



**PENNSYLVANIA**  
**Department of State**

For questions about this website, please [Click Here](#) to send an E-Mail , or to contact your Board directly, [Click Here](#).

Click the X at the upper right corner to close this window and return to the list of licensees.

**Person Information**

Name: ALBERT DWORKIN

**Address Information**

Address(city state zipcode): Wilmington DE 19802

**License Information**

Type:	Medical Physician and Surgeon	Secondary Type:		Number:	MD058874L
Profession:	Medicine	Status:	Active		
Issue Date:	6/11/1996	Expires:	12/31/2012	Last Renewed:	1/5/2011

**Discipline Action History**

No disciplinary actions were found for this license.

The Information above is considered primary source for verification of license credentials.

**myLicense Renewal Question Responses****License Number:** MD058874L**Name :** ALBERT DWORKIN**Online Submission Date :**

Renewal Question	Response
Are you submitting a name change with this renewal?	N
Are you licensed in another licensing jurisdiction in this profession (any status)?	Y
Since your last renewal, has a licensing jurisdiction taken any disciplinary action against you?	N
Since your last renewal, have you been convicted of a crime?	N
Since your last renewal, have you withdrawn an application for licensure in another licensing jurisdiction?	N
Have you met your current CE requirements?	Y
Since your last renewal, have your provider privileges been terminated by any medical assistance agency for cause?	N
Since your last renewal, have you had practice privileges denied, revoked or restricted in a hospital or health care facility?	N
Since your last renewal, have you had your DEA registration denied, revoked or restricted?	N
Since your last renewal, have you been arrested for criminal homicide, aggravated assault, sexual offenses or drug offenses in any state, territory or country?	N
Do you maintain current medical professional liability insurance in the Commonwealth?	Y
Medical Renewal - Since your last renewal, have you been the subject of a civil malpractice law suit?	N
Are you submitting a name change with this renewal?	N
Are you licensed in another licensing jurisdiction in this profession (any status)?	Y
Since your last renewal, has a licensing jurisdiction taken any disciplinary action against you?	N
Since your last renewal, have you been convicted of a crime?	N
Since your last renewal, have you withdrawn an application for licensure in another licensing jurisdiction?	N
Have you met your current CE requirements?	Y
Since your last renewal, have your provider privileges been terminated by any medical assistance agency for cause?	N
Since your last renewal, have you had practice privileges denied, revoked or restricted in a hospital or health care facility?	N
Since your last renewal, have you had your DEA registration denied, revoked or restricted?	N
Since your last renewal, have you been arrested for criminal homicide, aggravated assault, sexual offenses or drug offenses in any state, territory or country?	N
Do you maintain current medical professional liability insurance in the Commonwealth?	Y
Medical Renewal - Since your last renewal, have you been the subject of a civil malpractice law suit?	N

**Online Submission Date :** 11/21/2002 7:39:00AM

Renewal Question	Response
Are you submitting a name change with this renewal?	N
Are you licensed in another licensing jurisdiction in this profession (any status)?	Y
Since your last renewal, has a licensing jurisdiction taken any disciplinary action against you?	N
Since your last renewal, have you been convicted of a crime?	N
Since your last renewal, have you withdrawn an application for licensure in another licensing jurisdiction?	N
Is your malpractice insurance coverage current?	Y
Since your last renewal, have your provider privileges been terminated by any medical assistance agency for cause?	N
Since your last renewal, have you had practice privileges denied, revoked or restricted in a hospital or health care facility?	N
Since your last renewal, have you had your DEA registration denied, revoked or restricted?	N
Since May 19, 2002, have you been arrested for criminal homicide, aggravated assault, sexual offenses or drug offenses in any state territory or country?	N
Since May 19, 2002, have any malpractice complaints been filed against you?	N

**myLicense Renewal Question Responses**

**License Number:** MD058874L

**Name :** ALBERT DWORKIN

**Online Submission Date :** 10/19/2006 8:20:38AM

<b>Renewal Question</b>	<b>Response</b>
Are you submitting a name change with this renewal?	N
Are you licensed in another licensing jurisdiction in this profession (any status)?	Y
Since your last renewal, has a licensing jurisdiction taken any disciplinary action against you?	N
Since your last renewal, have you been convicted of a crime?	N
Since your last renewal, have you withdrawn an application for licensure in another licensing jurisdiction?	N
Have you met your current CE requirements?	Y
Since your last renewal, have your provider privileges been terminated by any medical assistance agency for cause?	N
Since your last renewal, have you had practice privileges denied, revoked or restricted in a hospital or health care facility?	N
Since your last renewal, have you had your DEA registration denied, revoked or restricted?	N
Since your last renewal, have you been arrested for criminal homicide, aggravated assault, sexual offenses or drug offenses in any state, territory or country?	N
Do you maintain current medical professional liability insurance in the Commonwealth?	Y
Medical Renewal - Since your last renewal, have you been the subject of a civil malpractice law suit?	N

## Person Info

Name: ALBERT DWORKIN

## Address Info

Street Address:

Email:

Phone

Fax

City

State

Zipcode

Country

County

## Survey Response Summary

## Question Response Summary

Are you submitting a name change with this renewal?	N
Do you hold a license/certificate (active, inactive or expired) to practice in any other state or jurisdiction?	Y
Since your initial application or last renewal, whichever is later, have you had disciplinary action taken against your license, certificate or registration issued to you in any profession in any other state or jurisdiction?	N
Since your initial application or last renewal, whichever is later, have you been convicted, found guilty or pleaded nolo contendere, or received probation without verdict, or accelerated rehabilitative disposition(ARD) as to any felony or misdemeanor, including any drug law violations, or do you have any criminal charges pending and unresolved in any state or jurisdiction? You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court.	N
Since your initial application or last renewal, whichever is later, have you withdrawn an application for a license, certificate or registration, had an application denied or refused, or for disciplinary reasons agreed not to reapply for a license, certificate or registration in any profession in any other state or jurisdiction?	N
Since your initial application or last renewal, whichever is later, have you been arrested for criminal homicide, aggravated assault, sexual offenses or drug offenses in any state, territory or country?	N
Since your last renewal, have you been the subject of a civil malpractice law suit? If yes, please submit a copy of the entire Civil Complaint which must include the filing date and the date you were served. If you previously reported the complaint, email or fax the docket number to the Board. (email at st-medicine@state.pa.us or fax at 717-787-7769)	N

Since your initial application or last renewal, whichever is later, have you had your DEA registration denied, revoked or restricted?	N
Since your initial application or last renewal, whichever is later, have you had practice privileges denied, revoked or restricted in a hospital or health care facility?	N
Since your initial application or last renewal, whichever is later, have your provider privileges been denied, revoked or restricted by any medical assistance agency for cause?	N
Do you maintain current medical professional liability insurance in the Commonwealth of Pennsylvania?	Y
Have you met your current CE requirements?	Y
Education Information	
No education records	
Employment Information	
No employment records	
remarks	
Remarks:	
Continuing Education Information	
No CE Course records	



Regular Mailing Address  
STATE BOARD OF MEDICINE  
P.O. BOX 2649  
HARRISBURG, PA 17105-2649  
717-783-1400  
717-787-2381

Courier Delivery Address  
STATE BOARD OF MEDICINE  
124 PINE STREET, 1st FLOOR  
HARRISBURG, PA 17101

960129 0449  
OFFICIAL USE ONLY

MD 058874 L  
DWORK APPL

**APPLICATION FOR A LICENSE TO PRACTICE  
MEDICINE WITHOUT RESTRICTION**  
For Graduates of **ACCREDITED** Medical Schools

Official Use Only

Amount

Date

Application Fee: \$20.00 *not refundable*  
Make check payable to the "Commonwealth of Pennsylvania."

*Note: A processing fee of \$20.00 will be charged for any check or money order returned unpaid by your bank, regardless of the reason for non-payment.*

Please print or type.

NAME:

DWORKIN

ALBERT

None

Permanent Address:

[Redacted]

Street

[Redacted]

City

State

Zip Code

Date of Birth:

[Redacted]

Social Security Number:

[Redacted]

If your medical/healthcare records are listed under another name or names list below:

LIST MEDICAL SCHOOL(S) ATTENDED:

DATES OF ATTENDANCE

Temple Univ. Med School

From: June 1950 to June 1952  
Mo. & Yr. Mo. & Yr.

Date of Graduation: June 1952

From: \_\_\_\_\_ to \_\_\_\_\_  
Mo. & Yr. Mo. & Yr.

List all states, territories and countries in which you have ever possessed a license without restriction to practice medicine and surgery (active or inactive, current or expired). If you never possessed a license, write

"NONE"

DELAWARE



Check licensing examination(s) passed:

- ( ) FLEX - indicate state where taken: \_\_\_\_\_ Date taken: \_\_\_\_\_  
( ) FLEX COMPONENT 1 - indicate state where taken: \_\_\_\_\_ Date taken: \_\_\_\_\_  
( ) FLEX COMPONENT 2 - indicate state where taken: \_\_\_\_\_ Date taken: \_\_\_\_\_  
( ) NATIONAL BOARD - PART I \_\_\_\_\_ PART II \_\_\_\_\_ PART III \_\_\_\_\_  
( ) USMLE - STEP 1 \_\_\_\_\_ STEP 2 \_\_\_\_\_ STEP 3 \_\_\_\_\_  
( ) LMCC - Canadian \_\_\_\_\_  
(X) STATE BOARD - indicate state where taken: DELAWARE

Post Graduate Education:

PGY1 Hospital: Wilm General Hospital From: 9/14/53 to: 9/14/54  
PGY2 Hospital: Wilm General Hospital From: 10/31/58 to: 10/31/59

Answer the following questions. If "YES" to any of them, provide complete details on a separate sheet as well as certified copies of relevant documents. Sign and date below.

- |   | YES   | NO      |
|---|-------|---------|
| 1. Has any disciplinary action been taken against your license in another state, territory or country?  | _____ | _____ ✓ |
| 2. Have you been convicted, found guilty, or pleaded guilty or nolo contendere, or received probation without verdict as to any felony or misdemeanor, including any drug law violation, in any state or federal court?   | _____ | _____ ✓ |
| 3. Have you had practice privileges denied, revoked or restricted in a hospital or other health care facility?  | _____ | _____ ✓ |
| 4. Have you had your DEA registration denied, revoked or restricted or have you had your provider privileges terminated by any medical assistance agency for cause?   | _____ | _____ ✓ |
| 5. Are you, or have you ever been, addicted to the intemperate use of alcohol or to the habitual use of narcotics or other habit-forming drugs? (Note: You may answer "NO" if you are currently a participant in or have successfully completed the requirements of the Board's Health Monitoring Program.) | _____ | _____ ✓ |

\*\*\*\*\*  
**VERIFICATION STATEMENT**

I verify that the statements in this application are true and correct to the best of my knowledge, information and belief. I understand that false statements are made subject to the penalties of 18 Pa. C.S. Section 4904 relating to unsworn falsification to authorities and may result in the suspension or revocation of my license. I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the State Board of Medicine any information, files or records requested by the Board.

Albert Dworkin  
SIGNATURE OF APPLICANT

86-8 W 3600  
3-11-96  
DATE

State Board of Medicine  
P.O. Box 2649  
Harrisburg, PA 17105-2649

960129 0119

### Certification of Moral Character

To be completed by two physicians with a license without restriction in good standing in the United States or Canada.

Name of Applicant: <u>ALBERT DWORIN</u>	
I hereby certify that I know the applicant to be of good moral character and to the best of my knowledge, he/she is not addicted to the intemperate use of alcohol or to the habitual use of a narcotic or other habit forming drug. I recommend the applicant for a license to practice medicine in the Commonwealth of Pennsylvania.	
I have been personally acquainted with the applicant for <u>19</u> year(s) <u>0</u> month(s).	
SIGNATURE: <u>Moses Hochman</u>	Date: <u>3/14/86</u>
Print or type name as signed above: <u>Moses Hochman</u>	
State in which licensed: <u>PA</u>	License Number: <u>MD 013647E</u>

Name of Applicant: <u>ALBERT DWORIN</u>	
I hereby certify that I know the applicant to be of good moral character and to the best of my knowledge, he/she is not addicted to the intemperate use of alcohol or to the habitual use of a narcotic or other habit forming drug. I recommend the applicant for a license to practice medicine in the Commonwealth of Pennsylvania.	
I have been personally acquainted with the applicant for <u>19</u> year(s) <u>0</u> month(s).	
SIGNATURE: <u>Moses Hochman</u>	Date: <u>3/14/86</u>
Print or type name as signed above: <u>Moses Hochman</u>	
State in which licensed: <u>PA</u>	License Number: <u>MD 033990-1</u>

Return Completed form to Applicant



MAY 13 '96 091000N HOBERT DWORKIN MD

Regular Mailing Address  
State Board of Medicine  
P.O. Box 1849  
Harrisburg, PA 17105-3849

Courier Delivery Address  
Penn. Board of Medicine  
Room 812, Transportation & Safety Bldg.  
Commonwealth Avenue, 4th Floor  
Harrisburg, PA 17120

160129 7442

0658874

# VERIFICATION OF ACGME APPROVED GRADUATE MEDICAL TRAINING

## Accredited Medical School Graduates

TO BE COMPLETED BY APPLICANT

Name: DWORKIN Albert M.D.

Address: [REDACTED]  
[REDACTED]  
[REDACTED] [REDACTED] [REDACTED]

1. If training began before July 1, 1987, one year of approved training at a first (PGY 1) or second (PGY 2) year level must be verified. If the training began on or after July 1, 1987, two (2) years of approved training are required, one at first (PGY 1) year level and one at second (PGY 2) year level.
2. Training at a first (PGY 1) year must be ACGME approved entry level (training which requires no previous training). Training at a second (PGY 2) year must be ACGME approved and can be any specialty. See listing on back.
3. If training was completed at more than one hospital, duplicate this form and submit to each hospital.

To be completed by the program director at the hospital where the graduate training occurred. If training was in Pennsylvania, information must coincide with data on graduate license. For applicants still in the second year of training, this form may be completed and signed by the program director fifteen (15) days prior to the completion of the approved training. Forms postmarked or signed prior to the fifteen days will not be accepted.

Name of Hospital: Wilmington General Hospital (now the Medical Center of Delaware)

Located in: Newark DE 19718

1st Year from 7/1/82 To 6/30/83 Specialty: OB/GYN Level: 1

2nd Year from 7/1/83 To 6/30/84 Specialty: OB/GYN Level: 2

"I certify that Albert Dworkin, M.D. successfully completed/will successfully complete this graduate medical training and that there was/is no disciplinary action outstanding against this applicant. If this applicant does not complete this training, the Board will be notified."

Signature of Program Director: [Signature]  
Date: 5/15/86

(Seal of Hospital)

If the hospital has no seal, complete the following section and have this form countersigned.  
I hereby certify that this hospital has no seal of stamp and that this form was countersigned at this hospital.

Program Director's Signature: [Signature]  
Date: 5/15/86

RETURN COMPLETED FORM DIRECTLY TO THE BOARD IN OFFICIAL HOSPITAL ENVELOPE



**MEDICAL CENTER OF DELAWARE**  
**Academic Affairs**

Christiana Hospital

475 Ogletown Station Road  
P.O. Box 601  
Newark, Delaware  
19718

STATE BOARD OF MEDICINE  
P.O. Box 2649  
Harrisburg, PA 17105



96 JUN -7 AM 7 96  
RECEIVED





Christiana Hospital

829876

MEDICAL CENTER OF DELAWARE

1773 Delaware Stadium Road  
P.O. Box 6000  
Newark, Delaware  
19710

Academic Affairs  
(302) 733-1042

April 30, 1996

State Board of Medicine  
P.O. Box 2649  
Harrisburg, PA 17105-2649

RE: ALBERT DWORKIN

To Whom It May Concern:

Due to the date of the residency served, we are able only by way of computer database to verify that Albert Dworkin, M.D. successfully completed an appointment as Intern in our fully accredited Obstetrics/Gynecology Residency Program at the Wilmington General Hospital (now the Medical Center of Delaware) from July 1, 1952 through June 30, 1953. Dr. Dworkin also successfully completed a residency in the same from September 15, 1953 through September 14, 1954 and October 1, 1958 through October 31, 1959.

Sincerely,

Leslie W. Whitney, M.D.  
Director  
Academic Affairs

LW/sdr



MAY 19 1986 00100001 ALBERT DWORAK III MD

Regular Mailing Address  
State Board of Medicine  
P.O. Box 2049  
Harrisburg, PA 17102-2049

*Albert Dworak III*

Courier Delivery Address  
State Board of Medicine  
Room 413, Transportation & Safety Bldg.  
Commonwealth Ave. & Penn St.  
Harrisburg, PA 17120

960129 0049

# VERIFICATION OF ACGME APPROVED GRADUATE MEDICAL TRAINING Accredited Medical School Graduates

TO BE COMPLETED BY APPLICANT

Name: DWORAK III ALBERT MD

Address: [REDACTED]  
[REDACTED]  
[REDACTED]

1. If training began before July 1, 1987, one year of approved training at a first (PGY 1) or second (PGY 2) year level must be verified. If the training began on or after July 1, 1987, two (2) years of approved training are required, one at first (PGY 1) year level and one at second (PGY 2) year level.
2. Training at a first (PGY 1) year must be ACGME approved entry level (training which requires no previous training). Training at a second (PGY 2) year must be ACGME approved and can be any specialty. See listing on back.
3. If training was completed at more than one hospital, duplicate this form and submit to each hospital.

To be completed by the program director at the hospital where the graduate training occurred. If training was in Pennsylvania, information must coincide with data on graduate license. For applicants still in the second year of training, this form may be completed and signed by the program director fifteen (15) days prior to the completion of the approved training. Forms postmarked or signed prior to the fifteen days will not be accepted.

Name of Hospital: Wilmington General Hospital (now the Medical Center of Delaware)

Located in: Newark DE 19710

1st Year from 7/1/82 To 6/30/83 Specialty OB/GYN Level 1

2nd Year from 7/1/83 To 6/30/84 Specialty OB/GYN Level 2

"I certify that Albert Dworak III, M.D. successfully completed/will

successfully complete this graduate medical training and that there was/is no disciplinary action outstanding against this applicant. If this applicant does not complete this training, the Board will be notified."

Signature of Program Director: Leslie W. Whitney, M.D.  
Date: 7/1/86

(Seal of Hospital)

If the hospital has no seal, complete the following section and have the form notarized.  
I hereby certify that this hospital has no seal or stamp and that this form was given to me by this hospital.

Program Director's Signature

Date

RETURN COMPLETED FORM DIRECTLY TO THE BOARD IN OFFICIAL HOSPITAL ENVELOPE

(Notary Seal)



State Board of Medicine  
717-783-1400  
717-787-2381

260129 0419  
**RECEIVED**  
MAR 27 1996

**VERIFICATION OF MEDICAL EDUCATION**  
For Graduates of Accredited Medical Schools.

State of Pennsylvania  
DEPARTMENT OF REVENUE  
HARRISBURG, PA 17103-2649

**SECTION 1: To be completed by applicant:**

Name: DWORKIN, ALBERT None  
Last First Middle

Name of medical school: TEMPLE UNIVERSITY

Location: Philadelphia, PA

**SUBMIT THIS VERIFICATION OF MEDICAL EDUCATION FORM TO YOUR MEDICAL SCHOOL AND REQUEST YOUR SCHOOL TO RETURN COMPLETED FORM DIRECTLY TO THE BOARD IN OFFICIAL SCHOOL ENVELOPE.**

**SECTION 2: To be completed by Dean or Registrar of medical school:**

Name of medical student: Albert Dworkin

Date student began to attend this medical school: 09/20/88  
Month/Day/Year

Date of graduation: 06/12/92  
Month/Day/Year



I certify that all of the above information is correct.

Signature of M. Judith Russo DIRECTOR  
Dean or Registrar

Date: March 29, 1996

OFFICE OF FACULTY AND STUDENT RECORDS

**Upon completion, school must return this completed form directly to the Pennsylvania State Board of Medicine in official school envelope. DO NOT RETURN TO APPLICANT.**

Regular Mailing Address  
State Board of Medicine  
P.O. Box 2649  
Harrisburg, PA 17103-2649  
U.S.A.

Courier Delivery Address  
State Board of Medicine  
124 Pine Street, 1st Floor  
Harrisburg, PA 17101  
U.S.A.



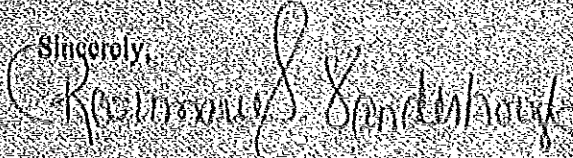
Anatomy - 83	Surgery - 84	Obstetrics - 84	Pathology - 88
Materin Medlen and Therapeutics - 83		Præctice of Medicine - 80	
Physiology - 85	Hygiene - 89	Chemistry - 86	Diagnosis - 85
General Average - 85			



950129 0449

If this office can be of further assistance in this matter please feel free to contact me at  
302-739-4522 extension 203.

Sincerely,

A handwritten signature in cursive script, appearing to read "Rosemarie S. Vanderhoogt".

Rosemarie S. Vanderhoogt  
Office Manager

RDAL



960129 0449

CURRICULUM VITAE

ALBERT DWORKIN, M.D. DATE OF BIRTH [REDACTED]

HONORABLE DISCHARGE U.S. NAVY 1945

BACHELOR OF ARTS TEMPLE UNIVERSITY 17 JULY 1948

DOCTOR OF MEDICINE TEMPLE UNIVERSITY 12 JUNE 1952

ROTATING INTERNSHIP MEMORIAL HOSPITAL WILMINGTON, DE  
1 JULY 1952 TO 30 JUNE 1953

RESIDENCY IN OBSTETRICS WILMINGTON GENERAL HOSPITAL  
15 SEPTEMBER 1953 TO 14 SEPTEMBER 1954

POST GRADUATE FELLOW MARGARET HAGUE MATERNITY HOSPITAL  
1 OCTOBER 1954 TO 31 DECEMBER 1954

PRECEPTORSHIP PROGRAM WITH DR. J. SLOVIN M.D.  
1 JANUARY 1955 TO 30 OCTOBER 1958

RESIDENCY IN GYNECOLOGY WILMINGTON GENERAL HOSPITAL  
31 OCTOBER 1958 TO 31 OCTOBER 1959

ACCREDITED FOR DELAWARE MEDICAL LICENSE NO. 1264 23 JULY 1953  
MEDICINE AND SURGERY

ACCREDITED FOR OB-GYN ULTRASOUND BOYMAN GREY DIVISION  
WAKE FOREST UNIVERSITY 16 FEBRUARY 1979

MEMBERSHIP IN MEDICAL SOCIETIES  
NEW CASTLE COUNTY MED. SOCIETY  
AMERICAN MEDICAL ASSOCIATION  
AMERICAN FERTILITY SOCIETY  
AMERICAN INSTITUTE OF ULTRA-SOUND IN MEDICINE

HOSPITAL AFFILIATIONS:  
MEDICAL CENTER OF DELAWARE ASSOCIATE ON ACTIVE TEACHING STAFF  
RIVERSIDE HOSPITAL COURTESY STAFF

IN ACTIVE PRACTICE OF OBSTETRICS & GYNECOLOGY  
LOCATED ENTIRELY IN WILMINGTON, DELAWARE FOR OVER 30 YEARS

ALBERT DWORKIN, M.D. P.A.  
ALBERT DWORKIN, M.D.  
MOSES HOCHMAN, M.D.

April 22, 1986

Dear Sir

My entire professional career has  
been in private practice from 11-1-59  
to the current date. This was  
all spent here in Wilmington, DE.  
this involves ALL TIME SINCE  
GRADUATION

Albert Dworkin, M.D.  
(Albert Dworkin)



BOARD OF ELECTRICAL EXAMINERS  
REAL ESTATE COMMISSION  
BOARD OF PILOT COMMISSIONERS  
BOARD OF ASSURANCE  
REGISTRARS FOR PROFESSIONAL LAND SURVEYORS  
BOARD OF EXAMINERS OF ARCHITECTS  
BOARD OF CHIROPODIST EXAMINERS  
BOARD OF CHINESE EXAMINERS  
BOARD OF DENTAL EXAMINERS  
BOARD OF MEDICAL PRACTICE  
BOARD OF NURSING  
BOARD OF EXAMINERS IN OPTOMETRY  
BOARD OF PHARMACY  
EXAMINERS BOARD OF PHYSICAL THERAPY  
BOARD OF PODIATRY  
BOULEY ENTERTAINMENT COMMISSION  
COUNCIL ON REAL ESTATE APPRAISERS  
DIVISION'S MAGISTRATE BORROWING COMMITTEE



STATE OF DELAWARE  
DIVISION OF PROFESSIONAL REGULATION

CANNON BUILDING, SUITE 203

P.O. BOX 1301

DOVER, DELAWARE 19903

OFFICE OF THE  
DIRECTOR

20023 8803 7  
PRIVATE ANTI-TRUST AGENCY  
ATHLETIC COMMISSION  
BANKING CONTROL BOARD  
BOARD OF REGISTRATION OF OLDS  
BOARD OF LANDSCAPE ARCHITECTS  
DEADLY WEAPONS BOARD  
BOARD OF EXAMINERS OF PHYSICIAN ASSISTANTS  
BOARD OF VETERINARY MEDICINE  
BOARD OF VETERINARY MEDICINE  
BOARD OF EXAMINERS OF NURSING LICENSING BOARD  
BOARD OF EXAMINERS OF SPEECH PATHOLOGY & AUDIOLOGY  
BOARD OF SOCIAL WORK EXAMINERS  
BOARD OF PROFESSIONAL COUNSELORS OF MENTAL HEALTH  
BOARD OF OCCUPATIONAL THERAPY  
PHYSICIAN ASSISTANT ADVISORY COUNCIL  
COMMITTEE ON MEDICAL PROFESSIONAL CONDUCT  
COMMITTEE ON MEDICAL PROFESSIONAL CONDUCT

TELEPHONE: (302) 739-4522  
FAX: (302) 739-2711

Date: March 28, 1976  
TO: Persephone H. Wheat Street  
P.O. Box 2649  
Harroburg, Pa. 17645

TO WHOM IT MAY CONCERN:

This is to verify that Albert F. Dancy, MD was issued a license to practice medicine and surgery in the State of Delaware by the Delaware Board of Medical Practice on 7-23-53.

Dr. Dancy a certificate number is 2367. Doctor's license is valid through June 30, 1977. There is no disciplinary action either contained in or pending against Doctor's file.

if this office can be of further assistance in this matter please feel free to contact me at 302-739-4522 extension 203.

Sincerely,

Rosemarie S. Vanderhoogt  
Rosemarie S. Vanderhoogt  
Office Manager  
Delaware Board of Medical Practice

BOARD SEAL



BOARD OF ELECTRICAL ENGINEERS  
 REAL ESTATE COMMISSION  
 BOARD OF PILOT COMMISSIONERS  
 BOARD OF ACCOUNTANTS  
 REGISTRATION FOR PROFESSIONAL LAND SURVEYORS  
 BOARD OF EXAMINERS OF ARCHITECTS  
 BOARD OF CHIROPRACTIC EXAMINERS  
 BOARD OF PODIATRY & PODIATRICAL  
 BOARD OF DENTAL EXAMINERS  
 BOARD OF MEDICAL PRACTICE  
 BOARD OF NURSING  
 BOARD OF EXAMINERS IN OPTOMETRY  
 BOARD OF PHARMACY  
 EXAMINING BOARD OF PHYSICAL THERAPY  
 BOARD OF PODIATRY  
 ADULT ENTERTAINMENT COMMISSION  
 COUNCIL ON REAL ESTATE APPEALS  
 GOVERNOR'S MAGISTRATE SELECTION COMMITTEE



STATE OF DELAWARE  
 DIVISION OF PROFESSIONAL REGULATION  
 CANNON BUILDING, SUITE 203  
 P.O. BOX 1901  
 DOVER, DELAWARE 19003

1960129 0000  
 300  
 PUBLIC DEFENDERS OFFICE  
 ATTORNEY GENERAL  
 MARINE CORPS BOARD  
 BOARD OF REGISTRATION OF NURSES  
 BOARD OF LANDSCAPE ARCHITECTURE  
 BOARD OF MECHANICAL ENGINEERS  
 BOARD OF EXAMINERS OF PROFESSIONAL ENGINEERS  
 BOARD OF VETERINARY MEDICINE  
 BOARD OF EXAMINERS OF JUDICIAL JUDGES  
 BOARD OF EXAMINERS OF SOCIAL WORKERS  
 BOARD OF PROFESSIONAL COUNSELORS  
 BOARD OF OCCUPATIONAL THERAPY  
 PROFESSIONAL ASSISTANT AUDITORS COUNCIL  
 COMMITTEE ON JUDICIAL SELECTIONS  
 COMMITTEE ON JUDICIAL SELECTIONS

OFFICE OF THE  
 DIRECTOR

TELEPHONE: (302) 739-4522  
 FAX: (302) 739-4711

Date: April 26, 1996

To: Board of Medicine  
 PO Box 2649  
 Harrisburg, PA 17105-2649

TO WHOM IT MAY CONCERN:

This is to verify that Albert Dworkin, M.D.  
 was issued a license to practice medicine and surgery in the  
 State of Delaware by the Delaware Board of Medical Practice on  
7/27/53.

Dr. Dworkin's certificate number is C10001264  
 Doctor's license is valid through June 30, 1997. There is no  
 disciplinary action either contained in or pending against  
 Doctor's file.

If this office can be of further assistance in this matter please  
 feel free to contact me at 302-739-4522 extension 203.

Sincerely,

Rosemarie S. Vanderhoof  
 Office Manager  
 Delaware Board of Medical Practice

BOARD SEAL



National Practitioner Data Bank  
P.O. Box 10832  
Charlottesville, VA 22021

Voice: (800) 767-6732  
FAX: (703) 002-4100  
TDD: (703) 002-0395

DCN# 8500000002145021  
Process Date: 04/18/96 07:30  
Page 1 of 1

To: ALBERT THORNTON, ALBERT NONE  
[REDACTED]

From: The National Practitioner Data Bank  
Re: Response to Your Request for Information Disclosure (Self-Query)

The enclosed information was submitted to the National Practitioner Data Bank (NPDB) under the provisions of Title IV of Public Law 90-060, the Health Care Quality Improvement Act of 1986, as amended.

The legislation established the NPDB as an information clearinghouse to collect and release certain information related to malpractice payment history and professional competence or conduct of physicians, dentists, and other licensed health care practitioners. Regulations governing the NPDB are codified at 45 CFR part 60. Responsibility for the NPDB resides with the Secretary of the U.S. Department of Health and Human Services, HHS, Division of Quality Assurance. Reports received from the NPDB contain only limited summary information and should be used in conjunction with information from other sources in granting clinical privileges or making employment affiliation or licensure decisions. The NPDB is a flagging system and a report may be included for a variety of reasons which do not necessarily reflect adversely on the professional competence or conduct of the practitioner.

All information received from the NPDB is considered confidential and must be used solely for the purpose for which it was disclosed. ANY PERSON WHO VIOLATES THE CONFIDENTIALITY PROVISIONS OF TITLE IV IS SUBJECT TO A CIVIL MONEY PENALTY OF UP TO \$10,000 FOR EACH VIOLATION. Individual health care practitioners who obtain information about themselves from the NPDB are permitted to share that information with anyone they choose.

If you require further assistance, please contact  
the National Practitioner Data Bank at  
1-800-767-6732

\*\*\*



National Practitioner Data Bank  
P.O. Box 10832  
Charlottesville, VA 22021

Voice: (800) 767-0732  
FAX: (703) 602-4100  
TDD: (703) 602-9395

DCNR 5500000002145021  
Process Date: 04/10/96 07:30  
Page: 01 of 1

## RESPONSE TO INFORMATION DISCLOSURE REQUEST

### A. REQUESTOR IDENTIFICATION

Requestor Name: ALBERT DWORKIN, ALBERT NONR

Address: [REDACTED]

### B. PRACTITIONER ON WHOM DISCLOSURE IS REQUESTED

Practitioner Name: ALBERT DWORKIN, ALBERT NONR  
Other Name Used:  
Gender:

Organization Name: ALBERT DWORKIN MD PA  
Work Address: 2409 BAYHARD BLVD  
WILMINGTON, DE 19802

Home Address: [REDACTED]

Social Security #: [REDACTED]

Date of Birth: [REDACTED]

Deceased:

Professional School(s) & Grad. Year: TEMPLE UNIVERSITY (1952)

License #, State, Field Code: 1264 DE  
ALLOPATHIC PHYSICIANS (MD) (010)

Drug Enforcement # (DEA #): AD2401026

### C. NPDB SEARCH RESULT

Based on the practitioner identification information provided by you in Section B above, a search of the NPDB has located no matching reports.

Copies of these reports are enclosed for restricted/unlimited use as prescribed by Public Law 09-600 The Health Care Quality Improvement Act of 1988, as amended. Recipients should verify that the practitioner identified in Section B of this report(s) is, in fact, the practitioner of interest. Reports from the NPDB are confidential; disclosure or use for any purpose other than that for which it was disclosed is subject to a civil monetary penalty of \$10,000 for each violation.



Women to Women C

Nancy Fan, M.D.  
Shauna B. McIntosh, M.D.

Albert Dworkin, M.D., PA

MD 058874 L  
DWORK MISC

November 20, 2002

Commonwealth of Pennsylvania  
Department of State  
Bureau of Professional Occupational Affairs  
State Board of Medicine  
P.O. Box 8414  
Harrisburg, PA 17105-8414

RE: ACCOUNT NO. MD-058874-L  
CHANGE OF ADDRESS

To Whom It May Concern:

This letter is to inform you that Women to Women OB/GYN Associates, P.A., Nancy Fan, M.D., LaShauna McIntosh, M.D. and Albert Dworkin, M.D., P.A. has moved to a NEW office location effective September 27, 2002. Our NEW address and NEW phone number is as follows:

WOMEN TO WOMEN OB/GYN ASSOCIATES, P.A.  
Donna Barcus, Practice Manager  
213 Greenhill Avenue, Suite B  
Wilmington, Delaware 19805  
(302) 778-2228 Office  
(302) 778-2250 Fax

Our old address was as follows:

Albert Dworkin, M.D., P.A.  
Women To Women OB/GYN Associates, P.A.  
2809 Baynard Boulevard  
Wilmington, DE 19802

Enclosed, please find a check in the amount of \$5.00 for a Duplicate License with the address change.

Thank you for your time and cooperation in this matter. If you have any questions, please feel free to contact me at (302) 778-2229 Ext. 14.

Sincerely,



Donna Barcus  
Practice Manager

COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF STATE  
BUREAU OF PROFESSIONAL AND  
OCCUPATIONAL AFFAIRS

Official Use Only

037751

M D - 0 5 8 8 7 4 - 1

D W O R K R N E W

THIS IS YOUR RENEWAL NOTICE - REQUIRED FEE \$125.00

STATE BOARD OF MEDICINE  
P.O. BOX 8414  
HARRISBURG, PA. 17105-8414

ALBERT DWORKIN

YOUR CURRENT LICENSE TO PRACTICE MEDICINE AND SURGERY IN PENNSYLVANIA WILL EXPIRE ON DECEMBER 31, 1999. TO REMAIN THROUGH DECEMBER 31, 2000, COMPLETE THE QUESTIONS BELOW AND RETURN WITH A CHECK OR MONEY ORDER IN THE AMOUNT OF \$125.00 PAYABLE TO THE COMMONWEALTH OF PA. WRITE YOUR LICENSE NUMBER ON THE FRONT OF THE PAYMENT. A LATE FEE OF \$5.00 PER DAY WILL BE CHARGED FOR RENEWALS POSTMARKED AFTER DECEMBER 31, 1999. A PROCESSING FEE OF \$20.00 WILL BE CHARGED FOR ANY CHECK OR MONEY ORDER UNPAID BY YOUR BANK, REGARDLESS OF THE REASON. IF YOU HAVE A CHANGE IN NAME AND/OR ADDRESS, INDICATE THE CHANGE NEXT TO THE PRE-PRINTED NAME AND ADDRESS ABOVE. A NAME CHANGE REQUIRES SUBMISSION OF A COPY OF A COURT ORDER, MARRIAGE CERTIFICATE, DECREE OR OTHER OFFICIAL DOCUMENT.

NOTICE: IF YOU PRACTICE IN PENNSYLVANIA, YOU MUST MAINTAIN THE REQUIRED AMOUNT OF PROFESSIONAL LIABILITY INSURANCE AND PAY THE REQUIRED FEE AND CAT FUND SURCHARGE. FAILURE TO DO SO WILL RESULT IN SUSPENSION OR REVOCATION OF YOUR LICENSE.

ANY DISCIPLINARY ACTION TAKEN IN ANOTHER STATE, TERRITORY OR COUNTRY SHALL BE REPORTED TO THE BOARD ON THE BIENNIAL RENEWAL NOTICE OR WITHIN 30 DAYS OF FINAL DISPOSITION, WHICHEVER IS SOONER.

THE FOLLOWING QUESTIONS MUST BE ANSWERED. IF YOU ANSWER "YES" TO QUESTIONS 2, 3, 4, OR 5 BELOW, YOU MUST PROVIDE COMPLETE DETAILS ON 8 1/2 X 11 SHEETS OF PAPER AND INCLUDE COPIES OF LEGAL DOCUMENTS, IF ANY. FAILURE TO PROVIDE DOCUMENTS WILL DELAY THE PROCESS.

YES NO

1. DO YOU HOLD A LICENSE TO PRACTICE MEDICINE AND SURGERY IN ANY OTHER JURISDICTION? IF YES, LIST EACH ONE BELOW.

1. ☒ 2. SINCE YOUR LAST RENEWAL, HAS ANOTHER STATE, TERRITORY OR COUNTRY TAKEN ANY DISCIPLINARY ACTION (INCLUDES VOLUNTARY SURRENDER OF A LICENSE) AGAINST YOU OR FILED CHARGES AGAINST YOU THAT HAVE NOT BEEN RESOLVED IN YOUR FAVOR?

3. SINCE YOUR LAST RENEWAL, HAVE YOU BEEN CONVICTED, FOUND GUILTY, PLEADED NOLO CONTENDERE, RECEIVED PROBATION WITHOUT VERDICT, OR RECEIVED ANY OTHER DISPOSITION (EXCLUDING ACQUITTAL OR DISMISSAL), WITH RESPECT TO ANY CRIMINAL OFFENSE, INCLUDING ANY DRUG LAW VIOLATIONS, OR DO YOU HAVE ANY CRIMINAL CHARGES PENDING AND UNRESOLVED IN ANY STATE OR FEDERAL COURT? (A SUMMARY TRAFFIC VIOLATION SHOULD NOT BE CONSIDERED AS A CRIMINAL OFFENSE.)

4. SINCE YOUR LAST RENEWAL, FOR DISCIPLINARY REASONS HAVE YOU WITHDRAWN AN APPLICATION FOR A LICENSE, HAD AN APPLICATION FOR A LICENSE DENIED OR REFUSED, OR AGREED NOT TO REAPPLY FOR A LICENSE IN ANOTHER STATE, TERRITORY OR COUNTRY? A LICENSE INCLUDES A REGISTRATION OR CERTIFICATION.

5. SINCE YOUR LAST RENEWAL, HAVE YOU HAD PRACTICE PRIVILEGES DENIED, REVOKED, SUSPENDED, RESTRICTED, SURRENDERED IN LIEU OF DISCIPLINE OR EMPLOYMENT TERMINATED IN A HOSPITAL OR ANY HEALTH CARE FACILITY?

6. SINCE YOUR LAST RENEWAL, HAVE YOU HAD YOUR DEA REGISTRATION DENIED, REVOKED OR RESTRICTED OR HAVE YOU HAD YOUR PROVIDER PRIVILEGES TERMINATED BY ANY MEDICAL ASSISTANCE AGENCY FOR CAUSE?

IF YOU WANT YOUR LICENSE PLACED ON "INACTIVE" STATUS PLACE AN "X" IN THE BLANK TO THE RIGHT. NO FEE IS REQUIRED. YOU ARE STILL REQUIRED TO ANSWER THE QUESTION, SIGN AND DATE BELOW.

MY REPRESENTATIONS AND RESPONSES IN THIS DOCUMENT ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT THEY ARE SUBJECT TO THE PENALTIES OF 18 PA. C.S. 4904, RELATING TO UNSWORN FALSIFICATION TO AUTHORITIES.

SIGNATURE

*Albert Dworkin*

DATE

10-23-98

00002385



COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF STATE  
BUREAU OF PROFESSIONAL AND  
OCCUPATIONAL AFFAIRS

Official Use Only

04655

M D - 0 5 8 8 7 4 - 1

D W O R K R N E W

THIS IS YOUR RENEWAL NOTICE - REQUIRED FEE - \$125.00

STATE BOARD OF MEDICINE  
P.O. BOX 8414  
HARRISBURG, PA. 17105-8414

ALBERT DWORKIN

YOUR CURRENT LICENSE TO PRACTICE MEDICINE AND SURGERY IN PENNSYLVANIA WILL EXPIRE ON DECEMBER 31, 2000. TO RENEW YOUR LICENSE THROUGH DECEMBER 31, 2002, COMPLETE THE QUESTIONS BELOW AND RETURN WITH A CHECK OR MONEY ORDER IN THE AMOUNT OF \$125.00 PAYABLE TO THE COMMONWEALTH OF PA. WRITE YOUR LICENSE NUMBER ON THE FRONT OF THE PAYMENT. A LATE FEE OF \$5.00 PER MONTH CHARGED FOR RENEWALS POSTMARKED AFTER DECEMBER 31, 2000. A PROCESSING FEE OF \$20.00 WILL BE CHARGED FOR ANY CHECK OR MONEY ORDER UNPAID BY YOUR BANK, REGARDLESS OF THE REASON. IF YOU HAVE A CHANGE IN NAME AND/OR ADDRESS, INDICATE THE CHANGE NEXT TO THE PRE-PRINTED NAME AND ADDRESS ABOVE. A NAME CHANGE REQUIRES SUBMISSION OF A COPY OF A COURT ORDER, MARRIAGE CERTIFICATE, DIVORCE DECREE OR OTHER OFFICIAL DOCUMENT.

NOTICE: IF YOU PRACTICE IN PENNSYLVANIA, YOU MUST MAINTAIN THE REQUIRED AMOUNT OF PROFESSIONAL LIABILITY INSURANCE AND PAY THE REQUIRED FEE AND CAT FUND SURCHARGE. FAILURE TO DO SO WILL RESULT IN SUSPENSION OR REVOCATION OF YOUR LICENSE.

ANY DISCIPLINARY ACTION TAKEN IN ANOTHER STATE, TERRITORY OR COUNTRY SHALL BE REPORTED TO THE BOARD ON THE BIENNIAL RENEWAL NOTICE OR WITHIN 30 DAYS OF FINAL DISPOSITION, WHICHEVER IS SOONER.

THE FOLLOWING QUESTIONS MUST BE ANSWERED. IF YOU ANSWER "YES" TO QUESTIONS 2, 3, 4, OR 5 BELOW, YOU MUST PROVIDE COMPLETE DETAILS ON 8 1/2 X 11 SHEETS OF PAPER AND INCLUDE COPIES OF LEGAL DOCUMENTS, IF ANY. FAILURE TO PROVIDE DOCUMENTS WILL DELAY THE PROCESS.

YES/NO

- ☒ 1. DO YOU HOLD A LICENSE TO PRACTICE MEDICINE AND SURGERY (ACTIVE OR INACTIVE, CURRENT OR EXPIRED) IN ANY OTHER JURISDICTION? IF YES, LIST EACH ONE: DELAWARE
- ☒ 2. SINCE YOUR LAST RENEWAL, HAS ANOTHER STATE, TERRITORY OR COUNTRY TAKEN ANY DISCIPLINARY ACTION (INCLUDES VOLUNTARY SURRENDER OF A LICENSE) AGAINST YOU OR FILED CHARGES AGAINST YOU THAT HAVE NOT BEEN RESOLVED IN YOUR FAVOR?
- ☒ 3. SINCE YOUR LAST RENEWAL, HAVE YOU BEEN CONVICTED, FOUND GUILTY, PLEADED NOLO CONTENDERE, RECEIVED PROBATION WITHOUT VERDICT, OR RECEIVED ANY OTHER DISPOSITION (EXCLUDING ACQUITTAL OR DISMISSAL), WITH RESPECT TO ANY CRIMINAL OFFENSE, INCLUDING ANY DRUG LAW VIOLATIONS, OR DO YOU HAVE ANY CRIMINAL CHARGES PENDING AND UNRESOLVED IN ANY STATE OR FEDERAL COURT? (A SUMMARY TRAFFIC VIOLATION SHOULD NOT BE CONSIDERED AS A CRIMINAL OFFENSE.)
- ☒ 4. SINCE YOUR LAST RENEWAL, FOR DISCIPLINARY REASONS HAVE YOU WITHDRAWN AN APPLICATION FOR A LICENSE, HAD AN APPLICATION FOR A LICENSE DENIED OR REFUSED, OR AGREED NOT TO REAPPLY FOR A LICENSE IN ANOTHER STATE, TERRITORY OR COUNTRY? A LICENSE INCLUDES A REGISTRATION OR CERTIFICATION.
- ☒ 5. SINCE YOUR LAST RENEWAL, HAVE YOU HAD PRACTICE PRIVILEGES DENIED, REVOKED, SUSPENDED, RESTRICTED, SURRENDERED IN LIEU OF DISCIPLINE OR EMPLOYMENT TERMINATED IN A HOSPITAL OR ANY HEALTH CARE FACILITY?
- ☒ 6. SINCE YOUR LAST RENEWAL, HAVE YOU HAD YOUR DEA REGISTRATION DENIED, REVOKED OR RESTRICTED OR HAVE YOU HAD YOUR PROVIDER PRIVILEGES TERMINATED BY ANY MEDICAL ASSISTANCE AGENCY FOR CAUSE?

IF YOU WANT YOUR LICENSE PLACED ON "INACTIVE" STATUS PLACE AN "X" IN THE BLANK TO THE RIGHT.  
NO FEE IS REQUIRED. YOU ARE STILL REQUIRED TO ANSWER THE QUESTION, SIGN AND DATE BELOW.

MY REPRESENTATIONS AND RESPONSES IN THIS DOCUMENT ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT THEY ARE SUBJECT TO THE PENALTIES OF 18 PA. C.S. 4904, RELATING TO UNSWORN FALSIFICATION TO AUTHORITIES.

SIGNATURE

*Albert Dworkin*

DATE 12/10/2000

COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF STATE  
BUREAU OF PROFESSIONAL AND  
OCCUPATIONAL AFFAIRS

Official Use Only

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D W O R K R N E

THIS IS YOUR RENEWAL NOTICE

STATE BOARD OF MEDICINE  
P.O. BOX 8414  
HARRISBURG, PA 17105-8

ALBERT DWORIN

YOUR CURRENT LICENSE TO PRACTICE MEDICINE AND SURGERY IN PENNSYLVANIA WILL EXPIRE ON DECEMBER 31, 1996. DECEMBER 31, 1996. PLEASE COMPLETE THE QUESTIONS BELOW AND SUBMIT A CHECK OR MONEY ORDER IN THE AMOUNT OF \$6. PAYABLE TO THE "COMMONWEALTH OF PA". RECORD YOUR LICENSE NUMBER ON THE FRONT OF YOUR PAYMENT. A LATE PENALTY 1 PER MONTH WILL BE CHARGED FOR RENEWALS POSTMARKED AFTER DECEMBER 31, 1996. A PROCESSING FEE OF \$20.00 WILL BE. ANY CHECK OR MONEY ORDER RETURNED UNPAID BY YOUR BANK, REGARDLESS OF THE REASON. IF YOU HAVE A CHANGE IN NAME, INDICATE THE CHANGE NEXT TO THE PRE-PRINTED NAME AND ADDRESS ABOVE AND ATTACH A COPY OF LEGAL DOCUMENTATION OF 1

NOTICE: IF YOU PRACTICE IN PENNSYLVANIA, YOU MUST MAINTAIN THE REQUIRED AMOUNT OF PROFESSIONAL LIABILITY INSURANCE AND PAY THE REQUIRED FEE AND CAT FUND SURCHARGE. FAILURE TO DO SO WILL RESULT IN SUSPENSION OR REVOCATION OF YOUR LICENSE.

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THE FOLLOWING QUESTIONS MUST BE ANSWERED. IF YOU ANSWER "YES" TO QUESTIONS 2, 3, 4, OR 5 BELOW, PLEASE PROVIDE COMPLETE DETAILS ON 8 1/2 X 11 SHEETS OF PAPER AND INCLUDE COPIES OF LEGAL DOCUMENTS. IF ANY

YES NO

- ☒ 1. DO YOU HOLD A LICENSE TO PRACTICE MEDICINE AND SURGERY IN ANY OTHER JURISDICTION? IF YES, LIST EACH ONE ON THE BACK.
- ☐ ☒ 2. SINCE YOUR LAST RENEWAL, HAS ANY DISCIPLINARY ACTION BEEN TAKEN AGAINST YOUR LICENSE IN ANOTHER STATE, TERRITORY OR COUNTRY?
- ☐ ☒ 3. SINCE YOUR LAST RENEWAL, HAVE YOU BEEN CONVICTED, FOUND GUILTY OR NOLO CONTENDERE, OR RECEIVED PROBATION WITHOUT VERDICT AS TO ANY FELONY OR MISDEMEANOR, INCLUDING ANY DRUG LAW VIOLATION, IN ANY STATE OR FEDERAL COURT?
- ☐ ☒ 4. SINCE YOUR LAST RENEWAL, HAVE YOU HAD PRACTICE PRIVILEGES DENIED, REVOKED OR RESTRICTED IN A HOSPITAL OR OTHER HEALTH CARE FACILITY?
- ☐ ☒ 5. SINCE YOUR LAST RENEWAL, HAVE YOU HAD YOUR DEA REGISTRATION DENIED, REVOKED OR RESTRICTED OR HAVE YOU HAD YOUR PROVIDER PRIVILEGES TERMINATED BY ANY MEDICAL ASSISTANCE AGENCY FOR CAUSE?

IF YOU WANT YOUR LICENSE PLACED ON "INACTIVE" STATUS PLACE AN "X" IN THE BLANK TO THE RIGHT. NO FEE IS REQUIRED. YOU ARE STILL REQUIRED TO ANSWER THE QUESTIONS ABOVE.

SIGN AND DATE BELOW AND PROVIDE THE REQUESTED INFORMATION

SOCIAL SECURITY NUMBER

DATE OF BIRTH

NAME OF MEDICAL SCHOOL

YEAR OF GRADUATION

I CERTIFY THAT THE INFORMATION CONTAINED IN THIS APPLICATION IS TRUE AND CORRECT UNDER 18 PA.C.S. SECTION 4904 RELATING TO KNOWING FALSIFICATION TO AUTHORITIES.

SIGNATURE

DATE

00001646