

2012 Online Renewal Summary

Name: Max Michael III

Transaction Date: 2011-12-05*

Registration Fee: 300

License Number: MD.8195

Transaction Number: VKVA3B764A61

Date of Birth: 1946-03-14

* - 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 1515 6th Ave South

City Birmingham

State Alabama

Zip 35233

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

Country United States

What is your practice Email? maxm@uab.edu

What is your practice Telephone? (205) 930-3771

What is your practice Fax? (205) 930-3497

What is your Home Address? (No PO Boxes)

Street 4316 Glenwood Ave

City Birmingham

State Alabama

Zip 35222-4303

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

Country United States

What is your Home Phone? (205) 591-7586

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 -1950

What is your Primary Specialty? (If None Please Choose None) Internal Medicine

Is your Primary Specialty Board Certified? Yes

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

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

What is your group name? Jefferson Clinic

What is the name of the Primary Hospital where you have staff privileges? Cooper Green Hospital

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

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

Are you licensed in another state? No

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**

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? Yes

Approximately how many hours per week do you practice the above defined primary care services in Alabama? (Approximately number of hours per week) 10

Approximately how many patient encounters (office, hospital, ER, etc.) per week do you have involving the above defined primary care services in Alabama? (Approximately number of encounters per week. 30

CME Certification: (Select One) I hereby certify that I have met the annual minimum continuing education requirement of 25 hours of AMA PRA Category I Credits™ or equivalent continuing medical education for the calendar year 2011 and have supporting documentation if audited.

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

Please answer the following questions.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



2011 Online Renewal Summary

Name: Max Michael III

Transaction Date: 2010-10-17*

Registration Fee: 300

License Number: MD.8195

Transaction Number: VXJF5FF24588

Date of Birth: 1946-03-14

* - 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 1515 6th Ave South

City Birmingham

State Alabama

Zip 35233

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

Country United States

What is your practice Email? maxm@uab.edu

What is your practice Telephone? (205) 930-3771

What is your practice Fax? (205) 930-3497

What is your Home Address? (No PO Boxes)

Street 4316 Glenwood Ave

City Birmingham

State Alabama

Zip 35222-4303

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

Country United States

What is your Home Phone? (205) 591-7586

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 1950

What is your Primary Specialty? (If None Please Choose None) Internal Medicine

Is your Primary Specialty Board Certified? Yes

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

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

What is your group name? Jefferson Clinic

What is the name of the Primary Hospital where you have staff privileges? Cooper Green Hospital

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

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

Are you licensed in another state? No

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**

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? Yes

Approximately how many hours per week do you practice the above defined primary care services in Alabama? (Approximately number of hours per week) 10

Approximately how many patient encounters (office, hospital, ER, etc.) per week do you have involving the above defined primary care services in Alabama? (Approximately number of encounters per week. 35

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.



2010 Online Renewal Summary

Name: Max Michael III

Transaction Date: 2009-10-19*

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License Number: MD.8195

Transaction Number: VUHF4B729659

Date of Birth: 1946-03-14

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* - This date reflects the date that the transaction was downloaded into the production system not the date the Registration Fee: 300

transaction was processed online.

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 If yes, please explain:

voluntarily surrendered under threat of suspension or revocation within the past year? no If ye: If you

Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under monit If yes, please explain:

If yes, conditions restricting your practice, within the past year? no Have y

Have you been denied a certificate of qualification or license to practice medicine in any state or has your application for a convict If yes, please explain: certificate of qualification or license to practice medicine been withdrawn under threat of denial within the past year? no If yes, p

Has you

Have you had a judgment rendered against you, or action settled relating to the performance of your professional service wi than a va If yes, ple the past year? no Note: The

To your knowledge, are you the subject of an investigation, or has a formal complaint against your license been filed by an application physician. Primary spe

licensing Board/Agency as of the date of this application within the past year? no

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Other County 2

Other State 2

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

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

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. 10

Approximately how many patient encounters (office, hospital, ER, etc.) per week do you have involving the above defined priary care services in Alabama? 30

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) 930-3771

Practice Address: Po Box 55845

Home Telephone: (205) 591-7586

Home Address: 4316 Glenwood Ave

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

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: Internal Medicine

Are you Board certified in your primary specialty? Y

Secondary specialty:
Are you Board certified in your secondary specialty?
Practice Type: G
If Group, provide the Group Name: Jefferson Clinic
Primary Hospital where you have privileges: (if any) null
Hospital Name: Cooper Green Hospital
Hospital City: Birmingham
Hospital State: AL
Are you licensed in another State: N
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



2009 Online Renewal Summary

Name: Max Michael III

Transaction Date: 2008-10-20*

Registration Fee: 300

License Number: MD.8195

Transaction Number: VTHF2EFF912D

Date of Birth: 1946-03-14

* - 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**

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: Internal Medicine

Are you Board certified in your primary specialty? Y

Secondary specialty:
Are you Board certified in your secondary specialty?
Practice Type: G
If Group, provide the Group Name: Jefferson Clinic
Primary Hospital where you have privileges: (if any) null
Hospital Name: Cooper Green Hospital
Hospital City: Birmingham
Hospital State:
Are you licensed in another State: N
Are you actively engaged in clinical practice in the State of Alabama? Y
What is your principal county of practice in the State of Alabama? Jefferson
(**indicate state if not in Alabama)
Other county(ies) of practice? Indicate state, if counties are not in Alabama). Click 'NONE' if you only practice in the indicated principal county. null
Other County1

Other State1

Other County 2

Other State 2

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

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. 10

Approximately how many patient encounters (office, hospital, ER, etc.) per week do you have involving the above defined priary care services in Alabama? 35

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) 930-3771

Practice Address: Po Box 55845

Home Telephone: (205) 591-7586

Home Address: 4316 Glenwood Ave

Public Address:

Mail Address:

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2008 Online Renewal Summary

Name: Max Michael III

Transaction Date: 2007-10-15*

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License Number: MD.8195

Transaction Number: VREF1D4AFA32

Date of Birth: 1946-03-14

* - This date reflects the date that the transaction was downloaded into the production system not the date the Registration Fee: 300 transaction was processed online.

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 If yes, please explain: 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 If yes, please explain: 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 If yes, please explain: certificate of qualification or license to practice medicine been withdrawn under threat of denial within the past year? no If y€ Has

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Have you had a judgment rendered against you, or action settled relating to the performance of your professional serv If yes, please explain:

the past year? no Note:

To your knowledge, are you the subject of an investigation, or has a formal complaint against your license been filed applic If yes, please explain: physic licensing Board/Agency as of the date of this application within the past year? no Primai

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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: Internal Medicine

Are you Board certified in your primary specialty? Y

Secondary specialty: Other

Are you Board certified in your secondary specialty?

Practice Type: G

if Group, provide the Group Name: Jefferson Clinic

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

Hospital Name: Cooper Green Hospital

Hospital City: Birmingham

Hospital State: AL

Are you licensed in another State: N

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) AL

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

Other County1

Other State1

Other County 2

Other State 2

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

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. 10

Approximately how many patient encounters (office, hospital, ER, etc.) per week do you have involving the above defined priary care services in Alabama? 35

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) 930-3292

Practice Address: Po Box 55845

Home Telephone: (205) 591-7586

Home Address: 4316 Glenwood Ave

Public Address:

Mail Address:

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2007 Online Renewal Summary

License Number: MD.8195

Transaction Number: VXJF0BFAE3C4

Date of Birth: 1946-03-14

Transaction Date: 2006-10-21*
Registration Fee: 200

Name: Max Michael III

* - 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 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 with 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

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: INTERNAL MEDICINE

Are you Board certified in your primary specialty? yes

Secondary specialty: Are you Board certified in your secondary specialty? Practice Type: Group If Group, provide the Group Name: Jefferson Clinic Primary Hospital where you have privileges: (if any) null Hospital Name: Cooper Green Hospital Hospital City: Birmingham Hospital State: AL Are you licensed in another State: no Are you actively engaged in clinical practice in the State of Alabama? yes What is your principal county of practice in the State of Alabama? Jefferson (**indicate state if not in Alabama) Other county(ies) of practice? Indicate state, if counties are not in Alabama). Click 'NONE' if you only practice in the indicated principal county. null

Other County1

Other-State 1

Other County 2

Other State 2

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

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

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

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

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

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. 8

Approximately how many patient encounters (office, hospital, ER, etc.) per week do you have involving the above defined priary care services in Alabama? 30

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

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

Exempt Reason

Practice Telephone: (205) 930-3292

Practice Address: PO BOX 55845

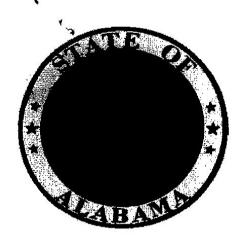
Home Telephone: (205) 591-7586

Home Address: 4316 GLENWOOD AVE

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



2006 Online Renewal Summary

Name: Max Michael III

Transaction Date: 2005-10-22*

Registration Fee: 200

License Number: MD.8195

Transaction Number: null

Date of Birth: 1946-03-14

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

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

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

Do you currently* have any mental or physical condition or impairment (including, but not limited to, substance abuse, alcohol affect or including, but not limited to, substance abuse, alcohol affect or condition) which in any way currently affects or if untreated could affect or abuse, or mental, emotional or nervous disorder or condition) which in any way currently affects or if untreated could affect or abuse. Do you currently* have any mental or physical condition or impairment (including, but not limited to, substance abuse, alconol affect, you currently affects, or if untreated could affect, you abuse, or mental, emotional or nervous disorder or condition) which in any way currently affects, or if untreated could affect, you abuse, or mental, emotional or nervous disorder or condition) which in any way currently affects, or if untreated could affect, you abuse, or mental, emotional or nervous disorder or condition) which in any way currently affects, or if untreated could affect, you abuse, or mental, emotional or nervous disorder or condition) which in any way currently affects, or if untreated could affect, you abuse, or mental, emotional or nervous disorder or condition) which in any way currently affects, or if untreated could affect, you abuse, or mental, emotional or nervous disorder or condition) which in any way currently affects, or if untreated could affect, you abuse, or mental, emotional or nervous disorder or condition) which in any way currently affects, or if untreated could affect, you abuse, and or nervous disorder or condition and the next very large to the property of the propert 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 ability to practice in a competent and professional manner or, within the past year, have you applied for and/or have you received ability to practice in a competent and professional manner or, within the past year, have you applied for and/or have you received any other psychotic disorder? N If yes, please explain:

any payment or other compensation for any mental or physical condition? N

Within the past year, have you ever raised the issue of consumption of drugs or alcohol or the issue of a mental, emotional, nearly the past year, have you ever raised the issue of consumption of drugs or alcohol or the issue of a mental, emotional, or explanation for your actions in the course of any mental, emotional, or explanation for your actions in the course of any mental, emotional, or explanation for your actions in the course of any mental, emotional, or explanation for your actions in the course of any mental, emotional, or explanation for your actions in the course of any mental, emotional, or explanation for your actions in the course of any mental, emotional, or explanation for your actions in the course of any mental, emotional, emoti Within the past year, have you ever raised the issue of consumption of drugs of alcohol of the issue of a mental, emotions in the course of any nervous, or behavioral disorder or condition as a defense, mitigation, or other proceeding or any indicator of the proceeding or investigation; any indicator of the proceeding of the pro nervous, or behavioral disorder or condition as a detense, mitigation, or explanation for your actions in the course of any administrative or judicial proceeding or investigation; any inquiry or other proceeding; of any proposed termination by an administrative or judicial proceeding or investigation; any inquiry or other proceeding; of any proposed termination by an administrative or judicial proceeding or investigation; any inquiry or other proceeding; of any proposed termination by an administrative or judicial proceeding or investigation; any inquiry or other proceeding; of any proposed termination by an administrative or judicial proceeding or investigation; any inquiry or other proceeding; of any proposed termination by an administrative or judicial proceeding or investigation; any inquiry or other proceeding; or any proposed termination by an administrative or judicial proceeding or investigation; any inquiry or other proceeding or investigation; any inquiry or other proceeding or investigation; and investigation or licensing authority? administrative or judicial proceeding or investigation; any inquiry or other proceeding; or any proposed tent administrative or judicial proceeding or investigation; any inquiry or other proceeding; or any proposed tent administrative or judicial proceeding or investigation; any inquiry or other proceeding; or any proposed tent administrative or judicial proceeding or investigation; any inquiry or other proceeding; or any proposed tent administrative or judicial proceeding or investigation; any inquiry or other proceeding; or any proposed tent administrative or judicial proceeding or investigation; any inquiry or other proceeding; or any proposed tent administrative or judicial proceeding or investigation; any inquiry or other proceeding; or any proposed tent administrative or judicial proceeding or investigation; any inquiry or other proceeding; or any proposed tent administrative or judicial proceeding or investigation; and investigation or licensing authority? If yes, please explain:

Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism? N If yes, please explain:

Prima

Are you currently* engaged in the illegal use of controlled dangerous substances? N If yes, please explain: Аге ус

general

If your answer to the preceding question is yes, are you currently* participating in a supervised rehabilitation program where you in order to accure that you are not appearing in the illegal use of controlled denorate substance? N If your answer to the preceding question is yes, are you currently participating in a supervised renabilitation program your answer to the preceding question is yes, are you currently participating in a supervised renabilitation program your answer to the preceding question is yes, are you currently participating in a supervised renabilitation program your answer to the preceding question is yes, are you currently participating in a supervised renabilitation program your answer to the preceding question is yes, are you currently participating in a supervised renabilitation program your answer to the preceding question is yes, are you currently participating in a supervised renabilitation program your answer to the preceding question is yes, are you currently participating in a supervised renabilitation program your answer to the preceding question is yes, are you currently participating in the illegal use of controlled dangerous substances? Notice the program of the Does y If yes, please explain: system, Have you been, within the past year, convicted of driving under the influence (DUI) or have you been charged with I Approxin you answ

If yes, please explain:

convicted of a lesser offense such as reckless driving? N CME Cert continuing I certify tha

Has your medical training or medical practice been interrupted or suspended for a period longer than 60 days f If yes, please explain: I am exemp: Practice Tele

than a vacation? N

Practice Addr.

*Note: The term "currently" does not mean on the day of, or even in the weeks or months preceding the c application. Rather, it means recently enough so that the condition referred to may have an ongoing imp If yes, please explain:

as a physician or an assistant to a physician, or within the past two years.

Primary specialty:

Are you Board certified in your primary specialty? Y

Home Telephone: (205) 591-7586

Home Address: 4316 GLENWOOD AVE

Public Address: Practice

Mail Address: Home

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Seconda	y specialty:

Are you Board certified in your secondary specialty? N

Practice Type:

Primary Hospital where you have privileges:

Are you licensed in another State: N

Primary Care Information:

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

Does your practice include the delivery of primary care medical services in Alabama? (Primary care is defined as: "Basic or general `gatekeeper` health care focused on the point at such a patient ideally first seeks assistance from the medical care system, exclusive of an emergency care situation.") **Y**

Approximately how many hours per week do you practice the above-defined primary care services in Alabama? Only answer if you answered YES to questions 1 and 2 above. 8

CME Certification: I hereby certify that I have met the annual minimum continuing education requirement of 12 hours of Category I continuing medical education for the Calendar Year 2005. **Y**

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

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

Practice Telephone: (205) 930-3292

Practice Address: PO BOX 55845

If yes, prease explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

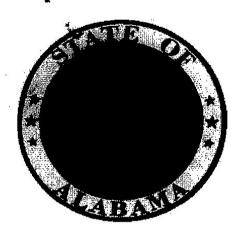
Has your medical training or medical practice been interrupted or suspended for a period longer than 60 days for any reason other than a vacation? N

If yes, please explain:

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

Primary specialty:

Are you Board certified in your primary specialty? Y



2005 Online Renewal Summary

Name: Max Michael III

Transaction Date: 2004-10-16*

Registration Fee: 200

License Number: MD.8195

Transaction Number: null

Date of Birth: 1946-03-14

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

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

Primary specialty:

Are you Board certified in your primary specialty? Y

Secondary	specialty:

Are you Board certified in your secondary specialty? N

Practice Type:

Primary Hospital where you have privileges:

Are you licensed in another State: N

Primary Care Information:

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

Does your practice include the delivery of primary care medical services in Alabama? (Primary care is defined as: "Basic or general `gatekeeper` health care focused on the point at such a patient ideally first seeks assistance from the medical care system, exclusive of an emergency care situation.") Y

Approximately how many hours per week do you practice the above-defined primary care services in Alabama? Only answer if you answered YES to questions 1 and 2 above. 8

CME Certification: I hereby certify that I have met the annual minimum continuing education requirement of 12 hours of Category I continuing medical education for the Calendar Year 2004. Y

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

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

Practice Telephone: (205) 975-7742

Practice Address: PO BOX 55845

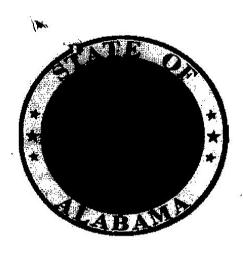
Home Telephone: (205) 591-7586

Home Address: 4316 GLENWOOD AVE

Public Address: Practice

Mail Address: Home

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2004 Online Renewal Summary

Name: Max Michael III

Transaction Date: 2003-10-19*

Registration Fee: 200

License Number: MD.8195

Transaction Number: null

Date of Birth: 1946-03-14

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

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

If yes, please explain:

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

If yes, please explain:

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

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- Have you been denied a certificate of qualification or license to practice medicine in any state or has your application for a certificate of qualification or license to practice medicine been withdrawn under threat of denial within the past year? N
 - If yes, please explain:
 - Have you had a judgement rendered against you, or action settled relating to the performance of your professional service within the past year? N
 - If yes, please explain:
 - To your knowledge, are you the subject of an investigation, or has a formal complaint against your license been filed by any licensing Board/Agency as of the date of this application within the past year? N
- at Feb 6, 2012 2:05 PM

Secondary	specialty:
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Are you Board certified in your secondary specialty? N

Practice Type:

Primary Hospital where you have privileges:

Are you licensed in another State: N

Primary Care Information:

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

Does your practice include the delivery of primary care medical services in Alabama? (Primary care is defined as: "Basic or general `gatekeeper` health care focused on the point at such a patient ideally first seeks assistance from the medical care system, exclusive of an emergency care situation.") **Y**

Approximately how many hours per week do you practice the above-defined primary care services in Alabama? Only answer if you answered YES to questions 1 and 2 above. 10

CME Certification: I hereby certify that I have met the annual minimum continuing education requirement of 24 hours of Category I continuing medical education within the past two Calendar Years ending December 31, 2004. Y

I certify that I am exempt from the minimum CME requirement. N

I am exempt from the CME requirement for the following reason: null

Practice Telephone: (205) 975-7742

Practice Address: PO BOX 55845

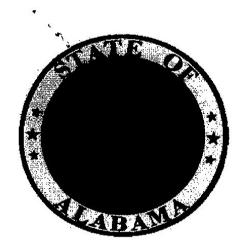
Home 7 (ephone: (205) 591-7586

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Mail Address: Home

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

2003 Online Renewal Summary

Name: Max Michael III

Transaction Date: 2002-10-24*

Registration Fee: 200

License Number: MD.8195

Transaction Number: null

Date of Birth: 1946-03-14

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

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

To your knowledge, are you the subject of an investigation by any licensing Board/Agency as of the date of this application within the past year? N

Feb 6, 2012 2:05 PM

If yes, please explain:

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

If yes, please explain:

Do you currently* have any mental or physical condition or impairment (including, but not limited to, substance abuse, alcohol abuse, or mental, emotional or nervous disorder or condition) which in any way currently affects, or if untreated could affect, your ability to practice in a competent and professional manner? **N**

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

Primary specialty:

Are you Board certified in your primary specialty? Y

Feb 6, 2012 2:05 PM

Secondary	specialty:
Cocontable y	specialty.

Are you Board certified in your secondary specialty? N

Practice Type:

Primary Hospital where you have privileges:

Are you licensed in another State: N

Primary Care Information:

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

Does your practice include the delivery of primary care medical services in Alabama? (Primary care is defined as: "Basic or general `gatekeeper` health care focused on the point at such a patient ideally first seeks assistance from the medical care system, exclusive of an emergency care situation.") Y

Approximately how many hours per week do you practice the above-defined primary care services in Alabama? Only answer if you answered YES to questions 1 and 2 above. 10

CME Certification: I hereby certify that I have met the annual minimum continuing education requirement of 24 hours of Category I continuing medical education within the past two Calendar Years ending December 31, 2003. Y

I certify that I am exempt from the minimum CME requirement. N

I am exempt from the CME requirement for the following reason: null

Practice Telephone: (205) 975-7742

Practice Address: PO BOX 55845

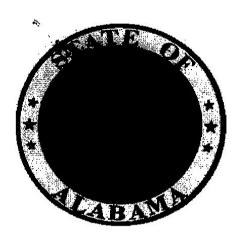
Home Telephone: (205) 591-7586

Home Address: 4316 GLENWOOD AVE

Public Address: Home

Mail Address: Home

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

2002 Online Renewal Summary

Name: Max Michael III

Transaction Date: 2001-11-06*

Registration Fee: 200

License Number: MD.8195

Transaction Number: null

Date of Birth: 1946-03-14

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

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

To your knowledge, are you the subject of an investigation by any licensing Board/Agency as of the date of this application within the past year? N

Feb 6, 2012 2:04 PM

if yes, please explain:

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

If yes, please explain:

Do you currently* have any mental or physical condition or impairment (including, but not limited to, substance abuse, alcohol abuse, or mental, emotional or nervous disorder or condition) which in any way currently affects, or if untreated could affect, your ability to practice in a competent and professional manner? N

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

Primary specialty:

Are you Board certified in your primary specialty? Y

Feb 6, 2012 2:04 PM

Secor	ndarv	special	ltv:
		ab a aim	

Are you Board certified in your secondary specialty? N

Practice Type:

Primary Hospital where you have privileges:

Are you licensed in another State: N

Primary Care Information:

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

Does your practice include the delivery of primary care medical services in Alabama? (Primary care is defined as: "Basic or general `gatekeeper` health care focused on the point at such a patient ideally first seeks assistance from the medical care system, exclusive of an emergency care situation.") **Y**

Approximately how many hours per week do you practice the above-defined primary care services in Alabama? Only answer if you answered YES to questions 1 and 2 above. 10

CME Certification: I hereby certify that I have met the annual minimum continuing education requirement of 24 hours of Category I continuing medical education within the past two Calendar Years ending December 31, 2002. Y

I certify that I am exempt from the minimum CME requirement. N

I am exempt from the CME requirement for the following reason:

Practice Telephone: (205) 975-7742

Practice Address: PO BOX 55845

Home Telephone: (205) 591-7586

Home Address: 4316 GLENWOOD AVE

Public Address: Practice

Mail Address: Home

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

License Renewal for 2001 Deadline is December 31, 2000

State of Alabama Medical Licensure Commission

334/242-4153

P.O. Box 887

25

5322

Montgomery, Alabama 36101-0887



MAX III MICHAEL , M.D.
PO BOX 55845
BIRMINGHAM, AL 35255-5845

Licensc #8195

Complete **BOTH** sides including signature. Be sure to correct or supply **ALL** information. Return with \$125.00 renewal fee. Incomplete applications will be returned. Failure to register and pay renewal fee will result in the automatic revocation of the current license to.

MICHAEL, MAX III

practice medicine or osteopathy.

Please make corrections or supply information: Licer Race: White [X] Black [_] Am. Indian [_] Oriental or Asian		
Office Address:	Home Address:	- 1
	4316 GLENWOOD AVE	
PO BOX 55845		1
City, State, Zip: BIRMINGHAM, AL 35255 5845	City, State, Zip: BIRMINGHAM, AL 35222 43	03 .
(Alabama) County: Jefferson	(Alabama) County: Jefferson	
Business Phone: (205)930-3600	Home Phone: (205)591-7506	r vÅs
Fax Number: (205)930-3497	(Will not be published)	* * * * * * * * * * * * * * * * * * *
Permission to publish in Roster: Yes [X] No [_]	Send official mail to: Business [] address Home []	
Specialty: Primary: INTERNAL MEDICINE	Board Certified: Yes	
Secondary:	Board Certified: Yes [] No [_]
Form of Practice: Solo Partnership (2, 3, or 4) [X] JEFFERSON CLINIC PC	Group (5 or more) If Group, give name below	V :
Name: COOPER GREEN HOSP City/State: BIRMINGHAM Are you licensed in another state: Yes [_] No [X] which on Primary Care Information: 1. Are you actively engaged in clinical practice in the State of Alab Yes [4] Go to Question 2. No [] Do NOT answer questions	nes: [] [] [] [] pama? s_2 and 3 below. Skip to CME Certification question	ns .
2: Does your practice include the delivery of primary care medical 'gatekeeper' health care focused on the point at which a patient ideal	services in Alabama? (Primary care is defined as: ly first seeks assistance from the medical care syste	"Basic or general m, exclusive of a
.emergency care situation.") Yes [9 Go to Question 3 No [] Do NOT answer question	3 helow. Skip to CME Certification questions	
3. Approximately how many hours per week do you practice the ab	pove-defined primary care services in Alabama? On	ly answer if you
answered YES to questions 1 and 2 above.) Approximately/O CME Certification: (Check one)	hours per week.	
I I hereby certify that I have met the annual minimum continuing of	education requirement of 24 hours of Category I	
continuing medical education within the past two calendar years ([] I certify that I am exempt from the minimum continuing medical	education requirements for the following reason:	osa j
[] I do not reside in the State of Alabama and do not have a signific	cant portion of my medical practice in Alabama.	
[7] I received my initial license to practice medicine in Alabama aft	er June 30th of this calendar year.	
[] I reinstated my license to practice medicine in the State of Alaba	ama after June 30° of this calendar year	1
[] I am a resident physician enrolled in a residency training program [] I am retired from the practice of medicine and have obtained a v DEADLINE IS DE	m. valver from the Board of Medical Examiners. CEMBER 31, 2000	# # # # # # # # # # # # # # # # # # #
Complete both sides including signature Supply of		OVER

•		Yes	M
1.	Pave you been convicted of a felony or of any offense (felony/misdemeanor) involving the practice of medicine within the past year?		
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?	6.3	[4
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?	[]	[4
4.	Have you been denied a certificate of qualification or license to practice medicine in any state with	[]	[]
5.	established of quantication of needise to practice medicine ocen withdrawn under threat of denial within the past year?	[]	[]
	Have you had a judgement rendered against you, or action settled relating to the performance of your professional service within the past year?	[]	(4)
6.	To your knowledge, are you the subject of an investigation by any licensing Board/Agency as of the date of this application within the past year?	[]	[]
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?		
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?	[]	[]
9.	Within the past year, have you ever raised the issue of consumption of drugs or alcohol or the issue of a mental, emotional, nervous, or behavioral disorder or condition as a defense, mitigation, or explanation for your actions in the course of any administrative or judicial proceeding or investigation; any inquiry or other proceeding; or any proposed termination by an educational institution, employer, government agency, professional organization or licensing authority?	[]	[]
0.	Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism?	[]	[] []
1.	Are you currently engaged in the illegal use of controlled dangerous substances?	[]-	d
2.	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?	[]	[]
3.	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?		[9]
4.	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?	F 1	Γ 9 ′
	The term "currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the condition referred to may have an ongoing impact on one's functioning as a physician or an assistant to a physician, or within the past two years.		.,
YOU	U HAVE ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, PLEASE ATTACH A DETAILED EXPLANATION YOUR APPLICATION UPON RETURNING IT TO THIS OFFICE.	ON	
	that all information on this form is correct	<i>10</i>	
	Signature Date		

Date

- Complete both sides, including signature.
- Be sure to correct or supply all information.
- Incomplete applications will be returned.

Return with \$125.00 renewal fee to:

Medical Licensure Commission P.O. Box 887 Montgomery, AL 36101-0887

icense Renewal for 2000 Deadline is December 31, 1999

State of Alabama Medical Licensure Commission

334/242-4153

P.O. Box 887

Montgomery, Alabama 36101-0887



MAX III MICHAEL , M.D. PO BOX 55845 BIRMINGHAM, AL 35255-5845 Complete BOTH sides including signature.

Be sure to correct or supply ALL information.

Return with \$100.00 renewal fee.

24 Incomplete applications will be returned.

Failure to register and pay renewal fee will result in the automatic revocation of the current license to practice medicine or osteopathy.

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Please make corrections or supply information: Lie	cense 8195 DATE-ISSUED: 2/15/78 Sex: M [X	33 (33 (34 (34 (34 (34 (34 (34 (34 (34 (
Race: White [X] Black [] Am. Indian [] Oriental or Asia	an Other Social Security # Enter SSAI	950 **
Office Address:	Home Address:	"
7 (4) 1 (4) 1 (4) 2 (4) 4 (4)	4316 GLENWOOD AVE	
PO BOX 55845	÷	4,*
City, State, Zip: BIRMINGHAM, AL 35255 5845	City, State, Zip: BIRMINGHAM, AL 35222	4303
- (Alabama) County: Jefferson	(Alabama) County: Jefferson	
Business Phone: (205)930-3600	Home Phone: (205)591-7506	7
Fax Number: (205)930-3497	(Will not be published)	
Permission to publish in Roster: Yes [X] No [_]	Send official mail to: Business [1] addre Home []	ess (check one)
Specialty: Primary: INTERNAL MEDICINE	Board Certified: Yes	MNoll
Secondary:	Board Certified: Yes	No □
Form of Practice:[] Solo [] Partnership (2, 3, or 4) [X JEFFERSON CLINIC PC	X] Group (5 or more) If Group, give name be	low:
A STATE OF THE PERSON CLINIC PC	<u> </u>	
Primary Hospital where you have staff privileges: Name: COOPER GREEN HOSP City/State: BIRMINGHA Are you licensed in another state: Yes [] No [X] which of Primary Care Information:	ones: [_][_][_]	
Yes [*] Go to Question 2 No [] Do NOT answer question 2 Does your practice include the delivery of primary care medica garckeeper health care focused on the point at which a patient idea emergency care situation.")	ons 2 and 3 below. Skip to CME Certification quest all services in Alabama? (Primary care is defined a ally first seeks assistance from the medical care sys	s: "Basic or general
Yes [Yes [Yes [Yes [Yes	n 3 below. Skip to CME Certification questions.	
Approximately how many hours per week do you practice the a	bove-defined primary care services in Alabama?	Only answer if you
answered YES to questions 1 and 2 above.) Approximately 10 CME Certification: (Check one)	hours per week.	
If I hereby certify that I have met the annual minimum continuing	education requirement of 12 hours of Category I	
continuing medical education during the calendar year ending D	December 31, 1999.	
[] I certify that I am exempt from the minimum continuing medical [] I do not reside in the State of Alabama and do not have a signif	al education requirements for the following reason	
I J I received my initial license to practice medicine in Alabama af	fter June 30th of this calendar year.	• •••
If I reinstated my license to practice medicine in the State of Alab	bama after June 30th of this calendar year.	
[] [] I am a resident physician enrolled in a residency training progra		
[] I am retired from the practice of medicine and have obtained a Complete both sides including signature. Supply of	CEMBER 31, 1999 COrrect all information.	OVER
Liceuse #8195	4989 MICHARY MAY III	

		Y	LS	N
	Have you been convicted of a felony or of any offense (felony/misdemeanor) involving the practice of medicine within the past year?	•	**	C
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?	۲	y.	Į.
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?	Į	1	[
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?	í]	E
5.	Have you had a judgement rendered against you, or action scaled relating to the performance of your professional service within the past year?	[]	[
6.	To your knowledge, are you the subject of an investigation by any licensing Board/Agency as of the date of this application within the past year?	Ĺ]	Į
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?	I	1	I S
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?	ſ	1	E
9.	Within the past year, have you ever raised the issue of consumption of drugs or alcohol or the issue of a mental, emotional, nervous, or behavioral disorder or condition as a defense, mitigation, or explanation for your actions in the course of any administrative or judicial proceeding or investigation; any inquiry or other proceeding; or any proposed termination by an educational institution, employer, government agency, professional organization or licensing authority?	1]	[]
10.	Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyenrism?	Ĺ)	
11.	Are you currently engaged in the illegal use of controlled dangerous substances?	[]	
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?	[1	[
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?	ι]	1
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?	[J	1
u est,	The term "currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the condition referred to may have an ongoing impact on one's functioning as a physician or an assistant to a physician, or within the past two years.			
I certify	IF YOU HAVE ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, PLEASE ATTACH A DETAILED EXPLANATION WITH YOUR APPLICATION UPON RETURNING IT TO THIS OFFICE. that all information on this form is correct. Signature // g/99		_	
	was w			

Complete both sides, including signature. Be sure to supply all information. Incomplete applications will be returned.

Return with \$100.00 renewal fee to:

Medical Licensure Commission P.O. Box 887 Montgomery, AL 36101-9887

License Renewal for 1999 Deadline is December 31, 1998

State of Alabama Medical Licensure Commission

334/242-4153

P.O. Box 887

28

4985

Montgomery, Alabama 36101-0887



********************************AUTO***3-DIGIT 352 MAX III MICHAEL, M.D. PO BOX 55845 BIRMINGHAM AL 35255-5845

Complete BOTH sides including signature. Be sure to correct or supply ALL information. Return with \$100.00 renewal fee.

Incomplete applications will be returned. Failure to register and pay renewal fee will result in the automatic revocation of the current license to practice medicine or osteopathy.

Please make corrections or supply information: Lice Race: White [X] Black [] Am. Indian [] Oriental or Asian	nsc 8195 DATE-ISSUED: 2/15/78 Sex: M [X] F [] [] Other [] Social Security # 1950
Office Address:	Home Address:
	4316 GLENWOOD AVE
PO BOX 55845	
City, State, Zip: BIRMINGHAM, AL 35255 5845	City, State, Zip: BIRMINGHAM, AL 35222 4303
(Alabama) County: Jefferson	(Alabama) County: Jefferson
Business Phone: (205)930-3600	Home Phone: (205)591-7506
Fax Number: (205)930-3497	(Will not be published)
Permission to publish in Roster: Yes [X] No [_]	Send official mail to: Business [* address (check one) Home []
Specialty: Primary: INTERNAL MEDICINE	Board Certified: Yes [No []
Secondary: Form of Practice: [] Solo [] Partnership (2, 3, or 4) [X] JEFFERSON CLINIC PC	Board Certified: Yes [] No [] Group (5 or more) If Group, give name below:
Primary Hospital where you have staff privileges: Name: COOPER GREEN HOSP City/State: BIRMINGHAM Are you licensed in another state: Yes [] No [X] which on Primary Care Information: 1. Are you actively engaged in clinical practice? (Check one): Yes 2. Does your practice include the delivery of primary care medical scare focused on the point at which a patient ideally first seeks ass room care."): (Check one): Yes [] No [] 3. Approximately how many hours per week do you practice the about CME Certification: (Check one) [Y I hereby certify that I have met the annual minimum continuing econtinuing medical education during the calendar year ending December 1 I certify that I am exempt from the minimum continuing medical	es: [_] [_] [_] [_] [YNo [] services? (Primary care is defined as: "Basic or general health distance from the medical care system, exclusive of emergency ove-defined primary care services?
[] I do not reside in the State of Alabama and do not have a signific [] I received my initial license to practice medicine in Alabama afte [] I reinstated my license to practice medicine in the State of Alabama are sident physician enrolled in a residency training program [] I am retired from the practice of medicine and have obtained a wear DEADLINE IS DE	er June 30th of this calendar year. ma after June 30th of this calendar year. n.

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

OVER

		YES	NO
1.	* Have you been convicted of a felony or of any offense (felony/misdemeanor) involving the practice of medicine within the past year?	[]	W
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?	[]	[*
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?	[]	. [3]
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?	[]	[4]
5.	Have you had a judgement rendered against you, or action settled relating to the performance of your professional service within the past year?	[]	[d
6.	To your knowledge, are you the subject of an investigation by any licensing Board/Agency as of the date of this application within the past year?	1 1	ινĬ
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?	11	[4]
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?	[]	[U
9.	Within the past year, have you over raised the issue of consumption of drugs or alcohol or the issue of a mental, emotional, norvous, 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?	[]	ાષ
10.	Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism?	ιj	[µY
11.	Are you currently engaged in the illegal use of controlled dangerous substances?	[]	[V
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?	[]	11
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?	[]	[4]
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?	. []	M
	The term "currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the condition referred to may have an ongoing impact on one's functioning as a physician or an assistant to a physician, or within the past two years.		
	IF YOU HAVE ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, PLEASE ATTACH A DETAILED EXPLANATION WITH YOUR APPLICATION UPON RETURNING IT TO THIS OFFICE.	_	
I certif	fy that all information on this form is correct. (0/20/	98	
	Signature Date		

Complete both sides, including signature. Be sure to supply all information. Incomplete applications will be returned.

Return with \$100.00 renewal fee to:

Medical Licensure Commission P.O. Box 887 Montgomery, AL 36101-0887

License Renewal for 1998 Deadline is December 31, 1997

MAX III MICHAEL, M.D.

State of Alabama Medical Licensure Commission

Complete BOTH sides including signature. Be sure to correct or supply ALL information.

Return with \$100.00 renewal fee.

334/242-4153

P.O. Box 887

16

Montgomery, Alabama 36101-0887



PO BOX 55845 67 BIRMINGHAM, AL 35255-5845 470	Incomplete applications will be returned. Failure to register and pay renewal fee will result in the automatic revocation of the current license to practice medicine or osteopathy.
Please make corrections or supply information: La Racc: White [X] Black [_] Am. Indian [_] Oriental or Ass	icense 8195 DATE-ISSUED: 2/15/78 Sex: M [X] F [_] ian [_] Other [_] Social Security #25566 4950
Office Address:	Home Address:
	4316 GLENWOOD AVE
PO BOX 55845	
City, State, Zip: BIRMINGHAM, AL 35255 5845	City, State, Zip: BIRMINGHAM, AL 35222 4303
(Alabama) County: Jefferson	(Alabama) County: Jefferson
Business Phone: (205)930-3600	Home Phone: (205)591-7506
Fax Number: (205)930-3497	(Will not be published)
Permission to publish in Roster: Yes [X] No [_]	Send official mail to: Business [/] address (check one) Home []
Specialty: Primary: INTERNAL MEDICINE Secondary:	Board Certified: Yes [4] No [_] Board Certified: Yes [_] No [_]
	X] Group (5 or more) If Group, give name below:
Primary Hospital where you have staff privileges: Name: COOPER GREEN HOSP Are you licensed in another state: Yes [_] No [X] which Primary Care Information:	City/State: BIRMINGHAM, AL ones: [] [] [] []
1. Are you actively engaged in clinical practice? (Check one):	Yes [+] No[]
Does your practice include the delivery of primary care medic	cal services? (Primary care is defined as: "Basic or general health assistance from the medical care system, exclusive of emergency
3. Approximately how many hours per week do you practice the CME Certification: (Check one)	
[4] I hereby certify that I have met the annual minimum continuin	
continuing medical education during the calendar year ending [] I certify that I am exempt from the minimum continuing medical	
[] I do not reside in the State of Alabama and do not have a sign [] I received my initial license to practice medicine in Alabama [] I reinstated my license to practice medicine in the State of Al [] I am a resident physician enrolled in a residency training pro-	after June 30 th of this calendar year. abama after June 30 th of this calendar year.

[] I am retired from the practice of medicine and have obtained a waiver from the Board of Medical Examiners.

		YES	Ne
1.	you been convicted of a felony or of any offense (felony/misdemeanor) involving the practice of medicine within the past year?	[]	Į.
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?	[]	[4]
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?	[]	[4
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?	[1	[4]
5.	Have you had a judgement rendered against you, or action settled relating to the performance of your professional service within the past year?	[]	[4]
6.	To your knowledge, are you the subject of an investigation by any licensing Board/Agency as of the date of this application within the past year?	[]	[]
7.	Within the past year, have you been diagnosed with or have you been treated for hi-polar disorder, schizophrenia, paranoia, or any other psychotic disorder?	[]	[4]
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?	í 1	L 4
9.	Within the past year, have you ever raised the issue of consumption of drugs or alcohol or the issue of a mental, emotional, nervous, or behavioral disorder or condition as a defense, mitigation, or explanation for your actions in the course of any administrative or judicial proceeding or investigation; any inquiry or other proceeding; or any proposed termination by an educational institution, employer, government agency, professional organization or licensing authority?	E]	· [*
10.	Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism?	[]	[}
1).	Are you currently engaged in the illegal use of controlled dangerous substances?	[]	[}
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?	1 1	ĺ
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?	[]	[\d
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?	[]	 [4
	The term "currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the condition referred to may have an ongoing impact on one's functioning as a physician or an assistant to a physician, or within the past two years.		
	IF YOU HAVE ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, PLEASE ATTACH A DETAILED EXPLANATION WITH YOUR APPLICATION UPON RETURNING IT TO THIS OFFICE.	in.	
certif	by that all information on this form is correct. 10/12/9	<u>J</u>	2
	Signature Date		

Medical Licensure Commission P.O. Box 887 Montgomery, AL 36101-0887

License Renewal for 1997 Deadline is December 31, 1996

State of Alabama Medical Licensure Commission

334/242-4153

P.O. Box 887

Montgomery, Alabama 36101-0887



Complete BOTH sides including signature. Be sure to correct or supply ALL information. Return with \$100.00 renewal fee. Incomplete applications will be returned. Failure to register and pay renewal fee will result in the automatic revocation of the current license to practice medicine or osteopathy.

MAX III MICHAEL, M.D. PO BOX 55845

PO BOX 55845 BIRMINGHAM AL 35255-5845	
lease make corrections or supply information; Li	cense 8195 DATE-ISSUED: 02/15/78 Sex: M [X] F [.]
lease make corrections or supply more accerdance Asian []	Home Address:
Office Address:	4316 GLENWOOD AVE
PO BOX 55845	4310 CLIAN (OOD 1 -)
AT 25255 5845	City, State, Zip: BIRMINGHAM, AL 35222 4303
City, State, Zip: BIRMINGHAM, AL 35255 5845	(Alabama) County: Jefferson
(Alabama) County: Jefferson	Home Phone: (205)591-7506
Business Phone: (205)930-3600	(Will not be published)
Fax Number: (205)930-3497 Permission to publish in Roster: Yes X No EXF	Send official mail to: Business [] address (check one) Home []
	Board Certified: Yes No L.
Speciality: Primary: INTERNAL MEDICINE	Board Certified: Yes [] No []
Form of Practice: [] Solo [] Partnership (2, 3, or 4) Y Group	~ 2 C
Primary Hospital where you have staff privileges:	City/State: BIRMINGHAM, AL
Name: COOPER GREEN HOSP Are your licensed in another state: Yes [_] No [X] Which or	
CME Certification: (Check one)	·
I hereby certify that I have met the annual minimum continuing medical education during the calendar year end	
I certify that I am exempt from the minimum continuing to	nedical education requirement for the following reason.
[] I do not reside in the State of Alabama and do not have [] I received my initial license to practice medicine in Ala [] I reinstated my license to practice medicine in the State [] I am a resident physician enrolled in a residency training [] I am a resident physician enrolled in a residency training []	a significant portion of my medical practice in Alabams. bama after June 30th of this calendar year. of Alabama after June 30th of this calendar year. ig program. tained a waiver from the Board of Medical Examiners.
O I am retired from the practice of medicine and markets. Suppose Complete both sides including signature. Suppose including signature.	pply of correct and market

Tag your name of a felony	
volunte the cate of any off	
Voluntarily surrendered under threat of suspension or revocation within the past year? 4. Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited on the past year? 4. Have you been decided a certificate of qualification or license to past year?	
Have your staff privileges at any hospital or health care facility been revoked, suspended, revoked, restricted, conditions restricting your practice, within the past year? Have you been denied a certificate of qualification or license to practice medicine in any state or has your placed on the past year? Have you been denied a certificate of qualification or license to practice medicine in any state or has your placed on the past year?	
your state of succession to practice and involving a	
conditions restricting your practice, within the past year? A moderate of medicine within the past year? A moderate of medicine within the past year? A moderate of medicine within the past year?	
restricting at any boards.	YES
4. Want practice with or health on within the past venetical suspended, reven	n the past ven
within the page facility has	tella i
continue of a certificate a certificate	tailed or
qualification or lies of qualificant	
Have were a mocase to practice or license to	[] [4
within a mad 2 judgement medicine how to practice medicine	ler is te
the past years withdrawn and store in any store	
Have you been denied a certificate of qualification or license to practice medicine in any state or has your application for a within the past year? Have you had a judgement rendered against you, or action settled relating to the performance of your practice. To your knowledge, are you the subject of an impact of	[] [42
10 your knowled	· · · · · · · · · · · · · · · · · · ·
within the performance are you the out.	•
That year?	[]
Have you had a judgement rendered against you, or action settled relating to the performance of your professional service within the past year? To you knowledge, are you the subject of an investigation by any licensing Board/Agency.	2 3
the past were L	
Of any other personal views you been diagrams.	[] W
respection disorder? This application	200
To your knowledge, are you the subject of an investigation by any licensing Board/Agency as of the date of this application within the past year? Within the past year, have you been diagnosed with or have you been treated for bi-polar disorder, schizophrenia, paranota, alcohol abuse, or mental, emotional, or nervous disorder or condition) which in any way currently affects, or if untreated within the past year, have your application or impairment (including, but not limited to, substance abuse, could affect, your ability to practice in a competent and professional manner?	
	() (see
alcohol house or manual or physical condition	***
could be a michial, emotional, or necessary or impairment (in a	
and your ability to machine in a worder or condition and including but not limited	[] KI
a competent and professional which in any way currently substance abuse	
alcohol abuse, or mental, emotional, or nervous disorder or condition) which in any way currently affects, or if untreated within the past year, have you ever raised the issue of contract.	
Within the past year, have you ever raised the issue of consumption of drugs or alcohol or the issue of a mental, emotional administrative or fudicial proceeding or investigation; any inquiry or other proceeding; or any proposed termination, employer, government agency, professional crysmination.	
administrative or Late and disorder or condition as a defence and dispersion of drugs or alcohol or the	() (x)
educational track proceeding or investigation, or explanation for the issue of a mental emotional	-
institution, employer, government and inquiry or other properties.	
administrative or judicial proceeding or investigation; any inquiry or other proceeding; or any proposed termination by an Have you ever been diagnosed as having or have you ever been diagnosed.	
Have you ever been diagnosed as have and	
Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism? Are you currently engaged in the illegal use of controlled described described described described.	[] M
Arr von pedophilia, exhibitionism or voverning	
Are you currently engaged in the illegal use of controlled dangerous substances?	[] LX
dangerous substances?	
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 was of account of the program.	[] [At
you currently participating in a supervised rehability	
which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances?	
	[1] [水]
lave you been, within the past year, convicted of driving under the influence (DUI) or have you been charged with	
)UI and been convicted of a lesser offense such as reckless driving?	
MAIN ACCUMANTAGE OF A LANGE AND ADDRESS OF A	[] [4]
· ·	, p
las your medical training or medical practice been interrupted or suspended for a period longer than 60 days for any reason	
ther than a vacation?	
	() ()
he term "corrently" does not mean on the day of, or even in the weeks or months preceding the completion of this application.	
tather, it means recently enough so that the condition referred to may have an ongoing impact on one's functioning as a physician	
tather, it means recently chosen so that the continue of the same services and the same services and the same services are same services are same services and the same services are sam	
an assistant to a physician, or within the past two years.	
	NN.
F YOU HAVE ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, PLEASE ATTACH A DETAILED EXPLANATION	/A1
WITH YOUR APPLICATION UPON RETURNING IT TO THIS OFFICE.	10.
(0/08	771
at all information on this form is correct. Signature Da	
at all information on this south a second Signature	16
1.14- American	
Complete both sides, including signature.	
to supply all information.	
Re sure to supply all information. Incomplete applications will be returned.	
Total Diese Transfer	
A Discourse of the second of t	

NO

Return we \$100.00 renewal fee to: Licensure Commission
Licensure Res 887
36101-0887

License Renewal for 1996 Deadline is December 31, 1995

State of Alabama Medical Licensure Commission

334/242-4153

P.O. Box 887

Montgomery, Alabama 36101-0887



Complete BOTH sides including signature. Be sure to correct or supply ALL information. Return with \$100.00 renewal fee. Incomplete applications will be returned. Failure to register and pay renewal fee will result in the automatic revocation of the current license to practice medicine or osteopathy.

Max Michael III, M.D.

PO Box 55845

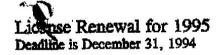
Birmingham, AL 35255 5845 Indledelsstateteldedelstatetelstatetelstatet

Please make corrections or supply information: L	icense 8195
Race: White X Black Am. Indian Tonental or Asia	an Other Social Security # 1950
Office Address:	Home Address:
PO BOX 55845	4316 GLENWOOD AVE
City, State, Zip: BIRMINGHAM, AL 35255 5845	City, State, Zip: BIRMINGHAM, AL 35222 4303
(Alabama) County: Jefferson	(Alabama) County: Jefferson
Business Phone: (205)930-3600	Home Phone: (205)591-7506 (Will not be published)
Fax Number: (205)930-3497 Permission to publish in Roster: Yes ∐ No [X]	Send official mail to:Business [] address (check one) Home []
Specialty: Primary: INTERNAL MEDICINE	Board Certified: Yes [] No []
d	Board Certified: Yes [] No []
Form of Practice: [] Solo [] Partnership (2, 3, or 4) [] G	Group (5 or more) If Group, give name below:
Primary Hospital where you have staff privileges:	
Name: COOPER GREEN HOSP	City/State: BIRMINGHAM, AL
Are you licensed in another state: Yes [] No [X] While	ch ones:
CME Certification: (Check one)	
medical education during the calendar year ending by	continuing education requirement of 12 hours of Category I continuecember 31, 1995.
I I and it short I am exempt from the minimum continuing	ng medical education requirement for the following reason:
[] I do not reside in the State of Alabama and do not have a line of the line	have a significant portion of my medical practice in Alabama. Alabama after June 30th of this calendar year. State of Alabama after June 30th of this calendar year.
I I am retired from the practice of medicine and have	e obtained a waiver from the Board of Medical Examiners.

	•			Yes	No
1.	Ha inv	ve you been convicted olving the practice of	of a felony or of any offense (felony/misdemeanor) medicine within the past year?		
2.	545	your certificate of qualification or license to practice medicine in any state been ended, revoked, restricted, curtailed or voluntarily surrendered under threat of ension or revocation within the past year?			a ⁄
	wit	ve your staff privileges at any hospital or health care facility been revoked, pended, curtailed, limited or placed under conditions restricting your practice, in the past year?			'
	prac	y state or has your application for a certificate of qualification or license to practice medicine in state or has your application for a certificate of qualification or license to actice medicine been withdrawn under threat of denial within the past year?			
5.	Are sub	you now or have you trances within the pass	been addicted to the use of alcohol or controlled tyear?		© ⁄
6.	Hav	e you been diagnosed and/or treated for a mental illness and/or serious physical		. 🗖	!
7.	Hav perf	e you had a judgement rendered against you, or action settled relating to the formance of your professional service within the past year?			
	Boa	rd/Agency as of the di	ou the subject of an investigation by any licensing ate of this application within the past year?		00/
	VI	OU HAVE ANSWEI ACH A DETAILED URNING IT TO THI	RED YES TO ANY OF THE ABOVE QUESTIONS, PLEASE EXPLANATION WITH YOUR APPLICATION UPON S OFFICE.		
I ce	rtify	that all information or	this form is correct.		
	y	m hu	0/19/95		
		Signature		Date	(80-3)
			 Complete both sides, including signature. Be sure to correct or supply all information. Incomplete applications will be returned. 	**** 74	

Return with \$100.00 renewal fee to:

Medical Licensure Commission P.O. Box 887 Montgomery, AL 36101-0887



State of Alabama Medical Licensure Commission

Complete BOTH sides including signature.

Be sure to correct or supply ALL information.

Pailure to register and pay renewal fee will result in the

automatic revocation of the current license to practice

Return with \$100.00 renewal fee.

medicine or osteopathy.

Incomplete applications will be returned.

205/242-4153

P.O. Box 887 Montgomery, Alabama 36101-0887



MAX MICHAEL III, M.D. PO BOX 55845

BIRMINGHAM, AL 35255

Please make corrections or supply information:	
Race: White [X] Black [Am. Indian [Oriental or Asia	un () Other () Social Security # 1950
Office Address:	Home Address:
PO BOX 55845	4316 GLENWOOD CIR
City, State, Zip: BIRMINGHAM, AL 35255	City, State, Zip: BIRMINGHAM, AL 35222
County: Jefferson	County: Jefferson
Business Phone: (205)930-3600	Home Phone: (205)591-7506 (Will not be published)
Fax Number: (205)930-3497 Permission to publish in Roster: Yes [] No [X]	Send official mail to Business or Home address (circle one)
Specialty: Primary: I	Board Certified: Yes [X] No []
Secondary:	Board Certified: Yes [] No [X]
	up (5 or more) If Group, give name:
Primary Hospital where you have staff privileges:	
Name: COOPER GREEN HOSP	City/State: BIRMINGHAM , AL
Are you licensed in another state: Yes [] No [X] Which	ones:
CME Certification: (Check one)	
I hereby certify that I have met the annual minimum commedical education during the calendar year ending December	tinuing education requirement of 12 hours of Category I continuing abor 31, 1994.
I certify that I am exempt from the minimum continuing	
 ☐ I do not reside in the State of Alabama and do not have ☐ I received my initial license to practice medicine in Ala ☐ I reinstated my license to practice medicine in the State ☐ I am a resident physician enrolled in a residency trainin ☐ I am retired from the practice of medicine and have obtained. 	of Alabama after June 30th of this calendar year.

Wi	thin The Past Year:	Yes	No
1.	invelving the practice of medicine?		b /
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?	D	•
3,	Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practice?		
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?	=	
5.	Are you now or have you been addicted to the use of alcohol or controlled substances?	b	
6.	ave you been diagnosed and/or treated for a mental illness and/or serious physical ness?		ਤ
7.	Have you had a judgement rendered against you, or action settled relating to the performance of your professional service?	•	4
8.	To your knowledge, are you the subject of an investigation by any licensing Board/Agency as of the date of this application?		D
I ce	rtify that all information on this form is correct:	<i>.</i> t.	
	ha hary 10/17/94	<u>.</u>	•
	Signature	Date	

Complete both sides, including signature.
Be sure to correct or supply all information.

Incomplete applications will be returned.

Return with \$100.00 renewal fee to: Medical Licensure Commission P.O. Box 887 Montgomery, AL 36101-0887

DEADLINE - DECEMBER 31, 1994

APPLICAT

For a certificate of registration to practice medicine in Alabama in 1994

Alabama Medical Licensure Commission • Post Office Box 887 • Montgomery, Alabama 36101-0887 • Phone (205) 242-4153

Name & Mailing Address

(Make address corrections in (4) below)

LICENSE #: 00008195 ISSUED: 2/15/1978

PO BOX 55845 MICHAEL MAX III

BIRMINGHAM AL 35255-5845

> Every Every physician and ostaopath licensed to practice medicine/ostaopathy in the State of Alabama shall, on or before the 31st of December of each year, apply to this Commission for a Certificate of Registration which shall be effective during the calendar year.

Renewal Fee: \$100.00 - Failure to register and pay the annual registration fee within 30 days after registration becomes due will result in the automatic revocation of the current license without further notice or hearing as provided in §34-24-337, Code of Alabama (1975).

(Check a or b) For CME Certification

- a) I hereby certify that I have met the annual minimum continuing education requirement of 12 hours of Category I continuing medical education during the calendar year ending December 31, 1993.
- certifiy that I am exempt from the minimum continuing medical education requirement for the following reason:

Check One Below If You Answered (b)

- t do not reside in the State of Alabama and do not have a significant portion of my medical practice in Alabama.
- medicine in Alabama after June 30th calendar year. practice of this
- calendar year. I reinstated my license to practice medicine in the State of Alabama after June 30th of this
- Medical Examiners. I am retired from the practice of medicine and have obtained a waiver from the Board of
- training program. I am a resident physician enrolled in a residency

Within The Past Year:

š

- Have you been convicted of a felony or of any offense (felony/misdemeanor) involving the practice of medicine?
- 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?
- Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practice?

Q

- 4. Have you been denied a certificate of qualification or incense 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?
- 5. Are you now or have you been addicted to the use of alcohol or controlled substances?

Q

- 6. Have you been diagnosed and/or treated for a mental illness and/or serious physical illness?
- 7. Have you had a judgement rendered against you, or action settled relating to the performance of your professional service?
- To your knowledge, are you the subject of an investigation of any licensing Board/Agency as of the date of this application?

certify that all information on this
certify that all information on this form is correct for the formation on the form is correct.

Oit

For a certificate of registration to practice medicine in Alabama in 1993

Alabama Medical Licensure Commission Post Office Box 887 Montgomery, Alabama 36101-0887 Phone (205) 242-4153

Name and Mailing Address LICENSE #: 0008195 ISSUED: 02/1	Home Address:	
MAX MICHAEL III P û box 55845	Street City	
BIRMINGHAM, AL 35255	State 7	p
	Business FAX#:(')	
Make corrections to mailing address on reverse.	☐Check if you authorize your FAX# to be publication	ished in a director:
Every physician and osteopath licensed to pro- 31st of December of each year, apply to this Co the calendar year.	ectice medicine/osteopathy in the State of Alabama shall, or ommission for a Certificate of Registration which shall be	or before the effective during
Renewal Fee: \$75.00 - Failure to regregistration becomes due will result in the notice or hearing as provided in § 34-24-	ister and pay the annual registration fee within ne automatic revocation of the current license w 337, Code of Alabama (1975).	30 days after /ithout further
(Check a or b) For CME Certification	Within The Past Year:	Yes No
i hereby certify that I have met the annual minimum continuing education requirement of 12 hours of Category I continuing medical education during the	Have you been convicted of a felony or of any offense (felony/misdemeanor) involving the practice of medicine?	
calendar year ending December 31, 1992. b) certifiy that am exempt from the	2. Has your certificate of qualification or license to practice medicine in any state been suspended, revoked, restricted, curtailed or voluntarity surrendered under threat of suspension or revocation?	1
minimum continuing medical education requirement for the following reason:	3. Have your staff privileges at any hospital or health care facility been revoked, suspended, curtalled, limited or pleased trades.	
Check One Below If You Answered (b)	limited or placed under conditions restricting your practice?	
I do not reside in the State of Alabama and do not have a significant portion of my medical practice in Alabama.	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	
I received my initial license to practice medicine in Alabama after June 30th of	to practice medicine been withdrawn under threat of denial?	<u> </u>
this calendar year.	5. Are you now or have you been addicted to the use of alcohol or controlled substances?	<u> </u>
I reinstated my license to practice medicine in the State of Alabama after June 30th of this calendar year.	 Have you been diagnosed and/or treated for a mental illness and/or serious physical illness? 	
I am retired from the practice of medicine and have obtained a waiver from the Board of Medical Examiners.	7. Have you had a judgement rendered against you, or action settled relating to the performance of your professional service?	
am a resident physician enrolled in a residency training program.	8 To your knowledge, are you the subject of an investigation by any licensing Board/Agency as of the date of this application?	
I certify that all information on this form	is correct . My hand to	10/27/9~
	Signature	Date
	(Do. Not Detach)	

FOR A CERTIFICATE OF REGISTRATION TO PRACTICE MEDICINE IN ALABAMA IN 1992
ALABAMA MEDICAL LICENSURE COMMISSION

Post Office Box 887

Montgomery, Alabama 36101-0887 Phone (205) 261-4153

Every physician and osteopath licensed to practice medicine/osteopathy in the State of Alabama shall, on or before the 31st day of December of each year, apply to this Commission for a Certificate of Registration which shall be effective during the calendar year.

RENEWAL FEE: \$75.00 --- Failure to register and pay the annual registration fee within 30 days after

registration becomes due will result in the automatic revocation of the current license without further notice or hearing as provided in § 34-24-337, Code of Alabama, (1975). Name and Mailing Address: MAX MICHAEL III BIRMINGHAM, AL 35255 P O BOX 55845 BIRMINGHAM, AL 1515 6TH AVE S SELF Business Address:

LICENSE #: 0008195 ISSUED: 02/15/78

WITHIN THE PAST YEAR If your addresses are different from those shown, make corrections on back

 Have you been convicted of a felony or of any offense (felony/misdemeanor) involving the practice of modicine. Has your certificate of qualifications or license to practice made in any state been suspended,—. revoked, restricted, curtailed or voluntarily surrendered under threat of suspension or revocation? Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practice? 1-12/1/1/1/1

Have you been denied a certificate of qualification or a license to pfactice medicine in any state or has your application for a certificate of qualification or license to practice medicine been withdrawn under threat or claim?

Are you now or have you been addicted to the use of alcohol or controlled substances?

Have you been diagnosed endfor treated for a mental illness?

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

To your knowledge, are you the subject of an investigation by any licensing Board/Agency as of the dete of this renewal application? I certify that the above information is correct My Web

Signature (Do Not Detach)

FOR A CENTIFICATE OF REGISTRATION TO PRACTICE MEDICINE IN ALABAMA IN 1991 ALABAMA MEDICAL LICENSURE COMMISSION Post Office Box 887

Montgomery, Alabama 36101-0887 Phone (205) 261-4153

Every physician and osteopath licensed to practice medicine/osteopathy in the State of Alabama shall, on or before the 31st day of December of each year, apply to this Commission for a Certificate of Registration which shall be effective during the calendar year.

RENEWAL FEE: \$75.00 Failure to register and pay the annual registration fee within 30 days after egistration becomes due will result in the automatic revocation of the current license without further	provided in § 34-24-337, Code of Alabama, (1975). 3 Address:	SELF	, 1515 STH AVE S	BIRMINGHAM, AL 35233
VENEWAL FEE: \$75.00 Failure egistration becomes due will resul	notice or hearing as provided in Name and Mailing Address:	MAX MICHAEL III	P O BOX 55845	BIRKINGHAM, AL 35255

 Have you been convicted of a felony or of any offense (felony/misdemesnor) involving the practice of medicine. Have your staff privileges at any hospital or health care facility been revoked, suspended, curtaited, limited or placed under conditions restricting your prectice? if your addresses are different from those shown, make corrections on back: Has your certificate of qualifications or license-to-practico-medicino in any state been suspended, revoked, restricted, curtailed or volutharily surrendered under threat of suspension or revocation? ISSUED: 02/15/78 WITHIN THE PAST YEAR LICENSE #: 0008195 N e,

- Have you been denicd a certificate of qualification or a license to practice medicine in any state or has your application for a certificate of qualification or license to practice medicine been withdrawn under threat or claim? 4
- Are you now or have you been addicted to the use of alcohol or controlled substances?
- Have you been diagnosed and/or treated for a mental Ulness?
- Have you had a judgement rendered against you, or action settled relating to the performance of your professional service? .
- To your knowledge, are you the subject of an investigation by any licensing Board/Agency as of the date of this ranewal application? ď

Soft S certify that the above information is correct

(Do Not Detach)

FOR A CERTIFICATE OF REGISTRATION TO PRACTICE MEDICINE IN ALABAMA IN 1990
ALABAMA MEDICAL LICENSURE COMMISSION
Post Office Box 887

Montgomery, Alabama 36101-0887 Phone (205) 261-4153

Every physician and ostaopath licensed to practice medicine/osteopathy in the State of Alabama shall, on or before the 31st day of December of each year, apply to this Commission for a Certificate of Registration which shall be effective during the calendar year.

registration becomes due will result in the automatic revocation of the current license without further RENEWAL FEE: \$50.00 --- Fallure to register and pay the annual registration fee within 30 days after

notice or hearing as provided in § 34-24-337, Code of Alabama, (1975). Name and Mailing Address: LICENSE #: 0008195 MAX MICHAEL III BIRMINGHAM, AL. P O BOX 55845 If your addresses are different from those shown, make corrections on back: 35255 ISSUED: 02/15/78 BIRMINGHAM, AL 1515 6TH AVE S Business Address:

 Have your staff privileges at any hospital or hasith care facility been revoked, suspended, ourtailed, limited or placed under conditions restricting your practice? 2. Hos your certificate of qualifications or license to practice-medicine in any extent bean suspended, restricted, curtailed or voluntarily surrendered under threat of suspension or revocation? WITHIN THE PAST YEAR 1. Have you been convicted of a falony or of any offense (felony/misdemesnor) involving the practice of Have you been denied a certificate of qualification or a liganse to practice medicine in any state or has your application for a certificate of qualification or figures to practice medicine been withdrawn under threat or claim? 14/4/4/

To your knowledge, are you the subject of an investigation by any licensing Board/Agency as of the dath of this renewal application? Have you had a judgement rendered against you, or action settled relating to the performance of your certify that the above information is correct Do Not Detachi ES. Signature

P

Have you been diagnosed and/or treated for a mental illness?

Are you now or have you been addicted to the use of slockel or controlled substances?

FOR A CERTIFICATE OF REGISTRATION TO PRACTICE MEDICINE IN ALABAMA IN 1989
ALABAMA MEDICAL LICENSURE COMMISSION

Post Office Box 887

Montgomery, Alabama 36101-0887 Phone (205) 261-4153

Every physician and osteopath licensed to practice medicine/osteopathy in the State of Alabama shall, on or before the 31st day of December of each year, apply to this Commission for a Certificate of Registration which shall be effective during the calendar year.

registration becomes due will result in the automatic revocation of the current license without further notice or hearing as provided in § 34-24-337, Code of Alabama, (1975).

Name and Mailing Address:

Business Address: RENEWAL FEE: \$50.00 --- Failure to register and pay the annual registration fee within 30 days after

1515 6TH AV S MAX MICHAEL III

BIRMINGHAM, AL

35233

LICENSE #: 0008195

BIRMINGHAM, AL 1515 6TH AVE S

1. Have you been convioted of a felony or of any offense (folony/misdomeanor) involving the practice of WITHIN THE PAST YEAR Has your certificate of qualifications or license to practice medicing in any state been suspended, revoked, restricted, curtailed or voluntarily surrendered under threat of suspension or revocation? Have your staff privileges at any hospital or health pare facility bosn revoked, suspended, curtailed, limited or placed under conditions restricting your practice? If your addresses are different from those shown, make corrections on back: ISSUED: 02/15/78" ... ;

Have you been diagnosed and/or treated for a mantal illiness? Have you been denied a certificate of qualification or a license to practice medicine in any state or has your application for a certificate of qualification or Neanse to practice medicine been withdrawn under threat or claim? Are you now or have you been addicted to the use of alcohol or controlled substances? hhly

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

To your knowledge, are you the subject of an investigation by any licensing Board/Agency as of the date of this renewal application? certify that the above information is correct | Mrt Mrth Signature 1 pt 21/0/0

(Do Not Detach)

FOR A CERTIFICATE OF REGISTRATION TO PRACTICE MEDICINE IN ALABAMA IN 1988
ALABAMA MEDICAL LICENSURE COMMISSION
Post Office Box 887
Montgomery, Alabama 36101-0887
Phone (205) 261-4153

*

Every physician and esteopath licensed to practice medicine/esteopathy in the State of Alabama shall, on or before the 31st day of December of each year, apply to this Commission for a Certificate of Registration which shall be effective during the calendar year. RENEWAL FEE: \$50.00 --- Failure to register and pay the annual registration fee within 30 days after registration

provided in § 34-24-337, Code of Alabama, (1975). becomes due will result in the automatic revocation of the current license without further notice or hearing as

Name and Mailing Address: MAX MICHAEL III

TOTS STH RY S

BIRMINGHAM, AL 35233

LICENSE 4: COORISE

ISSUED: 02/15/78

BIRMINGHAM, AL 1515 6TH AVE S

Business Address:

FOR A CERTIFICATE OF REGISTRATION TO PRACTICE MEDICINE IN ALABAMA IN 1987-ALABAMA MEDICAL LICENSURE COMMISSION
Post Office Box 887
Montgomery, Alabama 36101-0887
Phone (208) 261-4153

Every physician and osteopath licensed to practice medicine/osteopathy in the State of Alabama shall, on or before the 31st day of December of each year, apply to this Commission for a Certificate of Registration which shall be affective during the calendar year.

provided in § 34-24-337, Code of Alabama, (1975). becomes due will result in the automatic revocation of the current license without further notice or hearing as RENEWAL FEE: \$50,00 --- Failure to register and pay the annual registration fee within 30 days after registration

Name and Mailing Address: MAX MICHAEL III

1515 6TH AV S

BIRMINGHAM, AL 35233

LICENSE #: 0008195

ISSUED: 02/15/78

Business Address:

1515 STH AVE S

BIRMINGHAM, AL. 35233

FOR A CERTIFICATE OF REGISTRATION TO PRACTICE MEDICINE IN ALABAMA IN 1986 ALABAMA MEDICAL LICENSURE COMMISSION Post Office Box 887 Montgomery, Alabama 36101-0887

Every physician and esteopath licensed to practice medicing/osteopathy in the State of Alabama shall, on or before the 31st day of December of each year, apply to this Commission for a Certificate of Registration which shall be effective during the calendar year.

RENEWAL FEE: \$50.00 -- Failure to register and pay the annual registration fee within 30 days after registration becomes due will result in the automatic revocation of the current license without further notice or hearing as

provided in § 34-24-337, Code of Alabama, (1975).

Name and Mailing Address: MAX MICHAEL III

BIRMINGHAM, AL 35233

LICENSE #= 0008195

ISSUED: 02/15/78

Business Address:

SIRMINGHAM, AL 1515 6TH AVE S 35233

FOR A CERTIFICATE OF REGISTRATION TO PRACTICE MEDICINE IN ALABAMA IN 1985
ALABAMA MEDICAL LICENSURE COMMISSION
Post Office Box 887
Montgomery, Alabama 36101-0887
Phone (205) 261-4153

Every physician and osteopath ligensed to practice medicine/osteopathy in the State of Alabama shall, on or before the 31 at day of December of each year, apply to this Commission for a Certificate of Registration which shall be effective during the calendar year.

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MAX: MICHAEL III Name and Mailing Address:

1515 6TH AV S

BIRMINGHAM, AL 35233

LICENSE #: 0008195

ISSUED: 02/15/78

Business Address:

BIRMINGHAM, AL 1515 6TH AVE S 35233

FOR A CERTIFICATE OF REGISTRATION TO PRACTICE MEDICINE IN ALABAMA IN 1984
ALABAMA MEDICAL LICENSURE COMMISSION

Post Office Box 887 Montgomery, Alabama 36101 Phone (205) 832-5061

Every physician and osteopath licensed to practice medicine/osteopathy in the State of Alabama shall, on or before the 31st day of December of each year, apply to this Commission for a Certificate of Registration which shall be effective during the calendar year.

becomes due will result in the automatic revocation of the current license without further notice or hearing as provided in § 34-24-337, Code of Alabama, (1975). RENEWAL FEE: \$50.00 -- Failure to register and pay the annual registration fee within 30 days after registration

MAX MICHAEL Name and Mailing Address: IAX MICHAEL III

1515 6TH AV S

BIRMINGHAM, AL

LICENSE #: 0008195

ISSUED: 02/15/78

BIRMINGHAM, AL 1515 6TH AVE S 35233

Business Address:

FOR A CERTIFICATE OF REGISTRATION TO PRACTICE MEDICINE IN ALABAMA IN 1983

ALABAMA MEDICAL LICENSURE COMMISSION 908 South Hulf Street, Room 118 Montgomery, Alabama 36104 Phone 205/832-5051

Every physicien and esteopath licensed to practice medicine/esteopathy in the State of Alabama shall, on or before the 31st day of December of each year, apply to this Commission for a Certificate of Registration which shall be effective during the calendar year.

RENEWAL FEE \$50.00 — Fallure to register and pay the annual registration fee within 30 days after registration becomes due will result in the automatic revocation of the current license without further notice or hearing as provided in Act. No. 81-218, Code of Alabama, Section 12.

Name and Mailing Address:

MAX MICHAEL III 1515 6TH AV S

BIRMINGHAM, AL 35233

LICENSE #: 0608195

ISSUED: 02/15/78

Business Address:

BIRMINGHAM, AL 35233 1515 6TH AVE S

FOR A CERTIFICATE OF REGISTRATION TO PRACTICE MEDICINE IN ALABAMA IN 1982.

ALABAMA MEDICAL LICENSURE COMMISSION 908 South Hull Street, Room 110 Montgomery, Alabama 36104 Phone 206/832-8061

Every physician and esteopath licensed to practice medicine/esteopathy in the State of Alabama shall, on or before the 31st day of December of each year, apply to this Commission for a Certificate of Registration which shall be effective during the calendar year.

RENEWAL FEE \$50.00 — Failure to register and pay the annual registration fee within 30 days after registration becomes due will result in the automatic revocation of the current license without further notice or hearing as provided in Act., No. 81-218, Code of Alabame, Section 12.

Name and Mailing Address:

MAX MICHAEL III

1515 6TH AV S

BIRMINGHAM, AL 35233

LICENSE #: 0008195

ISSUED: 02/15/78

Business Address:

1515 6TH AVE S

BIRMINGHAM, AL 35233

2054

Z

FOR A CERTIFICATE OF REGISTRATION TO PRACTICE MEDICINE IN ALABAMA IN 1981.

STATE LICENSING BOARD FOR THE HEALING ARTS
908 S. Hull Street, Room 110
Montgomery, Alabama 36130
Phone 208/812-5051

DEC &

Every person licensed to practice any branch of the Healing Arts in the State of Alabama shall on or before the 31st day of December of each year apply to this Board for a Certificate of Registration which shall be effective during the calendar year.

RENEWAL FEE \$10,00 ... IF NOT RECEIVED BY JANUARY 31st. A PENALTY OF \$20,00 PLUS THE \$10,00 RENEWAL FEE WILL BE CHARGED, RETURN ENTIRE FORM WITH FEE.

Name and Mailing Address:

Birmingham, Alabama 35333 1515 6th Avenue South Max Michael, III, W. D.

8195

Jefferson

2/15/78

Ø

\$ 10.00

Business Address:

1515 6TH AVE S BIRMINGHAM, AL 35233 Yeron Clinica

933-9211

RENEWAL APPLICATION FOR A CERTIFICATE OF REGISTRATION TO PRACTICE MEDICINE IN ALABAMA IN 1980. Z O 3692

STATE LICENSING BOARD FOR THE HEALING ARTS

Public Safety Building

Nontgomery, Alabama 38130 Phone 205/832-5051

DEC 18 1979

Every person licensed to practice any branch of the Healing Arts in the State of Alabama shall on or before the 31st day of December of each year apply to this Board for a Certificate of Rogistration which shall be effective during the calendar year.

BECHARGED. RETURN ENTIRE FORM WITH FEE.

BECHARGED. RETURN ENTIRE FORM WITH FEE.

Name and Mailing Address:

BIRMINGHAM, AL MAX MICHAEL III

35233

LICENSE #: 0008195

ISSUED: 02/15/78

BIRMINGHAM, AL efferen camie P.C. 35233

128-626

THIS IS THE ONLY NOTICE YOU WILL RECEIVE.

APPLICATION

FOR CERTIFICATE OF REGISTRATION FOR 1979 STATE LICENSING BOARD FOR THE HEALING ARTS

Public Safety Building MONTGOMERY, ALABAMA 36130

Hvery person licensed to practice any branch of the Healing Arts in the State of Alabama shall on or before the 31st day of December of each year apply to this Board for a certificate of registration which shall be effective during the next calendar year. The \$10.00 fee must accompany this application.

If not paid by January fist you must pay an additional \$20.00 penalty for reinstate-

ment of your license.

Business Address License \$ Name and Series S ではない はいのではないから かいけい いっぱっぱっぱっぱっぱっぱっぱっぱっぱっぱっぱい Strateghon, Alabama 19035 1919 out wester Couth Date issued 5/15/73

wex lundand a 19.00

County

TOTTOTED DE

Signature

128-620

for change of address only DEC 2 0 1978

THIS IS THE ONLY NOTICE YOU WILL RECEIVE.

APPLICATION

FOR CERTIFICATE OF REGISTRATION FOR 1978 STATE LICENSING BOARD FOR THE HEALING ARTS

MONIGOMERY, ALABAMA 24130 Public Safety Bailding

Every person licensed to practice any branch of the Healing Arts in the State of Alabama shall on or before the 31st day of December of each year apply to this Board for a certificate of registration which shall be effective during the next calendar year. The \$10.00 fee must accompany this application. If licensed after July 1st, pay only \$5.00 for remainder of that year

If not paid by January 31st you must pay an additional \$20.00 penalty for reinstatement of your license.

Name and Address Business Max Michael, III, M. D. 1515 6th Avenue South Birmingham, Alabama 35233

Date issued

Jefferson

License #

Just Kurthaul (18) \$ 10.00

Signature

FOR CHANGE OF ADDRESS ONLY

APPLICATION TO STATE LICENSING BOARD FOR THE HEALING ARTS FOR LICENSE TO PRACTICE

Name in full (print) HAX MICHAEL 1111 Business address ISIS LAM AUL So. City Business address ISIS LAM AUL So. State- address ISIS LAM AUL So. Branch of Healing Arts you are to practice Suffer wat. Mudicary \$15.00 license fee attached. Date 218 signed Mak hundral (M	
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** PREFERRED MAILING ADDRESS:

Missis Read