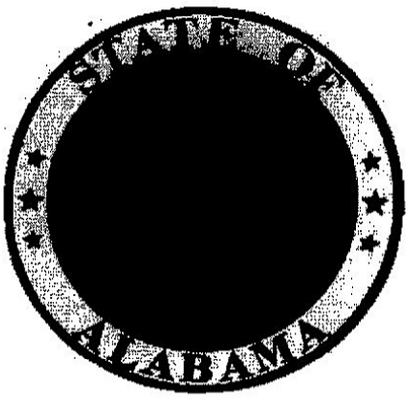


Medical Licensure Commission of the State of Alabama
PO Box 887
Montgomery, AL 36101

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**

Feb 6, 2012 2:07 PM

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[redacted]**-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**

Feb 6, 2012 2:07 PM

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**

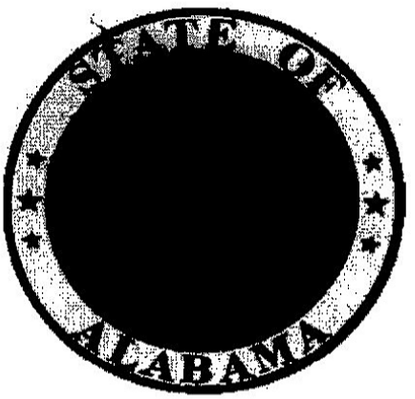
Have you been, within the past year, convicted of driving under the influence (DUI) or have you been charged with DUI and been convicted of a lesser offense such as reckless driving? **No**

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.

Feb 6, 2012 2:07 PM



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

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**

Feb 6, 2012 2:07 PM

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 [redacted]**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**

Feb 6, 2012 2:07 PM

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.

Feb 6, 2012 2:07 PM

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

2010 Online Renewal Summary

Name: **Max Michael III**
Transaction Date: **2009-10-19***
Registration Fee: **300**

License Number: **MD.8195**
Transaction Number: **VUHF4B729659**
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 o 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 wi 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 an licensing Board/Agency as of the date of this application within the past year? **no**

Other State1

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**

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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**

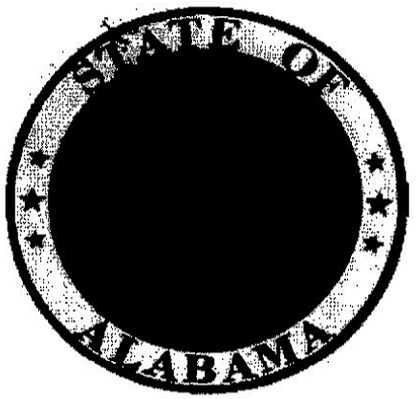
Are you actively engaged in clinical practice in the State of Alabama? **Y**

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



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

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**

Feb 6, 2012 2:06 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? **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**

Feb 6, 2012 2:06 PM

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

Feb 6, 2012 2:06 PM

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:

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

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

2008 Online Renewal Summary

Name: **Max Michael III**
Transaction Date: **2007-10-15***
Registration Fee: **300**

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 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 serv 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 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**

Feb 6, 2012 2:06 PM

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

Feb 6, 2012 2:06 PM

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:

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

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

2007 Online Renewal Summary

Name: **Max Michael III**
Transaction Date: **2006-10-21***
Registration Fee: **200**

License Number: **MD.8195**
Transaction Number: **VXJF0BFAE3C4**
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 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**

Feb 6, 2012 2:06 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? **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**

Feb 6, 2012 2:06 PM

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

Feb 6, 2012 2:06 PM

Other State1

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**

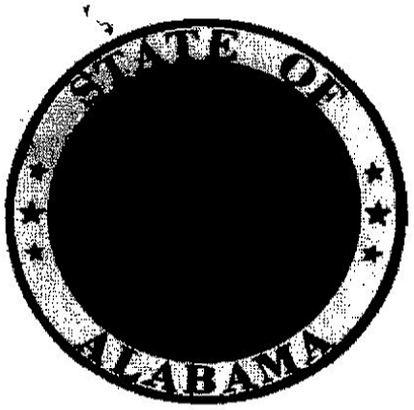
Home Address: **4316 GLENWOOD AVE**

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**

Feb 6, 2012 2:06 PM



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

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**

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 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:

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

Are yc If yes, please explain:

Does y Are you currently* engaged in the illegal use of controlled dangerous substances? **N**
genera
system, If yes, please explain:

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

CME Cert If yes, please explain:
continuing

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

I am exemp If yes, please explain:

Practice Tele Has your medical training or medical practice been interrupted or suspended for a period longer than 60 days f
than a vacation? **N**

Practice Addr If yes, please explain:

*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
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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Feb 6, 2012 2:05 PM

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 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**

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 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**

Feb 6, 2012 2:05 PM

Mail Address: **Home**

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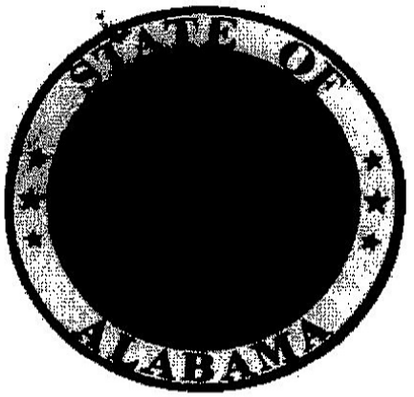
Feb 6, 2012 2:05 PM



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

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**

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 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**

Feb 6, 2012 2:05 PM

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**

Feb 6, 2012 2:05 PM

Home Telephone: **(205) 591-7586**

Home Address: **4316 GLENWOOD AVE**

Public Address: **Practice**

Mail Address: **Home**

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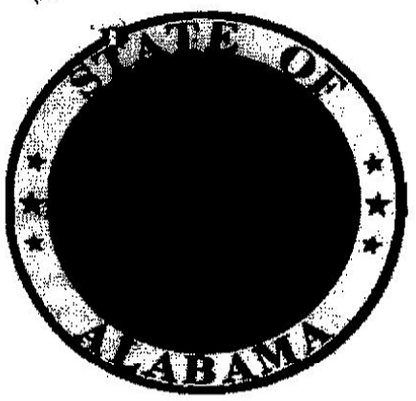

Medical Licensure Commission of the State of Alabama
PO Box 887
Montgomery, AL 36101

2004 Online Renewal Summary

Name: **Max Michael III**

License Number: **MD.8195**

Transaction Date: **2003-10-19***

Transaction Number: **null**

Registration Fee: **200**

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**

Feb 6, 2012 2:05 PM

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. **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 Telephone: **(205) 591-7586**

Home Address: **4316 GLENWOOD AVE**

Public Address: **Practice**

Mail Address: **Home**

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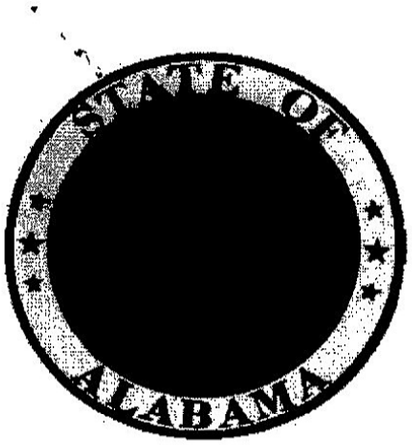


Medical Licensure Commission of the State of Alabama
PO Box 887
Montgomery, AL 36101

2003 Online Renewal Summary

Name: **Max Michael III**

License Number: **MD.8195**

Transaction Date: **2002-10-24***

Transaction Number: **null**

Registration Fee: **200**

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**

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. **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**

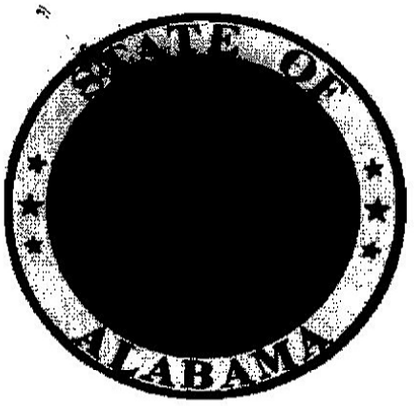
Home Telephone: **(205) 591-7586**

Home Address: **4316 GLENWOOD AVE**

Public Address: **Home**

Mail Address: **Home**

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.



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

2002 Online Renewal Summary

Name: **Max Michael III**

License Number: **MD.8195**

Transaction Date: **2001-11-06***

Transaction Number: **null**

Registration Fee: **200**

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**

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. **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
Montgomery, Alabama 36101-0887

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

25
1
5322

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 practice medicine or osteopathy.

Please make corrections or supply information: License **8195** DATE-ISSUED: 2/15/78 Sex: M [X] F [ ]
Race: White [X] Black [ ] Am. Indian [ ] Oriental or Asian [ ] Other [ ] Social Security #[redacted]-1950
Enter SSAN#

Office Address:

PO BOX 55845

City, State, Zip: BIRMINGHAM, AL 35255 5845

(Alabama) County: Jefferson

Business Phone: (205)930-3600

Fax Number: (205)930-3497

Home Address:

4316 GLENWOOD AVE

City, State, Zip: BIRMINGHAM, AL 35222 4303

(Alabama) County: Jefferson

Home Phone: (205)591-7506
(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 [✓] No [ ]
Board Certified: Yes [ ] No [ ]

Form of Practice: [ ] Solo [ ] Partnership (2, 3, or 4) [X] Group (5 or more) If Group, give name below:
JEFFERSON CLINIC PC

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: [ ] [ ] [ ] [ ] [ ]

Primary Care Information:

1. Are you actively engaged in clinical practice in the State of Alabama?
Yes [X] Go to Question 2 No [ ] Do NOT answer questions 2 and 3 below. Skip to CME Certification questions.

2. 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 which a patient ideally first seeks assistance from the medical care system, exclusive of an emergency care situation.")
Yes [✓] Go to Question 3 No [ ] Do NOT answer question 3 below. Skip to CME Certification questions.

3. 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.) Approximately __10__ hours per week.

CME Certification: (Check one)

[✓] 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, 2000.

[ ] I certify that I am exempt from the minimum continuing medical education requirements for the following reason:
[ ] I do not reside in the State of Alabama and do not have a significant portion of my medical practice in Alabama.
[ ] I received my initial license to practice medicine in Alabama after June 30th of this calendar year.
[ ] I reinstated my license to practice medicine in the State of Alabama after June 30th of this calendar year.
[ ] I am a resident physician enrolled in a residency training program.
[ ] I am retired from the practice of medicine and have obtained a waiver from the Board of Medical Examiners.

DEADLINE IS DECEMBER 31, 2000

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

OVER

License #8195 5322 MICHAEL, MAX III

		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?	[ ]	[✓]
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?	[ ]	[✓]
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?	[ ]	[✓]
5.	Have you had a judgement rendered against you, or action settled 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?	[ ]	[✓]
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?	[ ]	[✓]
10.	Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism?	[ ]	[✓]
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?	[ ]	[ ]
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?	[ ]	[✓]
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?	[ ]	[✓]

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 certify that all information on this form is correct. _____ 10/12/00

Signature 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

SERVICE PRINTING CO. (334) 269-0058

License 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

**********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.
24 Incomplete applications will be returned.
1 Failure to register and pay renewal fee will result
4989 in the automatic revocation of the current license to practice medicine or osteopathy.

Please make corrections or supply information: License **8195** DATE-ISSUED: 2/15/78 Sex: M [X] F [ ]
Race: White [X] Black [ ] Am. Indian [ ] Oriental or Asian [ ] Other [ ] Social Security #[redacted]1950
Enter SSAN#

Office Address:

PO BOX 55845

City, State, Zip: BIRMINGHAM, AL 35255 5845

(Alabama) County: Jefferson

Business Phone: (205)930-3600

Fax Number: (205)930-3497

Permission to publish in Roster: Yes [X] No [ ]

Home Address:

4316 GLENWOOD AVE

City, State, Zip: BIRMINGHAM, AL 35222 4303

(Alabama) County: Jefferson

Home Phone: (205)591-7506

(Will not be published)

Send official mail to: **Business** [✓] address (check one)
Home [ ]

Specialty: Primary: INTERNAL MEDICINE
Secondary: _____

Board Certified: Yes [✓] No [ ]
Board Certified: Yes [ ] No [ ]

Form of Practice: [ ] Solo [ ] Partnership (2, 3, or 4) [X] Group (5 or more) If Group, give name below:
JEFFERSON CLINIC PC

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: [ ] [ ] [ ] [ ] [ ]

Primary Care Information:

1. Are you actively engaged in clinical practice in the State of Alabama?
Yes [✓] Go to Question 2 No [ ] Do NOT answer questions 2 and 3 below. Skip to CME Certification questions.

2. 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 which a patient ideally first seeks assistance from the medical care system, exclusive of an emergency care situation.")
Yes [✓] Go to Question 3 No [ ] Do NOT answer question 3 below. Skip to CME Certification questions.

3. 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.) Approximately 10 hours per week.

CME Certification: (Check one)

[✓] 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, 1999.

[ ] I certify that I am exempt from the minimum continuing medical education requirements for the following reason:
[ ] I do not reside in the State of Alabama and do not have a significant portion of my medical practice in Alabama.
[ ] I received my initial license to practice medicine in Alabama after June 30th of this calendar year.
[ ] I reinstated my license to practice medicine in the State of Alabama after June 30th of this calendar year.
[ ] I am a resident physician enrolled in a residency training program.
[ ] I am retired from the practice of medicine and have obtained a waiver from the Board of Medical Examiners.

Complete both sides including signature. Supply or correct all information. **DEADLINE IS DECEMBER 31, 1999** **OVER**

License #8195 4989 MICHAEL, MAX III

		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?	[ ]	[✓]
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?	[ ]	[✓]
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?	[ ]	[✓]
5.	Have you had a judgement rendered against you, or action settled 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?	[ ]	[✓]
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?	[ ]	[✓]
10.	Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism?	[ ]	[✓]
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?	[ ]	[✓]
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?	[ ]	[✓]
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?	[ ]	[✓]

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 certify that all information on this form is correct. _____ 11/9/99
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 1999

Deadline is December 31, 1998

State of Alabama
Medical Licensure Commission

334/242-4153

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

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

28
1
4985

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: License **8195** DATE-ISSUED: 2/15/78 Sex: M [X] F [ ]
Race: White [X] Black [ ] Am. Indian [ ] Oriental or Asian [ ] Other [ ] Social Security #[redacted]-1950

Office Address:

PO BOX 55845

City, State, Zip: BIRMINGHAM, AL 35255 5845

(Alabama) County: Jefferson

Business Phone: (205)930-3600

Fax Number: (205)930-3497

Permission to publish in Roster: Yes [X] No [ ]

Home Address:

4316 GLENWOOD AVE

City, State, Zip: BIRMINGHAM, AL 35222 4303

(Alabama) County: Jefferson

Home Phone: (205)591-7506

(Will not be published)

Send official mail to: **Business** [✓] address (check one)
Home [ ]

Specialty: Primary: INTERNAL MEDICINE
Secondary: _____

Board Certified: Yes [✓] No [ ]
Board Certified: Yes [ ] No [ ]

Form of Practice: [ ] Solo [ ] Partnership (2, 3, or 4) [X] Group (5 or more) If Group, give name below:
JEFFERSON CLINIC PC

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: [ ] [ ] [ ] [ ] [ ]

Primary Care Information:

1. Are you actively engaged in clinical practice? (Check one): Yes [✓] No [ ]
2. Does your practice include the delivery of primary care medical services? (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 emergency room care."): (Check one): Yes [✓] No [ ]
3. Approximately how many hours per week do you practice the above-defined primary care services? 12-15

CME Certification: (Check one)

[✓] 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, 1998.

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

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

DEADLINE IS DECEMBER 31, 1998

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?	[ ]	[X]
2.	Has your certificate of qualification or license to practice medicine in any state been suspended, revoked, restricted, curtailed or voluntarily surrendered under threat of suspension or revocation within the past year?	[ ]	[X]
3.	Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practice, within the past year?	[ ]	[X]
4.	Have you been denied a certificate of qualification or license to practice medicine in any state or has your application for a certificate of qualification or license to practice medicine been withdrawn under threat of denial within the past year?	[ ]	[X]
5.	Have you had a judgement rendered against you, or action settled relating to the performance of your professional service within the past year?	[ ]	[X]
6.	To your knowledge, are you the subject of an investigation by any licensing Board/Agency as of the date of this application within the past year?	[ ]	[X]
7.	Within the past year, have you been diagnosed with or have you been treated for bi-polar disorder, schizophrenia, paranoia, or any other psychotic disorder?	[ ]	[X]
8.	Do you currently have any mental or physical condition or impairment (including, but not limited to, substance abuse, alcohol abuse, or mental, emotional, or nervous disorder or condition) which in any way currently affects, or if untreated could affect, your ability to practice in a competent and professional manner?	[ ]	[X]
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?	[ ]	[X]
10.	Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism?	[ ]	[X]
11.	Are you currently engaged in the illegal use of controlled dangerous substances?	[ ]	[X]
12.	If your answer to the preceding question is yes, are you currently participating in a supervised rehabilitation program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances?	[ ]	[ ]
13.	Have you been, within the past year, convicted of driving under the influence (DUI) or have you been charged with DUI and been convicted of a lesser offense such as reckless driving?	[ ]	[X]
14.	Has your medical training or medical practice been interrupted or suspended for a period longer than 60 days for any reason other than a vacation?	[ ]	[X]

The term "currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough 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 certify that all information on this form is correct. _____ 10/20/98
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

State of Alabama
Medical Licensure Commission

334/242-4153

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

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

16
67
4708

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: License 8195 DATE-ISSUED: 2/15/78 Sex: M [X] F [_]
Race: White [X] Black [_] Am. Indian [_] Oriental or Asian [_] Other [_] Social Security #[redacted]1950

Office Address:

PO BOX 55845

City, State, Zip: BIRMINGHAM, AL 35255 5845

(Alabama) County: Jefferson

Business Phone: (205)930-3600

Fax Number: (205)930-3497

Permission to publish in Roster: Yes [X] No [_]

Home Address:

4316 GLENWOOD AVE

City, State, Zip: BIRMINGHAM, AL 35222 4303

(Alabama) County: Jefferson

Home Phone: (205)591-7506

(Will not be published)

Send official mail to: **Business** [✓] address (check one)
Home [ ]

Specialty: Primary: INTERNAL MEDICINE
Secondary: _____

Board Certified: Yes [✓] No [_]
Board Certified: Yes [_] No [_]

Form of Practice:[] Solo [] Partnership (2, 3, or 4) [X] Group (5 or more) If Group, give name below:
JEFFERSON CLINIC PC

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: [__] [__] [__] [__] [__]

Primary Care Information:

1. Are you actively engaged in clinical practice? (Check one): Yes [✓] No [ ]
2. Does your practice include the delivery of primary care medical services? (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 emergency room care."): (Check one): Yes [✓] No [ ]
3. Approximately how many hours per week do you practice the above-defined primary care services? 10

CME Certification: (Check one)

[✓] 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, 1997.

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

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

Complete both sides including signature. Supply or correct all information.
DEADLINE IS DECEMBER 31, 1997

OVER
4708

		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?	[ ]	[X]
2.	Has your certificate of qualification or license to practice medicine in any state been suspended, revoked, restricted, curtailed or voluntarily surrendered under threat of suspension or revocation within the past year?	[ ]	[X]
3.	Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practice, within the past year?	[ ]	[X]
4.	Have you been denied a certificate of qualification or license to practice medicine in any state or has your application for a certificate of qualification or license to practice medicine been withdrawn under threat of denial within the past year?	[ ]	[X]
5.	Have you had a judgement rendered against you, or action settled relating to the performance of your professional service within the past year?	[ ]	[X]
6.	To your knowledge, are you the subject of an investigation by any licensing Board/Agency as of the date of this application within the past year?	[ ]	[X]
7.	Within the past year, have you been diagnosed with or have you been treated for bi-polar disorder, schizophrenia, paranoia, or any other psychotic disorder?	[ ]	[X]
8.	Do you currently have any mental or physical condition or impairment (including, but not limited to, substance abuse, alcohol abuse, or mental, emotional, or nervous disorder or condition) which in any way currently affects, or if untreated could affect, your ability to practice in a competent and professional manner?	[ ]	[X]
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?	[ ]	[X]
10.	Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism?	[ ]	[X]
11.	Are you currently engaged in the illegal use of controlled dangerous substances?	[ ]	[X]
12.	If your answer to the preceding question is yes, are you currently participating in a supervised rehabilitation program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances?	[ ]	[ ]
13.	Have you been, within the past year, convicted of driving under the influence (DUI) or have you been charged with DUI and been convicted of a lesser offense such as reckless driving?	[ ]	[X]
14.	Has your medical training or medical practice been interrupted or suspended for a period longer than 60 days for any reason other than a vacation?	[ ]	[X]

The term "currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough 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 certify that all information on this form is correct. _____ 10/20/93
Signature Date

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

SERVICE PRINTING CO. (334) 269-0056

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
BIRMINGHAM AL 35255-5845

Please make corrections or supply information: License 8195 DATE-ISSUED: 02/15/78 Sex: M [X] F [ ]

Race: ~~White [X] Black [ ] Am. Indian [ ] Oriental or Asian [ ] Other [ ]~~ Social Security #[redacted]1950 Enter SSAN#

Office Address:

PO BOX 55845

City, State, Zip: BIRMINGHAM, AL 35255 5845

(Alabama) County: Jefferson

Business Phone: (205)930-3600

Fax Number: (205)930-3497

Permission to publish in Roster: Yes [X] ~~No [ ]~~

Home Address:

4316 GLENWOOD AVE

City, State, Zip: BIRMINGHAM, AL 35222 4303

(Alabama) County: Jefferson

Home Phone: (205)591-7506
(Will not be published)

Send official mail to: **Business** [✓] address (check one)
Home [ ]

Speciality: Primary: INTERNAL MEDICINE

Board Certified: Yes [X] No [ ]

Secondary: _____

Board Certified: Yes [ ] No [ ]

Form of Practice: [ ] Solo [ ] Partnership (2, 3, or 4) [X] Group (5 or more) If Group, give name below:

Jefferson Clinic PC

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)

[X] 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, 1996.

[ ] I certify that I am exempt from the minimum continuing medical education requirement for the following reason:

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

OVER

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

DEADLINE IS DECEMBER 31. 1996

	YES	NO
...of a felony or of any offense (felony/misdemeanor) involving the practice of medicine within the past year?	[ ]	[X]
3. Has your certificate of qualification or license to practice medicine in any state been suspended, revoked, restricted, curtailed or voluntarily surrendered under threat of suspension or revocation within the past year?	[ ]	[X]
Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practice, within the past year?	[ ]	[X]
4. Have you been denied a certificate of qualification or license to practice medicine in any state or has your application for a certificate of qualification or license to practice medicine been withdrawn under threat of denial within the past year?	[ ]	[X]
Have you had a judgement rendered against you, or action settled relating to the performance of your professional service within the past year?	[ ]	[X]
To your knowledge, are you the subject of an investigation by any licensing Board/Agency as of the date of this application	[ ]	[X]
Within the past year, have you been diagnosed with or have you been treated for bi-polar disorder, schizophrenia, paranoia, or any other psychotic disorder?	[ ]	[X]
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?	[ ]	[X]
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?	[ ]	[X]
Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism?	[ ]	[X]
Are you currently engaged in the illegal use of controlled dangerous substances?	[ ]	[X]
If your answer to the preceding question is yes, are you currently participating in a supervised rehabilitation program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances?	[ ]	[X]
Have you been, within the past year, convicted of driving under the influence (DUI) or have you been charged with DUI and been convicted of a lesser offense such as reckless driving?	[ ]	[X]
Has your medical training or medical practice been interrupted or suspended for a period longer than 60 days for any reason other than a vacation?	[ ]	[X]

The term "currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough 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 attest that all information on this form is correct. _____ 10/28/91
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
[illegible] 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

CAR-RT-SORTB011
79
12

Please make corrections or supply information: License **8195** DATE-ISSUED: 02/15/197 Sex: M [X] F [ ]

Race: White [X] Black [ ] Am. Indian [ ] Oriental or Asian [ ] Other [ ] Social Security #[redacted]1950

Office Address:

PO BOX 55845

City, State, Zip: BIRMINGHAM, AL 35255 5845

(Alabama) County: Jefferson

Business Phone: (205)930-3800

Fax Number: (205)930-3497

Permission to publish in Roster: Yes [ ] No [X]

Specialty: Primary: INTERNAL MEDICINE

Secondary: _____

Home Address:

4316 GLENWOOD AVE

City, State, Zip: BIRMINGHAM, AL 35222 4303

(Alabama) County: Jefferson

Home Phone: (205)591-7506
(Will not be published)

Send official mail to: **Business** [ ] address (check one)
Home [ ]

Board Certified: Yes [ ] No [ ]

Board Certified: Yes [ ] No [ ]

Form of Practice: [ ] Solo [ ] Partnership (2, 3, or 4) [ ] 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] Which ones: [ ] [ ] [ ] [ ] [ ]

CME Certification: (Check one)

[X] I hereby certify that I have met the annual minimum continuing education requirement of 12 hours of Category I continui medical education during the calendar year ending December 31, 1995.

[ ] I certify that I am exempt from the minimum continuing medical education requirement for the following reason:

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

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?	☐	☑
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?	☐	☑
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?	☐	☑
5. Are you now or have you been addicted to the use of alcohol or controlled substances within the past year?	☐	☑
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 within the past year?	☐	☑
8. 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?	☐	☑

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 certify that all information on this form is correct.

[signature] 10/19/95

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

License Renewal for 1995
Deadline is December 31, 1994

State of Alabama
Medical Licensure Commission
205/242-4153

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

Please make corrections or supply information: License # 00008195 Sex: M [X] F[ ]

Race: White [X] Black [ ] Am. Indian [ ] Oriental or Asian [ ] Other [ ] Social Security #[redacted]-1950

Office Address:

PO BOX 55845

City, State, Zip: BIRMINGHAM, AL 35255

County: Jefferson

Business Phone: (205)930-3600

Fax Number: (205)930-3497

Permission to publish in Roster: Yes [ ] No [X]

Home Address:

4316 GLENWOOD CIR

City, State, Zip: BIRMINGHAM, AL 35222

County: Jefferson

Home Phone: (205)591-7506
(Will not be published)

Send official mail to **Business** or **Home** address (circle one)

Specialty: Primary: I

Board Certified: Yes [X] No [ ]

Secondary: _____

Board Certified: Yes [ ] No [X]

Form of Practice: [] Solo [] Partnership (2, 3 or 4) [] Group (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)

[X] 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, 1994.

[] I certify that I am exempt from the minimum continuing medical education requirement for the following reason:

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

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

OVER

Within The Past Year:	Yes	No
1. Have you been convicted of a felony or of any offense (felony/misdemeanor) involving the practice of medicine?	☐	☑
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?	☐	☑
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?	☐	☑
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?	☐	☑
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:

[signature] 10/12/94

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

(Rev. 08/93)

RENEWAL APPLICATION

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

MICHAEL MAX III
PO BOX 55845

BIRMINGHAM AL 35255-5845

- Every physician and osteopath licensed to practice medicine/osteopathy 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.

b) ____ I certify that I am exempt from the minimum continuing medical education requirement for the following reason:

Check One Below If You Answered (b)

____ I do not reside in the State of Alabama and do not have a significant portion of my medical practice in Alabama.

____ I received my initial license to practice medicine in Alabama after June 30th of this calendar year.

____ I reinstated my license to practice medicine in the State of Alabama after June 30th of this calendar year.

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

____ I am a resident physician enrolled in a residency training program.

Within The Past Year:	Yes	No
1. Have you been convicted of a felony or of any offense (felony/misdemeanor) involving the practice of medicine?	☐	☑
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?	☐	☑
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?	☐	☑
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?	☐	☑
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 ____ Signature ____ Date 11/7/93

(Rev. 08/9

RENEWAL APPLICATION

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: 02/15/78

MAX MICHAEL III
P O BOX 55845
BIRMINGHAM, AL 35255

Home Address:

Street _____
City _____
State _____ Zip _____
Business FAX#:( ) _____

☐ Make corrections to mailing address on reverse.

☐ Check if you authorize your FAX# to be published in a directory

■ Every physician and osteopath licensed to practice medicine/osteopathy 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: $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).**

(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, 1992.

b) ____ I certify that I am exempt from the minimum continuing medical education requirement for the following reason:

Check One Below If You Answered (b)

____ I do not reside in the State of Alabama and do not have a significant portion of my medical practice in Alabama.

____ I received my initial license to practice medicine in Alabama after June 30th of this calendar year.

____ I reinstated my license to practice medicine in the State of Alabama after June 30th of this calendar year.

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

____ I am a resident physician enrolled in a residency training program.

Within The Past Year:	Yes	No
1. Have you been convicted of a felony or of any offense (felony/misdemeanor) involving the practice of medicine?	____	✓
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?	____	✓
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?	____	✓
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?	____	✓
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 _____ 10/27/9~
Signature Date

(Do Not Detach)

RENEWAL APPLICATION

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
P O BOX 55845
BIRMINGHAM, AL 35255

Business Address:

SELF
1515 6TH AVE S
BIRMINGHAM, AL 35233

LICENSE #: 0008195 ISSUED: 02/15/78

If your addresses are different from those shown, make corrections on back:

WITHIN THE PAST YEAR:

		YES	NO
1.	Have you been convicted of a felony or of any offense (felony/misdemeanor) involving the practice of medicine.		✓
2.	Has your certificate of qualifications or license to practice medicine in any state been suspended, revoked, restricted, curtailed or voluntarily surrendered under threat of suspension or revocation?		✓
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 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?		✓
5.	Are you now or have you been addicted to the use of alcohol or controlled substances?		✓
6.	Have you been diagnosed and/or treated for a mental illness?		✓
7.	Have you had a judgement rendered against you, or action settled relating to the performance of your professional service?		✓
8.	To your knowledge, are you the subject of an investigation by any licensing Board/Agency as of the date of this renewal application?		✓

I certify that the above information is correct [signature] 10/21/91
Signature Date

(Do Not Detach)

RENEWAL APPLICATION

FOR A CERTIFICATE 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 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
P O BOX 55845
BIRMINGHAM, AL 35255

Business Address:

SELF
1515 6TH AVE S
BIRMINGHAM, AL 35233

LICENSE #: 0008195 ISSUED: 02/15/78

If your addresses are different from those shown, make corrections on back:

WITHIN THE PAST YEAR:

		YES	NO
1.	Have you been convicted of a felony or of any offense (felony/misdemeanor) involving the practice of medicine.		✓
2.	Has your certificate of qualifications or license to practice medicine in any state been suspended, revoked, restricted, curtailed or voluntarily surrendered under threat of suspension or revocation?		✓
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 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?		✓
5.	Are you now or have you been addicted to the use of alcohol or controlled substances?		✓
6.	Have you been diagnosed and/or treated for a mental illness?		✓
7.	Have you had a judgement rendered against you, or action settled relating to the performance of your professional service?		✓
8.	To your knowledge, are you the subject of an investigation by any licensing Board/Agency as of the date of this renewal application?		✓

I certify that the above information is correct [signature] 10/14/90
Signature Date

(Do Not Detach)

RENEWAL APPLICATION

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 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: $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
P O BOX 55845
BIRMINGHAM, AL 35255

Business Address:

SELF
1515 6TH AVE S
BIRMINGHAM, AL 35233

LICENSE #: 0008195 ISSUED: 02/15/78

If your addresses are different from those shown, make corrections on back.

WITHIN THE PAST YEAR:

		YES	NO
1.	Have you been convicted of a felony or of any offense (felony/misdemeanor) involving the practice of medicine.		✓
2.	Has your certificate of qualifications or license to practice medicine in any state been suspended, revoked, restricted, curtailed or voluntarily surrendered under threat of suspension or revocation?		✓
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 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?		✓
5.	Are you now or have you been addicted to the use of alcohol or controlled substances?		✓
6.	Have you been diagnosed and/or treated for a mental illness?		✓
7.	Have you had a judgement rendered against you, or action settled relating to the performance of your professional service?		✓
8.	To your knowledge, are you the subject of an investigation by any licensing Board/Agency as of the date of this renewal application?		✓

I certify that the above information is correct Wm. Michael 11/17/89
Signature Date

(Do Not Detach)

RENEWAL APPLICATION

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.

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
1515 6TH AV S
BIRMINGHAM, AL 35233

Business Address:

1515 6TH AVE S
BIRMINGHAM, AL 35233

LICENSE #: 0008195 ISSUED: 02/15/78

If your addresses are different from those shown, make corrections on back:

WITHIN THE PAST YEAR:

		YES	NO
1.	Have you been convicted of a felony or of any offense (felony/misdemeanor) involving the practice of medicine.		X
2.	Has your certificate of qualifications or license to practice medicine in any state been suspended, revoked, restricted, curtailed or voluntarily surrendered under threat of suspension or revocation?		X
3.	Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practice?		X
4.	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 license to practice medicine been withdrawn under threat or claim?		X
5.	Are you now or have you been addicted to the use of alcohol or controlled substances?		X
6.	Have you been diagnosed and/or treated for a mental illness?		X
7.	Have you had a judgement rendered against you, or action settled relating to the performance of your professional service?		X
8.	To your knowledge, are you the subject of an investigation by any licensing Board/Agency as of the date of this renewal application?		X

I certify that the above information is correct [signature] 10/31/88
Signature Date

(Do Not Detach)

RENEWAL APPLICATION

FOR A CERTIFICATE OF REGISTRATION TO PRACTICE MEDICINE IN ALABAMA IN 1988

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LICENSE #: 0008195 ISSUED: 02/15/78

☑ The above Addresses are correct.

RENEWAL APPLICATION

FOR A CERTIFICATE OF REGISTRATION TO PRACTICE MEDICINE IN ALABAMA IN 1987

ALABAMA MEDICAL LICENSURE COMMISSION
Post Office Box 887
Montgomery, Alabama 36101-0887
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BIRMINGHAM, AL 35233

LICENSE #: 0008195 ISSUED: 02/15/78

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RENEWAL APPLICATION

FOR A CERTIFICATE OF REGISTRATION TO PRACTICE MEDICINE IN ALABAMA IN 1986

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Montgomery, Alabama 36101-0887
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LICENSE #: 0008195 ISSUED: 02/15/78

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RENEWAL APPLICATION

FOR A CERTIFICATE OF REGISTRATION TO PRACTICE MEDICINE IN ALABAMA IN 1985

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Montgomery, Alabama 36101-0887
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LICENSE #: 0008195 ISSUED: 02/15/78

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RENEWAL APPLICATION

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) 832-5051

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: $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:

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1515 6TH AV S
BIRMINGHAM, AL 35233

Business Address:

1515 6TH AVE S
BIRMINGHAM, AL 35233

LICENSE #: 0008195 ISSUED: 02/15/78

☑ The above Addresses are correct.

RENEWAL APPLICATION

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

ALABAMA MEDICAL LICENSURE COMMISSION
908 South Hull Street, Room 110
Montgomery, Alabama 36104
Phone 205/832-5051

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 $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 Alabama, Section 12.

Name and Mailing Address:

MAX MICHAEL III
1515 6TH AV S
BIRMINGHAM, AL 35233

Business Address:

1515 6TH AVE S
BIRMINGHAM, AL 35233

LICENSE #: 0008195 ISSUED: 02/15/78

☑ The above Addresses are correct.

RENEWAL APPLICATION

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 206/832-5061

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.

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 Alabama, Section 12.

Name and Mailing Address:

MAX MICHAEL III
1515 6TH AV S
BIRMINGHAM, AL 35233

Business Address:

1515 6TH AVE S
BIRMINGHAM, AL 35233

LICENSE #: 0008195 ISSUED: 02/15/78

☑ The above Addresses are correct.

RENEWAL APPLICATION

NO. 3852 M

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 205/832-5051

DEC 8 1980

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:

Max Michael, III, M. D.
1515 6th Avenue South
Birmingham, Alabama 35233

8195 2/15/78

Jefferson $ 10.00

Business Address:

Jefferson Clinic
1515 6TH AVE S
BIRMINGHAM, AL 35233

933-9211

☑ The above Addresses are correct.

NO. 3692 M

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

STATE LICENSING BOARD FOR THE HEALING ARTS

Public Safety Building
Montgomery, Alabama 36130
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 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:

MAX MICHAEL III
1515 6TH AV S
BIRMINGHAM, AL 35233

Business Address:

Jefferson clinic P.C
1515 6TH AVE S
BIRMINGHAM, AL 35233

933-9211

LICENSE #: 0008195 ISSUED: 02/15/78

☒ The above addresses are correct.

THIS IS THE ONLY NOTICE YOU WILL RECEIVE.

No. 3247 M

RENEWAL APPLICATION

FOR CERTIFICATE OF REGISTRATION FOR 1979

STATE LICENSING BOARD FOR THE HEALING ARTS

Public Safety Building
MONTGOMERY, ALABAMA 36130

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

Name and Business Address: Max Michael, III, M. D.
1919 6th Avenue South
Birmingham, Alabama 35233

License # 8195

Date issued 12/13/78

County Jefferson

Fee 10.00

Max Michael III
Signature

933-9211

FOR CHANGE OF ADDRESS ONLY DEC 20 1978

THIS IS THE ONLY NOTICE
YOU WILL RECEIVE.

No 5718 M

APPLICATION

FOR CERTIFICATE OF REGISTRATION FOR 1978

STATE LICENSING BOARD FOR THE HEALING ARTS

Public Safety Building
MONTGOMERY, ALABAMA 36130

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

License #

Date issued

County Jefferson

Fee $ 10.00

Max Michael III
Signature

FOR CHANGE OF ADDRESS ONLY

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

Name in full (print) MAX MICHAEL, III

Business address 1515 6th Ave So.

City Birmingham County Jefferson

Branch of Healing Arts you are to practice Internal Medicine

$15.00 license fee attached.

Date 2/8 1978 Signed Max Michael III

** PREFERRED MAILING ADDRESS:

will send