2/23/17 DAVID M. BURKONS, M.D. 2088 GEORGETOWN BOULEVARD have info. 3/1/77/ ANN ARBOR, MICHIGAN 48105 Fed . 3/1/771 Rec · 3/1/77 / 82 To whom it may concern. I am presently a physican in michigan with a permanent mickeyou licence cosned 6/24/14 on the basic farhatimal Board of medical Gameners certificate issued m 1974. I will be going into practice in Cleveland, Ohio beginning 1 July 1977. Could you plense send me the forms needed for me to oftrin a Ohio medical licence Alere use the letterhead address. Thank you, Dave mysukm

APPLICATION FOR ENDORSEMENT OF A MEDICAL LICENSE

By

•.

The State Medical Board, State of Ohio

FORM I.

I hereby make application for a license to practice medicine and surgery in the State of Ohio, and submit the following statement regarding my preliminary and medical education.

| 1. | Name David M. Burkons 2. Place of birth CICK | cland, Ohia |
|-----------|---|--------------------------|
| | Address 2088 Georgetown Blud 48:05 Date of birth 2/4 | /1947 |
| 3 | Ann Arbod Michigan Shuken 14ts Ch | uyuhoga |
| | Where certificate is to be sent <u>2088</u> <u>Georgetown Blvd</u> | |
| | Ann Arbur Mich 48105 | |
| 5: | Name and Location of Institution Attended and Degree Received. Period and Date of Study. | |
| | Ohio State Univ B.A 10/05 - | a/lag |
| | | |
| | Ohio State Medical Board issued Certificate of Preliminary Education No. <u>5373</u> | <u>3 on 5/3/77 /</u> |
| 6. | B. MEDICAL EDUCATION | |
| | Was granted a diploma by UNIV, OF Michigun | , located at |
| | (Name of Medical Contege) Ann Arbor, State of Michigan, on the 200 day of _ | June , 1923 |
| <u></u> 7 | 7. I have made application to the following State Examining and Licensing operation and the | Michiann |
| | 3/76 by Netl Goard Pled Ex | aminers of |
| | (Give names of states and dates of application; indicate whether by reciprocity or written examination) | Resur. de |
| | | There |
| | and received a certificate from each except as follows: | |
| | | y of Michigan |
| 8. | 8. Time of practice 1/13 to present at Universit | 9 al Michigan |
| | Hospital's Ann Arbor, Michigan. | |
| | | |
| | · | / |
| | | V |
| 9 | 9. Has any license entitling you to practice in any foreign country or in any state or territory of | f the United States been |
| | suspended or revoked? No(Answer yes or no) | |
| | If so specify: | |
| | Have you ever been or are you now addicted to the use of drugs or alcohol? | (Date) |
| | Have you ever found it necessary to surrender your narcotic license? | (Yes or No) |
| | Have you ever been convicted of a violation of a Federal Law, State Law or a municipal ord | (Yes or No) |
| | Ma | |
| | traffic violation? (Yes or No) | |
| | If so, give full particulars:(Offense) | / |
| | (Place) (Disposition) (C | Date of Disposition) |
| 10 | 0. PHYSICAL DESCRIPTION OF APPLICANT | |
| | Color of Hair A Color of Eyes H | eight <u>6'3/2''</u> |
| | - Stout- | |
| | Medium Weight 225 Marks | |
| | Thin- (Cross out words not answering description) | |
| | | |
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| FORM II. | *AFFIDAVIT. | |
|--|----------------------------------|---|
| STATE OF Mychan | · · · | |
| COUNTY OF Wash tenaw SS: | | |
| On this 2017 day of APRIC | 19 | 22, personally appeared before me, |
| | ounty and State aforesaid, | David M. Burkanc |
| (Notary) , which are compared to the person referred to the person r | | (Applicant) |
| | | |
| State of Ohiouthet the statements therein are strictly true in a | every respect, and that | has read and understands this |
| Aff Alar Public, Washtenaw County, Michigan My Commission Expires October 15, 1979 | N mo | b b |
| | - and | (Signature of Applicant) |
| Signed and sworn to before me, this | day of | , 19 // |
| (Seal) Worbert John Helfen | (Official | designation of person administering oath) |
| *Must be sworn to before a notary public or other person sutho | orized to edminister oaths. | |
| | | |
| | RM III. | |
| CERTIFIED COPY OF STAT (A verbatim copy to follow here, over Seal of Stat | | |
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| | | |
| I hereby certify that the above is a verbatim copy of lice | ense No, issued | to Dr |
| by the on the_ | day of | , 19 |
| (Name of State Boerd) (Seal) | | |
| 50 | | Secretary |
| | IMENDATION OF SEC | RETARY. |
| Acting in behalf of the | | |
| I do hereby certify that Drw | (Nema of State Board) | |
| | | |
| 19, granted a license to practice Medicine and Surgery in | | 4 |
| on the basis of(State board exemine | ation, National Board of Medical | Exeminers, or reciprocity) |
| in the following subjects | | |
| | | |
| | | |
| | | · · · · · · · · · · · · · · · · · · · |
| on which he received an average of per cent, and | from evidence on file in this | office, I do hereby certify to the good |
| moral and professional standing of Dr. | | |
| of, State of | | |
| Medical Board of Ohio, as a proper person for medical licensu | | |
| The applicant must satisfy the Board of | | |
| | | |
| on the question of standing and moral character before seal o | i said duard is attixed. | |
| (Seal) | | |
| | | |
| (Data) | | Secretary |
| | | |

| FORM V. | |
|--|--|
| AFFIDAVIT OF PHYSICIANS. | |
| STATE OF Muchtenaw SS: COUNTY OF Washtenaw J. Robert 1 | villson |
| Before me, personally appeared(Affiant) | <u>M.D.</u> |
| known to me as a reputable practicing physician and surgeon, of good moral character, and known David M. M.D., well for david the second secon | years and knows <u>him</u> |
| to be of good moral and professional character, that he is a graduate of | |
| in the year $\underline{1973}$, thathe has been in the practice of Medicine for | |
| <u><i>Mniv.</i> of <i>Michigan</i></u> , and that <u>he recommends</u> recognition and that the foregoing physical description is correct. | A las |
| Address | I Celeston , M.D. |
| | (Afflient) , Certificate No. 14521 |
| Subscribed and sworn to this day of | , 19 |
| A Markhammy County Michigan | (Seal) |
| My Commission Expires October 15, 1979 | fort John Hellen |
| | |
| | |
| STATE OF In high M } ss: | |
| COUNTY OF WASK FEMAL | , M.D. |
| Before me, personally appeared <u>GLUNGLW</u> (Affinit) known to me as a reputable practicing physician and surgeon, of good moral character, an | |
| known to me as a reputable practicing physician and surgeon, or good moral character, and known <u>DAVIA</u> <u>M. Buy Kons</u> , M.D., well for _ | L years and knows <u>him</u> |
| to be of good moral and professional character, thathe is a graduate ofh | |
| in the year 4972 , thathe has been in the practice of Medicine f | or the last at at |
| A piv. of richight, and that he recommends | 11 m_ as worthy of professional |
| recognition and that the foregoing physical description is correct. | no 11) Man Con |
| Address Graduate of UL &F, N | (Afriant) |
| Subscribed and sworn to this day of | . 19 <u>2</u> 2 |
| HERBERT JOHN HELEEN | |
| Notary Public, Washtenaw County, Michigan My Commission Expires October 15, 1979 | tothe Helfen |
| | por por a second |
| | |
| | |
| FORM VI. | |
| CERTIFICATE OF ETHICAL AND MORAL CHARACTER | |
| P.O. Address | Date 19 |
| l certify that Dr of | |
| is a member in good standing of the | |
| and that he is an ethical practitioner of good moral character. | |
| Presi | Sent or Secretary , M.D. |
| (If you are not now or have never been a member of a medical society, please so state.) | 1 |
| | |

Filed Issued State Certificate STATE MEDICAL BOARD, APPLICATION FOR ENDORSEMENT OF A MEDICAL LICENSE BY THE APA 22 F112 01 STATE OF Z 60 100/27 BOLRO 8 OHO 19 ß 66. M.D

FOR USE OF SECRETARY ONLY

022-070-6/6/27.

Sec. 4731.09, R.C. (A) The state medical board shall appoint an entrance examiner who shall not be directly or indirectly connected with a medical college and who shall determine the sufficiency of the preliminary education of an applicant for admission to the examination. The minimum requirement shall be two years of collegiate work in an approved college of arts and sciences in addition to high school graduation. Provided that students already matriculated and enrolled in their professional colleges shall not be required to have the two years of college work but shall comply only with the preliminary requirements as existing and in effect at the time of their enrollment in their said colleges. In the absende of the foregoing qualifications, the entrance examiner may examine the applicant to overcome deficiencies. When the entrance examiner finds the preliminary education of the applicant sufficient, he shall issue a certificate of preliminary examination upon the payment to the treasurer of the board of a fee of ten dollars. Such certificate shall be attested by the secretary.

The applicant must also produce a diploma from a medical institution in the United States in good standing as defined by the board at the time the diploma was issued or produce a diploma from a school or college of osteopathy in the United States in good standing at the time the diploma was issued as defined by a committee consisting of the superintendent of public instruction of the state, a member of the board who holds the degree of doctor of medicine and a member of the board who holds the degree of doctor of osteopathy, or a diploma or license approved by the board which conferred the full right to practice all branches of medicine or surgery in a foreign country.

A foreign born graduate of a foreign medical school holding a diploma approved by the board or holding a right to practice in a foreign country, may, at the discretion of the hoard, be admitted to the examination upon completion of not because twenty-four months of post doctoral training in an approved hospital in the United States. This shall be in lieu of clinical training or post doctoral studies otherwise required by chapter 4731, of the Revised Code.

(B) A United States citizen who completed his undergraduate studies at a college or university in the United States approved for preliminary training by the State Medical Board and who has studied medicine at a medical school located outisde the United States which is listed by the World Health Organization but who is not authorized to practice all branches of medicine or surgery in the foreign country in which he studied medicine shall be admitted to the examination upon completion of each of the following requirements:

(1) The applicant successfully completed all of the formal requirements of the foreign medical school except internship or social service requirements.

(2) The applicant attained on a qualifying examination acceptable to the State Medical Board a score satisfactory to a medical school approved by the liaison committee on medical education.

(3) The applicant successfully completed one academic year of supervised clinical training at a hospital affiliated with a medical school approved by the liaison committee on medical education and, subsequent to that year, one year of internship or residency at a hospital in the United States having an internship or residency program approved by the State Medical Board.

(C) Satisfaction of the requirements of division (B) of this section shall be accepted in lieu of the completion of any foreign internship or social service requirements. No foreign internship or social service requirements shall be made conditions for admission to the examination or for licensure as a physician in this state for persons who have completed the requirements of division (B) of this section.

(D) Satisfaction of the requirements of division (B) of this section shall be accepted in lieu of certification by the education council for foreign medical graduates, and such certification shall not be made a condition for admission to the examination or for licensure as a physician in this state for persons who have completed the requirements of division (B) of this section.

(E) A person shall be deemed to hold the equivalent of a degree of a doctor of medicine for purposes of licensure and practice as physician in this state under section 4731.291 of the Revised Code and shall possess all the rights and privileges thereof, provided the following conditions are met:

(1) The person holds a document granted by a medical school located outside the United States which is listed by the World Health Organization.

(2) The document was issued upon satisfactory completion of all formal requirements of such medical school, except internship or social service requirements;

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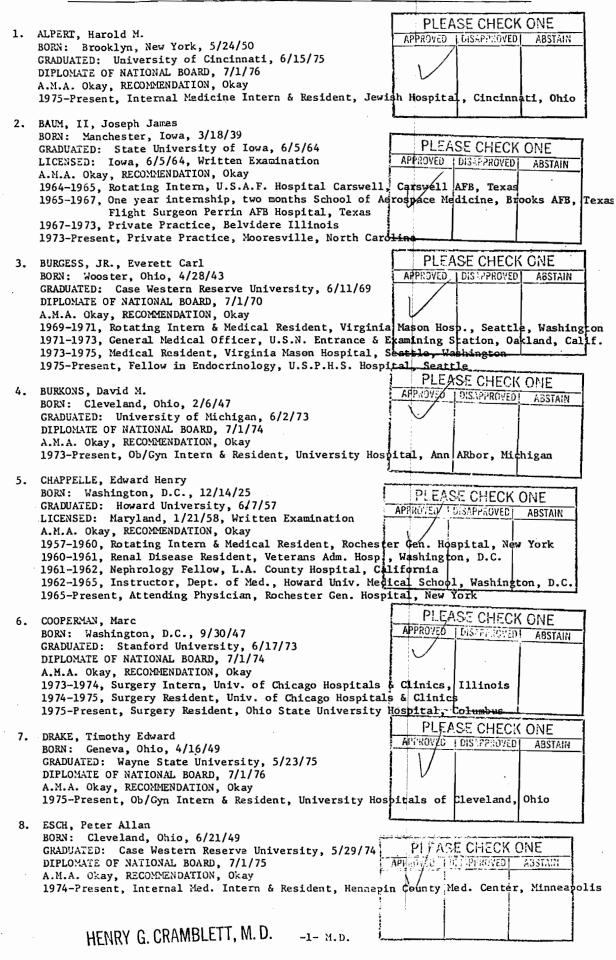
(3) The person satisfactorily completed one academic year of supervised clinical training at a hospital affiliated with a medical school approved by the liaison committee on medical education and holds a certificate to that effect from the medical school in which such training was received.

NOTE: Pursuant to Section 4731.09, Revised Code, upon submission to the State Medical Board of credentials of preliminary education satisfactory to the Board's entrance examiner and upon payment of the requisite fee, the Board will issue to the applicant a Certificate of Preliminary Education (examination).

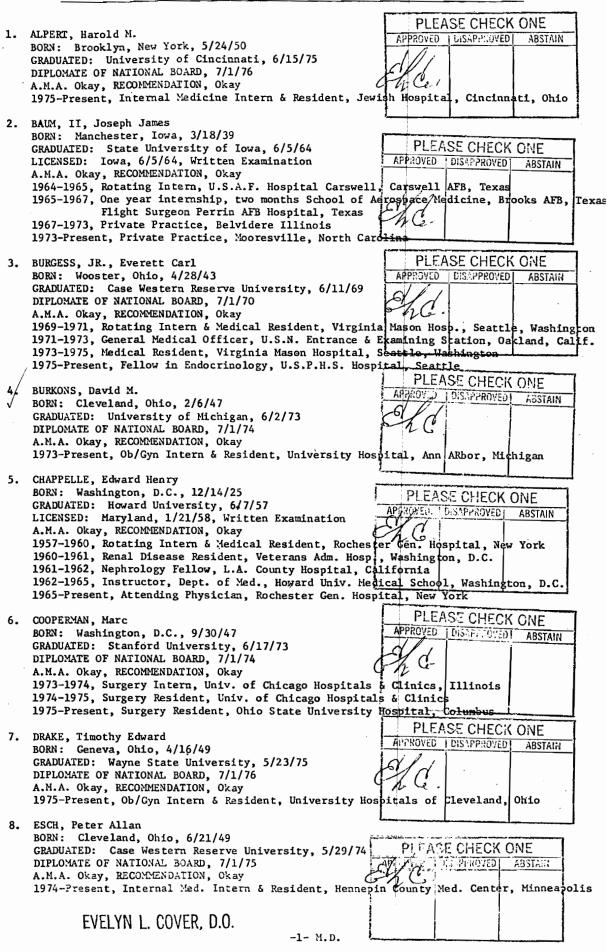
Sec. 4731.29, R.C. When a physician or surgeon licensed by the licensing department of another state, a territory, or the District of Columbia, or a diplomate of the national board of medical examiners or the national board of examiners for osteopathic physicians and surgeons wishes to remove to this state to practice his profession, the state medical board may, in its discretion, issue to him a certificate to practice medicine or surgery or osteopathic medicine and surgery without requiring the applicant to submit to examination, provided he meets the requirements for entrance as set forth in section 4731.09 of the Revised Code. The fee for registration in this manner shall be 150 dollars. Application shall be made on a form prescribed by the board.

All correspondence should be addressed to:

The Ohio State Medical Board Suite 1006 180 East Broad Street Columbus, Ohio 43215

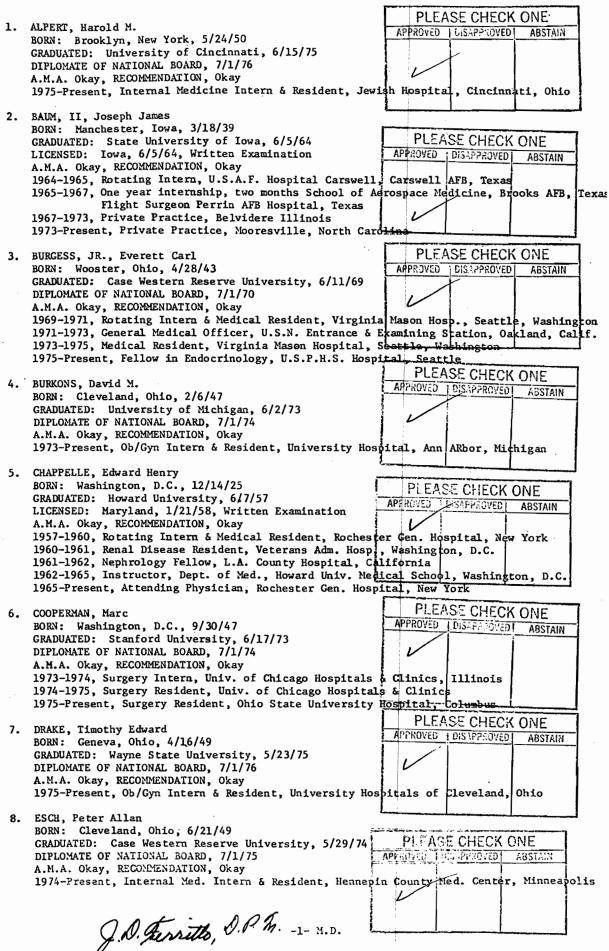


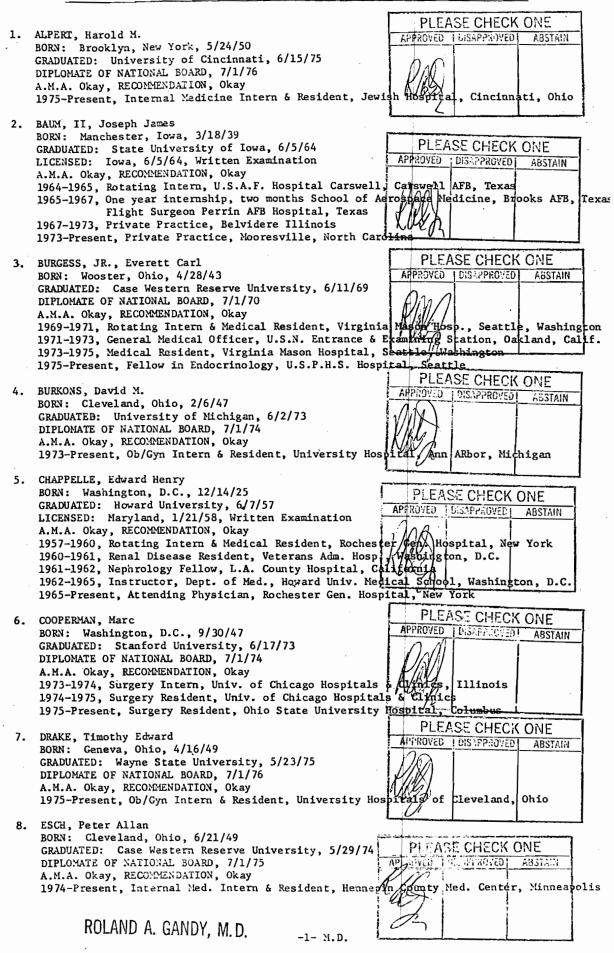
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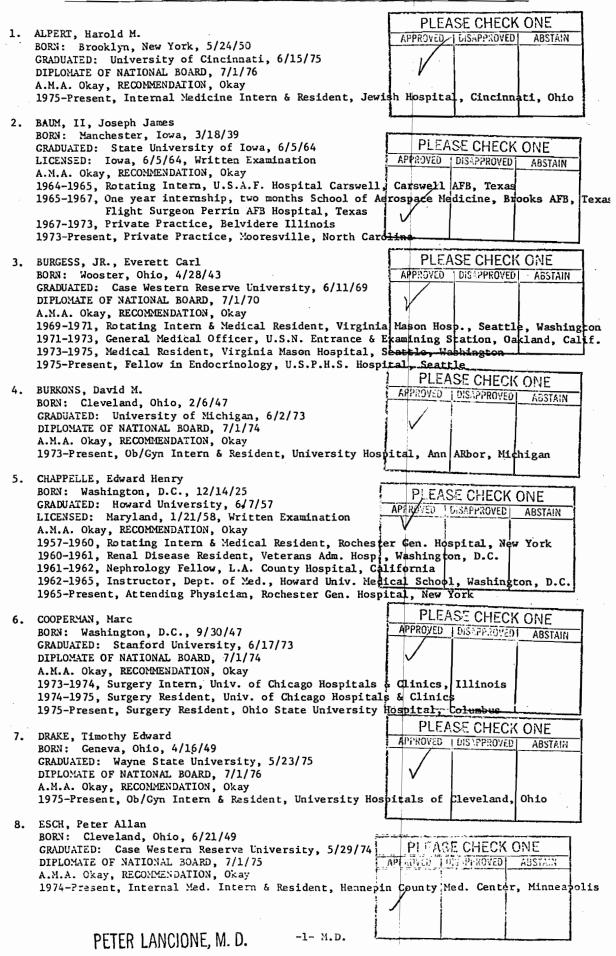


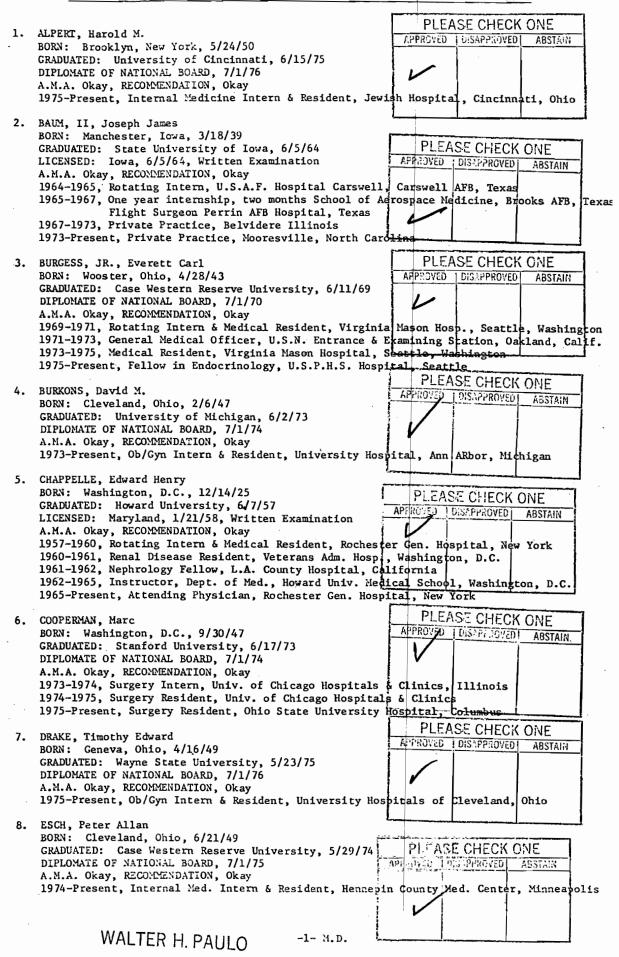
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| , | ALPERT Horold N | | SE CHECK | | |
| . . | ALPERT, Harold M. BORN: Brooklyn, New York, 5/24/50 | APPROVED | DISAPPROVED | ABSTAIN | |
| | GRADUATED: University of Cincinnati, 6/15/75 | | 1 | | 1 |
| | DIPLOMATE OF NATIONAL BOARD, 7/1/76 | Alen | | | 1 |
| | A.M.A. Okay, RECOMMENDATION, Okay | rae | | { | Į |
| | 1975-Present, Internal Medicine Intern & Resident, Jewi | sh Hospita | 1. Cincinn | ati, Ohio | |
| | 1) / · · · · · · · · · · · · · · · · · · | 1 | [, | , | i |
| 2. | BAUM, II, Joseph James | · | | | 4 |
| | BORN: Manchester, Iowa, 3/18/39 | | | | |
| | GRADUATED: State University of Iowa, 6/5/64 | PLEA | SE CHECK | ONE | |
| | LICENSED: Iowa, 6/5/64, Written Examination | APPROVED | DISAPPROVED | ABSTAIN | |
| | A.M.A. Okay, RECOMMENDATION, Okay | | | | |
| | 1964-1965, Rotating Intern, U.S.A.F. Hospital Carswell, | Carswell | AFB, Texas | | |
| | 1965-1967, One year internship, two months School of Ad | rospace Me | dicine, Br | ooks AFB, | Texas |
| | Flight Surgeon Perrin AFB Hospital, Texas | 40 | | | |
| | 1967-1973, Private Practice, Belvidere Illinois | Hal | | | |
| | 1973-Present, Private Practice, Mooresville, North Caro | line | | | |
| 2 | BURGESS, JR., Everett Carl | PIEA | SE CHECH | ONE | 7 |
| 5. | BORN: Wooster, Ohio, 4/28/43 | | 1 DIS GPROVED | | |
| | GRADUATED: Case Western Reserve University, 6/11/69 | AFFRONCU | DISAFFRUVED | ABSTAIN | - |
| | DIPLOMATE OF NATIONAL BOARD, 7/1/70 | 1 | | | i i |
| | A.M.A. Okay, RECOMMENDATION, Okay | HRO | | | • |
| | 1969-1971, Rotating Intern & Medical Resident, Virginia | Mason Hos | D. Seattl | e. Washing | |
| | 1971-1973, General Medical Officer, U.S.N. Entrance & E | kamining S | tation. 0a | kland. Cal | 5 F |
| | 1973-1975, Medical Resident, Virginia Mason Hospital, S | | | | <u> </u> |
| | 1975-Present, Fellow in Endocrinology, U.S.P.H.S. Hospi | | | | |
| | | | SE CHECK | ONE | 1 |
| 4. | BURKONS, David M | 67001984 | DISAP/PROVED | | |
| | BORN: Cleveland, Ohio, 2/6/47 | | OIS A PROVED | ABSTAIN | |
| | GRADUATED: University of Michigan, 6/2/73 | | | | |
| | DIPLOMATE OF NATIONAL BOARD, 7/1/74 | Man | | | |
| | A.M.A. Okay, RECOMMENDATION, Okay | stale | - 1 | | |
| | 1973-Present, Ob/Gyn Intern & Resident, University Hosp | ital, Ann | ARbor, Mic | higan | |
| | | | | 1 | |
| - | CUADDELLE Edward Variation | | | | |
| 5. | CHAPPELLE, Edward Henry | | | | |
| 5. | BORN: Washington, D.C., 12/14/25 | PLEAS | E CHECK | ONE | |
| 5. | BORN: Washington, D.C., 12/14/25 GRADUATED: Howard University, 6/7/57 | PLEAS | E CHECK | ONE | |
| 5. | BORN: Washington, D.C., 12/14/25 GRADUATED: Howard University, 6/7/57 LICENSED: Maryland, 1/21/58, Written Examination | PLEAS | E CHECK | | |
| 5. | BORN: Washington, D.C., 12/14/25 GRADUATED: Howard University, 6/7/57 LICENSED: Maryland, 1/21/58, Written Examination A.M.A. Okay, RECOMMENDATION, Okay | APPROVED 11 | DISAPPROVED | ABSTAIN | |
| 5. | BORN: Washington, D.C., 12/14/25 GRADUATED: Howard University, 6/7/57 LICENSED: Maryland, 1/21/58, Written Examination A.M.A. Okay, RECOMMENDATION, Okay 1957-1960, Rotating Intern & Medical Resident, Rochester | APPROVED 11 | pital, New | ABSTAIN | |
| 5. | BORN: Washington, D.C., 12/14/25 GRADUATED: Howard University, 6/7/57 LICENSED: Maryland, 1/21/58, Written Examination A.M.A. Okay, RECOMMENDATION, Okay 1957-1960, Rotating Intern & Medical Resident, Rochester 1960-1961, Renal Disease Resident, Veterans Adm. Hosp 1961-1962, Nephrology Fellow, L.A. County Hospital, Cal | APIROVED 11 rf/Gen. Hos Mashingto ifornia | opital, New on, D.C. | ABSTAIN V York | |
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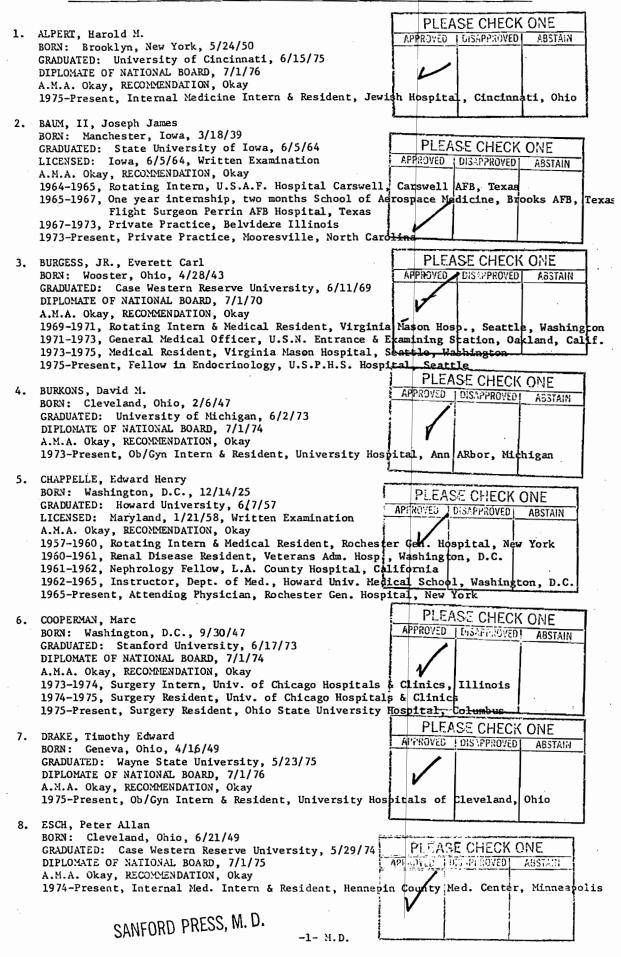
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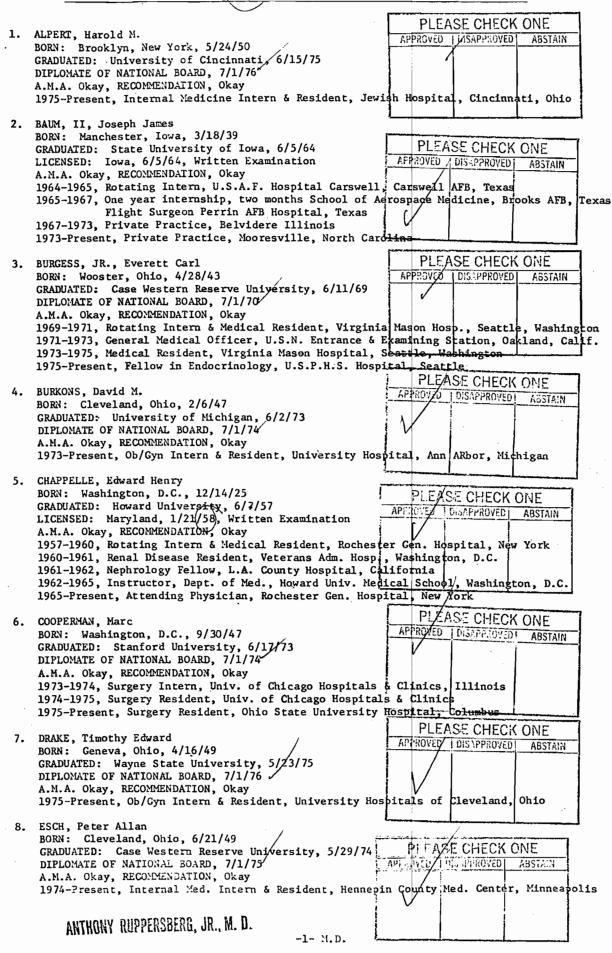












| STATE OF OHIO THE STATE MEDICAL BOARD |
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| 130 EAST BROAD STREET, SUITE 1006, COLUMBUS, OHIO 43215 |
| DATE Prarch 1 1977 |
| Dear Doctor, |
| |
| Dr. Dovid Th. Buskons who was is in Supl. of op/Lyn |
| is applying for licensure in the State of Ohio. We would appreciate your assistance in filling out the following evaluation so that we can process his/her papers for licensure. |
| Your immediate attention to this matter will be greatly appreciated by the doctor as well as by us. Thank you for your time and assistance. |
| <u>as by as</u> , mank you for your time and assistance. |
| (1) How long have you known the doctor? 6 years |
| (2) What was/is your supervisory capacity? Director, Residency Program |
| (3) At what hospital? University of Michigan Medical School |
| (4) How would you rate this doctor's medical knowledge and techniques? Excellent |
| (5) In your opinion, is this doctor a person of good moral and ethical character? Yes |
| (6) Does this doctor work well with peers and medical staff? Yes |
| (7) Does he/she relate well to patients? Yes |
| (8) How is his/her command of the English language? (If applicable) |
| (9) Would you recommend this doctor for licensure? Yes |
| Additional comments, please: (If needed, an extra sheet of paper may be used) |
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| Jlosetlelly 2 |
| Signature of Doctor |
| Charman Dept |
| of teles + freecel |
| |
| Sincerely, |
| Joan Camon & CEPTO |
| (Mrs.) Joan Elsman MAR a sub- Endorsement |
| OB/GYN ALCO |

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STATE OF OHIO THE STATE MEDICAL BOARD SUITE 1006

180 EAST BROAD STREET COLUMBUS, OHIO 43215

March 1, 1977

MAR 8 1977

Mrs. Fisher
Federation of State Medical Boards
 of the United States, Inc.
1612 Summit Avenue
Fort Worth, Texas 76102

Dear Mrs. Fisher:

Please forward a certified transcript of the FLEX grades for the following physician: <u>BURKONS, David M.</u>, if he has taken a FLEX examination(s) in any state(s) at any time.

If he has not taken a FLEX examination, please so note on this letter and return it to our office.

Very truly yours,

Joan Eleman

(Mrs.) Joan Elsman Endorsement Section

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MAR 3 1977 19

This office is unable to locate any records indicating that the above named doctor ever took the FLEX examination.

molipho

M.H. Crabb, M.D., Secretary Federation of State Medical Boards of U.S. MHC:mf N_{1} ?

THE UNIVERSITY OF MICHIGAN ANN ARBOR, MICHIGAN 48104

DEPARTMENT OF CLASSICAL STUDIES

The Regents of the University of Michigan send greeting to all reading this diploma.

Know that David Max Burkons, of good character and recommended by the Professors of the School of Medicine and Surgery as one who has been truly tested in the study and pursuit of the arts of Medicine and Surgery, has been by us distinguished with the degree Doctor of Medicine. In testimony whereof we have presented him this certificate bearing the names of the President, Secretary and Professors, and likewise bearing the Seal of the University.

Given at the University on the second day of June, 1973, in the one hundred fifty-seventh year of the University of Michigan.

R.L. Kennedy, Secretary R.W. Fleming, President John A. Gronvall, M.D., Dean and others

The above is a faithful translation of the University of Michigan M.D. degree of Dr. David M. Burkons.

Charles Witke, Ph.D. Professor of Greek and Latin

14 th. april, 1977

GRACE B. PRESTON Notary Public, Washtenaw County, Michi My Commission Expires Mar. 18, 1979

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This is a copy of, the true original dated <u>rimber</u>73 at Ann Arbor, Michigan. Subscribed and sworn to before me, a Natary Public, in and for the Countr of Wachtsnam. State of Michigen, on this the State of Michigen, on this the Nate of Michday of Notary Public Notary Public

My Commission LE M. DULLINGAYER . Expires Nutary Public, Washanaw County, Mich. My Commission Expires 8-31-76

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STATE OF OHIO THE STATE MEDICAL BOARD SUITE 1006 180 EAST BROAD STREET COLUMBUS, OHIO 43215

app 3/11/11 V a.m.a. 3/17/11 .

DATE: MARCH

Dear Doctor DAVID M. BURKONS

PLEASE BE ADVISED THAT ALL MATERIALS SUBMITTED TO THE BOARD WILL BE THOROUGHLY INVESTI-GATED AND INDIVIDUALS WILL BE CONTACTED REGARDING YOUR APPLICATION AS THE BOARD DEEMS NECESSARY PRIOR TO YOUR POSSIBLE LICENSURE IN OHIO.

Fhysicians may be licensed in Ohio by endorsement of a full license granted on the basis of a written examination in any other state or U.S. Territory, or by endorsement , of the certificate granted on the basis of the examination of the National Board of Redical Examiners, or the National Board of Osteopathic Examiners.

Applicants for endorsement licensure must be either full citizens of the United States by birth, or by Naturalization, or have a Declaration of Intention, an Alien Registration Receipt Card, or have a current approval of a petition for a permanent immigrant status. If you are not a citizen of the United States, it will be necessary for you to submit evidence of your status as defined earlier in the paragraph.

2 If you are licensed in another state, or by National Boards, you must have received a minimum average of 75% or better on the examination for licensure.

Q In order that we may send you an application or credential outline list for endorsement licensure, please answer all the questions on this sheet in the space provided. 12 If additional space is needed, please use reverse side. Õ

Your PLACE and DATE of birth: Cleveland The 2/6/47 a.

b. Your <u>MEDICAL SCHOOL</u> of graduation, its <u>LOCATION</u>, and <u>DATE</u> you received your degree: Mner of muchigun annala Much 6/2/13 The STATE in which you are licensed by written examination and the year you were

- BURKON с. licensed, if applicable: Muchyan by NBME 24 June 1974
 - The YEAR in which you were certified by the NATIONAL BOARD OF MEDICAL EXAMINERS or the NATIONAL BOARD OF OSTEOPATHIC EXAMINERS (please note which Board), if applicable: Mt Board med Crana 1974
 - Have you ever taken a Flex examination in any state at any time? If so, please list the state(s) for which you took the examination(s), and dates of examination(s).
 - f. List the most recent hospital(s) and the <u>complete</u> address(es) where you have worked or trained (intern, resident or fellow). Please specify dates and capacities served at each hospital. Please use reverse side of this sheet for information requested.

Ann Auker, Michigan Hospital 19 Please print the following: Burkons Very truly yours, NAME : Mis. Joan Elsman Georgetown Blod ADDRESS: Ann Arbor, Mich 48105

1 July 1473 through present induntil 30 June 1973 Atouse Officer I -IV. Dept of Ob. Lyn. Mouverarty of Muchigan Itoopitale ann arbor, muchigan 48105

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NATIONAL BOARD OF MEDICAL EXAMINERS

3930 CHESTNUT STREET, PHILADELPHIA, PENNA. 19104

NATIONAL BOARD OF MEDICAL EXAMINERS

OF THE

UNITED STATES OF AMERICA

David Max Burkons, M. D.

ENDORSEMENT OF CERTIFICATION

having satisfied all the requirements and having successfully passed the examinations is hereby declared a Diplomate of the National Board of Medical Examiners.

| Attest: J. D. Myers Chairman of the Board | SEAL | ION P HUBBARD |
|--|---------|---|
| Philadelphia, Pa. July 1, 1974 | Cert. # | JOAN P. HUBBARD Bresident of the Board 147411 |

It is certified that the above is a copy of the Diplomate Certificate issued to the named physician, a graduate of <u>University of Michigan School of Medicine</u>

on 06/02/1973, whose birth date is 02/06/1947, following successful completion of all examinations required for Certification by the National Board of Medical Examiners. The grades obtained are as follows:

| PART I passed 06/16/1971 | Standard* Score | Scale Score | |
|--|--------------------|----------------|------------------|
| Anatomy, incl. histology and embryology | 460 | 78 | |
| Physiology | 525 | 82 | |
| Biochemistry | 525 | 82 | |
| Pathology | 450 | 77 | |
| Microbiology, incl. immunology | 545 | 83 | |
| Pharmacology and Materia Medica | 420 | 75 | |
| Behavioral Sciences | | | |
| (Minimum Passing Grade 380/75) TOTAL GRADE/AVERACE** | 490 | 80 | |
| PART II passed 04/11/1973 | | | |
| Internal medicine and the medical specialties | 365 | . 75 | |
| Surgery and the surgical specialties | 465 | 80 | |
| Obstetrics and Gynecology | 640 | 89 | |
| Public Health and Preventive Medicine | 600 | 87 | |
| Pediatrics | 390 | 77 | |
| Psychiatry | 415 | 78 | |
| (Minimum Passing Grade 290/75) TOTAL GRADE/AVERAGE** | 470 | 81 | |
| PART III passed 03/06/1974 | | | |
| A General Test of Clinical Competence | | | |
| (Minimum Passing Grade 290/75) AVERAGE | 375 | 77.6 | . . . |
| GENERAL AVERAGE (Parts I, II, and III) | 7 | 9.5 | |
| | (Scal | e Score) | |
| *Examinations taken since June 1971 are reported wit | | V | |
| Standard and Scale Score Equivalents. | | | |
| *Since 1966 National Board criteria for certificatio | n are haged | | |
| upon candidate's Total passing grade in Part I, Par | | • | |
| Part III, and not scores of individual subjects wit | | - | |
| Part 111, and not scores of individual subjects with | nin each Par | | |

Secretary for Certification April 15, 1977

Date

SEAL

RESUME OF ACTIVITIES

List <u>ALL</u> activities from graduation to the present time. ACCOUNT FOR ALL TIME IN ALL COUNTRIES, including WORKING AND NON-WORKING TIME. If NON-WORKING, explain WHAT you were doing during that period.

| PLAC | E ACTIVITIES IN CHRONOLOGI | CAL ORDER | |
|------------------------|--------------------------------------|-----------------|-----------------------------|
| DATES | HOSPITAL OR UNIVERSITY | LOCATION | POSITION & DEPARTMENT |
| 1 July 73 - present | U. of Michigan + affiliated Hosps | Ann Arbor, Mich | House officer Dept Ob by |
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BURKONS, DAVID M.

NO. 40676 Iss. 6/6/77 ENDORS.

1 1

I hereby certify that the photograph on the reverse side to which this slip is pasted is a genuine likeness of

Hons

who was recommended by me to the State Medical Board for a license to practice in Ohio.

Willin



OFFUTT, FISHER & NORD

ATTORNEYS AT LAW

949 Third Avenue, Suite 300 Post Office Box 2868 Huntington, West Virginia 25728-2868

1/m/76 Huntington (304) 529-2868

Facsimile (304) 529-2999 -----

February 10, 1998

File No. 5020.0018

State Medical Board of Ohio 77 South High Street Seventeenth Floor Columbus, Ohio 43215

ATTN: **Debbie Jones Records Department**

David Burkons, M.D. Re: 1611 South Green Road South Euclid, Ohio 44121

Dear Ms. Jones:

Pursuant to the provisions of the Freedom of Information Act ORC § 149:43, please provide the full licensure and disciplinary file on David Burkons, M.D.. Please forward copies of this information to my attention at your earliest convenience. If there is a fee for this service, please include a copy of your invoice with the records.

Thank you for your cooperation in this matter. If you have any questions or need further information, please do not hesitate to contact me.

Very truly yours,

Dan-L.La

Sonja L. Carpenter

SLC/mak

D. C. Offutt, Jr. † Michael M. Fisher Steven K. Nord †‡ Fred B. Westfall, Jr. †‡ Scott W. Andrews Sonja L. Carpenter† Dianne D. Einstein‡ Chad S. Lovejoy

† also admitted in KY ‡ also admitted in OH

90 FEU

³CD

February 23, 1998

Sonja L. Carpenter Offutt, Fisher & Nord 949 Third Avenue, Suite 300 P.O. Box 2868 Huntington, WV 25728-2868

RE: David M. Burkons, M.D.

Dear Ms. Carpenter:

Enclosed is a copy of the licensure file for the physician listed above that you requested.

The license is current and in good standing (no formal or non-disciplinary action has been taken) and will expire on September 30, 1998.

If you need any additional information about this physician, please feel free to contact the Records Department at the telephone or facsimile numbers below.

Sincerely,

Kay L. Rieve

Kay L. Rieve Acting Administrative Officer

KLR:jdc

Enclosure

Direct Dial: (614) 728-3113 FAX: (614) 466-4670 Website: www.state.oh.us/med/

Shuman, Annand&

David L. Shuman Stephen D. Annand Edgar A. Poe, Jr. Charles R. Bailey Richard L. Earles David L. Wyant Mark W. Browning William R. Slicer Belinda Bartley Jackson G. Kenneth Robertson George J. Joseph Thomas E. Buck

Attorneys at Law

Suite 1007, 405 Capitol Street P. O. Box 3953 Charleston, West Virginia 25339 Telephone (304) 345-1400 Facsimile (304) 343-1826

Suite 3002, 1233 Main Street Wheeling, West Virginia 26003 Telephone (304) 233-3100 Facsimile (304) 233-0201

Desireé A. Halkias Paul L. Weber Roberta F. Green James J. A. Mulhall Kenneth N. Hickox, Jr. Teresa K. Thompson Richard N. Beaver John T. Molleur Noelle A. Starek Mark A. Kepple David J. Mincer Karen M. Tracy

39.14 1.5 0 5 MM 80

March 26, 1998

REPLY TO:

Charleston

State Medical Board of Ohio 77 S. High Street, 17th Floor Columbus, Ohio 43266-0315

Re: Dr. David M. Burkons **UV P** University Suburban Gynecologists, Inc. 1611 South Green Road, Suite #204 South Euclid, Ohio 44121

Dear Sir/Madam:

I am writing to request a complete copy of any and all public information contained in the Board's files pertaining to Dr. David M. Burkons. Dr. Burkons is testifying as an expert witness in a case against one of our clients.

Please forward the information to my attention as soon as possible. If there is a charge for this service, please forward an invoice, and I will see that prompt remittance is made. Also, please telephone me if prepayment is required for the release of this information.

Thank you for your assistance in this matter.

Very truly yours,

ticull. Franks

Patricia M. Franks Paralegal

PMF

April 28, 1998

Patricia M. Franks, Paralegal Shuma, Annand & Poe 405 Capitol Street, Suite 1007 P.O. Box 3953 Charleston, WV 25339

RE: David M. Burkons, M.D.

Dear Ms. Franks:

Enclosed is a copy of the licensure file for the physician listed above that you requested.

The license is current and in good standing (no formal or non-disciplinary action has been taken) and will expire on September 30, 1998.

If you need any additional information about this physician, please feel free to contact the Records Department at the telephone or facsimile numbers below.

Sincerely,

Kay L. Rieve

Kay L. Rieve Acting Administrative Officer

KLR:jdc

Enclosure

Direct Dial: (614) 728-3113 FAX: (614) 466-4670 Website: www.state.oh.us/med/



State Medical Board of Ohio

77 S. High Street, 17th Floor • Columbus, Ohio 43266-0315 • 614/ 466-3934 • Website: www.state.oh.us/med/

CERTIFICATION

I hereby certify that the attached copies are true and complete copies as they appear in the records of the State Medical Board of Ohio in the matter of David M. Burkons, M.D..

| License No.: | 35040676 |
|------------------|----------|
| Issue date: | 06/06/77 |
| Expiration date: | 07/01/01 |

License is/was in good standing (no formal action has been taken)

Investigations and complaints are confidential in nature and are not public information.

The certification is made by authority of the State Medical Board and on its behalf.

(SEAL)

Sandra K. Caldwell Administrative Officer

04/26/99 Date

SKC

OFFUTT, FISHER & NORD

D. C. Offutt, Jr. † Michael M. Fisher Steven K. Nord †‡ Scott W. Andrews † Sonja C. Vital † Cheryl A. Simpson Scott L. Summers Stephen S. Burchett * Perry W. Oxley †‡ Jon D. Hoover † Holly G. DiCocco † David E. Rich ‡ Robert M. Sellards

† also admitted in KY ‡ also admitted in OH * admitted in KY ATTORNEYS AT LAW 949 Third Avenue, Suite 300 Post Office Box 2868 Huntington, West Virginia 25728-2868

> Telephone: (304) 529-2868 Facsimile: (304) 529-2999

January 24, 2003

OHID STATE MEDICAL BO

JAN 2 8 2003

CHARLESTON OFFICE Post Office Box 2833 812 Quarrier Street, Suite 600 Charleston, WV 25330-2833

> Telephone (304) 343-2869

> Facsimile (304) 343-3053

File No.:4074.0001

State of Ohio Medical Board 77 South High Street, 17th Floor Columbus, Ohio 43215-6127

Re: David M. Burkons, M.D.

Dear Sir or Madam:

Pursuant to the provisions of the Freedom of Information Act, I would appreciate your providing me with a Verification of full licensure and the disciplinary file pertaining to David M. Burkons, M.D. Please forward copies of this information to me at the above Huntington address at your earliest convenience. If there is a fee for this service, please include an Invoice with the records and we will promptly pay your Invoice.

If you have any questions or need further information, please do not hesitate to contact me. Thank you for your assistance.

Sincerely yours,

E. Watte

Alicia E. Watts Certified Legal Assistant

/aw

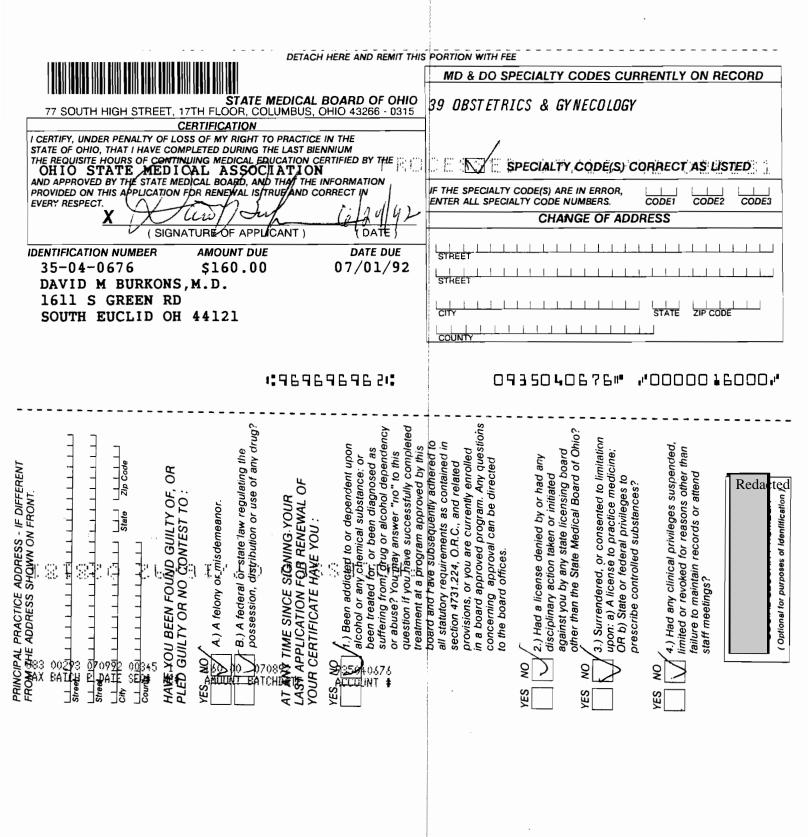
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| | DATE DUE | STREET ADDRESS | | |
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| STATE MEDICAL BOARD O MEDICINE AND SURGERY IN THE STATE OF OHIO, THAT I HAVE GONFLETED DUSING THE LAST WERNING THE CONTIN JING MEDICAL EDUCATION CERTIFIED BY THE AND APPROVED BY THE STATE MEDICAL BOARD AND HEREBY MAKE APPLICATION FOR RENEWAL, GIGNAUBE OF APPL | E REQUISITE HOU | | INSTRUCTION 1. DO NOT FOLD OR STAPLE THIS C 2. REVERSE SIDE MUST BE COMPL 3. MAKE CHECK OR MONEY ORDER TREASURER, STATE OF 4. PUT IDENTIFICATION NUMBER ON 5. UPDATE SPECIALTY IF NEEDED. 6. SEND PAYMENT (DO NOT SEND C APPLICATION IN ENCLOSED ENVE TREASURER, STATE (BOX 2438, COLUMBUS, O | ARD. ETED. PAYABLE TO: OHIO I CHECK. ASH) AND THIS ELOPE TO: DF OHIO HIO 43216 |
|---|---|--|--|--|
| APPLICATION FOR BIENNIAL LICENSE RENEWAL TO PRACTICE AS A; DU CTUR DF MEDICINE 1 DAVID M. BURKENS 1611 S GREEN RD SOUTH EUCLID DH 44121 | | ENTIFICATION NUMBER 4-06.76 | REPORT ANY CHANGE OF ADDI (PLEASE PRINT) LAST NAME FIRST NAME STREET ADDRESS | |
| MD & DO SPECIALTY CODES | MOUNT DUE | DATE DUE 1/01/88 THIS APPLICATIO | | ZIP CODE |
| THE ADDRESS SHOWN ON THE FRONT OF THIS CARD WILL BE PRINCIPAL PRACTICE ADDRESS—IF DIFFERENT FROM THAT SHOWN ON FRONT (PLEASE PRINT) Burkons David M. Burkons David M. IG11 S. Green Rd. #204 STREET ADDRESS S. Euclid Ohio 44121 CITY STATE ZIP CODE Cuyahoga | SECTION RESPONS MARK TH SINCE YO HAVE YOU OR NO CO | 4731.281, OHIC SE BE GIVEN TO E CORRECT BO DU LAST RENER U BEEN FOUND ONTEST TO: IO a.) a felony b.) a federal | D REVISED CODE REQUIRES T | THAT A N. PLEASE CENSE, |
| SOCIAL SECURITY NUMBER Redacted | 2 | ereinen den Verste | 白城县 嘲《部國王 2 五 | nen festige Ren festige |
| AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION | | | [] I or consented to limitation upon a licer | nelate caterolis |
| YES NO 1.) Been addicted to or dependent upon alcohol or any chemical substance? You may answer no to this question if you have suc- cessfully completed treatment at a program approved by this Board and have subsequently adhered to all statuatory re- quiraments as contained in Section 4731,224, O.R.C., and related provisions; or are currently enrolled in a Board approved program. | | med is a c subsub-cus | state or federal privileges to prescribe nical privileges suspended or revoked fo alntain records or attend staff meetings | controlled or other than |

.



DETACH HERE AND REMIT THIS PORTION WITH FEE MD & DO SPECIALTY CODES CURRENTLY ON RECORD STATE MEDICAL BOARD OF OHIO 17TH FLOOR, COLUMBUS, OHIO 43266 - 0315 OBG OBSTETRICS & GYNECOLOGY 77 SOUTH HIGH STREET. CERTIFICATION I CERTIFY, UNDER PENALTY OF LOSS OF MIT BIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 1992-1994 BIENNIUM THE REQUISITE FOURS OF COMUNUIN EDUCATION S TO SPECIALTY CODELS STED MARF BY THE CONTROL BY THE STATE MEDICAL BOARD, AND APPROVED BY THE STATE MEDICAL BOARD, PROVIDED ON THIS APPLICATION FOR RENEWAL HE INFORMATION AND THAT IF CORRECTIONS ARE NECESSARY, PLEASE D CORRECT IN EVERY TRUE ENTER ALL SPECIALTY CODES. CODE2 RESPECT. CODE1 CODE3 194 G REPORT ANY CHANGE OF ADDRESS (DATE) (SIGNATURE OF APPLICANT) DATE DUE **IDENTIFICATION NUMBER** AMOUNT DUE 35-04-0676 \$250.00 05/01/94 DAVID M BURKONS, M.D. 1611 S GREEN RD STATE ZIP CODE SOUTH EUCLID OH 44121 COUNT 1:9696969621 0935040676# ","00000 2 5000 **"**" - - - - question if you have successfully completed AT ANY, TIME SINCE SIGNING YOUR LAST APPLICATION suffering from drug or alcohol dependency guilty of, or pled guilty or no 2.) Been found guilty of, or pled guilty or no all statutory requirements as contained in sections 4731.224 and 4731.25 O.R.C., and enrolled in a board approved program. Any 9 contest to a federal or state law regulating F5.) Had any disgiplinary action taken or hinitiated against you by any state licensing board other than the State Medical 6.) Surrendered, or consented to limitation services to a person or facility in which either you or a member of your immediate family has board and have subsequently adhered to the possession, distribution or use of any Had malpractice insurance cancelled F.) Had any clinical privileges suspended than failure to maintain records or attend treatment at a program approved by this Been addicted to or dependent upon 8.) After January 14, 1993, referred a patient, participated in an arrangement or scheme for been treated for, or been diagnosed as upon: a) A license to practice medicine; Zip Code or abuse? You may answer "no" to this restricted or revoked for reasons other related provi致ons, or you are currently questions concerning approval can be any FOR BENEWAL OF YOUR CERTIFICATE HAVE YOU alcohol or any chemical substance; or referral of a patient, for clinical laboratory or limited for other than failure to pay PRINCIPAL PRACTICE ADDRESS - IF DIFFERENT FROM, THE ADDRESS SHOWN ON FRONT: Contest to a ferony or misdemeanor. OR b) State or federal privileges to prescribe controlled substances? 5 Redacted ownership or investment interest, SUCIAL SECURITY NUMBER directed to the board offices. State ۳Į staff meetings? Board of Ohio? 1.) Been found premiums? drug? 5 Street ş 93504087% ACCOUNT # ð 20 <u>.</u> HDATE ŝ ÊS Ŝ Coun ΈS ĨS S YES ŝ Stree ŝ

DETACH HERE AND REMIT THIS PORTION WITH FEE MD & DO SPECIALTY CODES CURRENTLY ON RECORD STATE MEDICAL BOARD OF OHIO 17TH FLOOR, COLUMBUS, OHIO 43266 - 0315 **ØBG OBSTETRICS & GYNECOLOGY** 77 SOUTH HIGH STREET. **CERTIFICATION** I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 1994-1996 BIENNIUM THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE OH IO STATE MEDICAL BOARD, AND THAT THE INFORMATION AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY DESDECT. SPECIALTY CODE(S) CORRECT AS LISTED ÷... F CORRECTIONS ARE NECESSARY, PLEASE cODE3 1 CODE2 RESPECT. CODE1 4 r), 4 REPORT ANY CHANGE OF ADDRESS (DATE) (SIGNATURE ØF APPLICANT) DATE DUE **IDENTIFICATION NUMBER** AMOUNT DUE \$250.00 05/01/96 35-04-0676 DAVID M BURKONS, M.D. 1611 S GREEN RD STATE ZIP CODE SOUTH EUCLID OH 44121 COUNT .969696962 0935040676# ",0000 5 2000" City で な State Zip Code Count Sign I I I I I I I I I Cont Count Si AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION FOR DEFINENAL OF YOUR CERTIFICATE HAVE YOU : question if you have successfully completed 1.) Been found guilty of, or pled guilty or no 2.) Been found guilty of, or pled guilty or no suffering from drug or alcohol dependency enrolled in a board approved program. Any contest to a federal or state law regulating sections 4731, 224 and 4731.25 O.R.C., and the possession, distribution or use of any drug? initiated against you by any state licensing board other than the State Medical 6.) Surrendered, or consented to limitation arrangement or scheme for referral of a patient, board and have subsequently adhered to all statutory requirements as contained in 7.) Had any clinical privileges suspended, 3.) Been addicted to or dependent upon 4.) Had malpractice insurance cancelled restricted or revoked for reasons other than failure to maintain records or attend treatment at a program approved by this been treated for, or been diagnosed as upon: a) A license to practice medicine; or abuse? You may answer "no" to this or facility in which either you or a member of related provisions, or you are currently alcohol or aný chemical substance; or questions concerning approval can be 5.) Had any disciplinary action taken or Zip Code 8.) Referred a patient, or participated in an your immediate family has an ownership or or limited for other than failure to pay for clinical laboratory services to a person PRINCIPAL PRACTICE ADDRESS - IF DIFFERENT FROM THE ADDRESS SHOWN ON FRONT: contest to a felony or misdemeanor. any compensation OR b) State or federal privileges to Redacted prescribe controlled substances? SOCIAL SECURITY NUMBER (Optional for purposes of identification lirected to the board offices State nvestment interest, or SECURI Board of Ohio? staff meetings? premiums? 20.00 AMOUNT SALCEDATE Street Street 07 CH 000 8 8 935040676 ACCOUNT # ð 8 ð ð ŝ ΈS ŝ ∃€ YES ŝ ŝ ŝ

DETACH HERE AND REMIT THIS PORTION WITH FEE **MD & DO SPECIALTY CODES CURRENTLY ON RECORD** STATE MEDICAL BOARD OF OHIO OOR, COLUMBUS, OHIO 43266 - 0315 OBG OBSTETRICS & GYNECOLOGY 77 SOUTH HIGH STREET, CERTIFICATION I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 1996-1998 BIENNIUM THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE OH IO STATE MEDICAL BOARD, AND THAT THE INFORMATION AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FROM RENEWAL IS TRUE AND CORRECT IN EVERY SPECIALTY CODE(S) CORRECT AS LISTED IF CORRECTIONS ARE NECESSARY, PLEASE 1-+-1 ENTER ALL SPECIALTY CODES. CODET RESPECT. CODE2 CODE3 Х REPORT ANY CHANGE OF ADDRESS (SIGNATURE OF APPLICANT) (DATE) AMOUNT DUE DATE DUE **IDENTIFICATION NUMBER** \$371.00 05/01/98 35-04-0676-B DAVID M BURKONS, M.D. 1611 S GREEN RD STATE ZIP CODE SOUTH EUCLID OH 44121 "000037100" 1:9696969621 0935040676" question if you have is uccessfully completed AT ÅNY TIME SINCE SIGNING YOUR LAST APPLICATION FOR REVEWAL OF YOUR CERTIFICATE HAVE YOU : 1.) Been found guilt of, or pled guilty or no contest to a felony for misdemeanor. 2.) Been found guilty of, or pled guilty or no contest to a federal or state law regulating suffering from, drug or alcohol dependency sections 4731.224 and 4731.25 O.R.C., and enrolled in a board <u>ab</u>proved program. Any questions concernin<u>a</u>approval can be 6.) Surrendered, or consented to limitation initiated against you by any state licensing arrangement or scheme for referral of a patient, board and have subsequently adhered to all statutory requirements as contained in Z.) Had any clinical privileges suspended, the possession, distribution or use of any Had malpractice insurance cancelled than failure to maintain records or attend treatment at a program approved by this board and have subsequently adhered to 6.) Been addicted to or dependent upon been treated for, or been diagnosed as or facility in which either you or a member of upon: a) A license to practice medicine, restricted or revoked for reasons other or abuse? You may answer "no" to this 5.) Had any disciplinary action taken or related provisions, pr-you are currently alcohol or any cheutical substance; or 8.) Referred a patient, or participated in an your immediate family has an ownership or for clinical laboratory services to a person Zip Code or limited for other than failure to pay investment interest, or any compensation ADDRESS - IF DIFFERENT OR b) State or federal privileges to prescribe controlled substances? board other than the State Medical Redacted PRINCIPAL PRACTICE ADDRESS.- IF DIFH FROM THE ADDRESS SHOWN, DN FRONT _ l Antional for nurnage of identificati offices. State 170 directed to the board ŀĤ Board of Ohio? staff meetings? <u>(†††††††††††††††</u> Streat premiums? drug? ð ğ ð ð /ES NO ş كليطبيا Viterati Altricati 다<u>1</u> 같은 -----County Street ရွိ YES ËS ĒS ĨS ŝ Ē

DETACH HERE AND REMIT THIS PORTION WITH FEE **MD & DO SPECIALTY CODES CURRENTLY ON RECORD** STATE MEDICAL BOARD OF OHIO 77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 43266 - 0315 OBG OBSTETRICS & GYNECOLOGY CERTIFICATION I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 1998-2001 REGISTRATION PERIOD THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE OHIO STATE MEDICAL ASSOCIATION AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT. SPECIALTY CODE(S) CORRECT AS LISTED F CORRECTIONS ARE NECESSARY, PLEASE. 1 ENTER ALL SPECIALTY CODES. CODE1 CODE2 CODE3 RESIDENCE ADDRESS-THIS MUST BE ENTERED AT EACH RENEWAL (SIGNATURE OF APPLICANT) (DATE) **IDENTIFICATION NUMBER** AMOUNT DUE DATE DUE \$305.00 04/01/2001 35-04-0676-B DAVID M BURKONS, M.D. 1611 S GREEN RD SOUTH EUCLID OH 44121 1:9696969621 0935040676" , "OOOOO 30 500," SINCE SIGNING YOUR LAST APPLICATION paid by you or by your behalf for acts occurring in any state other than Ohio? 6.) Have you had any clinical privileges or σ board approved program. Any questions 5.) Have you surrendered, or consented to to practice any healthcare profession or state or federal controlled substances in any jurisdiction? You may to this question if the only authority revoked for maintain to attend or been treated for, or been by this board and have 3.) Have any manoractice awards been ò atcohol or any chemical answer "NO" to this question if you have statutory sections are currently enrolled in guilty of, or pled received lieu of drug or alcohol dependenay or abuse? You may 4731.224 and 4731:25 O.R.C., and related agency, or other body, including those in 4.7 Has any board, bureau, department, filed any complaints such surrender or consent was given conviction of, a missemeanor or felony? treatment at directed 5 シーニッシー ついざい principle addicted 5 Redacte suffering from, as contained in records on a timely basis or 2 all Ohio, other than this board, 5 institutional concerning approval can be reasons other than failure prescribe ò adhered to 5 contest to, intervention חדחווחדח FOR RENEWAL OF YOUR CERTIFICAT () Have you been found leted limitation of a license UST BE ENTERED AT EACH-RENEW restricted been allegations nave טוראר רווחטווטר חרוויטט comp :7 program approvec provisions, or you nodn the board offices, you ğ as 5 staff meetings? 2 similar Ī answer "NO" 00 2 subsequently requirements successfully against you? suspended, Check this Box if Practice address. dependent substance; diagnosed this board Have privileges charges, ò treatment other guilty 44 Mar Da Gue -**いの中国** ti Buci ANY TIME a S. 8 20 S ş 9 YES ŝ ŝ YES KES /ES 5

DETACH HERE AND REMIT THIS PORTION WITH FEE MD & DO SPECIALTY CODES CURRENTLY ON RECORD 77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 43215 - 6127 OBG *OBSTETRICS & GYNECOLOGY* CERTIFICATION I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OF WILL HAVE COMPLETED DURING THE 2001- 2003 REGISTRATION THAT I HAVE COMPLETED OF WILL HAVE COMMENTED BY THE PERIOD THE RECURSION OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE OH TO SHATTE MEDICAL PLAND, AND THE INFORMATION PROVIDED AND APPROVED BY THE STATE MEDICAL BEARD, AND THAT THE INFORMATION PROVIDED SPECIALTY CODE(S) CORRECT AS LISTED IF CORRECTIONS ARE NECESSARY, PLEASE ON THIS APPLICAT AL IS pru AND C IN EVERY RESPECT. ENTER ALL SPECIALTY CODES. CODE1 CODE3 CODE2 RESIDENCE ADDRESS-THIS MUST BE ENTERED AT EACH RENEWAL. ATORE OF PEICANTY (DATE) ž4 IDENTIFICATION NUMBER DATE DUE AMOUNT DUE \$50 Late Fee Due Afte \$305.00 35-04-0676-B 04/01/03 07/01/03 EURKONS M.D. DAVID M S 21249 WOODLAND RD SHAKER HTS OH 44122 ā 0935040676 30500 AI ANT IIME SINCE SIGNING TUUK LASI APPLICATION FOR RENEWAL OF YOUR CERTIFICATE : 1.) Have you been found guilty of, or pled guilty or no 3 Pave you been addicted to or dependent upon alcohol or treatment or intervention in been treated for, or been enrolled in, a program approved if you have ever relapsed. Any questions concerning program approval or concerning this question can be directed to the A) Has any board, bureau, department, agency, or other body, including those in Ohio, <u>other than</u> <u>this board</u>, filed any charges, allegations or 2 prescribe controlled substances in any jurisdiction? You may answer "NO" to this or revoked for reasons other than failure to maintain records on a timely basis or to attend contest to, or received any chemical substance; or diagnosed as suffering from, drug or alcohol dependency or abuse? You may answer have successfully completed by this Board and have adhered to all statutory requirements ą profession or state or federal privileges to similar institutional authority suspended, restricted you or on your behalf for acts occurring in any state other than Ohio? concerning, a license to practice any healthcare question if the only such surrender or consent 6.) Have you had any clinical privileges or other 'NO" to this question if you during and subsequent to treatment. You must answer "YES' ilmitation of, or to reprimand or probation treatment at, or are currently lieu of conviction of, misdemeanor or felony? Have you been addicted \mathfrak{S} .) Have any mathractice awards been paid or consented PRINCIPAL PRACTICE ADDRESS - THIS ADDRESS Check this Box if you have NO principal Redacted 24 I O I VI U I I 5.) Have you surrendered, MUST BE ENTERED AT EACH RENEWAL S l complaints against you? was given to this board. [ş 2 8 staff meetings? 2 D MIE) YES CER SE Practice address. e. Clark . 21 040 200 1 098 ē board offices. 40676 3 000030500 ð ð 20 U M W 50 2 ì 5 YES YES YES **FES**

Date Posted: 3/6/2005 3:22:42 PM

Please review all information you have provided. Click on the "Review" button to change any information given or click on the "I Agree" button to verify that all information posted below is correct and to proceed to payment options.

Please note that knowingly providing false information may result in denial of registration.

| 1-8-0-1-4-0-14 | |
|---|-----------------------------|
| License Information | |
| License Number | 35.040676 |
| License Name | DAVID BURKONS |
| Email Address | |
| | |
| Fees | |
| Relicensure Fee | \$305.00 |
| | ======= |
| | Total Fees \$305.00 |
| | 101411003 3505.00 |
| Service the Conden | |
| Specialty Codes | |
| 1. Please select one specialty from the field below | |
| | ETRICS & GYNECOLOGY |
| 2. Please select one specialty from the field below, if a | pplicable. |
| | {not Answered} |
| 3. Please select one specialty from the field below, if a | nplicable. |
| | {not Answered} |
| | |
| | |
| CME | |
| 1. Have you met the above CME requirements for your | |
| | YES |
| | |
| Discipline | |
| 1. Have you been found guilty of, or pled guilty or no o | |
| treatment or intervention in lieu of conviction of, a n | nisdemeanor or felony? |
| | NO |
| 2. Have you surrendered, consented to limitation of, or | to suspension, reprimand or |
| probation concerning, a license to practice any health | care profession or state or |
| federal privileges to prescribe controlled substances | in any jurisdiction other |
| than Ohio? | |
| | NO |
| 3. Have any malpractice awards been paid by you or or | your behalf for acts |
| occurring in any state other than Ohio? | |
| | NO |

4. Has any board, bureau, department, agency, or any other body, including those in Ohio <u>other than this board</u>, filed any charges, allegations or complaints against you?

....NO

5. Have you had any clinical privileges or other similar institutional authority suspended, restricted or revoked for reasons <u>other than failure to maintain</u> <u>records on a timely basis or to attend staff meetings?</u>

....NO

6. Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse?

. NO

Social Security Number

1.

..... Redacted

Nurse Collaboration Info

1. Are you currently in a collaboration agreement with any Clinical Nurse Specialists, Certified Nurse-Midwives or Certified Nurse Practitioners?

....NO

2. List the name/names and type of licensure for each nurse with whom you are collaborating. For example: Jane Doe, CNP; Mary Smith, CNS.

..... {not Answered}

I understand that submitting a false, fraudulent, or forged statement or document or omitting a material fact in obtaining licensure may be grounds for disciplinary action against my license.

Under penalty of law, I hereby swear or affirm that the information I have provided in the application is complete and correct, and that I have complied with all criteria for applying on line.

Date Posted: 1/3/2007 10:28:17 PM

Please review all information you have provided. Click on the "Review" button to change any information given or click on the "I Agree" button to verify that all information posted below is correct and to proceed to payment options.

Please note that knowingly providing false information may result in denial of registration.

Address Information

| BUSINESS AI | DDRESS |
|-------------|--------|
|-------------|--------|

CREDENTIAL MAIL ADDRESS

1611 S GREEN RD S EUCLID, OH 44121 Cuyahoga County 216-381-3880

21249 S WOODLAND RD SHAKER HTS, OH 44122 Cuyahoga County 216-283-8712

License Information

License Number License Name Email Address

Fees Relicensure Fee 35.040676 DAVID BURKONS dmburkons@aol.com

\$305.00

Total Fees \$305.00

Specialty Codes

1. Please select one specialty from the field below

2. Please select one specialty from the field below, if applicable.

..... {not Answered}

..... GYNECOLOGY

.... {not Answered}

3. Please select one specialty from the field below, if applicable.

CME-Physicians

1. Have you met the above CME requirements for your license?

..... YES

Discipline

- 1. Have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?
- 2. Have you surrendered, consented to limitation of, or to suspension, reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction other than Ohio?
- 3. Have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?
- 4. Has any board, bureau, department, agency, or any other body, including those in Ohio other than this board, filed any charges, allegations or complaints against you?
- 5. Have you had any clinical privileges or other similar institutional authority suspended, restricted or revoked for reasons other than failure to maintain records on a timely basis or to attend staff meetings?
- 6. Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse?

....NO

Redacted

..... {not Answered}

Nurse Collaboration Info

Social Security Number

1.

1. Are you currently in a collaboration agreement with any Clinical Nurse Specialists, Certified Nurse-Midwives or Certified Nurse Practitioners?

....NO

2. List the name/names and type of licensure for each nurse with whom you are collaborating. For example: Jane Doe, CNP; Mary Smith, CNS.

I understand that submitting a false, fraudulent, or forged statement or document or omitting a material fact in obtaining licensure may be grounds for disciplinary action against my license.

Under penalty of law, I hereby swear or affirm that the information I have

....NO

....NO

....NO

....NO

....NO

provided in the application is complete and correct, and that I have complied with all criteria for applying on line.

Date Posted: 1/8/2009 2:25:22 PM

Please review all information you have provided. Click on the "Review" button to change any information given or click on the "I Agree" button to verify that all information posted below is correct and to proceed to payment options.

Please note that knowingly providing false information may result in denial of registration.

| License Information | |
|---------------------|-------------------|
| License Number | 35.040676 |
| License Name | DAVID BURKONS |
| Email Address | dmburkons@aol.com |
| | |
| Fees | |
| Relicensure Fee | \$305.00 |

Kelicensure Fee

\$305.00

Total Fees \$305.00

Specialty Codes

1. Please select one specialty from the field below

..... OBSTETRICS & GYNECOLOGY

2. Please select one specialty from the field below, if applicable.

..... {not Answered}

3. Please select one specialty from the field below, if applicable.

..... {not Answered}

CME-Physicians

1. Have you met the above CME requirements for your license?

..... YES

Discipline

1. Have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?

....NO

2. Have you surrendered, consented to limitation of, or to suspension, reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction other than Ohio?

....NO

3. Have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?

....NO

4. Has any board, bureau, department, agency, or any other body, including those in Ohio <u>other than this board</u>, filed any charges, allegations or complaints against you?

....NO

....NO

- 5. Have you had any clinical privileges or other similar institutional authority suspended, restricted, revoked or placed on probation for reasons <u>other than failure to maintain records on a timely basis or to attend staff meetings?</u>
- 6. Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse?

....NO

Social Security Number

1.

..... Redacted

Nurse Collaboration Info

1. Are you currently in a collaboration agreement with any Clinical Nurse Specialists, Certified Nurse-Midwives or Certified Nurse Practitioners?

..... YES

2. List the name/names and type of licensure for each nurse with whom you are collaborating. For example: Jane Doe, CNP; Mary Smith, CNS.

..... Cyndi Roller WHNP RNC

I understand that submitting a false, fraudulent, or forged statement or document or omitting a material fact in obtaining licensure may be grounds for disciplinary action against my license.

Under penalty of law, I hereby swear or affirm that the information I have provided in the application is complete and correct, and that I have complied with all criteria for applying on line.



Page 1 of 5

Date Posted: 6/1/2011 10:08:39 AM

Please review all information you have provided. Click on the "Review" button to change any information given or click on the "I Agree" button to verify that all information posted below is correct and to proceed to payment options.

Please note that knowingly providing false information may result in denial of registration.

| Tegistiation. | |
|---|-----------------------------|
| License Information | |
| License Number | 35.040676 |
| License Name | DAVID BURKONS |
| | |
| Fees | |
| Relicensure Fee | \$305.00 |
| | |
| | Total Fees \$305.00 |
| | 101111003 \$505.00 |
| Medical Board Connector and an as Email | |
| Medical Board Correspondence Email | a note this information is |
| 1. Did you provide a Credential email address? Plea a public record. | se note this information is |
| a public record. | YES |
| | 125 |
| | |
| Specialty Codes | - |
| 1. Please select one specialty from the field below | |
| OBSTI | ETRICS & GYNECOLOGY |
| 2. Please select one specialty from the field below, if an | plicable. |
| | |
| 3. Please select one specialty from the field below, if a | |
| 5. Flease select one specialty from the field below, if a | - |
| | {not Answered} |
| | |
| CME-Physicians | |
| 1. Have you met the above CME requirements for your | license? |
| | YES |
| | |
| Discipline | |
| 1. Have you been found guilty of, or pled guilty or no c | contest to, or received |
| treatment or intervention in lieu of conviction of, a n | |
| | NO |
| 2. Have you surrendered, consented to limitation of, or | |
| 2. Have you surrendered, consented to miniation of, or probation concerning, a license to practice any healt | |
| federal privileges to prescribe controlled substances | |
| than Ohio? | |
| | |

https://ohelicense.das.state.oh.us/actOnlineRenewalAgreement.asp?renewalIdnt=1427416 08/16/2012

| | | NO |
|----|---|-------------------------|
| 3. | Have any malpractice awards been paid by you or on occurring in any state other than Ohio? | your behalf for acts |
| | 5 | NO |
| 4. | Has any board, bureau, department, agency, or any ot in Ohio <u>other than this board</u> , filed any charges, all against you? | |
| | | NO |
| 5. | Have you had any clinical privileges or other similar suspended, restricted, revoked or placed on probation failure to maintain records on a timely basis or to | for reasons other than |
| | | NO |
| 6. | Have you been addicted to or dependent upon alcoho substance; or been treated for, or been diagnosed as s alcohol dependency or abuse? | - |
| | | NO |
| | cial Security Number | |
| 1. | | D 1 / 1 |
| | | Redacted |
| Nu | urse Collaboration Info | |
| | Are you currently in a collaboration agreement with a Specialists, Certified Nurse-Midwives or Certified N | |
| | | NO |
| 2. | List the name/names and type of licensure for each nu collaborating. For example: Jane Doe, CNP; Mary | 2 |
| | | |
| | | {not Answered} |
| OF | io Employment | |
| | Do you practice in Ohio? | |
| | | YES |
| OF | io Workforce Questions | |
| | "Clinical" - direct patient care | |
| | | 50-54 |
| 2. | "Research" - study of a treatment, procedure or medic | ation done in a medical |
| | setting or for a medical purpose | |
| | | 0 |

| 3. | "Administration" - activities related generally to patie contact with a patient (e.g. recordkeeping, clerical tas authorizations with insurers, claims, billing issues, etc | ks, chart review, prior |
|----|---|-------------------------|
| | | 1-4 |
| 4. | "Education" - preceptor, mentor, etc. | |
| | | 10-14 |
| 5. | "Volunteering" - providing medical and medical-relat | ed services at no cost |
| | | 1-4 |
| 6. | "Other" - medical professional activities not included | in above categories |
| | - | 0 |
| | | |
| Cl | inical - Practice setting | |
| 1. | Enter the number of hours per week spent in "Office/ care" (out-patient care). | Clinic/Ambulatory |
| | | 50-54 |
| 2. | Enter the number of hours per week spent in "Hospita | l (in-patient care)". |
| | | 1-4 |
| 3. | Enter the number of hours per week spent in "Emerge | ncy Room". |
| | | 0 |
| 4. | Enter the number of hours per week spent in "Urgent | Care". |
| | | 0 |
| 5. | Enter the number of hours per week spent in "Other". | |
| | | 0 |
| | | |
| | orkforce Counties | |
| 1. | Enter the first zip code: | |
| | | |
| 2. | Enter the first county: | ~ · |
| | | Cuyahoga |
| 3. | Enter the second zip code: | |
| | | |
| 4. | Enter the second county: | ~ . |
| | | Cuyahoga |
| 5. | Enter the third zip code: | |
| | | |
| 6. | Enter the third county: | |
| | | Summit |
| | | |

| Pr | actice Arrangement (size) | |
|----|--|-----------------------------|
| 1. | Solo practitioner | |
| • | | YES |
| 2. | Single-specialty Group | NT/A |
| | | N/A |
| 3. | Multi-specialty Group | |
| | | N/A |
| 4. | Employee of a clinical facility or hospital? (Clinical | facility is an urgent care, |
| | industrial clinic or similar entity) | VEO |
| | | YES |
| | | |
| | orkforce Language Question | |
| 1. | Do practitioners or staff in your practice communicat language other than spoken English? | e in sign language or in a |
| | | YES |
| | | |
| La | nguages | |
| 1. | Select a language from the drop down list. | |
| | | Spanish |
| 2. | Select a language from the drop down list. | |
| | | {not Answered} |
| 3. | Select a language from the drop down list. | |
| | | {not Answered} |
| | | , , , |
| AF | BMS Certified | |
| | Are you certified by an ABMS Board? | |
| | | YES |
| | | |
| AE | BMS Specialty | |
| | Choose specialty from the dropdown list. | |
| | | Obstetrics and Gynecology |
| 2. | Choose specialty from the dropdown list. | |
| | encode specially nom the dioputorin fish | {not Answered} |
| 3. | Choose specialty from the dropdown list. | |
| э. | choose specially from the dropdown list. | {not Answered} |
| | | ····· |

I understand that submitting a false, fraudulent, or forged statement or document or omitting a material fact in obtaining licensure may be grounds for disciplinary action against my license. Under penalty of law, I hereby swear or affirm that the information I have provided in the application is complete and correct, and that I have complied with all criteria for applying on line.