RECEIVED
FEB 05 2001

MEDICAL LICENSURE COMMISSION
STATE OF ALABAMA
P. O. BOX 887
MONTGOMERY, ALABAMA 36101

APPLICATION FOR LICENSE TO PRACTICE MEDICINE/OSTEOPATHY

NAME IN FULL NORMAN BRUCE ELLIOTT
(Last Name) (First Name) (Middle Name)

MAILING ADDRESS 4013 JOHN S ROBOTEAU

CITY RALEIGH STATE NC ZIP 27612

COUNTY WAKE TELEPHONE NUMBER (919) 5715024

TYPE OF PRACTICE OB/GYN

DATE FEB 1/2001 SIGNED B E Norman MD
SPECIFY ONE: MD/DO LICENSE

ALABAMA OFFICE MAILING ADDRESS:

ALL WOMEN HEALTH CARE
1001 17TH ST. SO
BIRMINGHAM, AL 35205

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

STATE OF ALABAMA
MEDICAL LICENSURE COMMISSION
POST OFFICE BOX 887
MONTGOMERY, ALABAMA 36101-0887

JERRY N. GURLEY, M.D.
CHAIRMAN/EXECUTIVE OFFICER

AMY T. DORMINEY
EXECUTIVE ASSISTANT

TELEPHONE
(334) 242-4153

RECEIVED
MAY 16 2003

REINSTATEMENT

LICENSE NUMBER: 00023937

DATE ISSUED: 2/28/01

NAME IN FULL: NORMAN (Last Name) BRUCE (First Name) ELLIOTT (Middle Name)

HOME ADDRESS: [redacted]

CITY: [redacted] STATE: [redacted] ZIP CODE: [redacted]

COUNTY: [redacted] TELEPHONE: ([redacted]) [redacted]

TYPE OF PRACTICE: GYN

ALABAMA PRACTICE ADDRESS: 303 WILLIAMS AVE SUITE 1211

CITY: HUNTSVILLE STATE: ALA ZIP CODE: 35801-6056

DATE: 11/5/02 SIGNATURE: BE Norman

Please specify the following:

Public Address: ☐ Home Address ☐ Practice Address
Mailing Address: ☐ Home Address ☐ Practice Address

334 348-4153 cell

PLEASE ATTACH LICENSE FEE OF $ ~~450.00~~ $1500.00 ✓ - will reinstate thru 12/31/02 all active licenses expire 12/31.

MAKE CHECK PAYABLE TO MEDICAL LICENSURE COMMISSION OF ALABAMA

YOU MUST SUBMIT PROOF (COPIES) OF HAVING OBTAINED TWELVE (12) HOURS OF CONTINUING MEDICAL EDUCATION WITHIN THE PRECEDING (12) TWELVE MONTH PERIOD, UNLESS EXEMPT BY LAW. ✓

GA ✓, MS ✓, NC ✓, OH ✓, MI ✓ DE ✓

APPLICATION FOR REINSTATEMENT OF LICENSE

To the Medical Licensure Commission of the State of Alabama:

I hereby make application for reinstatement of my license to practice medicine/osteopathy in the State of Alabama, Certificate Number _____, which was automatically revoked on the 1st day of February, 20____, for nonpayment of the annual registration fee as provided in §34-24-337, Code of Alabama, 1975. The following information is submitted in connection with this application for reinstatement.

Date: 11/5/02 DEA#: BN4566452 License #: 23937

Name: BRUCE ELLIOTT AUERMAN, M.D.

Date of Birth: 03/17/49 Social Security Number: _____

Professional Address: NORTH POINT TOWER
1001 LAKESIDE AVE SUITE 1200
CLEVELAND OHIO 44114-1153

Telephone: ( ) 216 479 5072

Other States or Jurisdictions in which you are currently licensed: ① GA 40176
② MS 17156
③ NC 9501030
④ OH 35079099
⑤ ME 4301080322

CURRENT PRACTICE

Specialty: OB/GYN

Board Certified: (Yes) No

Name of Board (if yes above): A.B.O.G.

Date of Certification and/or Recertification (if yes above) _____

Practice Pattern:

Percentage of Professional Time/Office: _____ %

Percentage of Professional Time/Clinic: 20 %

Percentage of Professional Time/Hospital: _____ %

Percentage of Professional Time/Other: 80 % ADMIN

CURRENT PROFESSIONAL CONNECTIONS

Specialty Society Member: _____ Yes (No)

Name of Specialty Society (if yes above): _____

Name/Location of Hospital(s): CLEVELAND CLINIC

Hospital Staff Status (active, etc.): ACTIVE

Hospital Privileges (specify): BASIC OB/GYN

CERTIFICATION OF CME COMPLIANCE

(Check a or b)

(a) ✓ I hereby certify that I have met the annual minimum continuing medical education requirement of twelve (12) hours of Category I continuing medical education within the preceding twelve (12) months.

(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 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 Alabama Board of Medical Examiners.

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

Names/Results of Practice Related Examinations taken in the past year: _____

_____

Other (specify for the past year): _____

Have you ever been convicted of a felony? _____Yes ✓ No

Have you ever been convicted of a crime or offense (felony or misdemeanor) in the practice of medicine?
_____Yes ✓ No

Have you ever been convicted of any violation of a state or federal law relating to controlled substances?
_____Yes ✓ No

Have you ever been denied a state or federal controlled substances certificate?
_____Yes ✓ 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?
_____Yes ✓ No

Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practice?
_____Yes ✓ No

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 of denial?
_____Yes ✓ No

Have you ever had a judgment rendered against you, or actions settled relating to the performance of your professional service?
✓ Yes _____ No

Within the past two years, have you been diagnosed with or have you been treated for bi-polar disorder, schizophrenia, paranoia, or any other psychotic disorder?
_____Yes ✓ 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?
_____Yes ✓ No

Within the past five years, 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?
_____Yes ✓ No

Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism?
_____Yes ✓ No

Are you currently engaged in the illegal use of controlled dangerous substances?[1]

_____Yes _____✓_____ No

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

_____Yes _____ No

Have you been, within the past five (5) years, 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?

_____Yes _____✓_____ 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?

_____Yes _____✓_____ No

[1]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 foregoing questions, please provide complete information.

_____ See attached

RELEASE/CERTIFICATION

I certify that the above information is currently accurate and truly reflects my professional activities. I hereby release this information for internal use to those state authorities responsible for medical licensure and/or discipline.

_____
Signature

SWORN to and subscribed before me this 13th day of May, 2003.

_____
Notary Public
My Commission Expires: Dec. 19 2007

PEGGY JO WORKMAN
NOTARY PUBLIC, STATE OF OHIO
Recorded in Cuyahoga County
My Comm. Expires 12-19-2007

RENEW ONLINE AT http://renewal.albme.org **Registration ID: 165852**

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

BRUCE ELLIOTT NORMAN , M.D.
10811 DETROIT AVE, UNIT B
CLEVELAND, OH 44102

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 . 00023937** Date-Issued: 02/28/2001 Sex: M [X] F [ ]

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

Office Address

SUITE 1211
303 WILLIAMS AVENUE

City, State, Zip: HUNTSVILLE, AL 35801-6086

(Alabama) County: Madison

Home Address

[redacted]

City, State, Zip: [redacted]

(Alabama) County: Out of State

Business Phone:

Home Phone: [redacted] (Will not be published)

Fax Number:

Permission to publish in Roster: Yes [X]

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

Specialty: Primary: OBSTETRICS & GYNECOLOGY
Secondary:

Board Certified: Yes [ ] No [ ]

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

Board Certified: Yes [X] No [ ]

OHIO PERMANENTE

Primary Hospital where you have staff privileges:
Name: CLEVELAND CLINIC

City/State: , CLEVELAND OHIO

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

Which ones: [ ] [ ] [ ] [ ] [ ]
N.C. GA DEL OHIO MISS

Primary Care Information:

1. Are you actively engaged in clinical practice in the State of Alabama?
   Yes [ ] Go to Question 2 No [X] 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)

[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, 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

		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. _____ (Signature) _____ 11/06/03 (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) 269-0050

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

2005 Online Renewal Summary

Name: **Bruce Elliott Norman**

License Number: **MD.23937**

Transaction Date: **2004-10-21***

Transaction Number: **null**

Registration Fee: **200**

Date of Birth: **1949-03-17**

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

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

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If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

Primary specialty:

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

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Secondary specialty:

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

Practice Type:

Primary Hospital where you have privileges:

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

Primary Care Information:

Are you actively engaged in clinical practice in the State of Alabama? **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 12 hours of Category I continuing medical education for the Calendar Year 2004. **Y**

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

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

Practice Telephone: **2565392746**

Practice Address: **SUITE 1211**

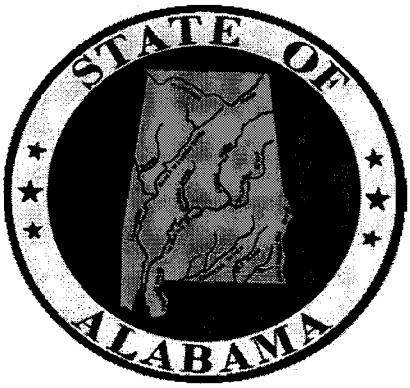
Home Telephone: [redacted]

Home Address: [redacted]

Public Address: **Practice**

Mail Address: **Home**

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



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

2006 Online Renewal Summary

Name: **Bruce Elliott Norman**
License Number: **MD.23937**
Transaction Date: **2005-12-01***
Transaction Number: **null**
Registration Fee: **200**
Date of Birth: **1949-03-17**

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

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

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If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

Primary specialty:

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

Feb 9, 2012 9:36 AM

Secondary specialty:

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

Practice Type:

Primary Hospital where you have privileges:

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

Primary Care Information:

Are you actively engaged in clinical practice in the State of Alabama? **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 12 hours of Category I continuing medical education for the Calendar Year 2005. **Y**

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

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

Practice Telephone: **2565392746**

Practice Address: **1001 17TH STREET SOUTH**

Feb 9, 2012 9:36 AM

Home Telephone: [redacted]

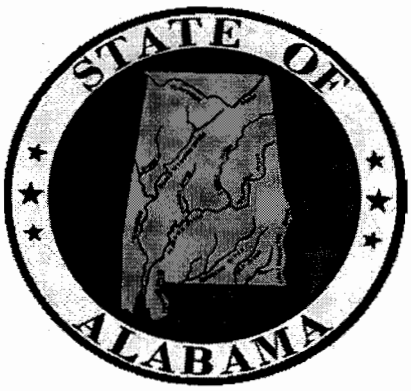
Home Address: [redacted]

Public Address: **Practice**

Mail Address: **Practice**

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

Feb 9, 2012 9:36 AM



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

2007 Online Renewal Summary

Name: **Bruce Elliott Norman**
License Number: **MD.23937**
Transaction Date: **2006-12-14***
Transaction Number: **VTHF0D24023B**
Registration Fee: **200**
Date of Birth: **1949-03-17**

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

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

Feb 9, 2012 9:37 AM

If yes, please explain: **potential acsc violation**

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

Primary specialty: **GYNECOLOGY (OB/GYN)**

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

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Secondary specialty:

Are you Board certified in your secondary specialty?

Practice Type:

If Group, provide the Group Name:

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

Hospital Name:

Hospital City:

Hospital State:

Are you licensed in another State:

DE

GA

NC

OH

MS

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

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

(**indicate state if not in Alabama)

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

Other County1

Other State1

Other County 2

Other State 2

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

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

Are you employed by the nurse practitioner/midwife or a corporation owned by the nurse practitioner/midwife? **No**

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

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

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

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

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

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

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

Exempt Reason

Practice Telephone: **(256) 539-2746**

Practice Address: **1001 17TH STREET SOUTH**

Home Telephone: [redacted]

Home Address: [redacted]

Public Address: **True**

Mail Address:

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

Feb 9, 2012 9:37 AM

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

2008 Online Renewal Summary

Name: **Bruce Elliott Norman**

License Number: **MD.23937**

Transaction Date: **2007-11-30***

Transaction Number: **VSJF1D778E8D**

Registration Fee: **300**

Date of Birth: **1949-03-17**

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

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

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If yes, please explain: **alabama board reviewing prescriptions in 2006 before obtaining state control licence (had federal DEA)**

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

Primary specialty: **Obstetrics & Gynecoloy**

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

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Secondary specialty: **Other**

Are you Board certified in your secondary specialty?

Practice Type: **G**

If Group, provide the Group Name: **Ohioi Permanente Medical Group**

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

Hospital Name:

Hospital City:

Hospital State:

Are you licensed in another State:

DE

GA

NC

OH

MS

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? **Jefferson**

(**indicate state if not in Alabama)

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

Other County1

Other State1

Other County 2

Other State 2

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

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

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

Does your practice include the delivery of primary care medical services in Alabama? **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 2007 and have supporting documentation if audited. **yes**

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

Exempt Reason

Practice Telephone: **205 9331118**

Practice Address: **1001 17th Street South**

Home Telephone: [redacted]

Home Address: [redacted]

Public Address: **True**

Mail Address:

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

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

2009 Online Renewal Summary

Name: **Bruce Elliott Norman**

License Number: **MD.23937**

Transaction Date: **2008-10-31***

Transaction Number: **VSJF2E817966**

Registration Fee: **300**

Date of Birth: **1949-03-17**

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

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

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If yes, please explain: **patient complaint being investigated by North Carloina Medical Board. I will appear before an informal inquiry on Nov 20th 2008**

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

Primary specialty: **Obstetrics & Gynecoloy**

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

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Secondary specialty:

Are you Board certified in your secondary specialty?

Practice Type: **S**

If Group, provide the Group Name:

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

Hospital Name:

Hospital City:

Hospital State:

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

DE

GA

NC

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? **Jefferson**

(**indicate state if not in Alabama)

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

Other County1 **wake**

Other State1 **NC**

Other County 2 **muscogee**

Other State 2 **GA**

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

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

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

Does your practice include the delivery of primary care medical services in Alabama? **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 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) 933-1118**

Practice Address: **1001 17th Street South**

Home Telephone: [redacted]

Home Address: [redacted]

Public Address: **True**

Mail Address:

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

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

2010 Online Renewal Summary

Name: **Bruce Elliott Norman**

License Number: **MD.23937**

Transaction Date: **2009-11-12***

Transaction Number: **VXHF4C89963A**

Registration Fee: **300**

Date of Birth: **1949-03-17**

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

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

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If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

Primary specialty: **Obstetrics & Gynecoloy**

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

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Secondary specialty:

Are you Board certified in your secondary specialty?

Practice Type: **S**

If Group, provide the Group Name:

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

Hospital Name:

Hospital City:

Hospital State:

Are you licensed in another State:

MS

GA

NC

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? **Jefferson**

(**indicate state if not in Alabama)

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

Other County1 **wake**

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Other State1 **NC**

Other County 2 **muscogee**

Other State 2 **GA**

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. **null**

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) 933-1118**

Practice Address: **1001 17th Street South**

Home Telephone: [redacted]

Home Address: [redacted]

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. **null**

Feb 9, 2012 9:37 AM

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

2011 Online Renewal Summary

Name: **Bruce Elliott Norman**
License Number: **MD.23937**
Transaction Date: **2010-10-29***
Transaction Number: **VUHF5FDD5F47**
Registration Fee: **300**
Date of Birth: **1949-03-17**

* - 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 **1001 17th Street South**

City **Birmingham**

State **Alabama**

Zip **35205**

County (If not in Alabama Choose 'Out of State' **Jefferson**

Country **United States**

What is your practice Email? **bruce.e.norman@hotmail.com**

What is your practice Telephone? **(205) 933-1118**

What is your Home Address? (No PO Boxes)

Street [redacted]

City [redacted]

State [redacted]

Zip [redacted]

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

Country **United States**

What is your Home Email? [redacted]

What is your Home Phone? [redacted]

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. **Home**

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 [redacted]

What is your Primary Specialty? (If None Please Choose None) **Obstetrics & Gynecology**

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? **none**

What City is the Primary Hospital where you have staff privileges located? **none**

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

Are you licensed in another state? **Yes**

Which Ones? **North Carolina Mississippi Georgia**

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) **Out of State**

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

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

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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**

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.

Feb 9, 2012 9:38 AM

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

2012 Online Renewal Summary

Name: **Bruce Elliott Norman**
License Number: **MD.23937**
Transaction Date: **2011-11-01***
Transaction Number: **VZVA2FAD7BD8**
Registration Fee: **300**
Date of Birth: **1949-03-17**

* - 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 **1001 17th Street South**

City **Birmingham**

State **Alabama**

Zip **35205**

County (If not in Alabama Choose 'Out of State' **Jefferson**

Country **United States**

What is your practice Email? **bruce.e.norman@hotmail.com**

What is your practice Telephone? **(205) 933-1118**

What is your Home Address? (No PO Boxes)

Street [redacted]

City [redacted]

State [redacted]

Zip [redacted]

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

Country **United States**

What is your Home Email?[redacted]

What is your Home Phone?[redacted]

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. **Home**

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[redacted]

What is your Primary Specialty? (If None Please Choose None) **Obstetrics & Gynecology**

Is your Primary Specialty Board Certified? **No**

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? **none**

What City is the Primary Hospital where you have staff privileges located? **none**

What State is the Primary Hospital where you have staff privileges located? **Not Known**

Are you licensed in another state? **Yes**

Which Ones? **Georgia Mississippi North Carolina**

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) **Jefferson**

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

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

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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**

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.

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