State Medical Board of Ohio

77 S. High Street, 17th Floor • Columbus, Ohio 43266-0315 • 614/ 466-3934 • Website: www.state.oh.us/med/

D-C-14-2000

FOR BOARD USE ONLY

☐ 34 ☐ 35

BK: 22 PG: 15 LN: 1

DATE: 12/26/00 FEE: $335.00 PMT: 2426

APPLICATION FOR CERTIFICATE - MEDICINE OR OSTEOPATHIC MEDICINE

PLEASE TYPE OR PRINT CLEARLY

IDENTIFICATION

Social Security Number: Redacted

Your social security number is required to facilitate reporting to the Healthcare Integrity & Protection Data Bank (42 U.S.C. §1320a-7e(b), 5 U.S.C. §552a, and 45 C.F.R. pt. 61) and for accurate identification under Ohio's child support enforcement law (§2301.373.O.R.C.) It may also be used for investigation/enforcement purposes.

	Last (Surname)	First	Middle	Suffix (Jr., II)
Full Name (Use no initials)	NORMAN	BRUCE	ELLIOTT	
Name (As you prefer it inscribed on your Ohio license)	NURMAN	BRUCE	ELLIOTT	
Maiden Name or Other Names Used (If none, enter "NONE"):				

Current Home **Address** IMPORTANT Nofity the Board office immediately in writing of any change in address	Number and Street: 4013 JOHN S RABOTEAU WYND	Apt.		
	City: RALEIGH	State: N.C.	Zip Code: 27612	Country: USA

Telephone Number	Business: area code & number ( )	Home: area code & number (919) 571 8024

Birth Date	month/day/year 03/17/49	Birth Place	City WINNIPEG	State MANITOBA	Country CANADA

Physical Description	Height 5'10"	Weight 160	Hair Color SILVER	Eye Color BROWN	Identifying marks NONE

Gender ☒ Male ☐ Female For statistics only (optional)

Are you currently in an accredited training program in Ohio? ☐ Yes ☒ No

If yes, please identify name of training program and location:

OVER ⇨

WRITTEN EXAMINATION

Indicate which licensing examination you have passed:

- ☐ National Boards (MD or DO)
- ☐ FLEX (Pre-1985)
- ☐ FLEX Components 1 & 2
- ☐ Other, explain:_____
- ☐ USMLE Steps 1, 2, 3
- ☐ State Board exam
- ☒ LMCC

LICENSES IN THE UNITED STATES AND CANADA

List ALL states/provinces in which you hold or have held a license to practice medicine and surgery or osteopathic medicine and surgery, including a temporary license, training certificate, educational permit, or other license or certificate, ***whether the license is current or not***. If additional space is needed, attach an extra sheet. **(If none, enter "N/A"). A Form 2, Verification of License, must be sent to each state listed.**

STATE/PROVINCE	ISSUE DATE (MO/YR)	LICENSE NO.	LICENSE CURRENT YES	LICENSE CURRENT NO	EXPIRE(S)
ONTARIO	1976	40,420	☒	☐	3/31/2001
N.C.	1995	95-01030	☒	☐	3/17/2001
GEORGIA	1991	40176	☐	☒	INACTIVE
			☐	☐	
			☐	☐	
			☐	☐	
			☐	☐	
			☐	☐	

SPECIALTY BOARDS

NAME OF SPECIALTY BOARD (If none, enter "N/A")	YEAR CERTIFIED	COUNTRY
OB/GYN	1998	USA
FRCS (CAN)	1983	CANADA

CONTINUED ⇨

DEC 1 4 2000

FEDERATION CREDENTIALS VERIFICATION SERVICE

Ohio requires verification of your core credentials directly through the Federation Credentials Verification Service (FCVS).

Have you completed and forwarded the FEDERATION CREDENTIALS VERIFICATION SERVICE (FCVS) application packet to FCVS? ☒ YES ☐ NO

If yes, date forwarded: 11/20/00

ECFMG CERTIFICATE
(International Medical School Graduates only)

ECFMG Number		Date Issued		Expiration Date	

TEST OF SPOKEN ENGLISH
(International Medical Graduates only)

Graduates of medical schools located outside the United States and Canada must achieve a score of at least 40 (230 if taken prior to 7/95) on the Educational Testing Services Test of Spoken English (TSE), regardless of citizenship or country of birth, unless you meet one of the following:

Have you completed two years of undergraduate college work in the United States?	☐ YES ☐ NO
Have you held a current license (includes temporary license, training certificate or educational permits) in the United States for **at least five years** **AND** have you been actively practicing medicine or osteopathic medicine and surgery in the United States (includes approved graduate medical education training) for **at least five years**?	☐ YES ☐ NO
Have you completed a Fifth Pathway program?	☐ YES ☐ NO

If you answered **NO** to all of the above questions you must take the TSE. Refer to the application instructions for contacting the Educational Testing Service.

THE TOEFL, ECFMG EXAM, ETC., ARE NOT EQUIVALENT AND CANNOT BE SUBSTITUTED FOR THE TEST OF SPOKEN ENGLISH.

CONTINUED ⇨

DEC 14 2000

MALPRACTICE QUESTIONNAIRE

USE ONE FORM FOR EACH MALPRACTICE SUIT – DUPLICATE THIS FORM IF NECESSARY

Bruce Elliott Norman MD 783-0444
Full Name of Physician Business Telephone Number

4013 John S. Raboteau Wynd Raleigh NC 27612
Address City State Zip Code

Name of Patient: ___
Last Name First Name Middle Name

Age of Patient _____ Years

Date of Occurrence: ____/____/____

Location of Incident: Rex Hospital
Site 4420 Lake Boone Trail
Address Raleigh NC 27607
City County State Zip

Position in Case: ☐ Intern ☐ Resident ☒ Primary Physician ☐ Other:

Filed Against: ☐ Individual Physician ☐ Group ☐ Hospital

List Names of Other Physicians/Hospitals: _____

Describe the claim/suit in your **own** words, including all facts as stated above. Do not reference attached documents.
① lawsuit filed ② Allegation - Erbs Palsy Baby - ③ OPEN, ACTIVE
FOR FURTHER INFO: BERT RADFORD, 465 DEEP CREEK POINT
ROANOKE RAPIDS, NORTH CAROLINA 27870
PHONE: 252 533-9219
FAX 252 533-9218

Disposition: ☒ Pending ☐ Settled

If settled, provide the following information: ☐ In Court ☐ Out of Court Date of settlement: ___/___/___

Total Amount of Settlement: $_____ Amount Attributable to you: $_____

In addition to this form, the Board must receive documentation of this information **directly from the insurance company or attorney.** Have all paperwork forwarded to the Board address. Such documentation should include: plaintiff's complaint, settlement agreement, and/or court order. Your application will not be considered by the Reinstatement Committee until this information has been received for their review prior to the scheduled Board meeting.

Signature 11/27/00
Date

The Carolina Permanente Medical Group, PA

909 Aviation Parkway, Suite 600 • Morrisville, North Carolina 27560-9153 • (919) 469-7200

NOV 14 2000

November 6, 2000

Bruce E., Norman, M.D.
4013 John S. Raboteau
Raleigh, NC 37612

Re: Bruce E. Norman, M.D.

Dear Dr. Norman:

In response to your request for information concerning claims and lawsuit history of the above referenced physician, please be advised Dr. Norman was employed by Carolina Permanente Medical Group (and The Carolina Permanente Medical Group, P.A.) from September 18, 1995 through November 30, 1999. The status is as follows:

Claims:	One
Allegations:	Erbs Palsy baby – parents allege a nerve injury in this delivery is responsibility of Dr. Norman
Date of Loss:	October 9, 1995
Coverage:	Occurrence

PLEASE NOTE: This case is open and active, is still in discovery stages and we have no evidence of negligence on the part of this physician at this time.

If I can be of further assistance, please do not hesitate to contact me at the following address: **465 Deep Creek Point, Roanoke Rapids, NC 27870, Telephone: (252) 533-9219; Fax (252) 533-9218.**

Yours truly,

Bert Radford
Risk Manager

MALPRACTICE QUESTIONNAIRE

DEC 14 2000

USE ONE FORM FOR EACH MALPRACTICE SUIT – DUPLICATE THIS FORM IF NECESSARY

BRUCE ELLIOTT NORMAN — 919-783-0444
Full Name of Physician — Business Telephone Number

4013 JOHN S. RABOTEAU WYND — RALEIGH — NC — 27612
Address — City — State — Zip Code

Name of Patient: AMENDOLA — ANNA
Last Name — First Name — Middle Name

Age of Patient _____ Years

Date of Occurrence: Oct / ____ / 1989 CASE FILED: 1991

Location of Incident: OSHAWA GENERAL HOSPITAL
Site 24 ALMA STREET
Address OSHAWA, ONTARIO L1G 2B9
City — County — State — Zip

Position in Case: ☐ Intern ☐ Resident ☒ Primary Physician ☐ Other:

Filed Against: ☐ Individual Physician ☐ Group ☐ Hospital

List Names of Other Physicians/Hospitals: _____

Describe the claim/suit in your **own** words, including all facts as stated above. Do not reference attached documents.

S/P BILATERAL OOPHORECTOMY, PATIENT HAD SYMPTOMATIC PAIN. HAD CYSTIC OVARIAN REMNANT REQUIRING REMOVAL. PATIENT ALLEGED I HAD KNOWINGLY LEFT IN OVARIAN TISSUE. EXPERT WITNESS FELT THIS WAS OVARIAN REMNANT SYNDROME - SMALL PIECE OF OVARIAN TISSUE COULD HAVE BEEN LEFT DUE TO DIFFICULT NATURE OF CASE AND SUBSEQUENTLY REGENERATED IN RESPONSE TO BODY'S PITUITARY HORMONES. CASE DROPPED IN JULY, 1997

Disposition: ☐ Pending ☐ Settled ☒ DROPPED

If settled, provide the following information: ☐ In Court ☐ Out of Court Date of settlement: __/__/__

Total Amount of Settlement: $_____ Amount Attributable to you: $_____

In addition to this form, the Board must receive documentation of this information **directly from the insurance company or attorney.** Have all paperwork forwarded to the Board address. Such documentation should include: plaintiff's complaint, settlement agreement, and/or court order. Your application will not be considered by the Reinstatement Committee until this information has been received for their review prior to the scheduled Board meeting.

BE Norman — 11/27/00
Signature — Date

DEC 1 4 2000

MALPRACTICE QUESTIONNAIRE

USE ONE FORM FOR EACH MALPRACTICE SUIT – DUPLICATE THIS FORM IF NECESSARY

BRUCE ELLIOTT NORMAN, MD — 919-783-0444
Full Name of Physician — Business Telephone Number

4013 JOHN S. RABOTEAU WYND — RALEIGH — NC — 27612
Address — City — State — Zip Code

Name of Patient: DINZWALL — MAXINE
Last Name — First Name — Middle Name

Age of Patient _____ Years

Date of Occurrence: MAY 1980

Location of Incident: OSHAWA GENERAL HOSPITAL
Site
24 ALMA STREET
Address
OSHAWA, ONTARIO — L1G 2B9
City — County — State — Zip

Position in Case: ☐ Intern ☐ Resident ☒ Primary Physician ☐ Other:

Filed Against: ☐ Individual Physician ☒ Group ☐ Hospital

List Names of Other Physicians/Hospitals: ANESTHETIST

Describe the claim/suit in your **own** words, including all facts as stated above. Do not reference attached documents.

CIVIL MALPRACTICE LAWSUIT RELATED TO COMPLICATION DIAGNOSTIC LAPAROSCOPY FOR ABDOMINAL PAIN. AFTER AWAKENING, DEVELOPED RIGHT LONG THORACIC NERVE PALSY. PATIENT ALLEGED RESULT WAS EITHER FROM SURGERY OR ANESTHESIA. AFTER EXAMINATION UNDER DISCOVERY, COMPLAINANT DROPPED HIS SUIT DUE TO LACK OF EVIDENCE ON EITHER MY PART OR THE ANESTHETIST INVOLVED BEING RESPONSIBLE FOR HER INJURY.

Disposition: ☐ Pending ☐ Settled ☒ DROPPED - LACK OF EVIDENCE

If settled, provide the following information: ☐ In Court ☐ Out of Court Date of settlement: __/__/__

Total Amount of Settlement: $_____ Amount Attributable to you: $_____

In addition to this form, the Board must receive documentation of this information **directly from the insurance company or attorney.** Have all paperwork forwarded to the Board address. Such documentation should include: plaintiff's complaint, settlement agreement, and/or court order. Your application will not be considered by the Reinstatement Committee until this information has been received for their review prior to the scheduled Board meeting.

B E Norman — 11/27/00
Signature — Date

DOW'S LAKE COURT
875 CARLING AVENUE

MAILING ADDRESS PO BOX 8225 STN T
OTTAWA ONTARIO
CANADA K1G 3H7

DEC 1 4 2000

THE CANADIAN
MEDICAL
PROTECTIVE
ASSOCIATION

March 27, 1995

To Whom It May Concern:

RE: Doctor Bruce E. Norman

The Canadian Medical Protective Association is a mutual defence organization which a Canadian physician may join to be eligible for assistance in the event of medico-legal difficulty arising from his/her professional work. Assistance at the Association includes provision of legal Counsel and payment of fees, payment of costs, and satisfaction of any court award or settlement that might be necessary. Membership is arranged on an occurrence basis.

Doctor Norman was a member of the Association between July 1976 and December 1981. He then rejoined in 1983, and remains a member. During his 16 years of membership, he needed assistance with two litigations. The first was reported in 1987, when a lady awoke from routine diagnostic laparoscopy with a right thoracic nerve palsy. The matter was fully evaluated. We received good expert support and the litigation was resolved by a discontinuance, and there was no payment to the plaintiff.

In 1992, litigation was commenced against Doctor Norman. He performed a laparotomy and removal of ovaries in a post hysterectomized patient with chronic pelvic pain. Subsequently, she was found to have ovarian remnants. This litigation has proceeded only slowly. We have good expert support, and we are in a position to have the litigation dismissed on summary judgment. We expect the litigation to be resolved in the near future. We do not expect to make a financial settlement on this file.

Yours very truly,

Ruth A. Cottrill, M.B., Ch.B.
Assistant Secretary-Treasurer

RAC/cp

TELEPHONE (613) 725-2000
1-800-267-6522

Farmers Insurance Group of Companies
Healthcare Professional Liability

CERTIFICATE OF INSURANCE

Issued by:
- [x] Truck Insurance Exchange, Los Angeles, CA
- [ ] Mid Century Insurance Company, Los Angeles, CA
- [ ] Farmers Insurance Company of Washington, Los Angeles, CA
- [ ] Texas Farmers Insurance Company, Los Angeles, CA

Producer & Address (if applicable):

DEC 1 4 2000

Insured: Carolina Premier Medical Group
909 Aviation Parkway, Suite 600
Morrisville, North Carolina 27560-9153

Policy Number: 1180-1000

- [x] Claims Made
- [ ] Occurrence

Insured Physician:
Address:

Specialty:
Subunit #:
Retro Date:

Type:
- [ ] A Named Insured
- [ ] A Locum Tenen
- [ ] An Additional Insured
- [ ] An Additional Named Insured

This certificate or verification of insurance is not an insurance policy and does not amend, extend or alter the coverage afforded by the policy referred to above. Notwithstanding any requirement, term or condition of any contract or other document with respect to which this certificate or verification of insurance may be issued or may pertain, the insurance afforded by the policy is subject to all the terms, exclusions, and conditions of such policy. Insured has Single Limit as indicated below.

Effective Date	Issue Date
December 1, 1999 to until December 1, 2000	12/20/99

Coverage	Limits of Liability
Professional Liability - per occurrence	$5,000,000
Professional Office Premises Liability	
A. Bodily Injury Liability	
B. Property Damage Liability	
Annual Aggregate Limit of Liability per Policy Year Shall Not Exceed	$N/A

Description of Operations/Vehicles/Special Items/Remarks:
RE: Evidence of Professional and General Liability Insurance as respects Bruce B. Norman, M. D.
Notice of cancellation of the coverage automatically terminates coverage. After cancellation this certificate becomes void and without effect. A breakdown of the limits will be provided upon demand.

Certificate Holder
Carolina Premier Medical Group
909 Aviation Parkway, Suite 600
Morrisville, North Carolina 27560-9153

I. LOCUM TENENS AND ADDITIONAL INSUREDS SHARE LIMITS OF LIABILITY WITH THE NAMED INSURED.
II. SHOULD THE ABOVE DESCRIBED POLICY BE CANCELLED OR THE TERMS AND CONDITIONS OF THE POLICY BE CHANGED BEFORE THE EXPIRATION DATE THEREOF, FARMERS INSURANCE GROUP OF COMPANIES IS UNDER NO OBLIGATION OR LIABILITY OF ANY KIND TO NOTIFY THE CERTIFICATE HOLDER.
III. PHOTOCOPIES OF THE CERTIFICATE OF INSURANCE ARE DEEMED AS VALID AS THE ORIGINAL.

Authorized Representative (if applicable)
Farmers Insurance Group of Companies
Healthcare Professional Liability
P.O. Box 4998
Los Angeles, CA 90051-4998
(800) 344-3611

S12/20/99

CMG
ENDORSEMENT OF LMCC

NAME: NORMAN, BRUCE ELLIOT
SCHOOL: QUEENS UNIV, KINGSTON ONTARIO
DEGREE CONFERRED: MD
DATE CONFERRED: 6/74

INTERNSHIP/RESIDENCY:

HOSPITAL: ROYAL VICTORIA HOSP
CITY: MONTREAL STATE: CANADA
STARTING DATE: 7/74 ENDING DATE: 6/76

EXAM:

EXAM TAKEN: LMCC PASSED

ALL AMA, AOA, TSE SCORES, FED REPORTS, REC FORMS AND ECFMG VERIFICATIONS HAVE BEEN OR WILL BE CHECKED PRIOR TO A LICENSE BEING ISSUED AS IT APPLIES TO THE APPLICANT.

DEC 1 4 2000

RESUME OF ACTIVITIES - MEDICINE OR OSTEOPATHIC MEDICINE

List ALL activities in chronological order beginning with medical school graduation, using **MONTH** and **YEAR**. *For any non-working time, you MUST state on the resume exactly what your activities were, such as "vacation" or "seeking employment", as well as your permanent address.* If in private practice, indicate the hospitals where you hold or have held privileges and include complete dates and addresses. If you worked for a physician staffing group or did locum tenens, you must list all facilities where you worked and include complete dates and addresses. **DO NOT SUBSTITUTE ANY OTHER RESUME FOR THIS FORM**. Be sure to indicate the percentage of working time spent in clinical and administrative duties. If you require more space, please attach separate sheets. You must account for ALL time.

From Month/Year	To Month/Year	Hospital, University or Other / Complete Street Address / City / State/Country / Zip Code	Position & Department	% Clinical / % Admin.
7/74	6/75	ROYAL VICTORIA HOSPITAL 687 PINE AVENUE, W MONTREAL, QUEBEC H3A 1A1	STRAIGHT SURGICAL INTERNSHIP	100
7/75	6/76	ROYAL VICTORIA HOSPITAL 687 PINE AVENUE, W. MONTREAL, QUEBEC. H3A 1A1	2ND YEAR RESIDENT OB/GYN	100
7/76	12/76	YORK FINCH HOSPITAL 2111 FINCH AVE W NORTH YORK, ONTARIO	FAMILY PRACTICE - ADMITTING PRIVILEGES	100
1/77	6/81	PEEL MEMORIAL HOSPITAL 20 LYNCH STREET BRAMPTON ONTARIO L6W 2Z8	FAMILY PRACTICE - ADMITTING PRIVILEGES - CHIEF DEPT FAMILY PRACTICE	
7/81	6/83	ROYAL VICTORIA HOSPITAL 687 PINE AVENUE W MONTREAL QUEBEC H3A 1A1	3RD AND 4TH YEAR RESIDENT OB/GYN	100

OVER ⇨

RESUME OF ACTIVITIES - MEDICINE OR OSTEOPATHIC MEDICINE
PAGE 2

From Month/Year	To Month/Year	Hospital, University or Other / Complete Street Address / City / State/Country / Zip Code	Position & Department	% Clinical / % Admin.
7/83	12/83	ROYAL VICTORIA HOSP 687 PINE AVENUE W MONTREAL QUEBEC H3A 1A1	ADMITTING PRIVILEGES OB/GYN	100
7/83	12/83	QUEEN ELIZABETH HOSP 2100 MARLOWE AVENUE MONTREAL QUEBEC H4A 3L6	ADMITTING PRIVILEGES	100
1/84	8/95	OSHAWA GENERAL HOSP 24 ALMA STREET OSHAWA ONTARIO	(1) ADMITTING PRIVILEGES OB/GYN (2) CHIEF OB/GYN (3) CHIEF SURGERY	90 10
9/95	PRESENT	REX HOSPITAL 4420 LAKE BOONE TRAIL RALEIGH NC 27607	ADMITTING PRIVILEGES OB/GYN	100
/	/			
/	/			

DEC 1 4 2000

ADDITIONAL INFORMATION - MEDICINE OR OSTEOPATHIC MEDICINE

If you answer "YES" to any of the following questions, you are required to furnish complete details, including date, place, reason and disposition of the matter. All affirmative answers must be thoroughly explained on a separate sheet of paper. You must submit copies of all relevant documentation, such as court pleadings, court or agency orders, and institutional correspondence and orders. Please note that some questions require very specific and detailed information. Make sure all responses are complete.

(Please place a ☑ in the yes or no box)

		YES	NO
1.	Have you ever been denied staff membership at any hospital, nursing home, clinic, health maintenance organization, or similar institution?	☐	☒
2.	Have you ever been warned, censured, disciplined, had admissions monitored, had privileges limited, had privileges suspended or terminated, been put on probation, or been requested to withdraw from or resign privileges at any hospital, nursing home, clinic, health maintenance organization, or other similar institution in which you have trained, been a staff member, or held privileges, for reasons other than failure to maintain records on a timely basis, or failure to attend staff or section meetings?	☐	☒
3.	Have you ever resigned from, withdrawn from, or terminated, or have you ever been requested to resign from, withdraw from, or otherwise been terminated from, a position with a medical partnership, professional association, corporation, health maintenance organization, or other medical practice organization, either private or public?	☐	☒
4.	Have you ever resigned from, withdrawn from, or have you ever been warned by, censured by, disciplined by, been put on probation by, been requested to withdraw from, dismissed from, been refused renewal of a contract by, or expelled from, a medical school, clinical clerkship, externship, preceptorship, residency, or graduate medical education program?	☐	☒
5.	Have you ever transferred from one graduate medical education program to another?	☐	☒
6.	Have you ever, for any reason, lost specialty board certification in the U.S. or elsewhere, or been denied such certification, or denied examination for such certification?	☐	☒
7.	Has any board, bureau, department, agency or other body, including those in Ohio, in any way limited, restricted, suspended, or revoked any professional license, certificate or registration granted to you; placed you on probation; or imposed a fine, censure or reprimand against you?	☐	☒
8.	Have you ever voluntarily surrendered, resigned, or otherwise forfeited any professional license, certificate or registration issued to you by any board, bureau, department, agency, or other body; or have you ever withdrawn any application for licensure, relicensure, or examination, in any state (including Ohio), territory, province, or country?	☐	☒
9.	Have you ever, for any reason, been denied licensure or relicensure, application for licensure or relicensure, or the privilege of taking an examination, in any state (including Ohio), territory, province, or country?	☐	☒

OVER ⇨

		YES	NO
10.	Have you ever been requested to appear before any board, bureau, department, agency, or other body, including those in Ohio, concerning allegations against you?	☐	☒
11.	Have you ever entered into an agreement of any kind, whether oral or written, with respect to a professional license, in lieu of or in order to avoid formal disciplinary action, with any board, bureau, department, agency, or other body, including those in Ohio?	☐	☒
12.	Have you ever been notified of any investigation concerning you by any board, bureau, department, agency, or other body, including those in Ohio, with respect to a professional license?	☐	☒
13.	Have you ever been notified of any charges, allegations, or complaints filed against you with any board, bureau, department, agency, or other body, including those in Ohio, with respect to a professional license?	☐	☒
14.	Have you ever been denied or have you ever surrendered a state or federal controlled substance or drug registration; had it revoked, terminated, or restricted in any way; or been warned, reprimanded, or fined by, or been requested to appear before, the responsible agency?	☐	☒
15.	Have you ever pled guilty to, been found guilty of a violation of any law, or been granted intervention or treatment in lieu of conviction regardless of the legal jurisdiction in which the act was committed, other than a minor traffic violation?	☐	☒
16	Have you ever forfeited collateral, bail, or bond for breach or violation of any law, police regulation, or ordinance other than for a minor traffic violation; been summoned into court as a defendant or had any lawsuit filed against you (other than a malpractice suit)?	☐	☒
17.	Have you been a defendant in a legal action involving professional liability (malpractice), or had a professional liability claim paid on your behalf, or paid such a claim yourself? If yes, include the case name, case number, court and address, date filed, and a summary of the underlying events. Indicate current status, including amount of settlement or judgment, if any. In addition, ask your malpractice insurance carrier(s) to provide a complete claims history report for the last 10 years to the State Medical Board of Ohio. If your current carrier has provided coverage for less than 10 years, ask your previous carrier to submit a claims history report to the Board.	☒	☐
18.	Have you ever been denied professional liability insurance or coverage, or had such insurance or coverage canceled, limited, or restricted in any way?	☐	☒
19.	Have you ever been denied or relinquished participation in any third party reimbursement program, whether governmental or private, including Medicaid and Medicare; or had such participation limited, restricted, suspended, or revoked; or been warned, reprimanded, requested to appear before, or fined by the responsible body?	☐	☒
20.	Have you ever been denied privileges, or had privileges revoked, suspended, restricted, reduced, or terminated by the Department of Defense, the Veteran's Administration, or any of their respective components?	☐	☒

CONTINUED ⇨

DEC 4 2000

		YES	NO
21.	Have you ever been diagnosed as having, or have you been treated for, pedophilia, exhibitionism, or voyeurism?	☐	☒
22.	a) Within the last ten years, have you been diagnosed with or have you been treated for, bipolar disorder, schizophrenia, paranoia, or any other psychotic disorder?	☐	☒
	b) Have you, since attaining the age of eighteen or within the last ten years, whichever period is shorter, been admitted to a hospital or other facility for the treatment of bipolar disorder, schizophrenia, paranoia, or any other psychotic disorder? If you answered "YES" to any part of this question, please provide details on a separate sheet, including date(s) of diagnosis or treatment, and a description of your present condition. Include the name, current mailing address, and telephone number of each person who treated you, as well as each facility where you received treatment, and the reason for treatment. Have each treating physician submit a letter detailing the dates of treatment, diagnosis and prognosis.	☐	☒

For purposes of questions 23 and 24 the following phrases or words have the following meaning:

"Ability to practice medicine" is to be construed to include all of the following:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments; and

2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and

3. The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical condition" includes physiological, mental, or psychological conditions or disorders, such as but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

		YES	NO
23.	Do you have, or have you been diagnosed as having, a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety?	☐	☒
	a) Are the limitations or impairment caused by your medical condition reduced or ameliorated because you receive ongoing treatment or received treatment in the past (with or without medication) or participate in a monitoring program? If you receive such ongoing treatment or participate in such monitoring program the board will make an individualized assessment of the nature, severity, and duration of the risk associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure. Have each treating physician submit a letter detailing the dates of treatment, diagnosis and prognosis.	☐	☐
	b) Are the limitation or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice?	☐	☐

OVER ⇨

"Chemical substances" is to be construed to include alcohol, drugs, or medications including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescribers direction, as well as those used illegally.

		YES	NO
24.	Do you use chemical substance(s) which in any way impair or limit your ability to practice medicine with reasonable skill and safety?	☐	☒
	a) Are the limitations or impairment caused by your use of chemical substances reduced or ameliorated because you receive ongoing treatment (with or without medication) or participate in a monitoring program? If you receive such ongoing treatment or participate in such monitoring program the board will make an individualized assessment of the nature, severity, and duration of the risk associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure. Have each treating physician submit a letter detailing the dates of treatment, diagnosis and prognosis.	☐	☐
	b) Are the limitation or impairments caused by your use of chemical substances reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice?	☐	☐

For purposes of question 25 the following phrases or words have the following meaning:

"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 use of drugs may have an ongoing impact on one's functioning as a licensee, or within the past two years.

"Illegal use of controlled substances" means the use of controlled substances obtained illegally (e.g. heroin or cocaine) as well as the use of controlled substances which are not obtained pursuant to a valid prescription or not taken in accordance with the direction of a licensed healthcare practitioner.

		YES	NO
25.	Are you currently engaged in the illegal use of controlled substances?	☐	☒
	a) If "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 using illegal controlled substances.	☐	☐

Allison Jacokes

OHIO MEDICAL BOARD
JAN 11 2001

State Medical Board of Ohio

77 S. High Street, 17th Floor • Columbus, Ohio 43266-0315 • 614/ 466-3934 • Website: www.state.oh.us/med/

MEDICINE OR OSTEOPATHIC MEDICINE
FORM 1 - CERTIFICATE OF RECOMMENDATION

This form is to be completed by a physician fully licensed in the STATE IN WHICH THE FORM IS NOTARIZED. The recommending physician must have known the applicant for at least **SIX months**. Relatives may not serve as recommending physicians. Recommending physicians are strongly urged to include additional comments. This form must be notarized. ALL questions must be answered. This form is not intended to standardize the recommendation or restrict it in any way. However, its form is designed to ensure that certain information is included.

DO NOT COMPLETE UNLESS A COLOR PHOTO OF APPLICANT IS ATTACHED TO THE BOTTOM OF THIS FORM
BLACK & WHITE PHOTOS ARE NOT ACCEPTABLE

I, Allison Jacokes (recommending physician, print name), a licensed and practicing physician in the state of NC (state of residence)

affirm that Bruce Norman (applicant, print name) has been known to me personally for _____ years and that he/she is of good moral character. Further, the photograph affixed hereto is a genuine likeness of the applicant. I offer the following in support of his/her application for licensure:

- I rate his/her medical knowledge and technique as: _____
- His/her relationship with patients is: _____
- I rate his/her ability to work well with peers and medical staff as: _____
- His/her command of the English language is: _____
- Additional comments: _____

I hereby recommend the applicant for a license to practice medicine or osteopathic medicine in the State of Ohio.

Address of Recommending Physician	Number & Street 4208 Berry D. Sims Wy. City Raleigh State NC Zip Code 27612	Telephone Number (include area code)	919-781-1387
Signature of Recommending Physician (name stamps not acceptable)		State of Licensure & License Number	NC 35380

Signature of Applicant

Date Photo Taken: 11/00 (Mo/Yr)

Subscribed and sworn to before me this 10th day of November, 2000.

Connie Woolen
Notary Public Signature

9-10-2004
Date Commission Expires

RETURN COMPLETED FORM TO THE STATE MEDICAL BOARD OF OHIO AT THE ABOVE ADDRESS.

John Smith

State Medical Board of Ohio

77 S. High Street, 17th Floor • Columbus, Ohio 43266-0315 • 614/ 466-3934 • Website: www.state.oh.us/med/

OHIO STATE MEDICAL BOARD
DEC 14 2000

MEDICINE OR OSTEOPATHIC MEDICINE
FORM 1 - CERTIFICATE OF RECOMMENDATION

This form is to be completed by a physician fully licensed in the STATE IN WHICH THE FORM IS NOTARIZED. The recommending physician must have known the applicant for at least **SIX months**. Relatives may not serve as recommending physicians. Recommending physicians are strongly urged to include additional comments. This form must be notarized. ALL questions must be answered. This form is not intended to standardize the recommendation or restrict it in any way. However, its form is designed to ensure that certain information is included.

DO NOT COMPLETE UNLESS A COLOR PHOTO OF APPLICANT IS ATTACHED TO THE BOTTOM OF THIS FORM
BLACK & WHITE PHOTOS ARE NOT ACCEPTABLE

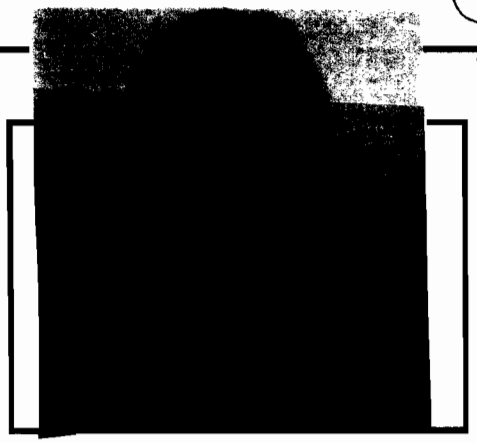
I, John Smith, MD (recommending physician, print name), a licensed and practicing physician in the state of NC (state of residence)

affirm that Bruce Norman (applicant, print name) has been known to me personally for 2-3 years and that he/she is of good moral character. Further, the photograph affixed hereto is a genuine likeness of the applicant. I offer the following in support of his/her application for licensure:

- I rate his/her medical knowledge and technique as: excellent
- His/her relationship with patients is: excellent
- I rate his/her ability to work well with peers and medical staff as: excellent
- His/her command of the English language is: Excellent
- Additional comments:

I hereby recommend the applicant for a license to practice medicine or osteopathic medicine in the State of Ohio.

Address of Recommending Physician	Number & Street 8008 Gresham Trace Ln	Telephone Number (include area code)	(919) 875-9071
	City Raleigh State NC Zip Code 27615		
Signature of Recommending Physician (name stamps not acceptable) John Smith MD		State of Licensure & License Number	NC 31651



Bruce Norman
Signature of Applicant

Date Photo Taken: 11/00
Mo/Yr

Subscribed and sworn to before me this 10th day of November, 2000.

Connie Wooten
Notary Public Signature

9-10-2004
Date Commission Expires

RETURN COMPLETED FORM TO THE STATE MEDICAL BOARD OF OHIO AT THE ABOVE ADDRESS.

63925

State Medical Board of Ohio

77 S. High Street, 17th Floor • Columbus, Ohio 43266-0315 • 614/466-3934 • Website: www.state.oh.us/med/

00 DEC 14 AM 9:08 STATE MEDICAL BOARD

DEC 18 2000

MEDICINE OR OSTEOPATHIC MEDICINE
FORM 2 - VERIFICATION OF LICENSE

I am applying for a license to practice medicine or osteopathic medicine in the State of Ohio. The State Medical Board of Ohio requires that this form be completed by each state or Canadian province in which I hold or have held licenses, whether now current or not. Please complete the form and return it directly to the State Medical Board of Ohio.

TO BE COMPLETED BY APPLICANT

Name	Last: NORMAN	First: BRUCE	Middle: ELLIOTT	Suffix (Jr., II):
Current Address	Number & Street: 4013 JOHN S RABOTEAU		License Number:	
	City: RALEIGH	State: NC	Zip: 27612	Date of Birth: 03/17/49 Month/Day/Year: 03/17/49
Medical/Osteopathic School of Graduation	QUEEN'S UNIVERSITY KINGSTON ONTARIO CAN			

I hereby authorize the licensing agency of the State of GEORGIA to furnish the information below to the State Medical Board of Ohio.

Signature of Applicant	Date
B E Norman	11/13/00

TO BE COMPLETED BY STATE BOARD OR CANADIAN PROVINCE

State: North Carolina Medical Board

Name of Licensee: Last: Norman, Bruce First: Elliott Middle: Suffix (Jr., II):

License Number	Issue Date month/day/year	License current? If not, please explain
95-01030	7/22/95	☑ Yes ☐ No

	Yes	No	Cannot answer under current state law
Is the applicant currently the subject of a pending investigation by a licensing or disciplinary authority in your state?	☐	☑	☐
Have formal disciplinary proceedings been initiated against applicant's license by a disciplinary authority in your state?	☐	☑	☐
Has the applicant ever been warned, censured or in any other manner disciplined or has applicant's license been revoked, suspended, or in any other manner limited by a licensing or disciplinary authority in your state?	☐	☑	☐

If yes, please attach complete details.

AFFIX BOARD SEAL NOT VALID WITHOUT SEAL

Signature: [signature]

Title: Executive Secretary

Date: 12-14-2000

RETURN COMPLETED FORM TO THE STATE MEDICAL BOARD OF OHIO AT THE ABOVE ADDRESS.

no ✓

COMPOSITE STATE BOARD OF MEDICAL EXAMINERS

EXECUTIVE DIRECTOR
Karen Mason

MEDICAL DIRECTOR
Jim H. McNatt, MD

2 Peachtree St., NW • Atlanta, Georgia 30303 • Phone: (404) 656-3913 • Fax (404) 656-9725
www.sos.state.ga.us/ebd-medical

Wednesday, December 20, 2000

TO WHOM IT MAY CONCERN:

This is to certify that **BRUCE NORMAN, MD** was issued Physician license number 40176, on June 8, 1995. It is further certified that the status of this License is: Inactive.

The license expiration date is December 31, 1997.

A review of public records indicates that no disciplinary orders have been docketed.

This day Wednesday, December 20, 2000.

Composite State Board of Medical Examiners

Karen Mason
Executive Director

Our mailing address of record for this licensee:
4013 JOHNS RABOTEAU WYND
RALEIGH, NC 27612

State Medical Board of Ohio

77 S. High Street, 17th Floor • Columbus, Ohio 43266-0315 • 614/ 466-3934 • Website: www.state.oh.us/med/

STATE MEDICAL BOARD
DEC 26 2000

MEDICINE OR OSTEOPATHIC MEDICINE
FORM 2 - VERIFICATION OF LICENSE

I am applying for a license to practice medicine or osteopathic medicine in the State of Ohio. The State Medical Board of Ohio requires that this form be completed by each state or Canadian province in which I hold or have held licenses, whether now current or not. Please complete the form and return it directly to the State Medical Board of Ohio.

TO BE COMPLETED BY APPLICANT

Name	Last: NORMAN	First: BRUCE	Middle: ELLIOTT	Suffix (Jr., II):
Current Address	Number & Street: 4013 JOHN S RABOTEAU		License Number:	
	City: RALEIGH	State: NC	Zip: 27612	Date of Birth: 03/17/49 Month/Day/Year: 03/17/49
Medical/Osteopathic School of Graduation	QUEEN'S UNIVERSITY KINGSTON ONTARIO CAN			

I hereby authorize the licensing agency of the State of OHIO to furnish the information below to the State Medical Board of Ohio.

Signature of Applicant	B E Norman	Date	11/12/00

TO BE COMPLETED BY STATE BOARD OR CANADIAN PROVINCE

State				
Name of Licensee	Last	First	Middle	Suffix (Jr., II)
License Number		Issue Date month/day/year / /	License current? If not, please explain	☐ Yes ☐ No

	Yes	No	Cannot answer under current state law
Is the applicant currently the subject of a pending investigation by a licensing or disciplinary authority in your state?	☐	☐	☐
Have formal disciplinary proceedings been initiated against applicant's license by a disciplinary authority in your state?	☐	☐	☐
Has the applicant ever been warned, censured or in any other manner disciplined or has applicant's license been revoked, suspended, or in any other manner limited by a licensing or disciplinary authority in your state?	☐	☐	☐

If yes, please attach complete details.

AFFIX BOARD SEAL NOT VALID WITHOUT SEAL

Signature

Title

Date

RETURN COMPLETED FORM TO THE STATE MEDICAL BOARD OF OHIO AT THE ABOVE ADDRESS.

AFFIDAVIT

DEC 4 2000

I, Connie Wooten, Notary Public for the State of North Carolina, County of Wake, certify that the attached documents are true copies of such documents that they represent and that I personally made the copies and notarized such copies.

Subscribed and copied by me this 6th day of November, 2000.

Connie Wooten 11/10/00

Connie Wooten – Notary Public

County of Wake – State of North Carolina

My Commission expires September 10, 2004.

STATE OF NORTH CAROLINA

THE NORTH CAROLINA MEDICAL BOARD

TO THE PEOPLE OF THE STATE OF NORTH CAROLINA

Whereas **Bruce Elliott Norman**

Has applied to us

The North Carolina Medical Board

For admission to practice as a **PHYSICIAN** within the State aforesaid

We do Certify *that he has produced to us sufficient testimonials of his upright character and upon examination before us is found to possess a competent knowledge of the*

SCIENCE OF MEDICINE

to entitle him to our License to practice the same within the limits of the said State.

Given under our hands and seals at Raleigh, N.C. *this* 22nd *day of* July *A.D.* 1995

No. 95-01030

Paul Sapienza, Member	[Seal]	J. Dorfard Bunn, Jr. M.D., Member	[Seal]
Matthew K. Walston, Member	[Seal]	L. Walter Roafe, M.D., Member	[Seal]
David L. Hoke, Member	[Seal]	Charles E. Beals, M.D., Member	[Seal]
Wayne W. VanSeggen, PA-C, P.A., Member	[Seal]	George C. Bauer, M.D., Member	[Seal]
George Johnson, Jr. M.D., Member	[Seal]	David L. Dodson, M.D., Member	[Seal]
C. B. Spangler, M.D., Member	[Seal]	Hilda H. Hunt, M.D., Member	[Seal]

NORTH CAROLINA MEDICAL BOARD

PHYSICIAN CERTIFICATE OF REGISTRATION

REGISTRATION REQUIRED
03/17/2001

REGISTRATION CERTIFICATE NO.
63925

THIS IS TO CERTIFY THAT THE PHYSICIAN NAMED BELOW HAS REGISTERED WITH THE BOARD AND HAS PAID THE REGISTRATION FEE OF $ 100.00 FOR THE YEAR ABOVE AS REQUIRED BY THE GENERAL STATUTES OF NORTH CAROLINA, SECTION 90-15.1 AND RULES PROMULGATED PURSUANT THERETO.

LICENSE NO: 9501030

BRUCE ELLIOTT NORMAN MD
4013 JOHN S RABOTEAU WYND
RALEIGH, NC 27612-5330

EXECUTIVE DIRECTOR

THIS IS YOUR REGISTRATION CERTIFICATE FOR YOUR WALLET. PLEASE DETACH AND DISCARD THIS PORTION.

DEC 4 2000

NORTH CAROLINA MEDICAL BOARD

REGISTRATION CERTIFICATE

REGISTRATION REQUIRED
03/17/2001

63925

THIS IS TO CERTIFY THAT THE PHYSICIAN NAMED BELOW HAS REGISTERED WITH THE BOARD AND HAS PAID THE REGISTRATION FEE FOR THE YEAR ABOVE AS REQUIRED BY THE GENERAL STATUTES OF NORTH CAROLINA, SECTION 90-15.1 AND RULES PROMULGATED PURSUANT THERETO.

BRUCE ELLIOTT NORMAN MD
LICENSE NO: 9501030

EXECUTIVE DIRECTOR
P.O. BOX 20007
RALEIGH, N.C. 27619

PLEASE DETACH AND DISCARD THIS PORTION.

American Board of Obstetrics and Gynecology

COMPOSED OF MEMBERS NOMINATED BY THE
AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY
AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS
AMERICAN GYNECOLOGICAL AND OBSTETRICAL SOCIETY
AMERICAN MEDICAL ASSOCIATION
ASSOCIATION OF PROFESSORS OF GYNECOLOGY AND OBSTETRICS

Obstetrics and Gynecology

Bruce Elliott Norman, M.D.

HAVING PURSUED AN ACCEPTED COURSE OF GRADUATE STUDY AND CLINICAL WORK,
HAS MET THE STANDARDS AND QUALIFICATIONS, AND PASSED THE EXAMINATIONS
REQUIRED BY THE AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY, INC.,
AND IS AN ACKNOWLEDGED DIPLOMATE OF THE BOARD
FROM NOVEMBER, 1998 THROUGH DECEMBER, 2008
NOVEMBER 20, 1998

President

Executive Director

American Board of Obstetrics & Gynecology

DIPLOMATE NO. 838136

License No.
40176

The State of Georgia

THIS IS TO CERTIFY THAT

Bruce Elliot Norman

has met all the requirements prescribed by the laws of the State of Georgia and the Composite State Board of Medical Examiners as required by an Act of the General Assembly of 1913, as amended by an Act of 1970, and is hereby licensed to practice

Medicine and Surgery in Georgia

In testimony whereof we have hereunto set our names and caused the official seal of the Board to be affixed this 8th day of June 1995

Larry E Brightwell, MD
PRESIDENT

William G. Mathis
JOINT SECRETARY, STATE EXAMINING BOARDS

DEC 4 2000

DEC 1 4 2000

The Medical Council of Canada

We, the Medical Council of Canada, by virtue of the authority given under the Canada Medical Act (1-2 George V) do hereby admit

Bruce Elliott Norman

A Licentiate of **THE MEDICAL COUNCIL OF CANADA,** *and have caused his name to be entered in the Canadian Medical Register.*

In Witness Whereof *the President, and Registrar have this day set their Signatures and the Seal of the Council.*

Given at Ottawa
this 30th *day of* April *1976.*

J. P. Dawson
PRESIDENT

REGISTRAR

Number
40,420

Signature of Licentiate

Bruce Elliott Norman

DEC 4 2000

MEMBERSHIP CERTIFICATE

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

CPSO Registration No.: 28171

Dr. BE Norman

is a Member of
The College of Physicians and Surgeons of Ontario.

Effective to: May 31 2001

Registrar

The College of Physicians and Surgeons of Ontario
80 College Street
Toronto, Ontario
M5G 2E2

Tel: (416) 967-2600
Fax: (416) 961-3330
Toll free (800) 268-7096

Signature of Member

Bruce E. Norman, MD
4013 John S. Raboteau Wynd
Raleigh, North Carolina 27612
DOB: March 17, 1949
SS # Redacted
Home Phone: (919) 571-8024
E-mail: bnjn5@prodigy.net
Place of Birth: Winnipeg, Manitoba, Canada
Nationality: Canadian

PROFESSIONAL EDUCATION AND HONORS:

I initially enrolled in Queen's University, Kingston, Ontario K7L 3N6 in Chemical Engineering and completed two years in that program. I then subsequently transferred over to the curriculum of Medicine.

I completed my medical degree in June 1994 and then subsequently did a straight internship from July 1974 until June 1975 in general medicine at Royal Victoria Hospital, 687 Pine Ave. W., Montreal, Quebec H3A 1A1, which is affiliated with McGill University.

It was during this internship that I decided to switch over into the residency program in OB/GYN.

I completed my second year residency in that program at McGill University, Royal Victoria Hospital, from July 1975 until June 1976.

1968 - 1970	Queen's University Kingston, Ontario K7L 3N6	Chemical Engineering - Switched to Medicine 1979
1970 - June 1974	Queen's University Registrar's Office Richardson Hall, Room 103 Kingston, Ontario K7L 3N6	Medical Degree Completed L.M.C.C. - 1974
Honors	Faculty Engineering Queen's University Faculty Medicine Queen's University	Scholarship for standing 1st in 1st year engineering (awarded to 3rd place (me) as 1st and 2nd already on scholarship (1) 1st year medicine prize for standing third. (2) 4th year medicine prize for honors in OB/Surgey/Med.

Bruce E. Norman, MD
Education and Professional History

July 1974 - June 1975	Royal Victoria Hospital 687 Pine Avenue W Montreal, Quebec H3A 1A1 Dr. L. D. McClean Chief of Service/Program Director	Straight Surgical Residency Hospital Affiliations: • Royal Victoria Hospital • St. Mary's Hospital Montreal Children's Hospital
July 1975 - June 1976	Royal Victoria Hospital Montreal, Quebec H3A 1A1 Drs. F. Naftolin/Dr. F. Tweedie Chief of Service/Program Director(s)	2nd year resident - OB/GYN

At the end of the above residency, I decided for several reasons to go into general practice. I subsequently moved to Toronto (Brampton). I then spent the next five years in Family Medicine eventually serving as Chief of Family Practice.

July 1976 - June 1981	Left to practice Family Medicine	
Jane- Clair Medicine Center (Group Dissolved) North York, Ontario July 1976 - January 1977	York Finch Hospital 2111 Fimhave W. North York, Ontario	Active Staff, Dept. of Family Medicine July 1976 - December 1976
Bramalea Medical Group 45 Bramalea Road Brampton, Ontario	Peel Memorial Hospital 20 Lynch Street Brampton, Ontario L6W 2Z8 Dr. B. Shore, Chief of Staff	Chief of General Practice 1980 - 1981 Active Staff, Dept. of Family Medicine January 1977 - June 1981

I re-applied to the OB/GYN residency program at McGill University in Montreal and was accepted back into the R-3 level and began in July 1981 and finished June 1983. I subsequently spent the next two years at McGill and obtained my fellowship in the Royal College of Physicians and Surgeons in June 1983.

I then went into the private practice of OB/GYN and was affiliated with Westmount OB/GYN Group from July 1983 to December 1983. At this time, I relocated to the Oshawa Clinic and worked there from January 1984

Resumed OB/GYN Residency Program July 1981 - June 1983		
July 1981 - June 1982 McGill University Montreal, Quebec	Queen Elizabeth Hospital 2100 Marlow Avenue Montreal, Quebec H4A 3L6	3rd year resident - OB/GYN
July 1982 - June 1983	Queen Elizabeth Hospital 2100 Marlow Avenue Montreal, Quebec H4A 3L6	4th year resident - OB/GYN Chief Administrative Resident
June 1983	F.R.C.S. (Canadian)	
June 1983	American Fellowship Written Exam	

Bruce E. Norman, MD
Education and Professional History

DEC 14 2000

Private Practice - OB/GYN		
July 1983 - December 1983	Westmount OB/GYN Group Sherbrooke Avenue Montreal, Quebec (Group may not be in practice now)	Royal Victoria Hospital 687 Pine Avenue W Montreal, Quebec H3A 1A1 Active Staff: Dept. OB/GYN July 1983 - December 1983 Queen Elizabeth Hospital 2100 Marlow Avenue Montreal, Quebec H4A 3L6 Dr. R. Cook
January 1984 - August 1995	Oshawa Clinic 117 King St. E. Oshawa, Ontario L1H 189 (905) 723- 8551	Oshawa General Hospital 24 Alma Street Oshawa, Ontario L1G 2B9 Active Staff: Dept. of Surgery Chief, Section of Obstetrics and Gynecology 1988 -1991 Chief, Department of Surgery 1992 - 1995 R. S. Davies, MD Chief of Staff

I relocated to the state of North Carolina in 1995 where I went to work for The Carolina Permanente Medical Group, PA, a group model for Kaiser Permanente where I practiced OB/GYN, became Chief of OB/GYN and then became the Statewide Medical Director for the Medical Group.

Kaiser Permanente then left the North Carolina market and The Carolina Permanente Medical Group reorganized and became an independent group December 1, 1999 which was renamed Carolina Premier Medical Group. I became the CEO/President of this organization.

October 31, 2000 --- Carolina Premier Medical Group was sold to Scott Medical, LLC and I became the Chief Medical Officer.

September 1995 - December 1, 1999	The Carolina Permanente Medical Group, PA 909 Aviation Parkway, Suite 600 Morrisville, North Carolina 27560	Rex Hospital 4420 Lake Boone Trail Raleigh, North Carolina 27612 Active Staff: Dept. OB/GYN
December 1, 1999 - October 31, 2000	Carolina Premier Medical Group 909 Aviation Parkway, Suite 600 Morrisville, North Carolina 27560	Rex Hospital 4420 Lake Boone Trail Raleigh, North Carolina 27612 Active Staff: Dept. OB/GYN
November 1, 2000 - Present	Scott Medical Group, LLC 2828 Croasdaile Drive Durham, North Carolina 27705	Rex Hospital As above

Bruce E. Norman, MD
Education and Professional History

DEC 1 4 2000

Professional Experience	
October 31 - Present	Scott Medical Group, LLC Chief Medical Office CPMG - windup of sale to Scott Medical Group, LLC CEO/President
December 1999 - October 31	Carolina Premier Medical Group, PA (CPMG) CEO/President
1995 - December 1999	The Carolina Permanente Medical Group, PA (Kaiser Permanente) • Statewide Medical Director • Triangle Area Medical Director • Chief of OB/GYN Department
1989 - 1995	Oshawa General Hospital • Chief, Department of Surgery • Chief, Section of Obstetrics and Gynecology Department of Surgery
1984 - 1995	Clinical Practitioner - OB/GYN
1984 - 1995	Queen's University • Lecturer/Clinical Coordinator, Family Practice
1979 - 1981	Peel Memorial Hospital • Chief of General Practice • Secretary, Medical Advisory Committee
1977 - 1981	Bramalea Medical Group Brampton, Ontario • General Practice
1976 - 1977	Jane-Clair Medical Center North York, Ontario • General Practice

EDUCATION AND CERTIFICATIONS	
1998	American Board Certified - OB/GYN
1983	F.R.C.S. (Canadian) Certified
1982 - 1983	Chief Administrative Resident - Obstetrics and Gynecology (R-4)
1981 - 1982	Third year Resident - Obstetrics and Gynecology (R-3)
1975 - 1976	Second Year Resident - Obstetrics and Gynecology
1974 - 1975	Straight Surgical Internship

Bruce E. Norman, MD
Education and Professional History

1974	Queen's University • Doctor of Medicine
1970	Completed two years Chemical Engineering
Medical School Award	• 1st year medicine - prize for standing 3rd • 4th year medicine - prize for Honors in Obstetrics, Surgery and Medicine
Pre-Medical School Awards	Queen's University Engineering Program • 1st year scholarship for standing 1st in class

PROFESSIONAL MEMBERSHIPS
American College of Physician Executives
American Medical Association
Society of Chief Medical Officers
American Association of Health Plans
North Carolina Association of Health Plans
North Carolina Medical Society
Ontario Medical Association
Canadian Medical Association

BCLS/ACLS/PALS

INSTRUCTOR REPORTING FORM

innovative solutions
5923 cherrycrest lane
charlotte, nc 28217
704-527-5119

Lead (Directing) Instructors Name Barbara A. Smith ID No.(Initials + last 4 numbers of SSN) BS 8522

Home Address (if changed since last class) _____

Telephone _____ County where class taught: Wake ZipCode: 27513

umber of class participants: 4 Minority 4 Non-minority 8 TOTAL

Type of course: ☐ Training ☐ Adult Heartsaver ☐ Adult and Pediatric Heartsaver ☒ HealthCare Provider

☐ Renewal ☐ ACLS Provider ☐ Pediatric Basic Life Support ☐ PALS Provider

(Print) Names of Assisting Instructors	ID Number (initials and last 4 numbers of SSN)	Address (if changed since last report)	Member of innovative solutions community training center? Yes (No) (if not, send a copy of this report to your CTC)
Yvette Yarn	YY3155		
For ACLS or PALS - Medical Director Name			

The above Instructors have demonstrated the knowledge and skills of a current BCLS, ACLS, or PALS Provider and Instructor:

10-13-99
Date Course Completed

Barbara Smith RN
Signature of Lead/Instructor/Course Director

❤BCLS/ACLS/PALS Instructor Reporting Form - Please maintain a copy of this record for at least two years.

Participant Roster Date: 10/13/99 Location: TMA Kaleva

	Name (Please Print)	Work Place & Address or Home Address	Telephone	Occupation
1	Donna White	Marketing 3002 Elk Ridge Rd Julian 27712	469-7095	SR. ACCT MGR
2	Tom McClain	DCMO 6350 Quadrangle Dr, Chapel Hill, NC 27514	403-4728	Matrl Mgmt
3	Mary Charles Sutphin.	BRMO - OB/Gyn. Raleigh.	W 786-6852 H 846-0027	Midwife
4	Alice Pettiford	NDMO 3116 N. Duke St	479-6300	Admin
5	Emily Jackson	NDMO "	4796327	Admin
6	Bruce Norman	TMA	469 7242	MD
7	Wesley Ellen	3600 Dunleigh Road	881-5408	MD
8	Robert Hall	WRMO Radiology	881-5509	X-Ray Technologist
9				
10				
11				
12				
13		ENTERED IN MSL: 10-15-99		
14				
15				

This roster should be kept in your records for a least two years.

OCT 15 1999

80 COLLEGE STREET, TORONTO, CANADA M5G2E2 TELEPHONE: (416) 967-2600 TOLL FREE: (800) 268-7096

PRIVATE AND CONFIDENTIAL

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

CERTIFICATE OF PROFESSIONAL CONDUCT

ISSUED TO:

Ohio State Medical Board
77 South High Street
17th Floor
Columbus Ohio
43266-0315

REGARDING:

Dr. Bruce Elliot Norman
2709 Blue Ridge Road
Raleigh, North Carolina
United States
27613

YEAR AND SOURCE OF MEDICAL DEGREE: 1974, Queen's University, M.D.

CPSO REGISTRATION NUMBER: 28171

STATUS OF REGISTRATION: Active Member

CURRENT CLASS OF CERTIFICATE OF REGISTRATION AND EFFECTIVE DATE: Independent Practice, 26 May 1976

HISTORY OF REGISTRATION:

First certificate of registration issued: Independent Practice certificate Effective: 26 May 1976

SPECIALTY QUALIFICATIONS FROM THE ROYAL COLLEGE OF PHYSICIANS AND SURGEONS OF CANADA AS RECORDED ON THE REGISTER:

Obstetrics and Gynecology	Effective: 06 Jun 1983
FRCSC	Effective: 17 Sep 1983

QUALIFICATIONS FROM THE COLLEGE OF FAMILY PHYSICIANS OF CANADA AS RECORDED ON THE REGISTER:

None

CURRENT REFERRALS TO THE DISCIPLINE OR FITNESS TO PRACTISE COMMITTEES AS AT THE DATE OF ISSUE OF THIS CERTIFICATE:

None

HISTORY OF DISCIPLINE OR FITNESS TO PRACTISE FINDINGS AS RECORDED ON THE REGISTER:

None

ANY RESTRICTION OR CANCELLATION OF HOSPITAL PRIVILEGES WITHIN THE LAST TEN YEARS INSOFAR AS ANY REPORT THEREOF APPEARS IN THE RECORDS OF THE COLLEGE:

None

.../2

PRIVATE AND CONFIDENTIAL

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

CERTIFICATE OF PROFESSIONAL CONDUCT

ISSUED TO:

Ohio State Medical Board
77 South High Street
17th Floor
Columbus Ohio
43266-0315

REGARDING:

Dr. Bruce Elliot Norman
2709 Blue Ridge Road
Raleigh, North Carolina
United States
27613

DATE OF ISSUE: 15 Jan 2001

CERTIFICATE NUMBER: 40023380

JOHN M. BONN
REGISTRAR

Not official without signature of Registrar and impression of College seal

No further entries below this line

JAN 23 2001

State Medical Board of Ohio

77 S. High Street, 17th Floor • Columbus, Ohio 43266-0315 • 614/ 466-3934 • Website: www.state.oh.us/med/
Direct Dial 614-728-3055
Fax 614-644-1464 or 466-4670

January 10, 2001

Dear Doctor:

Dr. Bruce E. Norman, MD who is/was Physician Admitting Privileges OB/GYN 9/95 - present is applying for licensure in the State of Ohio. We would appreciate your assistance in filling out the following evaluation so that we can process his/her application for licensure. To ensure processing of the physicians application please complete this form and return by mail or FAX to our office within two (2) weeks. Your immediate attention to this matter will be greatly appreciated by the applicant as well as by us. Information provided is considered confidential under Section 149.42 (A)(2)(a), Ohio Revised Code. Thank you for your time and assistance.

(1) How long have you known him/her? 4 years.

(2) What is/was your supervisory capacity? Chairman of Dept. OB/Gyn

(3) At what hospital? Rex Hosp.

(4) How would you rate his/her medical knowledge and techniques? excellent.

(5) In your opinion is he/she a person of good moral and ethical character? yes.

(6) Does he/she work well with peers and medical staff? yes.

(7) Does he/she relate well to patients? yes

(8) How is his/her command of the English language? (if applicable) good.

(9) Would you recommend him/her for licensure? yes

Additional comments, please: (if needed, an extra sheet of paper may be used)

Please return this form to the Ohio State Medical Board at the above address, or fax response to above number.

Sincerely,

Mendy Yokich

Mendy Yokich
Licensure Assistant

George M Tosky MD
Signature of Physician

George Tosky
Name of Physician *(please type or print clearly)*

Chairman OB/Gyn.
Position

919 781-8025
Telephone number *(include area code)*

JAN 23 2001

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George Tosky MD
Signature of Physician

George Tosky
Name of Physician *(please type or print clearly)*

Chairman OB/Gyn
Position

919 781-8025
Telephone number *(include area code)*

MEDICINE OR OSTEOPATHIC MEDICINE
AFFIDAVIT AND RELEASE OF APPLICANT

DEC 1 4 2000

The affidavit and release below MUST be completed by **ALL** applicants. The form must be notarized. Failure of any applicant to submit the affidavit completed and notarized with the application will result in your application being considered incomplete.

ss STATE OF: NORTH CAROLINA
COUNTY OF: WAKE

I, BRUCE ELLIOTT NORMAN, hereby certify under oath that I am the person named in this application for a license to practice medicine or osteopathic medicine in the State of Ohio; that all statements I have or shall make with respect thereto are true; that I am the original and lawful possessor and person named in the various forms and credentials furnished or to be furnished to this Board with respect to my application; and that all documents, forms, or copies thereof furnished or to be furnished with respect to my application are strictly true in every respect.

I acknowledge that I have read the general information and instructions for all applicants and that I have answered all questions in compliance with these instructions and understand that the fee I submitted is not refundable nor transferable.

I further state that by filing this application for a license to practice medicine or osteopathic medicine in the State of Ohio, I hereby authorize and consent to have an investigation made as to my moral character, professional reputation and fitness for a license to practice medicine or osteopathic medicine. I agree to give any further information which may be required in reference to my past record. I understand that I will not receive a copy of any reports or know their contents and I further understand that the contents of any investigative report will be privileged.

I further understand that my application for a license to practice medicine or osteopathic medicine in the State of Ohio is an ongoing process. I will immediately notify the State Medical Board of Ohio in writing of any changes to the answers to any of the questions contained in the ADDITIONAL INFORMATION section of the application if such a change occours at any time prior to a license to practice medicine or osteopathic medicine being granted to me by the State Medical Board of Ohio. I further understand that failure to complete this application as requested by the Board within six months can be considered abandonment of any request for a license to practice medicine or osteopathic medicine and that any fee I submitted is not refundable or transferable.

I authorize and request every person, hospital, clinic, governmental agency (local, state, federal or foreign), court, association, institution, or law enforcement agency having control of any documents, records and other information pertaining to me to furnish to the State Medical Board of Ohio any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data and to permit the State Medical Board of Ohio or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application, subsequent licensure or practice thereunder.

I hereby release, discharge, and exonerate the State Medical Board of Ohio, its agents or representatives and any person furnishing information of any and all liability of every nature and kind arising out of investigation made by the State Medical Board of Ohio. I authorize the State Medical Board of Ohio to release information, material, documents, orders or the like relating to me or to this application to any other governmental agency (local, state, federal or foreign); or to any hospital, nursing home, clinic, health maintenance organization or similar institution; or to any professional association.

I further understand that issuance of a certificate to practice medicine or osteopathic medicine in Ohio will be considered based on the truth of the statements and documents contained herein or to be furnished, which if false, can subject me to denial of said certificate.

BE Norman
Signature of Applicant

Subscribed and sworn to before me this 6 day of 11 2000.

Connie Wooten
Signature of Notary Public

(NOTARY SEAL)

9-10-2004
Date Commission Expires

FOR BOARD USE ONLY

NAME:_____

CERTIFICATE NO.:_____

DATE ISSUED:_____, 20_____

APPLICATION FOR CERTIFICATE TO PRACTICE MEDICINE OR OSTEOPATHIC MEDICINE

FILED: _____, 20_____

DETERMINATION:

BOARD ACTION:

The Federation of State Medical Boards of the United States, Inc.
Federation Credentials Verification Service
Federation Place
400 Fuller Wiser Road, Suite 300
Euless, Texas 76039-3855
Telephone: (817) 868-4000
Fax: (817) 868-4099

Physician Information Profile

This report is compiled exclusively for:

Name:	**Bruce Elliott Norman**
SSN:	Redacted
DOB:	**03/17/1949**
Recipient:	**State Medical Board of Ohio**

NOTICE:

The Federation Credentials Verification Service (FCVS) was retained by the above referenced physician to verify his/her medical credentials for submission to your agency/organization. Unless noted otherwise, all documents contained in this report were received directly from the issuing institution per written request made by FCVS. All documents bearing the official FCVS seal are ceritified to be an exact reproduction of the original. Where required, original documents are provided according to the agreements with the institution issuing such document. FCVS maintains all original documents (excluding third-party examination transcripts) in the physician's source file.

The Physician Information Profile is compiled and published by the Federation of State Medical Boards of the United States, Inc. as a reference source for its member boards and other authorized entities. The Physician Information Profile may not be republished, sold, resold or duplicated, in whole or in part, for commercial or any other purposes, or for purposes of compiling lists or files without the express written consent of the Federation's Executive Vice President as authorized by its Board Of Directors. The use of this Physician Information Profile to establish independent data files or compendiums or information is strictly prohibited.

Table of Contents

Section I

FCVS Reports

FEDERATION CREDENTIALS VERIFICATION SERVICE

Physician Information Report

Identity:

Name:	**Bruce Elliott Norman**	
Other Name Used:	**N/A**	
Gender:	**Male**	
Date of Birth:	**03/17/1949**	
Place of Birth:	**Winnipeg Canada**	
SSN:	Redacted	
Current Address:	**4013 John S Raboteau** **Raleigh, NC 27612**	
Permanent Address:	**Same**	
Telephone Numbers:	Bus:	**N/A**
	Fax:	**N/A**
	Home:	**919-571-8024**
	Other:	**N/A**
Physical Description:	Height:	**5' 10"**
	Weight:	**160 lbs**
	Eye Color:	**brown**
	Hair Color:	**Silver**
Physical Marks:	Description:	**N/A**
	Location:	**N/A**

Premedical Education (Reported by physician. Not verified by FCVS)**:**

Institution:	**Queens University, Kingston, Ontario, K7L3N6 Canada**
Dates of Attendance:	**09/1968 - 05/1970**
Degree Awarded:	**N/A**

Medical Education:

Current, valid ECFMG	**N/A**
ECFMG Number:	**N/A**
Date Issued:	**N/A**
Medical School:	**Queens University Faculty of Health Sciences** **Office of the Registrar** **Richardson Hall, Room 103** **Kingston, ON Canada K7L3N6**
Dates of Attendance:	**09/01/1970 - 05/00/1974**
Graduation Date:	**05/25/1974**
Degree Awarded:	**Doctor of Medicine**

Unusual Circumstance: **None**

Post Graduate Medical Education:

Institution: **Royal Victoria Hospital**
687 Pine Avenue West
Montreal, QC Canada H3A1A1

Post Graduate Year: **1**
Program Type: **Internship**
Department: **Surgery**
Dates of Attendance: **01/01/1975 - 06/30/1975**
Completion: **Yes**
Accreditation: **ACGME**

Post Graduate Year: **2-4**
Program Type: **Residency**
Department: **Obstetrics and Gynecology**
Dates of Attendance: **07/01/1975 - 06/30/1983**
Completion: **Yes**
Accreditation: **ACGME**

Unusual Circumstance: **None**

Fifth Pathway:

N/A

Examination History:

Transcripts Enclosed For: **LMCC Qualifying Examination Part I**
LMCC Qualifying Examination Part II

Board Action:

A Report of the results from a search of the Board Action Data Bank is enclosed.

Omission / Discrepancy Report

Physician Identification:

Name:	Bruce Elliott Norman
DOB:	03/17/1949
SSN:	Redacted
Packet ID:	17278
Request ID:	5874218

REPORT OF OMISSIONS

Omission 1:

Section of Profile: **Medical Education**

Omission: Queens Univ Fac Med did not certify the medical school diploma.

Follow-Up: FCVS has contacted the institution and requested a seal or notarization be affixed to the diploma.

REPORT OF DISCREPANCIES

Discrepancy 1:

Section of Profile: **Post-Graduate Education**

Discrepancy: The applicant reports Leave during attendance at Royal Victoria Hospital (documentation provided). The institution reports no unusual circumstances.

Follow-Up: A written explanation from the applicant is included immediately following the Postgraduate Medical Education form.

Discrepancy 2:

Section of Profile: **Examination History**

Discrepancy: The applicant reports sitting for LMCC Examination Part A & B in 04/1976. The LMCC transcript indicates the examination date was 05/01/1974.

Follow-Up: Left to Recipient`s discretion.

MISCELLANEOUS INFORMATION

Miscellaneous 1:

Section of Profile: **Post-Graduate Education**

Issue: The attendance dates reported by Royal Victoria Hospital (Dept of Surgery) are

irregular, beginning in 01/01/1975 and ending in 06/30/1975.

Follow-Up: This information is provided as information only.

Miscellaneous 2:

Section of Profile: **Continuity of Education**

Issue: There is a gap of approximately 7 months between graduation from medical school at Queens Univ Fac Med (05/25/1974) and entrance into the postgraduate training program at Royal Victoria Hosp (begins 01/01/1975).

Follow-Up: This information is provided as information only.

End of report for Bruce Elliott Norman

Packet Id: 17278 Request Id: 5874218 Report Created By: ACT

Board Action Databank Search

State Queried For:	**State Medical Board of Ohio**
Physician's Name:	**Norman, Bruce Elliott**
Date of Birth:	**03/17/1949**
Medical School:	**063030 - Queens Univ Fac Med**
Year of Graduation:	
Social Security Number:	Redacted
ECFMG Number:	**N/A**

Results:

WE HAVE NO UNFAVORABLE INFORMATION
REGARDING THE ABOVE NAMED PHYSICIAN

FEB 14 2001

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

Section II

Identity

AFFIDAVIT AND RELEASE

I, the undersigned, hereby certify under oath that I am the person named in this application, that all statements I have or shall make are true, that I am the person named in the various forms and credentials furnished or to be furnished with respect to my application and that all documents, forms or copies I furnish with my application are strictly true.

I acknowledge that I have read and understand the "INSTRUCTIONS FOR COMPLETING THE FCVS APPLICATION" and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted under appropriate federal and state laws.

I authorize every person, hospital, clinic, government agency (local, state, federal or foreign), institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me to furnish to the Federation Credentials Verification Service any such information, or true and correct copies of documents or records.

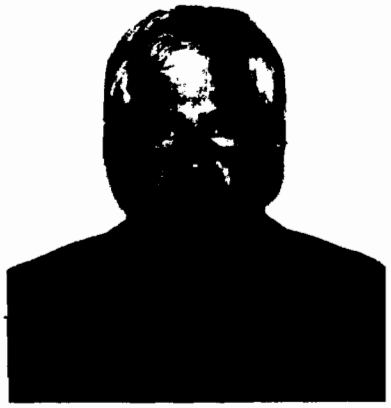
I hereby release, discharge and hold harmless the Federation Credentials Verification Service, its agents or representatives and any person furnishing information, records or documents of any and all liability. I authorize the Federation Credentials Verification Service to release information, material, documents, orders or the like relating to me or this application to any entity at my request.

Bruce E Norman
Applicant's Signature (must be signed in the presence of a notary)

NORMAN
Applicant's Printed Last Name

BRUCE E
Applicant's Printed First Name, Middle Initial, and Suffix (e.g., Jr.)

11-10-2000
Date of Signature (must correspond to date of notarization)



Bruce E Norman

State of NORTH CAROLINA, County of Wake

I certify that on the date set forth below the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document. The statements on this document are subscribed and sworn to before me by the applicant on this 10TH day of November, 2000.

Notary Public signature: Connie Worten

My commission expires: 9-10-2004

Notary:
The physician has been instructed to sign the front of the photograph. Your seal (or stamp) must be partly upon the photo and partly upon the signature of the applicant.

PACKET ID:

Manitoba CANADA

CERTIFICATE OF BIRTH

Manitoba Family Services
Services à la famille Manitoba

B090131

Name/Nom
BRUCE ELLIOTT NORMAN

Date of Birth/ Date de naissance	Sex/ Sexe	Place of Birth/ Lieu de naissance
MARCH 17, 1949	M	WINNIPEG

Name of Father/Nom du père
WILFRED HENRY NORMAN

Maiden Name of Mother/Nom de jeune fille de la mère
CORINNE ADELE STRONG

Registration No./N° d'enregistrement
49-06-004205

Date of Registration/Date d'enregistrement
MARCH 22, 1949

Given Under My Hand
ACCORDÉ de ma main,

ISSUED
DÉLIVRÉ
NOVEMBER 17, 1992

SEAL
VERIFIED

MJ Zyluk

ACTING DIRECTOR OF VITAL STATISTICS
DIRECTRICE INTÉRIMAIRE DE L'ÉTAT CIVIL

CERTIFIED EXTRACT FROM THE REGISTRATION OF BIRTH
ISSUED AT WINNIPEG
EXTRAIT OFFICIEL DU BULLETIN D'ENREGISTREMENT DE NAISSANCE
DÉLIVRÉ À WINNIPEG

Section III

Medical Education

FEDERATION CREDENTIALS VERIFICATION SERVICE (FCVS)

VERIFICATION OF MEDICAL EDUCATION

(This form must be completed by the medical school)

RECEIVED JAN 29 2001 By

INSTRUCTIONS TO THE DEAN

The individual identified on the attached Authorization For Release of Information, Documents and Records form has authorized your medical school to provide to the Federation Credentials Verification Service (FCVS) any and all information pertaining to their education at your institution. **Please complete this form and forward it to FCVS in the enclosed postage-paid, self-addressed envelope.**

Please note: If your institution processes transcript requests through another office, FCVS has likely made such a request under separate cover. **If your office also processes transcript requests, please attach the individual's official transcript (which indicates courses taken, dates and hours of attendance, and scores, grades, or evaluation).**

VERIFICATION OF MEDICAL EDUCATION

Name of Institution: Queens University Faculty of Health Sciences

Complete Address: Rm. 224 Botterell Hall
Street Address

Street Address
Kingston, Ontario K7L 3N6
City State Zip Code(Postal Code)

If name of institution was different when this individual attended, please note this name below:

Enrollment and Participation: Our records indicate that NORMAN, Bruce Elliott
(type/print individual's name: Last, First, Middle, Suffix)

attended our medical school for total of _____ weeks of continuous on-campus education on the following dates (mm/dd/yy):

From	To
Sept. / 1 / 1970	May / / 1971
Sept. / 7 / 1971	May / / 1972
Sept. / 5 / 1972	May / / 1973
June / 4 / 1973	May / / 1974
/ /	/ /

This individual (check one):

X was awarded the degree of Doctor of Medicine on May / 25 / 1974 (mm/dd/yy)

_____ was NOT awarded a degree (please attach an explanation)

VERIFICATION OF MEDICAL EDUCATION (continued)

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the individual's medical education. Please circle the appropriate response. **"Yes" responses to any of these questions requires a written explanation.**

Questions	Response	
Did this individual ever take a leave of absence or break from their medical education?	Yes	(No)
Was this individual ever placed on probation?	Yes	(No)
Was this individual ever disciplined or under investigation?	Yes	(No)
Were any negative reports regarding this individual ever filed by instructors?	Yes	(No)
Were any limitations or special requirements imposed on the individual because of questions or academic incompetence, disciplinary problems or any other reason?	Yes	(No)

Premedical Education: Does your school have a premedical education requirement? (Yes) No

If yes, include where your records indicate the individual completed his/her premedical education and the basic science courses taken (attach additional pages if necessary):

Premedical Institution(s): Queen's University

Check Courses Taken:
- ✓ Physics
- ✓ Biology/Zoology
- ✓ Organic Chemistry
- ✓ Inorganic Chemistry

Certification: By my signature, I, Thelma Rikley (type/print name), certify that the above information is an accurate account of the above named individual's official records maintained in this and is true and correct to my knowledge.

AFFIX INSTITUTIONAL SEAL HERE

(If your institution does not have an official seal, this form must be notarized.)

SEAL VERIFIED

Signature: T. Rikley

Title: Manager, Undergraduate Medical Education

Date of Signature: January 19, 2001

Telephone: (613) 533-2542

Fax: (613) 533-6884

Email: rikleyt@post.queensu.ca

SURNAME NORMAN
GIVEN NAMES BRUCE ELLIOT

STUDENT NUMBER 055-7950

PRIOR NAME

PAGE 1 OF 3

BASIS OF ADMISSION

LATEST PROGRAM M.D.

Office of the University Registrar
Queen's University
Kingston, Canada
K7L 3N6

PROVIDED BY APPLICANT

YEAR	TERM	SUBJECT AND COURSE	RPT.	WGT.	MK.	GR.	MI.	DESCRIPTION	# ENRL.	AVG.	% ENROLLED IN MARK RANGE 0+	50+	60+	65+	70+	75+	80+	90+
1968	F	REGISTERED IN B.SC. ENGINEERING																
1968	F	ENGD 100		05	PA			COMPUTER PROGRAMMING										
1968	F	MATH 126		15	90(1350)			MATH-CALCULUS										
1968-59	FW	CHEM 118		24	86(2064)			GENERAL CHEMISTRY										
1968-69	FW	ENGD 110		20	76(1520)			ENGINEERING GRAPHICS										
1968-69	FW	GEOL 010		13	92(1196)			INTRODUCTION TO GEOLOGY										
1968-69	FW	PHYS 111		14	82(1148)			MECHANICS, WAVES & HEAT										
1968-69	FW	PHYS 112		14	72(1008)			ELECTRICITY, MAGNETISM & LIGHT										
1969	W	MATH 127		15	89(1335)			CALCULUS, ALGEBRA, GEOMETRY										
SESS WGTS=*115 NUM MRK WGTS=*115 POINTS=*9621 SESS AVG=*9621/115 = 84%																		
RANK IN: PROGRAM ***0/***0 YEAR ***3/*360																		
1969 SEPT		AWARD GRANTED: J.P. BICKELL FOUNDATION SCHOLARSHIP																
1969	F	CHEE 210		11	82		*902	THERMODYNAMICS I										
1969	F	CHEE 211		08	81		*648	CHEMICAL ENGINEER COMPUTATIONS										
1969	F	CHEM 248		12	74		*888	PHYS. CHEMISTRY FOR ENGINEERS										
1969	F	CIVL 227		08	67		*536	INTROD. STRENGTH OF MATERIALS										
1969	F	MATH 226		09	86		*774	ORDINARY DIFF. EQUATIONS										
1969-70	FW	CHEM 288		18	90		1620	ORGANIC CHEM. FOR ENGINEERS										
1969-70	FW	ENGL 010		18	75		1350	MOD. ENG. & NORTH AM. LITERAT.										
1969-70	FW	MATH 291		04	87		*348	MATHEMATICS PROBLEMS										
1970	W	CHEE 212		11	78		*858	TRANSPORT PHENOMENA I										
1970	W	CHEE 213		11	83		*913	CHEMICAL PROCESS CALCULATIONS										
1970	W	MATH 227		09	72		*648	VECTOR ANALYSIS										
SESS #GTS=*119 NUM MRK WGTS=*119 POINTS=*9485 SESS AVG=*9485/119 = 80%																		
CUM WGTS=*119 NUM MRK WGTS=*119 POINTS=**9485 CUM AVG=**9485/*119 = 80%																		
RANK IN: PROGRAM ***3/**49 YEAR **27/*353																		
1970	F	REGISTERED IN M.D.																
1970-71	FW	ANAT 510		1.00	80	A		GROSS ANATOMY										
1970-71	FW	ANAT 511		1.00	81	A		HISTOLOGY & EMBRYOLOGY										
1970-71	FW	BCHM 510		1.00	80	A		BIOCHEMISTRY										
1970-71	FW	EPID 512		1.00	64	C		BIOSTATISTICS										
1970-71	FW	PHGY 510		1.00	74	B		PHYSIOLOGY										
1971 SEPT		AWARD GRANTED: DANIEL MACTAVISH BAKER SCHOLARSHIP																
1971 SEPT		AWARD GRANTED: W.W. NEAR AND SUSAN NEAR PRIZE																
1971	F	PATH 520		1.00	73	B		GENERAL PATHOLOGY										
1971-72	FW	MEDS 520		1.00	76	B		INTRO. TO CLINICAL SCIENCE										
1971-72	FW	MICR 520		1.00	80	A		MICROBIOLOGY										
1971-72	FW	PAED 520		1.00	70	B		PAEDIATRICS										
1971-72	FW	PHAR 520		1.00	81	A		MEDICAL PHARMACOLOGY										
1972	W	PATH 521		1.00	79	B		SPECIAL PATHOLOGY										
1972-73	FW	ANAE 532		1.00	PA			ANAESTHESIOLOGY										
1972-73	FW	EPID 530		1.00	71	B		COMMUNITY HEALTH										

**********TRANSCRIPT CONTINUES ON FOLLOWING PAGE**********

DATE PRINTED 2000 DEC 07

ISSUED TO STUDENT

DATE ISSUED 2000 DEC 07

UNIVERSITY REGISTRAR

2036

TRANSCRIPT VALID ONLY IF BEARING EMBOSSED SEAL AND OFFICIAL SIGNATURE

SURNAME NORMAN
GIVEN NAMES BRUCE ELLIOT

STUDENT NUMBER 055-7950

PRIOR NAME

PAGE 2 OF 3

BASIS OF ADMISSION

LATEST PROGRAM M.D.

Office of the University Registrar
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YEAR	TERM	SUBJECT AND COURSE	RPT.	WGT.	MK.	GR.	MI.	DESCRIPTION	# ENRL.	% ENROLLED IN CLASS AVG.	0+	50+	60+	65+	70+	75+	80+	90+
1972-73	FW	MEDS 530		1.00	79	B		THIRD YEAR MEDICINE										
1972-73	FW	MEDS 531		1.00	79	B		CLINICAL MEDICINE										
1972-73	FW	MEDS 532		1.00	PA			MEDICINE & THE LAW										
1972-73	FW	OBGY 530		1.00	78	B		OBSTETRICS & GYNAECOLOGY										
1972-73	FW	OPTH 532		1.00	78	B		OPHTHALMOLOGY										
1972-73	FW	OTOL 532		1.00	63	C		OTOLARYNGOLOGY										
1972-73	FW	PAED 530		1.00	72	B		PAEDIATRICS - 3RD YEAR										
1972-73	FW	PSIY 530		1.00	80	A		PSYCHIATRY-3RD YEAR										
1972-73	FW	RADD 532		1.00	PA			DIAGNOSTIC RADIOLOGY										
1972-73	FW	SURG 530		1.00	74	B		SURGERY-3RD YEAR										
1972-73	FW	SURG 531		1.00	74	B		CLINICAL SURGERY										
1973	W	RADO 532		1.00	89	A		THERAPEUTIC RADIOLOGY - 3RD YR										
1973-74	FW	ANAE 544		1.00	PA			ANAESTHESIOLOGY										
1973-74	FW	MEDS 540		1.00	HN			FOURTH YEAR MEDICINE										
1973-74	FW	OBGY 542		1.00	HN			OBSTETRICS & GYNAECOLOGY										
1973-74	FW	OPTH 544		1.00	PA			OPHTHALMOLOGY										
1973-74	FW	OTOL 544		1.00	PA			OTOLARYNGOLOGY										
1973-74	FW	PAED 542		1.00	PA			PAEDIATRICS - 4TH YEAR										
1973-74	FW	PSIY 542		1.00	HN			PSYCHIATRY - 4TH YR										
1973-74	FW	RADD 544		1.00	PA			DIAGNOSTIC RADIOLOGY - 4TH YR										
1973-74	FW	RADO 544		1.00	PA			THERAPEUTIC RADIOLOGY - 4TH YR										
1973-74	FW	RHBS 544		1.00	PA			REHABILITATION MEDICINE										
1973-74	FW	SURG 540		1.00	HN			SURGERY - 4TH YEAR										
1973-74	FW	UROL 544		1.00	PA			UROLOGY										
1974 JUNE		AWARD GRANTED: HANNAH WASHBURN POLSON PRIZE																

1977 AUG 25 NARRATIVE ACCOUNT, ACADEMIC PERFORMANCE: BRUCE ELLIOTT NORMAN

MR. NORMAN ENTERED OUR FACULTY IN SEPTEMBER OF 1970, HAVING COMPLETED TWO YEARS IN THE FACULTY OF APPLIED SCIENCE AT QUEEN'S UNIVERSITY AND HAVING SATISFIED THE HIGH STANDARDS OF THE ADMISSIONS AND PROGRESS COMMITTEE FOR STUDENTS WITH ONLY TWO YEARS OF UNIVERSITY EDUCATION. AS CAN BE SEEN FROM THE APPENDED LIST OF YEAR END STANDINGS, THE CONFIDENCE IN MR. NORMAN BY THE ADMISSIONS AND PROGRESS COMMITTEE WAS AMPLY JUSTIFIED BY HIS PERFORMANCE DURING OUR FOUR YEAR CURRICULUM WHICH HE COMPLETED IN THE REQUISITE PERIOD OF TIME.

BEGINNING WITH THE SESSION 1973/74, FACULTY CHANGED ITS METHOD OF EVALUATION FROM MARKS TO AN HONOURS/PASS/FAIL SYSTEM WITH DETAILED NARRATIVE ACCOUNTS. THESE ARE AVAILABLE FROM ALL SERVICES IN MR. NORMAN'S FOURTH AND CLERKSHIP YEAR. AS CAN BE SEEN FROM THE YEAR END STANDINGS, HE OBTAINED

**********TRANSCRIPT CONTINUES ON FOLLOWING PAGE**********

DATE PRINTED 2000 DEC 07

DATE ISSUED 2000 DEC 07

UNIVERSITY REGISTRAR

0036

TRANSCRIPT VALID ONLY IF BEARING EMBOSSED SEAL AND OFFICIAL SIGNATURE

SURNAME NORMAN
GIVEN NAMES BRUCE ELLIOT

STUDENT NUMBER 055-7950

PAGE 3 OF 3

PRIOR NAME

BASIS OF ADMISSION

LATEST PROGRAM M.D.

Office of the University Registrar
Queen's University
Kingston, Canada
K7L 3N6

PROVIDED BY APPLICANT

YEAR	TERM	SUBJECT AND COURSE	RPT.	WGT.	MK.	GR.	MI.	DESCRIPTION	# ENRL.	AVG.	% ENROLLED IN MARK RANGE 0+	50+	60+	65+	70+	75+	80+	90+

HONOURS IN MEDICINE, SURGERY, OBSTETRICS AND GYNAECOLOGY AND IN PSYCHIATRY. ALL THE NARRATIVE ACCOUNTS BASED ON HIS ROTATIONS WERE COMMENDATORY. IT WAS OBSERVED THAT HE WAS A VERY HARD WORKER, HAD EXCELLENT JUDGMENT AND THAT HE WOULD BE WELCOMED BACK TO QUEEN'S FOR GRADUATE WORK. HIS ELECTIVE WHICH WAS TAKEN EXTRAMURALLY IN THE COLLEGE OF PHYSICIANS AND SURGEONS OF COLUMBIA UNIVERSITY WAS EQUALLY SUCCESSFUL AND IN THE OPINION OF HIS SUPERVISORS THERE HE WAS IN THE UPPER THIRD OF HIS MEDICAL STUDENT CATEGORY. IT WAS FURTHER OBSERVED THAT HE WAS AN ATTRACTIVE, INTELLIGENT YOUNG MAN WHO WILL UNDOUBTEDLY CONTINUE TO HAVE A SERIOUS ATTITUDE TOWARDS HIS SPECIALTY INTEREST AND PROVE A CREDIT TO HIS TRAINING.

AS EXPECTED, MR. NORMAN GRADUATED WITH HIS M.D. DEGREE IN MAY OF 1974 AND BASED ON HIS PERFORMANCE IN THIS FACULTY, HE SHOULD HAVE A VERY PROMISING FUTURE.

HE IS OF EXCELLENT CHARACTER.

T. F. MCELLIGOTT, M.D.
ASSOCIATE DEAN, UNDERGRADUATE AFFAIRS

1974 MAY DEGREE GRANTED: M.D.

**********END OF TRANSCRIPT**********

DATE PRINTED 2000 DEC 07

DATE ISSUED 2000 DEC 07

UNIVERSITY REGISTRAR

0036

TRANSCRIPT VALID ONLY IF BEARING EMBOSSED SEAL AND OFFICIAL SIGNATURE

TRANSCRIPT LEGEND

FACULTY OF ARTS AND SCIENCE, SCHOOL OF BUSINESS, SCHOOL OF PHYSICAL AND HEALTH EDUCATION, SCHOOL OF GRADUATE STUDIES AND RESEARCH

GRADING:

Prior to September 1965:

Courses numbered under 10 (General Courses)

Grade	A	75 - 100%
	B	62 - 74%
	C	50 - 61%
	Pass mark	50%

Courses numbered 10 and over (Honours courses)

Grade	A	75 - 100%
	B	66 - 74%
	C	55 - 65%
	D	50 - 54%

For 1965-66

Courses numbered under 100 (General Courses)

Grade	A	75 - 100%
	B	62 - 74%
	C	50 - 61%
	Pass mark	50%

Courses numbered 100 or over (Honours Courses)

Grade	A	75 - 100%
	B	66 - 74%
	C	55-65%
	D	50-54%

Since September 1966:

Grade	A	80 - 100%
	B	65 - 79%
	C	50 - 64%
	F	0 - 49%
	PA	Pass
	Pass mark	50%

In the school of Graduate Studies, the pass mark in a primary course is 65%.

COURSE WEIGHTING:

Prior to September 1972:

Course weighting was indicated as hours of lecture per week per session (a full course was normally 3.0, a half course was normally 1.5).

Since September 1972:

Full course/half course system such that a full course (1.0) is approximately equal to 3 lecture hours per week per session and a half course (0.5) is equal to approximately three lecture hours per week per term. Normal full time course load for one session ranges from four to six full courses (4.0 to 6.0).

FACULTY OF HEALTH SCIENCES

School of Medicine

GRADING:

Each Department or Course provides the student with a set of educational objectives at the beginning of the period of instruction together with a description of the evaluation techniques to be used and a criteria-related statement of honours/pass/fail levels. At the end of the period of instruction, a report on the student's standing in each course is made to the Medical School Office in the form of an honour/pass/fail designation together with a narrative description of his/her performance where appropriate.

FACULTY OF EDUCATION

GRADING FOR B.Ed PROGRAM:

Prior to September1972:

Curriculum and Foundations courses (numbered EDUC 101 to EDUC 160 inclusive) were graded:

A	80 - 100%
B	65 - 79%
C	50 - 64%
E	35 - 49%
F	0 - 34%
Pass mark	50%

Courses in Supporting or Related Studies (numbered EDUC 174 - EDUC 194 inclusive) and Professional Issues (EDUC 100) were graded PA or F.

For 1972 - 73, 1973 - 74:

Grades were reported in one of three ways:

1. PA or FA (PA = 70, FA = 35)
2. Numeric 0 - 100, pass mark = 50%
3. Letter grades.

A+ = 92%	A = 87%	A- = 82%
B+ = 77%	B = 72%	B- = 67%
C+ = 62%	C = 57%	C- = 52%
E = 42%	F = 27%	I = Incomplete

Since September1974,

H = Honours,

PA = Pass

F = Fail

PN = Pass - no honours available in this course

CR=Credit

IN = Incomplete

NW = course not taken

There are no numerical equivalents.

GRADING FOR SUMMER COURSES:

For 1972:

PA or FA

For 1973 to 1978:

Grades were given in one of three ways:

1. PA or FA
2. A, B, C, E, F (letter grades equivalent to Arts and Science grading)
3. Numeric 0 - 100

Since 1978: same as B.Ed program

COURSE WEIGHTING:

Prior to September 1979:

Credit hour system - six credit hours for example implies that total in-campus learning time for that course is six hours per week. Normal full-time program load for one session ranges approximately from 30 - 33 hours.

Since 1979: Arts and Science weighting is used.

FACULTY OF APPLIED SCIENCE

GRADING:

Prior to September 1967:

Division I	75 - 100%
Division II	62 - 74%
Division III	50 - 61%
Pass mark	50%

Since September 1967:

Numeric system only.

A graduation average of 55% or more for all work at Queen's, not including that of the first year, is required to qualify for the degree of Bachelor of Science (B. Sc.) in the Faculty of Applied Science.

S = Substituted course (not included in averages)

The pass mark is 50% in all courses, although prior to May 1990 it was possible to graduate with as many as three courses in the 40% to 49% range.

COURSE WEIGHTING:

Prior to September 1968:

Course weighting was usually indicated as lecture hours per week per session. A normal full load was approximately 25 to 30 lecture/lab hours, depending on the program.

Since September 1968:

Each course was assigned a unit weight associated with the number of lecture, tutorial and laboratory hours per week per term in that course: Three units per lecture hour per week per term plus one unit per laboratory or tutorial hour per week per term. Sessional loads range normally from 100 to 130 units depending on the program.

Since July 1997:

The unit weights are assigned as follows: 1 AU for each hour of lecture, 0.5 AU for each hour of laboratory or tutorial. E.g. a course with {(36-6-9) 51} offers 36 hours of lectures, 12 hours of laboratories and 18 hours of tutorials. For practical components of the curriculum grades of "pass" and "not complete" are introduced. The normal sessional load for full-time students ranges from 450 to 550 AU.

FACULTY OF HEALTH SCIENCES

School of Nursing

GRADING:

A	80 - 100%
B	65 - 79%
C	50 - 64%
F	0 - 49%

Clinical courses are Pass/Fail. Pass mark for any required Nursing theory course is 60% except Nursing 323. Pass mark for all non-nursing courses is 50% including Nursing 323.

COURSE WEIGHTING:

Prior to September 1981:

Course weighting was the same as the Faculty of Arts and Science (Full course/half course system).

Since September1981:

Each course was assigned a unit weight associated with the number of hours of lecture, seminar, clinical laboratory and field work in the course. Sessional loads normally range from 99 to 126 units.

FACULTY OF HEALTH SCIENCES

School of Rehabilitation Therapy

GRADING:

A	80 - 100%
B	65 - 79%
C	50 - 64%
F	0 - 49%

Courses prefixed with OT, PT or RHBS

C	60 - 84%

Prior to September 1974:

Pass mark	50%

Since September 1974:

Note in ALL mandatory courses, whether conducted through the Faculty of Health Sciences or another Faculty the pass mark is 60%.

The passing grade for elective courses taken outside the School - the passing mark is at the level as deemed by the appropriate Faculty.

COURSE WEIGHTING:

Prior to September 1972:

Course weighting was indicated as hours of lecture per week per session (a full course was normally 3.0, a half course was normally 1.5).

Since September 1972:

Full course/half course system such that a full course (1.0) is approximately equal to [illegible] hours per week per term. Normal full time load for one session ranges from approximately four up to six full courses.

FACULTY OF LAW

GRADING:

Prior to September 1966:

A	75 - 100%
B	66 - 74%
C	55 - 65%
[illegible]	[illegible]

September 1966 to February 1970:

A	80 - 100%
B	65 - 79%
C	58 - 64%
D	50 - 57%
F	0 - 49%

February 1970 to August 1996:

Grade:	A	B+	B
	C+	C	D
	P	F	

Since September 1996:

Grade:	A	A-	B+	B
	B-	C+	C	D
	P	F		

Numerical equivalents not provided. A grade of P denotes a pass in a course graded only on a pass/fail basis. A grade of A is "excellent"; a grade of B is "good"; a grade of C is 'fair".

COURSE WEIGHTING:

Course weights are indicated as lecture hours per week per term. The "Term" column shows whether a course is a 1-term or a 2-term (sessional) course. Normal full-time course load for one term is five courses.

SYMBOL CODES

AE	Audit and exam
AG	Aegrotat grade
AU	Audit only
CC	Correspondence course
CR	Credit
DR	Dropped (no academic penalty)
ED	Exam deferred
EX	Exempt
GD	Grade deferred
IP	In progress
NC	Non-credit
NW	Not written
PR	Preregistered
X	Exam only
***	In progress

TERM CODES

F	Fall
W	Winter
FW	Fall and Winter
N	Spring
S	Summer
NS	Spring and Summer

Please note:

Grade point average is not calculated by Queen's University.

THE SENATE OF
QUEEN'S UNIVERSITY
AT KINGSTON

witnesses that

Bruce Elliot Norman

having completed the prescribed program and
having been recommended by the

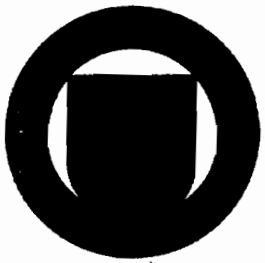
Faculty of Health Sciences

is hereby granted the Degree of

Doctor of Medicine

with all its rights, privileges and responsibilities.
In testimony whereof by the authority of Senate
we hereto sign our names and affix the seal of Senate.

Given at Kingston, Canada, this 25th day of May, 1974.



12/28/00

John G. Deutsch *Principal*

Margaret Horz *Secretary of Senate*

Section IV

Postgraduate Training

Federation Credentials Verification Service (FCVS)
Federation Place, 400 Fuller Wiser Road, Suite 300, Euless, TX 76039
Tel: (817) 868-5000 Fax: (817) 868-5099

Verification of Postgraduate Medical Education

Institution: **Royal Victoria Hospital**

Address: 687 Pine Avenue West
Montreal, QC H3A1A1

Attention: Administrative Services

University: McGill University

Verification For:

Name: **Norman. Bruce Elliott**
SSN: Redacted
DOB: **03/17/1949**

Physician's Name on Record (If different from above): _____

Program Participation:
Important:
Report incomplete postgraduate years (PGY) separate from those that were successfully completed.

If the postgraduate year is currently in progress report the expected completion date in the "To" field.

Report Internships, Residencies and Fellowships separately.

Use one section per department. If the department is rotating or transitional, please provide a schedule of rotations.

PGY: I	Department: Straight surgical Intern	
X Internship	From: 07 / 1 / 1975	To: 06 / 30 / 1975
___ Residency	Successfully Completed?: X Yes ___ No ___ In Progress	
___ Fellowship	Accredited by: X ACGME X AOA __ Not Accredited Other:	
___ Research		
PGY: II-IV	Department: Obstetrics/Gynaecology	
___ Internship	From: 07 / 1 / 1975	To: 06 / 30 / 1983
X Residency	Successfully Completed?: X Yes ___ No ___ In Progress	
___ Fellowship	Accredited by: X ACGME X AOA __ Not Accredited Other:	
___ Research		
PGY: _____	Department: _____	
___ Internship	From: ___/___/_____	To: ___/___/_____
___ Residency	Successfully Completed?: ___Yes ___ No ___ In Progress	
___ Fellowship	Accredited by: __ ACGME __ AOA __ Not Accredited Other:	
___ Research		

Unusual Circumstances:
Circle the correct response. Omitted responses require written explanation.

If necessary, you may continue you explanation on a separate sheet of paper.

Did this individual ever take a leave of absence or break from their training?	Yes No
Was this individual ever placed on probation?	Yes No
Was this individual ever disciplined or placed under investigation?	Yes No
Were any negative reports ever filed by instructors?	Yes No
Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason?	Yes No

Please explain any "Yes" response from above:

_____

_____

SEAL VERIFIED

Certification:

Affix your institutional seal in this space. If no seal is available, you must have this form notarized.

Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct. This section MUST be signed by the Program Director (M.D./D.O. only).

Name: Joanne MacPhail Signature: JMacPhail

Title: Ass't to Director Prof./Hosp. Services, MUHC Date of Signature: January 22, 2001

Tel: 514-843-1594 Fax: 514-843-1661 E-Mail: _____

07 FEV. 2001

The Federation of State Medical Boards of the United States, Inc.
Federation Credentials Verification Service
Federation Place
400 Fuller Wiser Road, Suite 300
Euless, TX 76039-3855
Telephone (817) 868-5000
FAX. (817) 868-5099

Fax Cover Sheet

TO: Joanne MacPhail
Ass't to Director Prof./Hosp Services, MUHC
Royal Victoria Hospital
514-843-1661

DATE: February 7, 2001

URGENT

FROM: Joyce Wingard

Packet ID: 17278
Request ID: 5874218
Bruce Elliott Norman, MD

The form you recently submitted to FCVS for Dr. Norman was either incomplete or requires further clarification. Please address these items listed below, initial the change and return by fax to the above number.

Please mail a hard copy of your changes to my attention.

1. Unusual Circumstances.

The Verification Form omitted any information as to whether any unusual circumstances may have occurred during any part of the applicant's postgraduate education. Please respond to each of the following questions and provide an explanation for any "yes" responses.

Did this individual ever take a leave of absence or break from their medical education?

___ Yes ✓ No

Was this individual ever placed on probation?

___ Yes ✓ No

Was this individual ever disciplined or under investigation?

___ Yes ✓ No

Were any negative reports regarding this individual ever filed by instructors?

___ Yes ✓ No

Were any limitations or special requirements imposed on the individual because of questions or academic incompetence, disciplinary problems or any other reason?

___ Yes ✓ No

Number of Pages Sent: 2 JM

Applicant: Print your complete last name: NORMAN

17. Postgraduate Medical Education

List all of the postgraduate medical education programs you attended in chronological order. Use one page per institution.

You are provided two pages (p. 6-7) in this application to report this information. You must make a photocopy(ies) of this page to report more than two (2) institutions.

Use one (1) page per institution. This page represents _____ of _____ institution(s).

ROYAL VICTORIA HOSPITAL
687 PINE AVENUE
Complete Name of Hospital Where Training was Conducted (Do not abbreviate)

MCGILL UNIVERSITY
Complete Name of Affiliated University or College (Do not abbreviate)

687 PINE AVE
Address Line 1

Address Line 2

MONTREAL
City

QUE
State/Province

CANADA
Country (U.S. or Canada only)

H3A 1A1 -
Zip/Postal Code

IMPORTANT:

Report incomplete postgraduate years (PGY) separate from those that were successfully completed.

If your postgraduate year is currently in progress, indicate the *expected* completion date in the "To" field.

Report Internships, Residencies and Fellowships separately.

Use one section per department.

PGY	Internship	Residency	Fellowship	Department	From (Month / Year)	To (Month / Year)	Successfully Completed?
1	☒	☐	☐	SURGERY	07 / 1974	06 / 1975	☒ Yes ☐ No ☐ In progress
2	☐	☒	☐	OBSTETRICS GYNECOLOGY	07 / 1975	06 / 1976	☒ Yes ☐ No ☐ In progress
3	☐	☒	☐	OBSTETRICS GYNECOLOGY	07 / 1981	06 / 1982	☒ Yes ☐ No ☐ In progress
4	☐	☒	☐	OBSTETRICS GYNECOLOGY	07 / 1982	06 / 1983	☒ Yes ☐ No ☐ In progress

18267

Unusual Circumstances (circle Yes or No):

Did you take a leave(s) of absence or break(s) from your medical education?	(YES)	NO
Were you ever placed on probation?	YES	(NO)
Were you ever disciplined or placed under investigation?	YES	(NO)
Were any negative reports ever filed against you?	YES	(NO)
Were any limitations or special requirements imposed on you because of academic incompetence, disciplinary problems, or for any other reason?	YES	(NO)

If necessary, you may continue your explanation of Unusual Circumstances on a separate 8½ x 11 sheet of paper. Your response may not exceed 100 words per question.

Please explain any "Yes" response from above:

Left OB/GYN program from 1976-1981 to practice as a family physician.

Section V

Examination History/Score Transcripts

Medical Council of Canada
Le Conseil médical du Canada

Suite 100, 2283 boul. St. Laurent Blvd.
Ottawa, Ontario, Canada K1G 5A2

W. DALE DAUPHINEE, M.D., FRCPC
Executive Director/Directeur général

10 January 2001

"CONFIDENTIAL"

Federation of State Medical Boards of the United States, Inc.
Federation Credentials Verification Service
Federation Place
400 Fuller Wiser Rd Ste 300
Euless Texas 76039-3855
USA

SUBJECT: Dr. Bruce Elliott NORMAN

D.O.B. 17 March 1949
L.M.C.C. No. 40420

The enclosed certificate is submitted to you on behalf of the person named. I hope that this will provide a satisfactory statement of this Licentiate's registration with this Council.

Sincerely

Noreen Nolan
Director
Credentials and Registrations

jm
Enc.

THE MEDICAL COUNCIL OF CANADA

P.O. Box 8234, Ottawa, Ontario, Canada, K1G 3H7

STATEMENT OF REGISTRATION **PRIVATE AND CONFIDENTIAL**

N.B. - This statement is issued subject to the following explanation:

(1) *Licensure of medical practitioners in Canada is in the hands of the medical licensing authorities of Canada, on whose behalf the Medical Council of Canada holds professional examinations leading to enrolment in the Canadian Medical Register as Licentiate of the Medical Council of Canada (L.M.C.C.). A person so qualified may obtain a license to practice if considered otherwise suitable by the medical licensing authority.*

(2) *This form of statement pertains only to Licentiates awarded standing upon success in the examinations inaugurated December 1, 1969 and whose names are entered in the Canadian Medical Register. These are conducted by the objective, multiple-choice method and embrace the subjects of (a) medicine, (b) obstetrics & gynaecology, (c) paediatrics, (d) public health & preventive medicine, (e) psychiatry, and (f) surgery. They may include such questions concerning the basic medical sciences as pertain to the practice of medicine. They consist of two separate Parts, namely, Part A, the Clinical Sciences Examination, and Part B, the Clinical Competence Examination. Part A is a multiple-choice examination containing questions in the subjects listed above in this paragraph, presented in interdisciplinary form so that the subject origin of a question is not announced to the candidate. Part B is a multiple-choice examination to test clinical competence and ability to manage patients.*

(3) *The pass mark in each of Part A and Part B is a converted score of 60.*

A statement is made below of the marks in each of the six subjects contained in Part A. This is for information only, and no pass level is stipulated for these subject marks. Note also that the Part A mark itself will not necessarily be an exact average of the six subject marks.

(4) *The information obtained by the Medical Council of Canada does not enable it to certify reliably concerning a licentiate's character or habits, nationality or citizenship, educational record or standing, or provincial registration or license as a practitioner. This information should be obtained from the Canadian medical licensing authority where the physician is licensed to practice.*

(5) *This statement is not evidence of the identity of its holder with the person named herein, and must not be used as such.*

I hereby certify that **Dr. Bruce Elliott NORMAN** having passed the required examinations, was registered on the Canadian Medical Register as Licentiate of the Medical Council of Canada under the registration number **40420** on **30 April 1976**. I further certify that the examination results of this licentiate are as follows:

Part A: 76 Part B: 72

Part A Subjects

Medicine	75	Public Health & Preventive Medicine	80
Obstetrics & Gynaecology	80	Psychiatry	75
Paediatrics	76	Surgery	71

The examination was taken by this candidate in **May 1974**

Date **10 January, 2001**

.....Registrar

DETACH HERE AND REMIT THIS PORTION WITH FEE

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

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 2002 - 2004 REGISTRATION PERIOD THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE **OHIO STATE MEDICAL ASSOCIATION** *AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.*

X [signature] 11/06/03
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE	$50 Late Fee Due After
35-07-9099-N	$305.00	01/01/04	04/01/04

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

0935079099 30500

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

☐ **SPECIALTY CODE(S) CORRECT AS LISTED**

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

RESIDENCE ADDRESS-THIS MUST BE ENTERED AT EACH RENEWAL.

STREET [redacted]
STREET
CITY [redacted] STATE [redacted] ZIP CODE [redacted]
COUNTY [redacted]

APPLICATION FOR RENEWAL OF YOUR CERTIFICATE:

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

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

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

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

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

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

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

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

[redacted]
Street
Street
City State Zip Code
County

REQUIRED: [redacted] Redacted
SOCIAL SECURITY NUMBER

Date Posted: 12/5/2005 1:25:05 PM

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

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

License Information

License Number	35.079099
License Name	BRUCE NORMAN
Email Address	

Fees

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

Specialty Codes

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

CME-Physicians

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

Discipline

1. Have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?
   ..... NO
2. Have you surrendered, consented to limitation of, or to suspension, reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction other than Ohio?
   ..... NO
3. Have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?
   ..... NO

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

. . . . . NO

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

. . . . . NO

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

. . . . . NO

Social Security Number

1.

. . . . . Redacted

Nurse Collaboration Info

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

. . . . . NO

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

. . . . . *{not Answered}*

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

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