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

RECEIVED
SEP 19 2006
ABME

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

AMY T. DORMINEY
EXECUTIVE ASSISTANT

TELEPHONE
(334) 242-4153

APPLICATION FOR LICENSE TO PRACTICE MEDICINE/OSTEOPATHY

NAME IN FULL: Diamond Iuan David
(Last Name) (First Name) (Middle Name)

HOME ADDRESS: [redacted]

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

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

TYPE OF PRACTICE: OB/gyn

ALABAMA PRACTICE ADDRESS: 1001 17th Str South

CITY: Birmingham STATE: Al ZIP CODE: _____

COUNTY: _____ TELEPHONE: (_____) _____

DATE: 9/13/06 SIGNATURE: [signature] M.D.

Specify One: MD/DO License

Please specify the following:

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

PLEASE ATTACH LICENSE FEE OF $75.00
MAKE CHECK PAYABLE TO MEDICAL LICENSURE COMMISSION OF ALABAMA

NOTE: The Medical Licensure Commission requires all licenses to be renewed 12/31 of each year regardless of when it is issued. Please indicate whether you wish your license to be issued immediately or on January 1. If you choose to have your license issued immediately it will be necessary for you to renew this license by December 31 of this year. Annual renewal fee is $200.00.

✓ **Issue Immediately** _____ **Issue January 1**

For Office Use Only:
Board Agenda - Jan Feb Mar Apr May June July Aug (Sept) Oct Nov Dec

Please see reverse side for important information.

2007 Medical License Renewal Application
Deadline: December 31, 2006

Second Notice

Renew online @ http://alrenewals.org
Registration ID: 204976
Use Only for Change of Mailing Address

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

Ivan David Diamond , MD
1001 17TH STREET SOUTH
BIRMINGHAM, Alabama

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

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

License#: MD.27687 Issue Date: 09/21/2006

Office Address

1001 17TH STREET SOUTH
BIRMINGHAM, Alabama

Work Telephone: 9331118 Fax #:

Primary Specialty: OB gyn
Secondary Specialty:

Home Address

[redacted]

Home Phone: [redacted]

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

Form of Practice: [ ] Resident [ ] Intern [ ] Fellowship [ ] Solo [X] Partnership (2, 3, or 4) [ ] Group (Name) New Women

Primary Hospital where you have staff privileges: Name: Northside Hospital Atlanta Ga. City/State: BIRMINGHAM AL

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

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

Primary Care Information

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

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

CME Certification: (Check one)

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

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

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

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

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

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

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

I CERTIFY THAT ALL INFORMATION ON THIS FORM IS CORRECT _____ 12/16/06

Signature Date

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

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

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

2008 Online Renewal Summary

Name: **Ivan David Diamond**
License Number: **MD.27687**
Transaction Date: **2007-11-01***
Transaction Number: **VSJF1CE5529A**
Registration Fee: **300**
Date of Birth: **1952-02-13**

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

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

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If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

Primary specialty: **Obstetrics & Gynecoloy**

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

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Secondary specialty: **Other**

Are you Board certified in your secondary specialty?

Practice Type: **P**

If Group, provide the Group Name: **NEW WOMEN**

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

Hospital Name: **NORTHSIDE HOSP**

Hospital City: **ATLANTA**

Hospital State:

Are you licensed in another State:

GA

TX

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

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

(**indicate state if not in Alabama)

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

Other County1 **Fulton**

Other State1 **GA**

Other County 2

Other State 2

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

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

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

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

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

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

CME Certification: I hereby certify that I have met the annual minimum continuing education requirement of 12 hours of Category I continuing medical education for the calendar year 2007 and have supporting documentation if audited. **yes**

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

Exempt Reason

Practice Telephone: **(205) 933-1118**

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

Home Telephone:

Home Address: [redacted]

Public Address: **True**

Mail Address:

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

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

2009 Online Renewal Summary

Name: **Ivan David Diamond**
License Number: **MD.27687**
Transaction Date: **2008-11-13***
Transaction Number: **VLEF3B305838**
Registration Fee: **300**
Date of Birth: **1952-02-13**

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

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

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If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

Primary specialty: **Obstetrics & Gynecoloy**

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

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Secondary specialty:

Are you Board certified in your secondary specialty?

Practice Type: **G**

If Group, provide the Group Name: **NEW WOMEN**

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

Hospital Name: **NORTHSIDE HOSP**

Hospital City: **ATLANTA**

Hospital State:

Are you licensed in another State:

GA

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

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

(**indicate state if not in Alabama)

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

Other County1 **Fulton**

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Other State1 **GA**

Other County 2

Other State 2

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

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

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

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

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

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

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

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

Exempt Reason

Practice Telephone: **(205) 933-1118**

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

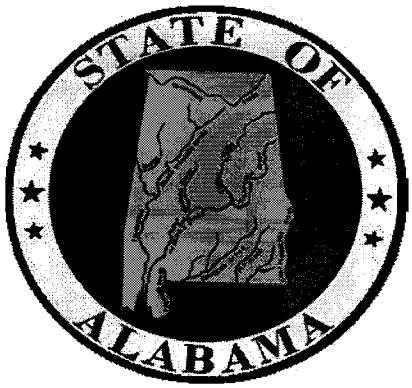
Home Telephone:

Home Address: [redacted]

Public Address:

Mail Address:

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



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

2010 Online Renewal Summary

Name: **Ivan David Diamond**
License Number: **MD.27687**
Transaction Date: **2009-11-05***
Transaction Number: **VSHF4B300001**
Registration Fee: **300**
Date of Birth: **1952-02-13**

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

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

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If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

Primary specialty: **Obstetrics & Gynecology**

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

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Secondary specialty:

Are you Board certified in your secondary specialty?

Practice Type: **G**

If Group, provide the Group Name: **Northside womens Specialists**

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

Hospital Name: **NORTHSIDE HOSP**

Hospital City: **ATLANTA**

Hospital State:

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

GA

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

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

(**indicate state if not in Alabama)

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

Other County1 **Fulton**

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Other State1 **GA**

Other County 2

Other State 2

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

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

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

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

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

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

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

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

Exempt Reason

Practice Telephone: **(205) 933-1118**

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

Home Telephone:

Home Address: [redacted]

Public Address: **TRUE**

Mail Address: **FALSE**

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

Feb 9, 2012 8:53 AM

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

2011 Online Renewal Summary

Name: **Ivan David Diamond**
License Number: **MD.27687**
Transaction Date: **2010-12-09***
Transaction Number: **VXJF6B960CA4**
Registration Fee: **300**
Date of Birth: **1952-02-13**

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

What is your Practice Address? (No PO Boxes)

Street **1001 17th Street South**

City **Birmingham**

State **Alabama**

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

Country **United States**

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

What is your Home Address? (No PO Boxes)

Street [redacted]

City [redacted]

State [redacted]

Zip [redacted]

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

Country **United States**

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What is your Home Email? [redacted]

What is your Home Phone? [redacted]

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

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

Social Security Number [redacted]

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

Is your Primary Specialty Board Certified? **Yes**

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

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

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

What is your group name? **Northside womens Specialists**

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

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

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

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

Which Ones? **Georgia**

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

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

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

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

Do you currently conduct office based surgery involving the administration of parenteral medication for analgesia/sedation, general anesthesia or major regional block anesthesia? **No**

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

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

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

Please answer the following questions.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2012 Online Renewal Summary

Name: **Ivan David Diamond**
License Number: **MD.27687**
Transaction Date: **2011-11-07***
Transaction Number: **VZNA2FE479B8**
Registration Fee: **300**
Date of Birth: **1952-02-13**

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

What is your Practice Address? (No PO Boxes)

Street **980 Johnson Ferry Road**

Apt/Suite **Suite 620**

City **Atlanta**

State **Georgia**

Zip **30342**

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

Country **United States**

What is your practice Telephone? **4042552057**

What is your practice Fax? **4042564238**

What is your Home Address? (No PO Boxes)

Street [redacted]

City [redacted]

State [redacted]

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Zip [redacted]

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

Country **United States**

What is your Home Email? [redacted]

What is your Home Phone? [redacted]

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

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

Social Security Number [redacted]

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

Is your Primary Specialty Board Certified? **Yes**

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

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

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

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

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

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

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Which Ones? **Georgia**

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

Please answer the following questions.

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