License Verification

Data As Of **2/28/2012**

GARY B BROADNAX
LICENSE NUMBER: **OS6815**

Profession

OSTEOPATHIC PHYSICIAN

License/Activity Status

Retired/

License Expiration Date

3/31/2008

License Original Issue Date

06/13/1994

Discipline on File

NO

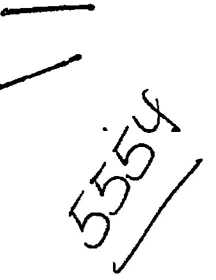
Public Complaint

NO

Address of Record

No current practice location in Florida - If further information is needed, please contact the Department of Health at (850) 488-0595.

The information on this page is a secure, primary source for license verification provided by The Florida Department of Health, Division of Medical Quality Assurance. This website is maintained by Division staff and is updated immediately upon a change to our licensing and enforcement database.



NWHO
National Women's Health Organization of Central Florida, Inc.

Deposit Date: 02-02-1999
Deposit #: 167072
Batch Number 0000661
Validation #: 989004796
Check Amount $ 100.00

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Batch Number 0000661
Validation #: 989004796
Check Amount $ 100.00

December 10, 1998

Department of Health
Board of Medicine
2020 Capitol Circle SE
BIN #C03
Tallahassee, FL 32399-3253

Dear Board of Medicine:

The following physicians would like their licenses revised to accomodate the dispensing of medicine from their office. Enclosed you will find a $300 check for the three revisions needed.

__________ Patrick Joseph Kelly, MD, ME0069167

__________ Carlito Arrogante, MD, ME0024940

__________ Gary Broadnax, DO, OS0006815

The dispensing location is 2208 Hillcrest Street, Orlando, 32803. Please continue to mail renewal licenses to the address that is indicated on each license.

Respectfully,

Pat Davis

done

duplicate

Practitioner's Name GARY B BROADNAX License # OS0006815

EXHIBIT 1 – REPORT ON PROFESSIONAL LIABILITY CLAIMS AND ACTIONS

Include information relating to liability actions occurring within the previous 10 years. The actions are required to be reported under section 455.697 F.S. You must submit a completed form for each occurrence. For Allopathic, Osteopathic and Podiatric physicians, copies of reports previously submitted under the requirements of s. 455.697, F.S., (formerly s. 355.247, F.S.) may be submitted in lieu of this exhibit to satisfy this reporting requirement.

Date of occurrence: ____/____/____ Date reported to licensee: ____/____/____

Injured person's name: (last, first, middle initial) ____________
Street Address: ____________
City: ____________ State: ________ Zip Code: ________
Age: ________ Sex: ________

Date of suit: ____/____/____

List other defendants involved in this claim:
1. ____________ 2. ____________
3. ____________ 4. ____________

Date of final claim disposition: ____/____/____

Was there an itemized verdict? ☐ Yes ☐ No (If "YES", attach copy of settlement verdict)

Indemnity paid on behalf of this defendant: $________
Loss adjustment expense paid to defense counsel: $________
All other loss adjustment expense paid: $________

Name of institution at which the injury occurred: ____________
Location of injury occurrence:

___ Patient's Room ___ Physical Therapy Dept. ___ Radiology ___ Labor & Delivery Room
___ Operating Suite ___ Nursery ___ Emergency Room ___ Special Procedure Room
___ Recovery Room ___ Critical Care Unit ___ Other ________

Final diagnosis for which treatment was sought or rendered. ____________

Describe misdiagnosis made, if any, of the patient's actual condition. ____________

Describe the operation, diagnostic or treatment procedure causing the injury. Use nomenclature and/or descriptions of the procedures used. Include method of anesthesia, or name of drug used for treatment, with detail of administration. ____________

Describe the principal injury giving rise to the claim. Use nomenclature and/or descriptions of the injury. Include type of adverse effect from drugs where applicable. ____________

Safety management steps taken by the licensee to make similar occurrences less likely. ____________

I affirm that these statements are true and correct and recognize that providing false information may result in disciplinary action against my license or criminal penalties pursuant to Sections 455.624, 458.327, 458.331, 459.013, 459.015, 460.413, 461.013, 775.082, 775.083, and 775.084, Florida Statutes.

Signature of Physician: ____________

Our records indicate the following reported claims:

Incident Date	Settlement Date	Incident Date	Settlement Date	Incident Date	Settlement Date	Incident Date	Settlement Date	Incident Date	Settlement Date
04/11/1996	5/12/97								

Payment for $2,500.00 to settle claim. Letter attached.
[signature]

License Verification

Data As Of **2/28/2012**

GARY B BROADNAX

LICENSE NUMBER: **OS6815**

Profession

OSTEOPATHIC PHYSICIAN

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STATE OF FLORIDA
DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE

INACTIVE RECEIPT

NOTICE: THIS IS A RECEIPT FOR YOUR INACTIVE RENEWAL FEE. THIS IS **NOT A LICENSE** AND **MAY NOT** BE USED FOR PURPOSES OF EMPLOYMENT. YOU WILL NOT RECEIVE A LICENSE TO PRACTICE YOUR PROFESSION IN THE STATE OF FLORIDA UNLESS OR UNTIL YOU REACTIVATE TO ACTIVE STATUS. SHOULD YOU WISH TO DO SO, PLEASE CONTACT THE DIVISION OF MEDICAL QUALITY ASSURANCE AT (850) 488-0595 FOR INFORMATION.

GARY B BROADNAX
PO BOX 2246
AUGUSTA, GA 30903

RECEIPT PRINTED: **03/18/2004**
RECEIPT EXPIRES: **MARCH 31, 2006**

COPY COPY COPY

COPY COPY COPY

(7/98) RETAIN THIS COPY FOR YOUR RECORDS

LICENSE NO.	CONTROL NO.
OS 6815	**13440**

EXPIRATION DATE: **MARCH 31, 2006**

YOUR LICENSE NUMBER IS **OS 6815** ,PLEASE USE IT IN ALL CORRESPONDENCE WITH YOUR BOARD/COUNCIL. EACH LICENSEE IS SOLELY RESPONSIBLE FOR NOTIFYING THE DEPARTMENT IN WRITING OF THE LICENSEE'S CURRENT MAILING ADDRESS. USE THIS SECTION TO REPORT NAME AND/OR MAILING ADDRESS CHANGES.

NAME CHANGES REQUIRE LEGAL DOCUMENTATION SHOWING THE NAME CHANGE. PLEASE MAKE SURE THAT A PHOTOCOPY OF ONE OF THE FOLLOWING ACCOMPANIES THIS FORM: A MARRIAGE LICENSE (MARRIAGE LICENSE MUST INDICATE THE ORIGINAL SIGNATURE AND SEAL FROM THE CLERK OF THE COURT), A DIVORCE DECREE INDICATING RESTORATION OF YOUR MAIDEN NAME, OR A COURT ORDER (E.G., ADOPTION, NAME CHANGE, OR FEDERAL IDENTITY CHANGE). ANY ONE OF THESE WILL BE ACCEPTED UNLESS THE DEPARTMENT HAS A QUESTION ABOUT THE AUTHENTICITY OF THE DOCUMENT. **A DRIVER'S LICENSE OR SOCIAL SECURITY CARD IS NOT CONSIDERED LEGAL DOCUMENTATION.**

TO REQUEST A DUPLICATE LICENSE SUBMIT THIS FORM AND A CHECK, PAYABLE TO THE DEPARTMENT OF HEALTH, IN THE AMOUNT OF $25.00.

☐ REQUEST DUPLICATE LICENSE

____
SIGNATURE REQUIRED

DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE
LICENSURE SERVICES
P.O.BOX 6320
TALLAHASSEE, FLORIDA 32314-6320

☐ NAME CHANGE (ATTACH LEGAL DOCUMENTATION)

FROM: ________________________
LAST FIRST MIDDLE

TO: ________________________
LAST FIRST MIDDLE

☐ MAILING ADDRESS CHANGE

____

____

____
CITY STATE ZIP

DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE
LICENSURE SERVICES
4052 BALD CYPRESS WAY, BIN #C-10
TALLAHASSEE, FLORIDA 32399-3260

GARY B BROADNAX
PO BOX 2246
AUGUSTA, GA 30903

CURRICULUM VITAE

NAME

Gary Burke Broadnax, D.O., FACOG
Colonel, Medical Corps
U.S. Army

CURRENT POSITION

Chief, Department of Obstetrics and Gynecology
Eisenhower Army Medical Center

Consultant to The Army Surgeon General in Obstetrics
and Gynecology

ACADEMIC APPOINTMENT

Associate Clinical Professor
Medical College of Georgia

ADDRESS

Department of Obstetrics and Gynecology
Eisenhower Army Medical Center
Fort Gordon, GA 30905-5650
(404) 791-6398/4165

HOME ADDRESS

1409 Waters Edge
Augusta, Georgia 30901

DATE OF BIRTH

1 June 1945
Aiken, South Carolina

Married, Lori
Daughter, Natalie

UNDERGRADUATE EDUCATION

Munich American High School
Munich, Germany
1958 - 1962

Mercer University
Macon, Georgia
Bachelor of Arts
1962 - 1966

PROFESSIONAL EDUCATION

Chicago College of Osteopathic Medicine
Chicago, Illinois
Doctor of Osteopathy
1969 - 1973

Obstetrics and Gynecology Internship
Walter Reed Army Medical Center
Washington, D.C.
1973 - 1974

Obstetrics and Gynecology Residency
Walter Reed Army Medical Center
Washington, D.C.
1974 - 1977

Board Certified, American College of Obstetrics and Gynecology
License: Georgia

PROFESSIONAL EXPERIENCE

Staff Physician
Department of Obstetrics and Gynecology
Eisenhower Army Medical Center
July 1977

Clinical Instructor
Medical College of Georgia
June 1978

Chief, Department of Obstetrics and Gynecology
Eisenhower Army Medical Center
July 1978

Assistant Clinical Professor
Medical College of Georgia
July 1988

Obstetrical and Gynecological Surgery Consultant
to The Surgeon General
1989 - present

Department of Defense Joint Healthcare Management
Engineering Team Consultant
1989 - 1991

Associate Clinical Professor
Medical College of Georgia
July 1990

Regional Consultant:

Martin Army Community Hospital
Fort Benning, GA

Blanchfield Army Community Hospital
Fort Campbell, KY

Moncrief Army Community Hospital
Fort Jackson, SC

Noble Army Community Hospital
Fort McClellan, AL

Bayne-Jones Army Community Hospital
Fort Polk, LA

Lyster Army Community Hospital
Fort Rucker, AL

Tuttle Army Community Hospital
Fort Stewart, GA

COMMITTEES:

Chairman, Eisenhower Army Medical Center Risk Management Committee, 1986 - 1989

Eisenhower Quality Assurance Committee

Eisenhower Therapeutic Agents Board

Eisenhower Medical Education Committee

Eisenhower Credentials Committee

Eisenhower Composite Health Care System Executive Committee

Member, Executive Committee - Department of OB/GYN, Medical College of Georgia

Member, Medical Advisory Committee, Planned Parenthood of East Central Georgia

Member, Resident Selection Committee, Department of OB/GYN, Medical College of Georgia

PROFESSIONAL MEMBERSHIP

Diplomate, American Board of Obstetrics and Gynecology

Fellow, American College of Obstetricians and Gynecologists

Georgia Obstetrical and Gynecological Society

Augusta Obstetrical and Gynecological Society President, 1984 - 1985

The American College of Physician Executives

HONORS/AWARDS

Program Chairman - 1984 Armed Forces District Meeting of the American College of Obstetricians and Gynecologists

President - Augusta Obstetrical and Gynecological Society, 1984 - 1985

Margaret Sanger Award, Planned Parenthood Federation of America, 1989

MILITARY

Bronze Star with Oak Leaf Cluster
Purple Heart
Air Medal
Army Commendation Medal with Oak Leaf Cluster
Army Achievement Medal
Order of Military Medical Merit
Vietnamese Gallantry Cross
Vietnam Service Medal
National Defense Medal
Combat Medical Badge
Airborne Badge
Army Flight Surgeon Wings

PRESENTATIONS

Termination Hysterectomy. Armed Forces District, American College of Obstetricians and Gynecologists, Las Vegas, Nevada, 1976

PRESENTATIONS (continued)

The Effect of Doxycycline in Reducing Post-Operative Morbidity in Vaginal Hysterectomy. Armed Forces District, American College of Obstetricians and Gynecologists, New Orleans, Louisiana, 1977

A Comparison of Prophylactic Antibiotic Regimens in Vaginal Hysterectomy. Armed Forces District, American College of Obstetricians and Gynecologists, San Antonio, Texas, 1979

Group B Streptococcus in Obstetrics. Armed Forces District, American College of Obstetricians and Gynecologists, Orlando, Florida, 1980

Management of Pelvic Abscess. Armed Forces District, American College of Obstetricians and Gynecologists, Orlando, Florida, 1980

Toxic-Shock Syndrome. Physician Assistant Annual Meeting, Fayetteville, North Carolina, 1981

OB/GYN Emergencies. Physician Assistant Annual Meeting, Fayetteville, North Carolina, 1981

Genital Herpes. Tennessee Osteopathic Medical Association, Chattanooga, Tennessee, 1982

Pelvic Inflammatory Disease. Georgia Osteopathic Medical Association, Callaway Gardens, Georgia, 1983

Abnormal Genital Bleeding. Physicia[illegible] ssistant Annual Meeting, Fayetteville, North C[illegible]rolina, 1985

Sexually Transmitted Diseases. Physician Assistant Meeting, Fayetteville, North Carolina, 1985

STD'S - Focus on Herpes. Maine Osteopathic Medical Association, Dixsville Notch, New Hampshire, 1985

Acquired Immune Deficiency Syndrome. Grand Rounds, Department of Obstetrics/Gynecology, Medical College of Georgia, 1985

PRESENTATIONS (continued)

STD'S - Focus on Herpes. 11th Annual Still Healthy Review, Charles E. Still Osteopathic Hospital, Jefferson City, Missouri, 1985

Antiviral Agents in STD'S. Missouri Society of the American College of General Practice, Kansas City, Missouri, 1986

STD Update. Medical College of Georgia Post Graduate Course, Kiawah Island, Georgia, 1987

Breast Disease. Medical College of Georgia Post Graduate Course, Kiawah Island, South Carolina, 1987

Sexually Transmitted Diseases. Grand Rounds, Greenville Hospital System, Greenville, South Carolina, 1989

Recent Trends in STD'S. Indiana Osteopathic Medical Association, Indianapolis, Indiana, 1989

Benign Breast Conditions. Medical College of Georgia Post Graduate Course, Kiawah Island, South Carolina, 1989

Early Diagnosis of Breast Disease. Obstetrics and Gynecology Continuing Medical Education Program, Uniformed Services University of Health Sciences, Garmisch, West Germany, 1990

Recent Trends in STD's. Obstetrics and Gynecology Continuing Medical Education Program, Uniformed Services University of Health Sciences, Garmisch, West Germany, 1990

Pelvic Inflammatory Disease. Obstetrics and Gynecology Continuing Medical Education Program Uniformed Services University of Health Sciences, Garmisch, West Germany, 1990

Sexually Transmitted Diseases. Obstetrics and Gynecology Continuing Medical Education Program, Uniformed Services University of Health Sciences, Willingen, Germany, 1992

PRESENTATIONS (continued)

The Bethesda System - What's The Fuss. Obstetrics and Gynecology Continuing Medical Education Program, Uniformed Services University of Health Sciences, Willingen, Germany, 1992

Early Diagnosis of Breast Disease. Obstetrics and Gynecology Continuing Medical Education Program, Uniformed Services University of Health Sciences, Willingen, Germany, 1992

Contraception in the 90's. Obstetrics and Gynecology Continuing Medical Education Program, Uniformed Services University of Health Sciences, Willingen, Germany, 1993

Recognition and Management of Urological Injuries. Obstetrics and Gynecology Continuing Medical Education Program, Uniformed Services University of Health Sciences, Willingen, Germany, 1993

Management of Benign Breast Conditions. Obstetrics and Gynecology Continuing Medical Education Program, Uniformed Services University of Health Sciences, Willingen, Germany, 1993

Controversies in Estrogen Replacement Therapy. Obstetrics and Gynecology Continuing Medical Education Program, Uniformed Services University of Health Sciences, Willingen, Germany, 1993

SCIENTIFIC EXHIBITS

Vaginal Hysterectomy-Operative Technique. Armed Forces District, American College of Obstetricians and Gynecologists, Orlando, Florida, 1980

FLORIDA DEPARTMENT OF BUSINESS AND PROFESSIONAL REGULATION

Lawton Chiles, Governor George Stuart, Secretary

May 24, 1994

APPLICATION BY: MMB
EXPIRATION DATE: 5/8/95

TO: Gary Burks Broadnax, D.O.
1409 Waters Edge Drive
Augusta, GA 30901-1045

From: Melissa Coggins

This is to advise that we have received your application for Osteopathic Licensure, the items indicated below are needed to complete your file.

1. ( ) All Applicable fees.
2. ( ) Photograph, head and shoulders, on NON-Polaroid paper.
3. ( ) Verification of education from your osteopathic college
4. ( ) Proof of completion of internship - see training evaluation form.
5. ( ) National Board grades mailed directly to us from the National Board or State Board grades mailed directly from state of examination.
6. (MM) Notarized copy of current military orders or discharge papers (form DD214) Please submit a notarized copy of your current orders or your personnel paper (already submitted, un-notarized, with your request for an exemption to the NICA assessment.
7. ( ) Notarized copy of legal name change document.
8. (MM) Verification of licensure from the state(s) of: GA
9. ( ) 2 letters of recommendation from physicians (MD or DO). These letters must be on letterhead paper and addressed TO THE BOARD OF OSTEOPATHIC MEDICINE.
10. ( ) Proof of 3 hours HIV/AIDS CME credits.
11. (XX) Other: AMA-approved training
Please submit a personal explanation regarding your decision to complete an AMA-approved year of training and not an AOA-approved internship.

( ) Internship Evaluation:
Walter Reed Army Medical Center

( ) Staff Privileges Verification:

( ) Residency Evaluation:

IF YOUR APPLICATION IS COMPLETE 30 DAYS PRIOR TO THE DATE OF THE NEXT MEETING, IT CAN BE SCHEDULED ON THE AGENDA AT THAT MEETING. WE CANNOT ASSURE THAT ANY APPLICATION COMPLETED LESS THAN THIRTY DAYS PRIOR TO A BOARD MEETING WILL BE PLACED ON THE AGENDA. IF POSSIBLE, WE WILL ATTEMPT TO SCHEDULE COMPLETED APPLICATIONS ON THE AGENDA AFTER THE THIRTY DAY TIME PERIOD.

DIVISION OF MEDICAL QUALITY ASSURANCE
BOARD OF OSTEOPATHIC MEDICINE
NORTHWOOD CENTRE • 1940 NORTH MONROE STREET • TALLAHASSEE, FLORIDA 32399-0757
Telephone (904) 922-6725

Florida Department of Health - Board of Osteopathic Medicine

License Renewal Notice

Active Dispensing Osteopathic Physician License # OS 6815 expires January 31, 2002.

To avoid a delinquent charge, the fee of **$554.00** and the renewal form must be postmarked or electronically submitted on or before January 31, 2002. Renewal notices/forms postmarked on or after February 1, 2002 require renewal and delinquency fees of **$754.00**.

1. CHANGE OF MAILING ADDRESS:

DEPARTMENT USE ONLY

Current Mailing Address:

GARY B BROADNAX
1409 WATERS EDGE DRIVE
AUGUSTA, GA 30901

New Mailing Address:

Licensee's Last Name First Middle Initial
Attn:
Street Address:
City: State: Zip:
Phone: ( )

2. CHANGE OF PRACTICE LOCATION:

Current Practice Location:

1409 WATERS EDGE DRIVE
AUGUSTA, GA 30901

New Practice Location:

Attn:
Street Address:
City: State: Zip:
Phone: ( )

3. Chapter 456, F.S., requires a background check to renew a license, please review the following data to verify that the information is correct and make any necessary corrections. This information is critical in ensuring that background checks are attributed to the correct licensee.

Description	Department Information	Information is Accurate		Correct Information
Social Security #		◯ Yes	◯ No	
Date of Birth	06/01/45	◯ Yes	◯ No	
Sex	Male	◯ Yes	◯ No	
Race	White	◯ Yes	◯ No	
Race Options: White, Black, Native, Asian, Other, Hispanic & not given				

4. COMPLETE THE FINANCIAL RESPONSIBILITY FORM ON THE REVERSE SIDE OF THIS FORM.

5. MILITARY STATUS:

◯ I am requesting Military Restricted Status. (Military Restricted must submit proof of active military duty. Attach a copy of your current active duty orders or a letter from your Commanding Officer.)

◯ Please remove the Military Restricted Status from my license. (Provide copy of DD214 or letter from Commanding Officer.)

6. Will you be available to provide health care services in special needs shelters or to help staff disaster medical assistance teams during times of emergency or major disaster?

◯ Yes

7. THERE ARE TWO RENEWAL METHODS AVAILABLE:

A. Internet E-Renewal: Web address http://www.doh.state.fl.us/erenewal

E-Renewal allows you to make address changes. E-Renewal does not allow you to renew online by adding or removing a status, such as paying a delinquency fee or changing a license status. Due to high volume, allow sufficient time to renew since **e-Renewal will not be available after midnight Eastern Time (ET) January 31, 2002**. E-Renewal will require the following information:

PIN Number:
License Number: OS 6815

B. U.S. Mail:

Mail this completed renewal form and fee payable to the Department of Health to:

P.O. Box 6320
Tallahassee, Florida 32314-6320

8. Other Information:

File Number: 5554 20 20 Sequence Number: 11

OS00000006815

FINANCIAL RESPONSIBILITY

The Financial Responsibility options are divided into two categories, coverage and exemptions.
Choose only ONE option of the ten provided pursuant to s.459.0085, Florida Statutes.

CATEGORY I - CATEGORIES OF FINANCIAL RESPONSIBILITY COVERAGE:

1. I do not have hospital staff privileges and I have established an irrevocable letter of credit or an escrow account in an amount of $100,000/$300,000, in accordance with Chapter 675, F. S., for a letter of credit and s. 625.52, F. S., for an escrow account.
2. I have hospital staff privileges and I have established an irrevocable letter of credit or escrow account in an amount of $250,000/$750,000, in accordance with Chapter 675, F. S., for a letter of credit and s. 625.52, F. S., for an escrow account.
3. I do not have hospital staff privileges and I have obtained and maintain professional liability coverage in an amount not less than $100,000 per claim, with a minimum annual aggregate of not less than $300,000 from an authorized insurer as defined under s. 624.09, F. S., from a surplus lines insurer as defined under s. 626.914(2), F.S., from a risk retention group as defined under s. 627.942, F.S., from the Joint Underwriting Association established under s. 627.351(4), F. S., or through a plan of self-insurance as provided in s. 627.367, F.S. I further certify that I have been continuously insured with an entity as outlined above for the past two years (retroactive coverage) or if I seek insurance from a different entity providing insurance; I will purchase retroactive coverage for the two years proceeding my inception date of coverage. I further certify that in the event my coverage is terminated or that I desire to become uninsured and meet the financial responsibility requirements through other provisions in s. 458.320 or 459.0085, F.S., I will maintain coverage for incidents which may have occurred during the two years preceding my becoming uninsured.
4. I have hospital staff privileges and I have professional liability coverage in an amount not less than $250,000 per claim, with a minimum annual aggregate of not less than $750,000 from an authorized insurer as defined under s. 624.09, F. S., from a surplus lines insurer as defined under s. 626.914(2), F. S., from a risk retention group as defined under s. 627.942, F.S., from the Joint Underwriting Association established under s. 627.351(4), F. S., or through a plan of self insurance as provided in s. 627.367, F .S. I further certify that I have been continuously insured with an entity as outlined above for the past two years (retroactive coverage) or if I seek insurance from a different entity providing insurance I will purchase retroactive coverage for the two years preceding my inception date of coverage. I further certify that in the event my coverage is cancelled or that I desire to become uninsured and meet the financial responsibility requirements through other provisions in s. 458.320 or 459.0085, F.S., I will maintain coverage for incidents which may have occurred during the two years preceding my becoming uninsured.
5. I have elected not to carry medical malpractice insurance, however, I agree to satisfy any adverse judgements up to the minimum amounts pursuant to s. 458.320(5)(g)1 or 459.008S(5)(g)1, F. S. I understand that I must either post notice in the form of a "sign" prominently displayed in the reception area or provide a written statement to any person to whom medical services are being provided that I have decided not to carry medical malpractice insurance. I understand that such a sign or notice must contain the wording specified in s. 458.320(5)(g) or 459.008S(5)(g), F. S.

CATEGORY II - EXEMPTION CATEGORIES OF FINANCIAL RESPONSIBILITY COVERAGE:

6. I practice medicine exclusively as an officer, employee, or agent of the federal government, or of the state or its agencies or subdivisions;
7. I hold a limited license issued pursuant to s. 458.317 or 459.0075, F. S., and practice only under the scope of the limited license;
8. I do not practice medicine in the State of Florida;
9. I meet all of the following criteria:

   (a) I have held an active license to practice in this state or another state or some combination thereof for more than 15 years;

   (b) I am retired or maintain part time practice of no more than 1000 patient contact hours per year;

   (c) I have had no more than two claims resulting in an indemnity exceeding $10,000 within the previous five year period;

   (d) I have not been convicted of or pled guilty or nolo contendere to any criminal violation specified in Chapter 458 or 459, F. S.; and

   (e) I have not been subject, within the past ten years of practice, to license revocation or suspension, probation for a period of three years or longer, or a fine of $500 or more for a violation of Chapter 458 or 459, F.S., or the medical practice act of another jurisdiction. A regulatory agency's acceptance of a relinquishment of license stipulation, consent order or other settlement offered in response to or in anticipation of filing of administrative charges against a license shall be construed as action against a license. I understand if I am claiming an exception under this section that I must either post notice in the form of a sign, prominently displayed in the reception area or provide a written statement to any person to whom medical services are being provided, that I have decided not to carry medical malpractice insurance. I understand such a sign or notice must contain the wording specified in s. 458.320(5)(t) or 459.0085(5)(t), F. S.; or
10. I practice only in conjunction with my teaching duties at an accredited medical school or its teaching hospitals. (Interns and residents do not qualify for this exemption).

AC# **COPY**

STATE OF FLORIDA
DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE

DATE	LICENSE NO.	CONTROL NO.
12/14/2001	OS 6815	6372

THE OSTEOPATHIC PHYSICIAN
NAMED BELOW HAS MET ALL REQUIREMENTS OF
THE LAWS AND RULES OF THE STATE OF FLORIDA.
EXPIRATION DATE: **MARCH 31, 2004**
GARY B BROADNAX
1289 BROAD ST
AUGUSTA, GA 30901

COPY COPY COPY

AC#
STATE OF FLORIDA
DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE

DATE	LICENSE NO	CONTROL NO
12/14/2001	OS 6815	6372

THE OSTEOPATHIC PHYSICIAN
NAMED BELOW HAS MET ALL REQUIREMENTS OF
THE LAWS AND RULES OF THE STATE OF FLORIDA.
EXPIRATION DATE: MARCH 31, 2004
GARY B BROADNAX

COPY - NOT A VALID LICENSE - COPY

AT LEAST 90 DAYS PRIOR TO THE EXPIRATION DATE SHOWN ON THIS LICENSE, A NOTICE OF RENEWAL WILL BE SENT TO YOUR LAST KNOWN ADDRESS. IF YOU HAVE NOT RECEIVED YOUR NOTICE 60 DAYS PRIOR TO THE EXPIRATION DATE, PLEASE CALL (850) 410-3359.

COPY - NOT A VALID LICENSE - COPY

EXPIRATION DATE: **MARCH 31, 2004**

YOUR LICENSE NUMBER IS **OS 6815** ,PLEASE USE IT IN ALL CORRESPONDENCE WITH YOUR BOARD/COUNCIL. EACH LICENSEE IS SOLELY RESPONSIBLE FOR NOTIFYING THE DEPARTMENT IN WRITING OF THE LICENSEE'S CURRENT MAILING ADDRESS. USE THIS SECTION TO REPORT NAME AND/OR MAILING ADDRESS CHANGES.

NAME CHANGES REQUIRE LEGAL DOCUMENTATION SHOWING THE NAME CHANGE. PLEASE MAKE SURE THAT A PHOTOCOPY OF ONE OF THE FOLLOWING ACCOMPANIES THIS FORM: A MARRIAGE LICENSE (MARRIAGE LICENSE MUST INDICATE THE ORIGINAL SIGNATURE AND SEAL FROM THE CLERK OF THE COURT), A DIVORCE DECREE INDICATING RESTORATION OF YOUR MAIDEN NAME, OR A COURT ORDER (E.G., ADOPTION, NAME CHANGE, OR FEDERAL IDENTITY CHANGE). ANY ONE OF THESE WILL BE ACCEPTED UNLESS THE DEPARTMENT HAS A QUESTION ABOUT THE AUTHENTICITY OF THE DOCUMENT. **A DRIVER'S LICENSE OR SOCIAL SECURITY CARD IS NOT CONSIDERED LEGAL DOCUMENTATION.**

TO REQUEST A DUPLICATE LICENSE SUBMIT THIS FORM AND A CHECK, PAYABLE TO THE DEPARTMENT OF HEALTH, IN THE AMOUNT OF $25.00.

☐ REQUEST DUPLICATE LICENSE ______________________________

SIGNATURE REQUIRED

DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE
LICENSURE SERVICES
4052 BALD CYPRESS WAY, BIN #C-10
TALLAHASSEE, FLORIDA 32399-3260

☐ NAME CHANGE (ATTACH LEGAL DOCUMENTATION)

FROM: ______________________________
LAST FIRST MIDDLE

TO: ______________________________
LAST FIRST MIDDLE

☐ MAILING ADDRESS CHANGE

____
____
____
CITY STATE ZIP

DH 2103, 5/98

DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE
LICENSURE SERVICES
4052 BALD CYPRESS WAY, BIN #C-10
TALLAHASSEE, FLORIDA 32399-3260

GARY B BROADNAX
PO BOX 2246
AUGUSTA, GA 30903

Jeb Bush
Governor

Robert G. Brooks, M.D.
Secretary

August 15, 2001

GARY B BROADNAX, D.O.
1409 WATERS EDGE DRIVE
AUGUSTA, GA-30901

Dear Dr. BROADNAX

The information published in your practitioner profile is printed below. In carrying out our legislative mandate to publish physician profiles, we want to do everything we can to ensure the information that is published is correct. You have the opportunity to review the data for any changes, corrections, and/or omissions. Under Section 456.042, Florida Statutes, you have thirty (30) days from the date you receive this letter to submit changes to 4052 Bald Cypress Way, Bin # C10, Tallahassee, Florida 32399-3260. If you have no changes, your profile will remain as it appears on the World Wide Web. Listed below is information that you should review carefully.

Florida law requires you to **report all disciplinary action** taken by facilities, including those outside the state of Florida. **Please review and identify any action which was taken by a hospital or ambulatory surgical center in Florida, this discipline will not be published in the profile.**

In addition, state law requires that all **criminal convictions** must be reported to the department pursuant to Section 456.039(1)(a)7, Florida Statutes. If your criminal conviction was expunged or the records were sealed, please send a copy of the court order expunging or sealing the records.

◯ My profiling information is correct
◯ My profiling information is incorrect; changes are noted below.

I. Practitioner Information

License Number : 6815
Profession : Osteopathic Physician

License Status : ACTIVE CLEAR
Year Began Practicing : 01/01/1973

Primary Business:

1409 WATERS EDGE DRIVE
AUGUSTA GA 30901

Secondary Locations:

Staff Privileges:
This practitioner does not currently hold staff privileges at any hospital/medical/health institution in Florida. To confirm out-of-state staff privileges please see other affiliations.

Faculty Appointments:
This practitioner has had the responsibility for graduate medical education within the last 10 years.

This practitioner currently holds faculty appointments at the following medical/health related institutions of higher learning:
Title : Institution : City : State
1. FACULTY : MEDICAL COLLEGE OF GEORGIA : *** : GEORGIA

Participates in Medicaid Program:

No

II. Education and Training

Medical School : Dates of Attendance : Graduation Date : Degree Title
1. CHICAGO COLLEGE OF OSTEOPATHIC : 09/01/1969 - 06/01/1973 : 06/01/1973 : DO

Other Health Related Degrees:

The practitioner did not provide this mandatory information.

III. Professional and Postgraduate Training

This practitioner has completed the following graduate medical education:
Program Name : Program Type : Specialty Area : City : State/Country : Dates Attended

1. WALTER REED ARMY MEDICAL CENTER : INTERNSHIP : OBG - OBSTETRICS AND GYNECOLOGY : WASHINGTON : DISTRICT OF COLUMBIA : 7/1/73 - 6/30/74

2. WALTER REED ARMY MEDICAL CENTER : RESIDENCY : OBG - OBSTETRICS AND GYNECOLOGY : WASHINGTON : DISTRICT OF COLUMBIA : 7/1/74 - 6/30/77

IV. Specialty

This practitioner holds the following certifications from specialty boards recognized by the Florida board which regulates the profession for which he/she is licensed:
Specialty Board : Certification
1. AMERICAN BOARD OF OBSTETRICS & GYNECOLOGY : OBG - OBSTETRICS AND GYNECOLOGY

V. Optional Information

Committees:/Memberships

This practitioner has not indicated any committees on which they serve for any health entity with which they are affiliated.

Professional or Community Service Awards

This practitioner has not provided any professional or community service activities, honors, or awards.

Publications

This practitioner has not provided any publications that he/she authored in peer-reviewed medical literature within the last ten years.

Languages Other Than English

This practitioner has not indicated that any languages other than English are used to communicate with patients, or that any translation service is available for patients, at his/her primary place of practice.

Other Affiliations

This practitioner has provided the following national, state, local, county, or professional affiliations:
1. GEORGIA OBSTETRIC AND GYNECOLOGICAL SOCIETY
2. AUGUSTA OBSTETRIC AND GYNECOLOGICAL SOCIETY
3. STAFF PRIV/UNIVERSITY HOSPITAL/AUGUSTA,GA
4. STAFF PRIV/MEDICAL COLLEGE OF GA/AUGUSTA,GA

E-Mail Address

Not Provided

Other State Licensure

This practitioner has not indicated any additional state licensure.

VI. Financial Responsibility

I do not practice medicine in the State of Florida.

VII. Criminal Offenses

The criminal history information, if any exists, will be incomplete; federal criminal history is not available to the public. The criminal history information provided by the practitioner has not been completely verified at this time. All criminal history checks should be completed by March 2000.

This practitioner has indicated that he/she has NO criminal offenses.

VIII. Final Disciplinary Action (Within last 10 years)

Pursuant to section 455.5651(5), F.S. the profile will not include disciplinary action taken by a hospital or ambulatory surgical centers licensed under chapter 395, F.S.

This practitioner has indicated that he/she has NOT had any final disciplinary action taken against him/her within the previous 10 years by a specialty board.

This practitioner has indicated that he/she has NOT had any final disciplinary action taken against him/her within the previous 10 years by a licensing agency.

This practitioner has indicated that he/she has NOT had any final disciplinary action taken against him/her within the previous 10 years by a health maintenance organization, pre-paid health clinic, nursing home, out-of-state hospital or out-of-state ambulatory surgical center.

This practitioner has indicated that he/she has NEVER been asked to or allowed to resign from or had any medical staff privileges restricted or revoked within the previous 10 years by a health maintenance organization, pre-paid health clinic, nursing home, out-of-state hospital or out-of-state ambulatory surgical center.

IX. Liability Claims Exceeding $5,000.00 (Within last 10 years)

Settlement of a claim may occur for a variety of reasons that do not necessarily reflect negatively on the professional competence or conduct of the physician. A payment settlement of a medical malpractice action or claim should not be construed as creating a presumption that medical malpractice has occurred.

There have not been any reported liability actions, which are required to be reported under section 455.697, F.S., within the previous 10 years.

If you wish to make changes to the profile after it has been published, please submit them to 4052 Bald Cypress Way, Bin # C10, Tallahassee, Florida 32399-3260.

If you have any questions or comments, please call (850)488-0595, Press 6, Monday through Friday, 8:00 a.m. to 5:00 pm., ET.

Sincerely,

Bureau of Operations

PART B OS 6815

RENEWAL NOTICE

20 20 5

STATE OF FLORIDA DEPARTMENT OF HEALTH
BOARD OF OSTEOPATHIC MEDICINE

IMPORTANT: BY SUBMITTING THE APPROPRIATE RENEWAL FEES TO THE DEPARTMENT, A LICENSEE AFFIRMS COMPLIANCE WITH ALL REQUIREMENTS FOR RENEWAL, INCLUDING CONTINUING EDUCATION CREDITS.

Signature: [signature]

YOUR OSTEOPATHIC PHYSICIAN LICENSE

Please Indicate Mailing Address Change Below

Licensee's Last Name	First	Middle Initial
Street Address		
Street Address		
City	State	Zip

WILL EXPIRE JANUARY 31, 2000

REMIT FEE OF $505.00

$705.00 AFTER EXPIRATION

GARY B BROADNAX
1409 WATERS EDGE DRIVE
AUGUSTA, GA 30901

12/03/1999 $505.00
ID: 1901-5554 Type: F
BT: H03075 DP: 168269
VL: 990043376

DR. GARY B. BROADNAX
1409 WATERS EDGE DRIVE
AUGUSTA, GA 30901-1045

AUGUSTA GA 309 AFCS 1
PM
24 NOV
1999

STAMP
COOL-lecting
IT'S HOBBY FORMING

DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE
LICENSURE SERVICES
P.O. BOX 6320
TALLAHASSEE, FLORIDA 32314-6320

32314+6320

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øFile: 5554                                                                              ø
øSSN:                      steopathic Physician                                          ø
øLic:  6815              CLEAR,ACTIVE                                                    ø
øName: GARY B BROADNAX (DBA:0 Old:0)                                                     ø
øAddr: 1409 WATERS EDGE DRIVE                               State:  GA                   ø
ø                                                           Zip:    30901                ø
øCity: AUGUSTA                                              County: UNKNOWN              ø
ø                                                                                        ø
øCertificate No: 106           First License:  06/13/1994                                ø
ø     "    Date: 05/28/1999    In Rank Since:  06/13/1994                                ø
øLast Renewal:                 License Method: ENNB                                      ø
øCurrent Expiry: 01/31/2000    Renewal Notice:                                           ø
ø                              In Directory?      Include                                ø
øStatus Date:    01/01/1801    Fee Exempt?     N                                         ø
øNote:                                                                                   ø
ø                                                                                        ø
ø                                                                                        ø
øAction:         Transfer  A-Address  B-Basic_Data  C-PSD  M-Modifiers ...               ø
ø        Go to view only options                                                         ø
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10/25/1999 $43.00
ID: 1901-5554 Type: F
BT: H01474 DP: 168195
VL: 99003804

AC# COPY

STATE OF FLORIDA
DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE

DATE	LICENSE NO.	CONTROL NO.
01/13/2000	OS 6815	2340

THE **OSTEOPATHIC PHYSICIAN**
NAMED BELOW HAS MET ALL REQUIREMENTS OF
THE LAWS AND RULES OF THE STATE OF FLORIDA.
EXPIRATION DATE: JANUARY 31, 2002
GARY B BROADNAX
1409 WATERS EDGE DRIVE
AUGUSTA, GA 30901

QUALIFICATION(S):
DISPENSING PRACTITIONER

COPY COPY COPY

STATE OF FLORIDA
DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE
AC#

DATE	LICENSE NO.	CONTROL NO.
01/13/2000	OS 6815	2340

THE OSTEOPATHIC PHYSICIAN
NAMED BELOW HAS MET ALL REQUIREMENTS OF
THE LAWS AND RULES OF THE STATE OF FLORIDA.
EXPIRATION DATE: JANUARY 31, 2002

GARY B BROADNAX

COPY - NOT A VALID LICENSE - COPY

AT LEAST 90 DAYS PRIOR TO THE EXPIRATION DATE SHOWN ON THIS LICENSE, A NOTICE OF RENEWAL WILL BE SENT TO YOUR LAST KNOWN ADDRESS. IF YOU HAVE NOT RECEIVED YOUR NOTICE 60 DAYS PRIOR TO THE EXPIRATION DATE, PLEASE CALL (850) 410-3359.

COPY - NOT A VALID LICENSE - COPY

EXPIRATION DATE: **JANUARY 31, 2002**

YOUR LICENSE NUMBER IS **OS 6815** ,PLEASE USE IT IN ALL CORRESPONDENCE WITH YOUR BOARD/COUNCIL. EACH LICENSEE IS SOLELY RESPONSIBLE FOR NOTIFYING THE DEPARTMENT IN WRITING OF THE LICENSEE'S CURRENT MAILING ADDRESS. USE THIS SECTION TO REPORT NAME AND/OR MAILING ADDRESS CHANGES.

NAME CHANGES REQUIRE LEGAL DOCUMENTATION SHOWING THE NAME CHANGE. PLEASE MAKE SURE THAT A PHOTOCOPY OF ONE OF THE FOLLOWING ACCOMPANIES THIS FORM: A MARRIAGE LICENSE (MARRIAGE LICENSE MUST INDICATE THE ORIGINAL SIGNATURE AND SEAL FROM THE CLERK OF THE COURT), A DIVORCE DECREE INDICATING RESTORATION OF YOUR MAIDEN NAME, OR A COURT ORDER (E.G., ADOPTION, NAME CHANGE, OR FEDERAL IDENTITY CHANGE). ANY ONE OF THESE WILL BE ACCEPTED UNLESS THE DEPARTMENT HAS A QUESTION ABOUT THE AUTHENTICITY OF THE DOCUMENT. **A DRIVER'S LICENSE OR SOCIAL SECURITY CARD IS NOT CONSIDERED LEGAL DOCUMENTATION.**

TO REQUEST A DUPLICATE LICENSE SUBMIT THIS FORM AND A CHECK, PAYABLE TO THE DEPARTMENT OF HEALTH, IN THE AMOUNT OF $25.00.

☐ REQUEST DUPLICATE LICENSE ______________________________
SIGNATURE REQUIRED

DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE
LICENSURE SERVICES
2020 CAPITAL CIRCLE, S.E., BIN #C-10
TALLAHASSEE, FLORIDA 32399-3260

☐ NAME CHANGE (ATTACH LEGAL DOCUMENTATION)

FROM: ______________________________
MIDDLE

TO: ______________________________
LAST FIRST MIDDLE

☐ MAILING ADDRESS CHANGE

____

____

____
CITY STATE ZIP

DH 2103, 5/98

DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE
LICENSURE SERVICES
2020 CAPITAL CIRCLE, S.E., BIN #C-10
TALLAHASSEE, FLORIDA 32399-3260

GARY B BROADNAX
1409 WATERS EDGE DRIVE
AUGUSTA, GA 30901

Florida Department of Health - Board of Osteopathic Medicine
License Renewal Notice

DEPARTMENT USE ONLY

Inactive Osteopathic Physician License # OS 6815 expires March 31, 2008.

The fee of **$230.00** and the renewal notice must be postmarked on or before March 31, 2008. Renewal notices postmarked on or after April 01, 2008 require renewal and delinquent fees of **$630.00.**

1. CURRENT MAILING ADDRESS:

This address will be used for all correspondence from the Department of Health.

GARY B BROADNAX
PO BOX 2246
AUGUSTA, GA 30903

2. CURRENT PRACTICE LOCATION:

This address will be printed on your license and posted on the Internet.

GARY B BROADNAX
1289 BROAD ST
AUGUSTA, GA 30901

3. RENEW YOUR LICENSE ONLINE:

Visit **www.flhealthsource.com**, from our main page, select **Licensee/Provider**, go to the **Practitioner Logon** box on the left side of the page, select your profession and enter your Account ID and password. If you are requesting a status change, you will be ineligible to renew your license online. Renew online and receive a temporary license immediately. The system will be available for renewals until midnight, Eastern Standard Time (EST), **March 31, 2008**.

The online system will also allow you to update your address and confirm licensure information maintained by the Department.

4. CHANGE OF LICENSE STATUS:

○ I request reactivation from inactive to active. The fee of **$630.00** and renewal notice must be postmarked on or before March 31, 2008. Renewal notices postmarked on or after April 01, 2008 will require renewal and delinquent fees of **$1,130.00.** (Note: Additional requirements may be applicable. Visit our web site at **http://www.doh.state.fl.us** then click on **Health Care Professions** and select your profession to get information and contacts.)

5. CHANGE TO MILITARY STATUS:

○ I am requesting Military Restricted Status. (You must submit proof of active military duty. Attach a copy of your current active duty orders or a letter from your Commanding Officer.) The fee for military restricted on or before March 31, 2008 is **$00.00**. The fee on or after April 01, 2008 is **$00.00.**

6. CHANGE TO RETIRED STATUS:

X I am requesting retired status. The fee for retired status on or before March 31, 2008 is **$55.00**. The fee for retired status on or after April 01, 2008 is **$555.00.**

7. DISPENSING:

○ I am renewing active status and I wish to dispense medicinal drugs for a fee from my practice location. I understand an annual inspection of my dispensing records will be conducted. The fee for registration as a dispensing practitioner is $100.00 in addition to your renewal fee.

Received Date: 1/10/2008
Deposit Date : 1/10/2008
Deposit # : 167257
Batch Number : 001013102
Validation # : 907139960
Check Amount : $55.00
PRO_CDE : 1901

8. FINANCIAL RESPONSIBILITY:

Please complete the enclosed Financial Responsibility form. Please select ONLY O[NE option on the] form.

9. OTHER INFORMATION:

By submitting the appropriate renewal fees to the Department, a licensee certifies compliance with all requirements for renewal, including continuing education credits.

A licensee who remains on inactive status for more than two consecutive biennial licensure cycles and who wishes to reactivate the license may be required to demonstrate the competency to resume active practice by sitting for a special purpose examination or by completing other reactivation requirements.

Avoiding complaints can protect your clients and your ability to practice. Go to **www.doh.state.fl.us/mqa/avoid.html** to find out more.

Verify your Continuing Education credits. Visit **www.cebroker.com** to find out more.

File No.: 5554 Seq. No.: 121
Profession Code: 1901 40 20

OS 6815

10. CHANGES TO CURRENT LICENSE INFORMATION:

○ **CHANGE OF NAME:**

Name changes require legal documentation showing the name change. Please make sure that a photocopy of one of the following accompanies this form: a marriage license (marriage license must indicate the original signature and seal from the clerk of the court), a divorce decree indicating restoration of your maiden name, or a court order (e.g., adoption, name change, or federal identity change). Any one of these will be accepted unless the department has a question about the authenticity of the document. A driver's license or social security card is not considered legal documentation.

If the name change cannot be completed, your license will be renewed using the current name.

Last | First | Middle | Title | Suffix | Qualifier

○ **CHANGE OF MAILING ADDRESS:**

Attention

Street Address | Apt./Suite No.

City | State | Zip Code | Country (if outside U.S.)

○ **CHANGE OF PRACTICE LOCATION:**

Attention

Street Address | Apt./Suite No.

City | State | Zip Code | Country (if outside U.S.)

If you are renewing to active status, would you be available to provide health care services in special needs shelters or to help staff disaster medical assistance teams during times of emergency or major disaster?

○ Yes

CHECKLIST FOR MAILING RENEWAL FORM:

If mailing your renewal form, use the checklist below as a guide for enclosing all the required items to ensure a smooth renewal. If renewing by mail, allow 2 - 4 weeks processing time.

<u>REQUIRED</u>:

- ⬭ Renewal notice
- ⬭ Cashier's Check or Money Order written to the Department of Health
- ⬭ Financial Responsibility form (check only one item on the FR form)
- ⬭ Updated paper copy of Profile
- ⬭ Mail to: PO Box 6320, Tallahassee, Florida 32314-6320

Dr. Gary B. Broadnax
P.O. Box 2246
Augusta, GA 30903-2246

Name ______________________

License OS 6815

Financial Responsibility Form
Osteopathic Physician

The Financial Responsibility options are divided into two categories, coverage and exemptions. **Choose *ONLY ONE* option that best describes your situation.**

Check only one option.

☐ 1. I do not have hospital staff privileges and I have obtained and maintain professional liability coverage in an amount not less than $100,000 per claim, with a minimum annual aggregate of not less than $300,000,from an authorized insurer as defined under s.624.09 FS, from a surplus lines insurer as defined under s.626.914(2)FS, from a risk retention group as defined under s.627.942 FS, from the Joint Underwriting Association established under s.627.351(4)FS, or through a plan of self-insurance as provided in s.627.357 FS.

☐ 2. I have hospital staff privileges and I have obtained and maintain professional liability coverage in an amount not less than $250,000 per claim, with a minimum annual aggregate of not less than $750,000,from an authorized insurer as defined under s.624.09 FS, from a surplus lines insurer as defined under s.626.914(2)FS, from a risk retention group as defined under s.627.942 FS, from the Joint Underwriting Association established under s.627.351(4)FS, or through a plan of self-insurance as provided in s.627.357 FS, or through a plan of self-insurance which meets the conditions specified for satisfying financial responsibility in s.766.110 FS.

☐ 3. I do not have hospital staff privileges and I have obtained and maintain an unexpired, irrevocable letter of credit, established pursuant to chapter 675 FS, in an amount of not less than $100,000 per claim with a minimum aggregate availability of credit of not less than $300,000.The letter of credit shall be payable to the osteopathic physician as beneficiary upon presentment of a final judgment indicating liability and awarding damages to be paid by the osteopathic physician or upon presentment of a settlement agreement signed by all parties to such agreement when such final judgment or settlement is a result of a claim arising out of the rendering of, or the failure to render, medical care and services. Such letter of credit shall be nonassignable and nontransferable. Such letter of credit shall be issued by any bank or savings association organized and existing under the laws of this state or any bank or savings association organized under the laws of the United States that has its principal place of business in this state or has a branch office which is authorized under the laws of this state or of the United States to receive deposits in this state. **OR** I do not have hospital staff privileges and I have established and maintain an escrow account consisting of cash or assets eligible for deposit in accordance with s.625.52 FS in the per-claim amounts specified above.

☐ 4. I have hospital staff privileges and I have obtained and maintain an unexpired, irrevocable letter of credit, established pursuant to chapter 675 FS, in an amount not less than $250,000 per claim, with a minimum aggregate availability of credit of not less than $750,000.The letter of credit shall be payable to the osteopathic physician as beneficiary upon presentment of a final judgment indicating liability and awarding damages to be paid by the osteopathic physician or upon presentment of a settlement agreement signed by all parties to such agreement when such final judgment or settlement is a result of a claim arising out of the rendering of, or the failure to render, medical care and services. Such letter of credit shall be nonassignable and nontransferable. Such letter of credit shall be issued by any bank or savings association organized and existing under the laws of this state or any bank or savings association organized under the laws of the United States that has its principal place of business in this state or has a branch office which is authorized under the laws of this state or of the United States to receive deposits in this state **OR** I have hospital staff privileges and I have established and maintain an escrow account consisting of cash or assets eligible for deposit in accordance with s.625.52 FS in the per-claim amounts specified above.

☐ 5. I have decided not to carry malpractice insurance or otherwise demonstrate financial responsibility; however, I agree to satisfy any adverse judgments pursuant to the terms and conditions contained in s.459.0085(5)(g),FS. I understand that I shall be required to either post notice in the form of a sign prominently displayed in the reception area and clearly noticeable by all patients and provide a written statement to any person to whom medical services are being provided. Such sign and statement shall state that: Under Florida law, osteopathic physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. YOUR OSTEOPATHIC PHYSICIAN HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This is permitted under Florida law subject to certain conditions. Florida law imposes strict penalties against noninsured osteopathic physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida law.

SEE OPPOSITE SIDE FOR EXEMPTIONS

Exemptions

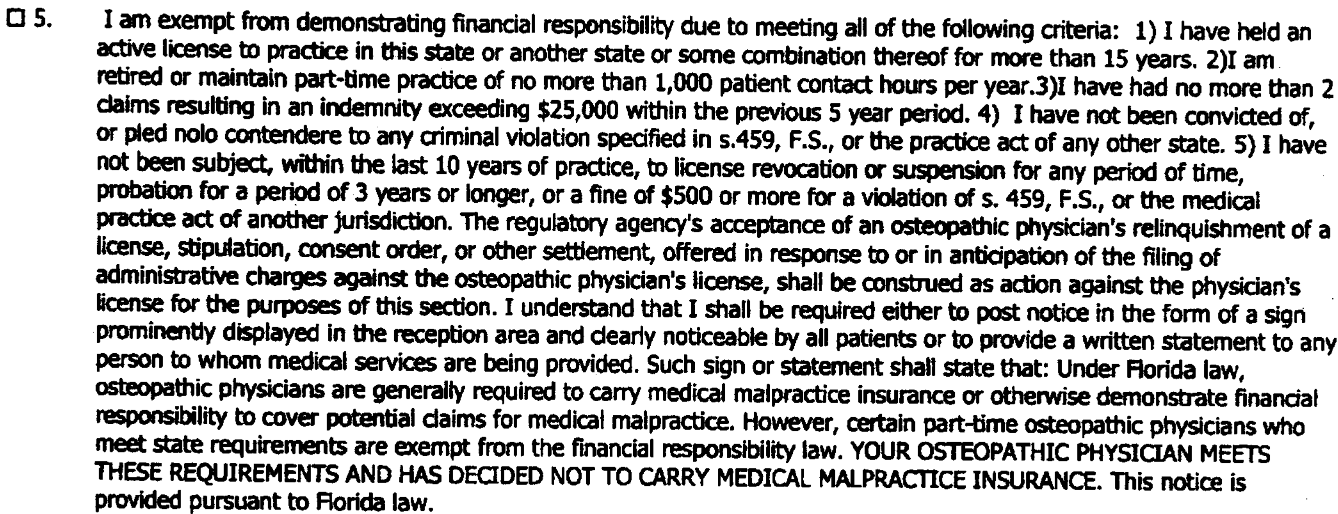
I am exempt from demonstrating financial responsibility because:

☐ 1. I practice medicine exclusively as an officer, employee, or agent of the federal government, or of the state or its agencies or its subdivisions.

☐ 2. I hold a limited license issued pursuant to s.459.0075, F.S., and practice only under the scope of such limited license.

☐ 3. I practice only in conjunction with my teaching duties at a college of osteopathic medicine. (Residents do not qualify for this exemption.)

4. I do not practice osteopathic medicine in the State of Florida. I will notify the department immediately before commencing practice in the state.



☐ 5. I am exempt from demonstrating financial responsibility due to meeting all of the following criteria: 1) I have held an active license to practice in this state or another state or some combination thereof for more than 15 years. 2)I am retired or maintain part-time practice of no more than 1,000 patient contact hours per year.3)I have had no more than 2 claims resulting in an indemnity exceeding $25,000 within the previous 5 year period. 4) I have not been convicted of, or pled nolo contendere to any criminal violation specified in s.459, F.S., or the practice act of any other state. 5) I have not been subject, within the last 10 years of practice, to license revocation or suspension for any period of time, probation for a period of 3 years or longer, or a fine of $500 or more for a violation of s. 459, F.S., or the medical practice act of another jurisdiction. The regulatory agency's acceptance of an osteopathic physician's relinquishment of a license, stipulation, consent order, or other settlement, offered in response to or in anticipation of the filing of administrative charges against the osteopathic physician's license, shall be construed as action against the physician's license for the purposes of this section. I understand that I shall be required either to post notice in the form of a sign prominently displayed in the reception area and clearly noticeable by all patients or to provide a written statement to any person to whom medical services are being provided. Such sign or statement shall state that: Under Florida law, osteopathic physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. However, certain part-time osteopathic physicians who meet state requirements are exempt from the financial responsibility law. YOUR OSTEOPATHIC PHYSICIAN MEETS THESE REQUIREMENTS AND HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This notice is provided pursuant to Florida law.

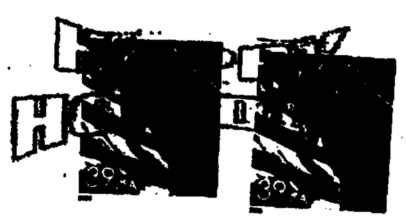
AFFIRMATION: I affirm that all statements given above are true and correct and recognize that providing false information may result in disciplinary action against my license or criminal penalties pursuant to Sections 456.072,459.013,459.015,775.082,775.083,and 775.084,Florida Statutes.

Signature [illegible] Date 12/31/2007

B
Mr. Gary B. Broadnax
196 E. Shoreline Dr.
North Augusta, SC 29841

AUGUSTA GA 309

07 JAN 2008 PM 2 T



Florida Dept. of Health
P.O. Box 6320
Tallahassee, FL 32314-6320

32314+6320

Florida Department of Health - Board of Osteopathic Medicine
License Renewal Notice

DEPARTMENT USE ONLY

Inactive Osteopathic Physician License # OS 6815 expires March 31, 2008.

The fee of **$230.00** and the renewal notice must be postmarked on or before March 31, 2008. Renewal notices postmarked on or after April 01, 2008 require renewal and delinquent fees of **$630.00**.

1. CURRENT MAILING ADDRESS:

This address will be used for all correspondence from the Department of Health.

GARY B BROADNAX
PO BOX 2246
AUGUSTA, GA 30903

2. CURRENT PRACTICE LOCATION:

This address will be printed on your license and posted on the Internet.

GARY B BROADNAX
1289 BROAD ST
AUGUSTA, GA 30901

3. RENEW YOUR LICENSE ONLINE:

Visit **www.flhealthsource.com**, from our main page, select **Licensee/Provider**, go to the **Practitioner Logon** box on the left side of the page, select your profession and enter your Account ID and password. If you are requesting a status change, you will be ineligible to renew your license online. Renew online and receive a temporary license immediately. The system will be available for renewals until midnight, Eastern Standard Time (EST), **March 31, 2008**.

The online system will also allow you to update your address and confirm licensure information maintained by the Department.

4. CHANGE OF LICENSE STATUS:

◯ I request reactivation from inactive to active. The fee of **$630.00** and renewal notice must be postmarked on or before March 31, 2008. Renewal notices postmarked on or after April 01, 2008 will require renewal and delinquent fees of **$1,130.00**. (Note: Additional requirements maybe applicable. Visit our web site at **http://www.doh.state.fl.us** then click on **Health Care Professions** and select your profession to get information and contacts.)

5. CHANGE TO MILITARY STATUS:

◯ I am requesting Military Restricted Status. (You must submit proof of active military duty. Attach a copy of your current active duty orders or a letter from your Commanding Officer.) The fee for military restricted on or before March 31, 2008 is **$00.00**. The fee on or after April 01, 2008 is **$00.00**.

6. CHANGE TO RETIRED STATUS:

◯ I am requesting retired status. The fee for retired status on or before March 31, 2008 is **$55.00**. The fee for retired status on or after April 01, 2008 is **$555.00**.

7. DISPENSING:

◯ I am renewing active status and I wish to dispense medicinal drugs for a fee from my practice location. I understand an annual inspection of my dispensing records will be conducted. The fee for registration as a dispensing practitioner is **$100.00** in addition to your renewal fee.

8. FINANCIAL RESPONSIBILITY:

Please complete the enclosed Financial Responsibility form. Please select ONLY ONE option from any category on the form.

9. OTHER INFORMATION:

By submitting the appropriate renewal fees to the Department, a licensee certifies compliance with all requirements for renewal, including continuing education credits.

A licensee who remains on inactive status for more than two consecutive biennial licensure cycles and who wishes to reactivate the license may be required to demonstrate the competency to resume active practice by sitting for a special purpose examination or by completing other reactivation requirements.

Avoiding complaints can protect your clients and your ability to practice. Go to **www.doh.state.fl.us/mqa/avoid.html** to find out more.

Verify your Continuing Education credits. Visit **www.cebroker.com** to find out more.

File No.: 5554 Seq. No.: 121
Profession Code: 1901 40 20

OS████████6815

10. CHANGES TO CURRENT LICENSE INFORMATION:

◯ **CHANGE OF NAME:**

Name changes require legal documentation showing the name change. Please make sure that a photocopy of one of the following accompanies this form: a marriage license (marriage license must indicate the original signature and seal from the clerk of the court), a divorce decree indicating restoration of your maiden name, or a court order (e.g., adoption, name change, or federal identity change). Any one of these will be accepted unless the department has a question about the authenticity of the document. A driver's license or social security card is not considered legal documentation.

If the name change cannot be completed, your license will be renewed using the current name.

Last _______ First _______ Middle _______ Title _______ Suffix _______ Qualifier _______

◯ **CHANGE OF MAILING ADDRESS:**

Attention _______

Street Address _______ Apt./Suite No. _______

City _______ State _______ Zip Code _______ Country (if outside U.S.) _______

◯ **CHANGE OF PRACTICE LOCATION:**

Attention _______

Street Address _______ Apt./Suite No. _______

City _______ State _______ Zip Code _______ Country (if outside U.S.) _______

If you are renewing to active status, would you be available to provide health care services in special needs shelters or to help staff disaster medical assistance teams during times of emergency or major disaster?

◯ Yes

CHECKLIST FOR MAILING RENEWAL FORM:

If mailing your renewal form, use the checklist below as a guide for enclosing all the required items to ensure a smooth renewal. If renewing by mail, allow 2 - 4 weeks processing time.

REQUIRED:
- ◯ Renewal notice
- ◯ Cashier's Check or Money Order written to the Department of Health
- ◯ Financial Responsibility form (check only one item on the FR form)
- ◯ Updated paper copy of Profile
- ◯ Mail to: PO Box 6320, Tallahassee, Florida 32314-6320

STATE OF FLORIDA
DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE

INACTIVE RECEIPT

NOTICE: THIS IS A RECEIPT FOR YOUR INACTIVE RENEWAL FEE. THIS IS **NOT A LICENSE** AND **MAY NOT** BE USED FOR PURPOSES OF EMPLOYMENT. YOU WILL NOT RECEIVE A LICENSE TO PRACTICE YOUR PROFESSION IN THE STATE OF FLORIDA UNLESS OR UNTIL YOU REACTIVATE TO ACTIVE STATUS. SHOULD YOU WISH TO DO SO, PLEASE CONTACT THE DIVISION OF MEDICAL QUALITY ASSURANCE AT (850) 488-0595 FOR INFORMATION.

GARY B BROADNAX
PO BOX 2246
AUGUSTA, GA 30903

RECEIPT PRINTED: 03/23/2006
RECEIPT EXPIRES: MARCH 31, 2008

COPY COPY COPY

COPY COPY COPY

(7/98) RETAIN THIS COPY FOR YOUR RECORDS

LICENSE NO. **OS 6815** CONTROL NO. **19223**

EXPIRATION DATE: **MARCH 31, 2008**

YOUR LICENSE NUMBER IS **OS 6815** ,PLEASE USE IT IN ALL CORRESPONDENCE WITH YOUR BOARD/COUNCIL. EACH LICENSEE IS SOLELY RESPONSIBLE FOR NOTIFYING THE DEPARTMENT IN WRITING OF THE LICENSEE'S CURRENT MAILING ADDRESS. USE THIS SECTION TO REPORT NAME AND/OR MAILING ADDRESS CHANGES.

NAME CHANGES REQUIRE LEGAL DOCUMENTATION SHOWING THE NAME CHANGE. PLEASE MAKE SURE THAT A PHOTOCOPY OF ONE OF THE FOLLOWING ACCOMPANIES THIS FORM: A MARRIAGE LICENSE (MARRIAGE LICENSE MUST INDICATE THE ORIGINAL SIGNATURE AND SEAL FROM THE CLERK OF THE COURT), A DIVORCE DECREE INDICATING RESTORATION OF YOUR MAIDEN NAME, OR A COURT ORDER (E.G., ADOPTION, NAME CHANGE, OR FEDERAL IDENTITY CHANGE). ANY ONE OF THESE WILL BE ACCEPTED UNLESS THE DEPARTMENT HAS A QUESTION ABOUT THE AUTHENTICITY OF THE DOCUMENT. **A DRIVER'S LICENSE OR SOCIAL SECURITY CARD IS NOT CONSIDERED LEGAL DOCUMENTATION.**

TO REQUEST A DUPLICATE LICENSE SUBMIT THIS FORM AND A CHECK, PAYABLE TO THE DEPARTMENT OF HEALTH, IN THE AMOUNT OF $25.00.

☐ REQUEST DUPLICATE LICENSE

____
SIGNATURE REQUIRED

DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE
LICENSURE SERVICES
P.O.BOX 6320
TALLAHASSEE, FLORIDA 32314-6320

☐ NAME CHANGE (ATTACH LEGAL DOCUMENTATION)

FROM: ______________________________
LAST FIRST MIDDLE

TO: ______________________________
LAST FIRST MIDDLE

☐ MAILING ADDRESS CHANGE

____
____
____
CITY STATE ZIP

DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE
LICENSURE SERVICES
4052 BALD CYPRESS WAY, BIN #C-10
TALLAHASSEE, FLORIDA 32399-3260

GARY B BROADNAX
PO BOX 2246
AUGUSTA, GA 30903

Florida Department of Health - Board of Osteopathic Medicine

LICENSE RENEWAL NOTICE

DEPARTMENT USE ONLY

Active Osteopathic Physician License # OS 6815 expires March 31, 2004.

The fee of **$430.00** and the renewal notice must be postmarked on or before March 31, 2004. Renewal notices postmarked on or after April 01, 2004 require renewal and delinquent fees of **$830.00**.

1. CURRENT MAILING ADDRESS:

This address will be used for all correspondence from the Department of Health.

GARY B BROADNAX
PO BOX 2246
AUGUSTA, GA 30903

(706) 791-6395

2. CURRENT PRACTICE LOCATION:

This address will be printed on your license and posted on the Internet.

1289 BROAD ST
AUGUSTA, GA 30901

3. RENEW ON LINE TODAY!

Go to www.doh-mqaservices.com and renew your license, change your address, update your profile, and confirm information maintained by the Department. Listed below is your user id and password for online services. If you renew online, you will receive a temporary license upon successful completion of your renewal. Online renewals are processed immediately and your license status is updated online within seven business days.

4. CHANGES TO CURRENT LICENSE INFORMATION:

If you have any changes to the name, mailing address, practice location address, license status or military status information associated with your license. Please provide the updated information in the appropriate fields of section 7 on the back of this form.

5. THERE ARE TWO RENEWAL METHODS AVAILABLE:

A. Online Renewal: Visit www.doh-mqaservices.com and click on Renew My License to renew your license online. If you are requesting a status change you will be ineligible to renew your license online. The system will be available for renewals until midnight, Eastern Standard Time (EST), March 31, 2004. To use the online system, you will need the following information:

Account ID: _

Password

(Note: Account Id and Password must be entered exactly as they appear.)

The online renewal system will allow practitioners to update their mailing and practice location addresses, profile, and to confirm licensee information maintained by the Department. Practitioners will receive a temporary license upon successful renewal before logging out of the system.

B. U.S. Mail: Mail completed form and fee payable to the Department of Health to the following address:

Department of Health
Division of Medical Quality Assurance
PO Box 6320
Tallahassee, FL 32314-6320

6. Other Information:

By submitting the appropriate renewal fees to the Department, a licensee certifies compliance with all requirements for renewal, including continuing education credits.

File Number: 5554　　Sequence Number: 505

Profession Code: 1901　　20　　20

* O S 0 0 0 0 0 0 6 8 1 5 *

Please make changes to your license information in section 7 on the BACK of this form.

7. CHANGES TO CURRENT LICENSE INFORMATION:

PLEASE READ THIS SECTION CAREFULLY BEFORE MAKING ANY CHANGES:

To indicate changes in any section, complete the change indicator oval like this ⬬
When providing updated information, print each character inside the box like this [A][B][C][1][2][3]
Use black/blue pen or No.2 pencil only for all changes.

⬭ CHANGE OF NAME:

Name changes require legal documentation showing the name change. Please make sure that a photocopy of one of the following accompanies this form: a marriage license (marriage license must indicate the original signature and seal from the clerk of the court), a divorce decree indicating restoration of your maiden name, or a court order (e.g., adoption, name change, or federal identity change). Any one of these will be accepted unless the department has a question about the authenticity of the document. A driver's license or social security card is not considered legal documentation.

If the name change cannot be completed, your license will be renewed using the current name.

Last Name:

First Name:

Middle Name: Title: Suffix: *(Jr,Sr,I,II,etc.)* Qualifier: *(PhD,DDS,etc.)*

⬭ CHANGE OF MAILING ADDRESS:

Attention:

Street Addr1:

Street Addr2:

City:

State: Zip: + Phone: ( ) -

⬭ CHANGE OF PRACTICE LOCATION: (This address can not be a Post Office Box)

Attention:

Street Addr1:

Street Addr2:

City:

State: Zip: + Phone: ( ) -

CHECKLIST FOR MAILING RENEWAL FORM

If mailing your renewal form, use the checklist below as a guide for enclosing all the required items to ensure a smooth renewal. If renewing by mail, allow 4-6 weeks processing time.

REQUIRED:
- ⬭ Renewal notice
- ⬭ Check or Money order written to Department of Health
- ⬭ Financial responsibility form (check only one item on the FR form)
- ⬭ Mail to: PO Box 6320, Tallahassee, Florida 32314-6320

If you are renewing to active status, would you be available to provide health care services in special needs shelters or to help staff disaster medical assistance teams during times of emergency or major disaster?

⬭ Yes

CHANGE OF LICENSE STATUS:

⬭ I wish to change my status from Active to Inactive. The fee for an inactive receipt is **$230.00**. The fee for inactive after March 31, 2004 is **$730.00**.

CHANGE OF MILITARY STATUS:

⬭ I am requesting Military Restricted Status. (You must submit proof of active military duty. Attach a copy of your current active duty orders or a letter from your Commanding Officer.) The fee for military restricted is **$00.00**.

DISPENSING:

⬭ I wish to dispense medicinal drugs for a fee from my practice location and I understand an annual inspection of my dispensing records will be conducted. The fee for registration as a dispensing practitioner **$100.00** in addition to your renewal fee.

Practitioner's Name GARY B BROADNAX

License # OS0006815

MANDATORY PRACTITIONER PROFILE QUESTIONNAIRE

FLORIDA DEPARTMENT OF HEALTH
Division of Medical Quality Assurance
P. O. Box 6330
Tallahassee, Florida 32314-6330

I. PRACTITIONER DATA

A. PROFESSIONAL LICENSE NUMBER: OS0006815 (check one) ☐ ME/MD ☒ OS/DO ☐ CH/DC ☐ PO/DPM

B. NAME (INCLUDE MAIDEN AND ON 2ND/3RD LINES ANY ALIASES, IF APPLICABLE):
CURRENT NAME:

BROADNAX (LAST) GARY (FIRST) B (MIDDLE AND MAIDEN NAME, IF APPLICABLE)

FORMER NAME(S):

(LAST) (FIRST) (MIDDLE)

(LAST) (FIRST) (MIDDLE)

C. SOCIAL SECURITY NUMBER ____________ (This will not be published as a part of the profile; also, see instructions on page iii)

D. MAILING ADDRESS: 1409 WATERS EDGE DRIVE AUGUSTA GA 30901
(STREET AND NUMBER) (CITY) (STATE) (ZIP CODE)

PRIMARY PRACTICE ADDRESS: (Authority: s.455.565(1)(a)3.,F.S.)
1409 WATERS EDGE DRIVE AUGUSTA GA 30901
(PRACTICE NAME) (STREET AND NUMBER) (CITY) (STATE) (ZIP CODE)

OTHER PRACTICE LOCATION(S): (OPTIONAL)
OFFICE 2: (OPTIONAL)
~~DEPT OF OB/GYN EISENHOWER ARMY MEDICAL CENTER FORT GORDON GA 30905~~
(PRACTICE NAME) (STREET AND NUMBER) (CITY) (STATE) (ZIP CODE)

OFFICE 3: (OPTIONAL)

(PRACTICE NAME) (STREET AND NUMBER) (CITY) (STATE) (ZIP CODE)

E. TELEPHONE: (706) 724-6633 (This will not be published as a part of the profile.)

F. YEAR BEGAN PRACTICING MEDICINE: 1973 (Authority: s. 455.565(1)(a)5., F.S.)

II. ALL MEDICAL EDUCATION

A. Name of all medical schools attended. (Authority: s. 455.565(1)(a)1., F.S.)

NAME OF SCHOOL/UNIVERSITY	DATES OF ATTENDANCE	DATE OF GRADUATION	TYPE OF DEGREE
Chicago College of Osteopathic Medicine	9/69–6/73	6-73	D.O.

B. Have you completed any graduate medical education? Yes ☒ No ☐
If "YES", list in chronological order from date of graduation to the present, all completed graduate medical education. Do not include coursework taken to meet the continuing education requirement for licensure renewal. (Authority: s. 455.565(1)(a)1., F.S.)

MEDICAL TRAINING PROGRAM NAME	INTERNSHIP / RESIDENCY / FELLOWSHIP / OTHER	SPECIALTY AREA	CITY / STATE / COUNTRY	FROM MM/DD/YYYY	TO MM/DD/YYYY
Walter Reed Army Medical Center	Internship	OB-GYN	Wash, D.C.	~~7/1/73~~ 6/73	6/30/74
Walter Reed Army Med	Residency	OB-GYN	Wash, D.C.	7/1/74	6/30/77

Practitioner's Name GARY B BROADNAX License # OS0006815

III. OTHER HEALTH RELATED DEGREES

Do you currently hold a degree in a health related profession other than the professional degree listed in II. A. above? Yes ☐ No ☒

If "YES", list all medical/professional schools from which a degree in a health related profession other than the professional degree was obtained. (Authority: s. 455.565.(1)(a)1., F.S.)

NAME OF SCHOOL / UNIVERSITY	CITY / STATE / COUNTRY	FROM MM/DD/YYYY	TO MM/DD/YYYY	DEGREE TITLE

IV. FACULTY APPOINTMENTS:

A. Have you had the responsibility for graduate medical education within the last 10 years? (Authority: s. 455.565.(1)(a)6., F.S.) Yes ☒ No ☐

B. Do you currently hold a faculty appointment at a medical/health related institution of higher learning? (Authority: s. 455.565(1)(a)6., F.S.) Yes ☐ No ☒

If "YES", to question "B" list the title of the current appointment, name(s) and city/state of institution(s).

	TITLE	INSTITUTION	CITY/STATE
1.	Associate Clinical Professor	Medical College of GA	Augusta, GA
2.			
3.			(9/78 TO 7/98)

V. STAFF PRIVILEGES:

Do you currently hold staff privileges in a hospital/medical/health institution? Yes ☒ No ☐

If "YES", list each hospital/medical/health institution at which you currently have staff privileges. (Authority: s. 455.565(1)(a)2., F.S.)

	NAME OF HOSPITAL/MEDICAL/HEALTH INSTITUTION	CITY/STATE
1.	PPH Surgicenter	Augusta, GA
2.	CWHO Surgicenter	Columbus, GA
3.		

VI. SPECIALTY BOARD CERTIFICATIONS:

Do you hold a certification from any specialty board recognized by the Florida board regulating the profession for which you are licensed? (Authority: s. 455.565(1)(a)4., F.S.) Yes ☒ No ☐

If "YES", complete section below.

	SPECIALTY BOARD NAME	CERTIFICATION / SPECIALITY / SUBSPECIALITY
1.	American Board of Obstetrics/Gynecology	– Board Certified – OB/GYN
2.		
3.		

VII. FINAL DISCIPLINARY ACTION:

A1. Within the previous ten (10) years, have you ever had any final disciplinary action taken against you by a specialty board recognized by the American Board of Medical Specialties, the American Osteopathic Association, the American Chiropractic Association, or other similar national organization? (Authority: s. 455.565(1)(a)8., F.S.) Yes ☐ No ☒

If "YES", list name(s) of specialty board(s), date, description of violation(s), description of the final disciplinary action(s), and indicate whether the final disciplinary action is under appeal. (attach copy of notice of appeal)

	SPECIALTY BOARD NAME	DATE	DESCRIPTION OF VIOLATION	DESCRIPTION OF FINAL DISCIPLINARY ACTION	UNDER APPEAL?
1.					Y / N
2.					Y / N
3.					Y / N

A2. Within the previous ten (10) years, have you ever had any final disciplinary action taken against you by the agency regulating your license, in this state or any other jurisdiction? (Authority: s. 455.565(1)(a)8., F.S.) Yes ☐ No ☒

If "YES", list name(s) of agency(s), date, description of violation(s), description of the final disciplinary action(s), and indicate whether the final disciplinary action is under appeal. (attach copy of notice of appeal)

	AGENCY NAME	DATE	DESCRIPTION OF VIOLATION	DESCRIPTION OF ACTION	UNDER APPEAL?
1.					Y / N
2.					Y / N
3.					Y / N

Practitioner's Name GARY B BROADNAX License # OS0006815

A3. Within the previous ten (10) years, have you ever had any final disciplinary action taken against you by a licensed hospital, health maintenance organization, prepaid health clinic, ambulatory surgical center, or nursing home? (Authority: s. 455.565(1)(a)8., F.S.) Yes ☐ No ☒

If "YES", list name(s) of medical institution(s), date, description of violation(s), description of the final disciplinary action(s), and indicate whether the final disciplinary action is under appeal. (attach copy of notice of appeal)

	ENTITY NAME	DATE	DESCRIPTION OF VIOLATION	DESCRIPTION OF ACTION	UNDER APPEAL?
1.					Y / N
2.					Y / N
3.					Y / N

B. Within the previous ten (10) years, have you ever been asked to or allowed to resign from or had any medical staff privileges restricted or not renewed by any medical/health-related institution in lieu of or in settlement of a pending disciplinary action related to competence or character? (Authority: s. 455.565(1)(a)8., F.S.) Yes ☐ No ☒

If "YES", list name(s) of the facility(s), date, description of violations, description of the final disciplinary action(s), and indicate whether the final disciplinary action is under appeal. (attach copy of notice of appeal)

	INSTITUTION NAME	DATE	DESCRIPTION OF VIOLATION	DESCRIPTION OF ACTION	UNDER APPEAL?
1.					Y / N
2.					Y / N
3.					Y / N

VIII. CRIMINAL OFFENSES

Have you ever been convicted or found guilty, regardless of whether adjudication of guilt was withheld, or pled guilty or nolo contendere to a criminal misdemeanor or felony in any jurisdiction? (Authority: s. 455.565 (1)(a)7., F.S.) Yes ☐ No ☒

If "YES", briefly describe the offense(s), indicate whether the conviction is under appeal, and attach copy of notice of appeal.

	DESCRIPTION OF OFFENSE	DATE	JURISDICTION	UNDER APPEAL?
1.				Y / N
2.				Y / N
3.				Y / N

IX. STATEMENT OF FINANCIAL RESPONSIBILITY (Allopathic and Osteopathic Physicians Only)

A. Hospital Privileges - (Check only one) (Authority s. 455.5651(4), F.S.)

☒ 1. I do not have hospital staff privileges and I have obtained and maintain professional liability coverage in an amount not less than $100,000 per claim, with a minimum annual aggregate of not less than $300,000 from an authorized insurer as defined under s. 624.09, F. S., from a surplus lines insurer as defined under s. 626.914(2), F.S., from a risk retention group as defined under s. 627.942, F.S., from the Joint Underwriting Association established under s. 627.351(4), F. S., or through a plan of self-insurance as provided in s. 627.367, F.S. I further certify that I have been continuously insured with an entity as outlined above for the past two years (retroactive coverage) or if I seek insurance from a different entity providing insurance, I will purchase retroactive coverage for the two years preceding my inception date of coverage. I further certify that in the event my coverage is terminated or that I desire to become uninsured and meet the financial responsibility requirements through other provisions in s. 458.320 or 459.0085, F.S., I will maintain coverage for incidents which may have occurred during the two years preceding my becoming uninsured.

☐ 2. I have hospital staff privileges and I have professional liability coverage in an amount not less than $250,000 per claim, with a minimum annual aggregate of not less than $750,000 from an authorized insurer as defined under s. 624.09, F. S., from a surplus lines insurer as defined under s. 626.914(2), F. S., from a risk retention group as defined under s. 627.942, F.S., from the Joint Underwriting Association established under s. 627.351(4), F. S., or through a plan of self insurance as provided in s.627.367, F.S. I further certify that I have been continuously insured with an entity as outlined above for the past two years (retroactive coverage) or if I seek insurance from a different entity providing insurance I will purchase retroactive coverage for the two years preceding my inception date of coverage. I further certify that in the event my coverage is canceled or that I desire to become uninsured and meet the financial responsibility requirements through other provisions in s. 458.320 or 459.0085, F.S., I will maintain coverage for incidents which may have occurred during the two years preceding my becoming uninsured.

☐ 3. I do not have hospital staff privileges and I have established an irrevocable letter of credit or an escrow account in an amount of $100,000/$300,000, in accordance with Chapter 675, F. S., for a letter of credit and s. 625.52, F. S., for an escrow account.

☐ 4. I have hospital staff privileges and I have established an irrevocable letter of credit or escrow account in an amount of $250,000/$750,000, in accordance with Chapter 675, F. S., for a letter of credit and s. 625.52, F. S., for an escrow account.

☐ 5. I have elected not to carry medical malpractice; however, I agree to satisfy any adverse judgments up to the minimum amounts pursuant to s. 458.320(5)(g)1 or 459.0085(5)(g)1, F. S. I understand that I must either post notice in the form of a "sign" prominently displayed in the reception area or provide a written statement to any person to whom medical services are being provided that I have decided not to carry medical malpractice insurance. I understand that such a sign or notice must contain the wording specified in s. 458.320(5)(g) or 459.0085(5)(g), F. S.

B. Exemption

I am exempt from demonstrating financial responsibility because I fall into one of the categories listed below: (Check one box only)

☐ 1. I practice medicine exclusively as an officer, employee, or agent of the federal government, or of the state or its agencies or subdivisions;

☐ 2. I hold a limited license issued pursuant to s. 458.317 or 459.0075, F. S., and practice only under the scope of the limited license;

☐ 3. I practice only in conjunction with my teaching duties at an accredited medical school or its teaching hospitals. (Interns and residents do not qualify for this exemption);

☐ 4. I do not practice medicine in the State of Florida; or

Practitioner's Name GARY B BROADNAX License # OS0006815

☐ 5. I meet all the following criteria:
(a) I have held an active license to practice in this state or another state or some combination thereof for more than 15 years;
(b) I am retired or maintain part time practice of no more than 1000 patient contact hours per year;
(c) I have had no more than two claims resulting in an indemnity exceeding $10,000 within the previous five year period;
(d) I have not been convicted of or pled guilty or nolo contendere to any criminal violation specified in Chapter 458 or 459, F. S.; and
(e) I have not been subject, within the past ten years of practice, to license revocation or suspension, probation for a period of three years or longer, or a fine of $500 or more for a violation of Chapter 458 or 459, F.S., or the medical practice act of another jurisdiction. A regulatory agency's acceptance of a relinquishment of license stipulation, consent order or other settlement offered in response to or in anticipation of filing of administrative charges against a license shall be construed as action against a license. I understand if I am claiming an exemption under this section that I must either post notice in the form of a sign, prominently displayed in the reception area or provide a written statement to any person to show medical services are being provided, that I have decided not to carry medical malpractice insurance. I understand such a sign or notice must contain the wording specified in s. 458.320(5)(f) or 459.0085(5)(f), F.S.

X. LIABILITY CLAIMS (Allopathic, Osteopathic and Podiatric Physicians Only)

A. Are you covered by an insurer required to report pursuant to s. 627.912 F.S. Yes ☒ No ☐
(Authority: s. 455.5651(4), F.S.; s. 455.565(1)(b),F.S.)

B. Have you been insured continuously during the last ten years? Yes ☒ No ☐
(Authority: s. 455.5651(4), F.S.; s. 455.565(1)(b),F.S.)

If you answered "NO" to either A or B above, you must complete the following: (Authority: s. 455.5651(4), F.S.; s. 455.5651(1)(b),F.S.)

Within the previous ten years have you had a liability claim or action for damages for personal injury settled or finally adjudicated in an amount that exceeds $5,000? Yes ☐ No ☒

If "YES", complete and attach a copy of EXHIBIT 1 for each occurrence. NOTE: Copies of reports previously submitted may be re-submitted with this questionnaire to satisfy this reporting requirement. (Authority: s. 455.5651(4), F.S.; s. 455.565(1)(b),F.S.)

XI. LIABILITY CLAIMS (Chiropractic Physicians Only)

Within the previous ten years have you had a liability claim or action for damages for personal injury settled or finally adjudicated in an amount that exceeds $5,000? Yes ☐ No ☒

If "YES", complete and attach a copy of EXHIBIT 1 for each occurrence. (Authority: s. 455.5651(4), F.S.; s. 455.565(1)(b),F.S.)

XII. OPTIONAL INFORMATION:

A. PUBLICATIONS: List any publications you have authored in peer-reviewed medical literature within the previous ten years:
(Authority s. 455.565(5)(a), F.S.)

	TITLE	PUBLICATION	DATE
1.	N/A		
2.			
3.			

B. DO YOU PARTICIPATE IN THE MEDICAID PROGRAM? (Authority s. 455.565(5)(d), F.S.) Yes ☐ No ☒

C. PROFESSIONAL OR COMMUNITY SERVICE ACTIVITIES, HONORS, OR AWARDS: (Authority s.455.565(5)(b), F.S.)

	COMMUNITY SERVICE/AWARD/HONOR	ORGANIZATION		COMMUNITY SERVICE/AWARD/HONOR	ORGANIZATION
1.			2.		
3.			4.		

D. NATIONAL, STATE, LOCAL, COUNTY, PROFESSIONAL AFFILIATIONS: (Authority s.455.565(5)(b), F.S.)
ORGANIZATION
1. GEORGIA OB/GYN SOCIETY
2. GEORGIA OSTEOPATHIC MEDICAL AS[SOC.]
3. AUGUSTA OB/GYN SOCIETY
4.

E. LANGUAGES, OTHER THAN ENGLISH: Indicate languages other than English used by you to communicate with patients and any translation service available for patients at your primary place of practice. (Authority: s. 455.565(5)(c), F.S.)
1. N/A
2.
3.
4.

F. E-MAIL ADDRESS: garybroadnax@excite.com

G. COMMITTEES/MEMBERSHIPS: Indicate any committees on which you serve for any health entity with which you are affiliated.
ORGANIZATION
1.
2.
3.
4.

H. OTHER STATE LICENSURE:

	STATE	PROFESSION
1.	GEORGIA	MEDICAL
2.	N.C.	MEDICAL
3.	MS	MEDICAL

I affirm these statements are true and correct and recognize that providing false information may result in disciplinary action against my license or criminal penalties pursuant to Sections 455.624, 458.327, 458.331, 459.013, 459.015, 460.413, 461.013, 775.082, 775.083 and 775.084, Florida Statutes.

[signature] (Signature of Physician) 4-7-99 (Date)

DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE
P O Box 6330
Tallahassee, Florida 32314-6330

PRESORTED
FIRST-CLASS MAIL
U.S. POSTAGE PAID
FLORIDA DEPARTMENT OF HEALTH
84321

SNGLP

TO: GARY B BROADNAX
1409 WATERS EDGE DRIVE
AUGUSTA GA 30901

The mission of the Department of Health is to promote and protect the health and safety of all Floridians.

7-7-99
* please see the additions.
Thanks.
G. Broadnax D.O.

June 22, 1999

Dr. GARY B BROADNAX, D.O.
1409 WATERS EDGE DRIVE
AUGUSTA, GA-30901

Dear Dr. BROADNAX

The information to be published on your practitioner profile is printed below. In carrying out our legislative mandate to publish physician profiles, we want to do everything we can to insure the information that is published is correct. We are providing this information to you prior to its publication to give you an opportunity to review the data for any changes, corrections, and/or omissions. Under the law, you have thirty (30) days from the date of this letter to submit changes to Post Office Box 6330, Tallahassee, Florida 32314-6330. If you have no changes, your profile will be published as it appears below on the World Wide Web. There are a couple of areas to which you should pay special attention.

First, although the law requires you to **report all disciplinary action** taken by facilities, including facilities outside Florida, the action taken by Florida licensed hospitals and ambulatory surgical centers will not be published on the profile. **PLEASE REVIEW AND IDENTIFY ANY ACTION, WHICH WAS TAKEN BY A HOSPITAL OR AMBULATORY SURGICAL CENTER LICENSED IN FLORIDA TO ENSURE THIS DISCIPLINE IS NOT INCLUDED ON THE PUBLISHED PROFILE.**

Second, the law requires that ALL criminal convictions must be reported to the department pursuant to Section 455.565(1)(a)7, Florida Statutes. If your criminal conviction was expunged or the records were sealed, please send a copy of the court order expunging or sealing the records. If you have any questions or concerns about the criminal convictions to be published on the profile, as they are stated in this letter, please provide them in writing to the department.

I. Practitioner Information

License Number : 6815
Profession : Osteopathic Physician

License Status : CLEAR ACTIVE
Year Began Practicing : 01/01/1973

Primary Business:

1409 WATERS EDGE DRIVE
AUGUSTA GA 30901

Secondary Locations:

Staff Privileges:

Institution Name	City	State
UNIVERSITY HOSPITAL	AUGUSTA	GEORGIA
MCG HOSPITAL	~~COLUMBUS~~ AUGUSTA	GEORGIA

Faculty Appointments:

This practitioner has had the responsibility for graduate medical education within the last 10 years.

If you wish to make changes to the profile after it has been published, please submit them to 2020 Capital Circle SE, Bin # C10, Tallahassee, Florida 32399-6230.

If you have any questions or comments, call (850) 410-3359 Extension 2009.

Sincerely,

Bureau of Operations

This practitioner currently holds faculty appointments at the following medical/health related institutions of higher learning: MEDICAL College of GEORGIA

Participates in Medicaid Program:

The practitioner did not indicate if he/she participates in the Medicaid program. — I DO NOT PARTICIPATE IN MEDICAID

II. Education and Training

Medical School : Dates of Attendance : Graduation Date : Degree Title

~~1. .... : .... 06/01/1973 : ....~~

1. CHICAGO COLLEGE OF OSTEOPATHIC : 09/01/1969 - 06/01/1973 : 06/01/1973 : DO

Other Health Related Degrees:

The practitioner did not provide this mandatory information. — I DO NOT HOLD ANOTHER HEALTH DEGREE

III. Professional and Postgraduate Training

This practitioner has completed the following graduate medical education:
Program Name : Program Type : Specialty Area : City : State/Country : Dates Attended

1. WALTER REED ARMY MEDICAL CENTER : INTERNSHIP : OBG - OBSTETRICS AND GYNECOLOGY : WASHINGTON : DISTRICT OF COLUMBIA : 7/1/73 - 6/30/74

2. WALTER REED ARMY MEDICAL CENTER : RESIDENCY : OBG - OBSTETRICS AND GYNECOLOGY : WASHINGTON : DISTRICT OF COLUMBIA : 7/1/74 - 6/30/77

IV. Specialty

This practitioner holds the following certifications from specialty boards recognized by the Florida board which regulates the profession for which he/she is licensed:
Specialty Board : Certification
1. AMERICAN BOARD OF OBSTETRICS & GYNECOLOGY : OBG - OBSTETRICS AND GYNECOLOGY

V. Optional Information

Committees:/Memberships

This practitioner has not indicated any committees on which they serve for any health entity with which they are affiliated.

Professional or Community Service Awards

This practitioner has not provided any professional or community service activities, honors, or awards.

Publications

This practitioner has not provided any publications that he/she authored in peer-reviewed medical literature within the last ten years.

Languages Other Than English

This practitioner has not indicated that any languages other than English are used to communicate with patients, or that any translation service is available for patients, at his/her primary place of practice.

Other Affiliations

GEORGIA OB/GYN SOCIETY
AUGUSTA OB/GYN SOCIETY

6815-2

This practitioner has not provided any national, state, local, county, or professional affiliations.

E-Mail Address
Not Provided

Other State Licensure

This practitioner has not indicated any additional state licensure.

VI. Financial Responsibility

MALPRACTICE INSURANCE – THE ST. PAUL INS. CO.

~~The practitioner did not provide this mandatory information.~~

VII. Criminal Offenses

The criminal history information, if any exists, will be incomplete; federal criminal history is not available to the public. The criminal history information provided by the practitioner has not been completely verified at this time. All criminal history checks should be completed by March 2000.

This practitioner has not indicated any criminal offenses.

VIII. Final Disciplinary Action (Within last 10 years)

Pursuant to section 455.5651(5), F.S. the profile will not include disciplinary action taken by a hospital or ambulatory surgical centers licensed under chapter 395, F.S.

This practitioner has not indicated any final disciplinary action taken against the practitioner within the previous 10 years by a specialty board.

This practitioner has not indicated any final disciplinary action taken against the practitioner within the previous 10 years by a licensing agency.

This practitioner has not indicated any final disciplinary action taken against the practitioner within the previous 10 years by a health maintenance organization, pre-paid health clinic, nursing home, out-of-state hospital or out-of-state ambulatory surgical center.

This practitioner has indicated that he has never been asked to or allowed to resign from or had any medical staff privileges restricted or revoked within the previous 10 years

IX. Liability Claims Exceeding $5,000.00 (Within last 10 years)

Settlement of a claim may occur for a variety of reasons that do not necessarily reflect negatively on the professional competence or conduct of the physician. A payment settlement of a medical malpractice action or claim should not be construed as creating a presumption that medical malpractice has occurred.

There have not been any reported liability actions, which are required to be reported under section 455.697, F.S., within the previous 10 years.

6815

COL(Ret)Gary B. Broadnax,D.O.
1409 Waters Edge Drive
Augusta, Georgia 30901

Ms. Pamela King
Regulation Specialist
Medical Quality Assurance
Board of Osteopathic Medicine
1940 North Monroe Street
Tallahassee, Florida 32399-0757

Dear Ms. King:

Thank-you for your letter of April 21, 1998 advising me of my selection to participate in your CME audit. I only wish it could have been the Florida Lottery.

In order to provide you with official documents of my CME, I have requested that the American College of Obstetricians and Gynecologists, Office of Continuing Medical Education, send me a transcript of my training for the last 2 years. I will send it to you as soon as it is received.

I as sorry for the confusion concerning my mailing address. This has been my address since 1991 and was the mailing address for my original application for the Florida medical license. This is where I live and where I receive my mail, and is also the address on my Florida license . I have not changed my mailing address, however, I am now retired from the U.S. Army and no longer serve as an army medical officer at the local army hospital, which is where your first letter was sent. If you have sent other mail to the Army address then I did not receive it. Fortunately you now have my address.

If you need to reach me by phone, my number is (706)724-6633.

Sincerely.

Gary B. Broadnax, D. O.
Colonel(Ret), U.S. Army

Chicago College of Osteopathic Medicine

On the recommendation of the Faculty
the Trustees of this College have conferred on

Gary Burks Broadnax

the Degree of

Doctor of Osteopathy

and have granted this Diploma as evidence that he has fulfilled the requirements prescribed by the College for that Degree.

Given at the City of Chicago in the State of Illinois on the [illegible]th day of June, 1973

U.S. Army Medical Department

This is to certify that

Major Gary B. Broadnax, MC

has successfully completed

A Straight Obstetrics and Gynecology
Internship

at

Walter Reed Army Medical Center

from 1 July 1973 *to* 30 June 1974

Spencer B. Reid, MD
Brigadier General, MC
Director, Medical Education

Robert Bernstein, MD
Major General, MC
Commanding

U.S. Army Medical Department

This is to certify that

Major Gary [illegible], MC

has successfully completed

Residency Training in Obstetrics and Gynecology

at

Walter Reed Army Medical Center
Washington, D. C.

from 1 July 1974 *to* 30 June 1977

Warren E. Palmer, MD
Colonel, MC
Chief, Department of Obstetrics
and Gynecology

Robert Bernstein, MD
Major General, MC
Commanding

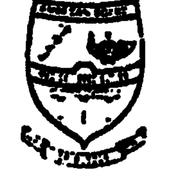
American Board of Obstetrics and Gynecology

COMPOSED OF MEMBERS NOMINATED BY THE
AMERICAN GYNECOLOGICAL SOCIETY
AMERICAN ASSOCIATION OF OBSTETRICIANS AND GYNECOLOGISTS
SECTION ON OBSTETRICS AND GYNECOLOGY, AMERICAN MEDICAL ASSOCIATION
AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS
ASSOCIATION OF PROFESSORS OF GYNECOLOGY OBSTETRICS
CERTIFIES THAT

GARY BURKS BROADNAX

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. HE HAS THEREBY DEMONSTRATED TO THE SATISFACTION OF THIS BOARD THAT HE IS POSSESSED OF SPECIAL KNOWLEDGE, AND BY THE AWARD OF THIS DIPLOMA HIS PROFICIENCY IN THE SPECIALTY OF OBSTETRICS AND GYNECOLOGY IS RECOGNIZED AND HE IS AN ACKNOWLEDGED DIPLOMATE OF THIS BOARD

NOVEMBER [illegible]



[illegible signatures]

THE AMERICAN COLLEGE
OF
OBSTETRICIANS AND GYNECOLOGISTS

CERTIFIES THAT

GARY BURKS BROADNAX

HAVING FULFILLED THE REQUIREMENTS
HAS BEEN ELECTED A **FELLOW** OF THIS COLLEGE
WHICH IS DEDICATED TO THE MAINTENANCE OF THE HIGHEST STANDARDS
IN PATIENT CARE, MEDICAL EDUCATION AND RESEARCH IN OBSTETRICS AND GYNECOLOGY
SEPTEMBER 30, 1982

PRESIDENT

SECRETARY

DEPARTMENT OF THE ARMY

HSHF-PD

25 May 1994

SUBJECT: Statement of Service

This is to certify that GARY B. BROADWAX, . is a member of the United States Army assigned to DDEAMC, Fort Gordon, GA 30905 since Aug 77. He has been a member of the Armed Services from 8 Jul 72 to present, with no lost time. This officer has no projected release. Officer's date of birth is 1 Jun 1945.

BRENT L. WALLACE
CPT, MS
Chief, Military
Personnel Branch

MIDWESTERN UNIVERSITY

April 19, 1994

Board of Osteopathic Medicine
Department of Professional Regulation
1940 No. Monroe Street
Tallahassee, FL 32399-0783

Regarding: Gary B. Broadnax, D.O.

To Whom It May Concern:

This is to verify that Gary B. Broadnax, D.O., was a student at the Chicago College of Osteopathic Medicine. He matriculated on September 8, 1969.

Dr. Broadnax completed all requirements for graduation and received the degree, "Doctor of Osteopathy" from C.C.O.M. on June 4, 1973.

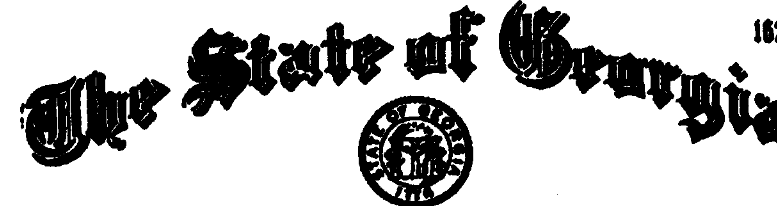
To our knowledge, Dr. Broadnax has always adhered to high standards of moral and ethical conduct.

Very truly yours,

Christy Schenk

Christy Schenk
Registrar
(708)515-6074

SCHOOL SEAL



16213

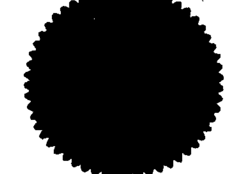
THIS IS TO CERTIFY THAT

Gary Burks Broadnax, D.O.

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 15th *day of* August 1974



C. L. Clifton

DEPARTMENT OF BUSINESS AND PROFESSIONAL REGULATION

BOARD OF OSTEOPATHIC MEDICINE
APPLICATION FOR OSTEOPATHIC LICENSURE

ALL APPLICABLE FEES MUST BE ENCLOSED

SEE ATTACHED INSTRUCTIONS

APPLICATION SHOULD BE TYPED OR PRINTED LEGIBLY IN BLACK INK

APPLICATION BY: NBOME Examination XX Florida Examination ___ Other State Examination ___

[1] Last Name	First Name	Middle Name
BROADWAX	GARY	BURKS

DO NOT WRITE IN THIS SPACE

[2]Social Security Number

[3]Date of Birth 1 JUNE 1945	[4]Place of Birth AIKEN, SOUTH CAROLINA
[5]Home Phone Number (706) 724-4633	[6]Work Phone Number (706) 791-6395

[7]Complete mailing address (where you receive mail) See item #7 in Instructions.

1409 WATERS EDGE DRIVE

AUGUSTA, GEORGIA 30901-1045

[8]Physical Address (where you can be located-No P.O. Boxes) See item #8 in Instructions

DEPARTMENT OF OB/GYN, EISENHOWER ARMY MEDICAL CENTER

FORT GORDON, GEORGIA 30905

[9]Name Changes - Aliases. YES ___ NO XX See item #9 in Instructions.

Maiden: Other:

[10]UNDERGRADUATE EDUCATION: See item #10 in Instructions.

Name and location of school	Dates Attended	Degree
MERCER UNIVERSITY, MACON, GEORGIA	9/62 - 6/66	B.A.

[11]OSTEOPATHIC EDUCATION: See item #11 in Instructions.

Name and location of school	Dates Attended	Degree
CHICAGO COLLEGE OF OSTEOPATHIC MEDICINE, CHICAGO, ILLINOIS	9/69 - 6/73	D.O.

APPLICATION FOR OSTEOPATHIC LICENSURE - PAGE 2

POSTGRADUATE TRAINING: See item #12 in Instructions.

Name of Institution	Full Mailing Address (street floor, room, box and ZIP)	Int/Res/Fel AOA/AMA	Program Director	Dates Attended
WALTER REED ARMY MEDICAL CENTER	COL. LYNN FARNSWORTH, CHIEF, DEPT. OF OB/GYN WALTER REED ARMY MEDICAL CENTER WASHINGTON, D.C. 20307-5001	INT/RES AMA-FEDERAL	COL. LYNN FARNSWORTH	7/73-6/77

Examination status. See item #13 in Instructions.
NBOME Certificate Number ________ Date awarded ________ List other state exams you have taken and the dates they were taken. ________________________

Staff Privileges. See item #14 in Instructions.

Name of Institution	Full Mailing Address (street Dept, Floor, Room, Box and ZIP)	Type of Privileges	Chief of Staff	Dates of service
EISENHOWER ARMY MEDICAL CENTER	CHIEF, DEPT. OB/GYN, BOX 212, EISENHOWER ARMY MEDICAL CENTER, FORT GORDON, GEORGIA 30905-3450	OB/GYN	COL. PHILIP KEATING	7/77-TO PRESENT

Accounting for time. See item #15 in Instructions.

N/A

State Licensure. See item #16 in Instructions.

State	Date	Method	Status & Number	State	Date	Method	Status & Number
GEORGIA	8/74	FLEX	ACTIVE - 16213				

APPLICATION FOR OSTEOPATHIC LICENSURE - PAGE 3

Specialties-Board Certification-Medical Affiliations. See item #17 in Instructions. Specialty: OB/GYN
Certified: YES XXX NO ___ Memberships: AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

Military. YES XXX NO ___ From 6/66 to PRESENT See item #18 in Instructions.

THE FOLLOWING QUESTIONS MUST BE ANSWERED YES OR NO. See items #19-33 in Instructions.

Question	Answer
Have you ever been dropped, suspended, placed on probation, expelled or requested to resign from any school, college or university?	YES ___ NO X
Have you ever been the subject of an investigation of any kind by any licensing Board, jurisdiction or Agency?	YES ___ NO X
Have you ever had your license to practice Osteopathic Medicine suspended, revoked or in any way acted against in any licensing jurisdiction?	YES ___ NO X
Have you ever been denied Osteopathic licensure in any licensing jurisdiction or been granted a license under restrictions of any kind?	YES ___ NO X
Have you ever discontinued practice for any reason for a period of one month or longer?	YES ___ NO X
Have any proceedings ever been filed or instituted against you either criminal, civil or Board related?	YES ___ NO X
Have you ever been convicted of a violation of or pled No Contest to any Federal, State or local statute, regulation or ordinance, or entered into any plea bargain relating to a felony or misdemeanor?	YES ___ NO X
Have charges, now or ever, been brought against you by any branch of the Armed Services of the United States?	YES ___ NO X
Have you ever been adjudged incompetent?	
Have you ever received any form of psychotherapy or any other treatment for any mental disorder, disability or illness of any kind?	
Do you have any chronic medical illness or medical condition which would affect your ability to practice your profession?	
Are you now or have you ever been addicted to narcotics, drugs, hallucinogenic, depressant or stimulatory substances or intoxicants?	
Have you ever been admitted to or confined within a hospital or institution for the purpose of obtaining treatment or therapy for any mental or nervous disorder, disability or illness of any kind?	
Have you ever had your staff privileges denied or suspended, or have you ever voluntarily resigned in lieu of disciplinary action?	YES ___ NO X
Are you now or have you ever been enrolled in or participated in any drug, alcohol or impaired practitioners program?	
COURT ACTIONS: See item #35 in Instructions. If you answered YES to this question, explain in full on additional space. List all cases by name in the space below.	YES ___ NO X

APPLICATION FOR OSTEOPATHIC LICENSURE - PAGE 4

**THE APPLICANT MUST COMPLETE THE FOLLOWING.

I, GARY BURKS BROADWAX, D.O., state that I am the person referred to in the foregoing application and supporting documentation, that said application and any supporting documentation are true and accurate, and that the attached photograph is a true likeness of myself.

I hereby authorize all hospitals, institutions, organizations, personal references, personal physicians, employers (past and present) and all governmental agencies and instrumentalities (local, state, federal, and foreign) to release to the Florida Board of Osteopathic Medicine, any information which is material to my application.

I have carefully read the instructions and questions in the foregoing application and have answered them completely, without reservations of any kind. Should I furnish any false information in this application, or in any supporting documentation, I hereby acknowledge that such an act shall constitute cause for denial, suspension or revocation of my license to practice as an osteopathic physician under Chapter 459, Florida Statutes, in the State of Florida. I hereby affirm that I have read and understand Chapters 459, Florida Statutes, and 21R, Florida Administrative Code, and acknowledge that I must abide by them. I agree that prior to beginning practice in the state of Florida I will comply with all insurance requirements.

Signature of Applicant [signature] Date Signed 4/21/94

NOTARIZATION:
Witness my hand and official seal this 21st Day of April
1994 In the County of Richmond State of Georgia
My commission expires on: May 27, 1996

Notary stamp and/or seal

Notary signature: [signature]

**We are required to ask that you furnish the following information as part of your voluntary compliance with Section 2, Uniform Guidelines on Employee Selection Procedures (1978) 43 FR38296 (August 25, 1978). This information is gathered for statistical purposes only and does not in any way affect your candidacy for licensure.

Sex: F____ M X____ Physical: Height 5'10"

Weight 210# Eye Color BR Hair Color BR

Ethnic Origin: Caucasian X Black____

Hispanic____ Oriental____ Native American____

Are you a US Citizen? Yes X No____

If no, give alien number____

HERE

DEPARTMENT OF THE ARMY
HEADQUARTERS DWIGHT DAVID EISENHOWER ARMY MEDICAL CENTER
FORT GORDON, GEORGIA [illegible]

RE: Letter of Recommendation
Gary B. Broadnax, DO

Board of Osteopathic Medicine,
Department of Professional Regulation
1940 N Monroe St.
Tallahassee, Florida

I have practiced Obstetrics and Gynecology these past two years with Dr. Broadnax in a military based group practice. In that time Dr. Broadnax has consistently practiced conscientious and intelligent medicine. He is well liked by his peers and is much appreciated by the younger staff members who often seek his advice.

He is a well respected physician both within the local and military community. It is a pleasure and a privilege to work with Dr. Broadnax.

Sincerely,

[signature] 5/4/99

Thomas E. Papa,DO
4690 Cutter Mill Rd.
Martinez, GA 30907

DEPARTMENT OF THE ARMY
HEADQUARTERS DWIGHT DAVID EISENHOWER ARMY MEDICAL CENTER
FORT GORDON GEORGIA [illegible]

29 April 1994

Board of Osteopathic Medicine
Department of Professional Regulation
1940 N. Monroe Street
Tallahassee, FL 32399-0783

Dear Sir:

I am pleased to recommend the granting of medical licensure in your state to Dr. Gary Broadnax. I have known Gary since 1969. He was 1 year behind me in Osteopathic Medical School (Dr. Broadnax graduated 1973). Both of us also took our residency at Walter Reed Army Medical Center (1974-1977). Dr. Broadnax distinguished himself academically in both institutions. Dr. Broadnax continued his career in the military and is serving as Chief, Department of Obstetrics and Gynecology at Eisenhower Army Medical Center. He also is the Consultant to The Army Surgeon General for OB-GYN. Dr. Broadnax is an excellent administrator.

I have practiced daily with Dr. Broadnax for the past 8 years (1986-present), and it is my opoinion that he practices excellent medicine. He brings a broad range of knowledge and experience to his care of patients. He is available for consultation and advice for our junior staff members.

Dr. Broadnax is hard working, highly ethical and has a stable personal life.

If you have further questions, do not hesitate to call me. I can be reached at (706) 791-2867.

Sincerely,

Lawrence A. Decker, DO
Department of Obstetrics
and Gynecology
Eisenhower Army Medical Center

Board of Osteopathic Medicine
CERTIFICATION OF COMPLIANCE
WITH THE
CONTINUING MEDICAL EDUCATION REQUIREMENT ON
HIV/AIDS

I hereby affirm that I have completed the required course on HIV/AIDS in accordance with s. 455.2226, Florida Statutes, and s. 21R-001, Florida Administrative Code, and that this course was a minimum of three (3) hours of American Osteopathic Association Category I, American Medical Association Category I, or board approved continuing medical education. I also affirm that the course that I have taken was offered and completed after July 1, 1991 as prescribed in ss. 21R-001(3), F.A.C., and that said course consisted of education on the transmission, control, treatment, and prevention of HIV/AIDS with emphasis on appropriate behavior and attitude change in compliance with ss. 455.2226(3), F.S., and ss. 21R-21.001(4)(a-e), F.A.C. A copy of the certificate demonstrating my completion of this requirement is attached.

* FOR INTERNS AND RESIDENTS ONLY * In the event that I have not taken a formal course on HIV/AIDS as described above but have attended a minimum of three (3) hours of formal didactic lectures within the time frame described above during the course of my training, I have attached a letter from my director of medical education that verifies the time period of my training, that there were formal didactic lectures available for the trainees to attend, and my attendance during these lectures. In addition, I understand that taking care of HIV/AIDS patients during my training is not sufficient to fulfill this requirement.

I recognize that providing false information to the department shall constitute cause for denial, suspension or revocation of my license to practice osteopathic medicine and surgery OR as a physician assistant certified under Chapter 459, F.S., in the state of Florida or criminal penalties pursuant to sections 455.2272, 459.013, 459.015, 775.082, 775.083, and 775.084, F.S.

GARY B. BROADNAX, D.O.
name of applicant (please print or type)

[signature]
signature of applicant

WITNESS my hand and official seal this 21st day of April, 1994.

[signature]
Notary Public
My commission ends: May 27, 1996

PLEASE NOTE: If you have not fulfilled this requirement prior to licensure, you must submit an affidavit (a letter or document separate from this form that is sworn and subscribed to before a notary) in which you state the reason(s) why you have not complied with this requirement and request that these reasons be determined to be good cause and therefore make you eligible for the six (6) month extension to complete this requirement as allowable by law in ss. 455.2226(5), F.S. and ss. 21R-21.001(6), F.A.C.

YOUR LICENSE/CERTIFICATE WILL NOT BE ISSUED UNTIL THIS REQUIREMENT IS COMPLETED OR YOUR AFFIDAVIT IS ACCEPTED BY THE BOARD AND YOU ARE GRANTED THE SIX MONTH EXTENSION.

DIVISION OF MEDICAL QUALITY ASSURANCE
BOARD OF OSTEOPATHIC MEDICINE
NORTHWOOD CENTRE • 1940 NORTH MONROE STREET • TALLAHASSEE, FLORIDA 32399-0757
Telephone (904) 922-6725

Dwight David Eisenhower Army Medical Center

This Certificate of Completion

is Awarded to

COL GARY S. BROADNAX, D.O.

for

"HIV EDUCATION FOR HEALTH CARE PROVIDERS"

on 25 March 1994 at Fort Gordon, Georgia and is awarded three credit hours in Category 1 of the Physician's Recognition Award of the American Medical Association.

this 25th *day of* March *19*94

Brigadier General

Commanding

OFFICE OF THE CONSULTANT
IN OBSTETRICS AND GYNECOLOGY
TO THE SURGEON GENERAL

5/24/94

Subject: Lotter of Explanation
To: Board of Osteopathic Medicine

This statement is made to clarify and explain why upon my graduation from the Chicago College of Osteopathic Medicine I did my internship and residency at Walter Reed Army Medical Center. My internship consisted of rotations in Internal Medicine, General Surgery, Pediatrics, Ob/Gyn, Anesthesiology, radiology and Emergency Medicine. In 1966 I accepted a Regular Army Commission in the U.S. Army and served 3 years on active duty until I entered CCOM in 1969. I remained in the Army Reserves and was on active duty each summer. In my senior year I accepted an Army scholarship and remained on active duty. The scholarship obligated me for three years on active duty after graduation in 1973. I have been on active duty for 27 years and that is why I did my training at Walter Reed Army Medical Center. Major General Ronald Blanck is the Commander at Walter Reed Army Medical Center and a distinguished Osteopathic Physician, so we should consider it an Osteopathic Hospital.

Sincerely,

Colonel Gary B. [illegible], MC
Department of Obstetrics and Gynecology
Eisenhower Army Medical Center
Fort Gordon, GA 30905-[illegible]
(706) 791-[illegible]

FLORIDA BOARD OF OSTEOPATHIC MEDICINE
TRAINING EVALUATION

TO: COL. LYNN FARNSWORTH INSTITUTION: WALTER REED ARMY MEDICAL CENTER DATE: 4/8/94

The doctor named below has applied for licensure in the State of Florida. Please complete the entire form and affix the hospital seal or have your signature notarized. Please also verify the dates of training and completion of the program by signing where indicated. This form can not be accepted without the hospital seal or a notarized signature.

NAME: GARY L. BROADWAY, D.O. SOCIAL SECURITY NO: ______

DATES ATTENDED: 7/73 - 6/77 TYPE OF TRAINING: INT (see below)* xx RES/FEL xx

	Poor	Fair	Good	Superior
PROFESSIONAL CHARACTER				
a. Basic Medical Knowledge				✓
b. Diagnostic/Clinical Ability				✓
c. Fitness for Clinical Practice				✓
PERSONAL CHARACTER				
a. Motivation				✓
b. Initiative				✓
c. Responsibility				✓
d. Integrity				✓
e. Appearance				✓
f. Knowledge of English				✓
g. Emotional Stability/Attitude				✓
PROFESSIONAL RELATIONSHIPS				
a. Teaching Staff				✓
b. Colleagues				✓
c. Nursing Staff				✓
d. Patients				✓

PERSONAL INFORMATION

a. Are there any physical conditions or personality problems which may affect the doctor's ability to practice with reasonable skill and safety? If yes, please explain in full on the reverse side

VERIFICATION:

a.*Has the physician named above completed a 12 month Internship/PGY I during the dates listed above? YES ✓ NO__

b. Please verify if this program is approved by the : AOA__ AMA ✓

OVERALL EVALUATION: If 3 or 4 is checked, please explain on reverse side.

1. ✓ Outstanding 2.____ Qualified/Competent 3.____ Some Reservations 4.____ Negative Recommendations

Name: COL LYNN S. FARNSWORTH, MC, CHIEF, DEPT. OF OB/GYN Signature: [signature]

Position: WALTER REED ARMY MEDICAL CENTER, WASHINGTON, D.C. 20307-5001 Phone Number: (202) 576-1201

Date: 15 April 1994

HOSPITAL SEAL OR NOTARIZATION OF SIGNATURE

DIVISION OF MEDICAL QUALITY ASSURANCE
BOARD OF OSTEOPATHIC MEDICINE
NORTHWOOD CENTRE • 1940 NORTH MONROE STREET • TALLAHASSEE, FLORIDA 32399-0757
Telephone (904) 922-6725

FLORIDA BOARD OF OSTEOPATHIC MEDICINE
STAFF PRIVILEGES VERIFICATION

TO: COL. PHILIP KEATING, M.D. DATE: 4/8/94

Institution: EISENHOWER ARMY MEDICAL CENTER
FORT GORDON, GEORGIA

The Doctor named below has applied for licensure in the State of Florida. Please complete this form and affix the hospital seal or have your signature notarized. Please note that this form can not be accepted without the hospital seal or a notarized signature.

NAME: GARY B. BROADNAX, D.O. SOCIAL SECURITY NO ______

1. Does/did the doctor have full staff privileges in his/her specialty? Yes If no, please explain.

2. What is/was the doctor's specialty? Obstetrics/Gynecology

3. Does/did he/she perform competently? Yes If no, please explain. ______

4. How would you rate the doctors professional attitude: Poor ___ Fair ___ Good ___ Superior X

5. Have any restrictions ever been placed on him/her beyond the original period of probation? No

   If yes, please explain. ______

6. Please list the doctor's dates of service 17 July 1977 - present (21 April 1994)

Philip J. Keating, Colonel, Medical Corps
Name of Person Providing Information

[signature]
Signature

21 April 1994
Date Signed

Deputy Commander for Clinical Services
Position/Title

(706) 791-2001
Phone Number

HOSPITAL SEAL OR NOTARIZATION OF SIGNATURE

[signature]
Notary Public, [illegible] County, Georgia
My Commission Expires Dec. 5, 19[illegible]

DIVISION OF MEDICAL QUALITY ASSURANCE
BOARD OF OSTEOPATHIC MEDICINE
NORTHWOOD CENTRE • 1940 NORTH MONROE STREET • TALLAHASSEE, FLORIDA 32399-0777
Telephone (904) [illegible]

FINANCIAL RESPONSIBILITY FILING FORM

THIS FORM MUST BE COMPLETED AND SUBMITTED WITH YOUR APPLICATION FOR LICENSURE. COMPLETE THE FORM BASED ON WHAT YOUR STATUS WILL BE UPON BEGINNING PRACTICE IN FLORIDA. IF THIS INFORMATION IS UNAVAILABLE, SEE SECTION 6D OF THIS FORM. PLEASE RETAIN A BLANK COPY OF THIS FORM SO THAT YOU MAY UPDATE YOUR STATUS IF NECESSARY AFTER YOU ARE APPROVED BY THE BOARD.

Check only the subsection box which applies to you - only one section should be checked.

1. [ ] I do not have hospital staff privileges and I have obtained and maintain professional liability coverage in an amount not less than $100,000 per claim, with a minimum annual aggregate of not less than $300,000, from an authorized insurer as defined under s. 624.09, from a surplus lines insurer as defined under s. 626.914(2), from a risk retention group as defined under s. 627.942, from the Joint Underwriting Association established under s. 627.351(4), or through a plan of self-insurance as provided in s. 627.357.

2. [ ] I have hospital staff privileges and I have obtained and maintain professional liability coverage in an amount not less than $250,000 per claim, with a minimum annual aggregate of not less than $750,000, from an authorized insurer as defined under s. 624.09, from a surplus lines insurer as defined under s. 626.914(2), from a risk retention group as defined under s. 627.942, from the Joint Underwriting Association established under s. 627.351(4), or through a plan of self-insurance as provided in s. 627.357, or through a plan of self-insurance which meets the conditions specified for satisfying financial responsibility in s. 766.110.

3. [ ] I do not have hospital staff privileges and I have obtained and maintain an unexpired, irrevocable letter of credit, established pursuant to chapter 675, in an amount of not less than $100,000 per claim with a minimum aggregate availability of credit of not less than $300,000. The letter of credit shall be payable to the osteopathic physician as beneficiary upon presentment of a final judgment indicating liability and awarding damages to be paid by the osteopathic physician or upon presentment of a settlement agreement signed by all parties to such agreement when such final judgment or settlement is a result of a claim arising out of the rendering of, or the failure to render, medical care and services. Such letter of credit shall be nonassignable and nontransferable. Such letter of credit shall be issued by any bank or savings association organized and existing under the laws of this state or any bank or savings association organized under the laws of the United States that has its principal place of business in this state or has a branch office which is authorized under the laws of this state or of the United States to receive deposits in this state. OR I do not have hospital staff privileges and I have established and maintain an escrow account consisting of cash or assets eligible for deposit in accordance with s. 625.52 in the per-claim amounts specified above.

4. [ ] I have hospital staff privileges and I have obtained and maintain an unexpired, irrevocable letter of credit, established pursuant to chapter 675, in an amount not less than $250,000 per claim, with a minimum aggregate availability of credit of not less than $750,000. The letter of credit shall be payable to the osteopathic physician as beneficiary upon presentment of a final judgment indicating liability and awarding damages to be paid by the osteopathic physician or upon presentment of a settlement agreement signed by all parties to such agreement when such final judgment or settlement is a result of a claim arising out of the rendering of, or the failure to render, medical care and services. Such letter of credit shall be nonassignable and nontransferable. Such letter of credit shall be issued by any bank or savings association organized and existing under the laws of this state or any bank or savings association organized under the laws of the United States that has its principal place of business in this state or has a branch office which is authorized under the laws of this state or of the United States to receive deposits in this state. OR I have hospital staff privileges and I have established and maintain an escrow account consisting of cash or assets eligible for deposit in accordance with s. 625.52 in the per-claim amounts specified above.

5. [ ] I have decided not to carry malpractice insurance or otherwise demonstrate financial responsibility; however, I agree to satisfy any adverse judgments pursuant to the terms and conditions contained in s. 459.0085(5)(g), F.S.. I understand that I shall be required to either post notice in the form of a sign prominently displayed in the reception area and clearly noticeable by all patients or provide a written statement to any person to whom medical services are being provided. Such sign or statement shall state that: Under Florida law, osteopathic physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. YOUR OSTEOPATHIC PHYSICIAN HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This is permitted under Florida law subject to certain conditions. Florida law imposes strict penalties against noninsured osteopathic physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida law.

FINANCIAL RESPONSIBILITY FILING FORM - PAGE 2

6. I am exempt from demonstrating financial responsibility because:

6A [X] I practice medicine exclusively as an officer, employee, or agent of the federal government, or of the state or its agencies or its subdivisions.

6B [ ] I hold a limited license issued pursuant to s. 459.0075, F.S., and practice only under the scope of such limited license.

6C [ ] I practice only in conjunction with my teaching duties at an college of osteopathic medicine. (Residents do not qualify for this exemption.)

6D [X] I do not practice osteopathic medicine in the State of Florida. I will notify the department immediately before commencing practice in the state.

6E [ ] I am exempt from demonstrating financial responsibility due to meeting all of the following criteria:

1) I have held an active license to practice in this state or another state or some combination thereof for more than 15 years.
2) I am retired or maintain part-time practice of no more than 1,000 patient contact hours per year.
3) I have had no more than 2 claims resulting in an indemnity exceeding $10,000 within the previous 5 year period.
4) I have not been convicted of, or pled nolo contendere to any criminal violation specified in s. 459, F.S., or the practice act of any other state.
5) I have not been subject, within the last 10 years of practice, to license revocation or suspension for any period of time, probation for a period of 3 years or longer, or a fine of $500 or more for a violation of s. 459, F.S., or the medical practice act of another jurisdiction. The regulatory agency's acceptance of an osteopathic physician's relinquishment of a license, stipulation, consent order, or other settlement, offered in response to or in anticipation of the filing of administrative charges against the osteopathic physician's license, shall be construed as action against the physician's license for the purposes of this section. I understand that I shall be required either to post notice in the form of a sign prominently displayed in the reception area and clearly noticeable by all patients or to provide a written statement to any person to whom medical services are being provided. Such sign or statement shall state that: Under Florida law, osteopathic physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. However, certain part-time osteopathic physicians who meet state requirements are exempt from the financial responsibility law. YOUR OSTEOPATHIC PHYSICIAN MEETS THESE REQUIREMENTS AND HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This notice is provided pursuant to Florida law.

AFFIRMATION:
I affirm that all statements given above are true and correct and recognize that providing false information may result in disciplinary action against my license or criminal penalties pursuant to Sections 455.227, 459.013, 459.015, 775.082, 775.083, and 775.084, Florida Statutes.

[signature] GARY B. BROADWAX, D.O.

Signature | Printed Name | Social Security Number

DISPENSING PRACTITIONER - This is optional and should be completed only if the $25.00 fee is enclosed.

Section 465.0276, F.S., requires that licensees of the Board of Osteopathic Medical Examiners who dispense medicinal drugs for a fee or remuneration of any kind, whether direct or indirect, shall be required to register with the Board and pay a fee of $25.00 at the time of such registration and upon each renewal of the practitioner's license. Practitioners who confine their activities to the dispensing of complimentary packages of medicinal drugs to their own patients in the regular course of their practice <u>shall not be required to register.</u> Please note that upon registration, your practice will be inspected annually by the Department's Investigative Services for compliance with Florida law relative to the dispensing of medicinal drugs.

YES, I plan to dispense medicinal drugs for a fee or other remuneration and hereby register pursuant to ss. 465.0276, F.S.. I understand that the fee for registration is $25.00 over and above the amount required for licensure.

YES [ ] ______________ Signature NO [x] No signature required

Jeb Bush
Governor

Robert G. Brooks, M.D.
Secretary

August 15, 2001

GARY B BROADNAX, D.O.
~~1409 WATERS EDGE DRIVE~~
AUGUSTA, GA ~~30901~~

Dr. Gary B. Broadnax
P.O. Box 2246
Augusta, GA 30903-2246

please see corrections GBox

Dear Dr. BROADNAX

The information published in your practitioner profile is printed below. In carrying out our legislative mandate to publish physician profiles, we want to do everything we can to ensure the information that is published is correct. You have the opportunity to review the data for any changes, corrections, and/or omissions. Under Section 456.042, Florida Statutes, you have thirty (30) days from the date you receive this letter to submit changes to 4052 Bald Cypress Way, Bin # C10, Tallahassee, Florida 32399-3260. If you have no changes, your profile will remain as it appears on the World Wide Web. Listed below is information that you should review carefully.

Florida law requires you to **report all disciplinary action** taken by facilities, including those outside the state of Florida. **Please review and identify any action which was taken by a hospital or ambulatory surgical center in Florida, this discipline will not be published in the profile.**

In addition, state law requires that **all criminal convictions** must be reported to the department pursuant to Section 456.039(1)(a)7, Florida Statutes. If your criminal conviction was expunged or the records were sealed, please send a copy of the court order expunging or sealing the records.

- [ ] My profiling information is correct
- [x] My profiling information is incorrect; changes are noted below.

I. **Practitioner Information**

License Number : 6815
Profession : Osteopathic Physician
License Status : ACTIVE CLEAR
Year Began Practicing : 01/01/1973

Primary Business:

~~1409 WATERS EDGE DRIVE~~
AUGUSTA GA ~~30901~~

Dr. Gary B. Broadnax
P.O. Box 2246
Augusta, GA 30903-2246

DEC 03 2001

Secondary Locations:

828 CRAWFORD AVENUE
AUGUSTA, GA. 30904

Staff Privileges:

This practitioner does not currently hold staff privileges at any hospital/medical/health institution in Florida. To confirm out-of-state staff privileges please see other affiliations.

Faculty Appointments:

This practitioner has had the responsibility for graduate medical education within the last 10 years.

This practitioner currently holds faculty appointments at the following medical/health related institutions of higher learning:
Title : Institution : City : State
1. FACULTY : MEDICAL COLLEGE OF GEORGIA : *** : GEORGIA

Participates in Medicaid Program:

No

II. Education and Training

Medical School : Dates of Attendance : Graduation Date : Degree Title
1. CHICAGO COLLEGE OF OSTEOPATHIC : 09/01/1969 - 06/01/1973 : 06/01/1973 : DO

Other Health Related Degrees: NONE

~~The practitioner did not provide this mandatory information.~~

III. Professional and Postgraduate Training

This practitioner has completed the following graduate medical education:
Program Name : Program Type : Specialty Area : City : State/Country : Dates Attended

1. WALTER REED ARMY MEDICAL CENTER : INTERNSHIP : OBG - OBSTETRICS AND GYNECOLOGY : WASHINGTON : DISTRICT OF COLUMBIA : 7/1/1973 - 6/30/1974

2. WALTER REED ARMY MEDICAL CENTER : RESIDENCY : OBG - OBSTETRICS AND GYNECOLOGY : WASHINGTON : DISTRICT OF COLUMBIA : 7/1/1974 - 6/30/1977

IV. Specialty

This practitioner holds the following certifications from specialty boards recognized by the Florida board which regulates the profession for which he/she is licensed:
Specialty Board : Certification
1. AMERICAN BOARD OF OBSTETRICS & GYNECOLOGY : OBG - OBSTETRICS AND GYNECOLOGY

V. Optional Information

Committees:/Memberships

This practitioner has not indicated any committees on which they serve for any health entity with which they are affiliated.

Professional or Community Service Awards

This practitioner has not provided any professional or community service activities, honors, or awards.

Publications

This practitioner has not provided any publications that he/she authored in peer-reviewed medical literature within the last ten years.

Languages Other Than English

This practitioner has not indicated that any languages other than English are used to communicate with patients, or that any translation service is available for patients, at his/her primary place of practice.

Other Affiliations

This practitioner has provided the following national, state, local, county, or professional affiliations:
1. GEORGIA OBSTETRIC AND GYNECOLOGICAL SOCIETY
2. AUGUSTA OBSTETRIC AND GYNECOLOGICAL SOCIETY
3. ~~STAFF PRIV/UNIVERSITY HOSPITAL/AUGUSTA,GA~~
4. ~~STAFF PRIV/MEDICAL COLLEGE OF GA/AUGUSTA,GA~~

E-Mail Address
Not Provided

Other State Licensure — GEORGIA

This practitioner has not ind~~icated any additional state licen~~sure.

VI. Financial Responsibility

I do not practice medicine in the State of Florida.

VII. Criminal Offenses

The criminal history information, if any exists, will be incomplete; federal criminal history is not available to the public. The criminal history information provided by the practitioner has not been completely verified at this time. All criminal history checks should be completed by March 2000.

This practitioner has indicated that he/she has NO criminal offenses.

VIII. Final Disciplinary Action (Within last 10 years)

Pursuant to section 455.5651(5), F.S. the profile will not include disciplinary action taken by a hospital or ambulatory surgical centers licensed under chapter 395, F.S.

This practitioner has indicated that he/she has NOT had any final disciplinary action taken against him/her within the previous 10 years by a specialty board.

This practitioner has indicated that he/she has NOT had any final disciplinary action taken against him/her within the previous 10 years by a licensing agency.

This practitioner has indicated that he/she has NOT had any final disciplinary action taken against him/her within the previous 10 years by a health maintenance organization, pre-paid health clinic, nursing home, out-of-state hospital or out-of-state ambulatory surgical center.

This practitioner has indicated that he/she has NEVER been asked to or allowed to resign from or had any medical staff privileges restricted or revoked within the previous 10 years by a health maintenance organization, pre-paid health clinic, nursing home, out-of-state hospital or out-of-state ambulatory surgical center.

IX. Liability Claims Exceeding $5,000.00 (Within last 10 years)

Settlement of a claim may occur for a variety of reasons that do not necessarily reflect negatively on the professional competence or conduct of the physician. A payment settlement of a medical malpractice action or claim should not be construed as creating a presumption that medical malpractice has occurred.

There have not been any reported liability actions, which are required to be reported under section 455.697, F.S., within the previous 10 years.

If you wish to make changes to the profile after it has been published, please submit them to 4052 Bald Cypress Way, Bin # C10, Tallahassee, Florida 32399-3260.

If you have any questions or comments, please call (850)488-0595, Press 6, Monday through Friday, 8:00 a.m. to 5:00 pm., ET.

Sincerely,

Bureau of Operations

Florida Department of Health - Board of Osteopathic Medicine
LICENSE RENEWAL NOTICE

DEPARTMENT USE ONLY

Inactive Osteopathic Physician License # OS 6815 expires March 31, 2006.

The fee of **$230.00** and the renewal notice must be postmarked on or before March 31, 2006. Renewal notices postmarked on or after April 01, 2006 require renewal and delinquent fees of **$630.00**.

1. CURRENT MAILING ADDRESS:

This address will be used for all correspondence from the Department of Health.

GARY B BROADNAX
PO BOX 2246
AUGUSTA, GA 30903
(706) 791-6395

2. CURRENT PRACTICE LOCATION:

This address will be printed on your license and posted on the Internet.

1289 BROAD ST
AUGUSTA, GA 30901
(706) 724-6633

3. RENEW ON LINE TODAY!

Go to **www.doh-mqaservices.com** to renew your license, change your address, and confirm information maintained by the Department. Listed below is your Account ID and password for online services. If you renew online, you will receive a temporary license upon successful completion of your renewal. Online renewals are processed immediately and your license status is updated online within seven business days.

Avoiding complaints can protect your clients and your ability to practice. Go to **www.doh.state.fl.us/mqa/avoid.html** to find out more.

4. CHANGES TO CURRENT LICENSE INFORMATION:

If you have any changes to the name, mailing address, practice location address, license status or military status information associated with your license, please provide the updated information in the appropriate fields of section 7 on the back of this form.

5. THERE ARE TWO RENEWAL METHODS AVAILABLE:

A. Online Renewal: Visit **www.doh-mqaservices.com** go to the Practitioner Logon box, select your profession and enter your Account ID and password. If you are requesting a status change, you will be ineligible to renew your license online. The system will be available for renewals until midnight, Eastern Standard Time (EST), March 31, 2006. To use the online system, you will need the following information:

Account ID

Password

(Note: Account ID and Password must be entered exactly as they appear.)

The online system will allow practitioners to update their address, profile, and to confirm licensee information maintained by the Department. Practitioners will receive confirmation of their successful renewal before logging out of the system.

B. **U.S. Mail:** Mail completed form and fee payable to the Department of Health to the following address:
Department of Health, Division of Medical Quality Assurance, PO Box 6320, Tallahassee, FL 32314-6320

6. OTHER INFORMATION:

By submitting the appropriate renewal fees to the Department, a licensee certifies compliance with all requirements for renewal, including continuing education credits.

File Number: 5554 — Sequence Number: 97
Profession Code: 1901 — 40 — 20

OS........6815

Please make changes to your license information in section 7 on the BACK of this form.

7. CHANGES TO CURRENT LICENSE INFORMATION:

◯ CHANGE OF NAME:

Name changes require legal documentation showing the name change. Please make sure that a photocopy of one of the following accompanies this form: a marriage license (marriage license must indicate the original signature and seal from the cle of the court), a divorce decree indicating restoration of your maiden name, or a court order (e.g., adoption, name change, or federal identity change). Any one of these will be accepted unless the department has a question about the authenticity of the document. A driver's license or social security card is not considered legal documentation.

If the name change cannot be completed, your license will be renewed using the current name.

Last Name:

First Name:

Middle Name: Title: Suffix: *(Jr,Sr,I,II,etc.)* Qualifier: *(PhD,DDS,etc.)*

◯ CHANGE OF MAILING ADDRESS:

Attention:

Addr1:

Addr2:

City:

State: Zip: - Phone: ( ) -

◯ CHANGE OF PRACTICE LOCATION: (This address can not be a Post Office Box)

Attention:

Addr1:

Addr2:

City:

State: Zip: - Phone: ( ) -

CHECKLIST FOR MAILING RENEWAL FORM

If mailing your renewal form, use the checklist below as a guide for enclosing all the required items to ensure a smooth renewal. If renewing by mail, allow 2-4 weeks processing time.

<u>REQUIRED:</u>
- ◯ Renewal notice
- ◯ Check or Money order written to Department of Health
- ◯ Financial Responsibility form (check only one item on the FR form)
- ◯ Mail to: PO Box 6320, Tallahassee, Florida 32314-6320

If you are renewing to active status, would you be available to provide health care services in special needs shelters or to help staff disaster medical assistance teams during times of emergency or major disaster?

◯ Yes

CHANGE OF LICENSE STATUS:

◯ I request reactivation from inactive to active. The fee of **$630.00** and renewal notice must be postmarked on or before <u>March 31, 2006</u>. Renewal notices postmarked on or after <u>April 01, 2006</u> will require renewal and delinquent fees of **$1,130.00**. (Note: Additional requirements may be applicable. Visit our web site at **<u>http://www.doh.state.fl.us</u>** , click on <u>Health Care Professions</u>, click on <u>Current License Holders</u>, then click on <u>Renewal Information</u> and select your profession to get information and contacts.)

CHANGE OF MILITARY STATUS:

◯ I am requesting Military Restricted Status. (You must submit proof of active military duty. Attach a copy of your current active duty orders or a letter from your Commanding Officer.) The fee for military restricted is **$00.00**.

CHANGE OF RETIRED STATUS:

◯ I am requesting retired status. The fee for retired status is **$55.00** postmarked on or before <u>March 31, 2006</u>. The fee for retired status on or after <u>April 01, 2006</u> is **$555.00**.

DISPENSING:

◯ I wish to dispense medicinal drugs for a fee from my practice location and I understand an annual inspection of my dispensing records will be conducted. The fee for registration as a dispensing practitioner **$100.00** in addition to your renewal fee.

ML 5/11/94

OSTEO

STATE OF GEORGIA
COMPOSITE STATE BOARD OF MEDICAL EXAMINERS
166 PRYOR ST , SW
ATLANTA, GEORGIA 30303
(404) 656-3913
05/09/94

MAY 12 1994

TO WHOM IT MAY CONCERN:

THIS IS TO CERTIFY THAT BROADNAX, GARY B••••••••

WAS ISSUED GEORGIA MEDICAL LICENSE NUMBER 016213, ISSUED ON 08/15/74 , AND AS OF 05/03/94 THE STATUS OF THIS LICENSE IS CURRENT.

THE DATE OF LAST RENEWAL WAS 12/15/93. THIS LICENSE EXPIRES 12/31/95.

A REVIEW OF PUBLIC RECORDS INDICATES THAT NO DISCIPLINARY ORDERS HAVE BEEN DOCKETED.

This 9th day of May, 1994.

ANDREW W. WATRY, EXECUTIVE DIRECTOR
COMPOSITE STATE BOARD OF MEDICAL EXAMINERS

Our mailing address of record for this licensee is:

BROADNAX, GARY B
1409 WATERS EDGE RD
AUGUSTA , GA 309011045

Florida Department of Health - Board of Osteopathic Medicine
LICENSE RENEWAL NOTICE

Received Date : 3/17/04
Deposit Date : 3/17/04
Deposit # : 167680
Batch Number : 017811
Validation # : 903154392
Check Amount : $230.00
PROD CDE : 1901

Active Osteopathic Physician License # OS 6815 expires March 31, 2004.

The fee of **$430.00** and the renewal notice must be postmarked on or before March 31, 2004. Renewal notices postmarked on or after April 01, 2004 require renewal and delinquent fees of **$830.00**.

1. CURRENT MAILING ADDRESS:
This address will be used for all correspondence from the Department of Health.

GARY B BROADNAX
PO BOX 2246
AUGUSTA, GA 30903

(706) 791-6395

2. CURRENT PRACTICE LOCATION:
This address will be printed on your license and posted on the Internet.

1289 BROAD ST
AUGUSTA, GA 30901

3. RENEW ON LINE TODAY!

Go to **www.doh-mqaservices.com** and renew your license, change your address, update your profile, and confirm information maintained by the Department. Listed below is your user id and password for online services. If you renew online, you will receive a temporary license upon successful completion of your renewal. Online renewals are processed immediately and your license status is updated online within seven business days.

4. CHANGES TO CURRENT LICENSE INFORMATION:

If you have any changes to the name, mailing address, practice location address, license status or military status information associated with your license. Please provide the updated information in the appropriate fields of section 7 on the back of this form.

5. THERE ARE TWO RENEWAL METHODS AVAILABLE:

A. Online Renewal: Visit **www.doh-mqaservices.com** and click on Renew My License to renew your license online. If you are requesting a status change you will be ineligible to renew your license online. The system will be available for renewals until midnight, Eastern Standard Time (EST), March 31, 2004. To use the online system, you will need the following information:

Account ID
Password:
(Note: Account Id and Password must be entered exactly as they appear.)

The online renewal system will allow practitioners to update their mailing and practice location addresses, profile, and to confirm licensee information maintained by the Department. Practitioners will receive a temporary license upon successful renewal before logging out of the system.

B. U.S. Mail: Mail completed form and fee payable to the Department of Health to the following address:

Department of Health
Division of Medical Quality Assurance
PO Box 6320
Tallahassee, FL 32314-6320

6. Other Information:

By submitting the appropriate renewal fees to the Department, a licensee certifies compliance with all requirements for renewal, including continuing education credits.

File Number: 5554 | Sequence Number: 505
Profession Code: 1901 | 20 | 20

Please make changes to your license information in section 7 on the BACK of this form.

7. CHANGES TO CURRENT LICENSE INFORMATION:

PLEASE READ THIS SECTION CAREFULLY BEFORE MAKING ANY CHANGES:

To indicate changes in any section, complete the change indicator oval like this

When providing updated information, print each character inside the box like this A B C 1 2 3

Use black/blue pen or No.2 pencil only for all changes.

CHANGE OF NAME:

Name changes require legal documentation showing the name change. Please make sure that a photocopy of one of the following accompanies this form: a marriage license (marriage license must indicate the original signature and seal from the clerk of the court), a divorce decree indicating restoration of your maiden name, or a court order (e.g., adoption, name change, or federal identity change). Any one of these will be accepted unless the department has a question about the authenticity of the document. A driver's license or social security card is not considered legal documentation.

If the name change cannot be completed, your license will be renewed using the current name.

Last Name:

First Name:

Middle Name: Title: Suffix: *(Jr,Sr,I,II,etc.)* Qualifier: *(PhD,DDS,etc.)*

CHANGE OF MAILING ADDRESS:

Attention:

Street Addr1:

Street Addr2:

City:

State: Zip: + Phone: ( ) -

CHANGE OF PRACTICE LOCATION: (This address can not be a Post Office Box)

Attention:

Street Addr1:

Street Addr2:

City:

State: Zip: + Phone: ( ) -

CHECKLIST FOR MAILING RENEWAL FORM

If mailing your renewal form, use the checklist below as a guide for enclosing all the required items to ensure a smooth renewal. If renewing by mail, allow 4-6 weeks processing time.

REQUIRED:
- Renewal notice
- Check or Money order written to Department of Health
- Financial responsibility form (check only one item on the FR form)
- Mail to: PO Box 6320, Tallahassee, Florida 32314-6320

If you are renewing to active status, would you be available to provide health care services in special needs shelters or to help staff disaster medical assistance teams during times of emergency or major disaster?

Yes

CHANGE OF LICENSE STATUS:

I wish to change my status from Active to Inactive. The fee for an inactive receipt is **$230.00**. The fee for inactive after March 31, 2004 is **$730.00**.

CHANGE OF MILITARY STATUS:

I am requesting Military Restricted Status. (You must submit proof of active military duty. Attach a copy of your current active duty orders or a letter from your Commanding Officer.) The fee for military restricted is **$00.00**.

DISPENSING:

I wish to dispense medicinal drugs for a fee from my practice location and I understand an annual inspection of my dispensing records will be conducted. The fee for registration as a dispensing practitioner **$100.00** in addition to your renewal fee

Exemptions

I am exempt from demonstrating financial responsibility because:

☐ 1. I practice medicine exclusively as an officer, employee, or agent of the federal government, or of the state or its agencies or its subdivisions.

☐ 2. I hold a limited license issued pursuant to s.459.0075,F.S.,and practice only under the scope of such limited license.

☐ 3. I practice only in conjunction with my teaching duties at an college of osteopathic medicine.(Residents do not qualify for this exemption.)

X 4. I do not practice osteopathic medicine in the State of Florida. I will notify the department immediately before commencing practice in the state.

☐ 5. I am exempt from demonstrating financial responsibility due to meeting all of the following criteria:1)I have held an active license to practice in this state or another state or some combination thereof for more than 15 years. 2)I am retired or maintain part-time practice of no more than 1,000 patient contact hours per year.3)I have had no more than 2 claims resulting in an indemnity exceeding $25,000 within the previous 5 year period. 4)I have not been convicted of, or pled nolo contendere to any criminal violation specified in s.459,F.S.,or the practice act of any other state. 5)I have not been subject, within the last 10 years of practice, to license revocation or suspension for any period of time, probation for a period of 3 years or longer, or a fine of $500 or more for a violation of s. 459,F.S.,or the medical practice act of another jurisdiction. The regulatory agency's acceptance of an osteopathic physician's relinquishment of a license, stipulation, consent order, or other settlement, offered in response to or in anticipation of the filing of administrative charges against the osteopathic physician's license, shall be construed as action against the physician's license for the purposes of this section. I understand that I shall be required either to post notice in the form of a sign prominently displayed in the reception area and clearly noticeable by all patients or to provide a written statement to any person to whom medical services are being provided. Such sign or statement shall state that: Under Florida law, osteopathic physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. However, certain part-time osteopathic physicians who meet state requirements are exempt from the financial responsibility law. YOUR OSTEOPATHIC PHYSICIAN MEETS THESE REQUIREMENTS AND HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This notice is provided pursuant to Florida law.

AFFIRMATION: I affirm that all statements given above are true and correct and recognize that providing false information may result in disciplinary action against my license or criminal penalties pursuant to Sections 456.072,459.013,459.015,775.082,775.083,and 775.084,Florida Statutes.

Signature [signature] Date 3/14/04

Name Dr. Gary B. Broadnax
P.O. Box 2246
Augusta, GA 30903-2246

License #OS 6815

Financial Responsibility Form
Osteopathic Physician

The Financial Responsibility options are divided into two categories, coverage and exemptions. **Choose *ONLY ONE* option that best describes your situation.**

Check only one option.

☐ 1. I do not have hospital staff privileges and I have obtained and maintain professional liability coverage in an amount not less than $100,000 per claim, with a minimum annual aggregate of not less than $300,000,from an authorized insurer as defined under s.624.09 FS, from a surplus lines insurer as defined under s.626.914(2)FS, from a risk retention group as defined under s.627.942 FS, from the Joint Underwriting Association established under s.627.351(4)FS, or through a plan of self-insurance as provided in s.627.357 FS.

☐ 2. I have hospital staff privileges and I have obtained and maintain professional liability coverage in an amount not less than $250,000 per claim, with a minimum annual aggregate of not less than $750,000,from an authorized insurer as defined under s.624.09 FS, from a surplus lines insurer as defined under s.626.914(2)FS, from a risk retention group as defined under s.627.942 FS, from the Joint Underwriting Association established under s.627.351(4)FS, or through a plan of self-insurance as provided in s.627.357 FS, or through a plan of self-insurance which meets the conditions specified for satisfying financial responsibility in s.766.110 FS.

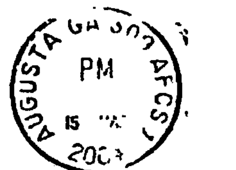
☐ 3. I do not have hospital staff privileges and I have obtained and maintain an unexpired, irrevocable letter of credit, established pursuant to chapter 675 FS, in an amount of not less than $100,000 per claim with a minimum aggregate availability of credit of not less than $300,000.The letter of credit shall be payable to the osteopathic physician as beneficiary upon presentment of a final judgment indicating liability and awarding damages to be paid by the osteopathic physician or upon presentment of a settlement agreement signed by all parties to such agreement when such final judgment or settlement is a result of a claim arising out of the rendering of, or the failure to render, medical care and services. Such letter of credit shall be nonassignable and nontransferable. Such letter of credit shall be issued by any bank or savings association organized and existing under the laws of this state or any bank or savings association organized under the laws of the United States that has its principal place of business in this state or has a branch office which is authorized under the laws of this state or of the United States to receive deposits in this state. OR I do not have hospital staff privileges and I have established and maintain an escrow account consisting of cash or assets eligible for deposit in accordance with s.625.52 FS in the per-claim amounts specified above.

☐ 4. I have hospital staff privileges and I have obtained and maintain an unexpired, irrevocable letter of credit, established pursuant to chapter 675 FS, in an amount not less than $250,000 per claim, with a minimum aggregate availability of credit of not less than $750,000.The letter of credit shall be payable to the osteopathic physician as beneficiary upon presentment of a final judgment indicating liability and awarding damages to be paid by the osteopathic physician or upon presentment of a settlement agreement signed by all parties to such agreement when such final judgment or settlement is a result of a claim arising out of the rendering of, or the failure to render, medical care and services. Such letter of credit shall be nonassignable and nontransferable. Such letter of credit shall be issued by any bank or savings association organized and existing under the laws of this state or any bank or savings association organized under the laws of the United States that has its principal place of business in this state or has a branch office which is authorized under the laws of this state or of the United States to receive deposits in this state OR I have hospital staff privileges and I have established and maintain an escrow account consisting of cash or assets eligible for deposit in accordance with s.625.52 FS in the per-claim amounts specified above.

☐ 5. I have decided not to carry malpractice insurance or otherwise demonstrate financial responsibility; however, I agree to satisfy any adverse judgments pursuant to the terms and conditions contained in s.459.0085(5)(g),FS.I understand that I shall be required to either post notice in the form of a sign prominently displayed in the reception area and clearly noticeable by all patients and provide a written statement to any person to whom medical services are being provided. Such sign and statement shall state that: Under Florida law, osteopathic physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. YOUR OSTEOPATHIC PHYSICIAN HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This is permitted under Florida law subject to certain conditions. Florida law imposes strict penalties against noninsured osteopathic physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida law.

SEE OPPOSITE SIDE FOR EXEMPTIONS

Dr. Gary B. Broadnax
P.O. Box 2246
Augusta, GA 30903-2246



Department of Health
Div. of Med. Qual. ASSUR.
P.O. BOX 6320
Tallahassee, FL 32314-6320

32314+6320

"DELETE DISPENSING"

Received Date : 12/3/01
Deposit Date : 12/12/01
Deposit # : 167445
Batch Number : 900047
Validation # : 30107709
Check Amount : $454.00
PRO_CDE : 1901

Florida Department of Health - Board of Osteopathic Medicine

License Renewal Notice

Active Dispensing Osteopathic Physician License # OS 6815 expires January 31, 2002

To avoid a delinquent charge, the fee of **$554.00** and the renewal form must be postmarked or electronically submitted on or before January 31, 2002. Renewal notices/forms postmarked on or after February 1, 2002 require renewal and delinquency fees of **$754.00**.

1. CHANGE OF MAILING ADDRESS:

DEPARTMENT USE ONLY

Current Mailing Address:

GARY B BROADNAX
~~1409 WATERS EDGE DRIVE~~
~~AUGUSTA, GA 30901~~
Dr. Gary B. Broadnax
P.O. Box 2246
Augusta, GA 30903-2246

New Mailing Address:

Licensee's Last Name / First / Middle Initial: BROADNAX GARY B.
Attn:
Street Address: P.O. BOX 2246
City: AUGUSTA State: GA Zip: 30903
Phone: (706) 737-5886

2. CHANGE OF PRACTICE LOCATION:

Current Practice Location:
1409 WATERS EDGE DRIVE
AUGUSTA, GA 30901

New Practice Location:
Attn: DR. GARY B. BROADNAX
Street Address: 1289 BROAD STREET
City: AUGUSTA State: GA Zip: 30901
Phone: (706) 724-5557

3. Chapter 456, F.S., requires a background check to renew a license, please review the following data to verify that the information is correct, please make any necessary corrections. This information is critical in ensuring that background checks are attributed to the correct licensee.

Description	Department Information	Information is Accurate	Correct Information
Social Security #		(X) Yes ( ) No	
Date of Birth	06/01/45	(X) Yes ( ) No	
Sex	Male	(X) Yes ( ) No	
Race	White	(X) Yes ( ) No	

Race Options: White, Black, Native, Asian, Other, Hispanic & not given

4. COMPLETE THE FINANCIAL RESPONSIBILITY FORM ON THE REVERSE SIDE OF THIS FORM.

5. MILITARY STATUS:

( ) I am requesting Military Restricted Status. (Military Restricted must submit proof of active military duty. Attach a copy of your current active duty orders or a letter from your Commanding Officer.)

( ) Please remove the Military Restricted Status from my license. (Provide copy of DD214 or letter from Commanding Officer.)

6. Will you be available to provide health care services in special needs shelters or to help staff disaster medical assistance teams during times of emergency or major disaster?

( ) Yes I LIVE IN GEORGIA

7. THERE ARE TWO RENEWAL METHODS AVAILABLE:

A. Internet E-Renewal: Web address http://www.doh.state.fl.us/erenewal

E-Renewal allows you to make address changes. E-Renewal does not allow you to renew online by adding or removing a status, such as paying a delinquency fee or changing a license status. Due to high volume, allow sufficient time to renew since **e-Renewal will not be available after midnight Eastern Time (ET) January 31, 2002**. E-Renewal will require the following information:

PIN Number:
License Number: OS 6815

B. U.S. Mail:

Mail this completed renewal form and fee payable to the Department of Health to:
P.O. Box 6320
Tallahassee, Florida 32314-6320

8. Other Information:

File Number: 5554 20 20 Sequence Number: 11

FINANCIAL RESPONSIBILITY

The Financial Responsibility options are divided into two categories, coverage and exemptions. Choose only ONE option of the ten provided pursuant to s.459.0085, Florida Statutes.

CATEGORY I - CATEGORIES OF FINANCIAL RESPONSIBILITY COVERAGE:

○ 1. I do not have hospital staff privileges and I have established an irrevocable letter of credit or an escrow account in an amount of $100,000/$300,000, in accordance with Chapter 675, F. S., for a letter of credit and s. 625.52, F. S., for an escrow account.

○ 2. I have hospital staff privileges and I have established an irrevocable letter of credit or escrow account in an amount of $250,000/$750,000, in accordance with Chapter 675, F. S., for a letter of credit and s. 625.52, F. S., for an escrow account.

○ 3. I do not have hospital staff privileges and I have obtained and maintain professional liability coverage in an amount not less than $100,000 per claim, with a minimum annual aggregate of not less than $300,000 from an authorized insurer as defined under s. 624.09, F. S., from a surplus lines insurer as defined under s. 626.914(2), F.S., from a risk retention group as defined under s. 627.942, F.S., from the Joint Underwriting Association established under s. 627.351(4), F. S., or through a plan of self-insurance as provided in s. 627.367, F.S. I further certify that I have been continuously insured with an entity as outlined above for the past two years (retroactive coverage) or if I seek insurance from a different entity providing insurance; I will purchase retroactive coverage for the two years proceeding my inception date of coverage. I further certify that in the event my coverage is terminated or that I desire to become uninsured and meet the financial responsibility requirements through other provisions in s. 458.320 or 459.0085, F.S., I will maintain coverage for incidents which may have occurred during the two years preceding my becoming uninsured.

○ 4. I have hospital staff privileges and I have professional liability coverage in an amount not less than $250,000 per claim, with a minimum annual aggregate of not less than $750,000 from an authorized insurer as defined under s. 624.09, F. S., from a surplus lines insurer as defined under s. 626.914(2), F. S., from a risk retention group as defined under s. 627.942, F.S., from the Joint Underwriting Association established under s. 627.351(4), F. S., or through a plan of self insurance as provided in s. 627.367, F .S. I further certify that I have been continuously insured with an entity as outlined above for the past two years (retroactive coverage) or if I seek insurance from a different entity providing insurance I will purchase retroactive coverage for the two years preceding my inception date of coverage. I further certify that in the event my coverage is cancelled or that I desire to become uninsured and meet the financial responsibility requirements through other provisions in s. 458.320 or 459.0085, F.S., I will maintain coverage for incidents which may have occurred during the two years preceding my becoming uninsured.

○ 5. I have elected not to carry medical malpractice insurance, however, I agree to satisfy any adverse judgements up to the minimum amounts pursuant to s. 458.320(5)(g)1 or 459.008S(5)(g)1, F. S. I understand that I must either post notice in the form of a "sign" prominently displayed in the reception area or provide a written statement to any person to whom medical services are being provided that I have decided not to carry medical malpractice insurance. I understand that such a sign or notice must contain the wording specified in s. 458.320(5)(g) or 459.008S(5)(g), F. S.

CATEGORY II - EXEMPTION CATEGORIES OF FINANCIAL RESPONSIBILITY COVERAGE:

○ 6. I practice medicine exclusively as an officer, employee, or agent of the federal government, or of the state or its agencies or subdivisions;

○ 7. I hold a limited license issued pursuant to s. 458.317 or 459.0075, F. S., and practice only under the scope of the limited license;

☒ 8. I do not practice medicine in the State of Florida;

○ 9. I meet all of the following criteria:

(a) I have held an active license to practice in this state or another state or some combination thereof for more than 15 years;

(b) I am retired or maintain part time practice of no more than 1000 patient contact hours per year;

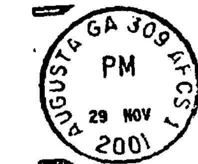
(c) I have had no more than two claims resulting in an indemnity exceeding $10,000 within the previous five year period;

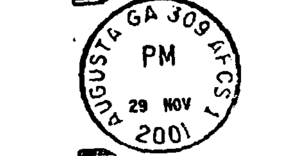
(d) I have not been convicted of or pled guilty or nolo contendere to any criminal violation specified in Chapter 458 or 459, F. S.; and

(e) I have not been subject, within the past ten years of practice, to license revocation or suspension, probation for a period of three years or longer, or a fine of $500 or more for a violation of Chapter 458 or 459, F.S., or the medical practice act of another jurisdiction. A regulatory agency's acceptance of a relinquishment of license stipulation, consent order or other settlement offered in response to or in anticipation of filing of administrative charges against a license shall be construed as action against a license. I understand if I am claiming an exception under this section that I must either post notice in the form of a sign, prominently displayed in the reception area or provide a written statement to any person to whom medical services are being provided, that I have decided not to carry medical malpractice insurance. I understand such a sign or notice must contain the wording specified in s. 458.320(5)(t) or 459.0085(5)(t), F. S.; or

○ 10. I practice only in conjunction with my teaching duties at an accredited medical school or its teaching hospitals. (Interns and residents do not qualify for this exemption).

Dr. Gary B. Broadnax
P.O. Box 2246
Augusta, GA 30903-2246





LICENSURE SERVICES
DIVISION OF MEDICAL QUALITY ASSURANCE
DEPARTMENT OF HEALTH
P.O. BOX 6320
TALLAHASSEE, FLORIDA 32314-6320

32314+6320

STATE OF FLORIDA
DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE

RETIRED

NOT AUTHORIZED TO PRACTICE

THIS IS A RETIRED LICENSE AND **MAY NOT** BE USED FOR PURPOSES OF PRACTICING IN THE STATE OF FLORIDA.

COPY COPY COPY

GARY B BROADNAX
PO BOX 2246
AUGUSTA, GA 30903

RECEIPT PRINTED:
01/16/2008

COPY COPY COPY

(7/98) RETAIN THIS COPY FOR YOUR RECORDS

LICENSE NO. **OS 6815**

CONTROL NO. **22882**

STATE OF FLORIDA
DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE
RETIRED
GARY B BROADNAX
PO BOX 2246
AUGUSTA, GA 30903

LICENSEE SIGNATURE

YOUR LICENSE NUMBER IS **OS 6815**, PLEASE USE IT IN ALL CORRESPONDENCE WITH YOUR BOARD/COUNCIL. EACH LICENSEE IS SOLELY RESPONSIBLE FOR NOTIFYING THE DEPARTMENT IN WRITING OF THE LICENSEE'S CURRENT MAILING ADDRESS. USE THIS SECTION TO REPORT NAME, AND/OR MAILING ADDRESS CHANGES.

TO CHANGE YOUR LICENSE TO ACTIVE STATUS, PLEASE CONTACT THE DIVISION OF MEDICAL QUALITY ASSURANCE AT (850) 488-0595 FOR FURTHER INFORMATION.

TO REQUEST A DUPLICATE RETIRED LICENSE, SUBMIT THIS FORM AND A CHECK, PAYABLE TO THE DEPARTMENT OF HEALTH, IN THE AMOUNT OF $25.00.

☐ REQUEST DUPLICATE RETIRED LICENSE

____
SIGNATURE REQUIRED

DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE
LICENSING AND AUDITING SERVICES UNIT
P.O.BOX 6320
TALLAHASSEE, FLORIDA 32314-6320

☐ NAME CHANGE (ATTACH LEGAL DOCUMENTATION)

FROM: ________________________
LAST FIRST MIDDLE

TO: ________________________
LAST FIRST MIDDLE

☐ MAILING ADDRESS CHANGE

____

____

____
CITY STATE ZIP

DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE
LICENSING AND AUDITING SERVICES UNIT
4052 BALD CYPRESS WAY, BIN #C-10
TALLAHASSEE, FLORIDA 32399-3260

GARY B BROADNAX
PO BOX 2246
AUGUSTA, GA 30903

Florida Department of Health - Board of Osteopathic Medicine
LICENSE RENEWAL NOTICE
Inactive Osteopathic Physician License # OS 6815 expires March 31, 2006.

Received Date : 3/22/2006
Deposit Date : 3/22/2006
Deposit # : 167548
Batch Number : 001022449
Validation # : 905241943
Check Amount : $230.00
PRO CODE : 1901

The fee of **$230.00** and the renewal notice must be postmarked on or before March 31, 2006. Renewal notices postmarked on or after April 01, 2006 require renewal and delinquent fees of **$630.00**.

1. CURRENT MAILING ADDRESS:
This address will be used for all correspondence from the Department of Health.

GARY B BROADNAX
PO BOX 2246
AUGUSTA, GA 30903
(706) 791-6395

2. CURRENT PRACTICE LOCATION:
This address will be printed on your license and posted on the Internet.

1289 BROAD ST
AUGUSTA, GA 30901
(706) 724-6633

3. RENEW ON LINE TODAY!

Go to www.doh-mqaservices.com to renew your license, change your address, and confirm information maintained by the Department. Listed below is your Account ID and password for online services. If you renew online, you will receive a temporary license upon successful completion of your renewal. Online renewals are processed immediately and your license status is updated online within seven business days.

Avoiding complaints can protect your clients and your ability to practice. Go to www.doh.state.fl.us/mqa/avoid.html to find out more.

4. CHANGES TO CURRENT LICENSE INFORMATION:

If you have any changes to the name, mailing address, practice location address, license status or military status information associated with your license, please provide the updated information in the appropriate fields of section 7 on the back of this form.

5. THERE ARE TWO RENEWAL METHODS AVAILABLE:

A. Online Renewal: Visit www.doh-mqaservices.com go to the Practitioner Logon box, select your profession and enter your Account ID and password. If you are requesting a status change, you will be ineligible to renew your license online. The system will be available for renewals until midnight, Eastern Standard Time (EST), March 31, 2006. To use the online system, you will need the following information:

Account ID
Password
(Note: Account ID and Password must be entered exactly as they appear.)

The online system will allow practitioners to update their address, profile, and to confirm licensee information maintained by the Department. Practitioners will receive confirmation of their successful renewal before logging out of the system.

B. **U.S. Mail:** Mail completed form and fee payable to the Department of Health to the following address:
Department of Health, Division of Medical Quality Assurance, PO Box 6320, Tallahassee, FL 32314-6320

6. OTHER INFORMATION:

By submitting the appropriate renewal fees to the Department, a licensee certifies compliance with all requirements for renewal, including continuing education credits.

File Number: 5554 Sequence Number: 97
Profession Code: 1901 40 20

Please make changes to your license information in section 7 on the BACK of this form.

7. CHANGES TO CURRENT LICENSE INFORMATION:

◯ **CHANGE OF NAME:**

Name changes require legal documentation showing the name change. Please make sure that a photocopy of one of the following accompanies this form: a marriage license (marriage license must indicate the original signature and seal from the clerk of the court), a divorce decree indicating restoration of your maiden name, or a court order (e.g., adoption, name change, or federal identity change). Any one of these will be accepted unless the department has a question about the authenticity of the document. A driver's license or social security card is not considered legal documentation.

If the name change cannot be completed, your license will be renewed using the current name.

Last Name:

First Name:

Middle Name: Title: Suffix: *(Jr,Sr,I,II,etc.)* Qualifier: *(PhD,DDS,etc.)*

◯ **CHANGE OF MAILING ADDRESS:**

Attention:

Addr1:

Addr2:

City:

State: Zip: - Phone: ( ) -

◯ **CHANGE OF PRACTICE LOCATION: (This address can not be a Post Office Box)**

Attention:

Addr1:

Addr2:

City:

State: Zip: - Phone: ( ) -

CHECKLIST FOR MAILING RENEWAL FORM

If mailing your renewal form, use the checklist below as a guide for enclosing all the required items to ensure a smooth renewal. If renewing by mail, allow 2-4 weeks processing time.

<u>REQUIRED:</u>
- ◯ Renewal notice
- ◯ Check or Money order written to Department of Health
- ◯ Financial Responsibility form (check only one item on the FR form)
- ◯ Mail to: PO Box 6320, Tallahassee, Florida 32314-6320

If you are renewing to active status, would you be available to provide health care services in special needs shelters or to help staff disaster medical assistance teams during times of emergency or major disaster?

◯ Yes

CHANGE OF LICENSE STATUS:

◯ I request reactivation from inactive to active. The fee of **$630.00** and renewal notice must be postmarked on or before <u>March 31, 2006</u>. Renewal notices postmarked on or after <u>April 01, 2006</u> will require renewal and delinquent fees of **$1,130.00**. (Note: Additional requirements may be applicable. Visit our web site at <u>**http://www.doh.state.fl.us**</u> , click on <u>Health Care Professions</u>, click on <u>Current License Holders</u>, then click on <u>Renewal Information</u> and select your profession to get information and contacts.)

CHANGE OF MILITARY STATUS:

◯ I am requesting Military Restricted Status. (You must submit proof of active military duty. Attach a copy of your current active duty orders or a letter from your Commanding Officer.) The fee for military restricted is **$00.00**.

CHANGE OF RETIRED STATUS:

◯ I am requesting retired status. The fee for retired status is **$55.00** postmarked on or before <u>March 31, 2006</u>. The fee for retired status on or after <u>April 01, 2006</u> is **$555.00**.

DISPENSING:

◯ I wish to dispense medicinal drugs for a fee from my practice location and I understand an annual inspection of my dispensing records will be conducted. The fee for registration as a dispensing practitioner **$100.00** in addition to your renewal fee.

Dr. Gary B. Broadnax
P.O. Box 2246
Name Augusta, GA 30903-2246

License 056815

Financial Responsibility Form
Osteopathic Physician

The Financial Responsibility options are divided into two categories, coverage and exemptions. **Choose *ONLY ONE* option that best describes your situation.**

Check only one option.

☐ 1. I do not have hospital staff privileges and I have obtained and maintain professional liability coverage in an amount not less than $100,000 per claim, with a minimum annual aggregate of not less than $300,000, from an authorized insurer as defined under s.624.09 FS, from a surplus lines insurer as defined under s.626.914(2)FS, from a risk retention group as defined under s.627.942 FS, from the Joint Underwriting Association established under s.627.351(4)FS, or through a plan of self-insurance as provided in s.627.357 FS.

☐ 2. I have hospital staff privileges and I have obtained and maintain professional liability coverage in an amount not less than $250,000 per claim, with a minimum annual aggregate of not less than $750,000, from an authorized insurer as defined under s.624.09 FS, from a surplus lines insurer as defined under s.626.914(2)FS, from a risk retention group as defined under s.627.942 FS, from the Joint Underwriting Association established under s.627.351(4)FS, or through a plan of self-insurance as provided in s.627.357 FS, or through a plan of self-insurance which meets the conditions specified for satisfying financial responsibility in s.766.110 FS.

☐ 3. I do not have hospital staff privileges and I have obtained and maintain an unexpired, irrevocable letter of credit, established pursuant to chapter 675 FS, in an amount of not less than $100,000 per claim with a minimum aggregate availability of credit of not less than $300,000. The letter of credit shall be payable to the osteopathic physician as beneficiary upon presentment of a final judgment indicating liability and awarding damages to be paid by the osteopathic physician or upon presentment of a settlement agreement signed by all parties to such agreement when such final judgment or settlement is a result of a claim arising out of the rendering of, or the failure to render, medical care and services. Such letter of credit shall be nonassignable and nontransferable. Such letter of credit shall be issued by any bank or savings association organized and existing under the laws of this state or any bank or savings association organized under the laws of the United States that has its principal place of business in this state or has a branch office which is authorized under the laws of this state or of the United States to receive deposits in this state. **OR** I do not have hospital staff privileges and I have established and maintain an escrow account consisting of cash or assets eligible for deposit in accordance with s.625.52 FS in the per-claim amounts specified above.

☐ 4. I have hospital staff privileges and I have obtained and maintain an unexpired, irrevocable letter of credit, established pursuant to chapter 675 FS, in an amount not less than $250,000 per claim, with a minimum aggregate availability of credit of not less than $750,000. The letter of credit shall be payable to the osteopathic physician as beneficiary upon presentment of a final judgment indicating liability and awarding damages to be paid by the osteopathic physician or upon presentment of a settlement agreement signed by all parties to such agreement when such final judgment or settlement is a result of a claim arising out of the rendering of, or the failure to render, medical care and services. Such letter of credit shall be nonassignable and nontransferable. Such letter of credit shall be issued by any bank or savings association organized and existing under the laws of this state or any bank or savings association organized under the laws of the United States that has its principal place of business in this state or has a branch office which is authorized under the laws of this state or of the United States to receive deposits in this state **OR** I have hospital staff privileges and I have established and maintain an escrow account consisting of cash or assets eligible for deposit in accordance with s.625.52 FS in the per-claim amounts specified above.

☐ 5. I have decided not to carry malpractice insurance or otherwise demonstrate financial responsibility; however, I agree to satisfy any adverse judgments pursuant to the terms and conditions contained in s.459.0085(5)(g),FS. I understand that I shall be required to either post notice in the form of a sign prominently displayed in the reception area and clearly noticeable by all patients and provide a written statement to any person to whom medical services are being provided. Such sign and statement shall state that: Under Florida law, osteopathic physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. YOUR OSTEOPATHIC PHYSICIAN HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This is permitted under Florida law subject to certain conditions. Florida law imposes strict penalties against noninsured osteopathic physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida law.

SEE OPPOSITE SIDE FOR EXEMPTIONS

Exemptions

I am exempt from demonstrating financial responsibility because:

☐ 1. I practice medicine exclusively as an officer, employee, or agent of the federal government, or of the state or its agencies or its subdivisions.

☐ 2. I hold a limited license issued pursuant to s.459.0075,F.S.,and practice only under the scope of such limited license.

☐ 3. I practice only in conjunction with my teaching duties at an college of osteopathic medicine.(Residents do not qualify for this exemption.)

X 4. I do not practice osteopathic medicine in the State of Florida. I will notify the department immediately before commencing practice in the state.

☐ 5. I am exempt from demonstrating financial responsibility due to meeting all of the following criteria: 1)I have held an active license to practice in this state or another state or some combination thereof for more than 15 years. 2)I am retired or maintain part-time practice of no more than 1,000 patient contact hours per year.3)I have had no more than 2 claims resulting in an indemnity exceeding $25,000 within the previous 5 year period. 4)I have not been convicted of, or pled nolo contendere to any criminal violation specified in s.459,F.S.,or the practice act of any other state. 5)I have not been subject, within the last 10 years of practice, to license revocation or suspension for any period of time, probation for a period of 3 years or longer, or a fine of $500 or more for a violation of s. 459,F.S.,or the medical practice act of another jurisdiction. The regulatory agency's acceptance of an osteopathic physician's relinquishment of a license, stipulation, consent order, or other settlement, offered in response to or in anticipation of the filing of administrative charges against the osteopathic physician's license, shall be construed as action against the physician's license for the purposes of this section. I understand that I shall be required either to post notice in the form of a sign prominently displayed in the reception area and clearly noticeable by all patients or to provide a written statement to any person to whom medical services are being provided. Such sign or statement shall state that: Under Florida law, osteopathic physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. However, certain part-time osteopathic physicians who meet state requirements are exempt from the financial responsibility law. YOUR OSTEOPATHIC PHYSICIAN MEETS THESE REQUIREMENTS AND HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This notice is provided pursuant to Florida law.

AFFIRMATION: I affirm that all statements given above are true and correct and recognize that providing false information may result in disciplinary action against my license or criminal penalties pursuant to Sections 456.072,459.013,459.015,775.082,775.083,and 775.084,Florida Statutes.

[signature] Signature 3/19/06 Date

Dr. Gary B. Broadnax
P.O. Box 2246
Augusta, GA 30903-2246

Dept. of Health
Div. [illegible] A.
P.O. Box 6320
Tallahassee, FL. 32314-6320

32314+6320 B033

AMA PHYSICIAN PROFILE

AMERICAN MEDICAL ASSOCIATION MAY 27 1994
515 NORTH STATE STREET
CHICAGO, ILLINOIS 60610

DIVISION OF SUR[illegible] AND DATA RESOURCES DATE: 05-23-94
DEPARTMENT OF [illegible]ICIAN DATA SERVICES TIME: 8:33 AM

NAME: BROADWAX,GARY B, D.O.
ADDRESS: 1409 WATERS EDGE
AUGUSTA GA 30901
BIRTHPLACE: AIKEN,SC
BIRTHDATE: 06/01/45
MEMBER OF AMA: NOT MEMBER
MEDICAL SCHOOL: 016-76
MIDWESTERN UNIV-CHICAGO COLL OF OSTEO MED, CHICAGO IL 60615
YEAR OF GRADUATION: 1973
LICENSES (INITIAL YEAR GRANTED BY STATE):
GA 1974
NATIONAL BOARD CERTIFICATION: NONE REPORTED TO DATE
SPECIALTY BOARD CERTIFICATION: AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

PHYSICIAN'S PROFESSIONAL ACTIVITIES: FULL-TIME HOSPITAL STAFF
SELF DESIGNATED SPECIALTIES
PRIMARY: OBSTETRICS AND GYNECOLOGY
SECONDARY: GYNECOLOGY
TERTIARY: UNSPECIFIED

CURRENT MEDICAL TRAINING: NONE REPORTED TO DATE
PRIOR MEDICAL TRAINING: RESIDENT
HOSPITAL: WALTER REED ARMY MED CTR WASHINGTON DC 20307
DATES OF TRAINING: 07/74-06/77 -- (CONFIRMED)
SPECIALTY: OBSTETRICS AND GYNECOLOGY
SPECIALTY: UNSPECIFIED

PRIOR MEDICAL TRAINING: INTERN
HOSPITAL: WALTER REED ARMY MED CTR WASHINGTON DC 20307
DATES OF TRAINING: 07/73-06/74 -- (CONFIRMED)
SPECIALTY: OBSTETRICS AND GYNECOLOGY
SPECIALTY: UNSPECIFIED

FELLOWSHIP: NONE REPORTED TO DATE

THE FOLLOWING IS HISTORICAL. CHECK WITH PRIMARY SOURCES FOR CURRENT STATUS:

NATIONAL SCIENTIFIC MEDICAL SOCIETIES:
AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

PROFESSORIAL APPOINTMENT:

MED COLL OF GA SCH OF MED, AUGUSTA GA 30912
SPECIALTY: OBSTETRICS AND GYNECOLOGY

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American Osteopathic Association
142 E. ONTARIO STREET • CHICAGO, ILLINOIS 60611
1-800-621-1773 or (312) 280-5800

PROFILE SERVICE

PHYSICIAN & ADDRESS:

32062-6
Col Gary B Brundnax
1407 Waters Edge
Augusta GA 30901-1045

REQUESTING INSTITUTION:

Florida Bd of Osteo Medicine
Dept Professional Regulation
1940 N Monroe St
Tallahassee, FL 32399 0757

DATE OF BIRTH:

June 1, 1945

06/18/96

MEDICAL EDUCATION:
Chicago Coll of Osteo Med, Chicago, IL - Graduated: 1973

POSTDOCTORAL TRAINING:

Walter Reed Army Medical Ctr	Washington, DC	07/01/73-06/30/74 INTERNSHIP	
Walter Reed Army Medical Ctr	Washington, DC	07/01/74-06/30/77 RESIDENCY	-- Obstetrics & Gynecology

MAJOR PROFESSIONAL ACTIVITY:
Office Based Patient Care

MAJOR PRACTICE FOCUS:
Obstetrics & Gynecology Surg

MINOR PRACTICE FOCUS:

Unknown

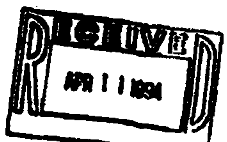
STATE LICENSURE REPORTED:
Licensure information is not available at this time.

AOA MEMBERSHIP STATUS:
Non Member

DIVISIONAL SOCIETY MEMBERSHIP:
Georgia Osteopathic Med Assn, Atlanta, GA

PRACTICE GROUP FELLOWSHIP:

AOA BOARD CERTIFICATION:



FEDERATION OF STATE MEDICAL BOARDS OF THE UNITED STATES, INC.
6000 Western Place, Suite 707, Fort Worth, Texas 76107-4618
Telephone: (817) 735-8445 FAX: (817) 738-6629

RECEIVED APR 25 1994

BOARD ACTION DATA BANK INQUIRY FORM

The FLORIDA BOARD OF OSTEOPATHIC MEDICINE

requests a Board Action Search concerning the following individual:

BROADNAX GARY BURKS D.O.

Practitioner's Name: (LAST, First, Middle) (Degree)

JUNE 1, 1945

Date of Birth: (mm / dd / yy) Social Security #

CHICAGO COLLEGE OF OSTEOPATHIC MEDICINE, CHICAGO, ILLINOIS

Medical School: (Include Complete Name and Branch Location)

1973 USA

Year of Graduation (Country of Medical School)

ECFMG Number: (If foreign medical graduate)

FROM: Please mail the result to the following address:

Department of Professional Regulation
Board of Osteopathic Medicine
1940 North Monroe Street
Tallahassee, FL 32399-0757

APR 15 1994

(Practitioner's Signature)