

From: Carla Kruger <CKruger@albme.org>
Sent: Tuesday, November 20, 2012 4:11 PM
To: 'Karen Silas'
Subject: FW: No subject

Follow Up Flag: Follow up
Flag Status: Flagged

There were no coq applications this early. Could you send whatever licensing/renewal apps you can locate? There is an "Examination Applicant" page at the end of his renewals file that includes his scores, I think that is the "coq app."

-----Original Message-----

From: jadenling@hushmail.com [<mailto:jadenling@hushmail.com>]
Sent: Monday, November 12, 2012 7:08 AM
To: ckruger@albme.org
Subject: No subject

11.12.12

Carla Kruger
Legal Dept.
The Alabama Board of Medical Examiners
848 Washington Avenue
Montgomery AL 36104

Dear Alabama Board of Medical Examiners,

Pursuant to the Alabama Public Records Law we are writing to acquire documents of everything in the file for Patrick H. Smith, License number MD.2857 and Controlled Substance License ACSC 2857.

This would also include all medical malpractice case information, all criminal documents, all complaints, all disciplinary actions, all applications and reapplications, all hospital admitting privileges, all temporary licenses, and all previous profiles.

This would be for all years since they have been licensed.

Electronic format is preferred.

Thank you very much.

Very truly yours,

Jaden Ling

ALABAMA BOARD OF MEDICAL EXAMINERS
EXAMINATION APPLICANT

Registration No. 148 Certificate No. 6781 Certificate Dated July 1, 1957

NAME IN FULL Smith, Patrick Henry
(Surname) (Given name) (Middle name)

Street Address Blodgett Avenue, North City Birmingham, Alabama

Medical College The Medical College of Alabama Year of Graduation 1956

Hospital Internship West End Baptist Hospital, Birmingham, Alabama Length 1 Year

Hospital Residency _____ Length _____

Military Service United States Navy Period January 1946-November 1947

PRELIMINARY EDUCATION

Degree A. B. College Howard College, Birmingham, Ala Date June 1952

Place of birth Birmingham, Alabama Date of birth January 10, 1928

Date of any previous examination by this Board None

Date certificate mailed July 11, 1957

School of Practice Regular Registration Date June 18, 1956

License No. 2857

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|--------------|
| Anatomy | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | <u>72.0</u> |
| Chemistry | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | <u>76.0</u> |
| Physiology | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | <u>86.0</u> |
| Etiology, Pathology, Symptomatology and Diagnosis of Diseases | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | <u>82.0</u> |
| Physical Diagnosis | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | <u>91.0</u> |
| Surgery | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | <u>86.5</u> |
| Obstetrics and Obstetrical Operations | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | <u>88.0</u> |
| Gynecology | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | <u>78.0</u> |
| Hygiene and Medical Jurisprudence | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | <u>92.0</u> |
| Diseases of the Eye, Ear, Nose and Throat | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | <u>97.0</u> |
| Final Average | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | <u>84.85</u> |

William Henry Smith
Secretary

~~SEP 8~~ 1961

CERTIFICATE OF QUALIFICATION

The Alabama Board of Medical Examiners
certifies to the
Alabama Licensing Board for the Healing Arts that

PATRICK HENRY SMITH

is qualified to practice Medicine
by virtue of successful completion of written examination conducted by the Alabama Board of Medical
Examiners.

Date December 15, 1959
Montgomery, Alabama

W. H. Smith, M. D.
Secretary.

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

SEP 8 1961

Name in full (print) PATRICK HENRY SWITH, M.D.

Business address 5532 FIRST AVENUE SOUTH

City BIRMINGHAM County JEFFERSON

Branch of Healing Arts in which you are licensed to practice MEDICINE

\$10.00 Fee attached.

Date SEPTEMBER 7 1961

Signed Patrick H. Swith, M.D.

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

Date September 7, 1961

SEP 8 1961

Complete this application in full

Name and Business Address
Dr. Patrick H. Smith
5532 First Avenue South
Birmingham, Alabama

License #. (omit) Date issued (omit)

County Jefferson Fee \$5.00 per year - pay only \$2.50 for remainder of 1961

Should any of the above information be incorrect, please correct in the space provided below:

(Type or Print) Name Street Address City and State

County _____ Date Issued _____ License No. _____

Has your license been recorded in the Probate Office of your County? Yes No.

Only the original 1957 (6784)

Patrick H. Smith, M.D.
Signature

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

Name and Business Address Dr. Patricia Henry Smith
5532 First Avenue, South
Birmingham, Alabama

Date 12-27-61

Complete this application in full

DEC 28 1961

License #2857 Date issued 9/11/61

County Jefferson Fee \$5.00

Should any of the above information be incorrect, please correct in the space provided below:

(Type or Print) Name _____ Street Address _____ City and State _____

County _____ Date Issued _____ License No. _____

Has your license been recorded in the Probate Office of your County? Yes No.

Patricia Henry Smith, M.D.
Signature

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

6/21/61
Name and Business Address
Dr. Patrick Henry Smith
5532 First Avenue, South
Birmingham, Alabama

Date

License # 2857 Date issued 9/11/61

County Jefferson Fee \$5.00

Patrick Henry Smith, M.D.
Signature

THE SPACE BELOW FOR CORRECTIONS ONLY

Name (Type or Print) _____ Address _____

City _____ and _____ State _____ License Number _____ Date Issued _____

DEC 4 1962

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

NOV 26 1953

MS

Name and Business Address
Dr. Patrick Henry Smith
~~500 1st Avenue, South~~
Birmingham, Alabama

Date

License # 2357 Date issued 9/11/61

County Jefferson Fee

Dr. Patrick H. Smith, M.D.
Signature Medicine

THE SPACE BELOW FOR CORRECTIONS ONLY

(Post Office Box 4147)

Name (Type or Print) Address

BIRMINGHAM, ALABAMA

City and State License Number Date Issued

11-25-63

DEC 16 1964
No M 2319 *pd*

STATE LICENSING BOARD FOR THE HEALING ARTS

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 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 Alabama, the license of such person shall be automatically revoked without further notice or hearing.

APPLICATION FOR CERTIFICATE OF REGISTRATION

Name and Business Address ~~_____~~ **9105 ~~500~~ 4TH AVE SO.**

License # _____ Date issued _____

County _____ Fee _____

Patricia S. Swinney
Signature

USE REVERSE SIDE FOR CORRECTIONS ONLY

No M 2433

STATE LICENSING BOARD FOR THE HEALING ARTS

MONTGOMERY, ALABAMA

DEC 9 - 1965

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 fail to register and pay the above fee within thirty (30) days after registration becomes due, as provided in Title 40, 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 Date

License # Date issued

County Fee

Paul Mitchell Smith M.D.
Signature

USE REVERSE SIDE FOR CORRECTIONS ONLY

No 2497 M

STATE LICENSING BOARD FOR THE HEALING ARTS

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 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 Alabama, the license of such person shall be automatically revoked without further notice or hearing.

APPLICATION FOR CERTIFICATE OF REGISTRATION

Name and Business Address Date

License # Date issued

RECEIVED Fee

NOV 22 1966

Signature

USE REVERSE SIDE FOR CORRECTIONS ONLY

HEALING ARTS BOARD

No. 2579 M

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

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 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 Alabama, the license of such person shall be automatically revoked without further notice or hearing.

Name and
Business
Address

License #

Date issued

PROPERTY

Fee

NOV 29 1967

Signature

USE REVERSE SIDE FOR CORRECTIONS ONLY

HEALING ARTS BOARD

No 2669 M

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 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
35206

License # 35206 Date issued 3/12/69

Fee \$2.50 + \$1.00

RECORDED

Signature *Randall*

FEB 13 1969

USE REVERSE SIDE FOR CORRECTIONS ONLY

HEALING ARTS BOARD

No 2761 M

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 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 #

Date issued

County

Fee

Signature

USE REVERSE SIDE FOR CORRECTIONS ONLY

NOV 14 1969

No. 2871 M

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

Room 209—Public 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 \$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 Alabama, the license of such person shall be automatically revoked without further notice or hearing.

Name and
Business
Address

License #

Date issued

County

Fee

Signature

USE REVERSE SIDE FOR CORRECTIONS ONLY

NOV 13 1970

No 3036 M

APPLICATION FOR CERTIFICATE OF REGISTRATION FOR 1972
STATE LICENSING BOARD FOR THE HEALING ARTS

Room 209--Public 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.

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 #

Date issued

County

Fee

DEC 6 1971

[Handwritten Signature]
Signature

USE REVERSE SIDE FOR CORRECTIONS ONLY

No 3172 M

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

Public 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.

Name and Business Address
1000 ...
Montgomery, Alabama 36104

License # _____ Date issued _____

County _____ Fee _____

Signature

NOV 29 1972 USE REVERSE SIDE FOR CORRECTIONS ONLY

No 3320 M

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

Public 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.

Name and
Business
Address

License #

Date issued

County

Fee


Signature

USE REVERSE SIDE FOR CORRECTIONS ONLY

OCT 24 1973

No 3479 M

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

Public 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.

Name and Business Address

License #

Date issued

County

Fee

[Handwritten Signature]
Signature

USE REVERSE SIDE FOR CORRECTIONS ONLY

NOV 13 1974

No 3683 M

A P P L I C A T I O N

FOR CERTIFICATE OF REGISTRATION FOR 1976

STATE LICENSING BOARD FOR THE HEALING ARTS

Public Safety Building

MONTSOMERY, ALABAMA 36130

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

License #

Date issued

County

Fee

Signature

JAN 14 1976

FOR CHANGE OF ADDRESS ONLY

9105 PARKWAY EAST

BIRMINGHAM 35206

Patrick A. ... MD

No. 4231 M

A P P L I C A T I O N

FOR CERTIFICATE OF REGISTRATION FOR 1977

STATE LICENSING BOARD FOR THE HEALING ARTS

Public Safety Building
MONTGOMERY, ALABAMA 36130

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

DR. J. W. BROWN, JR.
1015 1/2 N. 10th St.
Montgomery, Ala. 36102

License #

722973

Date issued

12/14/76

County

Montgomery

Fee

\$10.00

Signature _____

DEC 14 1976

FOR CHANGE OF ADDRESS ONLY

THIS IS THE ONLY NOTICE
YOU WILL RECEIVE.

No 4503 M

A P P L I C A T I O N

**FOR CERTIFICATE OF REGISTRATION FOR 1978
STATE LICENSING BOARD FOR THE HEALING ARTS**

Public Safety Building
MONTGOMERY, ALABAMA 36130

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.

If not paid by January 31st you must pay an additional \$20.00 penalty for reinstatement of your license.

Name and

Business

Address

License #

County

Date issued

Fee

DEC 13 1977

Signature

FOR CHANGE OF ADDRESS ONLY

THIS IS THE ONLY NOTICE YOU WILL RECEIVE.

No. 4526 M

RENEWAL APPLICATION
FOR CERTIFICATE OF REGISTRATION FOR 1979
STATE LICENSING BOARD FOR THE HEALING ARTS
Public Safety Building
MONTGOMERY, ALABAMA 36130

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 not paid by January 31st you must pay an additional \$20.00 penalty for reinstatement of your license.

Name and Business Address
D. J. ...
1105 ...
Montgomery, Alabama 36105

License # 02807 Date issued 04/17/78

County Jefferson Fee \$20.00

833-7113
 Signature

FOR CHANGE OF ADDRESS ONLY
DEC 11 1978

RENEWAL APPLICATION
FOR A CERTIFICATE OF REGISTRATION TO PRACTICE MEDICINE IN ALABAMA IN 1980.

NO. **5139** M

STATE LICENSING BOARD FOR THE HEALING ARTS NOV 7 1979

Public Safety Building
Montgomery, Alabama 36130
Phone 205/832-5051

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.

Name and Mailing Address:

PATRICK H SMITH
9105 PARKWAY EAST
BIRMINGHAM, AL 35206

Business Address:

9105 PARKWAY E
BIRMINGHAM, AL 35206

LICENSE #: 0002957 ISSUED: 07/11/77

The above addresses are correct.

833-7113

RENEWAL APPLICATION

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

NO. 5392

M

STATE LICENSING BOARD FOR THE HEALING ARTS

908 S. Hull Street, Room 110
Montgomery, Alabama 36130
Phone 205/832-5051

NOV 25 1980

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.

Name and Mailing Address:

Patrick Henry Smith, M. D.
9105 Parkway East
Birmingham, Alabama 35206

Business Address:

9105 PARKWAY E
BIRMINGHAM, AL 35206

2857

9/11/61

833-7113

Jefferson

\$10.00

The above Addresses are correct.

RENEWAL APPLICATION

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

ALABAMA MEDICAL LICENSURE COMMISSION

908 South Hull Street, Room 110
Montgomery, Alabama 36104
Phone 205/832-5051

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 Act. No. 81-218, Code of Alabama, Section 12.

Name and Mailing Address:

PATRICK H SMITH
9105 PARKWAY EAST
BIRMINGHAM, AL 35206

LICENSE #: 0002857

ISSUED: 07/11/57

Business Address:

9105 PARKWAY E
BIRMINGHAM, AL 35206

The above Addresses are correct.

RENEWAL APPLICATION

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
Phone 205/832-5051

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 Act. No. 81-218, Code of Alabama, Section 12.

Name and Mailing Address:

PATRICK H SMITH
9105 PARKWAY EAST
BIRMINGHAM, AL 35206

Business Address:

9105 PARKWAY E
BIRMINGHAM, AL 35208

LICENSE #: 0002857

ISSUED: 07/11/57



The above Addresses are correct.

RENEWAL APPLICATION

FOR A CERTIFICATE OF REGISTRATION TO PRACTICE MEDICINE IN ALABAMA IN 1984
ALABAMA MEDICAL LICENSURE COMMISSION

Post Office Box 887
Montgomery, Alabama 36101
Phone (205) 832-5051

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:

PATRICK H SMITH
9105 PARKWAY EAST
BIRMINGHAM, AL 35206

Business Address:

9105 PARKWAY E
BIRMINGHAM, AL 35208

LICENSE #: 0002857

ISSUED: 07/11/57

The above Addresses are correct.

RENEWAL APPLICATION

FOR A CERTIFICATE OF REGISTRATION TO PRACTICE MEDICINE IN ALABAMA IN 1985
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:

PATRICK H SMITH
9105 PARKWAY EAST
BIRMINGHAM, AL 35208

Business Address:

9105 PARKWAY E
BIRMINGHAM, AL 35208

LICENSE #: 0002857

ISSUED: 07/11/57



The above Addresses are correct.

RENEWAL APPLICATION

FOR A CERTIFICATE OF REGISTRATION TO PRACTICE MEDICINE IN ALABAMA IN 1986
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:

PATRICK H SMITH
9105 PARKWAY EAST
BIRMINGHAM, AL 35206

Business Address:

9105 PARKWAY E
BIRMINGHAM, AL 35208

LICENSE #: 0002857

ISSUED: 07/11/57

The above Addresses are correct.

RENEWAL APPLICATION

FOR A CERTIFICATE OF REGISTRATION TO PRACTICE MEDICINE IN ALABAMA IN 1987
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:

PATRICK H SMITH
9105 PARKWAY EAST
BIRMINGHAM, AL 35206

Business Address:

9105 PARKWAY E
BIRMINGHAM, AL 35206

LICENSE #: 0002537

ISSUED: 07/11/57

The above Addresses are correct.

RENEWAL APPLICATION

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.

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:
PATRICK H. SMITH
9105 PARKWAY EAST
BIRMINGHAM, AL 35206
LICENSE # 44 00000000

Business Address:
9105 PARKWAY E
BIRMINGHAM, AL 35206

ISSUED: 07/11/87

The above Addresses are correct.

RENEWAL APPLICATION

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:

PATRICK H SMITH
9105 PARKWAY EAST
BIRMINGHAM, AL 35206

Business Address:

9105 PARKWAY E
BIRMINGHAM, AL 35208

LICENSE #: 0002857

ISSUED: 07/11/57

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/misdemeanor) involving the practice of medicine. YES NO
2. Has your certificate of qualifications of license to practice medicine in any state been suspended, revoked, restricted, curtailed or voluntarily surrendered under threat of suspension or revocation? YES NO
3. Have your staff privileges at any hospital or health care facility been revoked suspended, curtailed, limited or placed under conditions restricting your practice? YES NO
4. Have you been denied a certificate of qualification or a 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 or claim? YES NO
5. Are you now or have you been addicted to the use of alcohol or controlled substances? YES NO
6. Have you been diagnosed and/or treated for a mental illness? YES NO
7. Have you had a judgement rendered against you, or action settled relating to the performance of your professional services? YES NO
8. To your knowledge, are you the subject of an investigation by any licensing Board/Agency as of the date of this renewal application? YES NO

I certify that the above information is correct

Signature

Date

(Do Not Detach)

Patrick H Smith 10-17-88

RENEWAL APPLICATION

FOR A CERTIFICATE OF REGISTRATION TO PRACTICE MEDICINE IN ALABAMA IN 1990
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:

PATRICK H SMITH
9105 PARKWAY EAST
BIRMINGHAM, AL 35206

Business Address:

9105 PARKWAY E
BIRMINGHAM, AL 35208

LICENSE #: 0002857 ISSUED: 07/11/57

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

WITHIN THE PAST YEAR:

- | | YES | NO |
|--|--------------------------|-------------------------------------|
| 1. Have you been convicted of a felony or of any offense (felony/misdemeanor) involving the practice of medicine. | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 2. Has your certificate of qualifications or license to practice medicine in any state been suspended, revoked, restricted, curtailed or voluntarily surrendered under threat of suspension or revocation? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 3. Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practice? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 4. Have you been denied a certificate of qualification or a 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 claim? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 5. Are you now or have you been addicted to the use of alcohol or controlled substances? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 6. Have you been diagnosed and/or treated for a mental illness? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 7. Have you had a judgement rendered against you, or action settled relating to the performance of your professional service? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 8. To your knowledge, are you the subject of an investigation by any licensing Board/Agency as of the date of this renewal application? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
- I certify that the above information is correct

Signature

Patrick H Smith

Date

10-25-89

(Do Not Detach)

RENEWAL APPLICATION

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: **PATRICK H SMITH**
9105 PARKWAY EAST
BIRMINGHAM, AL 35206
Business Address: **9105 PARKWAY E**
BIRMINGHAM, AL 35208

LICENSE #: 0002857 ISSUED: 07/11/57

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/misdemeanor) involving the practice of medicine. YES NO
- 2. Has your certificate of qualifications or license-to-practice medicine in any state been suspended, revoked, restricted, curtailed or voluntarily surrendered under threat of suspension or revocation? YES NO
- 3. Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practice? YES NO
- 4. Have you been denied a certificate of qualification or a 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 or claim? YES NO
- 5. Are you now or have you been addicted to the use of alcohol or controlled substances? YES NO
- 6. Have you been diagnosed and/or treated for a mental illness? YES NO
- 7. Have you had a judgement rendered against you, or action settled relating to the performance of your professional services? YES NO
- 8. To your knowledge, are you the subject of an investigation by any licensing Board/Agency as of the date of this renewal application? YES NO

I certify that the above information is correct

Signature: Patrick H Smith MD Date: 10-29-57
(Do Not Detach)

RENEWAL APPLICATION

FOR A CERTIFICATE OF REGISTRATION TO PRACTICE MEDICINE IN ALABAMA IN 1992
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:

PATRICK H SMITH
9105 PARKWAY EAST
BIRMINGHAM, AL 35206

Business Address:

9105 PARKWAY E
BIRMINGHAM, AL 35208

LICENSE #: 0002857

ISSUED: 07/11/57

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/misdemeanor) involving the practice of medicine. | YES | NO |
| 2. Has your certificate of qualifications or license to practice medicine in any state been suspended, revoked, restricted, curtailed or voluntarily surrendered under threat of suspension or revocation? | YES | NO |
| 3. Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practice? | YES | NO |
| 4. Have you been denied a certificate of qualification or a 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 claim? | YES | NO |
| 5. Are you now or have you been addicted to the use of alcohol or controlled substances? | YES | NO |
| 6. Have you been diagnosed and/or treated for a mental illness? | YES | NO |
| 7. Have you had a judgment rendered against you, or action settled relating to the performance of your professional services? | YES | NO |
| 8. To your knowledge, are you the subject of an investigation by any licensing Board/Agency as of the date of this renewal application? | YES | NO |

I certify that the above information is correct

Patrick H Smith
Signature _____ Date _____

(Do Not Detach)

RENEWAL APPLICATION

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 #: 0002857 ISSUED: 07/11/57

PATRICK H SMITH
9105 PARKWAY EAST
BIRMINGHAM, AL 35206

Home Address:

Street 1357 Starnest Drive
City Birmingham
State AL Zip 35206
Business FAX#:() _____

Make corrections to mailing address on reverse.

Check if you authorize your FAX# to be published in a directory

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: \$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).

(Check a or b) For CME Certification

a) 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, 1992.

b) I certify that I am exempt from the minimum continuing medical education requirement for the following reason:

Check One Below If You Answered (b)

I do not reside in the State of Alabama and do not have a significant portion of my medical practice in Alabama

I received my initial license to practice medicine in Alabama after June 30th of this calendar year.

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.

Within The Past Year:

1. Have you been convicted of a felony or of any offense (felony/misdemeanor) involving the practice of medicine? Yes No
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? Yes No
3. Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practice? Yes No
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? Yes No
5. Are you now or have you been addicted to the use of alcohol or controlled substances? Yes No
6. Have you been diagnosed and/or treated for a mental illness and/or serious physical illness? Yes No
7. Have you had a judgement rendered against you, or action settled relating to the performance of your professional service? Yes No
8. To your knowledge, are you the subject of an investigation by any licensing Board/Agency as of the date of this application? Yes No

I certify that all information on this form is correct

Patrick H Smith, M.D. 10-22-92
Signature Date

(Do Not Detach)

RENEWAL APPLICATION

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

Name & Mailing Address

(Make address corrections in (4) below.)

LICENSE #: 00002857 ISSUED: 9/11/1961
SMITH PATRICK HENRY
9105 PARKWAY E
BIRMINGHAM AL 35206-1508

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

- a) 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, 1993.
- b) I certify that I am exempt from the minimum continuing medical education requirement for the following reason:

Check One Below if You Answered (b)

- I do not reside in the State of Alabama and do not have a significant portion of my medical practice in Alabama.
- I received my initial license to practice medicine in Alabama after June 30th of this calendar year.
- 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 No

- 1. Have you been convicted of a felony or of any offense (felony/misdemeanor) involving the practice of medicine? Yes No
- 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? Yes No
- 3. Have your staff privileges, at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practice? Yes No
- 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? Yes No
- 5. Are you now or have you been addicted to the use of alcohol or controlled substances? Yes No
- 6. Have you been diagnosed and/or treated for a mental illness and/or serious physical illness? Yes No
- 7. Have you had a judgement rendered against you, or action settled relating to the performance of your professional service? Yes No
- 8. To your knowledge, are you the subject of an investigation by any licensing Board/Agency as of the date of this application? Yes No

Signature: Patrick Henry Smith MD 11-4-93
Date

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



PATRICK HENRY SMITH, M.D.
9105 PARKWAY E

BIRMINGHAM, AL 35206

Complete BOTH sides including signature.
Be sure to correct or supply ALL information.
Return with \$100.00 renewal fee.
Incomplete applications will be returned.
Failure to register and pay renewal fee will result in the
automatic revocation of the current license to practice
medicine or osteopathy.

Please make corrections or supply information: License # 00002857 Sex: M F

Race: White Black Am. Indian Oriental or Asian Other Social Security [REDACTED]

Office Address:

9105 PARKWAY E

Home Address:

STONECREST
1357 STONECREST DR

City, State, Zip: BIRMINGHAM, AL 35206

County: Jefferson

Business Phone: (205)833-7113

Fax Number: () _____

Permission to publish in Roster: Yes No

City, State, Zip: BIRMINGHAM, AL 35235

County: Jefferson

Home Phone: () _____

(Will not be published)

Send official mail to **Business** or **Home** address (circle one)

Specialty: Primary: O

Secondary: _____

Board Certified: Yes No

Board Certified: Yes No

Form of Practice: Solo Partnership (2, 3 or 4) Group (5 or more) If Group, give name: _____

Primary Hospital where you have staff privileges:

Name: MED CTR EAST

City/State: BIRMINGHAM, AL

Are you licensed in another state: Yes No Which ones: [AK] [TN] [] [] []

CME Certification: (Check one)

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, 1994.

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

- I do not reside in the State of Alabama and do not have a significant portion of my medical practice in Alabama.
- I received my initial license to practice medicine in Alabama after June 30th of this calendar year.
- I reinstated my license to practice medicine in the State of Alabama after June 30th of this calendar year.
- I am a resident physician enrolled in a residency training program.
- I am retired from the practice of medicine and have obtained a waiver from the Board of Medical Examiners.

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

Within The Past Year:

Yes No

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 voluntarily surrendered 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?
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 service?
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 is correct:

[Handwritten Signature]

11-2-94

Signature

Date

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

Incomplete applications will be returned.

Return with \$100.00 renewal fee to:

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

DEADLINE — DECEMBER 31, 1994

License Renewal for 1996
Deadline is December 31, 1995

State of Alabama
Medical Licensure Commission

334/242-4153

P.O. Box 887

Montgomery, Alabama 36101-0887



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.

.....
Patrick Henry Smith, M.D.
9105 Parkway E

**3-DIGIT 352
177
30

Birmingham, AL 35206 1508



Please make corrections or supply information: License **2857** DATE ISSUED: 09/11/61 Sex: M F

Race: White Black Am. Indian Oriental or Asian Other Social Security # XXXXXXXXXX

Office Address:

9105 PARKWAY E

City, State, Zip: BIRMINGHAM, AL 35206 1508

(Alabama) County: Montgomery

Business Phone: (205)833-7113

Fax Number:

Permission to publish in Roster: Yes No

Specialty: Primary: OBSTETRICS & GYNECOLOGY

Secondary:

Form of Practice: Solo Partnership (2, 3, or 4) Group (5 or more) If Group, give name below:

MEDICAL CENTER EAST, BIRHAM, AL 35206

Primary Hospital where you have staff privileges:

Name: MED CTR EAST

City/State: BIRMINGHAM, AL

Are you licensed in another state: Yes No Which ones:

CME Certification: (Check one)

I hereby certify that I have met the annual minimum continuing education requirement of 12 hours of Category I continui medical education during the calendar year ending December 31, 1995.

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

- I do not reside in the State of Alabama and do not have a significant portion of my medical practice in Alabama.
- I received my initial license to practice medicine in Alabama after June 30th of this calendar year.
- I reinstated my license to practice medicine in the State of Alabama after June 30th of this calendar year.
- I am a resident physician enrolled in a residency training program.
- I am retired from the practice of medicine and have obtained a waiver from the Board of Medical Examiners.

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

OVER

DEADLINE IS DECEMBER 31, 1995

- | | 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? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 5. Are you now or have you been addicted to the use of alcohol or controlled substances within the past year? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 6. Have you been diagnosed and/or treated for a mental illness and/or serious physical illness? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 7. Have you had a judgement rendered against you, or action settled relating to the performance of your professional service within the past year? | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input checked="" type="checkbox"/> | <input type="checkbox"/> |

*2-8
H. H. H. H. H.*

IF YOU HAVE ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, PLEASE ATTACH A DETAILED EXPLANATION WITH YOUR APPLICATION UPON RETURNING IT TO THIS OFFICE.

I certify that all information on this form is correct.

Signature

Date

10-16-95

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

Incomplete applications will be returned.

Return with \$100.00 renewal fee to:

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

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.

PATRICK HENRY SMITH, M.D.
9105 PARKWAY E
BIRMINGHAM AL 35206-1508

Please make corrections or supply information: License 2857 DATE ISSUED: 09/11/61 Sex: M F

Race: White Black Am. Indian Oriental or Asian Other Social Security # [REDACTED]
Enter SSAN#

Office Address:

9105 PARKWAY E

Home Address:

601 HICKORY ST

City, State, Zip: BIRMINGHAM, AL 35206 1508

(Alabama) County: Montgomery

Business Phone: (205)833-7113

Fax Number: ()

Permission to publish in Roster: Yes No

Specialty: Primary: ~~OBSTETRICS & GYNECOLOGY~~

Secondary: _____

City, State, Zip: BIRMINGHAM, AL 35206

(Alabama) County: Jefferson

Home Phone: (205) 833-2051

(Will not be published)

Send official mail to: **Business** address (check one)

Home

Board Certified: Yes No

Board Certified: Yes No

Form of Practice: Solo Partnership (2, 3, or 4) Group (5 or more) If Group, give name below:

Primary Hospital where you have staff privileges:

Name: MED CTR EAST

City/State: BIRMINGHAM, AL

Are you licensed in another state: Yes No Which ones: [AK] [TN]

CME Certification: (Check one)

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, 1996.

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

I do not reside in the State of Alabama and do not have a significant portion of my medical practice in Alabama.

I received my initial license to practice medicine in Alabama after June 30th of this calendar year.

I reinstated my license to practice medicine in the State of Alabama after June 30th of this calendar year.

I am a resident physician enrolled in a residency training program.

I am retired from the practice of medicine and have obtained a waiver from the Board of Medical Examiners.

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

OVER

DEADLINE IS DECEMBER 31, 1996

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? YES NO
- 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? YES NO
- 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? YES NO
- 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? YES NO
- 5. Have you had a judgement rendered against you, or action settled relating to the performance of your professional service within the past year? YES NO
- 6. To your knowledge, are you the subject of an investigation by any licensing Board/Agency as of the date of this application within the past year? YES NO
- 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? YES NO
- 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? YES NO
- 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? YES NO
- 10. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism? YES NO
- 11. Are you currently engaged in the illegal use of controlled dangerous substances? YES NO
- 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? YES NO
- 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? YES NO
- 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? YES 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 so that the condition referred to may have an ongoing impact on one's functioning as a physician or an assistant to a physician, or within the past two years.

IF YOU HAVE ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, PLEASE ATTACH A DETAILED EXPLANATION WITH YOUR APPLICATION UPON RETURNING IT TO THIS OFFICE.

I certify that all information on this form is correct.

[Signature]
Signature

11-18-96
Date

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

Return with \$100.00 renewal fee to:

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

License Renewal for 1998
Deadline is December 31, 1997

State of Alabama
Medical Licensure Commission

334/242-4153

P.O. Box 887

Montgomery, Alabama 36101-0887



*****5-DIGIT 35206

PATRICK HENRY SMITH, M.D.
9105 PARKWAY E
BIRMINGHAM, AL 35206-1508

14
43
3525

Complete **BOTH** sides including signature.
Be sure to correct or supply **ALL** information.
Return with \$100.00 renewal fee.
Incomplete applications will be returned.
Failure to register and pay renewal fee will result
in the automatic revocation of the current license to
practice medicine or osteopathy.



Please make corrections or supply information: License **2857** DATE-ISSUED: 9/11/61 Sex: M F
Race: White Black Am. Indian Oriental or Asian Other Social Security # XXXXXXXXXX

Office Address:

9105 PARKWAY E
City, State, Zip: BIRMINGHAM, AL 35206 1508
(Alabama) County: Montgomery
Business Phone: (205)833-7113
Fax Number: ()

Home Address:

601 HICKORY ST
City, State, Zip: BIRMINGHAM, AL 35206
(Alabama) County: Jefferson
Home Phone: (205)833-2051
(Will not be published)

Permission to publish in Roster: Yes No

Send official mail to: **Business** address (check one)
Home

Specialty: Primary: OBSTETRICS & GYNECOLOGY
Secondary: _____

Board Certified: Yes No
Board Certified: Yes No

Form of Practice: Solo Partnership (2, 3, or 4) Group (5 or more) If Group, give name below:

Primary Hospital where you have staff privileges:

Name: MED CTR EAST City/State: BIRMINGHAM, AL

Are you licensed in another state: Yes No which ones: [AK] [TN]

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
3. Approximately how many hours per week do you practice the above-defined primary care services? 1-15

CME Certification: (Check one)

- 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, 1997.
 I certify that I am exempt from the minimum continuing medical education requirements for the following reason:

- I do not reside in the State of Alabama and do not have a significant portion of my medical practice in Alabama.
- I received my initial license to practice medicine in Alabama after June 30th of this calendar year.
- I reinstated my license to practice medicine in the State of Alabama after June 30th of this calendar year.
- I am a resident physician enrolled in a residency training program.
- I am retired from the practice of medicine and have obtained a waiver from the Board of Medical Examiners.

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

DEADLINE IS DECEMBER 31, 1997

OVER

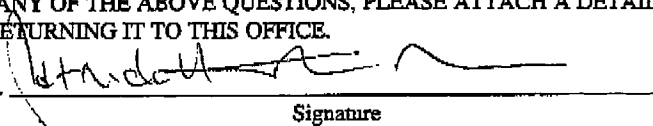
3525

- | | 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? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 5. Have you had a judgement rendered against you, or action settled relating to the performance of your professional service within the past year? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 6. To your knowledge, are you the subject of an investigation by any licensing Board/Agency as of the date of this application within the past year? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 10. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 11. Are you currently engaged in the illegal use of controlled dangerous substances? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

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

IF YOU HAVE ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, PLEASE ATTACH A DETAILED EXPLANATION WITH YOUR APPLICATION UPON RETURNING IT TO THIS OFFICE.

I certify that all information on this form is correct.



 Signature

10-23-97

 Date

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

Return with \$100.00 renewal fee to:

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

License Renewal for 1999
Deadline is December 31, 1998

State of Alabama
Medical Licensure Commission

334/242-4153

P.O. Box 887

Montgomery, Alabama 36101-0887



*****AUTO**3-DIGIT 352

PATRICK HENRY SMITH, M.D.
9105 PARKWAY E
BIRMINGHAM AL 35206-1508

25
1
3964

Complete **BOTH** sides including signature.
Be sure to correct or supply **ALL** information.
Return with \$100.00 renewal fee.
Incomplete applications will be returned.
Failure to register and pay renewal fee will result
in the automatic revocation of the current license to
practice medicine or osteopathy.

|||||

Please make corrections or supply information: License **2857** DATE ISSUED: 9/11/61 Sex: M F
Race: White Black Am. Indian Oriental or Asian Other Social Security # [REDACTED]

Office Address:

9105 PARKWAY E
City, State, Zip: BIRMINGHAM, AL 35206 1508
(Alabama) County: Montgomery
Business Phone: (205)833-7113
Fax Number: ()

Home Address:

601 HICKORY ST
City, State, Zip: BIRMINGHAM, AL 35206
(Alabama) County: Jefferson
Home Phone: (205)833-2051

(Will not be published)

Permission to publish in Roster: Yes No

Send official mail to: **Business** address (check one)
Home

Specialty: Primary: OBSTETRICS & GYNECOLOGY

Board Certified: Yes No

Secondary: _____

Board Certified: Yes No

Form of Practice: Solo Partnership (2, 3, or 4) Group (5 or more) If Group, give name below:

Primary Hospital where you have staff privileges:

Name: MED CTR EAST City/State: BIRMINGHAM, AL

Are you licensed in another state: Yes No which ones: [AK] [TN] [] [] []

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
3. Approximately how many hours per week do you practice the above-defined primary care services? 6

CME Certification: (Check one)

- I hereby certify that I have met the annual minimum continuing education requirement of 12 hours of Category I continuing medical education during the calendar year ending December 31, 1998.
 I certify that I am exempt from the minimum continuing medical education requirements for the following reason:

- I do not reside in the State of Alabama and do not have a significant portion of my medical practice in Alabama.
- I received my initial license to practice medicine in Alabama after June 30th of this calendar year.
- I reinstated my license to practice medicine in the State of Alabama after June 30th of this calendar year.
- I am a resident physician enrolled in a residency training program.
- I am retired from the practice of medicine and have obtained a waiver from the Board of Medical Examiners.

DEADLINE IS DECEMBER 31, 1998

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

OVER

License #2857

3964

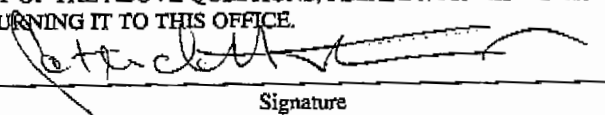
SMITH, PATRICK HENRY

- | | 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 5. Have you had a judgement rendered against you, or action settled relating to the performance of your professional service within the past year? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 6. To your knowledge, are you the subject of an investigation by any licensing Board/Agency as of the date of this application within the past year? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 10. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 11. Are you currently engaged in the illegal use of controlled dangerous substances? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

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

IF YOU HAVE ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, PLEASE ATTACH A DETAILED EXPLANATION WITH YOUR APPLICATION UPON RETURNING IT TO THIS OFFICE.

I certify that all information on this form is correct.


Signature

10-19-98
Date

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

Return with \$100.00 renewal fee to:

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

License Renewal for 2000
Deadline is December 31, 1999

State of Alabama
 Medical Licensure Commission

334/242-4153

P.O. Box 887

Montgomery, Alabama 36101-0887



*****AUTO**3-DIGIT 352
 PATRICK HENRY SMITH, M.D.
 601 HICKORY ST
 BIRMINGHAM, AL 35206-1616

22
 1
 3927

Complete **BOTH** sides including signature.
 Be sure to correct or supply **ALL** information.
 Return with \$100.00 renewal fee.
 Incomplete applications will be returned.
 Failure to register and pay renewal fee will result
 in the automatic revocation of the current license to
 practice medicine or osteopathy.



Please make corrections or supply information: License 2857 DATE-ISSUED: 9/11/61 Sex: M F
 Race: White Black Am. Indian Oriental or Asian Other Social Security # XXXXXXXXXX Enter SSAN#

Office Address:

601 HICKORY ST
 City, State, Zip: BIRMINGHAM, AL 35206
 (Alabama) County: Jefferson 37
 Business Phone: (205) ~~833-7113~~ 933-2548
 Fax Number: () _____

Home Address:

601 HICKORY ST
 City, State, Zip: BIRMINGHAM, AL 35206
 (Alabama) County: Jefferson
 Home Phone: (205)833-2051

Permission to publish in Roster: Yes No

Send official mail to: **Business** address (check one)
Home

Specialty: Primary: ~~OBTENTRICS & GYNECOLOGY~~ 29.10
 Secondary: _____

Board Certified: Yes No
 Board Certified: Yes No

Form of Practice: Solo Partnership (2, 3, or 4) Group (5 or more) If Group, give name below:

Primary Hospital where you have staff privileges: CLINIC PRACTICE ONLY
 Name: ~~MED CTR EAST~~ City/State: BIRMINGHAM, AL

Are you licensed in another state: Yes No which ones: [AK] [TN] [] [] []

Primary Care Information:

1. Are you actively engaged in clinical practice in the State of Alabama?
 Yes Go to Question 2 No Do NOT answer questions 2 and 3 below. Skip to CME Certification questions.
2. Does your practice include the delivery of primary care medical services in Alabama? (Primary care is defined as: "Basic or 'gatekeeper' health care focused on the point at which a patient ideally first seeks assistance from the medical care system, excluding emergency care situation.")
 Yes Go to Question 3 No Do NOT answer question 3 below. Skip to CME Certification questions.
3. Approximately how many hours per week do you practice the above-defined primary care services in Alabama? Only answer YES to questions 1 and 2 above.) Approximately 15 hours per week.

CME Certification: (Check one)

- 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, 1999.
- I certify that I am exempt from the minimum continuing medical education requirements for the following reason:
- I do not reside in the State of Alabama and do not have a significant portion of my medical practice in Alabama.
 - I received my initial license to practice medicine in Alabama after June 30th of this calendar year.
 - I reinstated my license to practice medicine in the State of Alabama after June 30th of this calendar year.
 - I am a resident physician enrolled in a residency training program.
 - I am retired from the practice of medicine and have obtained a waiver from the Board of Medical Examiners.

DEADLINE IS DECEMBER 31, 1999

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

License #2857

3927

SMITH, PATRICK H

- | | 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? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 5. Have you had a judgement rendered against you, or action settled relating to the performance of your professional service within the past year? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 6. To your knowledge, are you the subject of an investigation by any licensing Board/Agency as of the date of this application within the past year? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 10. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 11. Are you currently engaged in the illegal use of controlled dangerous substances? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

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

IF YOU HAVE ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, PLEASE ATTACH A DETAILED EXPLANATION WITH YOUR APPLICATION UPON RETURNING IT TO THIS OFFICE.

I certify that all information on this form is correct.

Patrick H. [Signature]
Signature

11-5-99
Date

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

Return with \$100.00 renewal fee to:

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

License Renewal for 2001
Deadline is December 31, 2000

State of Alabama
Medical Licensure Commission

334/242-4153

P.O. Box 887

Montgomery, Alabama 36101-0887



*****AUTO**3-DIGIT 352

PATRICK HENRY SMITH, M.D.
3055 TARALANE DR
BIRMINGHAM, AL 35216-4109

23

1

4425

Complete **BOTH** sides including signature.
Be sure to correct or supply **ALL** information.
Return with \$125.00 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 **2857** DATE-ISSUED: 9/11/61 Sex: M F

Race: White Black Am. Indian Oriental or Asian Other Social Security # Enter SSAN#

Office Address:

Home Address:

3055 TARALANE DRIVE

3055 TARALANE DRIVE

City, State, Zip: BIRMINGHAM, AL 35216

City, State, Zip: BIRMINGHAM, AL 35216

(Alabama) County: Jefferson

(Alabama) County: Jefferson

Business Phone: (205)933-2548

Home Phone: (205)833-2051

Fax Number: ()

(Will not be published)

Permission to publish in Roster: Yes No

Send official mail to: **Business** address (check one)
Home

Specialty: Primary: OBSTETRICS & GYNECOLOGY

Board Certified: Yes No

Secondary: _____

Board Certified: Yes No

Form of Practice: Solo Partnership (2, 3, or 4) Group (5 or more) If Group, give name below:

Primary Hospital where you have staff privileges:

Name: None City/State: _____

Are you licensed in another state: Yes No which ones: [AK] [TN] [] [] []

Primary Care Information:

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

Yes Go to Question 2 No Do NOT answer questions 2 and 3 below. Skip to CME Certification questions.

2. 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 which a patient ideally first seeks assistance from the medical care system, exclusive of an emergency care situation.")

Yes Go to Question 3 No Do NOT answer question 3 below. Skip to CME Certification questions.

3. 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.) Approximately _____ hours per week.

CME Certification: (Check one)

I hereby certify that I have met the annual minimum continuing education requirement of 24 hours of Category I continuing medical education within the past two calendar years ending December 31, 2000.

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

I do not reside in the State of Alabama and do not have a significant portion of my medical practice in Alabama.

I received my initial license to practice medicine in Alabama after June 30th of this calendar year.

I reinstated my license to practice medicine in the State of Alabama after June 30th of this calendar year.

I am a resident physician enrolled in a residency training program.

I am retired from the practice of medicine and have obtained a waiver from the Board of Medical Examiners.

DEADLINE IS DECEMBER 31, 2000

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

License #2857

4425

SMITH, PATRICK HENRY

- | | 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? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 5. Have you had a judgement rendered against you, or action settled relating to the performance of your professional service within the past year? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 6. To your knowledge, are you the subject of an investigation by any licensing Board/Agency as of the date of this application within the past year? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 10. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 11. Are you currently engaged in the illegal use of controlled dangerous substances? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

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

IF YOU HAVE ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, PLEASE ATTACH A DETAILED EXPLANATION WITH YOUR APPLICATION UPON RETURNING IT TO THIS OFFICE.

I certify that all information on this form is correct. *Patrick M. ...* 11-7-00
Signature Date

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

Return with \$125.00 renewal fee to:

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



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

2002 Online Renewal Summary

Name: **Patrick Henry Smith**

License Number: **MD.2857**

Transaction Date: **2001-11-25***

Transaction Number: **null**

Registration Fee: **200**

Date of Birth: **1928-01-10**

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

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain: **Western World Insurance Co., Inc vs. Danielle Colvin; New Woman, All Women Health Care, and Patrick H Smith, M.D., Medical Director of New Woman' Clinic. Settled in mediation.**

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**

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

Primary specialty:

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Are you Board certified in your primary specialty? **N**

Secondary specialty:

Are you Board certified in your secondary specialty? **N**

Practice Type:

Primary Hospital where you have privileges:

Are you licensed in another State: **Y**

Primary Care Information:

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

Does your practice include the delivery of primary care medical services in Alabama? (Primary care is defined as: "Basic or general 'gatekeeper' health care focused on the point at such a patient ideally first seeks assistance from the medical care system, exclusive of an emergency care situation.") **Y**

Approximately how many hours per week do you practice the above-defined primary care services in Alabama? Only answer if you answered YES to questions 1 and 2 above. **4**

CME Certification: I hereby certify that I have met the annual minimum continuing education requirement of 24 hours of Category I continuing medical education within the past two Calendar Years ending December 31, 2002. **Y**

I certify that I am exempt from the minimum CME requirement. **N**

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

Practice Telephone: **(205) 933-2548**

Practice Address: **1001 17th Street South**

Home Telephone: **2058332051**

Home Address: **3055 TARALANE DRIVE**

Public Address: **Practice**

Mail Address: **Home**

By agreeing with this data and submitting your credit information, you have signed this registration form attesting that the material has been supplied by you, the licensee, and that the information is correct. Knowingly providing false registration information to the Alabama Board of Medical Examiners may result in the loss of your license to practice medicine.



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

2003 Online Renewal Summary

Name: **Patrick Henry Smith**
Transaction Date: **2002-12-12***
Registration Fee: **200**

License Number: **MD.2857**
Transaction Number: **null**
Date of Birth: **1928-01-10**

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

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain: **Re: Danielle Colvin v. New Woman All Women Health Care, Patrick H. Smith, M.D. Jefferson County Circuit Court #CV-99-7364. Settled in mediation, Fall 2002**

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**

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

Primary specialty:

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Are you Board certified in your primary specialty? **N**

Secondary specialty:

Are you Board certified in your secondary specialty? **N**

Practice Type:

Primary Hospital where you have privileges:

Are you licensed in another State: **N**

Primary Care Information:

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

Does your practice include the delivery of primary care medical services in Alabama? (Primary care is defined as: "Basic or general 'gatekeeper' health care focused on the point at such a patient ideally first seeks assistance from the medical care system, exclusive of an emergency care situation.") **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. **10**

CME Certification: I hereby certify that I have met the annual minimum continuing education requirement of 24 hours of Category I continuing medical education within the past two Calendar Years ending December 31, 2003. **Y**

I certify that I am exempt from the minimum CME requirement. **N**

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

Practice Telephone: **(205) 933-2548**

Practice Address: **1001 17th Street South**

Home Telephone: **(205) 824-3504**

Home Address: **3055 TARALANE DRIVE**

Public Address: **Practice**

Mail Address: **Home**

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

2004 Online Renewal Summary

Name: **Patrick Henry Smith**

License Number: **MD.2857**

Transaction Date: **2003-12-08***

Transaction Number: **null**

Registration Fee: **200**

Date of Birth: **1928-01-10**

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

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain: **Danielle Colvin case (2002) was reviewed by the Board of Medical Examiners on August 19, 2003. I was required to have a neuro-psychiatric exam and I complied.**

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

Primary specialty:

Are you Board certified in your primary specialty? **N**

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Secondary specialty:

Are you Board certified in your secondary specialty? **N**

Practice Type:

Primary Hospital where you have privileges:

Are you licensed in another State: **N**

Primary Care Information:

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

Does your practice include the delivery of primary care medical services in Alabama? (Primary care is defined as: "Basic or general 'gatekeeper' health care focused on the point at such a patient ideally first seeks assistance from the medical care system, exclusive of an emergency care situation.") **Y**

Approximately how many hours per week do you practice the above-defined primary care services in Alabama? Only answer if you answered YES to questions 1 and 2 above. **15**

CME Certification: I hereby certify that I have met the annual minimum continuing education requirement of 24 hours of Category I continuing medical education within the past two Calendar Years ending December 31, 2004. **Y**

I certify that I am exempt from the minimum CME requirement. **N**

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

Practice Telephone: **(205) 933-2548**

Practice Address: **1001 17th Street South**

Home Telephone: **(205) 824-3504**

Home Address: **3055 TARALANE DRIVE**

Public Address: **Practice**

Mail Address: **Home**

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

2005 Online Renewal Summary

Name: **Patrick Henry Smith**
Transaction Date: **2004-12-16***
Registration Fee: **200**

License Number: **MD.2857**
Transaction Number: **null**
Date of Birth: **1928-01-10**

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

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

Primary specialty:

Are you Board certified in your primary specialty? **N**

Secondary specialty:

Are you Board certified in your secondary specialty? **N**

Practice Type:

Primary Hospital where you have privileges:

Are you licensed in another State: **N**

Primary Care Information:

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

Does your practice include the delivery of primary care medical services in Alabama? (Primary care is defined as: "Basic or general `gatekeeper` health care focused on the point at such a patient ideally first seeks assistance from the medical care system, exclusive of an emergency care situation.") **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. **5**

CME Certification: I hereby certify that I have met the annual minimum continuing education requirement of 12 hours of Category I continuing medical education for the Calendar Year 2004. **Y**

I certify that I am exempt from the minimum Continuing Medical Education requirement for the following reason: **N**

I am exempt from the Continuing Medical Education requirement for the following reason: (Reason Response) **null**

Practice Telephone: **(205) 933-2548**

Practice Address: **1032 18th Street South**

Home Telephone: **(205) 824-3504**

Home Address: **3055 TARALANE DRIVE**

Public Address: **Practice**

Mail Address: **Home**

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

2006 Online Renewal Summary

Name: **Patrick Henry Smith**

License Number: **MD.2857**

Transaction Date: **2005-12-28***

Transaction Number: **null**

Registration Fee: **200**

Date of Birth: **1928-01-10**

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

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

Primary specialty:

Are you Board certified in your primary specialty? **N**

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Secondary specialty:

Are you Board certified in your secondary specialty? **N**

Practice Type:

Primary Hospital where you have privileges:

Are you licensed in another State: **N**

Primary Care Information:

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

Does your practice include the delivery of primary care medical services in Alabama? (Primary care is defined as: "Basic or general 'gatekeeper' health care focused on the point at such a patient ideally first seeks assistance from the medical care system, exclusive of an emergency care situation.") **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. **4**

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 2005. **Y**

I certify that I am exempt from the minimum Continuing Medical Education requirement for the following reason: **N**

I am exempt from the Continuing Medical Education requirement for the following reason: (Reason Response) **null**

Practice Telephone: **(205) 933-6735**

Practice Address: **1801 14th Avenue South**

Home Telephone: **(205) 824-3504**

Home Address: **3055 TARALANE DRIVE**

Public Address: **Home**

Mail Address: **Home**

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

2007 Online Renewal Summary

Name: **Patrick Henry Smith**
Transaction Date: **2006-12-29***
Registration Fee: **200**

License Number: **MD.2857**
Transaction Number: **VLEF0DCE3C15**
Date of Birth: **1928-01-10**

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

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

Primary specialty: **GYNECOLOGY (OB/GYN)**

Are you Board certified in your primary specialty? **no**

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Secondary specialty:

Are you Board certified in your secondary specialty? **no**

Practice Type: **Solo**

If Group, provide the Group Name:

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

Hospital Name: **none**

Hospital City:

Hospital State:

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 in the State of Alabama? **Jefferson**

(**indicate state if not in Alabama)

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

Other County1

Other State1

Other County 2

Other State 2

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

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

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

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

PRIMARY CARE INFORMATION: Primary care is defined as: Basic or general health care focused on the point at which a patient ideally first seeks assistance from the medical care system, exclusive or an emergency situation. **null**

Does your practice include the delivery of primary care medical services in Alabama? **no**

Approximately how many hours per week do you practice the above defined primary care services in Alabama? NOTE: Enter the Average hours worked as a whole number. Do not enter ranges of hours or decimals. **0**

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

CME Certification: I hereby certify that I have met the annual minimum continuing education requirement of 12 hours of Category I continuing medical education for the calendar year 2006 and have supporting documentation if audited. **Y**

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

Exempt Reason

Practice Telephone: **(205) 933-1118**

Practice Address: **1701 10th Avenue South**

Home Telephone: **(205) 824-3504**

Home Address: **3055 TARALANE DRIVE**

Public Address:

Mail Address:

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



Medical Licensure Commission of the State of Alabama

PO Box 887

Montgomery, AL 36101

2008 Online Renewal Summary

Name: **Patrick Henry Smith**

License Number: **MD.2857**

Transaction Date: **2007-12-31***

Transaction Number: **VPFF1EB4793A**

Registration Fee: **300**

Date of Birth: **1928-01-10**

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

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

If your answer to the preceding question is yes, are you currently participating in a supervised rehabilitation program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances? **no**

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

Primary specialty: **Gynecology (OB/GYN)**

Are you Board certified in your primary specialty? **N**

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Secondary specialty: **None**

Are you Board certified in your secondary specialty? **N**

Practice Type: **S**

If Group, provide the Group Name:

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

Hospital Name: **none**

Hospital City:

Hospital State:

Are you licensed in another State:

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? **Jefferson**

(**indicate state if not in Alabama)

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

Other County1

Other State1

Other County 2

Other State 2

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

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 2007 and have supporting documentation if audited. **yes**

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

Exempt Reason

Practice Telephone: **(205) 933-1118**

Practice Address: **1701 10th Avenue South**

Home Telephone: **(205) 824-3504**

Home Address: **3055 Taralane Drive**

Public Address:

Mail Address:

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



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

2009 Online Renewal Summary

Name: **Patrick Henry Smith**
Transaction Date: **2008-12-03***
Registration Fee: **300**

License Number: **MD.2857**
Transaction Number: **VXHF3A570345**
Date of Birth: **1928-01-10**

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

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

Primary specialty: **Gynecology (OB/GYN)**

Are you Board certified in your primary specialty? **N**

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Secondary specialty: **None**

Are you Board certified in your secondary specialty? **N**

Practice Type: **S**

If Group, provide the Group Name:

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

Hospital Name: **none**

Hospital City:

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? **Jefferson**

(**indicate state if not in Alabama)

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

Other County1

Other State1

Other County 2

Other State 2

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

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

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. **3**

Approximately how many patient encounters (office, hospital, ER, etc.) per week do you have involving the above defined priary care services in Alabama? **15**

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) 933-1118**

Practice Address: **1701 10th Avenue South**

Home Telephone: **(205) 824-3504**

Home Address: **3055 Taralane Drive**

Public Address:

Mail Address:

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



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

2010 Online Renewal Summary

Name: **Patrick Henry Smith**
Transaction Date: **2009-12-14***
Registration Fee: **300**

License Number: **MD.2857**
Transaction Number: **VTHF4CFEC152**
Date of Birth: **1928-01-10**

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

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

Primary specialty: **Gynecology (OB/GYN)**

Are you Board certified in your primary specialty? **N**

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Secondary specialty:

Are you Board certified in your secondary specialty? **N**

Practice Type: **S**

If Group, provide the Group Name:

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

Hospital Name: **none**

Hospital City:

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? **Jefferson**

(**indicate state if not in Alabama)

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

Other County1 **Montgomery**

Other State1 **AL**

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. **null**

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

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. **2**

Approximately how many patient encounters (office, hospital, ER, etc.) per week do you have involving the above defined primary care services in Alabama? **15**

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) 933-1118**

Practice Address: **1701 10th Avenue South**

Home Telephone: **(205) 824-3504**

Home Address: **3055 Taralane Drive**

Public Address: **FALSE**

Mail Address: **FALSE**

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



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

2011 Online Renewal Summary

Name: **Patrick Henry Smith**
Transaction Date: **2010-12-14***
Registration Fee: **300**

License Number: **MD.2857**
Transaction Number: **VXJF6BB8B723**
Date of Birth: **1928-01-10**

* - 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 **1701 10th Avenue South**

Additional **811 S. Perry St., Montgomery AL 36104**

City **Birmingham**

State **Alabama**

Zip **35205**

County (If not in Alabama Choose 'Out of State' **Jefferson**)

Country **United States**

What is your practice Email? **[REDACTED]**

What is your practice Telephone? **(205) 933-1118**

What is your practice Fax? **N/A**

What is your Home Address? (No PO Boxes)

Street **3055 Taralane Drive**

City **Birmingham**

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State **Alabama**

Zip **35216**

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

Country **United States**

What is your Home Email? **paigelindsey@bellsouth.net**

What is your Home Phone? **(205) 824-3504**

What is your Home Fax? **N/A**

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. **Home**

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. **Home**

Social Security Number **[REDACTED]**

What is your Primary Specialty? (If None Please Choose None) **Gynecology (OB/GYN)**

Is your Primary Specialty Board Certified? **No**

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

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? **none**

What City is the Primary Hospital where you have staff privileges located? **N/A**

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

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) **Jefferson**

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

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

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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? **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? **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: **Patrick Henry Smith**
Transaction Date: **2011-12-26***
Registration Fee: **300**

License Number: **MD.2857**
Transaction Number: **VSJA8A74C1FF**
Date of Birth: **1928-01-10**

* - 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 **1701 10th Avenue South**

City **Birmingham**

State **Alabama**

Zip **35205**

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

Country **United States**

What is your practice Email? **paigelindsey@bellsouth.net**

What is your practice Telephone? **(205) 933-1118**

What is your practice Fax? **N/A**

What is your Home Address? (No PO Boxes)

Street **3055 Taralane Drive**

City **Birmingham**

State **Alabama**

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Zip **35216**

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

Country **United States**

What is your Home Email? **paigelindsey@bellsouth.net**

What is your Home Phone? **(205) 824-3504**

What is your Home Fax? **N/A**

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. **Home**

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. **Home**

Social Security Number **[REDACTED]**

What is your Primary Specialty? (If None Please Choose None) **Gynecology (OB/GYN)**

Is your Primary Specialty Board Certified? **No**

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

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? **N/A**

What City is the Primary Hospital where you have staff privileges located? **N/A**

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) **Jefferson**

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**

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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? **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.

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|---------------------------|---|------------------------------|
| ALABAMA STATE BOARD OF |) | |
| MEDICAL EXAMINERS, |) | |
| |) | |
| Complainant, |) | BEFORE THE MEDICAL LICENSURE |
| |) | COMMISSION OF ALABAMA |
| v. |) | |
| |) | |
| PATRICK HENRY SMITH, M.D. |) | Case Number <u>95-002</u> |
| |) | |
| Respondent. |) | |

STIPULATION AND CONSENT ORDER

Come now the Alabama State Board of Medical Examiners, complainant herein, and Patrick Henry Smith, M.D., Respondent herein, and respectfully submit to the Medical Licensure Commission the following:

STIPULATION

1. The Respondent, Patrick Henry Smith, M.D., admits the allegations contained in paragraphs 1, 2 and 3 of the Administrative Complaint.

2. This matter arises out of the gynecological and obstetrical medical care rendered by the Respondent to the patient, "D.S," on December 29, 1989. The Respondent first examined D.S. on December 29, 1989, when she was admitted to his services from the Emergency Room at Medical Center East with a diagnosis of incomplete abortion versus ectopic pregnancy. The Respondent performed a dilatation and curettage on December 30, 1989, without complication. On February 1, 1990, D.S. presented to the Respondent's office with complaints of pain associated with menstruation. The Respondent prescribed pain medication and instructed the patient to telephone the office in eighteen hours to report on her condition. The patient again presented to the

Respondent's office on February 6, 1990. A pregnancy test performed on that date was negative. On February 11, 1990, the Respondent examined D.S. in the Emergency Room at Medical Center East. At that time, he admitted her to the hospital and ordered appropriate tests. The Respondent did not have further occasion to treat D.S.

On January 28, 1992, the plaintiff filed a medical malpractice action in the Circuit Court of Jefferson County, Alabama. In her complaint, the patient alleges that the Respondent failed to diagnose an ectopic pregnancy. The defendant denied liability. Following discovery, a settlement was extended for \$10,000 which included an agreement that the defendant specifically denied liability.

3. Following report of the settlement agreement, the Credentials Committee of the Board of Medical Examiners interviewed the Respondent regarding the medical care rendered to D.S. At the interview, the Respondent presented evidence that his care and treatment of patient D.S. met the applicable standards of medical care. The Credentials Committee presented evidence that the Respondent committed acts that violate Ala. Code § 34-24-360(3).

4. Following this interview, the Alabama Board of Medical Examiners authorized that an Administrative Complaint be filed with the Medical Licensure Commission of Alabama.

5. The Respondent maintains that the care and treatment he rendered to the patient D.S. was reasonable and met the applicable standards of medical care. The Respondent agrees, however, that

the criticisms and suggestions voiced by the Credentials Committee are well taken. The Respondent agrees that the additional measures suggested by the Committee would have improved the care and treatment rendered to D.S.

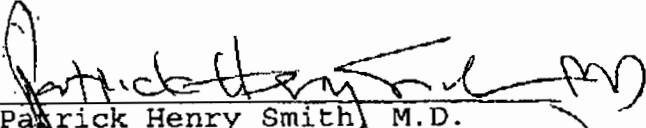
6. Although it is the opinion of the Respondent that the medical care he rendered to the patient was appropriate, the Respondent agrees that probable cause existed for the filing of the Administrative Complaint, and the Respondent acknowledges and admits that the facts alleged in paragraphs 1, 2, and 3 of the Administrative Complaint constitute grounds for the imposition of sanctions against his license to practice medicine in Alabama. The Respondent consents and agrees to the entry by the Medical Licensure Commission of Alabama of the Consent Order stated herein and agrees to be bound by the findings of fact, conclusions of law and the terms and conditions of the Consent Order. The respondent waives any further notice or hearing on the Administrative Complaint and any further findings of fact and conclusions of law with respect to the above styled matter.


7. The Alabama State Board of Medical Examiners stipulates and agrees to the entry of the Consent Order stated herein as a full and complete disposition of the charges set forth in the Administrative Complaint.

8. It is stipulated and agreed between the parties that this Stipulation and Consent Order be submitted to the Medical Licensure Commission of Alabama and is subject to the Commission's approval.

It is further agreed by the Respondent that the Medical Licensure Commission shall be permitted to examine and review, prior to any approval of this Stipulation, the records and documents now in the possession of the Alabama Board of Medical Examiners concerning the allegations set forth in the Administrative Complaint. It is further agreed that, should the Medical Licensure Commission decline to accept this Stipulation and Consent Order as a basis for the disposition of the alleged violation as set forth in the Administrative Complaint and requires the Board of Medical Examiners to go forward with its presentation of testimony and exhibits, any admissions made by the Respondent in this Stipulation shall not be binding upon the Respondent and the consideration by the Commission of this Stipulation and Consent Order and the evidence referred to above will not be considered prejudicial to the rights of the Respondent to receive a fair and impartial hearing. It is further agreed that the Respondent will not assert that such prior consideration would preclude any member of the Medical Licensure Commission from rendering a fair, just and impartial decision after hearing the evidence.

This Stipulation is entered into this 24th day of February, 1995.


Patrick Henry Smith, M.D.

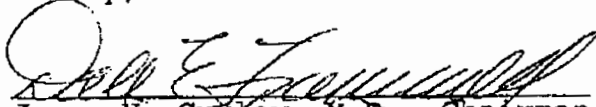

Patricia E. Shaner, Attorney for
the Alabama Board of Medical
Examiners

CONSENT ORDER

This matter is before the Medical Licensure Commission on the Administrative Complaint filed by the Alabama State Board of Medical Examiners and on the Stipulation of the parties entered on the 2/16 day of February, 1995. The Commission hereby finds that it has jurisdiction of the Administrative Complaint and of the parties thereto under Ala. Code §34-24-361(1975).

In consideration of the Stipulation of the parties, the Commission hereby finds that the Respondent, Patrick Henry Smith, M.D. has committed acts which violate Ala. Code §34-24-360(3)(1975). Based upon the foregoing findings and fact, the Medical Licensure Commission concludes that the Respondent, Patrick Henry Smith, M.D. has violated the provisions of Ala. Code §34-24-360(3)(1975). Upon the findings of act and conclusions of law as set forth herein it is the ORDER of the Medical Licensure Commission that the license to practice medicine in Alabama of Patrick Henry Smith, M.D. is hereby REPRIMANDED. In addition to and in conjunction with any other sanction contained herein, the Respondent shall pay to the Medical Licensure Commission of Alabama a fine of \$2500.00 to be paid in full within one hundred and twenty days of this Order.

ORDERED this 22nd day of February, 1995.


Jerry N. Gurley, M.D., Chairman
Medical Licensure Commission

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|---------------------------|---|------------------------------|
| ALABAMA STATE BOARD OF |) | |
| MEDICAL EXAMINERS, |) | |
| |) | BEFORE THE MEDICAL LICENSURE |
| Complainant, |) | COMMISSION OF ALABAMA |
| |) | |
| v. |) | CASE NO. <u>95-002</u> |
| |) | |
| PATRICK HENRY SMITH, M.D. |) | |
| |) | |
| Respondent. |) | |

ADMINISTRATIVE COMPLAINT

Comes now the Alabama State Board of Medical Examiners and submits herein its sworn petition pursuant to the authority of Ala. Code §34-24-361(e)(1975) and represents to the Medical Licensure Commission of Alabama the following:

1. On September 11, 1961, the Respondent, Patrick Henry Smith, M.D. was duly issued a license to practice medicine in the State of Alabama, license number 2857.
2. The Alabama State Board of Medical Examiners has caused an investigation to be made into the medical practice of the Respondent. Based upon information developed during the course of its investigation, the Board has determined that there exists probable cause to believe that the Respondent has committed the following violation of Ala. Code §34-24-360;

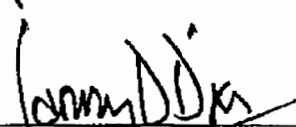
Practiced medicine in such a manner as to endanger the health of a patient of the practitioner, a violation of Ala. Code §34-24-360(3)(1975).

3. In support of the allegation of the violation of Section 34-24-360(3), the Board alleges that the Respondent rendered gynecological and obstetrical medical care to patient, "D.S.", and that the Respondent failed to act upon information suggesting the significant possibility of Ectopic pregnancy of the patient.

Wherefore, the foregoing premises considered, the Alabama State Board of Medical Examiners respectfully requests that the Medical Licensure Commission of Alabama set a hearing upon this Administrative Complaint and order that the Respondent, Patrick Henry Smith, M.D. appear and answer the allegations of this complaint. Further, the Board requests that at the conclusion of the hearing, the Medical Licensure Commission assess an administrative fine of \$2500.00, issue a reprimand against the Respondent, and/or take other action as the Commission may deem appropriate based upon the evidence presented for its consideration.

This Administrative Complaint is executed for and on behalf of the Alabama State Board of Medical Examiners by its Executive Director pursuant to the instructions of the Board as contained in its resolution of December 21, 1994, a copy of which is attached hereto and incorporated herein.

EXECUTED this 13th day of January, 1995.



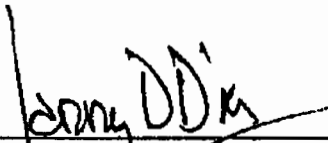
Larry D. Dixon, Executive Director
Alabama Board of Medical Examiners



Patricia E. Shaner, Attorney for the
Alabama Board of Medical Examiners
P.O. Box 946
Montgomery, AL 36101-0946
Telephone #(205)242-4116

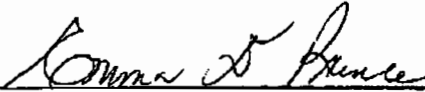
STATE OF ALABAMA)
)
MONTGOMERY COUNTY)

Before me, the undersigned, personally appeared Larry D. Dixon, who, being by me first duly sworn, deposes and says that he, in this capacity as Executive Director of the Alabama State Board of Medical Examiners, has examined the contents of the foregoing complaint and petition and affirms that the contents thereof are true and correct to the best of his knowledge, information and belief.

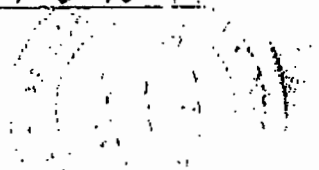


Larry D. Dixon, Executive Director
Alabama State Board of Medical Examiners

SWORN TO AND SUBSCRIBED before me this 13th day of January,
1995.



Notary Public
My Commission Expires: 4-6-98



STATE OF ALABAMA)
)
MONTGOMERY COUNTY)

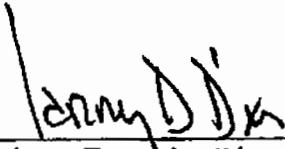
A F F I D A V I T

Before me, the undersigned, personally appeared Larry D. Dixon, Executive Director of the Alabama State Board of Medical Examiners, who, being by me first duly sworn, deposes and says as follows:

The Alabama State Board of Medical Examiners session on December 21, 1994, a quorum of the members of the Board being present, conducted an investigation into the medical practice of Patrick Henry Smith, M.D., and at the conclusion of the discussion, the Board adopted the following:

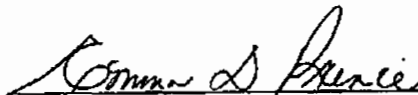
Patrick H. Smith, M.D., Birmingham. Dr. Smith met with the Credentials Committee to discuss his treatment of a patient which resulted in a malpractice settlement recently reviewed by the Board. The Credentials Committee recommended an Administrative Complaint alleging that Dr. Smith practiced medicine in such a manner as to endanger the health of the patient be filed with the Commission and that the Complaint recommend that upon any finding of guilt, Dr. Smith be issued a Reprimand and be assessed a fine of \$2500.00. The motion was adopted.

I further certify that the foregoing resolution was adopted by the Alabama State Board of Medical Examiners on the 21st day of December, 1994.



Larry D. Dixon, Executive Director
Alabama State Board of Medical Examiners

SWORN TO AND SUBSCRIBED before me this 13th day of January
1995.



Notary Public
My Commission Expires: 4-6-98