH-MD, Metro-Plex II, Suite 400, 8201 Corporate Drive, Landover, MD 20785. This form is due [illegible] to Promissor by December 31, 2002. Forms postmarked after the 31st of December must contain an additional penalty fee of $50.00.** If you have any questions call ASI at 888-204-6193.

1A. DEMOGRAPHIC INFORMATION

Please make name and address changes on the reverse side of this form.

HAROLD O. ALEXANDER

[redacted]

License Number: MD000000014315
Social Security #: [redacted]
Date of Birth:
Other Address:

7306 SUITE 1, CENTRAL AVE

CAPITAL HEIGHTS MD 20743

DEC 26 2002

2. ADDITIONAL INFORMATION

Pursuant to D.C. Code Section 2-3305.5(b) 2001 (Health Occupations Act), applicants are required to provide a Social Security number (SSN) on applications for a professional license. Please provide your SSN in Section 8D of this form. If a Social Security number is not available, a sworn affidavit stating that you do not have a Social Security Number must be submitted.

You must complete the enclosed Clean Hands form and mail it with your completed renewal application.

OFFICE ONLY
YES ☑ NO ☐

3. FEE CALCULATION

Please check the appropriate boxes to indicate other requests you would like to be processed with your license renewal and then total the fee column. This form will be returned unprocessed if the fee is not included or if the fee is less than required. Make check or money order payable to "CAT*ASI". CASH PAYMENTS WILL NOT BE ACCEPTED.

A.	☑ Renewal OR ☐ Paid Inactive Status Request	$240	=	$ 240-
B.	☐ Cancel License (No fee)			
C.	☐ Chiropractic Ancillary Procedures	$90	=	$
D.	☐ Late Fee (if postmarked after December 31, 2002)	$50	=	$
E.	☐ Duplicate License Request NUMBER OF LICENSES [ ]	x $20	=	$
		TOTAL FEE DUE	=	$ 240-

✓2620 $240

OFFICE ONLY 2480

Make fee payable to: CAT*ASI *A charge of $50.00 will be imposed for dishonored checks (Public Law 89-208).*

4. QUESTIONS ABOUT YOUR PRACTICE

If you have an "MD" or "DO" license prefix, please complete A-D. If you are a chiropractor ("CH" license prefix), complete A, B and E. Otherwise, complete A and B only.

A.	Are you in active practice now?	YES ☑ NO ☐
B.	If so, do you practice in the District of Columbia at all?	YES ☐ NO ☑
C.	**MD's and DO's Only** — If your practice is limited to a specialty, please indicate the code from the specialty list at the right.	CODE 08
D.	**MD's and DO's Only** — If you are certified by the American Board of any specialty, please indicate the code from the specialty list at the right.	CODE 08
E.	**Chiropractors Only** — Are you authorized to perform non-invasive ancillary procedures? (Requires additional fee of $90)	YES ☐ NO ☐

SPECIALTIES

AD	Administrative Medicine	OR	Orthopaedic Surgery
AL	Allergy & Immunology	OT	Otolaryngology
AN	Anesthesiology	PA	Pathology
CO	Colon & Rectal Surgery	PE	Pediatrics
DE	Dermatology	PH	Physical Medicine & Rehabilitation
EM	Emergency Medicine	PL	Plastic Surgery
FA	Family Practice	PR	Preventive Medicine/ Public Health
IN	Internal Medicine	PS	Psychiatry & Neurology
MG	Medical Genetics	RA	Radiology
NE	Neurological Surgery	SU	Surgery
NU	Nuclear Medicine	TH	Thoracic Surgery
OB	Obstetrics & Gynecology	UR	Urology
OP	Ophthalmology		

5. SCREENING QUESTIONS

ALL questions must be completed by all licensees. If you answer "Yes" to any of the questions below, please provide a complete explanation on a separate sheet of paper.

A.	Have you withdrawn an application (in DC or any other state/jurisdiction) to practice medicine, or has any authority taken adverse action against your license or privileges, or informed you of any pending charges not previously reported to this Board?	YES ☐	NO ☑	OFFICE ONLY ☐
B.	Have you been convicted of a crime (other than minor traffic violation) not previously reported to the Board?	YES ☐	NO ☑	OFFICE ONLY ☐
C.	Do you have a physical or medical condition that currently impairs your ability to practice your profession?	YES ☐	NO ☑	OFFICE ONLY ☐
D.	Since the last renewal, have you been diagnosed or treated for substance abuse?	YES ☐	NO ☑	OFFICE ONLY ☐
E.	Have you been involved in a malpractice suit since your last renewal? If yes, provide date of incident, allegation and disposition of case.	YES ☑	NO ☐	OFFICE ONLY ☑
F.	Have you been out of practice since the last renewal?	YES ☐	NO ☑	OFFICE ONLY ☐

6. SIGNATURE

All licensees are required to sign and date this form on the lines provided below. This form will be returned unprocessed if the form is not signed by the licensee. Make a photocopy of this form for your records.

[signature] — LICENSEE'S SIGNATURE

11/22/02 — DATE

OFFICE ONLY ☑

ALL RENEWING LICENSEES — Please complete sections 8 and/or 9 on the back of this form to update your home or business address, preferred mailing address, SSN/Birthdate, or to report a name change. Use your license prefix and number when calling for assistance at the number listed in General Instructions or when writing to Promissor or the Board.

Mail renewal form and fee to:

Promissor/DC DOH-MD • Metro-Plex II, Suite 400, 8201 Corporate Drive • Landover, MD 20785

District of Columbia — Department of Health
HEALTH OCCUPATION LICENSE RENEWAL FORM

7. CONTINUING EDUCATION – (CHIROPRACTORS AND PHYSICIAN ASSISTANTS ONLY)

Check the box below if you have completed the required credit hours to renew your license. Include the certificates of completion with this application. These courses must have been completed between 1/1/01 and 12/31/02.

Physician Assistants ONLY

☐ I have completed the 40 hours of Category I and 60 hours of Category I or Category II continuing education required to renew my license.

Chiropractors ONLY

☐ I have completed the 24 hours of continuing education required to renew my license.

OFFICE ONLY ☐☐☐.☐

8. ADDRESS CHANGE

Use the boxes below to indicate a change in your home or business address. Complete all fields, even if the address has only partially changed.

8A. HOME ADDRESS CHANGE

Please note your apartment, suite, floor or PO Box number below if applicable. If you do not enter your complete address, your address change cannot be processed.

(Choose only one) ☐ APARTMENT ☐ SUITE ☐ FLOOR ☐ PO BOX

NUMBER

STREET ADDRESS LINE 1

STREET ADDRESS LINE 2

CITY STATE ZIP CODE

AREA PHONE NUMBER AREA FAX NUMBER EMAIL ADDRESS

8B. BUSINESS ADDRESS CHANGE

Please note your apartment, suite, floor or PO Box number below if applicable. If you do not enter your complete address, your address change cannot be processed.

(Choose only one) ☐ APARTMENT ☐ SUITE ☐ FLOOR ☐ PO BOX

NUMBER

STREET ADDRESS LINE 1

STREET ADDRESS LINE 2

CITY STATE ZIP CODE

AREA PHONE NUMBER AREA FAX NUMBER EMAIL ADDRESS

8C. INDICATE YOUR PREFERRED MAILING ADDRESS

All correspondence for this license will be sent to the preferred mailing address.

☐ HOME ☐ BUSINESS

8D. SSN/BIRTHDATE

If your Social Security Number/FEIN and Birthdate are incorrect or missing, please enter them in the spaces provided.

SSN/FEIN* BIRTHDATE

MONTH DAY YEAR

9. NAME CHANGE

If your name has changed or is incorrect, enter it below exactly as it should appear on the license. Use all fields even if only the first or last name has changed. All name changes require a copy of the legal name change document. Acceptable documents are marriage certificates, divorce decrees, or court orders.

FIRST NAME

MIDDLE NAME

LAST NAME

SUFFIX (Jr., Sr., etc.)

OFFICE ONLY ☐

OFFICE ONLY

Clerk's Initials UY

4

396759-12

[redacted]

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
825 NORTH CAPITOL STREET, N.E.
WASHINGTON, DC 20002

Clean Hands Before Receiving a License or Permit Act of 1996 Certification Form

Please read this form carefully and completely before signing. Any false information provided requires that the Department of Health proceed immediately to revoke the license or permit for which you are now applying, and fine you one thousand dollars ($1,000.00). This *Certification Form* is required to be completed and submitted with any application for licensure or permit under the *Clean Hands Before Receiving a License or Permit Act of 1996*, effective May 11, 1996 (D.C. Law 11-118, D.C. Code §47-2861 et seq.).

I, Harold O. Alexander, MD, applying for a Medicine/Surgery
(name) *(type of health license)*

certify that, as of this date, do not owe more than one hundred dollars ($100.00) to the District of Columbia government as a result of

1. Fines, penalties or interest assessed pursuant to the Litter Control Administration Act of 1995, effective March 25, 1986 (D.C. Law 6-100; D.C. Code §6-2901 et seq.);
2. Fines, penalties or interest assessed pursuant to the Illegal Dumping Enforcement Act of 1994, effective May 20, 1994 (D.C. Law 10-117; D.C. Code §6-2911 et seq.);
3. Fines, penalties or interest assessed pursuant to the Civil Infractions Act of 1985, effective October 5, 1986 (D.C. Law 6-42; D.C. Code §6-2701 et seq.); or
4. Past due taxes.

246 - 2620
240

I understand that if I knowingly provide false information on this *Certification Form*, the Department of Health will move to revoke the license or permit for which I am applying and fine me one thousand dollars ($1,000.00). I further understand that the Department of Health and the Office of Tax and Revenue may conduct an investigation to ascertain the veracity of the information contained in this *Certification Form*.

240 - 240

I understand that this *Certification Form* is now required as part of my application for a license or permit, and that by completing it, I am not guaranteed that my license or permit will be approved.

[redacted]
Signature and Title/Responsible Officer

11/22/02
Date

[redacted]
Social Security #

OB 7306 Central Ave. #1
OB *Business/Home Address* Capitol Hts MD 20743

[redacted]
Phone Number

white copy – Department of Health
yellow copy - Tax and Revenue, Collections Division
pink copy – applicant
ASI# 6009-03 9/00

For Tax Assistance call:
(202) 442 – 4TAX.
(4829)

DEC 26 2002

File

Harold O. Alexander, M.D.

Malpractice Cases

Marcella McIntyre /

(2) D'Marco Clifton vrs HO Alexander, MD
Brachial plexus injury (P) 3/8/00
Filed P.G. County 2001
Settled – MIXK, 7/02 $335,000 –

(1) Myatho Walker vrs. HO Alexander, M.
Bladder perforation at time of
laparoscopy / micaosurgical tuboplasty
1989 Filed 1989 / D.C.
~~PIE Settled 1991 – $20,000~~

License # 14315
HO Alexander, MD

7306 CENTRAL AVENUE, SUITE 1 CAPITOL HEIGHTS, MARYLAND 20743 TELEPHONE (301) 350-5454

$180.00

CONSUMER AND REGULATORY AFFAIRS
D PROFESSIONAL LICENSING ADMINISTRATION
APPLICATIONS DIVISION
614 H STREET, N.W.
ROOM 904
VASHINGTON, D.C. 20001

93-703

APPLICATION FOR REINSTATEMENT OF HEALTH OCCUPATIONS LICENSE

(Attach 2 passport-type photographs 2" x 2")

9/24/93
Date of Application

Name Harold Oliver Alexander, MD Date of Birth [redacted]
Type or Print

Residence Address [redacted]

Business Address 7306 Central Ave. Cap. Hgts, MD 20743 2079

Social Security No. [redacted] Home Phone [redacted] Business Phone 301-350-5454

Type of License: Physician Original License No. 14315

Date Issued 1978 Date of Last Renewal 1991 (expired 12/31/92)

Method of Original Licensure: National Board Examinations

Reason for Not Renewing: Renewal mailed to incorrect-old address, therefore not received

PLEASE ACCOUNT FOR ALL PRACTICE, EMPLOYMENT OR PERIODS OF NON-EMPLOYMENT SINCE LAST REGISTERED TO PRACTICE IN THE DISTRICT OF COLUMBIA.

N/A - Practice has continued uninterrupted since original licensure.

ATTACH ADDITIONAL SHEETS, IF NECESSARY

Have you (if firm, any officer of firm) been arrested, indicted or convicted of crime (other than minor teraffic violations) *since last renewal*? _____YES__X__NO. IF YES, ATTACH WRITTEN EXPLANATION.

SEE REVERSE SIDE

7

GOVERNMENT OF THE DISTRICT OF COLUMBIA

DEPARTMENT OF CONSUMER AND REGULATORY AFFAIRS
OCCUPATIONAL AND PROFESSIONAL LICENSING ADMINISTRATION
605 G STREET, N.W. ROOM 202-LL
WASHINGTON, D.C. 20001
BOARD OF MEDICINE

ADDRESS ALL COMMUNICATIONS
TO THE BOARD

DISCIPLINARY INQUIRIES
Federation of State Medical Boards
6000 Western Place - Suite 707
Fort Worth, Texas 76107-4618

The District of Columbia Board of Medicine requests a disciplinary search concerning the following individual:

Harold O. Alexander, MD
Name

[redacted]
Address

[redacted]
City, State, and Zip Code

[redacted]
Date of Birth

[redacted]
Social Security Number

Howard U. College of Medicine, Wash. D.C.
Medical School of Graduation and Branch Location

1977
Date of Graduation

WE HAVE NO UNFAVORABLE INFORMATION
REGARDING THE ABOVE NAMED PHYSICIAN

SEP 30 1993

James R. Winn, M.D.
JAMES R. WINN, M.D.
EXECUTIVE VICE-PRESIDENT

Please mail the response to the following address:

D.C. Board of Medicine
605 G Street, N.W. - Room 202LL
Washington, D.C. 20001

Signature

Form No. LH-OPA-1
81—P6172

APPLICATION FOR D.C. LICENSE

3yrs active duty

FOR OFFICE USE ONLY			APPLICATION NO. 83-GM-427
	AMOUNT OF FEE	DATE PAID	BASIS OF LICENSURE — date
APPLICATION	$.....	.....	☐ EXAMINATION ..... test score .....
EXAMINATION	$.....	.....	☐ RECIPROCITY ..... state .....
LICENSE	$.....	.....	☐ ENDORSEMENT ..... state .....
BOARD APPROVED			☐ OTHER ....
LICENSE PERIOD from ..... to			CATEGORY CODE / AUDIT/LICENSE NO. / COMPLAINTS FILED ☐ Yes No ☐ / MIS ONLY STREET CODE ..... QUADRANT CODE .....

TO BE COMPLETED BY APPLICANT (PLEASE READ INSTRUCTIONS FIRST) (PRINT IN INK OR TYPE)

1. TYPE OF LICENSE: MEDICINE + SURGERY

2. NAME OF APPLICANT (Last, First, MI): Alexander, Harold O.

3. RESIDENCE ADDRESS (Street, City, State, Zip Code): [redacted]

4. BILLING ADDRESS (Street, City, State, Zip Code): same

5. ☒ Individual ☐ Partnership ☐ Corporation

6. BASIS OF APPLICATION: ☐ Examination ☐ Re-examination ☐ Reciprocity ☒ Endorsement ☐ Other ..... (specify)

7. SEX: ☒ Male ☐ Female

8. ☐ TRADE NAME ..... OR ☐ EMPLOYER NAME .....

9. BUSINESS ADDRESS (Street, City, State, Zip Code): 1453 Belmont St. Atwater, Ca. 95301

10. D.C. WARD: N.A.

11. DATE OF APPLICATION: 20 May 83

*12. SOCIAL SECURITY NUMBER: [redacted]

13. DATE OF BIRTH: [redacted]

14. PLACE OF BIRTH: [redacted]

15. TELEPHONE NUMBER: Residence [redacted] Business 209-726-2541

16. CERTIFICATE OF OCCUPANCY (if applicable) NUMBER .....

17. SCHOOL ATTENDED (name, city, state or foreign country)	18. Total No. of Hours	19. Date of Graduation	20. Type of Degree/Certificate	21. Year Degree Received
Howard U. College of Medicine Washington, D.C.	*120 Sem. hrs	5/77	M.D.	1977

22. Have you ever been arrested or convicted of a crime? (omit traffic violations) ☐ Yes ☒ No If yes, attach explanation.

23. Are you currently bonded? ☐ Yes ☒ No If yes, give expiration date .....

24. Are you now or have you ever been licensed in D.C. or any other jurisdiction? ☒ Yes ☐ No
If yes, give the following information on original licensure: Jurisdiction Maryland / California
License Date 1978 / 1981 License No. D22249 / G44916 Issue Basis N.B.

25. Have you ever surrendered license or has license been denied, revoked or suspended by any jurisdiction? ☐ Yes ☒ No
If yes, attach explanation.

26. AFFIDAVIT OF APPLICANT

HAROLD O. ALEXANDER, being duly sworn, deposes and says: That the information given in this application, including all writings and exhibits attached hereto, is true and complete.

STATE OF CALIFORNIA/COUNTY OF MERCED
~~District of Columbia~~ ss.

H O Alexander
Signature of Applicant

Subscribed and sworn to before me this 20th day of May, 19 83 by the affiant, who personally appeared before me.

OFFICIAL SEAL
RUTH KOTAKI
NOTARY PUBLIC - CALIFORNIA
MERCED COUNTY
My comm. expires APR 23, 1987

Ruth Kotaki
Notary Public

My Commission expires .....

1. All applicants must complete applicable portion of supplemental page and submit all supporting documents required.
2. Fee must accompany application. All fees are earned when paid and cannot be transferred or refunded.
3. Make checks payable to D.C. TREASURER. A charge of $15.00 will be imposed for dishonored checks. (Public Law 89-208)
4. False or misleading statements will be cause for rejection of application or revocation of license.
5. If more space is needed to fully answer questions, attach additional page(s).

*Under the authority of Public Law 93-579, Section 7(b), the Department of Licenses, Investigations and Inspections requests your Social Security Number to assist in the administration of D.C. tax laws. Disclosure is not required as a part of the licensing process and will not be made available to the public.

#0

GOVERNMENT OF THE DISTRICT OF C

COMMISSION ON LICENSURE TO PRACTICE THE
605 G Street, N.W., Room 202—Lower Le
Washington, D.C. 20001

SUPPLEMENTAL INFORMATIO

NAME: Harold Oliver Alexander
ADDRESS: [redacted]

METHOD OF HEALING:
- ☐ Osteopathy & Surgery
- ☒ Medicine & Surgery
- ☐ Chiropractic
- ☐ Other (specify) _____

1. If applying for licensure by endorsement, indicate whether FLEX ☐ or National Board ☒ and give date and place of examination.
[redacted] Washington, D.C. (? G.W. University) 1979

2. Training and practice since date of graduation to the present. Include periods of unemployment and other employment.

	Name of Employer	Address	Zip Code	From Mo./Yr.	To Mo./Yr.
(1)	Prince Georges Gen. Hosp.	Cheverly, Md.	20785	7/1977	7/1979
(2)	Providence Hospital	Varnum St. Wash. DC.	20017	7/1979	7/1981
(3)	USAF	Castle AFB, Merced, Ca.	95342	7/1981	present 5 Aug 83
(4)					
(5)					
(6)					

3. References. List the names and full mailing addresses, including zip codes, of three personal acquaintances, not relatives, who have knowledge of your character and professional practice, or give the name and address of the chartered State or County Medical Society or other Society nearest your residence.

	Name	Address	Zip Code
(1)	Dr. Ernest L. Hopkins	Howard U. Hosp. Wash., D.C.	20001
(2)	Dr. T. R. George, Jr.	5th & Kennedy Sts. N.W. Wash., D.C.	
(3)	Dr. J. Frawley	1150 Varnum St. N.E. Wash., D.C.	20017

4. Declaration of Intent:

As part of my application for licensure to practice the healing art in the District of Columbia, I hereby declare that it is my intention, if issued a license, to engage in the practice of the healing art in the District of Columbia.

I understand that should I be granted a license by examination to practice the healing art in the District of Columbia, the Commission on Licensure to Practice the Healing Art in the District of Columbia will not certify my examination scores to another jurisdiction unless and until I have engaged in the practice of the healing art in the District of Columbia for at least six months subsequent to the issuance of my District of Columbia license.

[signature] Signature of Applicant

20 May 83 Date

5. Have you ever taken an examination in the basic sciences or any examination in the healing art under the authority of the Commission on Licensure to Practice the Healing Art in the District of Columbia? ☐ Yes ☒ No
If the answer is yes, give date and type of examination.

83—7216-P

DEPARTMENT OF THE AIR FORCE
UNITED STATES AIR FORCE HOSPITAL, CASTLE (SAC)
CASTLE AIR FORCE BASE, CALIFORNIA 95342

4 August 1983

Board of Medical Licensure
Washington, D. C.

Re: HAROLD O. ALEXANDER, MD, [redacted]

Dr. Harold O. Alexander served as a staff obstetrician-gynecologist at USAF Hospital Castle from 30 June 1981 through 1 August 1983.

His duties involved provision of routine obstetrical and gynecologic care to the population served by our base. Care for high-risk OB patients was provided as limited by the services at our facility. He supervised the care provided by two nurse-midwives and a nurse practitioner. For six months he served as Chief of the OB/GYN Services here.

I have worked with Dr. Alexander for about one year, and have found him to be knowledgable and current in his field. His technical skills are quite adequate. He is a competent physician.

KATHLEEN M. MC CAULEY, CAPT, USAF, MC
CHIEF, OB/GYN SERVICES
USAF, HOSPITAL CASTLE AFB, CA

GOVERNMENT OF THE DISTRICT OF COLUMBIA

COMMISSION ON LICENSURE TO PRACTICE THE HEALING ART
605 G Street, N.W., Room 202 Lower Level
Washington, D.C. 20001

ADDRESS ALL COMMUNICATIONS TO THE COMMISSION

AUG 18 1983

Providence Hosp.
Varnum St., N.W.
Washington, D.C. 20017

Dear Sir:

The physician whose name appears below has applied to the Commission on Licensure to Practice the Healing Art, for a license to practice the healing art in the District of Columbia.

In order to aid us in evaluating this application, we would greatly appreciate your providing the following information.

Sincerely,

Joseph Sarnella
Staff Director

Name Harold O. Alexander Date of Birth [redacted]

Period of Employment: From 7/79 To 7/81

Title of Position Resident

Method of Healing Practiced Medicine/Surgery

Rating of Applicant's Performance Satisfactory

Remarks:

Thomas E. Curtin MD
Signature of Official (Facsimile not accepted)
Thomas E. Curtin, MD
Vice President, Medical Affairs
Title of Position
Providence Hospital
1150 Varnum Street, NE
Washington, D.C. 20017
Agency, Institution, or Address of Private Practice

GOVERNMENT OF THE DISTRICT OF COLUMBIA

COMMISSION ON LICENSURE TO PRACTICE THE HEALING ART

605 G Street, N.W., Room 202 Lower Level
Washington, D.C. 20001

ADDRESS ALL COMMUNICATIONS TO THE COMMISSION

Prince Georges General Hosp.
Cheverly, Md. 20785

Dear Sir:

The physician whose name appears below has applied to the Commission on Licensure to Practice the Healing Art, for a license to practice the healing art in the District of Columbia.

In order to aid us in evaluating this application, we would greatly appreciate your providing the following information.

Sincerely,

Joseph Sarnella
Staff Director

Name Harold O. Alexander Date of Birth [redacted]

Period of Employment: From 7/77 To 7/79

Title of Position Resident in Obstetrics and Gynecology

Method of Healing Practiced Medicine and Surgery

Rating of Applicant's Performance Poor to Fair

Remarks:

R. K. Skipton MD
Signature of Official (Facsimile not accepted)

R. K. Skipton, M.D.
Program Coordinator, Department of OB/GYN
Title of Position

Prince George's General Hospital
and Medical Center
Cheverly, Maryland 20785
Agency, Institution, or Address of Private Practice

providence hospital

1150 varnum street n.e.
washington, d.c. 20017
(202) 269-7000

September 8, 1983

Government of the District of Columbia
Commission on Licensure to Practice the Healing Art
605 G Street, N.W., Room 202 Lower Level
Washington, D.C. 20001

To whom it may concern:

I am writing this letter in support of Dr. Harold Alexander who is applying for a license to practice the healing arts in the District of Columbia.

This is to certify that Dr. Harold Alexander satisfactorily served as a resident in the Ob/Gyn Department from July, 1979 - June , 1981. The last year of that period was served as chief resident of the Ob/Gyn Department.

Dr. Alexander's progress was satisfactory in all respects. His association and relationship with his peers and attending staff was in all respects satisfactory. His professional posture and morals were satisfactory in all aspects.

It is without reservation that I recommend him to you for favorable action.

Sincerely,

James M Frawley M.D.
James M. Frawley, M.D.
Chief of Clinical Services
Department of Ob/Gyn

JMF/elr

CHARACTER REFERENCE'S VOUCHER

September 8, 1983, 19 _____

TO THE COMMISSION ON LICENSURE TO PRACTICE THE HEALING ART:

I hereby certify that since July 1, 1979 (insert date), I have been so closely associated with Dr. Harold Alexander, M.D. (applicant's name), residing in _____, as to be able to intelligently express an opinion as to his character, mental condition, and habits, and that to the best of my knowledge and belief, he/she is of good moral character and free from mental defects and drug habits liable to interfere with the proper practice of the healing art.

I certify further that to my personal knowledge he/she has been actually engaged in the practice of Obstetrics/Gynecology for not less than one continuous year immediately preceding August 18, 1983 (date of application).

Remarks: PLEASE SEE ATTACHED LETTER

Providence Hospital
Profession or Business

James M. Frawley, M.D.
(Name - print or type)

James M Frawley MD
Signature (Facsimile not acceptable)

1150 Varnum Street, NE

Washington, D.C. 20017
Address

19

CHARACTER REFERENCE'S VOUCHER

24 Aug, 19 83

TO THE COMMISSION ON LICENSURE TO PRACTICE THE HEALING ART:

I hereby certify that since 1975 (insert date), I have been so closely associated with Dr. HAROLD Alexander (applicant's name), residing in California, presently, as to be able to intelligently express an opinion as to his character, mental condition, and habits, and that to the best of my knowledge and belief, he/she is of good moral character and free from mental defects and drug habits liable to interfere with the proper practice of the healing art.

I certify further that to my personal knowledge he/~~she~~ has been actually engaged in the practice of MEDICINE for not less than one continuous year immediately preceding 24 Aug 83 (date of application).

Remarks: DR Alexander completed a preceptorship under my supervision, completed his specialty training in D.C. and is now serving the military

MEDICINE
Profession or Business

THEODORE R. GEORGE, JR. MD
(Name - print or type)

T R George Jr. MD.
Signature (Facsimile not acceptable)

5505 5th St N.W. Suite 300
Washington, DC 20011
Address

726-4847

20

DEPARTMENT OF THE AIR FORCE
UNITED STATES AIR FORCE HOSPITAL, CASTLE (SAC)
CASTLE AIR FORCE BASE, CALIFORNIA 95342

4 August 1983

Board of Medical Licensure
Washington, D. C.

Re: HAROLD O. ALEXANDER, MD, [redacted]

Dr. Harold O. Alexander served as a staff obstetrician-gynecologist at USAF Hospital Castle from 30 June 1981 through 1 August 1983.

His duties involved provision of routine obstetrical and gynecologic care to the population served by our base. Care for high-risk OB patients was provided as limited by the services at our facility. He supervised the care provided by two nurse-midwives and a nurse practitioner. For six months he served as Chief of the OB/GYN Services here.

I have worked with Dr. Alexander for about one year, and have found him to be knowledgable and current in his field. His technical skills are quite adequate. He is a competent physician.

KATHLEEN M. MC CAULEY, CAPT, USAF, MC
CHIEF, OB/GYN SERVICES
USAF, HOSPITAL CASTLE AFB, CA

Peace . . . . is our Profession

GOVERNMENT OF THE DISTRICT OF COLUMBIA

COMMISSION ON LICENSURE TO PRACTICE THE HEALING ART

605 G Street, N.W., Room 202 Lower Level
Washington, D.C. 20001

ADDRESS ALL COMMUNICATIONS TO THE COMMISSION

RECEIVED
SEP 2 1983
Comm. on Lic. To Prac. The H/A

AUG 18 1983

Providence Hosp.
Varnum St., N.W.
Washington, D.C. 20017

Dear Sir:

The physician whose name appears below has applied to the Commission on Licensure to Practice the Healing Art, for a license to practice the healing art in the District of Columbia.

In order to aid us in evaluating this application, we would greatly appreciate your providing the following information.

Sincerely,

Joseph Sarnella

Joseph Sarnella
Staff Director

Name Harold O. Alexander Date of Birth [redacted]

Period of Employment: From 7/79 To 7/81

Title of Position Resident

Method of Healing Practiced Medicine/Surgery

Rating of Applicant's Performance Satisfactory

Remarks:

Thomas E. Curtin MD

Signature of Official (Facsimile not accepted)

Thomas E. Curtin, MD
Vice President, Medical Affairs

Title of Position

Providence Hospital
1150 Varnum Street, NE
Washington, D.C. 20017

Agency, Institution, or Address of Private Practice

2

GOVERNMENT OF THE DISTRICT OF COLUMBIA

COMMISSION ON LICENSURE TO PRACTICE THE HEALING ART

605 G Street, N.W., Room 202 Lower Level
Washington, D.C. 20001

ADDRESS ALL COMMUNICATIONS TO THE COMMISSION

RECEIVED
AUG 3 1983

Prince Georges General Hosp.
Cheverly, Md. 20785

Dear Sir:

The physician whose name appears below has applied to the Commission on Licensure to Practice the Healing Art, for a license to practice the healing art in the District of Columbia.

In order to aid us in evaluating this application, we would greatly appreciate your providing the following information.

Sincerely,

F. Joseph Sarnella
Staff Director

Name Harold O. Alexander Date of Birth [redacted]

Period of Employment: From 7/77 To 7/79

Title of Position Resident in Obstetrics and Gynecology

Method of Healing Practiced Medicine and Surgery

Rating of Applicant's Performance Poor to Fair

Remarks:

R. K. Skipton MD
Signature of Official (Facsimile not accepted)

R. K. Skipton, M.D.
Program Coordinator, Department of OB/GYN
Title of Position

Prince George's General Hospital
and Medical Center
Cheverly, Maryland 20785
Agency, Institution, or Address of Private Practice

13

NATIONAL BOARD OF MEDICAL EXAMINERS® • 3930 CHESTNUT STREET, PHILADELPHIA, PENNA. 19104

ENDORSEMENT OF CERTIFICATION

NATIONAL BOARD OF MEDICAL EXAMINERS
OF THE
UNITED STATES OF AMERICA

Harold Oliver Alexander, M.D.

having satisfied all the requirements and having successfully passed the examinations is hereby declared a Diplomate of the National Board of Medical Examiners.

Attest JOHN S. MILLIS
Chairman of the Board

SEAL

EDITHE J. LEVIT
President of the Board

Philadelphia, Pa.

07/01/78

Certificate # 188218

It is certified that the above is a facsimile of the Diplomate Certificate which has been or will be* awarded to the physician named above, who graduated from HOWARD UNIV COL MEDICINE in MAY 1977 and whose birth date is [redacted]. This physician has successfully completed all examinations required for certification by the National Board of Medical Examiners. The scores obtained by this physician upon which his/her certification is based are as follows:

	Standard Score	Scale Score
PART I passed 06/75		
Anatomy, incl. histology and embryology	[redacted]	
Physiology		
Biochemistry		
Pathology		
Microbiology, incl. immunology		
Pharmacology and Materia Medica		
Behavioral Sciences		
TOTAL TEST (Minimum Passing Score 380/75)		
Part II passed 09/76		
Internal medicine and the medical specialties		
Surgery and the surgical specialties		
Obstetrics and Gynecology		
Public Health and Preventive Medicine		
Pediatrics		
Psychiatry		
TOTAL TEST (Minimum Passing Score 290/75)		
PART III passed 03/78		
A General Test of Clinical Competence		
TOTAL TEST (Minimum Passing Score 290/75)		
GENERAL AVERAGE (Parts, I, II, and III Scale Score)		

*For those individuals who have not yet satisfactorily completed one full year of post-M.D. training the date shown on the facsimile is the date which has been certified by the physician's residency program director as the date on which this requirement for certification by the National Board will be fulfilled and such certification will be awarded.

Ann K. Stevenling
Secretary for Certification

SEAL

05/25/83
Date

NATIONAL BOARD OF MEDICAL EXAMINERS® • 3930 CHESTNUT STREET, PHILADELPHIA, PENNA. 19104

ENDORSEMENT OF CERTIFICATION

NATIONAL BOARD OF MEDICAL EXAMINERS
OF THE
UNITED STATES OF AMERICA

Harold Oliver Alexander, M.D.

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		Standard Score	Scale Score
PART I passed	06/75		
Anatomy, incl. histology and embryology		[redacted]	[redacted]
Physiology			
Biochemistry			
Pathology			
Microbiology, incl. immunology			
Pharmacology and Materia Medica			
Behavioral Sciences			
TOTAL TEST (Minimum Passing Score 380/75)			
Part II passed	09/76		
Internal medicine and the medical specialties			
Surgery and the surgical specialties			
Obstetrics and Gynecology			
Public Health and Preventive Medicine			
Pediatrics			
Psychiatry			
TOTAL TEST (Minimum Passing Score 290/75)			
PART III passed	03/78		
A General Test of Clinical Competence			
TOTAL TEST (Minimum Passing Score 290/75)			
GENERAL AVERAGE (Parts, I, II, and III Scale Score)			

*For those individuals who have not yet satisfactorily completed one full year of post-M.D. training the date shown on the facsimile is the date which has been certified by the physician's residency program director as the date on which this requirement for certification by the National Board will be fulfilled and such certification will be awarded.

Ann K. Heverling
Secretary for Certification

SEAL

05/25/83
Date

PRINCE GEORGE'S GENERAL HOSPITAL

AND MEDICAL CENTER

CHEVERLY, MARYLAND

This is a true + correct copy of post-graduate training received 1978.

This is to Certify That

Harold Alexander M.D.

has served faithfully and satisfactorily as

RESIDENT IN OBSTETRICS & GYNECOLOGY

during the period JULY 1,1977 *to* JUNE 30,1978

in testimony whereof this certificate is hereby granted.

STATE OF CALIFORNIA
COUNTY OF MERCED
Subscribed and sworn to before me this 20 day of MAY 1983
at Castle AFB, CA 95342
Ruth Kotaki
NOTARY PUBLIC
My Commission Expires 4/23/87

OFFICIAL SEAL
RUTH KOTAKI
NOTARY PUBLIC - CALIFORNIA
MERCED COUNTY
My comm. expires APR 23, 1987

Stanley P. Foster, M.D.
CHIEF OF DEPARTMENT

VICE PRESIDENT FOR PROFESSIONAL EDUCATION

EXECUTIVE VICE PRESIDENT

Universitas Howardiana Washingtonii
in Regione Columbiana sita

omnibus ad quos hae litterae pervenerint salutem.

Harold Oliver Alexander

Medicinae Doctoris

Howard University

Washington, D.C.

Subscribed and sworn to before me this 2nd day of August 1983.

Ruth Kotaki

OFFICIAL SEAL
RUTH KOTAKI
NOTARY PUBLIC - CALIFORNIA
MERCED COUNTY
My comm. expires APR 23, 1987

This is a true and correct copy of my medical diploma received from Howard University College of Medicine 5/77.

Form No. LII-OPA-1
81—P6172

APPLICATION FOR D.C. LICENSE

3 yrs active duty

FOR OFFICE USE ONLY	APPLICATION NO. 83-PW-477

	AMOUNT OF FEE	DATE PAID
APPLICATION	$	
EXAMINATION	$	
LICENSE	$	

BOARD APPROVED .....

LICENSE PERIOD from 6-84 to 12/31/84

BASIS OF LICENSURE — date

- ☐ EXAMINATION ..... test score ..... date
- ☐ RECIPROCITY ..... state ..... date
- ☒ ENDORSEMENT Natl Bd state ..... date
- ☐ OTHER .... date

CATEGORY CODE 153

AUDIT/LICENSE NO. 17315

COMPLAINTS FILED ☐ Yes No ☐

MIS ONLY

STREET CODE .....

QUADRANT CODE .....

TO BE COMPLETED BY APPLICANT (PLEASE READ INSTRUCTIONS FIRST) (PRINT IN INK OR TYPE)

1. TYPE OF LICENSE: MEDICINE + SURGERY

2. NAME OF APPLICANT (Last, First, MI): Alexander, Harold O.

3. RESIDENCE ADDRESS (Street, City, State, Zip Code): [redacted]

4. BILLING ADDRESS (Street, City, State, Zip Code): Same

5. ☒ Individual ☐ Partnership ☐ Corporation

6. BASIS OF APPLICATION: ☐ Examination ☐ Re-examination ☐ Reciprocity ☒ Endorsement ☐ Other ..... (specify)

7. SEX ☒ Male ☐ Female

8. ☐ TRADE NAME ..... OR ☐ EMPLOYER NAME .....

9. BUSINESS ADDRESS (Street, City, State, Zip Code): 1453 Belmont St. Atwater, Ca. 95301

10. D.C. WARD: N.A.

11. DATE OF APPLICATION: 20 May 83

* 12. SOCIAL SECURITY NUMBER: [redacted]

13. DATE OF BIRTH: [redacted]

14. PLACE OF BIRTH: [redacted]

15. TELEPHONE NUMBER: Residence [redacted] Business 209-726-2541

16. CERTIFICATE OF OCCUPANCY (if applicable) NUMBER .....

17. SCHOOL ATTENDED (name, city, state or foreign country)	18. Total No. of Hours	19. Date of Graduation	20. Type of Degree/Certificate	21. Year Degree Received
Howard U. College of Medicine	120 sem. hrs	5/77	M.D.	1977
Washington, D.C.				

22. Have you ever been arrested or convicted of a crime? (omit traffic violations) ☐ Yes ☒ No If yes, attach explanation.

23. Are you currently bonded? ☐ Yes ☒ No If yes, give expiration date .....

24. Are you now or have you ever been licensed in D.C. or any other jurisdiction? ☒ Yes ☐ No
If yes, give the following information on original licensure: Jurisdiction Maryland / California
License Date 1978 / 1981 License No. D22219 / G44916 Issue Basis N.B.

25. Have you ever surrendered license or has license been denied, revoked or suspended by any jurisdiction? ☐ Yes ☒ No
If yes, attach explanation.

26. AFFIDAVIT OF APPLICANT

HAROLD O. ALEXANDER, being duly sworn, deposes and says: That the information given in this application, including all writings and exhibits attached hereto, is true and complete.

STATE OF CALIFORNIA/COUNTY OF MERCED
~~District of Columbia~~ ss.

Signature of Applicant

Subscribed and sworn to before me this 20th day of May, 19 83 by the affiant, who personally appeared before me.

OFFICIAL SEAL
RUTH KOTAKI
NOTARY PUBLIC - CALIFORNIA
MERCED COUNTY
My comm. expires APR 23, 1987

My Commission expires (SEAL)

Notary Public

1. All applicants must complete applicable portion of supplemental page and submit all supporting documents required.
2. Fee must accompany application. All fees are earned when paid and cannot be transferred or refunded.
3. Make checks payable to D.C. TREASURER. A charge of $15.00 will be imposed for dishonored checks. (Public Law 89-208)
4. False or misleading statements will be cause for rejection of application or revocation of license.
5. If more space is needed to fully answer questions, attach additional page(s).

*Under the authority of Public Law 93-579, Section 7(b), the Department of Licenses, Investigations and Inspections requests your Social Security Number to assist in the administration of D.C. tax laws. Disclosure is not required as a part of the licensing process and will not be made available to the public.

H E A L I N G A R T

PROCESSING CHECK LIST

Name Alexander Harold D.

Applications Clerk

1.	Is application form signed and notarized	✓
2.	Is photograph attached	✓
3.	Is internship certificate (or notarized copy) or certified statement from internship hospital	
4.	Notarized copy of medical diploma or certified copy of medical school transcript	✓
5.	Notarized copy of ECFMG Certificate (foreign grad. only)	✓
6.	Fee attached	N/A
7.	Declaration of Intent signed	$ 180.00
8.	File folder attached (Re-examination applicants only)	N/A
9.	Flex Form A (examination applicants only)	N/A

Applications Clerk

Applications Examiner

1.	Applicant is at least 18 years old	✓
2.	Applicant has accounted for all practice since M.D. degree or (reciprocity only) since issue of base license	✓
3.	Method of healing	MDS (indicate)
4.	Applying for license by	Nat'l Bd Exd. (indicate)
5.	(Examination applicant only)	
	(a) Applicant asks exemption from Basic Sciences	
	(b) Questions have been received directly from other Board	
6.	(Reciprocity applicant only)	
	(a) Written licensing examination by	(indicate)
	(b) Has provided information re base license	
	(c) Has practiced at least one year out of the last three years immediately prior to this application since issue of base license	
	(d) Applicant has been previously examined in District of Col.	NO (yes or no)
	(1) Exam taken and failed here before base license	
	(2) Exam taken and failed here after base license	
	Applicant has submitted proper fee	$180 (amount)

Applications Examiner Bay

? QUESTION #2 ON SUPPLEMENTAL FORM - [redacted] PLEASE [illegible]
AND YEARS.
? SEND ACTIVE MILITARY LETTER + 3MB CARD

H E A L I N G A R T

PROCESSING CHECK LIST

5-27-83

Ret 6-1-83

Name ALEXANDER, HAROLD O.

Applications Clerk

1.	Is application form signed and notarized	✓
2.	Is photograph attached	✓
3.	Is internship certificate (or notarized copy) or certified statement from internship hospital	✓
4.	Notarized copy of medical diploma or certified copy of medical school transcript	SEE ABOVE
5.	Notarized copy of ECFMG Certificate (foreign grad. only)	NA
6.	Fee attached	✓
7.	Declaration of Intent signed	NA
8.	File folder attached (Re-examination applicants only)	NA
9.	Flex Form A (examination applicants only)	[illegible]

Applications Clerk

Applications Examiner

1.	Applicant is at least 18 years old	✓
2.	Applicant has accounted for all practice since M.D. degree or (reciprocity only) since issue of base license	SEE ABOVE
3.	Method of healing	MBS (indicate)
4.	Applying for license by	3MB (indicate)
5.	(Examination applicant only)	
	(a) Applicant asks exemption from Basic Sciences	NA
	(b) Questions have been received directly from other Board	NA
6.	(Reciprocity applicant only)	
	(a) Written licensing examination by	NA (indicate)
	(b) Has provided information re base license	NA
	(c) Has practiced at least one year out of the last three years immediately prior to this application since issue of base license	NA
	(d) Applicant has been previously examined in District of Col.	NA (yes or no)
	(1) Exam taken and failed here before base license	NA
	(2) Exam taken and failed here after base license	NA
	Applicant has submitted proper fee	10 (amount)

Applications Examiner

GOVERNMENT OF THE DISTRICT OF
COMMISSION ON LICENSURE TO PRACTICE THE
605 G Street, N.W., Room 202—Lower Le
Washington, D.C. 20001

SUPPLEMENTAL INFORMATI

NAME Harold Oliver Alexander
ADDRESS [redacted]

METHOD OF HEALING:
- ☐ Osteopathy & Surgery
- ☒ Medicine & Surgery
- ☐ Chiropractic
- ☐ Other (specify) _____

1. If applying for licensure by endorsement, indicate whether FLEX ☐ or National Board ☒ and give date and place of examination.
[redacted] Washington, D.C. (? G.W. University) 1979

2. Training and practice since date of graduation to the present. Include periods of unemployment and other employment.

	Name of Employer	Address	Zip Code	From Mo./Yr.	To Mo./Yr.
(1)	Prince Georges Gen. Hosp.	Cheverly, Md.	20785	7/1977	7/1979
(2)	Providence Hospital	Varnum St. Wash., DC.	20017	7/1979	7/1981
(3)	USAF	Castle AFB, Merced, Ca.	95342	7/1981	present 5 Aug 83
(4)					
(5)					
(6)					

3. References. List the names and full mailing addresses, including zip codes, of three personal acquaintances, not relatives, who have knowledge of your character and professional practice, or give the name and address of the chartered State or County Medical Society or other Society nearest your residence.

	Name	Address	Zip Code
(1)	Dr. Ernest L. Hopkins	Howard U. Hosp. Wash., D.C.	20001
(2)	Dr. T. R. George, Jr.	5th + Kennedy Sts. N.W. Wash., D.C.	
(3)	Dr. J. Frawley	1150 Varnum St. N.E. Wash., D.C.	20017

4. Declaration of Intent:

As part of my application for licensure to practice the healing art in the District of Columbia, I hereby declare that it is my intention, if issued a license, to engage in the practice of the healing art in the District of Columbia.

I understand that should I be granted a license by examination to practice the healing art in the District of Columbia, the Commission on Licensure to Practice the Healing Art in the District of Columbia will not certify my examination scores to another jurisdiction unless and until I have engaged in the practice of the healing art in the District of Columbia for at least six months subsequent to the issuance of my District of Columbia license.

[signature] Signature of Applicant

20 May 83 Date

5. Have you ever taken an examination in the basic sciences or any examination in the healing art under the authority of the Commission on Licensure to Practice the Healing Art in the District of Columbia? ☐ Yes ☒ No
If the answer is yes, give date and type of examination.

Government of the District of Columbia

Alexander, Harold O.

Department of Health
Health Professionals
Licensing Administration

★ ★ ★

D.C. Board of Medicine Physician Profile

Please correct and initial any provided information that is inaccurate by drawing a line through the incorrect item and printing in ink the correction above or next to the incorrect item. Please type or print (legibly) any information that is not provided.

☐ **Please check this box if you are interested in volunteering for medical response during a bioterrorism event or any other public health emergency (Optional).**

DEC 4 2006

1. General Information:

1979
Initial License Date

12/31/06
License Expiration Date

MD14315

Maiden Name *(Optional)*: _____

Include maiden name in profile? *(Check one)* ☐ Yes ☐ No

NOTE: The information prepopulated above cannot be changed by the practitioner. If you have a name change, notify the Board in writing and include legal documentation that supports the change.

2. Emergency Contact Information:

Web Site *(Optional)*: _____

Include website address in profile? *(Check one)* ☐ Yes ☐ No

E-mail Address *(Optional)*: _____

Include email address in profile? *(Check one)* ☐ Yes ☐ No

NOTE: Please provide a non-emergency e-mail address if you wish to communicate with the Board of Medicine electronically in the future.

Fax Number: 301-336-5894

☐ Check this box if you do not have a fax number.

Security Verification *(Optional)*: _____

NOTE: If you provided a non-emergency e-mail address above, for verification purpose, please provide mother maiden name. This will facilitate electronic retrieval of a forgotten password in the future.

Mother's maiden name: _____

3. Address of Record:

(Used to receive license renewals, notifications, and orders)

11501 William Beanes Rd. Upper Marlboro MD 20772

1/16/07 C

4. Do you have primary Practice Address? ☒ Yes ☐ No

Practice Name *(Optional)*
Address *(Line 1)* 7306 Central Ave #1
Address *(Line 2)*
City Capitol Hgts
State MD
Zip code 20743
Telephone (301) 350-5454

% Time spent at this location 100 %
Translating Services available? *(check one)* ☐ Yes ☒ No

If yes, please check type (s) of translating services that are available:
☐ Hearing impaired ☐ Non-English languages spoken

Non-English Languages Spoken *(attach additional sheets if necessary)*.
Spanish

Non-English Languages Spoken by Practitioner. *(attach additional sheets if necessary)*.
Spanish

Days patients seen at this location (i.e. M-W-,F) *(Optional)* 5

5. Do you have an Additional Practice Address? ☐ Yes ☒ No
(attach additional sheets if necessary)

Practice Name *(Optional)*
Address *(Line 1)*
Address *(Line 2)*
City
State
Zip code
Telephone ( )

% Time spent at this location %
Translating Services available? *(check one)* ☐ Yes ☐ No

If yes, please check type (s) of translating services that are available:
☐ Hearing impaired ☐ Non-English languages spoken

Non-English Languages Spoken *(attach additional sheets if necessary).*

_____ _____ _____ _____ _____ _____

Non-English Languages Spoken by Practitioner *(attach additional sheets if necessary).*

_____ _____ _____ _____ _____ _____

Days patients seen at this location M-W, F):*(Optional)* _____

6. Education: Please select the U.S. or Canadian school **Osteopathic,** attended *(attach additional sheets if necessary).*

U.S. or Canadian School Attended Howard U. College of Medicine
U.S. or Canadian School Year of completion _____

If you attended a **non-U.S.** (and territories) **non-Canadian** school, please enter the name of the school below:

Non-U.S. School Attended _____
Non-U.S. Year of completion Non-U.S. State or Province _____
Non-U.S. Country _____

7. Post Graduate: Please indicate the name of the postgraduate medical or osteopathic education program attended (attach additional sheets if necessary):

Specialty OB/Gyn
Program Name Prince Georges Hosp. Ctr.
City Cheverly State/Province MD Country US
Years Attended _____
☒ Internship ☒ Residency ☐ Fellowship

Specialty OB/Gyn
Program Name Providence Hosp.
City Wash State/Province DC Country US
Years Attended _____
☐ Internship ☒ Residency ☐ Fellowship

Specialty _____
Program Name _____
City _____ State/Province _____ Country _____
Years Attended _____
☐ Internship ☐ Residency ☐ Fellowship

8. Board Certification: Are you currently Board certified or sub-certified as approved by American Board of Medical Specialties or the Bureau of Osteopathic Specialists of the American Osteopathic Association? ☒ Yes ☐ No

If yes, please indicate the initial year of certification/ certification, and the year of expiration *(attach additional sheets if necessary).*

Year of Certification 1986 Year of Expiration 2007

Year of Certification _____ Year of Expiration _____

Year of Certification _____ Year of Expiration _____

9. Self-Designated Practice Area: Please indicate designated areas of practice (attach additional sheets if necessary):

OB/Gyn _____ _____

10. Active/Clinical Practice: Please indicate total number of years in practice following completion of graduate medical, osteopathic, or education:

Number of years in active/clinical practice inside U.S./Canada Territories: 25

Number of years in active/clinical practice outside U.S./Canada Territories: _____

11. Medicaid:

Do you participate in District of Columbia Medicaid program? (check one) ☒ Yes ☐ No

Are you accepting new District of Columbia Medicaid patients? (check one) ☒ Yes ☐ No

12. Medicare:

Are you a Medicare participating provider? (check one) ☒ Yes ☐ No

Are you a Medicare non-participating provider? (Optional) (check one) ☐ Yes ☒ No

Are you accepting new Medicare patients? (Optional) (check one) ☒ Yes ☐ No

13. Current District of Columbia Hospitals with Admitting Privileges:

Please indicate from all the District of Columbia hospital/facilities at which you have admitting privileges (attach additional sheets if necessary). None

_____ _____ _____

_____ _____ _____

14. Current District of Columbia Hospital Affiliations: Please indicate from any other District of Columbia hospital privileges/affiliated (attached additional sheets if necessary).

None _____ _____

_____ _____ _____

15. Current Out-of-State Hospital Affiliations: Please list the hospital name, city, and state for all hospitals privileges/affiliations in all states other than the District of Columbia (attached additional sheets if necessary).

Hospital P.G. Hosp. City Chevely State MD

Hospital _____ City _____ State _____

16. Do you wish to provide information on Insurance Plans/Managed Care Plans Accepted *(Optional)*? ☐ Yes ☒ No

If yes, please list up to 10 health insurance plans that you accept. Include the name of the insurance company and the name of the specific insurance plan or managed care plan for each entry(e.g., Blue Cross and Blue Shield"). Check the box to the right of each entry if you also are a participating provider of the plan.

	Name of Insurance or Managed Care Plan Accepted	I am a participating provider in this plan
1		☐
2		☐
3		☐
4		☐
5		☐
6		☐
7		☐
8		☐
9		☐
10		☐

Please provide a contact telephone number that consumers can call for further information on Insurance Plans that you accept: (_____)_____.

17. US/Canada Academic Appointments: Please indicate U.S./Canada Territories academic appointments *(attach additional sheets if necessary)*.

School None Years Service _____to_____
School _____ Years Service _____to_____
School _____ Years Service _____to_____

18. Non-U.S./Canada Academic Appointments: Please list non-U.S/Canada Territories academic appointments. Provide the full name and country for the school *(attach additional sheets if necessary):*

School	Country	Years of Service
None		to
		to
		to

19. Publications: Please list publications in peer-reviewed literature within the last five years (maximum) of ten articles, attach additional sheets if necessary):

Title None
Journal
Volume
Website
Date

Title
Journal
Volume
Website
Date

Title
Journal
Volume
Website
Date

Title
Journal
Volume
Website
Date

Title
Journal
Volume
Website
Date

Title
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Date _____

Title _____
Journal _____
Volume _____
Website _____
Date _____

Title _____
Journal _____
Volume _____
Website _____
Date _____

Title _____
Journal _____
Volume _____
Website _____
Date _____

20. Honors/Awards *(Optional)*: If you wish to provide information on honors or awards received, please indicate in the space provided. You may also use this section to include board certifications that are not listed in the Board Certification section (attach additional sheets if necessary).

Name of Honor/Award _____
Received From _____
Year Received _____

Name of Honor/Award _____
Received From _____
Year Received _____

21. District of Columbia Board of Medicine Notices and Orders:

Have you been the subject of a District of Columbia Board of Medicine Public Order.

Yes:_____ No: X

22. Actions 1: You are required to report the following actions:

- Final orders of any regulatory board of another jurisdiction that result in the denial, probation, revocation, suspension, or restriction of any license;

- Final orders of any health regulatory board of another jurisdiction that result in reprimand or censure;
- Voluntary surrender of a license while under investigation in a state other than District of Columbia;
- Any disciplinary action taken by a federal health institution or federal agency.

Do you have any reportable actions? (check one) ☐ Yes ☒ No

NOTE: If yes, please complete the sections below (attach additional sheets if necessary):

Date of Action: _____

Entity Taking action: _____

Action Taken: _____

Date of Action: _____

Entity Taking action: _____

Action Taken: _____

23. Actions 2: Have you ever had any action taken by healthcare institutions, other practitioners, insurance companies, health maintenance organizations or professional organizations that resulted in a suspension or revocation of privileges or the of employment? *(check one)* ☐ Yes ☒ No

NOTE: If yes, please complete the sections below *(attach additional sheets if necessary):*

Date of Action: _____

Entity Taking action: _____

Action Taken: _____

Date of Action: _____

Entity Taking action: _____

Action Taken: _____

24. Paid Claims: You are required to provide a complete listing of all paid claims for the last ten years. This should include paid claims not only in the District of Columbia, but in other states and countries as well. Print the city, use the two letter state abbreviation, and print the country if non-U.S. For each paid claim, you may submit a brief description of the case for consumers to view. The presentation of this text will be limited to 300 characters on the web site. Please provide this text on an additional sheet of paper.

Payment Year: 2002
Total US Dollar Amount: 335,000 –
Code for the Specialty at the time of paid claim: P.G. County, MD
City/State and/or Country OB
Settlement: 335,000 – Judgment: _____

Payment Year: _____
Total US Dollar Amount: _____
Code for the Specialty at the time of paid claim: _____
City/State and/or Country _____
Settlement: _____ Judgment: _____

Payment Year: _____
Total US Dollar Amount: _____
Code for the Specialty at the time of paid claim: _____
City/State and/or Country _____
Settlement: _____ Judgment: _____

25. Felony Conviction Information: Have you ever been convicted in a court of law of committing a felony? *(check one)*

☐ Yes
☒ No

NOTE: If yes, please complete all of the sections below (attach additional sheets).

Date of conviction MM/DD/YYYY __/__/____

Were you convicted in the U.S. of a federal or state offense? *(check one)*

1. ☐ Federal State:
2. ☐ State - ***specify which state:*** _____
3. ☐ No-I was convicted of an offense in a non-U.S. country

Please specify U.S. state or federal code section (alpha numeric designation) that defines offense committed (do not complete if offense was committed in non-U.S. country): _____

Please provide a written description of the type of offense that was committed:

_____
_____
_____
_____

Please specify the jurisdiction where conviction occurred:
City/State and/or Country (if non-U.S.): _____

Type of sentence received (check only one):

1) Incarceration followed by probation ☐
2) Incarceration without probation ☐
3) Active supervised probation only ☐
4) Active unsupervised probation only ☐

Date of sentencing MM/DD/YYYY __/__/____

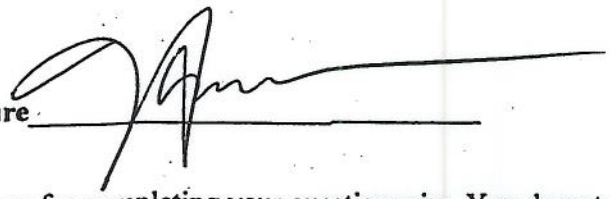
Length of sentence:

1. Suspended sentence: Number of years_____ Number of months_____
2. Sentence served: Number of years_____ Number of Months_____

Attestation:

I certify that the information provided in this questionnaire is true, complete, and accurate to the best of my knowledge. I further understand that providing incomplete or false information may constitute unprofessional conduct and may subject me to disciplinary action by the District of Columbia Board of Medicine.

District Of Columbia Board of Medicine Regulation **17 DCMR 4609** requires that I update my information within thirty days of a change.

Signature  **Date** 11/18/06

Thank you for completing your questionnaire. You do not need to return the Code Lists, By regulation, your information must be received by the Board within 30 days from the date of the initial request. Earlier submission will expedite the Practitioner Information Collection process and would be most appreciated.

Please mail your completed and signed questionnaire to:

District of Columbia Board of Medicine Practitioner Information

717 14th St. NW., Suite 600
Washington, DC 20005
If you have any questions, please call at:
(202) 724-4900

To view or edit your public profile online, visit the consumer website:

www.hpla.doh.dc.gov

Harold O. Alexander, M.D.

1/21/09

To whom it may concern:

This letter is intended as notification that since I no longer anticipate practicing in the District of Columbia, I will no longer maintain a license in that jurisdiction (MD 14315)

Thank you,

Harold O. Alexander, M.D

Dept of Health
Professional Licensing Admin.
Board of Medicine

(202)-442-4380 1/29
still unable to contact

RYLAND 20743 TELEPHONE (301) 350-5454