### **APPS. ETC**

### **FOR**

### LOUIS THOMASON PAYNE

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

M. D	Q.	Cice & Syneady	1. Camilling
1 15 to St.	County	ctice Obstetoice	Signed Arte
Name in full (print) (2000)	1 17	Branch of Healing Arts you are to practice	\$10.00 Fee attached.  Date

### STATE LICENSING BOARD FOR THE HEALING ARTS MONTGOMERY, ALABAMA

Every person licensed to practice any branch of the Healing Auts in the State of Alshams shall on or before the 31st day of December of each year apply to this Board for a certificate of registration which shall be effective during the next calendar year. The \$5.00 for must accompany this application. If licensed after July 1st, pay only \$2.50 for remainder of that year.

When any homsen shall fail to register and pay the above fee within thirty (30) days after registration becomes due, as provided in Title 46, Section 257 (11) Code of Alabama, the ficense of such person shall be automatically revoked without further notice or hearing.

APPLICATION FOR CERTIFICATE OF REGISTRATION

Louis Thomason Payne, M. D.Date 812-B West Total Different Birmingham, Alabama Name and Business Address

License #

Fee \$2.50

County Jefferson

Date issued

USE REVERSE SIDE FOR CORRECTIONS ONLY

### Nº M 3057

## STATE LICENSING BOARD FOR THE HEALING ARTS JAN 3 1 200 MONTGOMERY, ALABAMA

Every person licensed to practice any branch of the Healing Arts in the State of Alabama shall on or before the 31st day of December of each year apply to this Board for a curtificate of registration which shall be affective during the next calendar year. The \$5.00 fee must accompany this application, If licensed after July 1st, psy only \$2.50 for remainder of that year.

When any licensee shall fail to register and pay the above fee within thirty (30) days after registration becomes due, as provided in Title 46, Section 257 (11) Code of Alabama, the license of such person shall be automatically revoked without further notice or hearing.

# APPLICATION FOR CERTIFICATE OF REGISTRATION Name and Business Address

Address

License # 11 15

County

Date issued

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Signature

USE REVERSE SIDE FOR CORRECTIONS ONLY

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### STATE LICENSING BOARD FOR THE HEALING ARTS MONTGOMERY, ALABAMA

Every person licensed to practice any branch of the Healing Arts in the State of Alabams shall on or before the 31st day of December of each year apply to this Board for a certificate of registration which shall be effective during the next calendar year. The \$5.00 fee must accompany this application. If licensed after July 1st, pay only \$2.50 for remainder of that year.

When any licensee shall fail to register and pay the above fee within thirty (30) days after registration becomes due, as provided in Title 46, Section 257 (11) Code of Alabams, the license of such person shall be automatically revoked without further notice or hearing.

APPLICATION FOR CERTIFICATE OF REGISTRATION

Name and Business Address

County

License RECETATION Date issued

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DEC 8 1956

Signature,

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# APPLICATION FOR CERTIFICATE OF REGISTRATION

### STATE LICENSING BOARD FOR THE HEALING ARTS MONTGOMERY, ALAZAMA

Every person itemsed to practice any branch of the Heeling Arts in the State of Alabama shall on or before the 31st day of December of each year apply to this Board for a certificate of registration which shall be effective during the next calendar year. The \$5.00 fee must accompany this application. If licensed after July 1st, pay only \$2.50 for remainder of that, year. When any licensee shall full to register and pay the above fee within thirty (30) days after registration becomes due, as provided in Title 46, Section 257 (11) Code of Alabama, the license of such person shall be automatically revoked without further notice or hearing;

Name and Business

Address

License #

Date issued

DEC 7 1967

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HEALING ARTS BOARD

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APPLICATION FOR CERTIFICATE OF REGISTRATION

## STATE LICENSING BOARD FOR THE HEALING ARTS MONTGOMERY, ALABAMA 36104

Every person licensed to practice any branch of the Healing Arts in the State of Alabama shall on or before the 31st day of December of each year apply to this Board for a certificate of registration which shall be effective during the next calendar year. The \$5.00 fee must accompany this application. If licensed after July ist, pay only \$2.50 for remainder of that year. When any licensee shall fail to register and pay the above fee within thirty (30) days after registration becomes due, as provided in Title 46, Section 257 (11) Code of Alabama, the license of such person shall be automatically revoked without further notice or hearing.

Name and America Theorem Carries as De Bushase Market St. Carries and Carries Business Address はの人の Date issued

License #

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Signature

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HEALING ARTS BOARD

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## STATE LICENSING BOARD FOR THE HEALING ARTS APPLICATION FOR CERTIFICATE OF REGISTRATION

MONTGOMERY, ALABAMA 36104

Every person licensed to practice any branch of the Healing Arts in the State of Alabama shall on or before the 31st day of December of each year apply to this Board for a certificate of registration which shall be effective during the next calendar year. The \$5.00 fee must accompany this application. If licensed after July 1st, pay only \$2.50 for remainder of that year.

When any licensee shall full to register and pay the above fee within thirty (30) days after registration becomes due, as provided in Title 46, Section 257 (11) Code of Alabama, the license of such person shall be automatically revoked without further notice or hearing.

Name and Business

Address

License #

County

Date issued

Fee

Signature,

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Nº 2382

2002

# APPLICATION FOR CERTIFICATE OF REGISTRATION

STATE LICENSING BOARD FOR THE HEALING ARTS ROOM 2014—Public Safety Building MONTGOMERY, ALABAMA 36194

MONTGOMERY, ALALAMA 36104

Every person licensed to practice any branch of the Healing Arts in the State of Alabama shall on or before the 31st day of December of each year apply to this Board for a certificate of registration which shall be effective during the next is pay only \$2.50 fee must accompany this application. If licensed after July 1st, pay only \$2.50 for remainder of that year.

When any licensee shall fail to register and pay the above fee within thirty (30) days after registration becomes due, as provided in Title 46, Section 257 (11) Code of Alabama, the license of such person shall be automatically revoked without further notice or hearing.

Name and Business Address License #

County

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Date issued

13

Signature

USE REVERSE SIDE FOR CORRECTIONS ONLY

## STATE LICENSING BOARD FOR THE HEALING ARTS Room 209...Public Safety Britding MONTGOMERY, ALARAMA 26104 APPLICATION FOR CERTIFICATE OF REGISTRATION FOR 1972

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

When any licensee shall fail to register and pay the above fee within thirty (30) days after registration becomes due, as provided in Title 46. Section 257 (11) Code of Alabama, the license of such person shall be automatically revoked without further notice or hearing. or hearing.

Name and SIS She whences Business; Tax selected Sagar

Address

Date issued 8.3/6点

License # Caus

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## STATE LICENSING BOARD FOR THE HEALING ARTS APPLICATION FOR CERTIFICATE OF REGISTRATION FOR 1973

Fiblic Safety Building MONTGOMERY, ALABAMA 36104

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

In order to avoid paying a \$20.00 penalty this fee must be received by January 31st.

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河南中野的 有景景的复数形式 人名英英森西姓氏森林特 Name and

Business Address License # 1983

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County

Date issued [1.5]

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Signature

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## APPLICATION FOR CERTIFICATE OF REGISTRATION FOR 1974 STATE LICENSING BOARD FOR THE HEALING ARTS

MONTGOMERY, ALARAMA 36194 Public Safety Building

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

In order to avoid paying a \$20.00 penalty this fee must be received by January 31st.

Name and the strain of the str

Address

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License \$

Date issued

County

Signature

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## STATE LICENSING BOARD FOR THE HEALING ARTS APPLICATION FOR CERTIFICATE OF REGISTRATION FOR 1975.

Public Sefety Building MONTGOMERY, ALABAMA 36104

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

In order to avoid paying a \$20.00 penalty this fee must be received by January 31st.

Name and Business Address

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County

Date issued

Fee

Signature

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### APPLICATION

# STATE LICENSING BOARD FOR THE HEALII

MONTGOMERY, ALABAMA 36130

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

In order to avoid paying a \$20,00 penalty this fee must be received by Jamery 31st

Name and Louis of the contract of the said Business

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License #

County

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Date issued

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FOR CHANGE OF ADDRESS ONLY

Every person licensed to practice any branch of the Healing Arts in the State of Alabama shall on or before the Stat day of December of each year apply to this Board for a certificate of registration which shall be effective during the next calendar year. The \$16.00 feer must accompany this application. If licensed after July, 1st, pay only \$5.00 for remainder of that year. samery 31st you must pay an additional \$20.00 penalty for reinstate STATE LIGENSING BOARD FOR THE HEALIN FOR CHANGE OF ADDRESS ONLY Date issued 3/5/5 MONTCOMERY, ALABAMA 34130 A P P L I C A H L O N 中間 一面五石目的 四万件并打八五四 HIS IS THE ONLY ROTICE If not paid by J Name and Business License : Address County

If not paid by Jamery 31st you must pay an additional \$20.00 penalty for reinstate APPLICATION
FOR CERTIFICATE OF REGISTRATION FOR 1979
STATE LICENSING BOARD FOR THE HEALING ARTS Every person licensed to practice any branch of the Healing Arts in the S. Alabama shall on or before the 3tst day of December of each year apply Board for a certificate of registration which shall be effective during the calendar year. The \$10.00 fee must accompany this application. CAMPACT PROPERTY OF THE PROPER か行うの FOR CHANGE OF ADDRESS ONLY Public Schery, Building 36139 Date issued **特別を行るがあっているなのかりといわら** THIS IS THE ONLY NOTICE YOU WILL RECEIVE. ment of your license. Name and Business Address License \$ County

No. 4240 FOR A CERTIFICATE OF REGISTRATION TO PRACTICE MEDICINE IN ALABAMA IN 1980. RENEWAL APPLICATION

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STATE LICENSING BOARD FOR THE HEALING ARTS
Public Safety Building
Montgomery, Alabama 36130
Phone 205/822-8051

SLOW TO 1979

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

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

Name and Mailing Address:

1788 HCFARLAND SEVE BORTH TUSCALDOSA, AL 35406 LOUIS T PAYNE

PC 19179 Business. Address:

1758 MCFARLAND BLVD NORTH TUSCALDOSA, AL 35406

345-2110

LICENSE AT CORDON

ISSUED: 08/08/65

The above addresses are correct.

RENEWAL APPLICATION

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

STATE LICENSING BOARD FOR THE HEALING ARTS 908 \$. Hull Street, Room 110
Montgomery, Alabama 36130
Phone 206/832-5051

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

RENEWAL FEE \$10.00 ... IF NOT RECEIVED BY JANUARY 31st, A PENALTY OF \$20.00 PLUS THE \$10.00 RENEWAL FEE WILL BE CHARGED. RETURN ENTIRE FORM WITH FEE.

1788 MCFARLAND BLVD NORTH TUSCALOGSA, AL **Business Address** 1788 McFarland Boulevard, North 8/5/65 Louis Thomason Payne, M. D. Tuscaloosa, Alabama 35406 Name and Mailing Address: 3505

Tuscaloosa

\$ 10.00

The above Addresses are correct.

35406

4428

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

# ALABAMA MEDICAL LICENSURE COMMISSION 908 South Hull Strowt, Rosm 110 Montgomery, Alabama 36104 Phone 205/832-5081

Every physician and exteopath licensed to practice medicine/exteopathy in the State of Alebama shall, on or before the 31st day of December of each year, apply to this Commission for a Certificate of Resistration which shall be affective during the relender year. soomes due will result in the auto-ama, Section 12.

Name and Mailing Address:  LOUIS T PAYNE 1788 MCFARLAND BLVD NORTH 1USCALOGSA, AL 35405			matic revocation of the current license without further notice or hearing as provided in Act. No. 81-218, Code of Alabama, Section 12.		D SMUCOSO LICHTEIG SALE SASO OF WILLIAM SEL CONTRINGED FEBRUAR AND THE INVESTIGATION SIGNAL TO THE TRANSPORTER
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The above Addresses are correct.

ISSUED: 08/05/65

LICENSE #: 0003505

<b>₽</b>		Yes	No
1	Have you been charged with any offense (felony/misdemeanor) within the past year?	[]	Ŋ
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?	[]	Ŋ
3.		[]	<u>[</u> [
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?	[]	<u>[</u>
5.	Have you had a judgment rendered against you, or action settled relating to the performance of your professional service within the past year?	[]	X) [X]
6.	To your knowledge, are you the subject of an investigation, or has a formal complaint against your license been filed by any licensing Board/Agency as of the date of this application within the past year?	[]	[X]
7.		[]	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 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?	[]	<i>K</i> ]
9.	Within the past year, have you raised the issue of consumption of drugs or alcohol or the issue of a mental, emotional, nervous, or behavioral disorder or condition as a defense, mitigation, or explanation for your actions in the course of any administrative or judicial proceeding or investigation; any inquiry or other proceeding; or any proposed termination by an educational institution, employer, government agency, professional organization or licensing authority?	[]	
10.	Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism?		Ŋ
11.	Have you engaged in the illegal use of controlled dangerous substances within the past twelve months?	[]	<b>X</b>
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 (DVI)	- Lange of substances:	
	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?	[]	M
The te	"TIM "CUITERITY" does not mean on the day of		

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

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

I CERTIFY THAT ALL INFORMATION ON THIS FORM IS CORRECT

Signature

10/20/06

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

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

Have you engaged in the illegal use of controlled dangerous substances within the past twelve months?
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 beer 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.
Primary specialty:  Gynecology (OB/GYN)
Are you Board certified in your primary specialty? Y
Secondary specialty:
Are you Board certified in your secondary specialty? Y
Practice Type:

S
If Group, provide the Group Name:  West Alabama Women's Center Inc.
Primary Hospital where you have privileges: (if any)
Hospital Name:  Druid City Regional Medical Center
Hospital City: Tuscaloosa
Hospital State: AL
Are you licensed in another State:  N
Are you actively engaged in clinical practice in the State of Alabama? Y
What is your principal county of practice in the State of Alabama?  Tuscaloosa

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

Jan 5, 2012 3:04 PM

(\*\*indicate state if not in Alabama)

Other County1

,	Other State1
٠	Other County 2
	Other State 2
	Do you have a current collaborative agreement with a nurse or practitioner or midwife?  N
	Do you currently conduct office based surgery involving the administration of parenteral medication for analgesia/sedation, general anesthesia or major regional block anesthesia?  N
	PRIMARY CARE INFORMATION:Primary care is defined as: Basic or general health care focused on the point at which a patient ideally first seeks assistance from the medical care system, exclusive or an emergency situation.
	Does your practice include the delivery of primary care medical services in Alabama?  N
	Approximately how many hours per week do you practice the above defined primary care services in Alabama? NOTE: Enter the Average hours worked as a whole number. Do not enter ranges of hours or decimals.
	Approximately how many patient encounters (office, hospital, ER, etc.) per week do you have involving the above defined priary care services in Alabama?
	CME Certification: I hereby certify that I have met the annual minimum continuing education requirement of 12 hours of Category I continuing medical education for the calendar year 2009 and have supporting documentation if audited.  Y
	I certify that I am exempt from the minimum continuing medical education requirements for the following reason:
	Exempt Reason
	Practice Telephone: (205) 556-2026
	Practice Address:
	535 Jack Warner Parkway
	Jan 5, 2012 3:04 PM

•

Home Telephone (205) 345-4288
Home Address: 57 The Downs
Public Address: TRUE
Mail Address:

**TRUE** 

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.



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

### 2011 Online Renewal Summary

Name: Louis Thomason Payne

License Number: MD.3505

Transaction Date: 2010-11-09\* Transaction Number: VLEF6BF3A109

Registration Fee: 300 Date of Birth: 1939-04-20

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

What is your Practice Address? (No PO Boxes)

Street

535 Jack Warner Parkway

Apt/Suite

Suite 1

City

Tuscaloosa

State

Alabama

Zip

35404-5715

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

Tuscaloosa

Country

### **United States**

What is your practice Email? docglo@aol.com

What is your practice Telephone? (205) 556-2026

What is your practice Fax?

(205) 554-0584

What is your Home Address? (No PO Boxes)

Street

57 The Downs

City

Tuscaloosa

State

Alabama

Zip

35401-5843

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

Tuscaloosa

Country

**United States** 

What is your Home Email?

docglo@aol.com

What is your Home Phone?

(205) 345-4288

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

**Practice** 

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

**Practice** 

Social Security Number

416-50-6306

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

Gynecology (OB/GYN)

Is your Primary Specialty Board Certified?

Yes

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

Unknown

Is your Secondary Specialty Board Certified?

No

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

Solo

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

**Druid City Regional Medical Center** 

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

Tuscaloosa

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

Alabama

Are you licensed in another state?

No

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

Yes

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

Tuscaloosa

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

None

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

No

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

No

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

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

No

CME Certification: (Select One)

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

Please answer the following questions.

Have you been charged with any offense (felony/misdemeanor) within the past year?

No

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

No

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

No

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

No

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

No

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

No

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

Nο

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

No

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

No

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

### No

Have you engaged in the illegal use of controlled dangerous substances with the past twelve months?

### No

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

### No

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

### No

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

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



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

### 2012 Online Renewal Summary

Name: Louis Thomason Payne

License Number: MD.3505

Transaction Date: 2011-10-26\* Transaction Number: VXYA7F700579

Registration Fee: 300 Date of Birth: 1939-04-20

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

What is your Practice Address? (No PO Boxes)

Street

535 Jack Warner Parkway

Apt/Suite

Suite I

City

Tuscaloosa

State

Alabama

Zip

35404-5715

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

Tuscaloosa

Country

### **United States**

What is your practice Email? docglo@aol.com

What is your practice Telephone? (205) 556-2026

What is your practice Fax? (205) 554-0584

What is your Home Address? (No PO Boxes)

Street

57 The Downs

City

Tuscaloosa

State

Alabama

Zip

35401-5843

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

Tuscaloosa

Country

**United States** 

What is your Home Email?

docglo@aol.com

What is your Home Phone?

(205) 345-4288

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

**Practice** 

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

**Practice** 

Social Security Number

416-50-6306

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

Gynecology (OB/GYN)

Is your Primary Specialty Board Certified?

Yes

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

Unknown

Is your Secondary Specialty Board Certified?

No

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

Solo

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

**Druid City Regional Medical Center** 

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

Tuscaloosa

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

Alabama

Are you licensed in another state?

No

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

Yes

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

Tuscaloosa

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

None

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

No

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

No

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

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

No

CME Certification: (Select One)

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

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

Please answer the following questions.

Have you been charged with any offense (felony/misdemeanor) within the past year?

No

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

No

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

No

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

No

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

No

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

No

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

No

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

No

.

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

No

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

No

Have you engaged in the illegal use of controlled dangerous substances with the past twelve months?

No

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

No

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

Nο

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

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



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

### 2003 Online Renewal Summary

Name: Louis Thomason Payne

License Number: MD.3505

Transaction Date: 2002-10-22\*

Registration Fee: 200

Transaction Number: null

Date of Birth: 1939-04-20

\* - 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?

Ν

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?

Ν

If yes, please explain:

Jan 5, 2012 3:04 PM

Have you been denied a certificate of qualification or license to practice medicine in any state or has your application for a certificate of qualification or license to practice medicine been withdrawn under threat of denial within the past year?  N
If yes, please explain:
Have you had a judgement rendered against you, or action settled relating to the performance of your professional service within the past year? N
If yes, please explain:
To your knowledge, are you the subject of an investigation by any licensing Board/Agency as of the date of this application within the past year?  N
If yes, please explain:
Within the past year, have you been diagnosed with or have you been treated for bi-polar disorder, schizophrenia, paranoia, or any other psychotic disorder? N
If yes, please explain:
Do you currently* have any mental or physical condition or impairment (including, but not limited to, substance abuse, alcohol abuse, or mental, emotional or nervous disorder or condition) which in any way currently affects, or if untreated could affect, your ability to practice in a competent and professional manner?  N
If yes, please explain:
Within the past year, have you ever raised the issue of consumption of drugs or alcohol or the issue of a mental, emotional, nervous, or behavioral disorder or condition as a defense, mitigation, or explanation for your actions in the course of any administrative or judicial proceeding or investigation; any inquiry or other proceeding; or any proposed termination by an educational institution, employer, government agency, professional organization or licensing authority?  N
If yes, please explain:
Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism? N
Jan 5, 2012 3:04 PM

:

f yes, please explain:
Are you currently* engaged in the illegal use of controlled dangerous substances? N
f 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
Jan 5, 2012 3:04 PM

Practice Type:
Primary Hospital where you have privileges:
Are you licensed in another State:
Primary Care Information:
Are you actively engaged in clinical practice in the State of Alabama?  N
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.")  N
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.
CME Certification: I hereby certify that I have met the annual minimum continuing education requirement of 24 hours of Categor I continuing medical education within the past two Calendar Years ending December 31, 2003. Y
I certify that I am exempt from the minimum CME requirement.
Jan 5, 2012 3:04 PM

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

Practice Telephone: 2055562026

Practice Address:

535 JACK WARNER PKWY

### RENEW ONLINE AT http://renewal.albme.org

License Renewal for 2004

Deadline is December 31, 2003

Registration ID: 181855

State of Alabama
Medical Licensure Commission

334/242-4153

P.O. Box 887

Montgomery, Alubama 36101-0887



OVER

LOUIS THOMASON PAYNE, M.D. 535 JACK WARNER PKWY SUITE 1 TUSCALOOSA, AL 35404-5715 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	e: MD . 00003505 Date-lasued: 08/05/1965 Sex: M[X] F[]
Race: White [X] Black [] American Indian []	Oriental or Asian [ ] Other [ ] Social Security# 416-50-6306
Office Address	Home Address
535 JACK WARNER PKWY SUITE 1	57 THE DOWNS
City, State, Zlp: TUSCALOOSA, AL 35404-5715	City, State, Zip: TUSCALOOSA, AL 35401-5843
(Alabama) County: Tuscaloosa	(Alabama) County: Tuscaloosa
Business Phone: (205) 556-2026	Home Phone: (205) 345-4288 (Will not be published)
Fax Number: (205) 554-0584	
Permission to publish in Roster: Yes [ X ]	Send official mail to: Business [ ] address (check one)
Specialty: Primary: GYNECOLOGY (Ob/Gyn)	Home [ ]  Board Certified; Yes iv No [
Secondary:	Board Certified: Yes iv No [ ]
Form of Practice: [ Solo [ ] Partnership (2, 3, or 4)	[ ] Group If Group give Group Name below:
Primary Hospital where you have staff privileges:	/
Name: Druid City Regional Medical Center  Are you licensed in another state: Yes [秦]	City/State: Tuscaloosa, AL  No 1 Which ones: [ ] [ ] [ ] [ ] [ ]
And you need the amount of state. The [20]	NO P 3 VANICATIONES. [ ] [ ] [ ] [ ] [ ]
Primary Care Information:	
<ol> <li>Are you actively engaged in clinical practice in the</li> </ol>	State of Alabama?
Yes [X] Go to Question 2 No [ ] Do No	OT answer questions 2 and 3 below. Skip to CME Certification questions.  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.")	• •
Yes [ ] Ga to Question 3 No [ ] Do NO	T answer question 3 below. Skip to the CME Certification questions.
<ol> <li>Approximately how many hours per week do you Answered YES to questions 1 and 2 above. Approxim</li> </ol>	practice the above-defined primary care services in Alabama? Only answer if you nately:  hours per week.
CMF Certification: (Check one)  [-] I hereby certify that I have met the annual minimum cor	addressing and constant and are and all the constants of the constant of the constants of the constant of the constants of the constant
continuing medical education within the past two calend	turning education requirement of 24 hours of Category (
[ ] I certify that I am exempt from the minimum continuing	medical education requirements for the following reason:
[ ] 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     I reinstated my license to practice medicine in the S	Alabama after June 30" of this calendar year. State of Alabama after June 30 <sup>th</sup> of this calendar year.
I am a resident physician enrolled in a residency tra	sining program.
	obtained a waiver from the Board of Medical Examiners.
DEADLIN	TE IS DECEMBER 31, 2003

MD. QQQAFFFete both sides including signature. Supply or correct ANNIA SUPPLY AND ASON

### REKEW ONLINE AT http://renewal.albme.org

License Renewal for 2005 Deadline is December 31, 2004 Registration ID: 181855

State of Alabama Medical Licensure Commission

334/242-4153

P.O. Box 887

Montgomery, Alabama 36101-0887



LOUIS THOMASON PAYNE, M.D. 535 JACK WARNER PKWY SUITE 1 TUSCALOOSA. AL 35404-5715

Complete BOTH sides including signature. Be sure to correct or supply ALL information. Return with \$200.00 renewal fcc. 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 esteopathy.

Please make corrections or supply information: License: N	ID . 00003505 Date-Issued: 08/05/1965 Sex: M [X ] F [ ]
Race: White [X] Black [] American Indian []	Oriental or Asian [ ] Other [ ] Social Security# 416-50-6306
Office Address	Home Address
535 JACK WARNER PKWY SUITE 1	57 THE DOWNS
City, State, Zip: TUSCALOOSA, AL 35404-5715	City, State, Zip: TUSCALOOSA, AL 35401-5843
(Alabama) County: Tuscaloosa	(Alabama) County: Tuscaloosa
Business Phone: (205) 556-2026	Home Phone: (205) 345-4288 (Will not be published)
Fax Number: (205) 554-0584 Permission to publish in Roster: Yes [ X ]	Send official mail to: Business [X] Home [ ] Address (Check One)
Specialty: Primary: GYNECOLOGY (Ob/Gyn) Secondary: Form of Practice: [X] Solo [ ] Partnership (2, 3, or 4) [	Board Certified: Yes [ ] No [ ]  Board Certified: Yes [ ] No [ ]  Group If Group give Group Name below:
Primary Hospital where you have staff privileges: Name: Druid City Regional Medical Center	City/State: Tuscaloosa,
Are you licensed in another state: Yes [-X] No [X]	Which ones: [ ] [ ] [ ] [ ]
<ol> <li>Does your practice include the delivery of primary care med 'gatekeeper' health care focused on the point at such a patient is care situation.")</li> <li>Yes [ ] Go to Question 3 No [X] Do NOT answer</li> </ol>	Alabama? (Check One)  questions 2 and 3 below. Skip to CME Certification questions.  dical services in Alabama? (Primary care is defined as: "Basic or general deally first seeks assistance from the medical care system, exclusive of an emergancy question 3 below. Skip to the CME Certification questions.  e above-defined primary care services in Alabama? Only answer if you hours per week.
education for the calendar year 2004.	tinuing education requirement of 12 hours of Category I continuing medical nedical education requirement for the following reason (Check One):
I received my initial license to practice medicine in Alabama in the	year 2003 and I moved my residence to the State of Alabama during calendar year 2004. calendar year 2004. miners, and I do not engage in the practice of medicine in any form.  to illness, disability or other hardship condition which existed in the calendar year 2004.
DEADLINE	IS DECEMBER 31, 2004

MD . 00003505

PAYNE, LOUIS THOMASON

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?	[]	[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?	[]	H
3.	Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practice, within the past year?	[]	[4]
4.	Have you been denied a certificate of qualification or license to practice medicine in any state or has your application for a certificate of qualification or license to practice medicine been withdrawn under threat of denial within the past year?	[]	[7
5.	Have you had a judgement rendered against you, or action settled relating to the performance of your professional service within the past year?	[]	И
6.	To your knowledge, are you the subject of an investigation, or has a formal complaint against your license been filed by uny licensing Board/Agency as of the date of this application within the past year?	[]	Н
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?	Н	Ϊď
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?	[]	H
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?	[]	iT
10.	Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism?	[]	H
11.	Are you currently engaged in the illegal use of controlled dangerous substances?	[]	17
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!	<i>!</i> []	[]
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?	[]	[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?	[]	1
	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.		
ii YO WITII	OU HAVE ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, PLUASE ATTACH A DETAILED EXPLANATED YOUR APPLICATION UPON RETURNING IT TO THIS OFFICE.	ION	
certify	y that all information on this form is correct.  Signature  Date	104	•

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

### RENEW ONLINE AT http://renewal.albme.org

Registration ID: 181855

License Renewal for 2006 Deadline is December 31, 2005 State of Alabama Medical Licensure Commission

334/242-4153

P.O. Box 887

Montgomery, Alabama 36101-0887



LOUIS THOMASON PAYNE, M.D. 535 JACK WARNER PKWY SUITE 1 TUSCALOOSA, AL 35404-5715

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 ostcopathy.

Please make corre	ctions or sup	ply information:	License	. MD . 00003	505	Date-Issued: 0	8/05/1965	Sex: M[X]	F[]
Race: White [X]	Black [ ]	American India	n[]	Oriental or Asi	an[]	Other[]	Social S	ecurity# <u>416-50-</u>	<u>6306</u>
Office Address						Ho	me Addres	15	
535 JACK WARNER SUITE 1	RPKWY						57 TI+	IE DOWNS	
City, State, Zip: TUS	CALOOSA, A	L 35404-5715			City	, State, Zip: TUSC	CALOOSA,	AL 35401-5843	
(Alabama) County:	Tuscaloosa			(Alai	zeme) C	ounty: Tuecaloos	8		
Business Phone: (2	05) 556-2026			Hom	e Phone	: (205) 345-4288	(Will not b	e published)	
Fax Number: (205): Permission	554-0584 to publish in	Roster: Yes [X]		Send official	nail to: B	Business [X] H	ome [	] Address (Ched	xk One)
Specialty: Primary: Secondary: Form of Practice: [			or 4)	[] Group If G		ard Certified: Yes a Group Name be	[X] No [	d Certified: Yes ]	[] No[
Primary Hospital wi Name: Druid City R	ere you have	staff privileges:				/State: Tuscaloos		1	
Are you licensed in	another state:	Yea [ X ]	No	K	Wh	nich ones: [ ] [	1 [ ] [	][]	
Yes [ X 2. Does you 'gatekeeper' he care situation." Yes [ 3. Approxims	tively engaged  ] Go to Queatly practice included paith care focus  )  Go to Question  tely how many	e the delivery of primed on the point at suc	NOT and any care on a particular of the particul	swer questions 2 at medical services in ent ideally first seel ower question 3 bek ice the above-define	id 3 belov : Alabama s assistar w. Skip t d primary	nce from the medica to the CMF Certifica	iefined as: "B il care system tion question	lanic or general n, exclusive of an ( s.	емегрепсу
a di casian fi	y certify that I h	lave met the annual r year 2005. npt from the minimum							
[ ] i received my init	n the CME requi at license to pra- retirement wait waker from the	strement for the previous actice medicine in Ala ver from the Board of a Board of Medical Fi	bus cale barna ir Medica kaminac	ndar year 2004 and I the calendar year i I Examiners, and I d Is due to liness, dist	i moved ( 1905. o not eng bility or o	my residence to the age in the practice ( ther hardship condi	state of Anic of medicine in ion which exi	n any form.	

**DEADLINE IS DECEMBER 31, 2005** 

MD . 00003505

PAYNE, LOUIS THOMASON

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

**OVER** 

		Yes	No
ι.	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?	[]	<b>[21</b> ]
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]	×
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?	[]	X
6.	To your knowledge, are you the subject of an investigation, or has a formal complaint against your license been filed by any licensing Board/Agency as of the date of this application within the past year?	[]	KI
7.	Within the past year, have you been diagnosed with or have you been treated for bi-polar disorder, schizophrenia, paramoia, or any other psychotic disorder?	[]	<i>[</i> 8]
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?	[]	81
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?		.44
	educational institution, employer, government agency, professional organization or ricensing authority?	11	JY1
10.	Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism?		×
11.	Are you currently engaged in the illegal use of controlled dangerous substances?	[]	W
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?	[]	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?	[]	<b>X</b> I
	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 YC	OU HAVE ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, PLEASE ATTACH A DETAILED EXPLANATION UPON RETURNING IT TO BUS OFFICE.	ION	
certif	fy that all information on this form is correct.	% a	5

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

		Yes	No
	Have you been convicted of a felony or of any offense (felony/misdemeanor) involving the practice of medicine within the past year?		
2.	Has your certificate of qualification or license to practice medicine in any state been suspended, revoked, restricted, curtailed or voluntarily surrendered under threat of suspension or revocation within the past year?	0	
	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?		
	Are you now or have you been addicted to the use of alcohol or controlled substances within the past year?	. 🗆	
	Have you been diagnosed and/or treated for a mental illness and/or serious physical illness?		
	Have you had a judgement rendered against you, or action settled relating to the performance of your professional service within the past year?		
8.	To your knowledge, are you the subject of an investigation by any licensing Board/Agency as of the date of this application within the past year?		
	IF YOU HAVE ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, PLEA ATTACH A DETAILED EXPLANATION WITH YOUR APPLICATION UPON RETURNING IT TO THIS OFFICE.	3E	
I	certify that all information on this form)s correct.	16-95 Date	
-	Signature	Pare	
	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		

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

Incomplete applications will be returned.

The state of the s

Return with \$100.00 renewal fee to:

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

### License Renewal for 1997 Deadline is December 31, 1996

### State of Alabama Medical Licensure Commission

334/242-4153

P.O. Box 887



Montgomery, Alabama 36101-0887

Complete BOTH sides including signature.

Be sure to correct or supply ALL information.

Return with \$100.00 renewal fee.

Incomplete applications will be returned.

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

LOUIS THOMASON PAYNE, M.D. 1788 MCFARLAND BLVD N TUSCALOOSA AL 35406-2136

Picase make corrections or supply information: Licens	e 3505 DATE-ISSUED: 08/05/65 Sex: M [X] F []
Race: White (K) Black [.] Am: Indian [.] Oriental or Asian [.] O	ther [_] — Social Security #_416-50-6306
Office Address:	Home Address:
535 River Road, Suite I	57 THE DOWNS
City, State, Zip: TUSCALOOSA, AL-344669199	City, State, Zip: TUSCALOOSA, AL 35401 5843
(Alabama) County: Tusosloosa	(Alabama) County: Tuscalcosa
Business Phone: (205)346-2210 556 2626	Home Phone: (205)345-4288
Fax Number: (205)346-2115 205 5540584	(Will not be published)
Permission to publish in Roster: Yes [X] No [_]	Send official mail to: Business (check one)  Home
Speciality: Primary: GRAMMINGS & GYNECOLOGY	Board Certified: Yes Mo [_]
Secondary:	Board Certified: Yes [] No []
Form of Practice: Solo Francisco (2, 3, or 4) Group (5 or	more) If Group, give name below:
OR GOLLEGE THE MEDESA West Alchen	2 WOMEN'S CENTER, INC.
Primary Hospital where you have staff privileges:	
Name: DCH REGIONAL MED CTR	City/State: TUSCALOOSA, AL
Are you licensed in another state: Yes [ ] No [X] Which ones [ ]	
CME Certification: (Check one)	
I hereby certify that I have met the annual minimum continuing ed continuing medical education during the calendar year ending Dece	nucation requirement of 12 hours of Category I smber 31, 1996.
[] I certify that I am exempt from the minimum continuing medical e	ducation requirement for the following reason:
☐ I do not reside in the State of Alabama and do not have a significal I received my initial license to practice medicine in Alabama after ☐ I reinstated my license to practice medicine in the State of Alabama if I am a resident physician enrolled in a residency training program ☐ I am retired from the practice of medicine and have obtained a we Complete both sides including signature. Supply or	er June 30th of this calendar year. una after June 30th of this calendar year. un. vaiver from the Board of Medical Examiners.

**DEADLINE IS DECEMBER 31, 1996** 

### License Renewal for 1998 Deadline is December 31, 1997

### State of Alabama Medical Licensure Commission

334/242-4153

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



LOUIS THOMASON PAYNE , M.D. 17
STE I 73
535 RIVER RD NE 4952
TUSCALOOSA, AL 35404-5715

Complete BOTH sides including signature.

Be sure to correct or supply ALL information.

Return with \$100.00 renewal fee.

Incomplete applications will be returned.

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

Please make corrections or supply information: Lice Race: White [X] Black [_j Am. Indian [_] Oriental or Asian	nse 3505 DATE-ISSUED: 8/5/65 Sex: M [X] F [_]
Office Address:	Home Address:
STE I	57 THE DOWNS
535 RIVER RD	
City, State, Zip: TUSCALOOSA, AL 35404	City, State, Zip: TUSCALOOSA, AL 35401 5843
(Alabama) County: Tuscaloosa	(Alabama) County: Tuscaloosa
Business Phone: (205)556-2026	Home Phone: (205)345-4288
Fax Number: (205)554-0584	(Will not be published)
Permission to publish in Roster: Yes [X] No [_]	Send official mail to: Business [X] address (check one)  Home []
Specialty: Primary: ODG TOTAL & GYNECOLOGY Secondary:	Board Certified: Yes M No [_] Board Certified: Yes [_] No [_]
Form of Practice: [X] Solo [] Partnership (2, 3, or 4) [] G. W. AL. WOMEN'S CENTER INC.	roup (5 or more) If Group, give name below:
Primary Hospital where you have staff privileges: Name: DCH REGIONAL MED CTR Are you licensed in another state: Yes [ ] No [X] which one Primary Care Information:  1. Are you actively engaged in clinical practice? (Check one): Yes 2. Does your practice include the delivery of primary care medical care focused on the point at which a patient ideally first seeks as room care."): (Check one): Yes [ ] No [X]  3. Approximately how many hours per week do you practice the ab CME Certification: (Check one) [X] I hereby certify that I have met the annual minimum continuing e continuing medical education during the calendar year ending De [ ] I certify that I am exempt from the minimum continuing medical  [ ] I do not reside in the State of Alabama and do not have a signification of the process of the state of Alabama aft [ ] I received my initial license to practice medicine in the State of Alabama aft [ ] I am a resident physician enrolled in a residency training program	services? (Primary care is defined as: "Basic or general health sistance from the medical care system, exclusive of emergency cove-defined primary care services?  Education requirement of 12 hours of Category I becember 31, 1997.  Education requirements for the following reason:  Cant portion of my medical practice in Alabama.  Early June 30th of this calendar year.  The services of the following reason:  The services of the following reason:
[ ] I am retired from the practice of medicine and have obtained a v	valver from the Board of Medical Examiners.

### Lecense Renewal for 1999 Deadline is December 31, 1998

### State of Alabama Medical Licensure Commission

334/242-4153

P.O. Box 887

29

5179

Montgomery, Alabama 36101-9887



LOUIS THOMASON PAYNE, M.D.
STE I
535 RIVER RD NE
TUSCALOOSA AL 35404-5715

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.

STE I 57 THE DOWNS  City, State, Zip: TUSCALOOSA, AL 35401 5843  (Alabama) County: Tuscaloosa (Alabama) County: Tuscaloosa  Business Phone: (205)556-2026 Home Phone: (205)345-4288  Fax Number: (205)554-0584 (Will not be published)  Permission to publish in Roster: Yes [X] No Send official mail to: Business Jaddress (check one)  Home []  Specialty: Primary: Secondary: Board Certified: Yes No Secondary: Board Certified:
City, State, Zip: TUSCALOOSA, AL 35404  City, State, Zip: TUSCALOOSA, AL 35401 5843  (Alabama) County: Tuscaloosa  Business Phone: (205)556-2026  Home Phone: (205)345-4288  Fax Number: (205)554-0584  Permission to publish in Roster: Yes [X] No [] Send official mail to: Business [] address (check one) Home []  Specialty: Primary: Secondary:
City, State, Zip: TUSCALOOSA, AL 35401 5843  (Alabama) County: Tuscaloosa  Business Phone: (205)556-2026
(Alabama) County: Tuscaloosa  Business Phone: (205)556-2026  Home Phone: (205)345-4288  Fax Number: (205)554-0584  (Will not be published)  Permission to publish in Roster: Yes [X] No [
Business Phone: (205)556-2026  Fax Number: (205)554-0584  Permission to publish in Roster: Yes [X] No [
Permission to publish in Roster: Yes [X] No Send official mail to: Business [ address (check one) Home [ ]  Specialty: Primary: Secondary: GYNECOLOG( 29.10)  Secondary: Board Certified: Yes [ No [ ]  Form of Practice: [X] Solo[ ] Partnership (2, 3, or 4) [ ] Group (5 or more) If Group, give name below:  W. AL. WOMEN'S CENTER INC.  Primary Hospital where you have staff privileges:  Name: DCH REGIONAL MED CTR City/State: TUSCALOOSA, AL  Are you licensed in another state: Yes [ ] No [X] which ones: [ ] [ ] [ ] [ ]  Primary Care Information:  1. Are you actively engaged in clinical practice? (Check one): Yes [ ] No [ ]  2. Does your practice include the delivery of primary care medical services? (Primary care is defined as: "Basic or general health care focused on the point at which a patient ideally first seeks assistance from the medical care system, exclusive of emergency room care,"): (Check one): Yes [ ] No [ ]
Permission to publish in Roster: Yes [X] No [ ] Send official mail to: Business [ ] address (check one)  Home [ ]  Specialty: Primary: Secondary: Board Certified: Yes [ ] No [ ]  Form of Practice: [X] Solo [ ] Partnership (2, 3, or 4) [ ] Group (5 or more) If Group, give name below:  W. AL. WOMEN'S CENTER INC.  Primary Hospital where you have staff privileges:  Name: DCH REGIONAL MED CTR City/State: TUSCALOOSA, AL  Are you licensed in another state: Yes [ ] No [X ] which ones: [ ] [ ] [ ] [ ]  Primary Care Information:  1. Are you actively engaged in clinical practice? (Check one): Yes [ ] No [ ]  2. Does your practice include the delivery of primary care medical services? (Primary care is defined as: "Basic or general health care focused on the point at which a patient ideally first seeks assistance from the medical care system, exclusive of emergency room care."): (Check one): Yes [ ] No [ ]
Specialty: Primary: Secondary: GYNECOLOG (29.10)  Secondary: Board Certified: Yes [ No [ ] Form of Practice: [ X] Solo[ ] Partnership (2, 3, or 4) [ ] Group (5 or more) If Group, give name below: W. AL. WOMEN'S CENTER INC.  Primary Hospital where you have staff privileges: Name: DCH REGIONAL MED CTR City/State: TUSCALOOSA, AL.  Are you licensed in another state: Yes [ ] No [X] which ones: [ ] [ ] [ ] [ ]  Primary Care Information:  1. Are you actively engaged in clinical practice? (Check one): Yes [ ] No [ ]  2. Does your practice include the delivery of primary care medical services? (Primary care is defined as: "Basic or general health care focused on the point at which a patient ideally first seeks assistance from the medical care system, exclusive of emergency room care."): (Check one): Yes [ ] No [ ]
Secondary:  Secondary:  Secondary:  Board Certified: Yes [ No [ ]  Form of Practice: [ X] Solo[ ] Partnership (2, 3, or 4) [ ] Group (5 or more) If Group, give name below:  W. AL. WOMEN'S CENTER INC.  Primary Hospital where you have staff privileges:  Name: DCH REGIONAL MED CTR City/State: TUSCALOOSA, AL  Are you licensed in another state: Yes [ ] No [X] which ones: [ ] [ ] [ ] [ ]  Primary Care Information:  1. Are you actively engaged in clinical practice? (Check one): Yes [ ] No [ ]  2. Does your practice include the delivery of primary care medical services? (Primary care is defined as: "Basic or general health care focused on the point at which a patient ideally first seeks assistance from the medical care system, exclusive of emergency room care."): (Check one): Yes [ ] No [ ]
Name: DCH REGIONAL MED CTR City/State: TUSCALOOSA, AL  Are you licensed in another state: Yes [ ] No [X ] which ones: [ ] [ ] [ ] [ ]  Primary Care Information:  1. Are you actively engaged in clinical practice? (Check one): Yes [ ] No [ ]  2. Does your practice include the delivery of primary care medical services? (Primary care is defined as: "Basic or general health care focused on the point at which a patient ideally first seeks assistance from the medical care system, exclusive of emergency room care."): (Check one): Yes [ ] No [ ]
<ul> <li>3. Approximately how many hours per week do you practice the above-defined primary care services?</li> <li>CME Certification: (Check one)</li> <li>[1] 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.</li> <li>[2] I certify that I am exempt from the minimum continuing medical education requirements for the following reason:</li> <li>[3] I do not reside in the State of Alabama and do not have a significant portion of my medical practice in Alabama.</li> <li>[4] I received my initial license to practice medicine in Alabama after June 30th of this calendar year.</li> <li>[5] I reinstated my license to practice medicine in the State of Alabama after June 30th of this calendar year.</li> <li>[6] I am a resident physician enrolled in a residency training program.</li> <li>[7] I am retired from the practice of medicine and have obtained a waiver from the Board of Medical Examiners.</li> </ul>

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

**OVER** 

### License Renewal for 2000 Deadline is December 31, 1999

State of Alabama Medical Licensure Commission

334/242-4153

**57** 

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



LOUIS THOMASON PAYNE, M.D. STE I 535 RIVER RD TUSCALOOSA, AL 35404 Complete BOTH sides including signature.

Be sure to correct or supply ALL information.

Return with \$100.00 renswal 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: L	icense 3505 DATE-ISSUED: 8/5/65 Sex: M [X] F []
Race: White [X] Black [ ] Am. Indian [ ] Oriental or As	sian [ Other [ Social Security # 416-50-6306
Office Address:	Home Address:
STELL:	57 THE DOWNS
535 RIVER TO JACK WARNER PKWY	
City, State, Zip: TUSCALOOSA, AL 35404 5715	City, State, Zip: TUSCALOOSA, AL 35401 5843
(Alabama) County: Tuscaloosa	(Alabama) County: Tuscaloosa
Business Phone: (205)556-2026	Home Phone: (205)345-4288
Fax Number: (205)554-0584	(Will not be published)
Permission to publish in Roster: Yes [X] No []	Send official mail to: Business [   address (check one)   Home [ ]
Specialty: Primary: GYNECOLOGY (Ob/Gyz)	Board Certified: Yes [ No [ ]
Secondary:	Board Certified: Yes   No
Form of Practice: [X] Solo [] Partnership (2, 3, or 4) [ W: AL. WOMEN'S CENTER INC.	Group (5 or more) If Group, give name below:
Primary Hospital where you have staff privileges: Name: DCH REGIONAL MED CTR City/State: TUSCA Are you licensed in another state: Yes [ ] No [X ] which	ALOOSA, AL
Primary Care Information:  1 Are you actively engaged in clinical practice in the State of A	
Yes Li Go to Question 2 No 1 Do NOT answer quest	tions 2 and 3 below. Skip to CME Certification questions.
2. Does your practice include the delivery of primary care median 2 parties a patient id	ical services in Alabama? (Primary care is defined as: "Basic or general deally first seeks assistance from the medical care system, exclusive of a
emergency care situation.")	
Yes [] Go to Question 3 No [] Do NOT answer quest	tion 3 below. Skip to CME Certification questions. the above-defined primary care services in Alabama? Only answer if you
	10 hours per week.
CME Certification: (Check one)	the desired and the second of 12 house of Cotonomi I
Thereby certify that I have met the annual minimum continui continuing medical education during the calendar year ending	ing education requirement of 12 hours of Category 1  December 31, 1999.
I I certify that I am exempt from the minimum continuing med	dical education requirements for the following reason:
45.11 I do not reside in the State of Alabama and do not have a sign	enificant portion of my medical practice in Alabama.
[] I received my initial license to practice medicine in Alabama [] I reinstated my license to practice medicine in the State of A	a arrer June 30" or uns calendar year. Mabama after June 30 <sup>th</sup> of this calendar year.
I I am a resident physician enrolled in a residency training pro	ogram.
1 I am retired from the practice of medicine and have obtained	d a waiver from the Board of Medical Examiners.  DECEMBER 31, 1999
Complete both sides including signature. Supply	y or correct all information. OVER
License #3505	13318 PAYNE, LOUIS THOMASON

### License Renewal for 2001 Deadline is December 31, 2000

State of Alabama Medical Licensure Commission 23

334/242-4153

P.O. Box 887

Montgomery, Alabama 36101-0887



\*AUTO\*\*3-DIGIT 354 LOUIS THOMASON PAYNE, M.D. 535 JACK WARNER PKWY NE STE 1 TUSCALOOSA, AL 35404-5751

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

27

Incomplete applications will be returned. Failure to register and pay renewal fee will result 5489

in the automatic revocation of the current license to

	ँ विकास सिन्द्रां स्वासिक स्वास	practice medicine or osteopathy.
	Please make corrections or supply information: I Race: White [X] Black [ Am. Indian [ Oriental or A	
<u>.                                    </u>	Office Address:	Home Address:
	SUTTE 1	57 THE DOWNS
- / <del></del>	535 JACK WARNER PKWY	
	City, State, Zip: TUSCALOOSA, AL 35404 5715	City, State, Zip: TUSCALOOSA, AL 35401 5843
. 7	(Alabama) County: Tusculoosa	(Alabama) County: Tuscaloosa
ήĀ	Business Phone: (205)556-2026	Home Phone: (205)345-4288
- <u>2</u>	Fax Number: (205)554-0584	(Will not be published)
	Permission to publish in Roster: Yes [X] No [_]	Send official mail to: Business [X] address (check one)  Home []
	Specialty: Primary: GYNECOLOGY (Ob/Gyr)	Board Certified: Yes 🔀 No 📋
	Secondary:	Board Certified: Yes [ ] No [ ]
	Form of Practice: [X] Solo [] Partnership (2, 3, or 4) [ W. AL. WOMEN'S CENTER INC.	] Group (5 or more) If Group, give name below:
	Primary Hospital where you have staff privileges: Name: DCH REGIONAL MED CTR City/State: TUSCA Are you licensed in another state: Yes [ ] No [X ] whice Primary Care Information:  1. Are you actively engaged in clinical practice in the State of Active Yes [X]. Go to Question 2 No [ ] Do NOT answer question.	h ones: [] [] [] [] Alabama'? tions 2 and 3 below. Skip to CME Certification questions.
		ical services in Alabama? (Primary care is defined as: "Basic or general deally first seeks assistance from the medical care system, exclusive of an
	Yes [ ] Go to Question 3 No M Do NOT answer ques	
	answered YES to questions 1 and 2 above.) Approximately  CME Certification: (Check one)	nc above-defined primary care services in Alabama? Only answer if you hours per week.
	I hereby certify that I have met the annual minimum continu continuing medical education within the past two calendar ye	
7.	[1] I certify that I am exempt from the minimum continuing med	
	[] I do not reside in the State of Alabama and do not have a significant of the state of Alabama and for the state of Alabama.	(nificant portion of my medical practice in Alabama.  a after lune 30th of this calendar wear
3	[1] I reinstated my license to practice medicine in the State of A	
3	Lam a resident physician enrolled in a residency training pro	
		DECEMBER 31, 2000
ر د د د د د د	Complete both sides including signature. Supply License #3505	or correct all information.  S489  OVER PAYNE, LOUIS THOMASON

### License Renewal for 2002 Deadline is December 31, 2001

### State of Alabama Medical Licensure Commission

334/242-4153

P.O. Box 887

Montgomery, Alahama 36101-0687



LOUIS THOMASON PAYNE, M.D. 535 JACK WARNER PKWY SUITE 1 TUSCALOOSA, AL 35404-5715 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: Licon Race: White [X] Black [] American Indian [	nsc: MD . 00003505 Date-Issued: 08/05/1965 Sex: M [ X ] F [ ] Oriental or Aslan [ ] Other [ ] Social Security# 416-50-6306
Office Address	Home Address
535 JACK WARNER PKWY	57 THE DOWNS
SUITE 1 TUSCALOOSA, AL 35404-5715	TUSCALOOSA, AL 35401-5843
(Alabama) County:	(Alabama) County:
Business Phone: (205) 556-2026	Home Phone: (205) 345-4288 (Will not be published)
Fax Number: (205) 554-0584	
Permission to publish in Roster: Yes [X]	Send official mail to:Business [ X ] address (check one)  Home [ ] address
Specialty: Primary: GYNECOLOGY (Ob/Gyn)	Board Certified: Yes [ ] No [ ] Board Certified: Yes [ ] No [ ]
Secondary:  Form of Practice: [ X ] Solo [ ] Partnership (2, 3, o	r 4) [ ] Group If Group give Group Name below:
Primary Hospital where you have staff privileges: Name: DCH REGIONAL MED CTR	City/State: TUSCALOOSA, AL
Are you licensed in another state: Yes [X] N	o Xi Which ones: [ ] [ ] [ ] [ ] [ ]
<ol><li>Does your practice include the delivery of pri 'gatekeeper' health care focused on the point at an emergency care situation.")</li></ol>	mary care medical services in Alabama? (Primary care is defined as: "Basic or general such a patient ideally first seeks assistance from the medical care system, exclusive or NOT answer question 3 below. Skip to the CME Certification questions.
continuing medical education within the past two to a continuing medical education within the past two to a continuing medical education within the past two to a continuing medical education within the past two two to a continuing medical education within the past two two two two that I continue to practice medical education within the past two two two two two two two two two tw	o not have a significant portion of my medical practice in Alabama. ine in Alabama after June 30 <sup>th</sup> of this calendar year. In the State of Alabama after June 30 <sup>th</sup> of this calendar year.
MD. offermelete both sides in clading NE 48	DECEMBER ON CROCKET all informations THOMASON OVER

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

## ALABAMA MEDICAL LICENSURE COMMISSION 908 South Hull Street, Room 110 Montgomery, Alabama 36104 Phore 205/832-6051

Every physician and oxeopeth licensed to practice medicine/oxeopethy in the State of Alabama shall, on or before the 31st day of December of each year, apply to this Commission for a Certificate of Registration which shall be effective during the calendar year.
RENEWAL FEE \$50.00 — Failure to register and pay the annual registration fee within 30 days after registration becomes due will result in the suttomatic revocation of the current license without further notice or hearing as provided in Act. No. 81-218, Code of Alabama, Section 12.

Name and Mailing Address:

LOUIS T PAYNE

1788 MCFARLAND BLVD NORTH

35406 TUSCALDOSA, AL

**Business Address:** 

1788 MCFARLAND BLVD NORTH TUSCALDOSA, AL

> 1SSUED: 08/05/65 LICENSE #: 0003505

# FOR A CERTIFICATE OF REGISTRATION TO PRACTICE MEDICINE IN ALABAMA IN 1984 ALABAMA MEDICAL LICENSURE COMMISSION Post Office Box 887 Montgomery, Alabama 36101 Phone (206) 832-5051

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

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

Name and Mailing Address: LOUIS T PAYNE

1788 MCFARLAND BLVD NORTH

35400 TUSCALODSA, AL

LICENSE #: 0005505

ISSUED: 08/05/65

Business Address;

1788 MCFARLAND BLVD NORTH 35400 TUSC ALCOSA, AL

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

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

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

1748 MCFARLAND BLVD NORTH 35400 Name and Mailing Address: LOUIS T PAYNE TUSCALOOSA, AL

1788 MCFARLAND BLVD NORTH TUSCALDOSA, AL

Business Address:

ISSUED: 08/05/65 LICENSE #: 0003505

# FOR A CERTIFICATE OF REGISTRATION TO PRACTICE MEDICINE IN ALABAMA IN 1986 ALABAMA MEDICAL LICENSURE COMMISSION Post Office Box 887 Montgomery, Alabama 35101-0887 Phone (205) 261-4153 REVEWAL APPLICATION

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

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

Name and Mailing Address: LOUIS T PAYNE

1788 MCFARLAND BLVD NORTH

35406 TUSCALBOSA, AL

LICENSE ## COCNDON

ISSUED: 08/05/65

Business Address:

1788 MCFARLAND BLVD NORTH ₩2406 TUSCALDOSA, AL

FOR A CERTIFICATE OF REGISTRATION TO PRACTICE MEDICINE IN ALABAMA IN 1987
ALABAMA MEDICAL LICENSURE COMMISSION
Post Office Box 887
Montgomery, Alabama 35101-0887
Phone (208) 281-4153

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

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

Name and Mailing Address:

1755 ACFARLAND BLVD NORTH

35405 TUSCALODSA, AL

LICENSE 4: 0003505

ISSUED: 08/95/65

1753 MCFARLAND BLVD NORTH

**Business Address:** 

35406

TUSCALDOSA, AL

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

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

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

Name and Mailing Address:

LOUIS T PAYNE ITSS NCFARLAND BLVD NORTH

004DB TUSCALDOSM\* AL

しょうほんのい 本本 いののかりのい

ISSUED# Da/OS/65

1788 MCFARLAND BLVD NORTH TUSCALGOSA, AL

Business Address:

FOR A CERTIFICATE OF REGISTRATION TO PRACTICE MEDICINE: IN ALABAMA IN 1989
ALABAMA MEDICAL LICENSURE COMMISSION
Post Office Box 887

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

Every physician and osteopath licensed to practice medicine/osteopathy in the State of Alabama shall, on or before the 31st day of December of each year, apply to this Commission for a Certificate of Registration which shall be effective during the calendar year. RENEWAL. FEE: \$50.00 --- Failure to register and pay the annual registration fee within 30 days after registration becomes due will result in the automatic revocation of the current license without further

notice or hearing as provided in § 34-24-337, Code of Alabama, (1975). Name and Mailing Address: LOUIS T PAYNE

1788 MCFARLAND BLVD NORTH 35406 TUSCALOOSA, AL

1788 MCFARLAND BLVD NORTH 35406 TUSCALOOSA, AL

**Business Address:** 

ISSUED: 08/05/65 LICENSE #: 0003505

If your addresses are different from those shown, make corrections on back: WITHIN THE PAST YEAR Heve you been convicted of a felony or of any offense (felony/misdemosnor) involving the practice of

Ñ

- ď
  - Has your certificate of Goalifications or license to practice medicine in any state been suspended;" revoked, restricted, curtailed or valuntarily surrendered under threat of suspension or revocation?
    - Nave your staff privileges at ony hospital or health care facility been revoked, suspended, curtailed, Imited or placed under conditions testricting your practice? <del>-</del>
- Have you been denied a corrificate of quelification or a license to practice medicine in any state or hes your application for a certificate of quelification or license to practice medicine been withdrawn under threat or cloim?
  - Are you now or have you been addicted to the use of alephol or controlled substances? ιά
    - Hove you been diagnosed and/or treated for a mental illness? ø
- Nave you had a judgement rendered against you, or netion suttled relating to the performance of your professional nervice? ~
  - To your knowledge, are you the subject of an investigation by any licensing Board/Agency as of the date of this cenewal application? œ

i certify that the above information is dorrect

Do Not Detach

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

Every physician and osteopath licensed to practice medicine/osteopathy in the State of Alabama shall, on or before the 31st day of December of each year, apply to this Commission for a Certificate of Registration which shall be effective during the calendar year. Montgomery, Alabama 36101--0887 Phone (205) 261--4153

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

LOUIS T PAYNE

1788 MCFARLAND BLVD NORTH 35406 TUSCALCOSA, AL

1788 MCFARLAND BLVD NORTH 35406 TUSCALCOSA, AL

> ISSUED: 08/05/65 LICENSE #: 0003505

KES

if your addresses are different from those shown, make corrections on back: WITHIN THE PAST YEAR Have you boon convicted of a felony of of any offense ifelony/misdemeanor) involving the practice of

. !

Huss your cartificate of questious and Hoense-to-precision, madicing in any state-been susponded, revoked, restricted, curtailed or voluntarily surrendered under threat of suspension or revocation?

Nave your staff privileges at any hospital or health care facility been revoked; suspended, curtailed, imited or plocod under conditions restricting your practice? ej

Have you been denied a cortificate of quelification or afficense to practice medicino in any state or has your application for a certificate of qualification or license to practice medicino been withdrawn under throat or claim? 4

Are you now or have you been addicted to the use of elcohol or controlled substances? ĸ,

Have you been diagnound and/or treated for a mental illness? 6

Have you had a judgement rendered against you, or action settled relating to the performance of your professional service? ۲.

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

certify that the above information is correct

(Do Not Detach)

FOR A CERTIFICATE OF REGISTRATION TO PRACTICE MEDICINE IN ALABAMA IN 1991
ALABAMA MEDICAL LICENSURE COMMISSION
Post Office Box 887
Montgomery, Alabama 36101-0887
Phone (205) 261-4153

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

RENEWAL FEE: \$75.00 --- Failure to register and pay the annual registration fee within 30 days after registration becomes due will result in the automatic revocation of the current license without further notice or hearing as provided in § 34-24-337, Code of Alabama, (1975). Name and Mailing Address:

1788 MCFARLAND BLVD NORTH 35406 TUSCALOOSA, AL LOUIS T PAYNE

1788 MCFARLAND BLVD NORTH 35406

Business Address:

TUSCALOOSA, AL

If your addresses are different from those shown, make corrections on back: ISSUED: 08/05/65 LICENSE #: 0003505

 Have you been convicted of a felony or of angloffense-Melony/misdemeanor! involving the practice of WITHIN THE PAST YEAR

YES

- medicing
- Haz, your cartificate of quelifications or liganse to practica madicine in any state been suspended, revokad, restricted, curtailed or voluntarily surrendered under threat of suspension or revocation? N
- Have your staff privilogus at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practica? ei
- Have you been denind a certificate of qualification or a license to practice medicine in any state or her your application for a certificate of qualification or license to practice medicine been withdrawn under threat or claim? 4
- Are you now or have you been addicted to the use of alcohol or controlled substances? ø
- Have you been diagnosed and/or treated for a mental illiness? o,
- Have you had a judgement rendered against you, or oction settled relating to the performance of your professional service? ĸ.
- To your knowledge, are you the subject of an investigation by any Reensing Board/Agency as of the date of this renewal application? ø

certify that the above information is correct

Do Not Detach)

FOR A CERTIFICATE OF REGISTRATION TO PRACTICE MEDICINE IN ALABAMA IN 1992
ALABAMA MEDICAL LICENSIRE COMMISSION
Post Office Box 887

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

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

registration becomes due will result in the automatic revocation of the current license without further notice or hearing as provided in § 34-24-337, Code of Alabama, (1975). RENEWAL FEE: \$75.00 --- Failure to register and pay the annual registration fee within 30 days after Business Address: Name and Mailing Address:

1788 MCFARLAND BLVD NORTH 35406 TUSCALOOSA, AL

1788 MCFARLAND BLVD NORTH

TUSCALCOSA, AL

ISSUED: 08/05/65 LICENSE #: 0003505

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

WITHIN THE PAST YEAR:

1. Have you been convicted of a felony or of any offense (felony/misdemesnor) involving the practice of medicine.

'n

Has your derifficate of qualifications or licenserio practice modicine in eny state been suspended, revoked, restricted, curtailed or voluntarily surrondered under threat of suspension or revocation?

Have your staff privileges at any hospitel or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practice? ci

Have you been delied a certificate of qualification or a liconse to practice modicine in any state or has your application for a certificate of qualification or liconse to practice medicine bean withdrawn under threat or claim? 4

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

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

Heva you had a judgament randered against you, or ection setticd relating to the performance of your professions! service? ۲.

To your knowledge, are you the subject of an investigation by incomeng Board/Agency as of the date of this renewal application? œ

I certify that the above information is correct

(Do Not Detach)

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

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

Name and Mailing Address LICENSE #: 0003505 ISSUED: 08/05/ LOUIS T PAYNE 1788 NCFARLAND BLVD NORTH TUSCALOOSA, AL 35406	Street 57 The Do. City Turclus	3540 / 52//5
Stat of December of each year, apply to this Con the calendar year.	nmission for a Certificate of Registration which shall be a	ffective during
registration becomes due will result in the notice or hearing as provided in § 34-24-3	iter and pay the annual registration fee within 3 a automatic revocation of the current license w 137, Code of Alabama (1975).	io days after ithout further
(Check a or b) For CME Certification	Within The Past Year:	Yes No
b) I certifiy that I am exempt from the minimum continuing medical education requirement for the following reason:  Check One Below If You Answered (b)  I do not reside in the State of Alabama and do not have a significant portion of my medical practice in Alabama.  I received my initial license to practice medicine in Alabama after June 30th of this calendar year.	<ol> <li>Have you been convicted of a felony or of any offense (felony/misdemeanor) involving the practice of medicine?</li> <li>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?</li> <li>Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practice?</li> <li>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?</li> <li>Are you now or have you been addicted to the use of alcohol or controlled substances?</li> </ol>	
medicine in the State of Alabama after June 30th of this calendar year.	Have you been diagnosed and/or treated for a mental illness and/or serious physical illness?	
medicine and have obtained a weiver from the Board of Medical Examiners.	7. Have you had a judgement rendered against you, or action settled relating to the performance of your professional service?	
residency training program.	8. To your knowledge, are you the subject of an investigation by any licensing Board/Agency as of the date of this application?	/
I certify that all information on this form i	Cimeran	//- 9'-9 2_ Date

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

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

Address
iling
& Ma
Name &

Make address corrections in (4) below;

LICENSE #: 0000350S ISSUED: 8/05/1965

PAYNE LOUIS THOMASON 1788 MCFARLAND BLV

TUSCAL005A 35401~

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

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

## (Check a or b) For CME Certification

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

I certify that all information on this form is correct

# Within The Past Year:

£

Yes

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- 1. Have you been convicted of a felony or of any offense (felony/misdemeanor) involving the practice of medicine?
  - 2. Has your certificate of qualification or license to practice medicine in any state been suspended, revoked, restricted, curtailed or voluntarity surrandered under threat of suspension or revocation?
    - 3. Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practice?

Ø

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

Signature Tit Holy Line

11-1-63

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



LOUIS THOMASON PAYNE, M.D. 1788 MCFARLAND BLV

TUSCALOOSA, AL 35401

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: Li	cense # 00003505 Sex: M [X] F[_]
Race: White [X] Black [_] Am. Indian [_] Oriental or Asian [	Other   Social Security # 416-50-6306
Office Address:	Home Address:
1788 MCFARLAND BLV	57 THE DOWNS
City, State, Zip: TUSCALOOSA, AL 35401	City, State, Zip: TUSCALOOSA, AL 35401
County: Tuscaloosa	County: Tuscaloosa
Business Phone: (205)345-2110	Home Phone: (205)345-4288
Fax Number: (205)345-2115	(Will not be published)
Permission to publish in Roster: Yes [X] No []	Send official mail to Business or Home address (circle one)
Specialty: Primary: 0 B - G yr	Board Certified: Yes [X] No []
Secondary:	Board Certified: Yes [ ] No [X]
	5 or more) If Group, give name:
	4 ' 9
Primary Hospital where you have staff privileges:	
Name: DCH REGIONAL MED CTR	City/State: TUSCALOOSA , AL
Are you licensed in another state: Yes [ ] No [X] Which on	es: [ ] [ ] [ _ ( [ ] [ ]
CME Certification: (Check one)	•
I hereby certify that I have met the annual minimum continumedical education during the calendar year ending December	
[] I certify that I am exempt from the minimum continuing mea	tical education requirement for the following reason:
[] I do not reside in the State of Alabama and do not have a s [] I received my initial license to practice medicine in Alabam [] I reinstated my license to practice medicine in the State of [] I am a resident physician enrolled in a residency training p [] I am retired from the practice of medicine and have obtains	na after June 30th of this calendar year. Alabama after June 30th of this calendar year. rogram.

### License Renewal for 1996 Deadline is December 31, 1995

State of Alabama Medical Licensure Commission

334/242-4153

P.O. Box 887

Montgomery, Alabama 36101-0687



Louis Thomason Payne , M.D. 1788 McFarland Blvd N

\*\*CAR-RT-SORT\*\*C053

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.

Tuscaloosa, AL 35406 2136

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Please make corrections or supply information: Li Race: White [X] Black [ ] Am. Indian [ ] Oriental or Asian	Cense 5005 DATE ISSUED 08/05/196 Sex: M [X] FL
Office Address:	Home Address:
1788 MCFARLAND BLVD N	57 THE DOWNS
City, State, Zip: TUSCALOOSA, AL 35406 2199  (Alabama) County: Tuscaloosa  Business Phone: (205)345-2110  Fax Number: (205)345-2115  Permission to publish in Roster: Yes [X] No [_]  Specialty: Primary: OBSTETRICS & GYNECOLOGY  Secondary:  Form of Practice: [] Solo [] Partnership (2(3)or 4) [] Group OB-6ya	Board Coddings, 165 El No.
Name: DCH REGIONAL MED CTR  Are you licensed in another state: Yes [_] No [X] Which o	City/State: TUSCALOOSA, AL
CME Certification: (Check one)  I hereby certify that I have met the annual minimum continued medical education during the calendar year ending Decemend of the certify that I am exempt from the minimum continuing medical education in the State of Alabama and do not have a line of the certify in the State of Alabama and do not have a line of the certify in the state of the certify in the state of the certification in the certifica	edical education requirement for the following reason: a significant portion of my medical practice in Alabama, ma after June 30th of this calendar year, of Alabama after June 30th of this calendar year.
Complete both sides including signature. Supply or c	

### 2007 Medical License Renewal Application Deadline: December 31, 2006

Renew online @ http://alrenewals.org

Registration ID: 181855	
Use Only for Change of Mailing Address	;

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

Louis Thomason Payne, MD 535 JACK WARNER PKWY SUITE 1 TUSCALOOSA, Alabama 35404-5715

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

vill Result in the Automatic Revocation of the Current License to Practice Medicine or Osteopathy F

ailure to Renew this License will Resu	It in the Automatic Re	vocation of the Current	License to Practice	Medicine or Osteopatriy
				Issue Date: 08/05/1965
License#: MD.3505			Home Address	
Office Address				
TOT LACK WADNED DKWY			57 THE DOWNS	Johanna 25401-5843
535 JACK WARNER PKWY SUITE 1			TUSCALOUSA, A	labama 35401-5843
TUSCALOOSA, Alabama 35404-5	5715 #-	(005) 554 0594	Home Phone: (205	) 345-4288
Work Telephone: (205) 556-2026	rax #:	(205) 554-0584		
Primary Specialty: GYNECOLOGY Secondary Specialty:			Board Certified: Yes Board Certified: Yes	s[ ] No[ ]
Form of Provideor I 1 Resident I 1 Intern	[ ] Fellowship [X] Solo	Partnership (2, 3, or	4) [ ] Group (Name) (Name) (V-5	t Ala Womens Carter
Primary Hospital where you have staff	f privileges: Name: Dru	id City Regional Medica	Ca Ony/Outro-1400	
Are you ilcensed in another state: Y	es [ ] No	[X] W		11111
		Nabema?	Tuck	Yes, Answer Questions 2 through 7 Ng, Answer Question 2 only
Are you actively engaged in clinica     What is your principal county of proof other county(ies) of practice? (Ind.)	actice? (Indicate state if p	rincipal county is not in Ala not in Alabama):	bame) 195	
Check "None" if you only practice i  3. Do you have a current collaborativ	in the indicated principal or re agreement with a nurse	county. practitioner or midwife?	į X	None Yes, Answer Questions 3a through 7 No, Answer Questions 4 through 7 Yes [ ] No
3a. Does the nurse practitioner/mi 3b. Are you employed by the nurs	e hi extronomination	· •	1 1	Yes [ ]No
the nurse practitioner/midwife'  Do you currently conduct office be analgesia/sedation, general anest		administration of perentent ock anesthesia?	al medication for	Yes [ ] No
Primary Care Information Primary care is defined as: Basic or gene	ral health care focused or	n the point at which a patier	nt ideally first seeks assi	stance from the medical care system,
exclusive of an emergency situation.	ud adament nord mor	tical services in Alabama?	ι	Yes, Answer Questions 6 and 7
5. Does your practice include the de	Mivery of primary care med	alogi gor vidos ir i deciment	X) EmedalA ni seciones econ	No, Do not answer Questions 6 and 7
Approximately how many hours p     Approximatelyhours ;	er week do you practice t er week.	ne above detined primary v	t touch ing the ob	
7. Approximately how many patient defined primary care services in /		al, ER, etc.) per week do y encounters (	ou nave involving the ab per week.	O46
CME Certification: (Check one)  (a)	e met the annual minimum	n continuing education requing documentation if audited	irement of 12 hours of C 1. uirement for the following	ategory i continuing medical greason (Check One):
(b) [ ] I certify that I am exempt	MON RIGHT HARMAN COLORS		Oloho m	f Alabama
The second my initial license in Draci	ce medicine in Alabama in from the Board of Medica	n the calendar year 2006.  Examiners, and I do not a	ingage in the practice of	medicine in any form. n which existed in the calendar year 2008.
[ ] I am enrolled or was enrolled in a re	stockich naming broderin	INE IS DECEMBER	-	ayne , Louis Thomason
MD.3505			,	
Complete both sides	including signat	ture. Supply or c	OFFECT AN INION	nauvii. v , —

### 2008 Medical License Renewal Application Deadline: December 31, 2007

### Medical Licensure Commission of the State of Alabama

33

### Renew online @ http://airenewals.org Registration ID: 181855

Use Only for Change of Mailing Address

edical Licensure Commission of the State of Alabama O Box 887, Montgomery, AL 36101 34/242-4153	
Louis Thomason Payne , MD 535 Jack Warner Parkway Suite 1 Tuscaloosa, Alabama 35404-5715	Fees: \$300 Renewal Fee: October 1 - December 31 \$100 Late Fee Added: January 1 - January 31 (After January 31 - Reinstatement is required)
FAILURE TO RENEW THIS LICENSE BY JANUARY 31 WILL RESUL	T IN YOUR LICENSE BECOMING INACTIVE
WITHOUT FURTHER NOTICE. License#: MD.3505	Issue Date: 08/05/1965
Office Address	Home Address
535 Jack Warner Parkway Suite 1	57 The Downs Tuscaloosa, Alabama 35401-5843
Tuscaloosa, Alabama 35404-5715 Work Telephone: (205) 556-2026 Fax #: (205) 554-058	4 Home Phone: (205) 345-4288
Primary Specialty: Gynecology (OB/GYN) Secondary Specialty: Other	Board Certified: Yes [X] No [ ] Board Certified: Yes [X] No [ ]
Form of Practice: [ ] Resident [ ] Intern [ ] Fellowship [X] Solo [ ] Partnership (	2, 3, or 4) [ ] Group West Alabama Women's Center
Primary Hospital where you have staff privileges: Name: Druid City Regional M	Medical CerCity/State: Tuscaloosa AL
Are you licensed in another state: Yes [ ] No [4]	Which ones: [ ] [ ] [ ] [ ]
Are you actively engaged in clinical practice in the State of Alabama?	[ ] Yes, Answer Questions 2 through 7
<ol> <li>What is your principal county of practice? (indicate state if principal county is no Other county(ies) of practice? (Indicate state if counties are not in Alabama): Check "None" if you only practice in the indicated principal county.</li> <li>Do you have a current collaborative agreement with a nurse practitioner or midv</li> </ol>	None None
4. Do you currently conduct office based surgery involving the administration of pa analgesia/sedation, general anesthesia or major regional block anesthesia?	renteral medication for [X] Yes [ ] No
Primary Care Information Primary care is defined as: Basic or general health care focused on the point at which a exclusive of an emergency situation.	a patient ideally first seeks assistance from the medical care system,
5. Does your practice include the delivery of primary care medical services in Alak	
<ol> <li>Approximately how many hours per week do you practice the above defined principle.</li> <li>Approximately / hours per week.</li> <li>Approximately how many patient encounters (office, hospital, ER, etc.) per week defined primary care services in Alabama? Approximately / / / / encounters.</li> </ol>	ek do you have involving the above
CME Certification: (Check one)  (a) [ ] I hereby certify that I have met the annual minimum continuing education education for the calendar year 2007 and have supporting documentation if (b) [ ] I certify that I am exempt from the minimum continuing medical education is continuing medical education.	on requirement of 12 hours of Category I continuing medical audited. ion requirement for the following reason (Check One):
[ ]I do not reside in the State of Alabama and do not have a significant portion of my [ ]I was exempt from the CME requirement for the previous calendar year 2006 and [ ]I received my initial license to practice medicine in Alabama in the calendar year 2 [ ]I have obtained a retirement waiver from the Board of Medical Examiners, and I d [ ]I have obtained a waiver from the Board of Medical Examiners due to illness, disa [ ]I am enrolled or was enrolled in a residency training program or clinical fellowship	medical practice in the State of Alabama.  I moved my residence to the State of Alabama during calendar year 2007 2007.  to not engage in the practice of medicine in any form.  It is the practice of the existed in the calendar year 2007.
DEADLINE IS DECEM	IBER 31, 2007

Payne , Louis Thomason

MD.3505

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

OVER



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

Transaction Number: VQFF2EFC6B4B

### 2009 Online Renewal Summary

Name: Louis Thomason Payne

License Number: MD.3505

Transaction Date: 2008-10-15\*

Registration Fee: 300 Date of Birth: 1939-04-20

\* - 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?

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?

Jan 5, 2012 3:04 PM

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?
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 of 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?

If yes, please explain: Jan 5, 2012 3:04 PM

Have you engaged in the illegal use of controlled dangerous substances within the past twelve months?
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?
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.
Primary specialty:  Obstetrics & Gynecoloy
Are you Board certified in your primary specialty? Y
Secondary specialty:
Are you Board certified in your secondary specialty? Y
Practice Type: Jan 5, 2012 3:04 PM

If Group, provide the Group Name:
West Alabama Women's Center Inc.
Primary Hospital where you have privileges: (if any)
Hospital Name:
Druid City Regional Medical Center
Hospital City:
Tuscaloosa
Hospital State:
Are you licensed in another State:
N .
Are you actively engaged in clinical practice in the State of Alabama?  Y
What is your principal county of practice in the State of Alabama?  Tuscaloosa
(**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.
Jan 5, 2012 3:04 PM

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?  N
PRIMARY CARE INFORMATION:Primary care is defined as: Basic or general health care focused on the point at which a patient ideally first seeks assistance from the medical care system, exclusive or an emergency situation.
Does your practice include the delivery of primary care medical services in Alabama?  N
Approximately how many hours per week do you practice the above defined primary care services in Alabama? NOTE: Enter the Average hours worked as a whole number. Do not enter ranges of hours or decimals.
Approximately how many patient encounters (office, hospital, ER, etc.) per week do you have involving the above defined priary care services in Alabama?  100
CME Certification: I hereby certify that I have met the annual minimum continuing education requirement of 12 hours of Category I continuing medical education for the calendar year 2008 and have supporting documentation if audited.  yes
I certify that I am exempt from the minimum continuing medical education requirements for the following reason:
Exempt Reason
Practice Telephone: (205) 556-2026
Practice Address: 535 Jack Warner Parkway
Jan 5, 2012 3:04 PM

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Home Telephone:
(205) 345-4288
Home Address:
57 The Downs
Public Address:
True
Mail Address:
True

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.



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

### **2010 Online Renewal Summary**

Name: Louis Thomason Payne

License Number: MD.3505

Transaction Date: 2009-10-16\*

Transaction Number: VUHF4B67C2F1

Registration Fee: 300

Date of Birth: 1939-04-20

\* - 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?

Jan 5, 2012 3:04 PM

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 of 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?

If yes, please explain: Jan 5, 2012 3:04 PM