aug

MEDICAL LICENSURE COMMISSION STATE OF ALABAMA P.O. BOX 946 MONTGOMERY, ALABAMA 36102

APPLICATION FOR LICENSE TO PRACTICE MEDICINE/OSTEOPATHY

NAME IN FULL / YA/A/, (Last Name)	SHERWOOD (First Name)	CHANG, JR (Middle Name)
MAILING ADDRESS 603 CHUR	ен 57	
CITY MOBILE	STATE ALABAMA	ZIP <u>3660</u> %
COUNTY MOBILE	TELEPHONE NUMBER((205) 433-3147
TYPE OF PRACTICE OB-GYA		
DATE 15 Aug 93	SIGNED <u>JA</u>	2m)
ALABAMA OFFICE MAILING ADDRESS:		
RASI Fillingim St. Mobile, AL 36617-22	7.3	

Please attach license fee of \$75.00 Make check payable to AL Medical Licensure Commission

or 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!

8/19/1993 ISSUED: LICENSE #: 00017601

LYNN SHERWOOD CHANG UR 2451 FILLINGIM STREET 36617-2238 USAMC/DEPT OBGYN MOBILE AL

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

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

(Check a or b) For CME Certification

- certify that I have met the annual 12 hours of Category I continuing medical calendar year ending minimum continuing education requirement of education during the December 31, 1993. i hareby
- 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
- I reinstated my license to practice medicine in the State of Alabama after June 30th of this calendar year.
- l am retired from the practice of medicine and obtained a waiver from the Board Medical Examiners.
- l am a resident physician enrolled in a residency training program.

I certify that all information on this form is correct

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Within

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Xes

- Ø 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 curtailed or voluntarily surrendered under threat of suspension revoked, restricted, medicine in any state been suspended, or revocation?

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- 3. Have your staff privileges at any hospital or health care facility curtailed, limited or placed under conditions restricting your practice? been revoked, suspended,
- to practice medicine in any state or has your application for a Have you been denied a certificate of qualification or license certificate of qualification or license to practice medicine been withdrawn under threat of denial?
- ō 5. Are you now or have you been addicted to the use alcohol or controlled substances?
- 6. Have you been diagnosed and/or treated for a mental illness and/or serious physical illness?
- of your professional 7, Have you had a judgement rendered against you, settled relating to the performance service?

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8. To your knowledge, are you the subject of an investigation by any licensing Board/Agency as of the date of this application?

11-5-93 Signature

Oate

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

SHERWOOD CHANG LYNN JR, M.D. USAMC/DEPT OBGYN 2451 FILLINGIM STREET MOBILE, AL 36617 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 # 00017601	Sex: M [X] F[_]
Race: White [X] Black [] Am. Indian [] Oriental or Asia	n [] Other [] Soci	al Security #
Office Address:	Home Addres	s:
USAMC/DEPT OBGYN	603 CHURCH	ST
2451 FILLINGIM STREET		•
City, State, Zip: MOBILE, AL 36617	City, State, Zip	o: MOBILE, AL 36602
County: Mobile	County: Mobile	:
Business Phone: (205)471-7947	Home Phone: (205)433-3147
Fax Number: (205) 471-7740		(Will not be published)
Permission to publish in Roster: Yes [X] No []	Send official m	ail to Business or Home address (circle one)
Specialty: Primary: OB/GYN		Board Certified: Yes [X] No []
Secondary:		Board Certified: Yes [] No [X]
Form of Practice: [] Solo [] Partnership (2, 3 or 4) X Grou	p (5 or more) If Group	, give name: LISAMC, Ob-GANDUN.
Primary Hospital where you have staff privileges:		
• • • • • •	City/\$	tate: MOBILE , AL
Name: UNIV SO AL MED CTR Are you licensed in another state: Yes [X] No [X] Which	Ones: [X] [M] [W] [TEXAS NEW WEST MEXICO VIRCUM	
CME Certification: (Check one)	•	
I hereby certify that I have met the annual minimum conti- medical education during the calendar year ending Decemb	nuing education requir	ement of 12 hours of Category I continuing
I certify that I am exempt from the minimum continuing to	nedical education requi	rement for the following reason:
[] I do not reside in the State of Alabama and do not have a [] I received my initial license to practice medicine in Alab [] I reinstated my license to practice medicine in the State of [] I am a resident physician enrolled in a residency training [] I am retired from the practice of medicine and have obtain	ama after June 30th of of Alabama after June : program.	this calendar year. 30th of this calendar year.

Wii	thin The Past Year:	Yes	No
1.	Have you been convicted of a felony or of any offense (felony/misdemeanor) involving the practice of medicine?	a	¥
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? Am voluntarily surrendering WV L'couse	夏	×
3.	Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practice?	п	×
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?	D	×
7.	Have you had a judgement rendered against you, or action settled relating to the performance of your professional service?	n	×
8.	To your knowledge, are you the subject of an investigation by any licensing Board/Agency as of the date of this application?	Ω	×

I certify that all information on this form is correct:

Signature

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

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



Sex: M [X] F[_]

CAR-RT-SORTC010

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

DATE-ISSUED: 08/19/93

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

Sherwood Chang Lynn Jr, M.D. 2451 Fillingim St USAMC/DEPT OBGYN Mobile, AL 36617 2238

Please make corrections or supply information: License 17601

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Race: White [X] "Black 🔝 Am. Indian 🔲 Oriental or Asia	in [] Other [] Social Security	
Office Address:	Home Address:	
2451 FILLINGIM ST	603 CHURCH ST	
USAMC/DEPT OBGYN	•	
City, State, Zip: MOBILE, AL 36617 2238	City, State, Zip: MOBILE, AL 36602	1601
(Alabama) County: Mobile	(Alabama) County: Mobile	
Business Phone: (334)471-7947	Home Phone: (334)433-3147	L D
Fax Number: (334)471-7740 Permission to publish in Roster: Yes [X] No [_]	(Will not be publis Send official mail to:Business ⊠ Home	•
Specialty: Primary: OBSTETRICS & GYNECOLOGY	Board Certified: Y	es 🔀 No 📋
Secondary:	Board Certified: Y	es [_] No [_]
Form of Practice: [] Solo [] Partnership (2, 3, or 4) [X] G USA OB/GYN DEPT	roup (5 or more) If Group, give name bek)W:
Primary Hospital where you have staff privileges:		
Name: USA MEDICAL CENTER	City/State: MOBILE, AL	
Are you licensed in another state: Yes [X] No [] Whic	Tones: [TX] [MM] [WV] []	
CME Certification: (Check one)		
I hereby certify that I have met the annual minimum co medical education during the calendar year ending Dec	ntinuing education requirement of 12 hour ember 31, 1995.	s of Category I continui
[] I certify that I am exempt from the minimum continuing	medical education requirement for the fo	llowing reason:
]] I do not reside in the State of Alabama and do not hat [] I received my initial license to practice medicine in Al [] I reinstated my license to practice medicine in the State [] I am a resident physician enrolled in a residency train [] I am retired from the practice of medicine and have o	abama after June 30th of this calendar yea te of Alabama after June 30th of this cale ing program	ar, ndar year.
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?		Ø
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?		മ
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?		溪
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?		Ø
7.	Have you had a judgement rendered against you, or action settled relating to the performance of your professional service within the past year?		Ø
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 ce	ertify that all information on this form is correct.		
	Hym /	10-13-	95
	Signature	Date	
	Complete both sides, including signature. Require to correct on example all information.		

Incomplete applications will be returned.

Return with \$100.00 renewal fee to:

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



Be sure to correct or supply ALL information.

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Complete BOTH sides including signature.

SHERWOOD CHANG LYNN JR, M.D. USAMC/DEPT OBGYN 2451 FILLINGIM ST MOBILE AL 36617-2238

Please make corrections or supply information: License	= 17601 date-issued: 08/19/93 Sex: M[X] F
Race: White [X] Black [] Am Indian [] Oriental or Asian [] Other	
Office Address:	Home Address:
2451 FILLINGIM ST	603 CHURCH ST
USAMC/DEPT OBGYN	
City, State, Zip: MOBILE, AL 36617 2238	City, State, Zip: MOBILE, AL 36602 1601
(Alabama) County: Mobile	(Alabama) County: Mobile
Business Phone: (334)471-7947	Home Phone: (334)433-3147
Fax Number: (334)471-7740	(Will not be published)
Permission to publish in Roster: Yes [X] No [_]	Send official mail to: Business [] address (check one) Home []
Speciality: Primary: OBSTETRICS & GYNECOLOGY	Board Certified: Yes 🔀 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:
USA OB/GYN DEPT	
Primary Hospital where you have staff privileges:	
Name: USA MEDICAL CENTER	City/State: MOBILE, AL
Are you heensed in another state: Yes [X] No [_] Which ones: [TX]	J[NMJ[WV][]]
CME Certification: (Check one)	
I hereby certify that I have met the annual minimum continuing education during the calendar year ending Dece	
[] I certify that I am exempt from the minimum continuing medical $c\bar{c}$	lucation requirement for the following reason:
[] I do not reside in the State of Alabama and do not have a signific [] I received my initial license to practice medicine in Alabama afte [] I reinstated my license to practice medicine in the State of Alabam [] I am a resident physician chrolled in a residency training program [] I am retired from the practice of medicine and have obtained a way	r June 30th of this calendar year. ma after June 30th of this calendar year. n.
Complete both sides including signature. Supply or	correct all information. OVER
YARA TAT TAYER AND	FRED of 1004

DEADLINE IS DECEMBER 31, 1996

	$oldsymbol{\epsilon}$		
• 16		YES	ΝO
I.	Have you been convicted of a felony or of any offense (felony/misdemeanor) involving the practice of medicine within the past year?	[]	M
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?		N)
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?	1)	K)
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? I limit fulled in 1995		K
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?	[]	鸠
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?	ſĵ	Ŋ
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?	í]	×
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?	[]	Ø
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?	[]	М
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?	[]	iΧI
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?	IJ	₩)
	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.

Signature

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

Return with \$100.00 renewal fee to:

License Renewal for 1998 Deadling is December 31, 1997

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.

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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: Lic Race: White [X] Black [_] Am. Indian [_] Oriental or-Asia	
Office Address:	Home Address:
USAMC/DEPT OBGYN	603 CHURCH ST
2451 FILLINGIM ST	
City, State, Zip: MOBILE, AL 36617 2238	City, State, Zip: MOBILE, AL 36602 1601
(Alabama) County: Mobile	(Alabama) County: Mobile
Business Phone: (334)471-7947 799\$	Home Phone: (334)433-3147
Fax Number: (334)471-7740	(Will not be published)
Permission to publish in Roster: Yes [X] No [_] Specialty: Primary: OBSTETRICS & GYNECOLOGY	Send official mail to: Business [X] address (check one) Home [] Board Certified: Yes [X] No []
Secondary: Form of Practice:[] Solo [] Partnership (2, 3, or 4) [X] USA OB/GYN DEPT	Board Certified: Yes [_] No [_] Group (5 or more) If Group, give name below:
Primary Hospital where you have staff privileges: Name: USA MEDICAL CENTER Welliam & Women's Ho Are you licensed in another state: Yes [X] No [] which or Primary Care Information: 1. Are you actively engaged in clinical practice? (Check one): Ye 2. Does your practice include the delivery of primary care medical care focused on the point at which a patient ideally first seeks as room care."): (Check one): Yes K! No [] 3. Approximately how many hours per week do you practice the al CME Certification: (Check one) X I hereby certify that I have met the annual minimum continuing continuing medical education during the calendar year ending De [] I certify that I am exempt from the minimum continuing medical	res: [TX] [NM] [WV] [] [] res: [X] No [] I services? (Primary care is defined as: "Basic or general health ssistance from the medical care system, exclusive of emergency bove-defined primary care services? education requirement of 12 hours of Category I ecomber 31, 1997. I education requirements for the following reason:
[] I do not reside in the State of Alabama and do not have a signification of the state of Alabama and the state of Alabama after a resident my license to practice medicine in the State of Alabama after a resident physician enrolled in a residency training program of the state of the practice of medicine and have obtained a state of the state of the practice of medicine and have obtained as the state of t	ter June 30 th of this calendar year. ama after June 30 th of this calendar year. am.

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

OVER

		YE\$.	NO
1.	Have you been convicted of a felony or of any offense (felony/misdemeanor) involving the practice of medicine within the past year?	[]	k]
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?	[]	M
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?	[]	[7]
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?	[]	[V]
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?	[]	DI
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?	_[<u>]</u> _	[ĕ]
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?	[]	DX]
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?	[]	[<u>k</u>]
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?	[]	M
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?	[]	[کلر
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?	[]	KJ
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?	[]	ķΊ
	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 engoing 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.	;7	
I certify	y that all information on this form is correct. 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:

License Renewal for 1999 Deadline is December 31, 1998

State of Alabama Medical Licensure Commission

334/242-4153

P.O. Box 887

43

Montgomery, Alabama 36101-0887



*******AUTO**3-DIGIT 366 SHERWOOD CHANG LYNN JR, M.D. USAMC/DEPT OBGYN 2451 FILLINGIM ST MOBILE AL 36617-2238

Complete BOTH sides including signature. Be sure to correct or supply AEL information. Return with \$100.00 renewal fee. **8137** 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.

Specialty: Primary: OBSTETRICS & GYNECOLOGY Sccondary: Form of Practice: [] Solo [] Partnership (2, 3, or 4) [X] Group (5 or more) If Group, give name below: USA OB/GYN DEPT Primary Hospital where you have staff privileges: Name: USA CHILDRENS & WOMENS HOSP City/State: MOBILE. AL. Are you licensed in another state: Yes [X] No [] which ones: [TX] [NM] [WV] [] Primary Care Information: 1. Are you actively engaged in clinical practice? (Check one): Yes [N] No [] 2. Does your practice include the delivery of primary care medical services? (Primary care is defined as: "Basic or general healt 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 [N] No [] 3. Approximately how many hours per week do you practice the above-defined primary care services? CME Certification: (Check one) [M] 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:	Please make corrections or supply information: L Race: White [X] Black [_] Am. Indian [_] Oriental or As	
City, State, Zip: MOBILE, AL 36617 2238 City, State, Zip: MOBILE, AL 36602 1601 (Alabama) County: Mobile Business Phone: (334)471-7947 Home Phone: (334)433-3147 Fax Number: (334)471-7740 Permission to publish in Roster: Yes [X] No [] Send official mail to: Business [] address (check on Home []) Specialty: Primary: OBSTETRICS & GYNECOLOGY Secondary: Form of Practice: [] Solo [] Partnership (2, 3, or 4) [X] Group (5 or more) If Group, give name below: USA OB/GYN DEPT Primary Hospital where you have staff privileges: Name: USA CHILDRENS & WOMENS HOSP City/State: MOBILE. AL Are you actively engaged in clinical practice? (Check one): Yes [X] No [] Primary Care Information: 1. Are you actively engaged in clinical practice? (Check one): Yes [X] No [] 2. Does your practice include the delivery of primary care medical services? (Primary care is defined as: "Basic or general healt 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 [V] No [] 3. Approximately how many hours per week do you practice the above-defined primary care services? CME Certification: (Check one) [V] 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. [] 1 certify that I am exempt from the minimum continuing medical education requirements for the following reason:	Office Address:	Home Address:
City, State, Zip: MOBILE, AL 36617 2238 City, State, Zip: MOBILE, AL 36602 1601 (Alabama) County: Mobile Business Phone: (334)471-7947 Home Phone: (334)433-3147 Fax Number: (334)471-7740 Permission to publish in Roster: Yes [X] No [] Send official mail to: Business [] address (check on flome []] Specialty: Primary: OBSTETRICS & GYNECOLOGY Secondary: Board Certified: Yes [] No [] Form of Practice: [] Solo [] Partnership (2, 3, or 4) [X] Group (5 or more) If Group, give name below: USA OB/GYN DEPT Primary Hospital where you have staff privileges: Name: USA CHILDRENS & WOMENS HOSP City/State: MOBILE, AL, Are you licensed in another state: Yes [X] No [] which ones: [TX] [NM] [VVII []] Primary Care Information: 1. Are you actively engaged in clinical practice? (Check one): Yes [V] No [] 2. Does your practice include the delivery of primary care medical services? (Primary care is defined as: "Basic or general healt 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 [V] No [] 3. Approximately how many hours per week do you practice the above-defined primary care services? CME Certification: (Check one) [V] I hereby certify that I have met the annual minimum continuing education requirements for the following reason:	USAMC/DEPT OBGYN	603 CHURCH ST
(Alabama) County: Mobile Business Phone: (334)471-7947	2451 FILLINGIM ST	
Business Phone: (334)471-7947 Fax Number: (334)471-7740 Permission to publish in Roster: Yes [X] No [] Send official mail to: Business [] address (check on Home []) Specialty: Primary: OBSTETRICS & GYNECOLOGY Secondary: Board Certified: Yes [] No [] Form of Practice: [] Solo [] Partnership (2, 3, or 4) [X] Group (5 or more) If Group, give name below: USA OB/GYN DEPT Primary Hospital where you have staff privileges: Name: USA CHILDRENS & WOMENS HOSP City/State: MOBILE. AL. Are you licensed in another state: Yes [X] No [] which ones: [TX] [NM] [WV] [] [] Primary Care Information: 1. Are you actively engaged in clinical practice? (Check one): Yes [M] No [] 2. Does your practice include the delivery of primary care medical services? (Primary care is defined as: "Basic or general healt 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 [v] No [] 3. Approximately how many hours per week do you practice the above-defined primary care services? CME Certification: (Check one) [V] Thereby 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:	City, State, Zip: MOBILE, AL 36617 2238	City, State, Zip: MOBILE, AL 36602 1601
Permission to publish in Roster: Yes [X] No [] Send official mail to: Business [] address (check o Home []] Specialty: Primary: OBSTETRICS & GYNECOLOGY Board Certified: Yes [] 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: USA OB/GYN DEPT Primary Hospital where you have staff privileges: Name: USA CHILDRENS & WOMENS HOSP City/State: MOBILE. Al. Are you licensed in another state: Yes [X] No [] which ones: [TX] [NM] [W] [] [] Primary Care Information: 1. Are you actively engaged in clinical practice? (Check one): Yes [M] No [] 2. Does your practice include the delivery of primary care medical services? (Primary care is defined as: "Basic or general healt care focused on the point at which a patient ideally first seeks assistance from the medical care system, exclusive of emergenc room care."): (Check one): Yes [M] No [] 3. Approximately how many hours per week do you practice the above-defined primary care services? CME Certification: (Check one) [M] Thereby 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:	(Alabama) County: Mobile	(Alabama) County: Mobile
Permission to publish in Roster: Yes [X] No [] Send official mail to: Business [] address (check on Home []] Specialty: Primary: OBSTETRICS & GYNECOLOGY Board Certified: Yes [] 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: USA OB/GYN DEPT Primary Hospital where you have staff privileges: Name: USA CHILDRENS & WOMENS HOSP City/State: MOBILE AL Are you licensed in another state: Yes [X] No [] which ones: [TX] [NM] [WV] [] [] Primary Care Information: 1. Are you actively engaged in clinical practice? (Check one): Yes [V] No [] 2. Does your practice include the delivery of primary care medical services? (Primary care is defined as: "Basic or general healt care focused on the point at which a patient ideally first seeks assistance from the medical care system, exclusive of emergency common care."): (Check one): Yes [V] No [] 3. Approximately how many hours per week do you practice the above-defined primary care services? CME Certification: (Check one) [V] Thereby 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:	Business Phone: (334)471-7947	Home Phone: (334)433-3147
Specialty: Primary: OBSTETRICS & GYNECOLOGY Secondary: Form of Practice: [] Solo [] Partnership (2, 3, or 4) [X] Group (5 or more) If Group, give name below: USA OB/GYN DEPT Primary Hospital where you have staff privileges: Name: USA CHILDRENS & WOMENS HOSP City/State: MOBILE. AL. Are you licensed in another state: Yes [X] No [] which ones: [TX] [NM] [WV I []] 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 healt 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 [V] No [] 3. Approximately how many hours per week do you practice the above-defined primary care services? CME Certification: (Check one) [M] 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:	Fax Number: (334)471-7740	(Will not be published)
Specialty: Primary: OBSTETRICS & GYNECOLOGY Secondary: Secondary: Board Certified: Yes No Secondary: Form of Practice: Solo Partnership (2, 3, or 4) Solo Solo Solo Solo Solo Solo Solo Sol	Permission to publish in Roster: Yes [X] No [_]	* * * * * * * * * * * * * * * * * * * *
Primary Hospital where you have staff privileges: Name: USA CHILDRENS & WOMENS HOSP City/State: MOBILE. AL Are you licensed in another state: Yes [X] No [] which ones: [TX] [NM] [WV] [] Primary Care Information: 1. Are you actively engaged in clinical practice? (Check one): Yes [V] No [] 2. Does your practice include the delivery of primary care medical services? (Primary care is defined as: "Basic or general healt 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 [V] No [] 3. Approximately how many hours per week do you practice the above-defined primary care services? CME Certification: (Check one) [V] 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:		Board Certified; Yes [] No []
Name: USA CHILDRENS & WOMENS HOSP City/State: MOBILE. AL. Are you licensed in another state: Yes [X] No [] which ones: [TX] [NM] [WV] [] [] Primary Care Information: 1. Are you actively engaged in clinical practice? (Check one): Yes [N No []] 2. Does your practice include the delivery of primary care medical services? (Primary care is defined as: "Basic or general healt 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 [N No []] 3. Approximately how many hours per week do you practice the above-defined primary care services? CME Certification: (Check one) [M 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:	Form of Practice:[] Solo [] Partnership (2, 3, or 4) [USA OB/GYN DEPT	X] Group (5 or more) If Group, give name below:
[] 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	Name: USA CHILDRENS & WOMENS HOSP City/State Are you licensed in another state: Yes [X] No [] which Primary Care Information: 1. Are you actively engaged in clinical practice? (Check one): 2. Does your practice include the delivery of primary care medicare focused on the point at which a patient ideally first seeks room care."): (Check one): Yes [v] No [] 3. Approximately how many hours per week do you practice the CME Certification: (Check one) [v] I hereby certify that I have met the annual minimum continuing continuing medical education during the calendar year ending [] I certify that I am exempt from the minimum continuing medical education the minimum continuing medical if received my initial license to practice medicine in Alabama [] I reinstated my license to practice medicine in the State of Ali I am a resident physician enrolled in a residency training prog [] I am retired from the practice of medicine and have obtained	Yes No [] cal services? (Primary care is defined as: "Basic or general health is assistance from the medical care system, exclusive of emergency e above-defined primary care services? In geducation requirement of 12 hours of Category 1 December 31, 1998. In a december 30th of this calendar year. In a december 30th of this calendar year.

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

OVER

		YES	ÑĆ
1.	Have you been convicted of a felony or of any offense (felony/misdemeanor) involving the practice of medicine within the past year?	[]	[v]
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?	I J	M
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?	[]	M
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?	[]	[v]
5.	Have you had a judgement rendered against you, or action settled relating to the performance of your professional service within the past year?	[]	M
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?	[]	M
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?	[]	M
9.	Within the past year, have you ever raised the issue of consumption of drugs or alcohol or the issue of a mental, emotional, nervous, or behavioral disorder or condition as a defense, mitigation, or explanation for your actions in the course of any administrative or judicial proceeding or investigation; any inquiry or other proceeding; or any proposed termination by an educational institution, employer, government agency, professional organization or licensing authority?	1]	M
10.	Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism?	[]	M
11.	Are you currently engaged in the illegal use of controlled dangerous substances?	[]	M
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?	[]	M
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?	[]	MÍ
14.	Has your medical training or medical practice been interrupted or suspended for a period longer than 60 days for any reason other than a vacation?	[]	M
	The term "currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the condition referred to may have an ongoing impact on one's functioning as a physician or an assistant to a physician, or within the past two years.		
Certify	IF YOU HAVE ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, PLEASE ATTACH A DETAILED EXPLANATION WITH YOUR APPLICATION UPON RETURNING IT TO THIS OFFICE. (that all information on this form is correct. 13 14 15 15 16 Signature Date	<u>8</u>	
	 Complete both sides, including signature. Be sure to supply all information. Incomplete applications will be returned. 		

Return with \$100.00 renewal fee to:

License Renewal for 2000 Deadline is December 31, 1999

State of Alabama Medical Licensure Commission

334/242-4153

P.O. Box 887

36

Montgomery, Alabama 36101-0887



SHERWOOD CHANG LYNN JR, M.D. USAMC/DEPT OBGYN 2451 FILLINGIM ST MOBILE, AL 36617-2238

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Be sure to correct or supply ALL information. Return with \$100.00 renewal fee. Incomplete applications will be returned.

Complete BOTH sides including signature.

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: Li	cense 17601 DATE-ISSUED: 8/19/93 Sex: M [X] F [_]
Race: White [X] Black [_] Am. Indian [_] Oriental or Asi	an [_] Other [_] Social Security #
Office Address:	Home Address:
USAMC/DEPT OBGYN	603 CHURCH ST
-2451 FILLINGIMST 251 COX St, Scult 100	
City, State, Zip: MOBILE, AL 36617-223 8 كالدالوه ط	City, State, Zip: MOBILE, AL 36602 1601
(Alabama) County: Mobile	(Alabama) County: Mobile
Business Phone: (334)471-7947 415-1557	Home Phone: (334)433-3147
Fax Number: (334)471-7740 4/5-/552	(Will not be published)
Permission to publish in Roster: Yes [X] No [_]	Send official mail to: Business [] address (check one) Home []
Specialty: Primary: OBSTETRICS & GYNECOLOGY	Board Certified: Yes 🗹 No [_]
Secondary:	Board Certified: Yes [] No []
Form of Practice: [] Solo [] Partnership (2, 3, or 4) [USA OB/GYN DEPT	X] Group (5 or more) If Group, give name below:
gatekeeper' health care focused on the point at which a patient ide emergency care situation.") Yes [4] Go to Question 3 No [1] Do NOT answer questi	abama? ens-2 end-3 below. Skip to CME Certification questions. all services in Alabama? (Primary care is defined as: "Basic or general ally first seeks assistance from the medical care system, exclusive of an on 3 below. Skip to CME Certification questions. above-defined primary care services in Alabama? Only answer if you hours per week. geducation requirement of 12 hours of Category I December 31, 1999. all education requirements for the following reason: ificant portion of my medical practice in Alabama. after June 30th of this calendar year. abama after June 30th of this calendar year.
	DECEMBER 31, 1999

Complete both sides including signature. Supply or sorrect all information thereood Chango YER

		YEŞ	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]-
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?	[]	[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?	[]	[5 6]
5.	Have you had a judgement rendered against you, or action settled relating to the performance of your professional service within the past year?	[]	i ka
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?	[]	5 ×3
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?	[]	p×3
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?	[]	W
9.	Within the past year, have you ever raised the issue of consumption of drugs or alcohol or the issue of a mental, emotional, nervous, or behavioral disorder or condition as a defense, mitigation, or explanation for your actions in the course of any administrative or judicial proceeding or investigation; any inquiry or other proceeding; or any proposed termination by an educational institution, employer, government agency, professional organization or licensing authority?	[]	1 \$1
l 0.	- Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism?	[1]_	M
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?	[]	D×1
14.	Has your medical training or medical practice been interrupted or suspended for a period longer than 60 days for any reason other than a vacation?	[]	<u>[</u> \
	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.		
certify	that all information on this form is correct.	9	İ
	Signature Date Complete both sides, including signature. Be sure to supply all information. Incomplete applications will be returned.		
<u> 24.</u>	Return with \$100.00 renewal-fee to:	- 19 - 12.	
	Medical Licensure Commission		

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

License Renewal for 2001 Deadline is December 31, 2000

State of Alabama RECRIVED OCT 2 4 2000 Medical Licensure Commission

334/242-4153

P.O. Box 887

8390

Montgomery, Alabama 36101-0887



SHERWOOD CHANG LYNN JR, M.D. 251 COX ST STE 100 MOBILE, AL 36604-3302

Tallalladladlanladalladlamılıllalılalıdı

Complete **BOTH** sides including signature. Be sure to correct or supply **ALL** information. Return with \$125.00 renewal fee.

39 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: Lie		
Race: White [X] Black [] Am. Indian [] Oriental or Asia	nn [] Other [] Social Security #	· · · · · · · · · · · · · · · · · · ·
Office Address:	Home Address:	
SUTTE 100	603 CHURCH \$T	
≗2\$1 COX ST		-
City, State, Zip; MOBILE, AL 36604	City, State, Zip: MOBILE, AL 36602 1601	
(Alabama) County: Mobile	(Alabama) County: Mobile	
Business Phone: (334)415-1557	Home Phone: (334)433-3147	
Fax Number: (334)415-1552	(Will not be published)	() () () () () () () () () ()
Permission to publish in Roster: Yes [X] No [_]	Send official mail to: Business [X] address (of Home []	check one)
Specialty: Primary: OBSTETRICS & GYNECOLOGY	Board Certified: Yes 🔀	
Secondary:	Board Certified: Yes []	
Form of Practice:[] Solo [] Partnership (2, 3, or 4) []	(] Group (5 or more) If Group, give name below:	·
USA OB/O I N DEFI		
-Primary Hospital where you have staff privileges:	MODUE	
Name: USA CHILDRENS & WOMENS HOSP City/State: Are you licensed in another state: Yes [X] No [_] which of	mobile, AL	
Primary Care Information:		
1. Are you actively engaged in clinical practice in the State of Ala	abama?	
Yes [5] Go to Question 2 No [] Do NOT answer question 2. Does your practice include the delivery of primary care medical	ins 2 and 3 below. Skip to CME Certification questions.	Rasic or general
gatekeeper' health care focused on the point at which a patient ide	ally first seeks assistance from the medical care system,	, exclusive of an
emergency care situation.")	,	
Yes [X] Go to Question 3 No [] Do NOT answer question	on 3 below. Skip to CME Certification questions.	
3. Approximately how many hours per week do you practice the answered YES to questions 1 and 2 above.) Approximately		answer ir you
CME Certification: (Check one)	nous per work.	
[18] I hereby certify that I have met the annual minimum continuing		
continuing medical education within the past two calendar year		v€.
[-] I certify that I am exempt from the minimum continuing medic [-] I do not reside in the State of Alabama and do not have a signi		
. [A] [A] I received my initial license to practice medicine in Alabama a		
[] I reinstated my license to practice medicine in the State of Ala		
[] Lam a resident physician enrolled in a residency training progi	ram.	9 E
[] am retired from the practice of medicine and have obtained a	waiver from the Board of Medical Examiners. ECFMRER 31, 2000	
Complete both sides including signature. Supply	õr correct all information.	OVER -
License #17601	8390 LVNN, SHERWOOD CHANG J	IR

		Yes	N
1.	Have you been convicted of a felony or of any offense (felony/misdemeanor) involving the practice of medicine within the past year?	[]	K
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?	()	[2]
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?	[]	(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, paranoic, or any other psychotic disorder?	[]	[k]
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?	[]	[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?	[]	[x]
13.	Have you been, within the past year, convicted of driving under the influence (DUI) or have you been charged with DUI and been convicted of a lesser offense such as reckless driving?	[]	[2]
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.		
F YOU	U HAVE ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, PLEASE ATTACH A DETAILED EXPLANAT YOUR APPLICATION UPON RETURNING IT TO THIS OFFICE.	-	·
certify	that all information on this form is correct. 30 Kgmm 23 Oct	2000	
•	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:

License Renewal for 2002 Deadline is December 31, 2001

State of Alabama Medical Licensure Commission

334/242-4153

P.O. Box 887

Montgomery, Alabama 36101-0887



SHERWOOD CHANG LYNN, M.D. 251 COX ST SUITE 100 MOBILE, AL 36604 Complete BOTH sides including signature. Be sure to correct or supply ALL information. Return with \$200.00 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: Race: White [X] Black [] American Indian []	MD . 00017601 Oriental or Asian []	Date-Issued: 08/ Other []	19/1993 Sex: Social Security# (F[]
Office Address	Home Addres	is s			
251 COX ST SUITE 100	603 CHURCH	ST			
MÖBILE, AL 36604	MOBILE, AL 3	6602-1601			
(Alabama) County: Mob? (e. Business Phone: (354) 415-1557 Fax Number: (354) 415-1552	(Alabama) Coi	unty: <i>Mehile</i> 251 (35 4) 433-3147 (V			
Business Phone: (384) 415-1557	Home Phone:	257 (364) 433-3147 (V	Will not be publishe	ed)	
Fax Number: (354) 415-1552					
Permission to publish in Roster: Yes [X]	Send official m	nail to:Business [X		one)	
Specialty: Primary: OBSTETRICS & GYNECOLOGY	Bos	ard Certified: Yes I] address X] No []		
Secondary: Form of Practice: [Solo [] Partnership (2, 3, or 4)	Society	ard Certified: Yes [e Group Name bek ne , 06-64*	NOLL Dept.	ith AL Co	ellege
Primary Hospital where you have staff privileges: Name: USA CHILDRENS & WOMENS HOSP		State: MOBILE, AL	. ,		
Are you licensed in another state: Yes [X] No [] Which ones: [TX]] [] [] []] []		
Does your practice include the delivery of primary 'gatekeeper' health care focused on the point at such a an emergency care situation.")	T answer questions 2 and care medical services in A patient ideally first seeks OT answer question 3 beloratice the above-defined	Alabama? (Primary assistance from thoo w. Skip to the CM primary care services.)	care is defined as se medical care sys E Certification que	: "Basic or g stem, exclus estions.	sive of
CME Certification: (Check one) [✓] I hereby certify that I have met the annual minimum cont continuing medical education within the past two calends. [] I certify that I am exempt from the minimum continuing material in I certify that I am exempt from the minimum continuing material I certify that I am exempt from the State of Alabama and do not form the I is a state of Alabama and do not form the I is a feet of the I is a	ar years ending Decembe nedical education requirer ave a significant portion o Alabama after June 30 th of tate of Alabama after Jun ining program.	er 31, 2001. ments for the follow of my medical practi f this calendar year. e 30 th of this calend	ring reason: ice in Alabama dar year.		

		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?	[]	Ŋ
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?	IJ	网
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?	[]	[k]
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?	- []	M
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?	Гì	M2
10		.[]	Ø
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?	ĹĴ	[]
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?	LЈ	M
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.		
WITH	OU HAVE ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, PLEASE ATTACH A DETAILED EXPLANATE A YOUR APPLICATION UPON RETURNING IT TO THIS OFFICE.	ΓΙΟΝ	
certif	fy that all information on this form is correct. Company		
	(/ y.g.mare		

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

Return with \$200.00 renewal fee to:

License Renewal for 2003 Deadline is December 31, 2002

State of Alabama Medical Licensure Commission

334/242-4153

P.O. Box 887

Montgomery, Alabama 36101-0887



SHERWOOD CHANG LYNN, M.D. 251 COX ST SUITE 100 MOBILE, AL 36604

Complete BOTH sides including signature. Be sure to correct or supply ALL information. Return with \$200.00 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: MI	0.00017601	Date-Issued: 08/19	9/1993 Sex: M[X] F[]					
Race: White [X] Black [] American Indian [] Or	iental or Asian []	Other[] S	ocial Security#					
Office Address	Home Address	;						
251 COX ST SUITE 100	03 CHURCH ST							
City, State, Zip: MOBILE, AL 36604	ity, State, Zip: MOBILE,	, AL 36602-1601						
(Alabama) County:	(Alabama) Coun	nty:						
্রের Business Phone: (251) 415- 1557	Home Phone: (2	251) 433-3147 (Wi	ill not be published)					
Fax Number: (251) 415-1552								
Permission to publish in Roster: Yes [X]	Send official ma	il to: Business [X] Home 「	address (check one)					
Specialty: Primary: OBSTETRICS & GYNECOLOGY Secondary: Form of Practice: [] Solo [] Partnership (2, 3, or 4) []	Board (Group If Group give G	Board Certified: Yes [] No [] Board Certified: Yes [] No []						
 Does your practice include the delivery of primary care 'gatekeeper' health care focused on the point at such a pat an emergency care situation.") Yes [X] Go to Question 3 No [] Do NOT at 3. Approximately how many hours per week do you pract Answered YES to questions 1 and 2 above. Approximately 	te of Alabama? swer questions 2 and 3 medical services in Ala ient ideally first seeks and answer question 3 below- ice the above-defined p	abama? (Primary ca ssistance from the v. Skip to the CME orimary care service	ME Certification questions. are is defined as: "Basic or general medical care system, exclusive of Certification questions.					
CME Certification: (Check one) [X] I hereby certify that I have met the annual minimum continuing medical education within the past two calendar years of the certify that I am exempt from the minimum continuing medical in I do not reside in the State of Alabama and do not have in I received my initial license to practice medicine in Alabama in I reinstated my license to practice medicine in the State in I am a resident physician enrolled in a residency training in I am retired from the practice of medicine and have obtained.	ears ending December (cal education requirems a significant portion of r ama after June 30 th of th of Alabama after June 3 g program.	31, 2002. ents for the following my medical practice his calendar year. 30 th of this calendar	g reason: e in Alabama. r year.					
DEADLINE IS	DECEMBER 31, 2	2002						

MD . 00017601

LYNN, SHERWOOD CHANG

		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?	[]	K
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?	[]	[12]
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?	[]	[٧]
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?	[] {	[k]
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?	[]	K
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?	[]	[3]
10.	Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism?	[]	لا]
11.	Are you currently engaged in the illegal use of controlled dangerous substances?	[]	M
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?	-{-}	<u> </u>
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?	[]	[y]
	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.		
WITH:	OU HAVE ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, PLEASE ATTACH A DETAILED EXPLANAT I YOUR APPLICATION UPON RETURNING IT TO THIS OFFICE.	TON	
certif	fy that all information on this form is correct. Signature Date	<u>~</u>	
	// Organite Date		

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

Return with \$200.00 renewal fcc to:



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

2004 Online Renewal Summary

Name: Sherwood Chang Lynn Jr.

Transaction Date: 2003-12-30*

Registration Fee: 200

License Number: MD.17601

Transaction Number: null

Date of Birth: 1940-06-14

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

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

Primary specialty:

Are you Board certified in your primary specialty? Y

Secondary specialty:

Are you Board certified in your secondary specialty? N

Practice Type:

Primary Hospital where you have privileges:

Are you licensed in another State: Y

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. **60**

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: (251) 415-1563

Practice Address: 251 COX ST

Home Telephone: (251) 433-3147

Home Address: 603 CHURCH ST

Public Address: Practice

Mail Address: Practice

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

2005 Online Renewal Summary

Name: Sherwood Chang Lynn Jr.

Transaction Date: 2004-12-03*

Registration Fee: 200

License Number: MD.17601

Transaction Number: null

Date of Birth: 1940-06-14

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

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

Primary specialty:

Are you Board certified in your primary specialty? Y

Secondary specialty:

Are you Board certified in your secondary specialty? N

Practice Type:

Primary Hospital where you have privileges:

Are you licensed in another State: Y

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. **70**

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: (251) 415-1563

Practice Address: 251 COX ST

Home Telephone: (251) 433-3147

Home Address: 603 CHURCH ST

Public Address: Practice

Mail Address: Practice

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.

RENEW ONLINE AT http://renewal.albme.org **2ND.NOTICE**

License Renewal for 2006 Deadline is December 31, 2005 Registration ID: 178086

State of Alabama Medical Licensure Commission

334/242-4153

P.O. Box 887

Montgomery, Alabama 36101-0887



32 25 2402 LYNN SHERWOOD CHANG JR, MD 251 COX ST STE 100 MOBILE, AL 36604-3302

Complete BOTH sides including signature. Be sure to correct or supply ALL information. Return with \$200.00 renewal fee. Incomplete applications will be returned. Failure to register and pay renewal fec will result in the automatic revocation of the current license to practice medicine or osteopathy.

Please make correct	ions or supp	ly information:	License:	MD . 0001760	1	Date-Issue	d: 08/	19/1993	Sex:	M [X]	F[
Race: White [X]	Black[]	American Indi	an []	Oriental or As	ian[]	Other (1	Social S	ecurit <u>u</u>		
Office Address 251 COX ST SUITE 100		· · · · · · · · · · · · · · · · · · ·			603	CHURCH ST	Home	e Address			
City, State, Zip: MOBIL	E, AL 36604			City, S	State, Zip	: MOBILE, AL 3	6602-160	1			
(Alabama) CountyMo	obile			(Alab	ama) Coı	unty:Mobile					
Business Phone: (251)	415-1563			Home	Phone:(251) 433-3147 ((Will n	ot be publi	ished)		
Fax Number: (251) 415- Permission t		Roster: Yes [/]		Send official n	nail to: B	usiness [] Home	e [] <i>A</i>	ddress (C	heck Or	ne)
Specialty; Primary: o Secondary: Form of Practice: [] <u>Solo [_]</u>	Partnership (2,		[/] Group If	Board	l Certified: l Certified: ve Group N	Yes [] No[]			
Primary Hospital who Name: USA Children Are you licensed in a	's and Wome	en's Hos	No [1		tate: Mobil h ones: [TX		1 []	1 1]	
Yes [X] (2. Does your p 'gatekeeper' hee emergency care Yes [X] [3. Approximate	vely engaged Go to Question bractice include alth care focus situation.") Go to Question ely how many	le the delivery of passed on the point at	NOT ansirimary care such a par NOT ansv you prac	wer questions 2 an e medical services i tient ideally first se ver question 3 belo tice the above-defi	d 3 below n Alabam eks assista w. Skip t ned prima	a? (Primary cance from the CME C	are is d e medic ertificat	efined as: "I tal care syste tion guestion	Basic or ge em, exclusions. ns.	ve of an	
education for	certify that I i the calendar	have met the annu year 2005. mpt from the minin						_		=	ical
[]! do not reside in the control of	the CME requ Il license to pretirement wa vaiver from the	uirement for the pr actice medicine in a liver from the Board ne Board of Medica	evious cald Alabama i d of Medic I Examine	endar year 2004 and the calendar year tal Examiners, and rs due to illness, dis	d I moved 2005. I do not e ability or	my residend ngage in the other hardsi	e to the practic	e State of Al e of medicin dition which	labama du ne in any fo existed in	orm.	
[] I am enrolled or wa MD . 00017601	as enrolled in	a residency training	g program	or clinical fellows	ni p prog ra	ım during th	e calend	dar year 200	15.		

DEADLINE IS DECEMBER 31, 2005 LYNN, SHERWOOD CHANG JR

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

OVER

	•	Yes	Ñо
ι.	Have you been convicted of a felony or of any offense (felony/misdemeanor) involving the practice of medicine within the past year?	[]	1
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?	11	N
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?	[]	N
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?	[]	M
5.	Have you had a judgement rendered against you, or action settled relating to the performance of your professional service within the past year?	[]	N
6.	To your knowledge, are you the subject of an investigation, or has a formal complaint against your license been filed by any licensing Board/Agency as of the date of this application within the past year?	[]	[/]
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 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?	[]	И
9,	Within the past year, have you ever raised the issue of consumption of drugs or alcohol or the issue of a mental, emotional, nervous, or behavioral disorder or condition as a defense, mitigation, or explanation for your actions in the course of any administrative or judicial proceeding or investigation; any inquiry or other proceeding; or any proposed termination by an educational institution, employer, government agency, professional organization or licensing authority?	[]	£1
10.	Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism?	[]	Ø
11.	Are you currently engaged in the illegal use of controlled dangerous substances?	[]	И
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?	[]	И
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?	[]	N
	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 YO WITH	OU HAVE ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, PLEASE ATTACH A DETAILED EXPLANATION OF THE ABOVE QUESTIONS, PLEASE ATTACH A DETAILED EXPLANATION OF THE ABOVE QUESTIONS, PLEASE ATTACH A DETAILED EXPLANATION OF THE ABOVE QUESTIONS, PLEASE ATTACH A DETAILED EXPLANATION OF THE ABOVE QUESTIONS, PLEASE ATTACH A DETAILED EXPLANATION OF THE ABOVE QUESTIONS, PLEASE ATTACH A DETAILED EXPLANATION OF THE ABOVE QUESTIONS, PLEASE ATTACH A DETAILED EXPLANATION OF THE ABOVE QUESTIONS, PLEASE ATTACH A DETAILED EXPLANATION OF THE ABOVE QUESTIONS, PLEASE ATTACH A DETAILED EXPLANATION OF THE ABOVE QUESTIONS, PLEASE ATTACH A DETAILED EXPLANATION OF THE ABOVE QUESTIONS, PLEASE ATTACH A DETAILED EXPLANATION OF THE ABOVE QUESTIONS, PLEASE ATTACH A DETAILED EXPLANATION OF THE ABOVE QUESTIONS, PLEASE ATTACH A DETAILED EXPLANATION OF THE ABOVE QUESTIONS, PLEASE ATTACH A DETAILED EXPLANATION OF THE ABOVE QUESTIONS.	_	
certify	y that all information on this form is correct. 12-13- Signature Date	05	
	Signature/ Date		

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

Return with \$200.00 renewal fee to:



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

2007 Online Renewal Summary

Name: Sherwood Chang Lynn Jr.

Transaction Date: 2006-12-06*

Registration Fee: 200

License Number: MD.17601

Transaction Number: VPFF0CD4AD6A

Date of Birth: 1940-06-14

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

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

Primary specialty: OBSTETRICS & GYNECOLOGY

Are you Board certified in your primary specialty? yes

Secondary specialty:

Are you Board certified in your secondary specialty?

Practice Type: Solo

If Group, provide the Group Name:

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

Hospital Name: U So Al Children's and Women's Hospital

Hospital City: Mobile

Hospital State: AL

Are you licensed in another State: yes

TX

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? Mobile

(**indicate state if not in Alabama)

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

Other County1

Other State1

Other County 2

Other State 2

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

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

Are you employed by the nurse practitioner/midwife or a corporation owned by the nurse practitioner/midwife?

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? no

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. **0**

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

CME Certification: I hereby certify that I have met the annual minimum continuing education requirement of 12 hours of Category I continuing medical education for the calendar year 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: (251) 433-3147

Practice Address: 603 Church Street

Home Telephone: (251) 433-3147

Home Address: 603 CHURCH ST

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: Sherwood Chang Lynn Jr.

Transaction Date: 2008-01-02*

Registration Fee: 300

License Number: MD.17601

Transaction Number: VSHF1E177ABF

Date of Birth: 1940-06-14

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

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

Primary specialty: Obstetrics & Gynecoloy

Are you Board certified in your primary specialty? Y

Secondary specialty: Other

Are you Board certified in your secondary specialty?

Practice Type: S

If Group, provide the Group Name:

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

Hospital Name: U So Al Children's and Women's Hospital

Hospital City: Mobile

Hospital State:

Are you licensed in another State: Y

TX

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

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

(**indicate state if not in Alabama) TX

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

Other County1

Other State1

Other County 2

Other State 2

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

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

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?

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

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

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

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

Exempt Reason

Practice Telephone: (251) 433-3147

Practice Address: 603 Church Street

Home Telephone: (251) 433-3147

Home Address: 603 Church St

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**