License Verification

Data As Of 2/28/2012

GARY B BROADNAX

LICENSE NUMBER: 056815

Profession

OSTEOPATHIC PHYSICIAN

License/Activity Status

Retired/

License Expiration Date

3/31/2008

Discipline on File

NO

License Original Issue Date

06/13/1994

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.



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

Deposit Date: 02-02-1999

Deposit #: 167072

Batch Number 000 (0) 98900 4796

Check Amount: \$ 160,000

Deposit Date: 02-02-1999
Deposit #: 167072
Batch Number
Validation #: 98900 4 796
Check Amount: \$ / 0.000

Deposit Date: 02-02-1999
Deposit #: 167072
Batch Number 000 (0)

Validation #: 989004776
Check Amount: \$100.

December 10, 1998

Department of Health Board of Medicine 2020 Capitol Circle SE BIN #G03 Tallahassee, FL 32399-3253

Dear Board of Medicine:

The following physicians would like their licenses revised to accommodate 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, OSO006815

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

duplicate

Practitioner's Name GAR	A R	RHOADNAX
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License #	OS0006815
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EXHIBIT 1 - REPORT ON PROFESSIONAL LIABILITY CLAIMS AND ACTIONS

requirements of s. 455.697, F.S., (formerly s. 355.247, F.S.) may be submodate of occurrence:// Date reported to license.		thic reporting requi	viously submitt	
rate in talkitieties / / { 1200 reported to licent		ting tehorong tequ	AI CITICIL.	
njured person's name: (last, first, middle initial)				
Street Address:	State:	Zin Cod	<u></u>	
\ge: Sex:	Juic		в	
Date of suit: / /				
ist other defendants involved in this claim:				
3.	4			
Date of final claim disposition://				
Was there an itemized verdict? \square Yes \square No \square (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.				0
	Radiology Emergency Room		ibor & Delivery pecial Proceduri	
Operating Suite Nursery Recovery Room Critical Care Unit	Other		Josiai i Toocaii	
Final diagnosis for which treatment was sought or rendered.				
Describe the operation, diagnostic or treatment procedure causing the in	njury. Use nomenclature and/or desc stration.	riptions of the proc	edures used. In	clude method
Describe the principal injury giving rise to the claim. Use nomenclature	e and/or descriptions of the injury.			
of anesthesia, or name of drug used for treatment, with detail of adminis Describe the principal injury giving rise to the claim. Use nomenclature applicable. Safety management steps taken by the licensee to make similar occurrence.	e and/or descriptions of the injury.	include type of adve	erse effect from	drugs where
Describe the principal injury giving rise to the claim. Use nomenclature applicable.	e and/or descriptions of the injury. Inces less likely. Eviding false information may result in	nclude type of adve	erse effect from	drugs where
Describe the principal injury giving rise to the claim. Use nomenclature applicable. Safety management steps taken by the licensee to make similar occurred affirm that these statements are true and correct and recognize that propenalties pursuant to Sections 455.624, 458.327, 458.331, 459.013, 459.	e and/or descriptions of the injury. Inces less likely. Eviding false information may result in 1015, 460.413, 461.013, 775.062, 775	disciplinary action 5.083, and 775.084,	against my licer	n drugs where
Describe the principal injury giving rise to the claim. Use nomenclature applicable. Safety management steps taken by the licensee to make similar occurrent affirm that these statements are true and correct and recognize that propenalties pursuant to Sections 455.624, 458.327, 458.331, 459.013, 459	e and/or descriptions of the injury. Inces less likely. Incident settlement incident	nclude type of adve	erse effect from	drugs where
Describe the principal injury giving rise to the claim. Use nomenclature applicable. Safety management steps taken by the licensee to make similar occurred affirm that these statements are true and correct and recognize that propenalties pursuant to Sections 455.624, 458.327, 458.331, 459.013, 459.	e and/or descriptions of the injury. Inces less likely. Incident settlement incident	disciplinary action 5.083, and 775.084,	against my licer Florida Statutes	a drugs where
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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.

RECEIPT PRINTED: 03/18/2004

RECEIPT EXPIRES AUGUSTA, GA Y COPY (7/98) RETAIN THIS COPY FOR YOUR RECORDS 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. EACH 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 DECRÉE 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 MAILING ADDRESS CHANGE NAME CHANGE (ATTACH LEGAL DOCUMENTATION) FROM: MIDDLE LAST FIRST TO: FIRST MIDDLE LAST ZIP CITY STATE

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

GARY B BROADNAX PO BOX 2246 AUGUSTA, GA 30903

CHRECOLUM VITAL

Cary Burks Stoadner, D.C., FACOG Colonel, Medical Corps U.S. Army

CHARLE POSTRICE

Chief, Department of Obstetrios and Gynecology

Commultant to The Army Surgeon General in Chatatrics and Symmoology

PROPERTY APPOINTMENT

Associate Clinical Professor Medical College of Georgia

ADDRESS

25

Department of Obststrine and Symeoelogy Risembours Army Medical Center Port Sorden, St. 30905-8450 (404) 791-6398/4165

HOME ADDRESS

1409 Waters Hige Augusta, Georgia 30901

DATE OF BIRTH

1 June 1945 Aiken, South Carolina

Married, Lori Daughter, Matalie

THE PROPERTY AND PROPERTY OF

Manich American High School Munich, Germany 1988 - 1962

Marger University Macon, Georgia Machelor of Arts 1962 - 1966

PROPERTONAL RISICATION

Chicago College of Osteopathic Medicine Chicago, Illinois Doctor of Osteopathy 1909 - 1973

Obstetrios and Gymesology Internship Halter Reed Army Medical Center Washington, D.C. 1973 - 1974

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

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

PROPERTORAL EXPERIENCE

Staff Mysician Department of Obstetrics and Gynecology Eisenhouer Army Medical Center July 1977

Clinical Instructor Medical College of Georgia June 1978

Chief, Department of Obstatrics and Gynsoology Riseshower Army Hedical 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 1988 - 1991

Associate Clinical Professor Medical College of Georgia July 1990

-2-

* ****

Regional Consultant:

Martin Army Community Hospital Fort Benning, GA

Blanchfield Army Community Hospital Fort Campbell, KY

Monorief Army Community Rospital Fort Jackson, SC

Noble Army Community Hospital Fort McClellan, AL

Bayne-Jones Army Community Hospital Fort Polk, IA

Lyster Army Community Hospital Fort Bunder, AL

Tuttle Army Community Hospital Port Stewart, GA

CONTITUES:

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

Eisenhower Quality Assurance Committee

Eisenhower Therapeutic Agents Board

Risenhover Medical Education Coumittee

Eisenhower Credentials Committee

Risenhower Composite Health Cure System Executive Committee

Nember, Executive Committee - Department of CR/GYM, Nedical College of Georgia

Number, Medical Advisory Counittee, Planned Parenthood of Rest Central Georgia

Number, Resident Selection Committee, Department of CS/GYM, Medical College of Georgia

PROPERTONAL MEMBERGHIP

Diplomate, American Board of Chatetries and Gynecology

Fellow, American College of Obstetricians and Gynecologists

Georgia Obstetrical and Gynesological Society

Augusta Obstetrical and Gynecological Society President, 1984 - 1985

The American College of Physician Executives

HOMODA/AWARDS

75

Program Chairman - 1984 Armed Forces District Meeting of the American College of Obstetricians and Gynecologists 135

1340

and the same

President - Augusta Obstetrical and Gynecological Society, 1984 - 1985

Margaret Sanger Award, Planned Parenthood Pederation of America, 1989

HILLIAMY

Bronse Star with Oak Leaf Cluster Purple Heart Air Hedal Army Commendation Hedal with Oak Leaf Cluster Army Achievement Hedal Order of Hilitary Hedical Herit Vistnamese Gallantry Cross Vistnam Service Hedal National Defense Hedal Combat Hedical Bedge Airborne Bedge Army Flight Surgeon Wings

PRESENTATIONS

Remination Hysterectony. Armed Forces District, American College of Obstatricians and Gymecologists, Las Vegas, Nevada, 1976

PRESENTATIONS (continued)

The Effect of Descripting in Reducing Post-Operative Morbidity in Vaginal Rystacontomy. Armed Forces District, American College of Obstatricians and Gynecologists, New Orleans, Louisiana, 1977

A Commerison of Prophylactic Antibiotic Regisses in Vacinal Rysteractory. Armed Porces District, American College of Chatetricians and Gynecologists, San Antonio, Texas, 1979

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Group B Strautopocous in Chatetries. Araud Porces District, American College of Chatetricians and Gynecologists, Orlando, Florida, 1980

Names of Palvic Abscess. Armed Forces District, American College of Obstatricians and Gynecologists, Orlando, Florida, 1980

<u>Torrio-Chock Syndrome.</u> Physician Assistant Annual Hesting, Fayetteville, Horth Carolina, 1981

OR/OWN Beargengies. Physician Assistant Annual Meeting, Payetteville, North Carolina, 1981

<u>Genital Harpes.</u> Tennessee Osteopathic Hedical Association, Chattanooga, Tennessee, 1982

Palvio Inflammatory Disease. Georgia Osteopathic Medical Association, Callavay Gardens, Georgia, 1983

Abnormal Genital Bleeding. Physicis: Jesistant Annual Meeting, Fayetteville, North C rolina, 1985

Securally Transmitted Diseases. Physician Assistant Hesting, Payetteville, North Carolina,

<u>STD'S - Focus on Herpes.</u> Haine Osteopathic Medical Association, Dixsville Hotoh, Heav Hampehire, 1985

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

-5-

PRESENTATIONS (continued)

1)

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

Antiviral Agents in STD'S. Rissouri Society of the American College of General Practice, Eansas City, Rissouri, 1986 (

STD Undata. Nedical College of Georgia Post Graduate Course, Riswah Island, Georgia, 1987

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

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

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

Benism Breest Conditions. Hedical College of Georgia Post Graduate Course, Riswah Island, South Carelina, 1989

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

Recent Transa in STD's. Obstetrics and Gynecology Continuing Hadical Education Program, Uniformed Services University of Health Sciences, Garnisch, West Germany, 1990

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

<u>Semally Transmitted Diseases.</u> Obstatrics and Gynecology Continuing Medical Education Program, Uniformed Services University of Health Sciences, Willingen, Germany, 1992

PRESENTATIONS (continued)

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

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Barly Diagramic of Breast Disease. Obstetrics and Gynecology Continuing Medical Education Program, Uniformed Services University of Bealth Sciences, Millingen, Germany, 1992

Continuoustion in the 20's. Obstetrics and Gynecology Continuing Medical Education Program, Uniformed Services University of Health Sciences, Willingson, Germany, 1993

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

Integrated of Resign Breast Conditions. Obstetrics and Proposity Continuing Medical Education Program, Uniformed Services University of Realth Sciences, Willingen, Germany, 1993

Controversies in Estroyen Benlacement Therapy. Obstatrics and Synacology Continuing Medical Education Program, Uniformed Services University of Realth Sciences, Willingen, Germany, 1993

SCIENTIFIC EMPLOYEE

Vaginal Pysteragtomy-Operative Technique. Armed Porces District, American College of Obstetricians and Gymecologists, Orlando, Florida, 1980

Will off the first



FLORIDA DEPARTMENT OF BUSINESS AND PROFESSIONAL REGULATION

Nay 24, 1994

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

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

Prom: Melissa Coggins

A 1

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- 1 - 5

100 TO 1800

, S.C.

110 11 10

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

1.	5 }	All Applicable fees,
2.	()	Photograph, head and shoulders, on NON-Polaroid paper.
3.	()	Verification of education from your established and less
4.	ĊÌ	Proof of completion of intermehip - see training evaluation form.
5.,	<i>)</i> ;	Mational Board grades mailed directly to us from the Mational Board
7	` '	western would have writer directly to me tion the Mational Board
		or State Board grades mailed directly from state of examination.
\/P•		Motarised copy of current military orders or discharge papers (form
•	-1	PD214) Please submit a notarised copy of your ourrent orders
		or your personnel paper (already submitted, un-notarised, with your
		The property of the party of th
		request for an exemption to the MICA essessment.
/i:		Notarised copy of legal name change document.
	(MA)	Verification of licensure from the state(s) of: GA
		B labbana at mamanatables to the same

() Pro

Verification of licensure from the state(s) of: GA

2 letters of recommendation from physiciams (MD or DO). These
letters must be on letterhead paper and addressed TO THE BOARD OF
OSTROPATHIC HEDICINE.

Proof of 3 hours HIV/AIDS CHE credits.

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:

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

DIVISION OF MEDICAL QUALITY ASSURANCE BOARD OF OSTEOPICHE MEDICERS * 1940 NORTH MONEDS STREET * TALLAMASSES, PLOSEDA 22709-0557 Thiphan 600 022-025

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 <u>January 31, 2002</u>. Renewal notices/forms postmarked on or after February 1, 2002 require renewal and delinquency fees of \$754.00.

1. CHANGE OF MA Current Mailing	**************************************	New Mailing A	ddress:		DEPARTMENT USE ONLY
GARY	B BROADNAX	Licensee's Last Name	First	Middle Initial	
1409 V	WATERS EDGE DRIVE	***************************************			
AUGU	STA, GA 30901	Attn:			
		Street Address:			
		City:	State:	Zip:	
		Phone: ()			
2, CHANGE DE PR	Concentration:			211212	
Current Practice	Location:	New Practice L	ocation:		
1409 WATERS E	DGE DRIVE	Attn:			
AUGUSTA, GA	30901	Street Address:			
		City:	State:	Zip:	
		Phone: ()	State.	ΖΙΡ.	
		Site raper, Billianes i			
Description	Department Information	Information is Ac	curate	Cor	rrect Information
Social Security #		Yes (◯ No		
Date of Birth	06/01/45	Yes	◯ No		
Sex	Male	Yes (No No		-
Race	White	Yes (◯ No		
	hite, Black, Native, Asian, Othe				
4. GOMPLETE THE	EMANCIAL RESPONSIBILITY	FORM ON THE REVI	ERSE BIDE	OF THIS FO	RML
I am request your current	ing Military Restricted Status. (I active duty orders or a letter from the Military Restricted Status) we the Military Restricted Status	Military Restricted must m your Commanding C s from my license. (Prov	submit prod officer.) vide copy of	of active m	ilitary duty. Attach a copy o
6. Will pout le availe	ibleito provido junitar ere se	rvices in special need		arto help st	att disester medical
	sGuning-times of contengency (r major disaster?		4.00	
Yes			- 41 - 40 (- 44 - 44 - 45 - 44		
A Internet E Bo	ORENEWAL METHODE AVAIL	ABLE:	+ + + + + + +	indice e district	Made a Barris and Archer Cares a
A. Internet E-Rei	newar:	b address <u>http://www.do</u>	oh.state.fi.us	<u>/erenewal</u>	
status, such	as paying a delinquency fee or of ewal will not be available after	hanging a license status	s. Due to hig	h volume, allo	ow sufficient time to renew
	PIN	Number:			
	Lice	ense Number: OS 681	5		
B. U.S. Mail:					
Mail this con	npleted renewal form and fee pa		nt of Health	to:	
		. Box 6320	4 6000		
	a.	ahassee, Florida 32314			

Sequence Number: 11

File Number: 5554

20

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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.

	GORY 1 - CATEGORIES OF FINANCIAL RESPONSIBILITY COVERAGE:
O 1.	I do <u>not</u> 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 <u>not</u> 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.
CATE	notice must contain the wording specified in s. 458.320(5)(g) or 459.008S(5)(g), F. S. GORY II - EXEMPTION CATEGORIES OF FINANCIAL RESPONSIBILITY COVERAGE:
	notice must contain the wording specified in s. 458.320(5)(g) or 459.008S(5)(g), F. S.
<u>6</u> .	GORY II - EXEMPTION CATEGORIES OF FINANCIAL RESPONSIBILITY COVERAGE: I practice medicine exclusively as an officer, employee, or agent of the federal government, or of the state or its agencies or subdivisions;
○ 6. ○ 7.	GORY II - EXEMPTION CATEGORIES OF FINANCIAL RESPONSIBILITY COVERAGE: I practice medicine exclusively as an officer, employee, or agent of the federal government, or of the state or its agencies or
6.7.8.	GORY II - EXEMPTION CATEGORIES OF FINANCIAL RESPONSIBILITY COVERAGE: I practice medicine exclusively as an officer, employee, or agent of the federal government, or of the state or its agencies or subdivisions; 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;
6.7.8.	GORY II - EXEMPTION CATEGORIES OF FINANCIAL RESPONSIBILITY COVERAGE: I practice medicine exclusively as an officer, employee, or agent of the federal government, or of the state or its agencies or subdivisions; 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; I do not practice medicine in the State of Florida; I meet all of the following criteria:
6.7.8.	GORY II - EXEMPTION CATEGORIES OF FINANCIAL RESPONSIBILITY COVERAGE: I practice medicine exclusively as an officer, employee, or agent of the federal government, or of the state or its agencies or subdivisions; 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; I do not practice medicine in the State of Florida; 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;
6.7.8.	GORY II - EXEMPTION CATEGORIES OF FINANCIAL RESPONSIBILITY COVERAGE: I practice medicine exclusively as an officer, employee, or agent of the federal government, or of the state or its agencies or subdivisions; 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; I do not practice medicine in the State of Florida; 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;
6.7.8.	GORY II - EXEMPTION CATEGORIES OF FINANCIAL RESPONSIBILITY COVERAGE: I practice medicine exclusively as an officer, employee, or agent of the federal government, or of the state or its agencies or subdivisions; 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; I do not practice medicine in the State of Florida; 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;
6.7.8.9.	GORY II - EXEMPTION CATEGORIES OF FINANCIAL RESPONSIBILITY COVERAGE: I practice medicine exclusively as an officer, employee, or agent of the federal government, or of the state or its agencies or subdivisions; 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; I do not practice medicine in the State of Florida; 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.

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

1289 BROAD ST

AUGUSTA GA 30901

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GARY

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) **MAILING ADDRESS CHANGE** FROM LAST FIRST MIDDLE TO: LAST FIRST MIDDLE 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

August 15, 2001

Robert G. Brooks, M.D. Secretary

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.

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

I. **Practitioner Information**

License Number : 6815

License Status

: ACTIVE CLEAR

Profession

: Osteopathic Physician

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

20 20 5	MEDICINE YOUR OSTEOPATHIC PHYSICIAN LICENSE	2Y 31, 2000	AFTER EXPIRATION	
20	E OSTEO	ANUAF	\$505.00 \$705.00	
815 RENEWAL NOTICE 20 STATE OF FLORIDA DEPARTMENT OF HEALTH	IOARD OF OSTEOPATHIC ENEWAL FEES TO THE WITH ALL REQUIREMENTS IN CREDITS.	Middle hritesi WILL EXPIRE JANUARY 31, 2000	Zp Zp \$505.00 \$705.00	
PARIES OS 68	IMPORTANT: 67 SUBMITTING THE API DEPARTMENT; A LICENSEE AFFIRMS (FOR RENEWAL, INCLUDING CONTINUI Signature:	Licensee's Last Name First Street Address Street Address	GARY B BROADNAX 1409 WATERS EDGE DRIVE AUGUSTA, GA 30001	

945540066 :70

69Z89T :40 BT: H03075 Type: F

7999-T06T : @I \$202.00

15/03/1999

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



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

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øFile: 5554
øSSN:
                steopathic Physician
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øLic: 6815
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øName: GARY B BROADNAX (DBA:0 Old:0)
øAddr: 1409 WATERS EDGE DRIVE
                                         State:
                                               GΑ
                                         Zip:
                                               30901
øCity: AUGUSTA
                                         County: UNKNOWN
øCertificate No: 106
                         First License:
                                      06/13/1994
        Date: 05/28/1999
                         In Rank Since:
                                      06/13/1994
øLast Renewal:
                         License Method: ENNB
øCurrent Expiry: 01/31/2000
                         Renewal Notice:
                         In Directory?
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VL: 990033804

\$43.00 Type: F

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

QUALIFICATION(S):

RY B B DADNER DIVE Y S1, 20 C OF THE RACTITIONED CO SUBSTRACT TO SEE DE LIVE AUGUSTA, GA 30901

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DPY - NOT A VALID LICENSE - CC

GARY

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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.

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)

MAILING ADDRESS CHANGE

MIDDLE

TO: _____

DH 2103, 5/98

LAST

FIRST

MIDDLE

CITY

STATE

ZIP

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**

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.

EPARTMENT USE ONLY

GARY B BROADNAX **1289 BROAD ST** AUGUSTA, GA 30901

3. RENEW YOUR LICENSE ONLINE:

Visit www.fihealthsource.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 <u>Professions</u> 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.

HANGE TO RETIRED STATUS:

am requesting retired status. The fee for retired status on or before March 31, 2008 is \$55.00. Ti fter April 01, 2008 is \$555.00.

e fee for retired status on or

7. DISPENSING:

O 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 records will be conducted. The fee for registration as a dispensing records will be conducted. addition to your renewal fee.

8. FINANCIAL RESPONSIBILITY:

Please complete the enclosed Financial Responsibility form. Please select ONLY OF

Deposit Date: 1/10/2008 Deposit #: 167257

Batch Number : 001013102 Validation # : 907139960 Check Amount: \$55.00 PRO_CDE: 1901

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

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

File No.: 5554

Profession Code: 1901

Seq. No.: 121 40

20



HANGES TO CURRENT LICENSE INFORMATION: HANGE OF NAME: Imme changes require legal documentation showing the name chan lowing accompanies this form: a marriage license (marriage license rick of the court), a divorce decree indicating restoration of your main federal identity change). Any one of these will be accepted unless to document. A driver's license or social security card is not consider the name change cannot be completed, your license will be reneated. If It Is Is It Is It Is It Is It Is It Is Is Is Is It Is	e must indicate the en name, or a court le department has a ed legal documenta	original signature a corder (e.g., adoption question about the tion. It name. Suffix Apt./Suite No.	and seal from, name characteristics authenticit
ame changes require legal documentation showing the name challowing accompanies this form: a marriage license (marriage license k of the court), a divorce decree indicating restoration of your make federal identity change). Any one of these will be accepted unless a document. A driver's license or social security card is not consider the name change cannot be completed, your license will be renewalt. First Middle HANGE OF MAILING ADDRESS: State HANGE OF PRACTICE LOCATION: State Are renewing to active status, would you be available to persor to help staff disaster medical assistance teams during sor to help staff disaster medical assistance teams during your renewal form, use the 2-4 weeks processing time. ACLIST FOR MAILING RENEWAL FORM: are instituted by mail, allow 2 - 4 weeks processing time. ACLIST FOR mail in the Completed in the Co	e must indicate the en name, or a court te department has a ed legal documentated using the curre	original signature a corder (e.g., adoption question about the tion. It name. Suffix Apt./Suite No.	and seal from, name characteristics authenticit
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Financial Responsibility form (check only one it	closing all the requir	ed items to ensure	a smooth
Updated paper copy of Profile	m on the FR form)		
Mail to: PO Box 6320, Tallahassee, Florida 323	14-6320		

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

name				
License	OS	6	815	

Financial Responsibility Form Osteopathic Physician

The Financial Responsibility options are divided into two categories, coverage and exemptions. Choose <u>ONLY ONF</u> 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 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 daim, 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.

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.
- 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.)



D 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

12/3/2007

AUGUSTA GA 309

07 JAN 2008 PM 2 T



Florida Jegs. of Health P.O. Box 6320

Tallahadee, FL 323/4-6320

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

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:

) 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.

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.

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/mga/avoid.html to find out

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

File No.: 5554

Sea. No.: 121

Profession Code: 1901

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10.	CHANGES TO CURRENT LICENSE INFORMATION:
0	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.
	Lest First Middle Title Suffix Qualifier
\bigcirc	CHANGE OF MAILING ADDRESS:
	Attention
	Street Address Apt./Suite No.
	City State Zip Code Country (if outside U.S.)
0	CHANGE OF PRACTICE LOCATION:
	Attention
	Street Address Apt./Suite No.
	City State Zip Code Country (if outside U.S.)
lf y she	ou are renewing to active status, would you be available to provide health care services in special needs liters or to help staff disester medical assistance teams during times of emergency or mejor disaster? Yes
CH	FCKUST 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.

PO BOX 2246
AUGUSTA, GA 30903

RECEIPT PRINTED 03/23/2006

RECEIPT PRINTED 03/23/2006

RECEIPT EXPIRES: MARCH 31, 2008

COPY COPY COPY

(7/98) RETAIN THIS COPY FOR YOUR RECORDS

LICENSE NO. OS 6815

CONTROL NO. 19223

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

FROM:	VAME CHANGE (ATTACH	H LEGAL DOCUMENTA	TION)	MAILING ADDRESS CHANGE						
	LAST	FIRST	MIDDLE							
TO:	LAST	FIRST	MIDDLE							
				CITY STATE ZIP						

DEPARTMENT OF HEALTH DRYSSION OF MEDICAL QUALITY ASSURANCE LICENSURE SERVICES 4952 BALD CYPRESS WAY, BIN 4C-10 TALLAHASSEE, FLORDA 3239-3230

> GARY B BROADNAX PO BOX 2246 AUGUSTA, GA 30903

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

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.

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

GARY B BROADNAX PO BOX 2246 AUGUSTA, GA 30903

1. CURRENT MAILING ADDRESS:

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

DEPARTMENT USE ONLY

1289 BROAD ST AUGUSTA, GA 30901

(706) 791-6395

3-RENEWONLINE TODAY

Go to www.doh-mgaservices.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:

Online Renewal: Visit www.doh-mqaservices.com and click on Renew My License to renew your license A. 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.

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

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

6. Other Information: A PURE LESS OF THE PROPERTY OF THE PURE LESS OF THE

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

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MANDATORY PRACTITIONER PROFILE QUESTIONNAIRE

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

l.	PRACTITIONER DA	ATA													
A.	PROFESSIONAL LICENSE	NUMBER: OSOOC	6815		(check or	ne) ME/MD	■ 0\$/	DO CH/DO	C PO/DPM						
В.	NAME (INCLUDE MAIDEN A														
	BROADNAX		GA	IR Y	B										
	(LAST) FORMER NAME(S):		(FIR			DOLE AND MAIDEN	NAME, IF	APPLICABLE)							
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C.	SOCIAL SECURITY NUMBE	R		(This w	rill not be published as a	part of the pro	file: also	see instruction	ns on page iii)						
D.	SOCIAL SECURITY NUMBER (This will not be published as a part of the profile; also, see instructions on a MAILING ADDRESS:1409 WATERS EDGE DRIVE AUGUSTA GA 30901														
	PRIMARY PRACTICE ADDR	•	ND NUMBER) 55.565(1)(a)3.,F.S.)		(CITY)		(STATE)		(ZIP CODE)						
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	(PRACTICE NAME)	(STREET A	ND NUMBER)	7.00.00	(CITY)	477	(STATE)	· · · · · · · · · · · · · · · · · · ·	(ZIP CODE)						
	OTHER PRACTICE LOCATION OFFICE 2: (OPTIONAL)	ON(S): (OPTIONAL	.)		()		(0 11 11 2)	•	(Eli OOOE)						
_	DERT OF OBIGYN EISENHOWER ARMY MEDICAL CENTER FORT GORDON GA 30905														
	(PRACTICE NAME) OFFICE 3: (OPTIONAL)	(STREET A	IND NUMBER)		(CITY)		(STATE)		(ZIP CODE)						
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F	TELEPHONE: (706)	724-66		(This will	• •		(STATE)		(ZIP CODE)						
	YEAR BEGAN PRACTICING		973	(Authority: s. 455.5	not be published as a pa 65(1)(a)5., F.S.)	art of the profile	B.)								
N/	Name of all medical school AME OF SCHOOL/UNIVERSIT	Is attended. (Author			DATES OF ATTENDANCE	DATE O GRADU	ATION		TYPE OF DEGREE						
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B.	Have you completed any g If "YES", list in chronologi to meet the continuing edu	cal order from date	e of graduation	Yes to the present, renewal. (Authori	all completed graduate n	nedical education	on. Do n	ot include cou	rsework taken						
Ļ	MEDICAL TRAINING PROGRAM NAME ALTER REED ARM/	INTERNSHIP / RESIDENC' FELLOWSHIP / OTHER	()	SPECIA	LTY AREA	CITY / S COUI		TANDETY ST	TO MM/DD/YYYY						
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\vdash								•	•						

1. OTHER HEALTH RELATED DEGREES 19 you currently hold a degree in a health related profession ofter than the professional degree listed in II. A above? 18 'YES'. Bit all indecisiprofessions abools from which a degree in a health related profession other than the professional degree was obtained. (Amonty: a. 65.566.(1901. ES.) 18 'YES'. In a midestalprofessional degree was obtained. (Amonty: a. 65.566.(1901. ES.) 19 'YES'. In a question the professional degree was obtained. (Amonty: a. 65.566.(1901. ES.) 19 'YES'. To question the professional paper than the professional degree was obtained. (Amonty: a. 65.566.(1901. ES.) 19 'YES'. To question the list the title of the guzzent appointment, name(s) and city/state of institution(s). 19 'YES'. To question the list the title of the guzzent appointment, name(s) and city/state of institution(s). 19 'YES'. It question the profession that the profession is a hospital/medical/health institution? Yes W. No Converted the profession that hospital/medical/health institution? Yes W. No Converted the profession that hospital/medical/health institution? Yes W. No Converted the profession that hospital/medical/health institution? Yes W. No Converted the profession that hospital/medical/health institution? Yes W. No Converted the profession that hospital/medical/health institution? Yes W. No Converted the profession that hospital/medical/health institution? Yes W. No Converted the profession that hospital/medical/health institution? Yes W. No Converted the profession that hospital/medical/health institution? Yes W. No Converted the profession that hospital/medical/health institution? Yes W. No Converted the profession that hospital/medical/health institution? Yes W. No Converted the profession that hospital/medical/health institution? Yes W. No Converted the profession that hospital/medical/health institution? Yes W. No Converted the profession that hospital/health institution? Yes W. No Converted the profession that hospital/health institution? Yes W. No Converted the pro	ractitioner's Name GARY B BRO	ADNAX		License # C	S0006815
FACULTY APPOINTMENTS: Have you had the responsibility for graduate medical education within the last 10 years? (Authority: 4.455.955(1)06, E.S.) Yes No Doy ou currently hold a faculty appointment at a medical/health related institution of higher learning? (Authority: 4.455.955(1)06, E.S.) Yes No If YES?', to question "B" list the title of the current; appointment, name(s) and city/state of institution(s). If YES?', to question "B" list the title of the current; appointment, name(s) and city/state of institution(s). If YES?', to question "B" list the title of the current; appointment, name(s) and city/state of institution(s). If YES?', to question "B" list the title of the current; appointment, name(s) and city/state of institution(s). If YES?', to question "B" list the title of the current paper in the state of the current paper in the paper in the paper in the current paper in the paper	o you currently hold a degree in a heal If "YES", list all medical/professional	THE PRIVILEGES: It carriedly hold a degree in a health related profession other than the professional degree listed in II. A above? Yes Mo Yes Mo To To To To To To To			
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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.) 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 WINDER TY/N Y/N					
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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.) 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 Y/N Y/N					Y/N
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	citioner's Name GARY B BROADNAX						
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							Y/N Y/N
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or	I have elected not to carry medical malpractics (8.320(5)(g)1 or 459.0085(5)(g)1, F. S. I underst provide a written statement to any person to who understand that such a sign or notice must contain	m modical con-	icon are being annuit at the	orini or a signi p	nommentry displayed (unts pursuan n the reception Upractice insu	nt to s. On area Urance.
Ex	emption	- : 8 9	,	, v: ¬03.0000(3)	(y), r. o.		
i a	m exempt from demonstrating financial responsit	pility because I	fall into one of the categori	ies listed below:	(Check one box only)		
2.	practice medicine exclusively as an officer, emp I hold a limited license issued pursuant to s. 458	Noyee, or agent 3.317 or 459.00	of the federal government, 75. F. S., and practice only	or of the state of	r its agencies or subdi	visions;	
1 3.	I hold a limited license issued pursuant to s. 458 practice only in conjunction with my teaching d for this exemption);	luties at an acc	redited medical school or it	ts teaching hospi	tals. (interns and resid	dents do not o	qualify
3 4.	I do not practice medicine in the State of Florida;	or					

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actitioner's Name GARY B BROADNAX	License #O	S0006815
 5. I meet <u>all</u> the following criteria: (a) I have held an active license to practice in this state or another state (b) I am retired or maintain part time practice of no more than 1000 part (c) I have had no more than two claims resulting in an indemnity excess (d) I have not been convicted of or pled guilty or nolo contendere to an (e) I have not been subject, within the past ten years of practice, to lice fine of \$500 or more for a violation of Chapter 458 or 459, F.S., or to far relinquishment of license stipulation, consent order or other set against a license shall be construed as action against a license. I un notice in the form of a sign, prominently displayed in the reception being provided, that I have decided not to carry medical malpractice in s. 458.320(5)(f) or 459.0085(5)(f), F.S. 	atient contact hours per year; ading \$10,000 within the previous five year period; by criminal violation specified in Chapter 458 or 459, F. nse revocation or suspension, probation for a period of the medical practice act of another jurisdiction. A regulation and the medical practice act of another jurisdiction of filling the medical practice act of another jurisdiction of filling the medical practice act of another jurisdiction of filling the medical practice and present to any person to a provide a written statement to any person to	S.; and i three years or longer, or latory agency's acceptang g of administrative charge tion that I must either po show medical services a
. LIABILITY CLAIMS (Allopathic, Osteopathic	and Podiatric Physicians Only)	
Are you covered by an insurer required to report pursuant to s. 627.912 (Authority: s. 455.5651(4), F.S.; s. 455.565(1)(b), F.S.)	2 F.S.	Yes 🕦 No [
Have you been insured continuously during the last ten years? (Authority: s. 455.5651(4), F.S.; s. 455.565(1)(b),F.S.)		Yes 🗷 No [
If you answered "NO" to either A or B above, you <u>must</u> complete the followithin the previous ten years have you had a liability claim or action for finally adjudicated in an amount that exceeds \$5,000?	llowing: (Authority: s. 455.5651(4), F.S.; s. 455.5651(1)(b),F.S.) r damages for personal injury settled or	Yes □ No ¶
If "YES", complete and attach a copy of EXHIBIT 1 for each occurrence, questionnaire to satisfy this reporting requirement. (Authority: s. 455.5651(4)	NOTE: Copies of reports previously submitted may be	e re-submitted with this
I. LIABILITY CLAIMS (Chiropractic Physicians Within the previous ten years have you had a liability claim or action for an amount that exceeds \$5,000?	Uniy) r damages for personal injury settled or finally adjudica	ted in 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.)	
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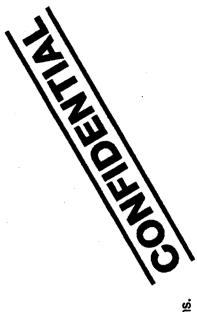
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PRESORTED

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

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.

1-1-99

* please see The additions.
Thanks.
Sobroachunk 20,

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.

ı. 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 HOSPITAL MCG HOSPITAL

AUGUSTA COLUMBUS AUGUSTA State **GEORGIA 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 PARTICIPAT

II. Education and Training

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

Other Health Related Degrees:

I DO NOT HOLD ANOTHER HEALTH DEGRE

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

GEORGIA 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

MAL PRACTICE 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 ciaim 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.

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

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Gary Burks Broadnax the Souger of

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Wedical Department

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30 June 1974



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AMPARAN MARTITHIS OF OBSTETERCIANS AND GYNECOLOGISTS
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GARY BURKS BROADNAX

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CPIRTIFIEN THAT

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THE AMERICAN COLLEGE

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





Village S. Trigram_My





HENY-PO

35 Kay 1994

sumJECT: Statement of Service

CPT, M8 Chief, Military Personnel Branch

MIDWESTERN UNIVERSITY

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April 19, 1994

Board of Osteopathic Redicine Department of Professional Regulation 1940 No. Honroe Street Tallahassee, FL 32359-0783

Regarding: Cary 2. Breadnex, D.O.

To Whom It May Concern:

This is to varify that Gary B. Broadnex, D.O., was a student at the Chisago College of Ostsopathic Redicine. He matriculated on September 8, 1969.

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

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

Very truly yours, Christy Schenk Christy Schenk Registrar (708)515-6074

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SCHOOL STAL



THIS IS TO CERTIFY THAT

Medicine und Surgery in Georgin



DEPARTMENT OF BUSINESS AND PROFESSIONAL REGULATION

BOARD OF OSTEOPATHIC MEDICINE APPLICATION FOR OSTEOPATHIC LICENSURE ALL APPLICABLE HERE MUST BE ENCLOSED

SEE ATTACHED INSTRUCTIONS APPLICATION SHOULD BE TYPED OR PRINTED LEGISLY IN BLACK INK											
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Complete melling address (tokens you re	ective mail) See Item #7	in Instructions.									
1409 WATERS EDGE BRIVE											
AMONETA, GROBERTA 30901-1045											
Thyriad Address (aloss you can be los	ated-No P.O. Boxes) Se	e Rem #\$ in Inst	meticas								
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MERCER UNIVERSITY. MACON, GR	MCIA		9/62 - 6/66	B.A.							
*OFTHOPATHIC EDUCATION See	item #11 in Instructions	•									
Name as	d location of school		Dates Attended Degree								
CHICAGO COLLEGE OF OSTROPATHIC	MEDICINE, CHICAGO,	ILLIMOIS	9/69 - 6/73	D.O.							
DECEMBER 18											

APPLICATION FOR OSTEOPATHIC LICENSURE - PAGE 2 "POSTGRADUATE TRADUNG: See inm #12 in Intruction. Full Mailing Address (street flows, room, box and ZIP) IndResPoi ACAMANA CALTRY HE WARMY OLD CANTER THE DEPT. OF OR/GYR INT/RES COL. 1798 7/73-6/77 WILL HADICAL "Staff Privileges. Des hom #14 in Instruction Pull Mailing Address (attest Dept, Floor, Saum, Bux and 200) Type of Privileges OR/OTH Chief of Staff Dans of service CHIEF, DEFT. OB/OTH, BOX 212, EISHHOURR ARMY MEDICAL CENTER, FORT GORDON, GHORGIA 30903-345 COL PRILIT 7/77-TO KRATING PRESENT ng for time. See hom #15 to Instruction See hom #16 in Instructions. States & Number Dete A 8/74 nex ACTIVE - 16213

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APPLICATION FOR OSTEOPATHIC LICENSURE - PAGE 3

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*Boschiller Beand Cartification Medical Affiliations. See hom 917 in hatmothes. Seesisby: Of Cartificit. YES XXX NO. Memberships/MERICAN COLLEGE OF OBSTRIBICIANS AND GRAD	S/CTN COLOCISIS
"Military, YMERER 100 Prom 6/66 of RESERT See hom #18 in Instruction.	
THE POLLOWING QUARTICHS MINT BE AMENUALED YES OR NO. See home /19-33 in in	structions.
"More you over been dropped, empended, placed on probation, expelled or requested to resign from any school, college or university?	128 NO X
"Risne you over been the subject of an investigation of any kind by any ileenalng Board, jurisdiction or Agency!	AB8 NO x
*Bore you ever hed you. Heans to practice Osteopathic Medicine suspended, seveled or in any way acted against in any Heaning jurisdiction?	ASE NO _ Y
There yes over been dealed Cateopublic Resource in any Recessing jurisdiction or been granted a Recess under restrictions of any kind?	YESNOx_
"How you over discontinued practice for my reason for a period of one wouth or longer?	YES NO X
"Eleve any proceedings over been filed or instituted against you either criminal, civil or Board soluted?"	YES NO_X_
"Here you over been counted of a violation of or plad No Custest to any Pederal, State or local stance, regulation or ordinance, or entered into any place bergeln relating to a follow or mindements?"	YES NO
"Have therees, now or over, been brought against you by say branch of the Armed Services of the United Second	Y28 NO_X
"Have you over been adjuiged incompetent?	
"Hore you over seedeed any form of psychothology or any other treatment for any mental disorder, disability or Blace of any kind?	
"Do you have any chronic medical librars or medical condition which would affect your ability to passive year producted?"	
Thee you near or have you ever been addicted to according drugs, hellectrogenic, depressent or administracy substances or interferent?	
¹⁹ Here you over been admitted to or confined within a hospital or institution for the purpose of obtaining neutroest or through for any mostal or nervous disorder, disability or linear of any bind?	
"Hore you over had your staff privileges dealed or suspended, or have you over voluntarily surigued in lies of disalplinery action?	A38 NO X
"Are you now or have you over been enrolled in or participated in any drug, elected or impaired providences program?	<u> </u>
*COUNT ACTIONS: See hom #35 in Instruction. If you assured YES to this question, explain in full on additional space. List all cases by same in the space below.	YES100_X

(2)

APPLICATION FOR OSTEOPATHIC LICENSURE - PAGE 4

THE APPLICANT MUST COMPLETE THE POLLOWI	NG.
1_ CARY BURKS BROADMAX, B. (). application and supporting documentation, that said applications, and that the stracked photograph is a true libeases	state that I am the person referred to in the foregoing tion and any supporting documentation are true and a of myself.
I hereby authorize di hospitale, instinctione, organizatione, and praesal) and all governmental agencies and instrument Florida Board of Catsopathic Modicine, any information wi	personal teleronous, personal physicians, amployers (past China (Jonal, annu, fedural, and fundan) to release to the high is meterial to my application.
I have carefully read the interactions and questions in the fi- without reservations of any blad. Should I furnish any this documentation, I knowly acknowledge that such as act shall my literate to presente as an enterpolitic physician under Ci- hantly affers that I know read and understand Chapters 451 and antanoulogue that I must abide by those. I agree that p comply with all insurance requirements.	o information in this application, or in any supporting i constitute cause for dealst, suspension or suvention of inputer 459, Floride Statutes, in the State of Floride. I J. Floride Stanton, and ZEE. Floride Administrative Code.
Signature of Applican A	CDateStignet4/21/94
NOTARIZATION: Whene my best and official seel this 2/s- Day	
1994 to the County of Richmonel State	ed Georgia
My commission expires es: May 27, 1996	
Many square Afonall a Nice Pr	Notery stanse matter and
We are required to ask that you fareith the following should be part of your voluntary compliance with setten 2, Uniform Chebelines on Buytoyee Selection section (1978) 42 PRINTON (August 25, 1978). Tale formation is gardened for satisfied purposes only and see not in any very affect your candidacy for licenseurs. IN: FN_X Physical: Height_5'10" Inight_10' Byn Color_SR Hair Color_SR their Color_SR	G003





Popularia.

RE: Letter of Recommendation Gary B. Broadma, DO

oard of Osteopathic Medicine, opartment of Professional Regulation Department of Profe 1940 N Mource St. Tallahassee, Florida

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

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

Thomas B. Paya, DO
4690 Cutter Mill Rd.
Martinez, GA 30907



DEPARTMENT OF THE ARMY



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29 April 1994

Board of Osta-methic Medicine Department of Professional Regulation 1940 H. Monroe Street Tallahasses, 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 Ostacpathic Medical School (Dr. Broadnax graduated 1973). Both of us also took our residency at Walter Read Army Medical Center (1974-1977). Dr. Broadnax distinguished himself academically in both institutions. Dr. Broadnax continued his curser in the military and is serving as chief, Department of Obstatrics and Gymsoology at Bisenhouser Army Medical Center. He also is the Consultant to The Army Surgeon General for CB-GYE. Dr. Broadnax is an excellent administrator.

I have practiced daily with Dr. Broadnex for the past 8 years (1986-present), and it is my opointon that he practices emcallent 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. Broadnam is hard working, highly athical 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 Einenhower Army Medical Center

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

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I hereby affirm that I have completed the required course on HIVIAIDS in accordance with a. 458.2226, Rotide Statutes, and a. 21R-001, Floride Administrative Code, and that this course was a minimum of three (3) hours of American Octoopathic 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, 1891 as prescribed in as. 21R-001(8), F.A.C., and that said course consisted of subsection on the trensmission, control, treatment, and presention of HIVIAIDS with emphasis on appropriate behavior and attitude change in compliance with as. 488.2228(8), F.S., and as. 21R-21.001(4)(e-c), F.A.C. A copy of the certificate demonstrating my completion of this requirement is attached.

* POR INTERIS AND RECIDENTS CHLY * In the event that I have not taken a formal course on HIVIAIDS as described above but have attended a minimum of three (3) hours of formal didectic lectures within the three feare described above during the course of my training. I have attached a letter from my disector of medical education that varilles the time period of my training, that there were formal didectic lectures available for the trainess to attend, and my attendence during these lectures. In addition, I understand that taking care of HIVIAIDS patients during my training is not sufficient to fulfill this requirement.

I recognise that providing false information to the department shall constitute cause for deniel, suspension or reveastion of my Sonnes to practice esteopathic medicine and surgery OR as a physician estimate certified under Chapter 488, F.S., in the state of Fiorida or criminal penalties pursuant to sections 486.2272, 488.013, 488.018, 775.082, 778.083, and 775.084, F.S.

PLEASE MOTE: If you have not fulfilled this requirement prior to licensure, you must submit an affidevit (a letter or document separate from this form that is sworn and subscribed to before a notary) in which you attes the rescentit why you have not compiled with this requirement and request that these rescens be determined to be good cause and therefore make you eligible for the six (6) month extension to complete title requirement as allowable by law in so. 488.2228(8), P.S. and so. 21R-21.001(8), F.A.C.

YOUR LICENSEICERTIFICATE WILL NOT SE ISSUED UNTIL THIS REQUIREMENT IS COMPLETED OR YOUR AFFIDAVIT IS ACCEPTED BY THE BOARD AND YOU ARE GRANTED THE SIX MONTH EXTENSION.

> Develor of Medical Quality Assurance Board of Ostbonethic Medicals Morthwood-Center - 1849 Morth Moneso ether - 1847 - Marses, Floren 1889-483 Tables 800 182-183



Binight Bavid Sisenhower frmy Medical Center



This Corlificate of Camptolica is Awarded to

COL GARY B. BROADNAK, D.O.

"HIV EDUCATION FOR MEALTH CARE PROVIDERS"

id 25th day of Haren 19se



OFFICE OF THE CONSULTANT GREETERS AND GYNECOLOGY TO THE LUNGEON GENERAL 5/24/94

Subject: Letter 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 Welter Reed Army Medical Center. My internship consisted of rotations in Internal Medicine. General Surgery, Pediatrics, Ob/Gyn. Anesthesiology.rediology 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 as 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. Mejor General Rouald Blanck is the Commander at Walter Reed Army Medical Center and a distinguished Osteopathi Physician, so we should consider it an Osteopathic Mospital.

Sincerely,

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FLORIDA BOARD OF OSTEOPATHIC MEDICINE TRAINING EVALUATION

TO: COM. LYBIN FARMINGSTH. INS	MA:NOLLALLL	LTER REED A	OFT HEDICAL (ENTER DA	TE: 4/8/94
The ductor annual below has applied for lice and or have your algoritms naturated. Pleas Indicated. This form can not be accepted wit	neure in the States also verify the Chout the hospita	e of Floride. F datas of establ i seal or a not	lease complete d ng and completic missel signeture.	n eatire form and n of the program	affix the hospital by signing where
MANCE: GARY IL DECIAIDAX, D.O.	80	CIAL SECURI	TY NO:		
DATES ATTEMPED: 1/73 - 6/77	171	PB OF TRAIN	ING: INT éso l	ndow)* <u>25</u> 22	SFEL :
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b. Please verify if this pregram is approved	by the :				NOV_NAVE
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FLORIDA BOARD OF GSTEOPATHIC MEDICINE STAFF FRIVILIBUS VERIFICATION

TO: COL. PHILIP REATING, H.D.	DATE:_4/8/94
Institution: RISEMENTER ARMY MEDICAL CENTER FORT CORBOR, GEORGIA	_
The Dector mened below has applied for licensure in the hopeled seed or have your signature notarized. Ple hospital seel or a notarized signature.	he State of Florida. Please complete this form and affin sees note that this form can not be accepted without the
MAMER: GARY 8. BROADMAN, D.O. SOCIAL S	
Dozadid the doster have full staff privileges in his	s/her specialty? <u>You</u> If no, please explain.
2. What is was the doctor's specialty? Obstatries	Gyescology
3. Does/did he/she perform competently? <u>Yes</u> If n	o, piesse explain.
4. How would you rate the doctors professional andre	nic: Poor Peir Good Superior X
S. Have any restrictions over been placed on him/her	beyond the original period of probution?No
If yes, piecese explain.	
6. Please list the doctor's dates of service 17 July	1977 - present (21 April 1994)
Philip J. Reuting, Colonel, Hedical Corps Name of Person Providing Information	Son Chen allingues
21 April 1994 Data Stenad	Seputy Communder for Clinical Services
(706) 791-3001	Petrosc/1306
Photo Mouber	MOSPEPAL ARAG. OC. PAUTABLETON OF SERVICION
Division of Missical	GUNLETY ASSERTING
MORTHMOOD CITALIST . MAY MOSTLE PROMISE	PHYTHE MEMORINE My Commission Supres Des. S. 1967 1 STREET - TALLAHAMER, PLONING 2500-0517 DA MEMORIA

FINANCIAL RESPONSIBILITY FILING PORM

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 elected.

- [] I do not have hospital staff privileges and I have obtained and maintain professional liability occurage in an amount not loss than \$100,000, from an authorized insure as defined under a. 404.00, from a majorized insure as defined under a. 404.00, from a risk retention group as defined under a. 407.9142, from a risk retention group as defined under a. 407.9142, from the Joint Underwriting Association conditional under a. 407.9140, or through a plan of self-insurance as growlded in a. 427.937.
- 2. [] I have hospital staff privileges and I have obtained and maintain professional Subliny coverage in an amount not less than \$250,000 per cloim, with a minimum named aggregate of not less than \$250,000, from an authorised immeer on defined under a. 626.014(2), from a stak, naturalise group as defined under a. 627.945, from the Joint Underwriting Association conhibited under a. 627.351(4), or through a pion of off-insumes no provided in c. 627.357, or through a pion of off-insumes which meets the conditions specified for authorizing Resocial measured think in a. 266.110.

43.77

- 2. [] I do not have heapled staff privileges and I lave clasined and maintain as watespierd, increasable letter of cardit, established presents to chapter 675, in an account of not less than \$100,000 per claim with a minimum agapeans availability of contine of not less than \$100,000. The letter of credit shall be payable to the extemptale physician as beneficiary youn presentates of a final judgment indicating liability and associate physician to the payable to the extemptale physician or upon parameters of a notificant apparament signed by all perties to each agreement when such final judgment or estimates in a result of a naturalizable and asstanciarable. Both letter of result shall be naturalizable and notification that is a post of the state of a part of such as the state of a part of the state of a part of the state - 4. [] I have hospital staff privileges and I have obtained and maintain on unempired, irrovosable letter of uselit, conditional procuses to despite 675, in an amount not less than \$250,000 per claim, with a minimum aggraph wellfulfully of could of not less than \$750,000. The letter of could that he popule to the extraordic physicien on headfacter young presentations of a that judgment indicating liability and averaging desauges to be paid by the enterpublic physicien or upon presentations of a sufficient agreement elegand by all parties to ruch agreement when such final judgment or settlement in a result of a claim acting out of the sundering of, or the follows to neader, suction once may not the continuous and acting under the laws of each later of each shall be instead by any heat or enterpulse accordance organized under the laws of the United Dates that he impression is the class or has a branch office which is sufficient under the laws of this other of the United Dates to the later of the state or has a branch office which is sufficient under the laws of this state or then a branch office which is sufficient under the laws of this other or of the United Dates that he impression to receive advent or the sufficient or the later of the state or the sufficient or sufficient under the laws of this state or the sufficient or sufficient under the laws of this state.
- 6. [] I have desided not to earry uniquestics immenses or otherwise demonstrate Sannald suppossibility; however, I agent to antidy any adverse judgments parament to the terms and conditions contained in a. 450.004(7)(g), F.S., I undensted that I shall be explained to either past notice in the form of a sign prominently displayed in the ecopities can not clearly astronable by all patients or provide in written statement to any parson to whom mudical coverage one being provided, Such sign or eitherment shall state their: Under Periods low, contemptate physicians are generally required to entry audical uniquestion increases or estimated measurements Sannald responsibility to cover potential claims for medical subjection. YOUR OSTROPATHIC PHYSICIAN HAS DECIDED NOT TO CARRY MEDICAL MALFRACTICE DESUBANCE. This is permitted under Florids low religion to certain conditions. Florids low imposes strict penalties against excitanted extrapable physicians who fall to esticly adverse judgments origing from claims of medical analysection. This notice is provided parament to Florids low.

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FINANCIAL RESPONSIBILITY FILING FORM - PAGE 2

6	I am ensays	from demonstrating	financial suppossibility because:	
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- 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 subdivision.
- agandes or in subdivision.

 68 [] I hild a limited license insued pursuant to a. 499,0075, F.S., out practice only under the scape of such its
- ction with my teaching duties at an college of esternation medicine. (Resid
- 68 [] I then the lineau.

 60 [] I practice only in conjunction qualify for this exemption.)

 60 [x] I do not practice otherpublic connection in their demonstration of their demonstration in their lineau demonstration.
- e descriptions in the state.

 If the state, the state, the state of Plantan. I was being the deficient minimum of the state, the state of the following estantia:

 I have held an active license to practice in this state or earther state or some combination thereof for state than 15 years.

 I am estimal or maintain part-time practice of no more than 1,000 patient contest hours per year.

 I have had no mose than 2 cisions resulting in an indemnity encerting \$10,000 within the provious of management.
- 3) I have had no more than a unious seasons as a season of a purpose of the not been convicted of, or pled note contenders to any original violation specified in a. 450, F.S., or the practice act of any other state.

 5) I have not been subject, within the last 10 years of passine, to license severation or suspension robustion for a pariod of 3 years or langua; or a fine of \$500 or more for a violation of a. 459, F.S., or the mobiler jurisdiction. The regulatory agency's acceptance of an enterpolic physician's relimphishment of a test order, or other settlement, officed in suspense to or in antiquation of the filling of administrative charge hydrian's license, shall be construed as action against the physician's license for the purposes of this section. bysician's license, shall be co against the obserptile physician's licens, 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 past section in the form of a sign prominently displayed in the reception same and clienty nedicable by all pulsests or to provide a written statement to any person to whom medical covides so being possible. Such sign or statement shall state that: Under Florida law, estemptible physicians are generally required to early medical independent our observation diamentates financial responsibility to cover potential chiese for medical and parties. However, earties partition extensives physicians who sent attact represents are except from the financial responsibility law. YOUR OBTEOPATHIC PHYSICIAN MINETS THESE REQUIREMENTS AND HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE BESURANCE. This notice is provided premiant to Florida law.

APPENATION:

I offices that all eletements given above are true and correct and secognise that providing false information may ment in disciplinary artises against my license or orininal penalties pursuent to Sections 435.227, 459.013, 459.015, 775.022, 775.023, and 775.034, Florida Sunniss.

Someone	GARY B. BROADMAX, I).0.
-	Printed Name	Social Security Number

DEPENDING PRACTITIONER - This is optional and should be completed only if the \$25.00 fin in small

n 405.0276, P.S., requires that licensess of the Board of Ostoopathic Modical Beaminess who dispense medicinal drage for a rememeration of any kind, whether direct or indirect, shall be required to register with the Broad and pay a fine of \$25.00 as no of such registeries and upon each reserved of the prosthieser's license. Practitioners who conflict their articles to the sing of complications patchages of medicinal drage to their sum patients in the regular course of their practice adult not be all magnitudes are note that upon registeries, pure practice will be impacted examply by the Department's Encocligative to the complicace with Florids low relative to the dispossing of medicinal drage.

YES, I plut to dispense medicinal drops for a fee or other summercious and heady register pursuant to so. 465.0276, F.S.. I understand that the fire registration is \$25.00 ever and above the amount required for licenses.

Y20[] Mo[x]1	No signature required
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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

leose see conections SPOX

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

License Status

: ACTIVE CLEAR

Profession

: Osteopathic Physician

Year Began Practicing: 01/01/1973

Primary Business:

1400 WATERS EDGE DRIVE AUGUSTA GA 20904

Dr. Gary B. Broadnax P.O. Box 2246

Augusta, GA 30903-2246

DEC 0 3 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 resportsibility 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 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 maioractice 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

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 <u>March 31, 2006</u>. Renewal notices postmarked on or after <u>April 01, 2006</u> 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.

DEPARTMENT USE

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 <u>www.doh-mqaservices.com</u> 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>U.S. Mail:</u> 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, Taliahassee, 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

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USTEED OF

STATE OF GEORGIA COMPOSITE STATE BOARD OF SEDICAL EXAMINERS 166 PRYOR ST , SW ATLANTA, GEORGIA 20303 (404) 636-3913 05/09/94

MAY 12 1984

TO WHOM IT MAY CONCERN:

DOCKZTED.

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THIS IS TO CERTIFY THAT BROADNAK, GARY B*******

MAS ISSUED GEORGIA MEDICAL LICENSE MUMBER 016213, ISSUED ON 08/15/74, AND

AS OF 05/03/94 THE STATUS OF THIS LICENSE IS CURRENT.

THE DATE OF LAST REMINAL MAS 12/15/93. THIS LICENSE EXPIRES 12/31/95.

A PEVIEW OF PUBLIC RECORDS INDICATES THAT NO DISCIPLIMARY ORDERS HAVE RESERVED.

This 9th day of May, 1994.

AMERIA V. MATRY EXECUTIVE DIRECTOR COMPOSITE STATE BUARD AND MEDICAL BRANCHERS

Our mailing address of record for this licensee is:

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

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

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 <u>March 31, 2004</u>. Renewal notices postmarked on or after <u>April 01, 2004</u> require renewal and delinquent fees of \$830.00.

Received Date: 3/17/04 Deposit Date: 3/17/04 Deposit #: 187680 Baten Number: 017811 Validation #: 903154392 Check Amount: \$230.00 PRO CDE: 1901

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.

1289 BROAD ST AUGUSTA, GA 30901

(706) 791-6395

3. RENEW ON LINE TODAY!

Go to www.doh-mgaservices.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, malling 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 Renewat: 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

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



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	you															_											_														

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.
- 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.)
- I do not practice osteopathic medicine in the State of Florida. I will notify the department immediately before commencing practice in the state.
- I am exempt from demonstrating financial responsibility due to meeting all of the following criteria:1)I have **5**. 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 noto 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

3/14/04 Date Dr. Gary B. Broadnax P.O. Box 2246 Name Augusta, GA 30903-2246

License # 05 6815

Financial Responsibility Form Osteopathic Physician

The Financial Responsibility options are divided into two categories, coverage and exemptions. Choose <u>ONLY ONE</u> 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.

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



Dev. of Med. Qual. ASSUR. Div. of Med. Qual. ASSUR. P.O. Box 6320 Tallahapper, FL 32314-6320

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January 31, 2002. Re	t charge, the fee of \$554.00 and the newal notices/forms postmarked	he renewal form must be postma I on or after <u>February 1, 2002</u> requ	rked or electronically submitted on or before uire renewal and delinquency fees of \$754.00.
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File Number: 5554

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Sequence Number: 11

FINANCIAL RESPONSIBILITY

The Financial Responsibility options are divided into two categories, coverage and exemptions.

<u>Choose only ONE option</u> of the ten provided pursuant to s.459.0085, Florida Statutes.

CATE	GORY 1 - CATEGORIES OF FINANCIAL RESPONSIBILITY COVERAGE:
	1 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.
l	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 <u>not</u> 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.
0 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.
O 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.
CATE	GORY 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;
O 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;
₩	I do not practice medicine in the State of Florida;
O 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
O 10.	(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 maloractice insurance. I understand such a sign or

Augusta, GA 30903-2248 Dr. Gary B. Broadnax P.O. Box 2248



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

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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.

DEPARENT OF THE LITTLE DIVISION OF INESTITA CALLITY ASSURED THE TIRED GARY B BROADNAX PO BOX 2248 AUGUSTA, GA 30903

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

YOUR LICENSE NUMBER IS **0\$ 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

P.O.BOX 6320 TALLAHASSEE, FLORIDA 32314-6320

NAME CHANGE (/	ATTACH LEGAL DOCUME	NTATION)	MAILING ADDR	ESS CHANGE	
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LAST	FIRST	MIDDLE			
TO:					
LAST	FIRST	MIDDLE	CITY '	STATE	ŽIP

DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE
LICEMENING AND AUDITING SERVICES UNIT
4852 BALD CYPRESS WAY, BM 8C-19
TALLAHASSEE, PLORIDA 32398-3260

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.

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.

Received Date: 3/22/2006 Deposit Date : 3/22/2006

Deposit # : 167548 Batch Number : 001022449 Validation #: 905241943 Check Amount: \$230.00 PROCCDE: 1901

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-maservices.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/mga/avoid.html to find out

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-mgaservices.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

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



7. 0	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 discourse decree indicating actorities of the court.																																											
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\bigcirc	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																																											
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Dr. Gary B. Broadnax P.O. Box 2246 Augusta, GA 30903-2246

License <u>OS 6815</u>

Financial Responsibility Form Osteopathic Physician

The Financial Responsibility options are divided into two categories, coverage and exemptions. Choose <u>ONLY ONE</u> 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 r less than \$100,000 per claim, with a minimum annual aggregate of not less than \$300,000, from an authorized insurer defined under s.624.09 FS, from a surplus lines insurer as defined under s.626.914(2)FS, from a surplus lines insurer as defined under s.626.914(2)FS, from the Joint Underwriting Association established under s.627.351(4)FS, or through a	as 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.	1

- □ 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:

- I practice medicine exclusively as an officer, employee, or agent of the federal government, or of the state or its agencies or its subdivisions.
 I hold a limited license issued pursuant to s.459.0075,F.S.,and practice only under the scope of such limited license.
 I practice only in conjunction with my teaching duties at an 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.
- I am exempt from demonstrating financial responsibility due to meeting all of the following criteria: 1)I have **D** 5. 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.

Maradan (18)

Signature

3/19/06 Date

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





Dept. of Nearly Dio. Box 6320 Tallahasse, FR. 32314-6320

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AMA PHYSICIAN PROFILS

AMERICAN MEDICAL ASSOCIATION 919 NORTH STATE STREET CHICAGO, ILLINOIS 50510

MAY 27 1994

DATE: 05-23-94 TIME: 8:33 AM

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HAME: EROADHAX, GARY B, D.O.
ADDRES: 1409 WATERS EDGE
AUGUSTA GA 38901

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PHYRICIAN'S PROVIDEIONAL ACTIVITIES: YULL-TIME HOSPITAL STAFF SELF BEIGNATED SPECIALITIES PRIMAT: GENTERALCS AND GYNROGLOGY SECONDARY: GYNECOLOGY TERPIAN': UNSPECIFED

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MALTER REED ARMY MED CYR 07/74-06/77 -- (CONFIRMED) 086787: ICS AND GYMECOLOGY UMSPECIFIED

PRIOR MEDICAL TRAINING:

IMPERN WALTER REED ARMY NED CTR 07/73-06/74 -- (COMPINNED OBSTETRICS AND GYNECOLOGY HOSPITAL: DRIES OF TRAINING: SPECIALTY: SPECIALTY: IMAPECIPIED

YELLOWSHIP: NOWE REPORTED TO DATE

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

MATICAL SCIENTIFIC MEDICAL SOCIETIES: AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

PROFESSORIAL APPOINTMENT:

MED COLL OF GA SCH OF MED, AUGUSTA GA 30912 SPECIALTY: OBSTRTRICS AND GYMSCOLOGY

COPYRIGHT 1994 AMERICAN MEDICAL ASSOCIATION. SEE REVERSE. ***AMA PILES CHECKED



American Osterpathic Association 148 E. Ostano STREET • CHICAGO, RUMOIS 50811 1400-521-1773 of \$120 580-5800

PROFILE SERVICE

PHYSIONS ADDRESS. 32062-49 Eul Bary B Brundsox 1407 Belair 5 tige Rugusta GR 30901-1045

REQUESTING INSTITUTION:

Floride Bd of Osteo Hedfolier Dept Professional Regulation 1940 If Monroe St Follohossee, 11, 32399 8757

DATE OF BUTTH

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07/01/73-04/30/74 INTERESTIP 07/01/74-04/30/77 RESIDENCE -- Obstetries & Synowlogs

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MINIOR PRACTICE FOCUS:

STATE LICENSIME REPORTED: Licensime information is not overlable at this time.

Conditions, SCCIETY INCLUDENCIES: Georgia Boloopothic Red Ason, Otlanto, EA

PRICTICE SHOUP FELLOUISH

AOA BOARD CERTIFICATION



BOARD CCZON DATA BANK ZNOCZRY FORM

500	PLORIDA BOARD OF OSTROPATHIC ME	DIGINE
requests a Sverd Ac	tiun Search concerning the foll	oving individuali
SHOADHAX GARY BURKS	i	D. O.
Prestitioner's Name:	(LAST, First, Middle)	(Degree)
JUNE 1, 1945		
Date of Birth: (m	1 / dd / yy)	Social Security #
CHICAGO COLLEGE OF OST	COPATHIC HEDICINE, CHICAGO, ILLINOIS	
Medical School: (In	clude Complete Name and Branch	Loostion) 88A
Year of Graduation	(Country	ef Nedical School)
	. •	
SCPNS Numbers	(if foreign awlical graduate)	
76031	Please mail the result to the	following address:
Dept	rtment of Professional Begulat: Board of Osteopathic Hedicina 1940 North Monroe Street	ien
	Tallahassas, FL 32399-0787	R ALL D RECORD MARKETS
	1-London	APR 15 1994
	(Prestigioner's Signature)	A MANUFACTOR AND A SECOND A SECOND AND COND AND CTION ASSECTI

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