APPS. ETC

FOR

LOUIS THOMASON PAYNE

APPLICATION TO STATE LICENSING BOARD FOR THE HEALING ARTS
FOR LICENSE TO PRACTICE

Name in full (print) Louis Thomason Payne, M.D.

Business address 813 So. 15th St.

City Birm. County Ala.

Branch of Healing Arts you are to practice Obstetrics & Gynecology

$10.00 Fee attached.

Date July 23 1965 Signed Louis T. Payne, M.D.

№ M 3118.

STATE LICENSING BOARD FOR THE HEALING ARTS

MONTGOMERY, ALABAMA

Every person licensed to practice any branch of the Healing Arts in the State of Alabama shall on or before the 31st day of December of each year apply to this Board for a certificate of registration which shall be effective during the next calendar year. The $5.00 fee must accompany this application. If licensed after July 1st, pay only $2.50 for remainder of that year.

When any licensee shall fail to register and pay the above fee within thirty (30) days after registration becomes due, as provided in Title 46, Section 257 (11) Code of Alabama, the license of such person shall be automatically revoked without further notice or hearing.

APPLICATION FOR CERTIFICATE OF REGISTRATION

Name and Business Address: Louis Thomason Payne, M. D. Date
~~812 B. Ward 1700 Street~~
Birmingham, Alabama

License # Date issued

County Jefferson Fee $2.50

Louis T. Payne M.D.
Signature

USE REVERSE SIDE FOR CORRECTIONS ONLY

No. M 3057

STATE LICENSING BOARD FOR THE HEALING ARTS JAN 31 1980

MONTGOMERY, ALABAMA

Every person licensed to practice any branch of the Healing Arts in the State of Alabama shall on or before the 31st day of December of each year apply to this Board for a certificate of registration which shall be effective during the next calendar year. The $5.00 fee must accompany this application. If licensed after July 1st, pay only $2.50 for remainder of that year.

When any licensee shall fail to register and pay the above fee within thirty (30) days after registration becomes due, as provided in Title 46, Section 257 (11) Code of Alabama, the license of such person shall be automatically revoked without further notice or hearing.

APPLICATION FOR CERTIFICATE OF REGISTRATION

Name and Business Address

Date

License #

Date issued

County

Fee

Louis T. Payne, M.D.
Signature

USE REVERSE SIDE FOR CORRECTIONS ONLY

No. 2085 M

STATE LICENSING BOARD FOR THE HEALING ARTS

MONTGOMERY, ALABAMA

Every person licensed to practice any branch of the Healing Arts in the State of Alabama shall on or before the 31st day of December of each year apply to this Board for a certificate of registration which shall be effective during the next calendar year. The $5.00 fee must accompany this application. If licensed after July 1st, pay only $2.50 for remainder of that year.

When any licensee shall fail to register and pay the above fee within thirty (30) days after registration becomes due, as provided in Title 46, Section 257 (11) Code of Alabama, the license of such person shall be automatically revoked without further notice or hearing.

APPLICATION FOR CERTIFICATE OF REGISTRATION

Name and Business Address

Date

License

RECEIVED

Date issued

County

Fee

DEC 8 1966

Louis T. Payne, M.D.
Signature

HEALING ARTS USE REVERSE SIDE FOR CORRECTIONS ONLY

№ 2154 M

APPLICATION FOR CERTIFICATE OF REGISTRATION

STATE LICENSING BOARD FOR THE HEALING ARTS

MONTGOMERY, ALABAMA

Every person licensed to practice any branch of the Healing Arts in the State of Alabama shall on or before the 31st day of December of each year apply to this Board for a certificate of registration which shall be effective during the next calendar year. The $5.00 fee must accompany this application. If licensed after July 1st, pay only $2.50 for remainder of that year.

When any licensee shall fail to register and pay the above fee within thirty (30) days after registration becomes due, as provided in Title 46, Section 257 (11) Code of Alabama, the license of such person shall be automatically revoked without further notice or hearing.

Name and Business Address

License # **Date issued**

RECEIVED

DEC 7 1967

Fee

Louis T. Payne, M.D.

Signature

USE REVERSE SIDE FOR CORRECTIONS ONLY

HEALING ARTS BOARD

No. 2220 M

APPLICATION FOR CERTIFICATE OF REGISTRATION

STATE LICENSING BOARD FOR THE HEALING ARTS

MONTGOMERY, ALABAMA 36104

Every person licensed to practice any branch of the Healing Arts in the State of Alabama shall on or before the 31st day of December of each year apply to this Board for a certificate of registration which shall be effective during the next calendar year. The $5.00 fee must accompany this application. If licensed after July 1st, pay only $2.50 for remainder of that year.

When any licensee shall fail to register and pay the above fee within thirty (30) days after registration becomes due, as provided in Title 46, Section 257 (11) Code of Alabama, the license of such person shall be automatically revoked without further notice or hearing.

Name and Business Address [redacted] P C

License # [redacted] Date issued 8/31/65

County [redacted] Fee $5.00

RECEIVED

Louis T. Payne, M.D.
Signature

NOV 15 1968

USE REVERSE SIDE FOR CORRECTIONS ONLY

HEALING ARTS BOARD

№ 2298 M

APPLICATION FOR CERTIFICATE OF REGISTRATION

STATE LICENSING BOARD FOR THE HEALING ARTS

MONTGOMERY, ALABAMA 36104

Every person licensed to practice any branch of the Healing Arts in the State of Alabama shall on or before the 31st day of December of each year apply to this Board for a certificate of registration which shall be effective during the next calendar year. The $5.00 fee must accompany this application. If licensed after July 1st, pay only $2.50 for remainder of that year.

When any licensee shall fail to register and pay the above fee within thirty (30) days after registration becomes due, as provided in Title 46, Section 257 (11) Code of Alabama, the license of such person shall be automatically revoked without further notice or hearing.

Name and Business Address _____

License # _____ Date issued _____

County _____ Fee _____

Louis T. Payne M.D.
Signature

NOV 1 8 1969

USE REVERSE SIDE FOR CORRECTIONS ONLY

No. 2382 M

APPLICATION FOR CERTIFICATE OF REGISTRATION

STATE LICENSING BOARD FOR THE HEALING ARTS

Room 209—Public Safety Building
MONTGOMERY, ALABAMA 36104

Every person licensed to practice any branch of the Healing Arts in the State of Alabama shall on or before the 31st day of December of each year apply to this Board for a certificate of registration which shall be effective during the next calendar year. The $5.00 fee must accompany this application. If licensed after July 1st, pay only $2.50 for remainder of that year.

When any licensee shall fail to register and pay the above fee within thirty (30) days after registration becomes due, as provided in Title 46, Section 257 (11) Code of Alabama, the license of such person shall be automatically revoked without further notice or hearing.

Name and
Business
Address

License # Date issued

County Fee

Louis T. Pope, M.D.
Signature

USE REVERSE SIDE FOR CORRECTIONS ONLY

NOV 18 1970

№ 2528 M

APPLICATION FOR CERTIFICATE OF REGISTRATION FOR 1972

STATE LICENSING BOARD FOR THE HEALING ARTS

Room 209—Public Safety Building
MONTGOMERY, ALABAMA 36104

Every person licensed to practice any branch of the Healing Arts in the State of Alabama shall on or before the 31st day of December of each year apply to this Board for a certificate of registration which shall be effective during the next calendar year. The $10.00 fee must accompany this application. If licensed after July 1st, pay only $5.00 for remainder of that year.

When any licensee shall fail to register and pay the above fee within thirty (30) days after registration becomes due, as provided in Title 46, Section 257 (11) Code of Alabama, the license of such person shall be automatically revoked without further notice or hearing.

Name and Business Address: Louis Thaddeus Payne, M. D.
[illegible] 35401

License # 2528 Date issued 12/3/65

County [illegible] Fee $30.00

NOV 16 1971

Louis T. Payne, M.D.
Signature

USE REVERSE SIDE FOR CORRECTIONS ONLY

№ 2637 M

APPLICATION FOR CERTIFICATE OF REGISTRATION FOR 1973

STATE LICENSING BOARD FOR THE HEALING ARTS

Public Safety Building
MONTGOMERY, ALABAMA 36104

Every person licensed to practice any branch of the Healing Arts in the State of Alabama shall on or before the 31st day of December of each year apply to this Board for a certificate of registration which shall be effective during the next calendar year. The $10.00 fee must accompany this application. If licensed after July 1st, pay only $5.00 for remainder of that year

In order to avoid paying a $20.00 penalty this fee must be received by January 31st.

Name and Business Address: [illegible]

License #: [illegible] Date issued: [illegible]

County: [illegible] Fee: [illegible]

Signature

USE REVERSE SIDE FOR CORRECTIONS ONLY

DEC 13 1972

Nº 2750 M

APPLICATION FOR CERTIFICATE OF REGISTRATION FOR 1974

STATE LICENSING BOARD FOR THE HEALING ARTS

Public Safety Building
MONTGOMERY, ALABAMA 36104

Every person licensed to practice any branch of the Healing Arts in the State of Alabama shall on or before the 31st day of December of each year apply to this Board for a certificate of registration which shall be effective during the next calendar year. The $10.00 fee must accompany this application. If licensed after July 1st, pay only $5.00 for remainder of that year

In order to avoid paying a $20.00 penalty this fee must be received by January 31st.

Name and Business Address

License # Date issued

County Fee

Signature

USE REVERSE SIDE FOR CORRECTIONS ONLY

OCT 16 1973

No 2884 M

APPLICATION FOR CERTIFICATE OF REGISTRATION FOR 1975

STATE LICENSING BOARD FOR THE HEALING ARTS

Public Safety Building
MONTGOMERY, ALABAMA 36104

Every person licensed to practice any branch of the Healing Arts in the State of Alabama shall on or before the 31st day of December of each year apply to this Board for a certificate of registration which shall be effective during the next calendar year. The $10.00 fee must accompany this application. If licensed after July 1st, pay only $5.00 for remainder of that year

In order to avoid paying a $20.00 penalty this fee must be received by January 31st.

Name and Business Address

License # Date issued

County Fee

Signature

USE REVERSE SIDE FOR CORRECTIONS ONLY

NOV 21 1974

No. 3040 M

APPLICATION

FOR CERTIFICATE OF REGISTRATION FOR 1976

STATE LICENSING BOARD FOR THE HEALING ARTS

Public Safety Building

MONTGOMERY, ALABAMA 36130

Every person licensed to practice any branch of the Healing Arts in the State of Alabama shall on or before the 31st day of December of each year apply to this Board for a certificate of registration which shall be effective during the next calendar year. The $10.00 fee must accompany this application. If licensed after July 1st, pay only $5.00 for remainder of that year.

In order to avoid paying a $20.00 penalty this fee must be received by January 31st.

Name and Business Address

License # 3535 Date issued 8/15/55 PC

County Tuscaloosa Fee

OCT 31 1975

Signature

FOR CHANGE OF ADDRESS ONLY

№ 3498 M

APPLICATION

FOR CERTIFICATE OF REGISTRATION FOR 1977

STATE LICENSING BOARD FOR THE HEALING ARTS

Public Safety Building
MONTGOMERY, ALABAMA 36130

Every person licensed to practice any branch of the Healing Arts in the State of Alabama shall on or before the 31st day of December of each year, apply to this Board for a certificate of registration which shall be effective during the next calendar year. The $10.00 fee must accompany this application. If licensed after July 1st, pay only $5.00 for remainder of that year

In order to avoid paying a $20.00 penalty this fee must be received by January 31st.

Name and Business Address: Louis Thompson Payne, M. D.
100 B Jack Hale Circle
Tuscaloosa, Alabama 35401

License # 3505

Date issued 8/5/05

County Tuscaloosa

Fee $ 10.00

NOV 29 1976

Louis T. Payne
Signature

FOR CHANGE OF ADDRESS ONLY

THIS IS THE ONLY NOTICE YOU WILL RECEIVE.

No 3716 M

APPLICATION

FOR CERTIFICATE OF REGISTRATION FOR 1978

STATE LICENSING BOARD FOR THE HEALING ARTS

Public Safety Building
MONTGOMERY, ALABAMA 36130

Every person licensed to practice any branch of the Healing Arts in the State of Alabama shall on or before the 31st day of December of each year apply to this Board for a certificate of registration which shall be effective during the next calendar year. The $10.00 fee must accompany this application. If licensed after July 1st, pay only $5.00 for remainder of that year.

If not paid by January 31st you must pay an additional $20.00 penalty for reinstatement of your license.

Name and Business Address [redacted] 1788 McFarland Blvd. North Tuscaloosa, Ala.

License # [redacted] Date issued [redacted]

County [redacted] Fee [redacted]

DEC 7 1977

Signature

FOR CHANGE OF ADDRESS ONLY

Effective Nov. 5, 1977
1788 McFarland Blvd. No.
Tuscaloosa, Al. 35401

THIS IS THE ONLY NOTICE
YOU WILL RECEIVE.

No. 3727 M

RENEWAL
APPLICATION
FOR CERTIFICATE OF REGISTRATION FOR 1979

STATE LICENSING BOARD FOR THE HEALING ARTS

Public Safety Building
MONTGOMERY, ALABAMA 36130

Every person licensed to practice any branch of the Healing Arts in the State of Alabama shall on or before the 31st day of December of each year apply to this Board for a certificate of registration which shall be effective during the next calendar year. The $10.00 fee must accompany this application.

If not paid by January 31st you must pay an additional $20.00 penalty for reinstatement of your license.

Name and Business Address: [illegible] M. D. [illegible] Boulevard, [illegible] Alabama 35401

License $ [illegible] Date issued 8/5/[illegible]

County [illegible] Fee [illegible]

345 2110

Signature

DEC 14 1978

FOR CHANGE OF ADDRESS ONLY

RENEWAL APPLICATION NO. 4240 M

FOR A CERTIFICATE OF REGISTRATION TO PRACTICE MEDICINE IN ALABAMA IN 1980.

STATE LICENSING BOARD FOR THE HEALING ARTS

Public Safety Building
Montgomery, Alabama 36130
Phone 205/832-5051

NOV 19 1979

Every person licensed to practice any branch of the Healing Arts in the State of Alabama shall on or before the 31st day of December of each year apply to this Board for a Certificate of Registration which shall be effective during the calendar year.
RENEWAL FEE $10.00 ... IF NOT RECEIVED BY JANUARY 31st, A PENALTY OF $20.00 PLUS THE $10.00 RENEWAL FEE WILL BE CHARGED. RETURN ENTIRE FORM WITH FEE.

Name and Mailing Address:

LOUIS T PAYNE
1788 MCFARLAND BLVD NORTH
TUSCALOOSA, AL 35406

PC 10/19/79 ck

Business Address:

1788 MCFARLAND BLVD NORTH
TUSCALOOSA, AL 35406

LICENSE #: 0003505 ISSUED: 08/05/65

345-2110

☐ The above addresses are correct.

RENEWAL APPLICATION

NO. 4428 M

FOR A CERTIFICATE OF REGISTRATION TO PRACTICE MEDICINE IN ALABAMA IN 1981.

STATE LICENSING BOARD FOR THE HEALING ARTS
908 S. Hull Street, Room 110
Montgomery, Alabama 36130
Phone 205/832-5051

OCT 8 1980

Every person licensed to practice any branch of the Healing Arts in the State of Alabama shall on or before the 31st day of December of each year apply to this Board for a Certificate of Registration which shall be effective during the calendar year.

RENEWAL FEE $10.00 ... IF NOT RECEIVED BY JANUARY 31st, A PENALTY OF $20.00 PLUS THE $10.00 RENEWAL FEE WILL BE CHARGED. RETURN ENTIRE FORM WITH FEE.

Name and Mailing Address:

Louis Thomason Payne, M. D.
1788 McFarland Boulevard, North
Tuscaloosa, Alabama 35406

Business Address:

1788 MCFARLAND BLVD NORTH
TUSCALOOSA, AL 35406

3505 8/5/65

Tuscaloosa $ 10.00

☑ The above Addresses are correct. 345-2110

RENEWAL APPLICATION

FOR A CERTIFICATE OF REGISTRATION TO PRACTICE MEDICINE IN ALABAMA IN 1982.

ALABAMA MEDICAL LICENSURE COMMISSION
906 South Hull Street, Room 110
Montgomery, Alabama 36104
Phone 205/832-5051

Every physician and osteopath licensed to practice medicine/osteopathy in the State of Alabama shall, on or before the 31st day of December of each year, apply to this Commission for a Certificate of Registration which shall be effective during the calendar year.

RENEWAL FEE $50.00 — Failure to register and pay the annual registration fee within 30 days after registration becomes due will result in the automatic revocation of the current license without further notice or hearing as provided in Act. No. 81-218, Code of Alabama, Section 12.

Name and Mailing Address:

LOUIS T PAYNE
1788 MCFARLAND BLVD NORTH
TUSCALOOSA, AL 35406

LICENSE #: 0003505 ISSUED: 08/05/65

Business Address:

1788 MCFARLAND BLVD NORTH
TUSCALOOSA, AL 35406

☐ The above Addresses are correct.

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

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

IF YOU ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, PLEASE INCLUDE A DETAILED EXPLANATION WITH YOUR APPLICATION

I CERTIFY THAT ALL INFORMATION ON THIS FORM IS CORRECT Louis T. Payne MD 10/20/06

Signature Date

- Complete Both Sides, Including Signature
- Correct or Supply All Information
- Incomplete Application will be Returned
- Return with $200 renewal fee to:

MEDICAL LICENSURE COMMISSION
P.O. BOX 887
MONTGOMERY, AL 36101-0887

Have you engaged in the illegal use of controlled dangerous substances within the past twelve months?

no

If yes, please explain:

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

n/a

If yes, please explain:

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

no

If yes, please explain:

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

no

If yes, please explain:

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

Primary specialty:

Gynecology (OB/GYN)

Are you Board certified in your primary specialty?

Y

Secondary specialty:

Are you Board certified in your secondary specialty?

Y

Practice Type:

Jan 5, 2012 3:04 PM

S

If Group, provide the Group Name:
West Alabama Women's Center Inc.

Primary Hospital where you have privileges: (if any)

Hospital Name:
Druid City Regional Medical Center

Hospital City:
Tuscaloosa

Hospital State:
AL

Are you licensed in another State:
N

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

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

(**indicate state if not in Alabama)

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

Jan 5, 2012 3:04 PM

Other County1

Other State1

Other County 2

Other State 2

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

N

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

N

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

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

N

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

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

CME Certification: I hereby certify that I have met the annual minimum continuing education requirement of 12 hours of Category I continuing medical education for the calendar year 2009 and have supporting documentation if audited.

Y

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

Exempt Reason

Practice Telephone:

(205) 556-2026

Practice Address:

535 Jack Warner Parkway

Jan 5, 2012 3:04 PM

Home Telephone:
(205) 345-4288

Home Address:
57 The Downs

Public Address:
TRUE

Mail Address:
TRUE

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

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

2011 Online Renewal Summary

Name: **Louis Thomason Payne**

License Number: **MD.3505**

Transaction Date: **2010-11-09***

Transaction Number: **VLEF6BF3A109**

Registration Fee: **300**

Date of Birth: **1939-04-20**

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

What is your Practice Address? (No PO Boxes)

Street
535 Jack Warner Parkway

Apt/Suite
Suite 1

City
Tuscaloosa

State
Alabama

Zip
35404-5715

County (If not in Alabama Choose 'Out of State'
Tuscaloosa

Country
Jan 5, 2012 3:04 PM

United States

What is your practice Email?
docglo@aol.com

What is your practice Telephone?
(205) 556-2026

What is your practice Fax?
(205) 554-0584

What is your Home Address? (No PO Boxes)

Street
57 The Downs

City
Tuscaloosa

State
Alabama

Zip
35401-5843

County (If not in Alabama Choose 'Out of State'
Tuscaloosa

Country
United States

What is your Home Email?
docglo@aol.com

What is your Home Phone?
(205) 345-4288

Please choose which address you would like to be your MAILING ADDRESS. The mailing address will be the address that the Board and Commission will use to mail all communications to the Licensee. (Examples: Renewal Certificates, Renewal Notices, Important Notices from the Board or Commission, etc) IMPORTANT NOTE: By law you are required to notify the Board and the Commission of change in address within 15 days of that change. Change of Address can be submitted using the Change of Address form found on the www.albme.org website.
Practice

Jan 5, 2012 3:04 PM

Please choose which address you would like to be your PUBLIC ADDRESS. The public address will be the address given out if an address is requested. IMPORTANT NOTE: If a valid public address is not provided then the mailing address will be given out instead of the public address. By law you are required to notify the Board and the Commission of change in address within 15 days of that change. Change of Address can be submitted using the Change of Address form found on the www.albme.org website.

Practice

Social Security Number

416-50-6306

What is your Primary Specialty? (If None Please Choose None)

Gynecology (OB/GYN)

Is your Primary Specialty Board Certified?

Yes

What is your Secondary Specialty? (If None Please Choose None)

Unknown

Is your Secondary Specialty Board Certified?

No

Form of Practice: Resident, Intern, Fellowship, Solo, Partnership (2, 3, or 4,) Group

Solo

What is the name of the Primary Hospital where you have staff privileges?

Druid City Regional Medical Center

What City is the Primary Hospital where you have staff privileges located?

Tuscaloosa

What State is the Primary Hospital where you have staff privileges located?

Alabama

Are you licensed in another state?

No

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

Yes

What is your principal county of practice? (If principal county is not in Alabama choose Out of State)

Tuscaloosa

Other counties of practice? Type "None" if you only practice in the indicated principal county.

None

Jan 5, 2012 3:04 PM

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

No

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

No

Primary Care Information - Primary care is defined as: Basic or general health care focused on the point at which a patient ideally first seeks assistance from the medical care system, exclusive of an emergency situation.

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

No

CME Certification: (Select One)

I hereby certify that I have met the annual minimum continuing education requirement of 25 hours of AMA PRA Category I Credits™ or equivalent continuing medical education for the calendar year 2010 and have supporting documentation if audited.

Please answer the following questions.

Have you been charged with any offense (felony/misdemeanor) within the past year?

No

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

No

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

No

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

No

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

No

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

No

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

No

Jan 5, 2012 3:04 PM

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

No

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

No

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

No

Have you engaged in the illegal use of controlled dangerous substances with the past twelve months?

No

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

No

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

No

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

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

Jan 5, 2012 3:04 PM

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

2012 Online Renewal Summary

Name: **Louis Thomason Payne**

License Number: **MD.3505**

Transaction Date: **2011-10-26***

Transaction Number: **VXYA7F700579**

Registration Fee: **300**

Date of Birth: **1939-04-20**

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

What is your Practice Address? (No PO Boxes)

Street
535 Jack Warner Parkway

Apt/Suite
Suite I

City
Tuscaloosa

State
Alabama

Zip
35404-5715

County (If not in Alabama Choose 'Out of State'
Tuscaloosa

Country

Jan 5, 2012 3:04 PM

United States

What is your practice Email?
docglo@aol.com

What is your practice Telephone?
(205) 556-2026

What is your practice Fax?
(205) 554-0584

What is your Home Address? (No PO Boxes)

Street
57 The Downs

City
Tuscaloosa

State
Alabama

Zip
35401-5843

County (If not in Alabama Choose 'Out of State'
Tuscaloosa

Country
United States

What is your Home Email?
docglo@aol.com

What is your Home Phone?
(205) 345-4288

Please choose which address you would like to be your MAILING ADDRESS. The mailing address will be the address that the Board and Commission will use to mail all communications to the Licensee. (Examples: Renewal Certificates, Renewal Notices, Important Notices from the Board or Commission, etc) IMPORTANT NOTE: By law you are required to notify the Board and the Commission of change in address within 15 days of that change. Change of Address can be submitted using the Change of Address form found on the www.albme.org website.
Practice

Jan 5, 2012 3:04 PM

Please choose which address you would like to be your PUBLIC ADDRESS. The public address will be the address given out if an address is requested. IMPORTANT NOTE: If a valid public address is not provided then the mailing address will be given out instead of the public address. By law you are required to notify the Board and the Commission of change in address within 15 days of that change. Change of Address can be submitted using the Change of Address form found on the www.albme.org website.

Practice

Social Security Number

416-50-6306

What is your Primary Specialty? (If None Please Choose None)

Gynecology (OB/GYN)

Is your Primary Specialty Board Certified?

Yes

What is your Secondary Specialty? (If None Please Choose None)

Unknown

Is your Secondary Specialty Board Certified?

No

Form of Practice: Resident, Intern, Fellowship, Solo, Partnership (2, 3, or 4,) Group

Solo

What is the name of the Primary Hospital where you have staff privileges?

Druid City Regional Medical Center

What City is the Primary Hospital where you have staff privileges located?

Tuscaloosa

What State is the Primary Hospital where you have staff privileges located?

Alabama

Are you licensed in another state?

No

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

Yes

What is your principal county of practice? (If principal county is not in Alabama choose Out of State)

Tuscaloosa

Other counties of practice? Type "None" if you only practice in the indicated principal county.

None

Jan 5, 2012 3:04 PM

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

No

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

No

Primary Care Information - Primary care is defined as: Basic or general health care focused on the point at which a patient ideally first seeks assistance from the medical care system, exclusive of an emergency situation.

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

No

CME Certification: (Select One)

I hereby certify that I have met the annual minimum continuing education requirement of 25 hours of AMA PRA Category I Credits™ or equivalent continuing medical education for the calendar year 2011 and have supporting documentation if audited.

If you choose I have obtained a retirement waiver or a medical waiver the waiver MUST ALREADY be on file in our office.

Please answer the following questions.

Have you been charged with any offense (felony/misdemeanor) within the past year?

No

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

No

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

No

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

No

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

No

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

No

Jan 5, 2012 3:04 PM

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

No

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

No

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

No

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

No

Have you engaged in the illegal use of controlled dangerous substances with the past twelve months?

No

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

No

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

No

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

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

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

2003 Online Renewal Summary

Name: **Louis Thomason Payne**

License Number: **MD.3505**

Transaction Date: **2002-10-22***

Transaction Number: **null**

Registration Fee: **200**

Date of Birth: **1939-04-20**

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

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

N

If yes, please explain:

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

N

If yes, please explain:

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

N

If yes, please explain:

Jan 5, 2012 3:04 PM

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

N

If yes, please explain:

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

N

If yes, please explain:

To your knowledge, are you the subject of an investigation by any licensing Board/Agency as of the date of this application within the past year?

N

If yes, please explain:

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

N

If yes, please explain:

Do you currently* have any mental or physical condition or impairment (including, but not limited to, substance abuse, alcohol abuse, or mental, emotional or nervous disorder or condition) which in any way currently affects, or if untreated could affect, your ability to practice in a competent and professional manner?

N

If yes, please explain:

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

N

If yes, please explain:

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

N

Jan 5, 2012 3:04 PM

If yes, please explain:

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

N

If yes, please explain:

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

N

If yes, please explain:

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

N

If yes, please explain:

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

N

If yes, please explain:

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

Primary specialty:

Are you Board certified in your primary specialty?

Y

Secondary specialty:

Are you Board certified in your secondary specialty?

N

Jan 5, 2012 3:04 PM

Practice Type:

Primary Hospital where you have privileges:

Are you licensed in another State:
N

Primary Care Information:

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

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

Approximately how many hours per week do you practice the above-defined primary care services in Alabama? Only answer if you answered YES to questions 1 and 2 above.
0

CME Certification: I hereby certify that I have met the annual minimum continuing education requirement of 24 hours of Category I continuing medical education within the past two Calendar Years ending December 31, 2003.
Y

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

Jan 5, 2012 3:04 PM

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

Practice Telephone:
2055562026

Practice Address:
535 JACK WARNER PKWY

Jan 5, 2012 3:04 PM

RENEW ONLINE AT http://renewal.albme.org **Registration ID: 181855**

License Renewal for 2004
Deadline is December 31, 2003

State of Alabama
Medical Licensure Commission

334/242-4153

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

LOUIS THOMASON PAYNE , M.D.
535 JACK WARNER PKWY
SUITE 1
TUSCALOOSA, AL 35404-5715

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

Please make corrections or supply information: License: **MD . 00003505** Date-Issued: 08/05/1965 Sex: M [X] F [ ]

Race: White [X] Black [ ] American Indian [ ] Oriental or Asian [ ] Other [ ] Social Security# 416-50-6306

Office Address

535 JACK WARNER PKWY
SUITE 1

City, State, Zip: TUSCALOOSA, AL 35404-5715

(Alabama) County: Tuscaloosa

Business Phone: (205) 556-2026

Fax Number: (205) 554-0584

Home Address

57 THE DOWNS

City, State, Zip: TUSCALOOSA, AL 35401-5843

(Alabama) County: Tuscaloosa

Home Phone: (205) 345-4288 (Will not be published)

Permission to publish in Roster: Yes [X]

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

Specialty: Primary: GYNECOLOGY (Ob/Gyn)
Secondary:

Board Certified: Yes [✓] No [ ]

Board Certified: Yes [✓] No [ ]

Form of Practice: [✓] Solo [ ] Partnership (2, 3, or 4) [ ] Group If Group give Group Name below:

Primary Hospital where you have staff privileges:
Name: Druid City Regional Medical Center City/State: Tuscaloosa, AL

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

Primary Care Information:

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

CME Certification: (Check one)

[✓] I hereby certify that I have met the annual minimum continuing education requirement of 24 hours of Category I continuing medical education within the past two calendar years ending December 31, 2003.

[ ] I certify that I am exempt from the minimum continuing medical education requirements for the following reason:
- [ ] I do not reside in the State of Alabama and do not have a significant portion of my medical practice in Alabama.
- [ ] I received my initial license to practice medicine in Alabama after June 30th of this calendar year.
- [ ] I reinstated my license to practice medicine in the State of Alabama after June 30th of this calendar year.
- [ ] I am a resident physician enrolled in a residency training program.
- [ ] I am retired from the practice of medicine and have obtained a waiver from the Board of Medical Examiners.

DEADLINE IS DECEMBER 31, 2003

MD . 00003505 *Complete both sides including signature. Supply or correct all information.* PAYNE, LOUIS THOMASON **OVER**

RENEW ONLINE AT http://renewal.albme.org **Registration ID: 181855**

License Renewal for 2005
Deadline is December 31, 2004

State of Alabama
Medical Licensure Commission

334/242-4153

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

LOUIS THOMASON PAYNE , M.D.
535 JACK WARNER PKWY
SUITE 1
TUSCALOOSA, AL 35404-5715

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

Please make corrections or supply information: License: **MD . 00003505** Date-Issued: 08/05/1965 Sex: M [X] F [ ]

Race: White [X] Black [ ] American Indian [ ] Oriental or Asian [ ] Other [ ] Social Security# 416-50-6306

Office Address

535 JACK WARNER PKWY
SUITE 1

City, State, Zip: TUSCALOOSA, AL 35404-5715

(Alabama) County: Tuscaloosa

Business Phone: (205) 556-2026

Fax Number: (205) 554-0584

Home Address

57 THE DOWNS

City, State, Zip: TUSCALOOSA, AL 35401-5843

(Alabama) County: Tuscaloosa

Home Phone: (205) 345-4288 (Will not be published)

Permission to publish in Roster: Yes [X] Send official mail to: Business [X] Home [ ] Address (Check One)

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

Primary Hospital where you have staff privileges:
Name: Druid City Regional Medical Center City/State: Tuscaloosa,

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

Primary Care Information:

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

CME Certification: (Check one)

(a) [X] I hereby certify that I have met the annual minimum continuing education requirement of 12 hours of Category I continuing medical education for the calendar year 2004.

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

[ ] I do not reside in the State of Alabama and do not have a significant portion of my medical practice in the State of Alabama.
[ ] I was exempt from the CME requirement for the previous calendar year 2003 and I moved my residence to the State of Alabama during calendar year 2004.
[ ] I received my initial license to practice medicine in Alabama in the calendar year 2004.
[ ] I have obtained a retirement waiver from the Board of Medical Examiners, and I do not engage in the practice of medicine in any form.
[ ] I have obtained a waiver from the Board of Medical Examiners due to illness, disability or other hardship condition which existed in the calendar year 2004.
[ ] I am enrolled or was enrolled in a residency training program or clinical fellowship program during the calendar year 2004.

DEADLINE IS DECEMBER 31, 2004

MD . 00003505 **PAYNE, LOUIS THOMASON**

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

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

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

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

I certify that all information on this form is correct. Lori T. Rogers 10/19/04

Signature Date

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

Return with $200.00 renewal fee to:

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

SERVICE PRINTING CO. (334) 269-0058

RENEW ONLINE AT http://renewal.albme.org **Registration ID: 181855**

License Renewal for 2006
Deadline is December 31, 2005

State of Alabama
Medical Licensure Commission

334/242-4153

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

LOUIS THOMASON PAYNE , M.D.
535 JACK WARNER PKWY
SUITE 1
TUSCALOOSA, AL 35404-5715

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

Please make corrections or supply information: License: **MD . 00003505** Date-Issued: 08/05/1965 Sex: M [X] F [ ]

Race: White [X] Black [ ] American Indian [ ] Oriental or Asian [ ] Other [ ] Social Security# 416-50-6306

Office Address

535 JACK WARNER PKWY
SUITE 1

City, State, Zip: TUSCALOOSA, AL 35404-5715

(Alabama) County: Tuscaloosa

Business Phone: (205) 556-2026

Fax Number: (205) 554-0584
Permission to publish in Roster: Yes [X]

Home Address

57 THE DOWNS

City, State, Zip: TUSCALOOSA, AL 35401-5843

(Alabama) County: Tuscaloosa

Home Phone: (205) 345-4288 (Will not be published)

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

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

Primary Hospital where you have staff privileges:
Name: Druid City Regional Medical Center City/State: Tuscaloosa, Alabama

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

Primary Care Information:

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

CME Certification: (Check one)

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

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

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

DEADLINE IS DECEMBER 31, 2005

MD . 00003505 **PAYNE, LOUIS THOMASON**

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

OVER

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

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

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

I certify that all information on this form is correct. Louis T. Payne MD (Signature) 10/27/05 (Date)

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

Return with $200.00 renewal fee to:

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

SERVICE PRINTING CO. (334) 269-0058

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

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

I certify that all information on this form is correct.

Signature _____ Date 10-16-95

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

Incomplete applications will be returned.

Return with $100.00 renewal fee to:

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

License Renewal for 1997
Deadline is December 31, 1996

State of Alabama
Medical Licensure Commission

334/242-4153

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

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

LOUIS THOMASON PAYNE, M.D.
1788 MCFARLAND BLVD N
TUSCALOOSA AL 35406-2136

Please make corrections or supply information: License 3505 DATE-ISSUED: 08/05/65 Sex: M [X] F [ ]

Race: White [X] Black [ ] Am. Indian [ ] Oriental or Asian [ ] Other [ ] Social Security # 416-50-8306
Enter SSAN#

Office Address:

~~1788 MCFARLAND BLVD N~~
535 River Road, Suite I
35404

City, State, Zip: TUSCALOOSA, AL ~~35406-2199~~

(Alabama) County: Tuscaloosa

Business Phone: (205)~~346-2310~~ 556 2026

Fax Number: ~~(205)345-2115~~ 205 554 0584

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

Home Address:

57 THE DOWNS

City, State, Zip: TUSCALOOSA, AL 35401 5843

(Alabama) County: Tuscaloosa

Home Phone: (205)345-4288
(Will not be published)

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

Speciality: Primary: ~~OBSTETRICS~~ & GYNECOLOGY

Board Certified: Yes [✓] No [ ]

Secondary: _____

Board Certified: Yes [ ] No [ ]

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

~~OB-GYN ASSOCIATES OF TUSCALOOSA~~ West Alabama Women's Center, INC.

Primary Hospital where you have staff privileges:

Name: DCH REGIONAL MED CTR City/State: TUSCALOOSA, AL

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

CME Certification: (Check one)

[✓] I hereby certify that I have met the annual minimum continuing education requirement of 12 hours of Category I continuing medical education during the calendar year ending December 31, 1996.

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

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

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

DEADLINE IS DECEMBER 31, 1996

License Renewal for 1998
Deadline is December 31, 1997

State of Alabama
Medical Licensure Commission

334/242-4153

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

**********5-DIGIT 35404
LOUIS THOMASON PAYNE , M.D.
STE I
535 RIVER RD NE
TUSCALOOSA, AL 35404-5715

17
73
4952

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

Please make corrections or supply information: License 3505 DATE-ISSUED: 8/5/65 Sex: M [X] F [_]
Race: White [X] Black [_] Am. Indian [_] Oriental or Asian [_] Other [_] Social Security # 416-50-6306

Office Address:
STE I
535 RIVER RD
City, State, Zip: TUSCALOOSA, AL 35404
(Alabama) County: Tuscaloosa
Business Phone: (205)556-2026
Fax Number: (205)554-0584

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

Home Address:
57 THE DOWNS
City, State, Zip: TUSCALOOSA, AL 35401 5843
(Alabama) County: Tuscaloosa
Home Phone: (205)345-4288
(Will not be published)

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

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

Form of Practice: [X] Solo [] Partnership (2, 3, or 4) [] Group (5 or more) If Group, give name below:
W. AL. WOMEN'S CENTER INC.

Primary Hospital where you have staff privileges:
Name: DCH REGIONAL MED CTR City/State: TUSCALOOSA, AL
Are you licensed in another state: Yes [_] No [X] which ones: [_] [_] [_] [_] [_] _____

Primary Care Information:

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

CME Certification: (Check one)

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

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

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

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

DEADLINE IS DECEMBER 31, 1997 4952

License Renewal for 1999
Deadline is December 31, 1998

State of Alabama
Medical Licensure Commission

334/242-4153

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

**********AUTO**3-DIGIT 354
LOUIS THOMASON PAYNE , M.D.
STE I
535 RIVER RD NE
TUSCALOOSA AL 35404-5715

29
1
5179

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

Please make corrections or supply information: License **3505** DATE-ISSUED: 8/5/65 Sex: M [X] F [ ]
Race: White [X] Black [ ] Am. Indian [ ] Oriental or Asian [ ] Other [ ] Social Security # 416-50-6306

Office Address:

STE I

535 RIVER RD

City, State, Zip: TUSCALOOSA, AL 35404

(Alabama) County: Tuscaloosa

Business Phone: (205)556-2026

Fax Number: (205)554-0584

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

Home Address:

57 THE DOWNS

City, State, Zip: TUSCALOOSA, AL 35401 5843

(Alabama) County: Tuscaloosa

Home Phone: (205)345-4288

(Will not be published)

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

Specialty: Primary: [redacted]GYNECOLOGY 29.10
Secondary: _____

Board Certified: Yes [✓] No [ ]
Board Certified: Yes [ ] No [ ]

Form of Practice:[X] Solo[ ] Partnership (2, 3, or 4) [ ] Group (5 or more) If Group, give name below:
W. AL. WOMEN'S CENTER INC.

Primary Hospital where you have staff privileges:
Name: DCH REGIONAL MED CTR City/State: TUSCALOOSA, AL
Are you licensed in another state: Yes [ ] No [X] which ones: [ ] [ ] [ ] [ ] [ ]

Primary Care Information:

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

CME Certification: (Check one)

[✓] I hereby certify that I have met the annual minimum continuing education requirement of 12 hours of Category I continuing medical education during the calendar year ending December 31, 1998.

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

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

DEADLINE IS DECEMBER 31, 1998

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

License #3505 5179 PAYNE, LOUIS THOMASON

License Renewal for 2000
Deadline is December 31, 1999

State of Alabama
Medical Licensure Commission

334/242-4153

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

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

ALL FOR AADC 350
LOUIS THOMASON PAYNE , M.D.
STE I
535 RIVER RD
TUSCALOOSA, AL 35404

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13318

Please make corrections or supply information: License **3505** DATE-ISSUED: 8/5/65 Sex: M [X] F [ ]
Race: White [X] Black [ ] Am. Indian [ ] Oriental or Asian [ ] Other [ ] Social Security # 416-50-6306
Enter SSAN#

Office Address:
STE I
535 ~~RIVER RD~~ Jack Warner PKWY
City, State, Zip: TUSCALOOSA, AL 35404 5715
(Alabama) County: Tuscaloosa
Business Phone: (205)556-2026
Fax Number: (205)554-0584
Permission to publish in Roster: Yes [X] No [ ]

Home Address:
57 THE DOWNS
City, State, Zip: TUSCALOOSA, AL 35401 5843
(Alabama) County: Tuscaloosa
Home Phone: (205)345-4288
(Will not be published)
Send official mail to: **Business** [✓] address (check one)
Home [ ]

Specialty: Primary: GYNECOLOGY (Ob/Gyn)
Secondary: _____
Board Certified: Yes [✓] No [ ]
Board Certified: Yes [ ] No [ ]

Form of Practice:[X] Solo [ ] Partnership (2, 3, or 4) [ ] Group (5 or more) If Group, give name below:
W. AL. WOMEN'S CENTER INC.

Primary Hospital where you have staff privileges:
Name: DCH REGIONAL MED CTR City/State: TUSCALOOSA, AL
Are you licensed in another state: Yes [ ] No [X] which ones: [ ] [ ] [ ] [ ] [ ]

Primary Care Information:

1. Are you actively engaged in clinical practice in the State of Alabama?
Yes [✓] Go to Question 2 No [ ] Do NOT answer questions 2 and 3 below. Skip to CME Certification questions.

2. Does your practice include the delivery of primary care medical services in Alabama? (Primary care is defined as: "Basic or general gatekeeper' health care focused on the point at which a patient ideally first seeks assistance from the medical care system, exclusive of an emergency care situation.")
Yes [ ] Go to Question 3 No [✓] Do NOT answer question 3 below. Skip to CME Certification questions.

3. Approximately how many hours per week do you practice the above-defined primary care services in Alabama? Only answer if you answered YES to questions 1 and 2 above.) Approximately 40 hours per week.

CME Certification: (Check one)

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

DEADLINE IS DECEMBER 31, 1999

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

License Renewal for 2001
Deadline is December 31, 2000

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

OCT 23

**********AUTO**3-DIGIT 354
LOUIS THOMASON PAYNE , M.D.
535 JACK WARNER PKWY NE STE 1
TUSCALOOSA, AL 35404-5751

27
1
5489

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

Please make corrections or supply information: License **3505** DATE-ISSUED: 8/5/65 Sex: M [X] F [ ]
Race: White [X] Black [ ] Am. Indian [ ] Oriental or Asian [ ] Other [ ] Social Security # 416-50-6306
Enter SSAN#

Office Address:
SUITE 1
535 JACK WARNER PKWY
City, State, Zip: TUSCALOOSA, AL 35404 5715
(Alabama) County: Tuscaloosa
Business Phone: (205)556-2026
Fax Number: (205)554-0584

Home Address:
57 THE DOWNS
City, State, Zip: TUSCALOOSA, AL 35401 5843
(Alabama) County: Tuscaloosa
Home Phone: (205)345-4288
(Will not be published)

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

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

Specialty: Primary: GYNECOLOGY (Ob/Gyn) Board Certified: Yes [X] No [ ]
Secondary: _____ Board Certified: Yes [ ] No [ ]

Form of Practice: [X] Solo [ ] Partnership (2, 3, or 4) [ ] Group (5 or more) If Group, give name below:
W. AL. WOMEN'S CENTER INC.

Primary Hospital where you have staff privileges:
Name: DCH REGIONAL MED CTR City/State: TUSCALOOSA, AL
Are you licensed in another state: Yes [ ] No [X] which ones: [ ] [ ] [ ] [ ] [ ]

Primary Care Information:

1. Are you actively engaged in clinical practice in the State of Alabama?
Yes [X] Go to Question 2 No [ ] Do NOT answer questions 2 and 3 below. Skip to CME Certification questions.

2. Does your practice include the delivery of primary care medical services in Alabama? (Primary care is defined as: "Basic or general 'gatekeeper' health care focused on the point at which a patient ideally first seeks assistance from the medical care system, exclusive of an emergency care situation.")
Yes [ ] Go to Question 3 No [X] Do NOT answer question 3 below. Skip to CME Certification questions.

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

CME Certification: (Check one)

[X] I hereby certify that I have met the annual minimum continuing education requirement of 24 hours of Category I continuing medical education within the past two calendar years ending December 31, 2000.

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

DEADLINE IS DECEMBER 31, 2000

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

License #3505 5489 PAYNE, LOUIS THOMASON

License Renewal for 2002
Deadline is December 31, 2001

State of Alabama
Medical Licensure Commission

334/242-4153

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

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

LOUIS THOMASON PAYNE, M.D.
535 JACK WARNER PKWY
SUITE 1
TUSCALOOSA, AL 35404-5715

Please make corrections or supply information: License: **MD . 00003505** Date-Issued: 08/06/1965 Sex: M [X] F [ ]
Race: White [X] Black [ ] American Indian [ ] Oriental or Asian [ ] Other [ ] Social Security# 416-50-6306

Office Address

535 JACK WARNER PKWY
SUITE 1
TUSCALOOSA, AL 35404-5715

(Alabama) County:

Business Phone: (205) 556-2026

Fax Number: (205) 554-0584

Permission to publish in Roster: Yes [X]

Home Address

57 THE DOWNS

TUSCALOOSA, AL 35401-5843

(Alabama) County:

Home Phone: (205) 345-4288 (Will not be published)

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

Specialty: Primary: GYNECOLOGY (Ob/Gyn)
Secondary:

Board Certified: Yes [ ] No [ ]
Board Certified: Yes [ ] No [ ]

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

Primary Hospital where you have staff privileges:
Name: DCH REGIONAL MED CTR City/State: TUSCALOOSA, AL

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

Primary Care Information:

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

CME Certification: (Check one)

[X] I hereby certify that I have met the annual minimum continuing education requirement of 24 hours of Category I continuing medical education within the past two calendar years ending December 31, 2001.

[ ] I certify that I am exempt from the minimum continuing medical education requirements for the following reason:
- [ ] I do not reside in the State of Alabama and do not have a significant portion of my medical practice in Alabama.
- [ ] I received my initial license to practice medicine in Alabama after June 30th of this calendar year.
- [ ] I reinstated my license to practice medicine in the State of Alabama after June 30th of this calendar year.
- [ ] I am a resident physician enrolled in a residency training program.
- [ ] I am retired from the practice of medicine and have obtained a waiver from the Board of Medical Examiners.

MD . 00003505 *Complete both sides including* DEADLINE IS DECEMBER 31, 2001 *correct all information* THOMASON **OVER**

RENEWAL APPLICATION

FOR A CERTIFICATE OF REGISTRATION TO PRACTICE MEDICINE IN ALABAMA IN 1983

ALABAMA MEDICAL LICENSURE COMMISSION
908 South Hull Street, Room 110
Montgomery, Alabama 36104
Phone 205/832-5051

Every physician and osteopath licensed to practice medicine/osteopathy in the State of Alabama shall, on or before the 31st day of December of each year, apply to this Commission for a Certificate of Registration which shall be effective during the calendar year.

RENEWAL FEE $50.00 — Failure to register and pay the annual registration fee within 30 days after registration becomes due will result in the automatic revocation of the current license without further notice or hearing as provided in Act. No. 81-218, Code of Alabama, Section 12.

Name and Mailing Address:

LOUIS T PAYNE
1788 MCFARLAND BLVD NORTH
TUSCALOOSA, AL 35406

LICENSE #: 0003505 ISSUED: 08/05/65

Business Address:

1788 MCFARLAND BLVD NORTH
TUSCALOOSA, AL 35406

☑ The above Addresses are correct.

RENEWAL APPLICATION

FOR A CERTIFICATE OF REGISTRATION TO PRACTICE MEDICINE IN ALABAMA IN 1984
ALABAMA MEDICAL LICENSURE COMMISSION
Post Office Box 887
Montgomery, Alabama 36101
Phone (205) 832-5051

Every physician and osteopath licensed to practice medicine/osteopathy in the State of Alabama shall, on or before the 31st day of December of each year, apply to this Commission for a Certificate of Registration which shall be effective during the calendar year.

RENEWAL FEE: $50.00 -- Failure to register and pay the annual registration fee within 30 days after registration becomes due will result in the automatic revocation of the current license without further notice or hearing as provided in § 34-24-337, Code of Alabama, (1975).

Name and Mailing Address:
LOUIS T PAYNE
1788 MCFARLAND BLVD NORTH
TUSCALOOSA, AL 35406

Business Address:

1788 MCFARLAND BLVD NORTH
TUSCALOOSA, AL 35406

LICENSE #: 0003505 ISSUED: 08/05/65

☑ The above Addresses are correct.

RENEWAL APPLICATION

FOR A CERTIFICATE OF REGISTRATION TO PRACTICE MEDICINE IN ALABAMA IN 1986

ALABAMA MEDICAL LICENSURE COMMISSION
Post Office Box 887
Montgomery, Alabama 36101-0887
Phone (205) 261-4153

Every physician and osteopath licensed to practice medicine/osteopathy in the State of Alabama shall, on or before the 31st day of December of each year, apply to this Commission for a Certificate of Registration which shall be effective during the calendar year.

RENEWAL FEE: $50.00 -- Failure to register and pay the annual registration fee within 30 days after registration becomes due will result in the automatic revocation of the current license without further notice or hearing as provided in § 34-24-337, Code of Alabama, (1975).

Name and Mailing Address:

LOUIS T PAYNE
1788 MCFARLAND BLVD NORTH
TUSCALOOSA, AL 35406

Business Address:

1788 MCFARLAND BLVD NORTH
TUSCALOOSA, AL 35406

LICENSE #: 0003505 ISSUED: 08/05/65

☐ The above Addresses are correct.

RENEWAL APPLICATION

FOR A CERTIFICATE OF REGISTRATION TO PRACTICE MEDICINE IN ALABAMA IN 1986

ALABAMA MEDICAL LICENSURE COMMISSION
Post Office Box 887
Montgomery, Alabama 36101-0887
Phone (205) 261-4153

Every physician and osteopath licensed to practice medicine/osteopathy in the State of Alabama shall, on or before the 31st day of December of each year, apply to this Commission for a Certificate of Registration which shall be effective during the calendar year.

RENEWAL FEE: $50.00 -- Failure to register and pay the annual registration fee within 30 days after registration becomes due will result in the automatic revocation of the current license without further notice or hearing as provided in § 34-24-337, Code of Alabama, (1975).

Name and Mailing Address:

LOUIS T PAYNE
1788 MCFARLAND BLVD NORTH
TUSCALOOSA, AL 35406

Business Address:

1788 MCFARLAND BLVD NORTH
TUSCALOOSA, AL 35406

LICENSE #: 0003505 ISSUED: 08/05/65

☑ The above Addresses are correct.

RENEWAL APPLICATION

FOR A CERTIFICATE OF REGISTRATION TO PRACTICE MEDICINE IN ALABAMA IN 1987

ALABAMA MEDICAL LICENSURE COMMISSION
Post Office Box 887
Montgomery, Alabama 36101-0887
Phone (205) 261-4153

Every physician and osteopath licensed to practice medicine/osteopathy in the State of Alabama shall, on or before the 31st day of December of each year, apply to this Commission for a Certificate of Registration which shall be effective during the calendar year.

RENEWAL FEE: $50.00 --- Failure to register and pay the annual registration fee within 30 days after registration becomes due will result in the automatic revocation of the current license without further notice or hearing as provided in § 34-24-337, Code of Alabama, (1975).

Name and Mailing Address:

LOUIS T PAYNE
1788 MCFARLAND BLVD NORTH
TUSCALOOSA, AL 35406

Business Address:

1788 MCFARLAND BLVD NORTH
TUSCALOOSA, AL 35406

LICENSE #: 0003505 ISSUED: 08/05/65

☑ The above Addresses are correct.

RENEWAL APPLICATION

FOR A CERTIFICATE OF REGISTRATION TO PRACTICE MEDICINE IN ALABAMA IN 1988

ALABAMA MEDICAL LICENSURE COMMISSION
Post Office Box 887
Montgomery, Alabama 36101-0887
Phone (205) 261-4153

Every physician and osteopath licensed to practice medicine/osteopathy in the State of Alabama shall, on or before the 31st day of December of each year, apply to this Commission for a Certificate of Registration which shall be effective during the calendar year.

RENEWAL FEE: $50.00 --- Failure to register and pay the annual registration fee within 30 days after registration becomes due will result in the automatic revocation of the current license without further notice or hearing as provided in § 34-24-337, Code of Alabama, (1975).

Name and Mailing Address:

LOUIS T PAYNE
1788 MCFARLAND BLVD NORTH
TUSCALOOSA, AL 35406

LICENSE #: 0003535 ISSUED: 08/05/65

Business Address:

1788 MCFARLAND BLVD NORTH
TUSCALOOSA, AL 35406

☑ The above Addresses are correct.

RENEWAL APPLICATION

FOR A CERTIFICATE OF REGISTRATION TO PRACTICE MEDICINE IN ALABAMA IN 1989
ALABAMA MEDICAL LICENSURE COMMISSION
Post Office Box 887
Montgomery, Alabama 36101-0887
Phone (205) 261-4153

Every physician and osteopath licensed to practice medicine/osteopathy in the State of Alabama shall, on or before the 31st day of December of each year, apply to this Commission for a Certificate of Registration which shall be effective during the calendar year.

RENEWAL FEE: $50.00 --- Failure to register and pay the annual registration fee within 30 days after registration becomes due will result in the automatic revocation of the current license without further notice or hearing as provided in § 34-24-337, Code of Alabama, (1975).

Name and Mailing Address:

LOUIS T PAYNE
1788 MCFARLAND BLVD NORTH
TUSCALOOSA, AL 35406

Business Address:

1788 MCFARLAND BLVD NORTH
TUSCALOOSA, AL 35406

LICENSE #: 0003505 ISSUED: 08/05/65

If your addresses are different from those shown, make corrections on back:

WITHIN THE PAST YEAR:

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

I certify that the above information is correct Louis T. Payne, M.D. 10/18/88
Signature Date

(Do Not Detach)

RENEWAL APPLICATION

FOR A CERTIFICATE OF REGISTRATION TO PRACTICE MEDICINE IN ALABAMA IN 1990
ALABAMA MEDICAL LICENSURE COMMISSION
Post Office Box 887
Montgomery, Alabama 36101-0887
Phone (205) 261-4153

Every physician and osteopath licensed to practice medicine/osteopathy in the State of Alabama shall, on or before the 31st day of December of each year, apply to this Commission for a Certificate of Registration which shall be effective during the calendar year.

RENEWAL FEE: $50.00 --- Failure to register and pay the annual registration fee within 30 days after registration becomes due will result in the automatic revocation of the current license without further notice or hearing as provided in § 34-24-337, Code of Alabama, (1975).

Name and Mailing Address:

LOUIS T PAYNE
1788 MCFARLAND BLVD NORTH
TUSCALOOSA, AL 35406

Business Address:

1788 MCFARLAND BLVD NORTH
TUSCALOOSA, AL 35406

LICENSE #: 0003505 ISSUED: 08/05/65

If your addresses are different from those shown, make corrections on back.

WITHIN THE PAST YEAR:

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

I certify that the above information is correct Louis T. Payne 10/4/89
Signature Date

(Do Not Detach)

RENEWAL APPLICATION

FOR A CERTIFICATE OF REGISTRATION TO PRACTICE MEDICINE IN ALABAMA IN 1991
ALABAMA MEDICAL LICENSURE COMMISSION
Post Office Box 887
Montgomery, Alabama 36101-0887
Phone (205) 261-4153

Every physician and osteopath licensed to practice medicine/osteopathy in the State of Alabama shall, on or before the 31st day of December of each year, apply to this Commission for a Certificate of Registration which shall be effective during the calendar year.

RENEWAL FEE: $75.00 --- Failure to register and pay the annual registration fee within 30 days after registration becomes due will result in the automatic revocation of the current license without further notice or hearing as provided in § 34-24-337, Code of Alabama, (1975).

Name and Mailing Address:

LOUIS T PAYNE
1788 MCFARLAND BLVD NORTH
TUSCALOOSA, AL 35406

Business Address:

1788 MCFARLAND BLVD NORTH
TUSCALOOSA, AL 35406

LICENSE #: 0003505 ISSUED: 08/05/65

If your addresses are different from those shown, make corrections on back:

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

I certify that the above information is correct Louis T Payne 10/14/90
Signature Date

(Do Not Detach)

RENEWAL APPLICATION

FOR A CERTIFICATE OF REGISTRATION TO PRACTICE MEDICINE IN ALABAMA IN 1992
ALABAMA MEDICAL LICENSURE COMMISSION
Post Office Box 887
Montgomery, Alabama 36101-0887
Phone (205) 261-4153

Every physician and osteopath licensed to practice medicine/osteopathy in the State of Alabama shall, on or before the 31st day of December of each year, apply to this Commission for a Certificate of Registration which shall be effective during the calendar year.

RENEWAL FEE: $75.00 --- Failure to register and pay the annual registration fee within 30 days after registration becomes due will result in the automatic revocation of the current license without further notice or hearing as provided in § 34-24-337, Code of Alabama, (1975).

Name and Mailing Address:

LOUIS T PAYNE
1788 MCFARLAND BLVD NORTH
TUSCALOOSA, AL 35406

Business Address:

1788 MCFARLAND BLVD NORTH
TUSCALOOSA, AL 35406

LICENSE #: 0003505 ISSUED: 08/05/65

If your addresses are different from those shown, make corrections on back:

WITHIN THE PAST YEAR:

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

I certify that the above information is correct Louis T. Payne MD 10/8/91

Signature Date

(Do Not Detach)

(Rev. 08/92)

RENEWAL APPLICATION

For a certificate of registration to practice medicine in Alabama in 1993

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

Name and Mailing Address

LICENSE #: 0003505 ISSUED: 08/05/65

LOUIS T PAYNE
1788 MCFARLAND BLVD NORTH
TUSCALOOSA, AL 35406

Home Address:

Street 57 The Downs
City Tuscaloosa
State AL Zip 35401
Business FAX#:(205) 345-2115

☐ Make corrections to mailing address on reverse.

☑ Check if you authorize your FAX# to be published in a directory

■ Every physician and osteopath licensed to practice medicine/osteopathy in the State of Alabama shall, on or before the 31st of December of each year, apply to this Commission for a Certificate of Registration which shall be effective during the calendar year.

■ **Renewal Fee: $75.00 - Failure to register and pay the annual registration fee within 30 days after registration becomes due will result in the automatic revocation of the current license without further notice or hearing as provided in § 34-24-337, Code of Alabama (1975).**

(Check a or b) For CME Certification

a) ✓ I hereby certify that I have met the annual minimum continuing education requirement of 12 hours of Category I continuing medical education during the calendar year ending December 31, 1992.

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

Check One Below If You Answered (b)

____ I do not reside in the State of Alabama and do not have a significant portion of my medical practice in Alabama.

____ I received my initial license to practice medicine in Alabama after June 30th of this calendar year.

____ I reinstated my license to practice medicine in the State of Alabama after June 30th of this calendar year.

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

____ I am a resident physician enrolled in a residency training program.

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

I certify that all information on this form is correct Louis T. Payne, M.D. 11-9-92

Signature Date

(Do Not Detach)

(Rev. 08/93)

RENEWAL APPLICATION

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

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

Name & Mailing Address

(Make address corrections in (4) below.)

LICENSE #: 00003505 ISSUED: 8/05/1965

PAYNE LOUIS THOMASON
1788 MCFARLAND BLV

TUSCALOOSA 35401-

■ Every physician and osteopath licensed to practice medicine/osteopathy in the State of Alabama shall, on or before the 31st of December of each year, apply to this Commission for a Certificate of Registration which shall be effective during the calendar year.

■ Renewal Fee: $100.00 - Failure to register and pay the annual registration fee within 30 days after registration becomes due will result in the automatic revocation of the current license without further notice or hearing as provided in §34-24-337, Code of Alabama (1975).

(Check a or b) For CME Certification

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

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

Check One Below If You Answered (b)

____ I do not reside in the State of Alabama and do not have a significant portion of my medical practice in Alabama.

____ I received my initial license to practice medicine in Alabama after June 30th of this calendar year.

____ I reinstated my license tc practice medicine in the State of Alabama after June 30th of this calendar year.

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

____ I am a resident physician enrolled in a residency training program.

Within The Past Year:

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

I certify that all information on this form is correct. Louis T. Payne M.D. (Signature) 11-1-93 (Date)

License Renewal for 1995
Deadline is December 31, 1994

State of Alabama
Medical Licensure Commission
205/242-4153

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

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

LOUIS THOMASON PAYNE , M.D.
1788 MCFARLAND BLV

TUSCALOOSA, AL 35401

Please make corrections or supply information: License # 00003505 Sex: M [X] F[ ]

Race: White [X] Black [ ] Am. Indian [ ] Oriental or Asian [ ] Other [ ] Social Security # 416-50-6306

Office Address:

1788 MCFARLAND BLV

City, State, Zip: TUSCALOOSA, AL 35401

County: Tuscaloosa

Business Phone: (205)345-2110

Fax Number: (205)345-2115

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

Home Address:

57 THE DOWNS

City, State, Zip: TUSCALOOSA, AL 35401

County: Tuscaloosa

Home Phone: (205)345-4288
(Will not be published)

Send official mail to Business or Home address (circle one)

Specialty: Primary: OB-Gyn

Secondary: _____

Board Certified: Yes [X] No [ ]

Board Certified: Yes [ ] No [X]

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

Primary Hospital where you have staff privileges:

Name: DCH REGIONAL MED CTR City/State: TUSCALOOSA , AL

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

CME Certification: (Check one)

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

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

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

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

License Renewal for 1996
Deadline is December 31, 1995

State of Alabama
Medical Licensure Commission

334/242-4153

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

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

Louis Thomason Payne , M.D.
1788 McFarland Blvd N

Tuscaloosa, AL 35406 2136

"CAR-RT-SORT"C053
87
13

Please make corrections or supply information: License **3505** DATE ISSUED: 08/05/196 Sex: M [X] F [ ]

Race: White [X] Black [ ] Am. Indian [ ] Oriental or Asian [ ] Other [ ] Social Security # 416-50-6306

Office Address:

1788 MCFARLAND BLVD N

City, State, Zip: TUSCALOOSA, AL 35406 2199

(Alabama) County: Tuscaloosa

Business Phone: (205)345-2110

Fax Number: (205)345-2115

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

Home Address:

57 THE DOWNS

City, State, Zip: TUSCALOOSA, AL 35401 5843

(Alabama) County: Tuscaloosa

Home Phone: (205)345-4288
(Will not be published)

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

Specialty: Primary: OBSTETRICS & (GYNECOLOGY) only

Secondary: _____

Board Certified: Yes [✓] No [ ]

Board Certified: Yes [ ] No [ ]

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

OB-GYN Assoc. Tuscaloosa, P.C.

Primary Hospital where you have staff privileges:

Name: DCH REGIONAL MED CTR

City/State: TUSCALOOSA, AL

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

CME Certification: (Check one)

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

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

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

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

OVER

DEADLINE IS DECEMBER 31, 1995

2007 Medical License Renewal Application
Deadline: December 31, 2006

Renew online @ http://alrenewals.org
Registration ID: 181855
Use Only for Change of Mailing Address

_____

_____

_____

Medical Licensure Commission of the State of Alabama
PO Box 887, Montgomery, AL 36101
334/242-4153

Louis Thomason Payne , MD
535 JACK WARNER PKWY
SUITE 1
TUSCALOOSA, Alabama 35404-5715

Complete Both Sides Including Signature
Correct or Supply All Information
Return with $200 Renewal Fee
Incomplete Application will be Returned

Failure to Renew this License will Result in the Automatic Revocation of the Current License to Practice Medicine or Osteopathy

Issue Date: 08/05/1965

License#: MD.3505

Office Address

535 JACK WARNER PKWY
SUITE 1
TUSCALOOSA, Alabama 35404-5715
Work Telephone: (205) 556-2026 Fax #: (205) 554-0584

Home Address

57 THE DOWNS
TUSCALOOSA, Alabama 35401-5843
Home Phone: (205) 345-4288

Primary Specialty: GYNECOLOGY (Ob/Gyn)
Secondary Specialty:

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

Form of Practice: [ ] Resident [ ] Intern [ ] Fellowship [X] Solo [ ] Partnership (2, 3, or 4) [ ] Group (Name) West Ala Womens Center

Primary Hospital where you have staff privileges: Name: Druid City Regional Medical Ctr City/State: Tuscaloosa AL

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

1. Are you actively engaged in clinical practice in the State of Alabama? [X] Yes, Answer Questions 2 through 7 [ ] No, Answer Question 2 only
2. What is your principal county of practice? (Indicate state if principal county is not in Alabama) Tuscaloosa
   Other county(ies) of practice? (Indicate state if counties are not in Alabama):_____
   Check "None" if you only practice in the indicated principal county. [X] None
3. Do you have a current collaborative agreement with a nurse practitioner or midwife? [ ] Yes, Answer Questions 3a through 7 [X] No, Answer Questions 4 through 7
   3a. Does the nurse practitioner/midwife practice at a site other than your office: [ ] Yes [ ] No
   3b. Are you employed by the nurse practitioner/midwife or a corporation owned by the nurse practitioner/midwife? [ ] Yes [ ] No
4. Do you currently conduct office based surgery involving the administration of parenteral medication for analgesia/sedation, general anesthesia or major regional block anesthesia? [X] Yes [ ] No

Primary Care Information

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

5. Does your practice include the delivery of primary care medical services in Alabama? [ ] Yes, Answer Questions 6 and 7 [X] No, Do not answer Questions 6 and 7
6. Approximately how many hours per week do you practice the above defined primary care services in Alabama?
   Approximately _____hours per week.
7. Approximately how many patient encounters (office, hospital, ER, etc.) per week do you have involving the above defined primary care services in Alabama? Approximately _____encounters per week.

CME Certification: (Check one)

(a) [X] I hereby certify that I have met the annual minimum continuing education requirement of 12 hours of Category I continuing medical education for the calendar year 2006 and have supporting documentation if audited.

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

[ ] I do not reside in the State of Alabama and do not have a significant portion of my medical practice in the State of Alabama.
[ ] I was exempt from the CME requirement for the previous calendar year 2005 and I moved my residence to the State of Alabama during calendar year 2006.
[ ] I received my initial license to practice medicine in Alabama in the calendar year 2006.
[ ] I have obtained a retirement waiver from the Board of Medical Examiners, and I do not engage in the practice of medicine in any form.
[ ] I have obtained a waiver from the Board of Medical Examiners due to illness, disability or other hardship condition which existed in the calendar year 2006.
[ ] I am enrolled or was enrolled in a residency training program or clinical fellowship program during the calendar year 2006.

DEADLINE IS DECEMBER 31, 2006 Payne , Louis Thomason

MD.3505

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

2008 Medical License Renewal Application
Deadline: December 31, 2007

Renew online @ http://alrenewals.org
Registration ID: 181855

Medical Licensure Commission of the State of Alabama
PO Box 887, Montgomery, AL 36101
334/242-4153

Use Only for Change of Mailing Address

Louis Thomason Payne , MD
535 Jack Warner Parkway
Suite 1
Tuscaloosa, Alabama 35404-5715

Fees:
$300 Renewal Fee: October 1 - December 31
$100 Late Fee Added: January 1 - January 31
(After January 31 - Reinstatement is required)

FAILURE TO RENEW THIS LICENSE BY JANUARY 31 WILL RESULT IN YOUR LICENSE BECOMING INACTIVE WITHOUT FURTHER NOTICE.

License#: MD.3505

Issue Date: 08/05/1965

Office Address

535 Jack Warner Parkway
Suite 1
Tuscaloosa, Alabama 35404-5715
Work Telephone: (205) 556-2026 Fax #: (205) 554-0584

Home Address

57 The Downs
Tuscaloosa, Alabama 35401-5843
Home Phone: (205) 345-4288

Primary Specialty: Gynecology (OB/GYN)
Secondary Specialty: Other

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

Form of Practice: [ ] Resident [ ] Intern [ ] Fellowship [X] Solo [ ] Partnership (2, 3, or 4) [ ] Group (Name) West Alabama Women's Center

Primary Hospital where you have staff privileges: Name: Druid City Regional Medical Cer City/State: Tuscaloosa AL

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

1. Are you actively engaged in clinical practice in the State of Alabama? [ ] Yes, Answer Questions 2 through 7 [ ] No, Answer Question 2 only
2. What is your principal county of practice? (Indicate state if principal county is not in Alabama) Tuscaloosa
   Other county(ies) of practice? (Indicate state if counties are not in Alabama): _____
   Check "None" if you only practice in the indicated principal county. [X] None
3. Do you have a current collaborative agreement with a nurse practitioner or midwife? [ ] Yes [X] No
4. Do you currently conduct office based surgery involving the administration of parenteral medication for analgesia/sedation, general anesthesia or major regional block anesthesia? [X] Yes [ ] No

Primary Care Information

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

5. Does your practice include the delivery of primary care medical services in Alabama? [ ] Yes, Answer Questions 6 and 7 [X] No, Do not answer Questions 6 and 7
6. Approximately how many hours per week do you practice the above defined primary care services in Alabama?
   Approximately 37 hours per week.
7. Approximately how many patient encounters (office, hospital, ER, etc.) per week do you have involving the above defined primary care services in Alabama? Approximately 100 encounters per week.

CME Certification: (Check one)

(a) [✓] I hereby certify that I have met the annual minimum continuing education requirement of 12 hours of Category I continuing medical education for the calendar year 2007 and have supporting documentation if audited.

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

[ ] I do not reside in the State of Alabama and do not have a significant portion of my medical practice in the State of Alabama.
[ ] I was exempt from the CME requirement for the previous calendar year 2006 and I moved my residence to the State of Alabama during calendar year 2007.
[ ] I received my initial license to practice medicine in Alabama in the calendar year 2007.
[ ] I have obtained a retirement waiver from the Board of Medical Examiners, and I do not engage in the practice of medicine in any form.
[ ] I have obtained a waiver from the Board of Medical Examiners due to illness, disability or other hardship condition which existed in the calendar year 2007.
[ ] I am enrolled or was enrolled in a residency training program or clinical fellowship program during the calendar year 2007.

DEADLINE IS DECEMBER 31, 2007

Payne , Louis Thomason

MD.3505

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

OVER

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

2009 Online Renewal Summary

Name: **Louis Thomason Payne**

License Number: **MD.3505**

Transaction Date: **2008-10-15***

Transaction Number: **VQFF2EFC6B4B**

Registration Fee: **300**

Date of Birth: **1939-04-20**

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

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

Jan 5, 2012 3:04 PM

no

If yes, please explain:

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

no

If yes, please explain:

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

no

If yes, please explain:

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

no

If yes, please explain:

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

no

If yes, please explain:

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

no

If yes, please explain:

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

no

If yes, please explain:

Jan 5, 2012 3:04 PM

Have you engaged in the illegal use of controlled dangerous substances within the past twelve months?

no

If yes, please explain:

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

no

If yes, please explain:

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

no

If yes, please explain:

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

no

If yes, please explain:

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

Primary specialty:

Obstetrics & Gynecoloy

Are you Board certified in your primary specialty?

Y

Secondary specialty:

Are you Board certified in your secondary specialty?

Y

Practice Type:

Jan 5, 2012 3:04 PM

S

If Group, provide the Group Name:
West Alabama Women's Center Inc.

Primary Hospital where you have privileges: (if any)

Hospital Name:
Druid City Regional Medical Center

Hospital City:
Tuscaloosa

Hospital State:

Are you licensed in another State:
N

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

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

(**indicate state if not in Alabama)

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

Jan 5, 2012 3:04 PM

Other County1

Jan 5, 2012 3:04 PM

Other State1

Other County 2

Other State 2

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

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

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

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

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

Approximately how many patient encounters (office, hospital, ER, etc.) per week do you have involving the above defined priary care services in Alabama?
100

CME Certification: I hereby certify that I have met the annual minimum continuing education requirement of 12 hours of Category I continuing medical education for the calendar year 2008 and have supporting documentation if audited.
yes

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

Exempt Reason

Practice Telephone:
(205) 556-2026

Practice Address:
535 Jack Warner Parkway

Jan 5, 2012 3:04 PM

Home Telephone:
(205) 345-4288

Home Address:
57 The Downs

Public Address:
True

Mail Address:
True

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

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

2010 Online Renewal Summary

Name: **Louis Thomason Payne**

License Number: **MD.3505**

Transaction Date: **2009-10-16***

Transaction Number: **VUHF4B67C2F1**

Registration Fee: **300**

Date of Birth: **1939-04-20**

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

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

Jan 5, 2012 3:04 PM

no

If yes, please explain:

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

no

If yes, please explain:

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

no

If yes, please explain:

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

no

If yes, please explain:

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

no

If yes, please explain:

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

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no

If yes, please explain:

Jan 5, 2012 3:04 PM