THE STATE MEDICAL BOARD, STATE OF OHIO

| State | Stat

FORM L

foll	lowing s	atement regarding my preliminary and me	edical education.	burgery in the plate of Omo,	ma sabam me
1.	Name	Thomas William Michaelis (Full Name)	2. Place o	f birth Oklahoma City,	Oklahoma
		i •	Date of	birthDecember_23,_19	44
3.	Intended	Ohio residence Toledo (City)		Lucas	<i>,</i>
				1.1-4	,/
4.	Where c	ertificate is to be sent 2711 Grantwo	od' notego'	Oh15_43613	,
		The Applicant Must Give	e Full Answ	ers to the Following:	
		GINARY EDUCATION. position of Institution Attended and Degree Receive	ed)	(Period and Date of Study)	
	The Un	iversity of Michigan Ann Arbor, Michigan	B. S <u>.</u>	1962-1966	
	Receive	d Ohio Medical Student's Certificate No.	36787, fron	Ohio Medical Board	1966 (Date)
6.	MEDIC	al Education.		,	(Date)
•	XXXX PT	AL EDUCATION. 11 be anted a diploma by The Ohio State	University C	ollege of Medicine	, located at
	Columb	Obdo	(Name of Med	ical College)	
	COTOMO	us Ohio	, on the	12th day of June	1910
7	Time of	practice		/	
••	I mie or	practice	(Give Places	and Dates)	
8.	been su		(A	nswer Yes or No)	(Date)
		ou ever found it necessary to surrender you			
	Have y	ou ever been charged with a violation of a	a Federal Law, S		
	traffic i	rioletion? no			
	a anic		(Yes o	r No)	
	If so, g	ive full particulars:(Offense)	(Place	(Disposi	tion)
		(4)			
	(1)	ate of Disposition)			
9.	PHYSI	CAL DESCRIPTION OF APPLICANT.			
	Race	Caucasian Native of	USA	Complexion	
	Color	f hair Brown Color of eyes	sBlue	Height	5'9"
{	MAGNICAL Thin	Weight 140 Marks Li		ight ear	

* AFFIDAVIT

STATE OF OHIO
COUNTY OF FRANKLIN
On thisday ofAge
Helen L. Evans within and for the County and State aforesaid
Thomas William Michaelis , who being duly sworn says thathe is the person referred
to in the foregoing application for certificate to practice medicine in the State of Ohio; that the state-
ments herein contained are strictly true in every respect, thathe is the person named on the accom-
panying diploma, and is the lawful possessor of the same, and that he has read and understands this
Affidavit. Thomas W. Michaelis
The war at the second
Signature of Applicant.
Signature of Applicant. Signed and sworn to before me this 3-4 day of April 1970
Signature of Applicant.
Signed and sworn to before me this 3 ⁻¹ day of Apr. 1, 1970
Signature of Applicant. Signature of Applicant. Signature of Applicant. April 1970 (SEAL) Official designation of officer administering oath. My Commission expires on August 7th , 19-74
Signature of Applicant. Signature of Applicant. Apr. \

Preliminary Educational Requirement

From the General Code of Ohio

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

The applicant must also produce a diploma from a medical institution in the United States in good standing as defined by the board at the time the diploma was issued *** or a diploma or license approved by the board which conferred the full right to practice all branches of medicine or surgery in a foreign country. However, a person holding a diploma approved by the board which does not confer on him the full right to practice all branches of medicine or surgery in a foreign country may in the discretion of the board be admitted to the examination upon completion of a course of training approved by the board consisting of not less than twelve months of residency or internship in a hospital in the United States.

Sec. 4731.11. At the time of his application the applicant shall present such diploma or license with his affidavit that he is the person named therein and is the lawful possessor thereof, stating his age, residence, the college or colleges at which he obtained his medical education, the time spent in each, the time spent in the study of medicine *** and such other facts as the state medical board requires. If engaged in the practice of medicine or surgery *** the affidavit shall state the period during which and the place where he has been so engaged.

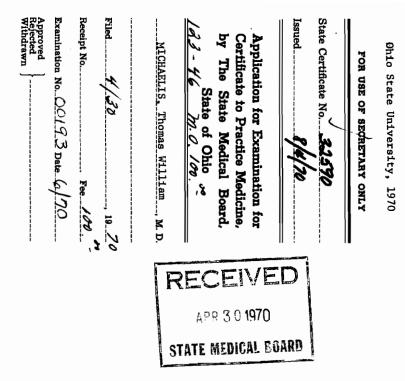
Sec. 4731.12. *** The state medical board shall admit to the examination an applicant holding the credentials set forth in section 4731.09 Revised Code.

Certificate of Preliminary and Medical Education

This certificate must be properly made out and signed by the president, dean or secretary of the medical school of which the applicant is a graduate.

It is	hereby cert	ified that	Th	omas Will	iam Michae	elis			
holding	Ohio	Medica	l Cert	ificate N	o. <u>3</u> 6787				
						as evidence o	f preliminary	education on	
the	12th	day of			Ju	ne	, 1970/	will receive ***********************************	•
	The Ohio	State	Univer	sity Coll	ege of Med	licine		1	
a diplon	na conferrin	g on him	the de	gree of doo	tor of medi	cine and that he p	reviously stu	died medicine	
at least.	4	full year	s, inclu	dingl	t	_regular courses o	f lectures as	follows:	
1	MONTH	YEAR		MONTH	YEAR	NAME	OF INSTITUTIO)N	
Septemb	er 26	<u>1 966</u>	to	June 3	1 967	The Ohio State	University	College of	Medicir
						The Ohio State			
July 1		1 968	to	June 30	1 969	The Ohio State	University	College of	Medicir
July 1	e month of	1 969	to	June 12	1 970	The Ohio State	University	College of	Medicir
(One	e month or	-1	to		1				
Dat	ed atC	olumbus	, Ohio)		01101	1		
						Richard L. 11	Techny		
	Marc	h 25		, 19 ⁷⁰		Richard L. Mei Dean	ling, M.D.		
	(Seal of Colle	ge)				(A. C.)			
		,							
			Cont	ificato of	Good Mor	al Character			
	1	(Signed				ysicians in good stand	ling.)		
This	s certifies th	at we ha	ve been	personally	acquainted	with Dr. Thoma	as W. M	ichaelis	
						_) () years, 1			
to be of						to the State			
					actice medic	ine in the State of	Ohio, pursus	ent to law.	
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P. O. Ad	ldress	40 Ce,	100	h Airen	u Ou	anthis & de	<i>i</i>)		
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* Certifi	cate No	3000	29V	State of	Plus	of Milaryland	_	_	
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P. O. Ad	idress_4	10 W	10	th a	ience	Columba	000	à	
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* Certifi	icate No. /	4284		State of	mick	Michiga			
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Physicians signing should give number of their certificate from this Board.
 Parties signing certificate must be registered physicians.



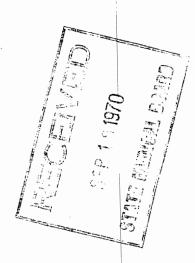
The following facts are stated for the information of those desiring to practice medicine or surgery in the State of Ohio.

- 1. No person can lawfully practice medicine in the State of Ohio unless licensed to do so by the State Medical Board.
- 2. Certificates entitling the holder to practice medicine and surgery in Ohio are issued only after examination by the Board, except in the following case:

Sec. 4731.29. *** When a physician or surgeon licensed by the licensing department of another state, a territory or the District of Columbia or a diplomate of the national board of medical examiners wishes to remove to this state to practice his profession, the state medical board may, in its discretion, issue to him a certificate to practice medicine or surgery in Ohio without requiring the applicant to submit to examination, provided he meets the requirements for entrance as set forth in section 4731.09 and section 4731.12. Application shall be made on a form prescribed by the board.

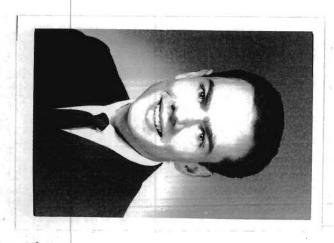
- 3. Examinations will be held in June and December of each year.
- 4. Completed applications must be filed with the Secretary of the Board by the first day of the month preceding the month set for the examination which the applicant desires to enter.
- 5. The fee must accompany each application. Personal checks not accepted. Send certified check, draft or money order. This fee shall not be refundable.
- 6. Only graduates in medicine from colleges recognized by the State Medical Board are admitted to the examinations.
- 7. The examination is written and must be in the English language. It includes Anatomy, Physiology, Pathology, Chemistry, Materia Medica and Therapeutics, the Principles and Practice of Medicine, Diagnosis, Surgery, Obstetrics.
- 8. The applicant's diploma must in every case accompany his application papers. After certifying the diploma the Secretary will return it.
- 9. All correspondence should be addressed to The State Medical Board, Wyandotte Building, 21 W. Broad Street, Columbus, Ohio 43215.
 - 10. Applicants must be at least 21 years of age and citizens of the United States.

Please sign the receipt below a	ad return at once to: Secretary of the State Me 21 W. Broad Street Columbus, Ohio 43215	dical Board
	O., Sept. 14	19 70
Received of The State	Medical Board, Certificate No	32590
bearing my name	Thomas William Micha	
	P.O. Address 347 Bostwick	NE aptios
	Grand Rapids, Michig	an ,



MICHAFLIS, THOMAS W 32590 ISSUED 8-4-70 EXAM





65 SOUTH FRONT ST., SUITE 510 COLUMBUS, OHIO 43215	ARD		D OR STAPLE THIS CARD.	Ms.
FY, UNDER PERMATT OF THE LOSS OF MY RIGHT TO PRACTICE MEDICINE RECERT IN THE STATE OF OHIO, THAT I HAVE COMPLETED DURING THE LAST BIENHUM THE REQUISITE HOURS OF UNING MEDICAL EDUCATION CERTIFIED BY THE DIFFICIAL STATE MEDICAL BOARD AND HEREBY MAKE APPLICATION FOR RENEWAL SIGNATURE OF APPLICANTS	155N 777	3. MAKE CHECK TRE. 4. PUT IDENTIF 5. MARK CORR 6. SEND PAYM APPLICATION TRE.	DE MUST BE COMPLETED. K OR MONEY ORDER PAYA SSUPRE, STATE OF OH FICATION NUMBER ON CHE ECT SPECIALTY CODE(S) BI ENT (DO NOT SEND CASH IN ENCLOSED ENVELOPE ASURER, STATE OF OH 38 COLUMBUS, OHIO 4	CK. ELOW.) AND THIS E TO:
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against you by a state licensing agency?

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arr	STATE ZIP CODE			distribution of	use of any drug:	
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	cessfully completed treatment at a program approved by this	<u>. </u>	X	substances r	and the second s	
	Board and have subsequently adhered to all statuatory re- quirements as contained in Section 4731.224, O.R.C., and		Г у ł	4.) Had any clinical pr	ivileges suspended or re	voked for other than
	related provisions; or are currently enrolled in a Board approved		LX	failure to maintain	records or attend staff n	neetings.
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Г	2.) Had any disciplinary action taken or initiated against you by a					OT.00224.0B

DETACH HERE AND REMIT THIS PORTION WITH FEE MD & DO SPECIALTY CODES CURRENTLY ON RECORD STATE MEDICAL BOARD OF OHIO 77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 43266 39 OBSTETRICS & GYNECOLOGY CERTIFICATION I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED DURING THE LAST BIENNIUM THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE OHIO STATE MEDICAL BOARD. AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWALTS TRUE AND CORRECT IN EVERY RESPECT. X SPECIALTY CODE(S) CORRECT AS LISTED IF THE SPECIALTY CODE STARE IN ERROR ENTER ALL SPECIALTY CODE NUMBERS. 50 CODET CHANGE OF ADDRESS DATE SIGNATURE OF APPLICANT) DATE DUE IDENTIFICATION NUMBER: AMOUNT DUE 11/01/90 35-03-2590 \$160.00 THOMAS WILLIAM MICHAELIS, M.D. 3740 WEST SYLVANIA SUITE 103 TOLEDO OH 43623 0935032590" 10000016000 1:9696969621 possession, distribution or use of any drug? or revoked for reasons other than failure to maintain records or attend staff meetings? 3.) Surrendered, or consented to limitation at a program approved by this board and have subsequently adhered to all statutory 4.) Had any clinical privileges suspended 1.) Been addicted to or dependent upon alcohol or any chemical substance? You 4731.224, O.R.C., and related provisions, upon: a) A license to practice medicine; Zip Code B.) A federal or state law regulating the may answer "no" to this question if you or you are currently enrolled in a board have successfully completed treatment concerning approval can be directed requirements as contained in section PRINCIPAL PRACTICE ADDRESS - IF DIFFERENT FROM THE ADDRESS SHOWN ON FRONT: 2.) Had any disciplinary action taken HAVE YOU BEEN FOUND GUILTY OF, OR OR b) State or federal privileges to prescribe controlled substances? or initiated against you by any state approved program. Any questions AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION FOR RENEWAL OF PLEAD GUILTY OR NO CONTEST TO: Redacted (Optional for purposes of identificati State YOUR CERTIFICATE HAVE YOU: to the board offices. icensing board? A.) A felony NO res

DETACH HERE AND REMIT THIS PORTION WITH FEE MD & DO SPECIALTY CODES CURRENTLY ON RECORD STATE MEDICAL BOARD OF OHIO
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OHIO STATE MEDICAL ASSOCIATION
AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION
PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN
EVERLY RESPECT. SPECIALTY CODE(S) CORRECT AS LISTED IF THE SPECIALTY CODE(S) ARE IN ERROR. ENTER ALL SPECIALTY CODE NUMBERS. CODE1 CODE2 CODE3 EVERY RESPECT. 10/16 CHANGE OF ADDRESS (DATE) (SIGNATURE OF APPLICANT) DATE DUE IDENTIFICATION NUMBER AMOUNT DUE \$160.00 07/01/92 35032590 THOMAS WILLIAM MICHAELIS, M.D. 6206 MEYERS DR CINCINNATI OH 45215 4.9696969624 0935032590 "00000 LE000" in a board approved program. Any questions against you by any state licensing board other than the State Medical Board of Ohio? possession, distribution or use of any drug? question if you have successfully completed suffering from, drug or alcohol dependency Suggedered, or consented to limitation board and have subsequently adhered to all statutory requirements as contained in 4.) Had any clinical privileges suspended, limited or revoked for reasons other than treatment at a program approved by this. 1.) Been addicted to or dependent upon provisions, or you are currently enrolled upontal A license to practice medicine; been treated for, or been diagnosed as B.) A federal or state law regulating the or abuse? You may answer "no" to this Had a license denied by or had any concerning approval can be directed alcohol or any chemical substance; or section 4731.224, O.R.C., and related Zip Code failure to maintain records or attend PRINCIPAL PRACTICE ADDRESS - IF DIFFERENT FROM THE ADDRESS SHOWN ON FRONT: HAVE YOU BEEN FOUND GUILTY OF, OR disciplinary action taken or initiated OR b) State or faderal privileges to prescribe controlled substances? LAST APPLICATION FOR RENEWAL OF Reda (Optional for purposes of identification) AT ANY TIME SINCE SIGNING YOUR PLED GUILTY OR NO CONTEST TO A.) A felony or misdemeanor. YOUR CERTIFICATE HAVE YOU to the board offices. staff meetings? \times ş

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IDENTIFICATIO		STREET
35-03-		832 E. Country Gables Dr.
	WILLIAM MICHAELIS, M.D.	STREET
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PHOEN I	X AZ 54003	MARICODE
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CERTIFICATION I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 1994-1996 BIENNIUM THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE OHIO STATE MEDICAL ASSOCIATION AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT. X Nomas W. Muchaulis 4/8/96 (SIGNATURE OF APPLICANT) (DATE)	IF CORRECTIONS ARE NECESSARY, PLEASE CODE1 CODE2 CODE3 REPORT ANY CHANGE OF ADDRESS			
IDENTIFICATION NUMBER AMOUNT DUE DATE DUE 35-03-2590 \$250.00 05/01/96	STREET			
THOMAS WILLIAM MICHAELIS, M.D.	STREET			
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MD & DO SPECIALTY CODES CURRENTLY ON RECORD STATE MEDICAL BOARD OF OHIO 17TH FLOOR, COLUMBUS, OHIO 43266 - 0315 OBG OBSTETRICS & GYNECOLOGY CERTIFICATION I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 1996-1998 OHIO, THAT HAVE COMPLETED ON WILL HAVE COMPLETED DURING THE 1996-1998 BIENNIUM THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE OHIO STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY SPECIALTY CODE(S) CORRECT AS LISTED IF CORRECTIONS ARE NECESSARY, PLEASE CODE3 ENTER ALL SPECIALTY CODES. CODE2 RESPECT. REPORT ANY CHANGE OF ADDRESS (SIGNATURE OF APPLICANT) (DATE IDENTIFICATION NUMBER AMOUNT DUE DATE DUE \$243.00 05/01/98 35-03-2590-M THOMAS WILLIAM MICHAELIS, M.D. 600 W GROVE PKWY #1105 **TEMPE AZ 85283** #00000 24 **3**00# 1296969696212 0935032590# AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION FOR RENEWAL OF YOUR CENTIFICATE HAVE YOU: 1.) Been found guity of, or pled guilty or no 2.) Been found guilty-of, or pled guilty or no suffering from, drug or alcohol dependency successfully completed contest to a federal or state law regulating enrolled in a board approved program. Any sections 4731.224 and 4731.25 O.R.C., and the possession, distribution or use of any board and have subsequently adhered to all statutory requirements as contained in 6.) Surrendered, or consented to limitation initiated against you by any state licensing 3.) Been addicted tq.or dependent upon treatment at a program approved by this 7.) Had any clinical privileges suspended, arrangement or scheme for referral of a patient for clinical laboratory services to a person 4.) Had malpractice insurance cancelled been treated for, or been diagnosed as or abuse? You may answer "no" to this question if you have successfully compl than failure to maintain records or attend upon: a) A license to practice medicine; related provisions, leryou are currently facility in which either you or a member of alcohol or any cherdical substance; or questions concerning approval can be 5.) Had any disciplinary action taken or restricted or revoked for reasons other 8.) Referred a patient, or participated in an MINCIPAL PRACTICE ADDRESS - IF DIFFERENT or limited for other than failure to pay your immediate family has an ownership or contest to a felony or misdemeanor investment interest, or any compensation OR b) State or federal privileges to board other than the State Medical prescribe controlled substances? SOCIAL SECURITY NUMBER 25 (Optional for purposes of identification Company (Continuation Company (Continuation Company (Continuation Continuation Co SHOWN ON FRONT. directed to the boded offices. staff meetings? Board of Ohio? premiums? irrangement? drug? haenix ъ × Š ð 8 × * ð 985xX2574 40000#1 # YES ÆS, ÆS,

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77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 43215 - 6127

CERTIFICATION

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

OBG OBSTETRICS & GYNECOLOGY

	IDENTIFICATION 35-03-25 THOMAS 6131 N APT C- PHOEN I	NUMBER 90-H 16TI	OURS OF CONTINUES	TINUING ME ED I CAI BOARD, AN TRUE AND URE OF A DUE OO CI CHAEI	ASSOC ASSOC NO THAT THE I CORRECT IN I MANUAL MPPLICANT DATE DUE	TION CERT LIATI NFORMATI EVERY RES S50 L	TIFIED BY THE ON ION PROVIDED	After	ENTER ALL SP	ADDRESS-TH	ES.	SE CODE	D AT EAC	
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AT ANT TIME SINCE SIGNING TOUR LAST	YES NO TYPES NO	00 53	any chemical substance; any chemical substance; been treated for, or be diagnosed as suffering fro drug or alcohol dependent	or abuser <u>fou may answer</u> "NO" to this question if you have successfully completed treatment at, or are currently enrolled in, a program approved	Board and have adhered to all statutory requirements and subsequent to treatment. You must answer "YES" ave ever relapsed. Any questions concerning program al or concerning this question can be directed to the ffices.	3.) Have any malpractice awards been paid by you ron your behalf for acts occurring in any state other than Ohio?	4.) Has any board, bureau, department, agency, other body, including those in Ohio, other this board, filed any charges, allegations complaints against you?	5.) Have you surrendered, or con limitation of, or to reprimand or	concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction? You may answer "NO" to this question if the only such surrender or consented was given to this board.	6.) Have you had any clinical privileges or other similar institutional authority suspended, restricted or revoked for reasons other than fallure to maintain records on a timely basis or to attend staff meetings?	CIPAL PRACTICE ADDRESS - THIS ADDRESS I BE ENTERED AT EACH RENEWAL. Check this Box if you have NO principal Practice address.		State Zip Code	Redacted Nowall Second Nowall
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I CERTIFY, UND THAT I HAVE CO CONTINUING M OH AND APPROVE	STATE MEDICAL BOARD OF OHIO HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 43215 - 6127 CERTIFICATION ER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, OMPLETED DURING THE 2002 - 2004 CME PERIOD THE REQUISITE HOURS OF EDICAL EDUCATION CERTIFIED BY THE IO STATE MEDICAL ASSOCIATION DISTANCE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED CATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT. (SIGNATURE OF APPLICANT) NUMBER AMOUNT DUE DATE DUE \$50 Late Fee Due After	MD & DO SPECIALTY CODES CURRENTLY ON RECORD OBG OBSTETRICS & GYNECOLOGY SPECIALTY CODE(S) CORRECT AS LISTED IF CORRECTIONS ARE NECESSARY, PLEASE ENTER ALL SPECIALTY CODES. CODE1 CODE2 CODE3 RESIDENCE ADDRESS-THIS MUST BE ENTERED AT EACH RENEWAL 24 1 (C. M. d. d.) P.S.C.X. DY N. C.
	WILLIAM MICHAELIS, M.D. HONROE ST new home address ->	STREET TOLEDO OH 43606 STATE ZIP CODE COUNTY
R RENEWAL OF IVE you been so, or pled guilty St to, or rece ent or interven	ves No state and have adhered to all statements y this Board and have adhered to all statements vo a wave ver relapsed. Any questions concerning this question can be directed to the oard offices. Solved Solved	cerning, a license to practice a prescribe controlled substances on rescribe controlled substances on You may answer "NO" to the enny You may answer "NO" to the enny such surrender or const his board. The enny clinical privileges or other than fallure on a timely basis or to attain the pass on a timely basis or to attain the pass on a timely basis or to attain the pass of th

Date Posted: 5/25/2006 12:09:36 AM

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

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

Address Information

BUSINESS ADDRESS

1160 SYLVANIA AVE. TOLEDO, OH 43612 Lucas County 419-478-6801

CREDENTIAL MAIL ADDRESS

3416 MIDDLESEX DRIVE APT D TOLEDO, OH 43606 Lucas County 419-297-1927

MAIN

3416 MIDDLESEX DRIVE APT D TOLEDO, OH 43606 Lucas County 419-297-1927

License Information

License Number

35.032590

License Name

THOMAS MICHAELIS

Email Address

Fees

Relicensure Fee

\$305.00

Total Fees \$305.00

Specialty Codes

1.	Please select one specialty from the field belowOBSTETRICS & GYNECOLOGY
2.	Please select one specialty from the field below, if applicable {not Answered}
3.	Please select one specialty from the field below, if applicable {not Answered}
CN	IE-Physicians
	Have you met the above CME requirements for your license?YES
Dis	scipline
	Have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?
	NO
2.	Have you surrendered, consented to limitation of, or to suspension, reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction other than Ohio?
	NO
3.	Have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?
	NO
4.	Has any board, bureau, department, agency, or any other body, including those in Ohio <u>other than this board</u> , filed any charges, allegations or complaints against you?
	NO
5.	Have you had any clinical privileges or other similar institutional authority suspended, restricted or revoked for reasons <u>other than failure to maintain records on a timely basis or to attend staff meetings?</u>
	NO
6.	Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse?
	NO

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Nurse Collaboration Info

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

. . . . NO

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

..... {not Answered}

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

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

Date Posted: 3/30/2008 11:56:21 AM

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

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

License Information

License Number

35.032590

License Name

THOMAS MICHAELIS

Email Address

tom44tom@buckeye-express.com

Fees

Relicensure Fee

\$305.00

Total Fees \$305.00

Specialty Codes

- 1. Please select one specialty from the field below
 - OBSTETRICS & GYNECOLOGY
- 2. Please select one specialty from the field below, if applicable.

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

..... {not Answered}

CME-Physicians

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

. YES

Discipline

- 1. Have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?
 - NO
- 2. Have you surrendered, consented to limitation of, or to suspension,

	reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe
	controlled substances in any jurisdiction other than Ohio?
2	
3.	Have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?
	NO
4.	Has any board, bureau, department, agency, or any other body, including those in Ohio <u>other than this board</u> , filed any charges, allegations or complaints against you?
	NO
5.	Have you had any clinical privileges or other similar institutional authority suspended, restricted or revoked for reasons other than failure to maintain records on a timely basis or to attend staff
	meetings?
6.	Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse?
	NO
	cial Security Number
1.	Redacted
Nu	rse Collaboration Info
1.	Are you currently in a collaboration agreement with any Clinical Nurse Specialists, Certified Nurse-Midwives or Certified Nurse Practitioners?
	NO
2.	List the name/names and type of licensure for each nurse with whom you are collaborating. For example: Jane Doe, CNP; Mary Smith, CNS.
	{not Answered}
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I understand that submitting a false, fraudulent, or forged statement or document or omitting a material fact in obtaining licensure may be grounds for disciplinary action against my license.

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

Date Posted: 5/14/2010 2:30:55 PM

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

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

License Information

License Number

35.032590

License Name

THOMAS MICHAELIS

Fees

Relicensure Fee

\$305.00

Total Fees \$305.00

Specialty Codes

1. Please select one specialty from the field below

..... OBSTETRICS & GYNECOLOGY

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

....... {not Answered}

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

CME-Physicians

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

. YES

Discipline

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

. NO

2. Have you surrendered, consented to limitation of, or to suspension, reprimand or probation concerning, a license to practice any

	healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction other than Ohio?
	NO
3.	Have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?
	NO
4.	Has any board, bureau, department, agency, or any other body, including those in Ohio <u>other than this board</u> , filed any charges, allegations or complaints against you?
	NO
5.	Have you had any clinical privileges or other similar institutional authority suspended, restricted, revoked or placed on probation for reasons other than failure to maintain records on a timely basis or to attend staff meetings?
	NO
6.	Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse?
	NO
~	
	cial Security Number
1.	Padagtad
	Redacted
Vii	rse Collaboration Info
1.	Are you currently in a collaboration agreement with any Clinical Nurse Specialists, Certified Nurse-Midwives or Certified Nurse Practitioners?
	NO
2.	List the name/names and type of licensure for each nurse with whom you are collaborating. For example: Jane Doe, CNP; Mary Smith, CNS.
	{not Answered}
	····· (not illiswered)

I understand that submitting a false, fraudulent, or forged

statement or document or omitting a material fact in obtaining licensure may be grounds for disciplinary action against my license.

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

Date Posted: 6/15/2012 2:54:22 PM

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

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

License Information

License Number

35.032590

License Name

THOMAS MICHAELIS

Fees

Relicensure Fee

\$305.00

Total Fees \$305.00

Medical Board Correspondence Email

1. Did you provide a Credential email address? Please note this information is a public record.

. YES

Specialty Codes

- 1. Please select one specialty from the field below
 - OBSTETRICS & GYNECOLOGY
- 2. Please select one specialty from the field below, if applicable.

....... {not Answered}

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

....... {not Answered}

CME-Physicians

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

..... YES

Discipline

1. Have you been found guilty of, or pled guilty or no contest to, or

	received treatment or intervention in lieu of conviction of, a misdemeanor or felony?
	NO
2.	Have you surrendered, consented to limitation of, or to suspension, reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction other than Ohio?
	NO
3.	Have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?
	NO
4.	Has any board, bureau, department, agency, or any other body, including those in Ohio <u>other than this board</u> , filed any charges, allegations or complaints against you?
	NO
5.	Have you had any clinical privileges or other similar institutional authority suspended, restricted, revoked or placed on probation for reasons other than failure to maintain records on a timely basis or to attend staff meetings?
	NO
6.	Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse?
	NO
So	ial Security Number
1.	
	Redacted
	rse Collaboration Info
1.	Are you currently in a collaboration agreement with any Clinical Nurse Specialists, Certified Nurse-Midwives or Certified Nurse Practitioners?
	NO
2.	List the name/names and type of licensure for each nurse with whom you are collaborating. For example: Jane Doe, CNP; Mary Smith, CNS.

	{not Answered}
Oł	io Employment
1.	Do you practice in Ohio?
	YES
Οł	io Workforce Questions
	"Clinical" - direct patient care
	25-29
2.	"Research" - study of a treatment, procedure or medication done in a medical setting or for a medical purpose
	0
3.	"Administration" - activities related generally to patient care other than direct contact with a patient (e.g. recordkeeping, clerical tasks, chart review, prior authorizations with insurers, claims, billing issues, etc.)
	1-4
4.	"Education" - preceptor, mentor, etc.
	1-4
5.	"Volunteering" - providing medical and medical-related services at no cost
	0
6.	"Other" - medical professional activities not included in above categories
	0
Cli	nical - Practice setting
۱.	Enter the number of hours per week spent in "Office/Clinic/Ambulatory care" (out-patient care).
	25-29
2.	Enter the number of hours per week spent in "Hospital (in-patient care)".
	0
3.	Enter the number of hours per week spent in "Emergency Room"0

4.	Enter the number of hours per week spent in "Urgent Care".
	0
5.	Enter the number of hours per week spent in "Other".
	0
W	orkforce Counties
1.	Enter the first zip code:
	43612
2.	Enter the first county:
	Lucas
3.	Enter the second zip code:
	43205
4.	Enter the second county:
	Franklin
5.	Enter the third zip code:
	44223
6.	Enter the third county:
••	Summit
7.	Do you have more than one practice location?
′•	YES
W	orkforce Practice Address
	Please list all practice locations. Include street address, city, state
	and zip. Example "123 E Main St, Suite 2, Anywhere, OH 55555;"
	Separate multiply addresses with a semicolon.
	1160 W. Sylvania Ave., Toledo, OH 43612; 1243 E. Broad St., Columbus, OH 43205; 2127 State Rd., Cuyahoga Falls, OH
	44223; 222 S. Elizabeth St., Lima, OH 45801; 4818 Indianola Ave.,
	Columbus, OH 43214
Pr	actice Arrangement (size)
1.	Solo practitioner
	NO
2.	Single-specialty Group
	2-5

3.	Multi-specialty Group
	N/A
4.	Employee of a clinical facility or hospital? (Clinical facility is an urgent care, industrial clinic or similar entity)
	YES
W	orkforce Language Question
	Do practitioners or staff in your practice communicate in sign language or in a language other than spoken English?
	NC
ΑB	MS Certified
1.	Are you certified by an ABMS Board?
	YES
AB	MS Specialty
1.	Choose specialty from the dropdown list.
	Obstetrics and Gynecology
2.	Choose specialty from the dropdown list.
	{not Answered}
3.	Choose specialty from the dropdown list.
	{not Answered}
sta	derstand that submitting a false, fraudulent, or forged ement or document or omitting a material fact in obtaining nsure may be grounds for disciplinary action against my license.
I h	der penalty of law, I hereby swear or affirm that the information we provided in the application is complete and correct, and that we complied with all criteria for applying on line.