39667 — License # — 9-14-05 — Date Issued

TP837 — TP # — 6-7-05 — Date Issued

ROUMELL, Theodore L. — Name — [redacted] — DOB — NAT

Mailing: [redacted]

Practice: **100 Medical Ctr. Dr. Hazard, KY 41701** (097)

U. MI, Ann Arbor (02101)-1960 — Medical School, Year Graduated

MI — Endorsed — **OB/GYN** — Specialty — **10** — Status

2/5/05 — Acknowledged — [redacted] — SS#

$250.00 2/8/05 — Fees paid — Fees Paid

TP Approved 6-7-05 DS

Board Approved 9-14-05

IBL Mar/June/Sept/Dec

BL Mar/June/Sept/Dec 6-10-05

Jennifer Marmon

Authorized Persons: ~~Stacy DeGraaf~~ and ~~Amy Sayre~~

To Complete Application:

Form 1- Medical Education

Form 2 – Postgraduate Training ~~3~~ 1

Form 3 – Licensure Verification MI, CA, OZ

Form 4A- Hospital Affiliations # ~~4~~ 1 ~~3~~ ~~7~~ 1

Form 4 – Hospital Affiliations List

Form 5 – References ~~1~~ 2

Form 6 – Waiver

AMA/AOA

Form 8 – Federation

National Practitioner Data Bank

USMLE/FLEX/~~NBME~~/NBOME/COMLEX/LMCC/State Board Exam MI

Photograph

~~ECFMG #~~

~~5th Pathway~~

AIDS Affidavit Signed _____

AIDS Course Completed _____

CME's

CRIMINAL BACKGROUND CHECK

Temporary Permit Information

Location: Practice Hall

Start Date: 1-26-05

Mail To : _____

NPDB Malpractice
2 over 5 yrs
① $30,000
② 10,000

ABOB/GYN

COPY

Danny M. Clark, M.D.
President

Telephone (502) 429-8046
Fax (502) 429-9923

KENTUCKY BOARD OF MEDICAL LICENSURE

Hurstbourne Office Park
310 Whittington Parkway, Suite 1B
Louisville, Kentucky 40222
www.kbml.ky.gov

TO: Theodore L. Roumell, M.D.

FROM: C. William Schmidt, Executive Director

DATE: June 10, 2005

RE: Temporary Permit

Enclosed is your temporary permit to practice medicine and surgery in the state of Kentucky. Your temporary permit number TP937 was issued 6/7/2005 and will expire 12/7/2005.

Please note that your temporary permit has been issued for a ***maximum period of six months and is not renewable.*** Within this six-month period, you MUST complete your application in its entirety. ***Your full license to practice medicine in Kentucky will not be issued until all requirements have been met.***

Your application has been presented or will be presented to the Board as indicated below and the following items are needed to complete your application for licensure:

_____ June 16, 2005 Board Meeting

_X_ September 14, 2005 Board Meeting

_X_ HIV/AIDS Education Requirement

_____ Form 2 – Post-Graduate Training Verification

_____ Criminal Background Check

_____ National Practitioner Data Bank Self Query

_____ Application is complete

If you decide to discontinue your practice in Kentucky, please notify this office immediately. Please be advised that your incomplete file will remain in this office for one year from date of your application. Also, you should be aware that your temporary permit is subject to cancellation without prior hearing upon violation of any provision of the Kentucky Medical and Osteopathic Practice Act.

Should you have any questions regarding the above, please contact the Medical Licensure Coordinator at (502) 429-8046 between the hours of 8:00am and 12:30pm EST.

Northern Arizona Healthcare
Flagstaff Medical Center

1200 North Beaver Street
Flagstaff, Arizona 86001
928-779-3366
www.nahealth.com

March 9, 2005

Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, Kentucky 40222

Re: **Theodore L. Roumell, MD**
Primary Specialty: OB/GYN

To Whom It May Concern:

Theodore L. Roumell, MD was a Locum Tenens physician at Flagstaff Medical Center during the time period of 6/6/2004 – 6/7/2004, covering in the area of OB/GYN.

Sincerely,

Susan Peters
Medical Staff Services
(928) 214-3501

COPY

Danny M. Clark, M.D.
President

Telephone (502) 429-8046
Fax (502) 429-9923

KENTUCKY BOARD OF MEDICAL LICENSURE

Hurstbourne Office Park
310 Whittington Parkway, Suite 1B
Louisville, Kentucky 40222
www.kbml.ky.gov

ACKNOWLEDGMENT OF APPLICATION

To: Theodore L. Roumell, M.D.
February 15, 2005

This is to acknowledge receipt of your recent application for medical/osteopathic licensure in the state of Kentucky. Your application will be presented to the Board at the next regularly scheduled meeting, which will be held on June 16, 2005, provided that we receive the following by the next Board ***deadline on May 6, 2005:***

_____ Form 1 – Verification of Medical Education

__X__ Form 2 – Verification of Postgraduate Training-Henry Ford Hospital

__X__ Form 3 – Verification of Licensure (MI)

_____ Form 4 – Hospital/Clinic Affiliation Listing

__X__ Form 4A – Hospital/Clinic Affiliation Verification

__X__ Form 5 – Reference Form (2 Required)

_____ Form 6 – Release and Waiver of Rights

__X__ National Practitioner Data Bank "Self Query" Report(On-line: **www.npdb-hipdb.com**)

_____ ECFMG Certification

__X__ Exam Scores (FLEX,NBME,NBOME,LMCC,USMLE,State Board)

_____ Recent Photograph – Must be signed and dated

_____ AMA Profile/AOA Profile (www.ama-assn.org/amaprofiles)(www.aoa-net.org)

__X__ HIV/AIDS Affidavit

__X__ *HIV/AIDS Education Requirement(Copy of certificate once completed for full license) (http://chs.ky.gov/publichealth/hiv-aids.htm)

_____ CME Form

__X__ *Criminal Background Check

*Items do not have to be in the office for the deadline but MUST be received in order to issue full licensure

Please be advised that your incomplete file will remain in this office for one year from the date of your application. ***After one year, all incomplete files will be purged. NO faxes accepted.*** The above forms may be printed from our web site: www.kbml.ky.gov. If you have any questions regarding your application, please call this office between 8:00 a.m. and 12:30 p.m. EST, at (502) 429-8046, Ext. 222.

Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, KY 40222
(502) 429-8046

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K.B.M.L.

Staff Case 27601 $250-

Application for License to Practice Medicine/Osteopathy by Endorsement

NOTE: Application must be legible and fully completed with all requested information and documentation supplied. Initial licensure fee of $250.00 must accompany application. This fee is non-refundable.

SSN: [redacted]

1. Name in Full:
Theodore (first) LOUIS (middle) Roumell (last) M.D. (degree)

2. Address1:Practice address in Kentucky: (A license will not be issued without this)
Street: 100 Medical Center Drive
City, State: Hazard, KY Zipcode: 41701

3. Address 2: Mailing address (**All correspondence regarding application will be sent to this address**):
Street: [redacted]
City, State: [redacted] Zipcode: [redacted]

4. DEA #(if applicable): AR2723701
5.Work#: (606) 524-1628
6.Home#: [redacted]

7. Date of Birth: [redacted] 8.Birthplace [redacted]

9. Have you ever applied for or been issued a Kentucky medical license? ☐Yes ☒ No If Yes, #_____

10. Specify reason for requiring medical licensure in Kentucky: Employment

11. Specialty: OB/GYN American Specialty Board Certification: American Board of OB/GYN

12. Specify your type of practice: (check one)

☐Hospital Base	☐Occupational Medicine	☐Instructor	☐Military
☐Admin. Medicine	☐Research	☐Resident/Fellow	☐Emergency Medicine
☐Private Practice	☐Inactive/Semi-Retired	☒Locum Tenens	

13. Indicate your ECFMG number:(International Medical Graduates only) N/A

14. List the name, location and dates of attendance of every college and medical/osteopathic school you have attended:

Name	Location	Dates (From-To)	Degree
University of Michigan School of Medicine	Ann Arbor, MI	1956-1960	M.D.

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KBMI

15. In what state or Canadian province did you receive your **original license** to practice medicine/osteopathy?

State/Province	License #	Date of Issuance	Current? Yes/No
MI	#24086	6/1961	

16. List all other states and Canadian provinces where you **currently hold or ever held** any type of medical/osteopathic license:

State/Province	Type	License #	Date of Issuance	Current? Yes/No
CA	Perm.	C27076	5/1965	NO
AZ	Perm.	28481	1/2002	Yes

17. List all internship, residency and fellowship programs you have completed since medical/osteopathic school graduation:*(Please list in chronological order)*

INTERNSHIP: (List US and Canadian only)
Hospital: Denver Prysheteran City, State: Denver, CO
Specialty: Rotating-Internal Med. To – From: 7/60 - 7/61

RESIDENCY: (List US and Canadian only)
Hospital: Henry Ford Hospital City, State: Detroit, MI
Specialty: OB/GYN, Rotations in Urology, Anesthesiology & Gen. Surgery To – From: 1963 - 1967

RESIDENCY: (List US and Canadian only)
Hospital: _____ City, State: _____
Specialty: _____ To – From: _____

18. *In chronological order*, list all locations where you have practiced medicine/osteopathy since obtaining your original licensure. Also list and explain dates of all extended absence periods. **Please attach additional sheets if necessary.**

Location, City, State	Type of Activity	Dates (From-To)
Private Practice, Rochester, MI	OB/GYN	1967 - Present
FLIGHT SURGEON USAF	FORCE	1961 - 1963

19. Indicate which licensing examination(s) you have taken. Include all attempts, locations, scores, and dates. Be exact, including all attempts and failures.

Type (FLEX,NBME,USMLE,LMCC,etc)	Location	Score	Date
National Boards	MI	Passed-1 time	1969

[Category I]

Please answer all questions on this application. Category I will help the Board determine if you meet the essential eligibility requirements for licensure by virtue of your background, education, training and experience. If you are qualified to practice under Category I, Category II will be reviewed to help the Board determine if you are qualified to practice safely and competently, with or without reasonable modification.

If you answer "Yes" to any of the questions, you must attach a complete written explanation of the event(s) or condition(s), including dates, names, addresses, circumstances, and results along with your returned application.

NOTE: Intentional false answers or misrepresentation in applying for or procuring a license, registration or reactivation in Kentucky are grounds for disciplinary action, including denial or revocation of license, and are reported to the National Practitioner Data Bank and/or appropriate national professional credentialing organization. You must answer "yes" to any question if the event(s) described in that question has actually occurred. You must answer "yes" in such circumstance even if you have been advised by an attorney or other person that you may answer "no". You must also answer "yes" in such circumstance even if the record of the event has been sealed or expunged by Court order, or has been designated "confidential" by the body involved. After answering "yes" to the appropriate question(s), you may advise the Board of any additional relevant information pertaining to your answer (i.e., record has been sealed or expunged, record is designated "confidential," attorney has advised that you properly answer "no"). The Board will consider this additional information, along with your answer(s), in determining the appropriate action. If you have any question about whether or not you should answer "yes" to a question, you should err in favor of answering "yes" and providing an explanation, because any non-disclosure violation will likely result in denial of your application or disciplinary action against your license. This application may not be altered in any way.

1. Have you ever been dismissed from, resigned while under investigation, failed to complete an academic year, taken a leave of absence, or been placed on probation or reprimanded at a medical school or a postgraduate training program?
   ☐Yes ☒No
2. Are you currently in default on any student loan repayment obligations payable to the financial aid programs administered by the Kentucky Higher Education Assistance Authority?
   ☐Yes ☒No
3. Have you ever been denied a license or denied the privilege of taking a licensure examination by any State, Federal or International licensure jurisdiction?
   ☐Yes ☒No
4. Have you ever had any license, certificate, registration or other privilege as a health care professional denied, revoked, suspended, probated, restricted or limited, or subjected to any other disciplinary action, by a State medical/osteopathic licensing board, or Federal, or International authority?
   ☐Yes ☒No
5. Have you ever been disciplined by any licensed hospital (including postgraduate training) or the medical staff of any licensed hospital, including removal, suspension, probation, limitation of hospital privileges or any other disciplinary action if the action was based upon what the hospital or medical staff found to be unprofessional conduct, professional incompetence, malpractice or a violation of a provision(s) of a Medical Practice Act?
   ☐Yes ☒No

6. Have you surrendered such credential, or placed it into an inactive status, to avoid disciplinary action or in connection with or in anticipation of a disciplinary investigation/action by the licensing authority of such jurisdiction?
☐Yes ☒No

7. Have you ever resigned your privileges or failed to renew privileges at a licensed hospital or from the medical staff of the hospital, while under investigation or while you were subject to disciplinary proceedings by the hospital?
☐Yes ☒No

8. Have you ever been removed, suspended, expelled or disciplined by any professional medical facility, association or society?
☐Yes ☒No

9. Have you ever voluntarily or involuntarily surrendered a medical or osteopathic license, or controlled substance registration certificate issued to you?
☐Yes ☒No

10. Have you ever been or are you currently under investigation by any State, Federal or International licensure authority or any drug licensure/enforcement authority?
☐Yes ☒No

11. Are any legal proceedings regarding licensure presently pending against you by any State, Federal or International licensure authority or any drug licensure/enforcement authority?
☐Yes ☒No

12. Have you ever been convicted of a felony or misdemeanor by any State, Federal or International court?
☐Yes ☒No

13. Are any criminal charges presently pending against you in any of those courts?
☐Yes ☒No

14. To your knowledge, are you the subject of an investigation for a criminal act?
☐Yes ☒No

15. In the past ten (10) years have you had to pay a judgment in a malpractice action or other civil action against your medical practice or are any malpractice or other civil actions against your medical practice presently pending in any court? **(If yes, complete enclosed Medical Malpractice Form)**
☐Yes ☒No

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[Category II]

The answers to these questions are exempt from public disclosure under KRS 61.878(1)(a) and (l) and KRS 311.619 and shall be subject to inspection only upon order of a court of competent jurisdiction, except that no court shall authorize the inspection by any party of any materials pertaining to civil litigation beyond that which is provided by the Kentucky Rules of Civil Procedure governing pretrial discovery. The answers to these questions may be considered by the Board (KBML) and may be disclosed in any contested case proceeding, including a Show Cause proceeding, or appeal of a licensing decision based upon them.

"Illegal drug use" means the use of an illegally obtained controlled substance or dangerous drug; the term "illegal drug use" also means the use of a legally obtained controlled substance or dangerous drug which is not taken in accordance with the direction of the licensed health care professional who prescribed the controlled substance or dangerous drug.

1. Do you currently, or have you had within the past 5 years, any physical, mental, or emotional condition which impaired, or might reasonably impair your ability to practice your health care profession safely and competently?
[redacted]
2. Within the past 5 years, have you been admitted to any hospital or other in-patient care facility for any physical, mental or emotional condition, which impaired, or might reasonably be considered to impair, your ability to practice your health care profession safely and competently?
[redacted]
3. Do you currently have, or have you had within the past 5 years, a dependency on or abuse of the use of alcohol or drugs, which impaired, or might reasonably impair, your ability to practice your health care profession safely and competently?
[redacted]
4. Within the past 5 years, have you engaged in the excessive use of alcohol or illegal drugs, or received any in-patient or outpatient or individual therapy/treatment or been hospitalized for alcoholism, or illegal use, or been arrested for a DUI (Driving Under The Influence)?
[redacted]
5. Within the past 5 years, have you been the subject of any chemical substance screening test which resulted in an indication of the presence in your body of any controlled substance, any dangerous drug, or alcohol level above .10% BAC? (This does not include those drugs taken by you as a result of a legitimate health care diagnosis, and prescribed for you in good faith by another licensed health care professional.)
[redacted]

See above exemption

*****Affidavit of Applicant*****

I hereby state that the information contained in this application has not been altered in any way and is true, accurate, and complete to the best of my knowledge and belief. I understand that under Kentucky law the submission of any false, fraudulent or forged statement, document or other matter in connection with this application is grounds for criminal prosecution and the denial of licensure. I authorize the Board (KBML) or its agents to obtain from other sources any information necessary for determining my qualifications for licensure. I also authorize them to furnish any information they may now or in the future have concerning my qualifications and fitness to practice medicine/osteopathy to any person, institution, association, school/hospital or government entity.

Theodore L. Rousell M.D. 1/31/05

(Signature of Applicant) **(Date)**

THEODORE L. ROUSSELL M.D.

(Print Name)

Subscribed and sworn to before me by the above named applicant on this 3RD day of FEBRUARY, 2005
(month, year)

Fran Cagle

Seal of Notary **(Signature of Notary)**

FRAN CAGLE
Notary Public, State of Michigan
County of Macomb
My Commission Expires Sept. 10, 2007
Acting in the County of OAKLAND

My commission expires: _____

RECEIVED

FEB 0 8 [illegible]

K.B.M.L.

Affidavit of Applicant

I hereby state that the information contained in this application has not been altered in any way and is true, accurate, and complete to the best of my knowledge and belief. I understand that under Kentucky law the submission of any false, fraudulent or forged statement, document or other matter in connection with this application is grounds for criminal prosecution and the denial of licensure. I authorize the Board (KBML) or its agents to obtain from other sources any information necessary for determining my qualifications for licensure. I also authorize them to furnish any information they may now or in the future have concerning my qualifications and fitness to practice medicine/osteopathy to any person, institution, association, school, hospital or government entity.

Theodore Roumell MD 1/31/05

(Signature of Applicant) **(Date)**

THEODORE L. ROUMELL M.D.

(Print Name)

Subscribed and sworn to before me by the above named applicant on this 3rd day of FEBRUARY, 2005

(month,year)

Fran Cagle

(Signature of Notary)

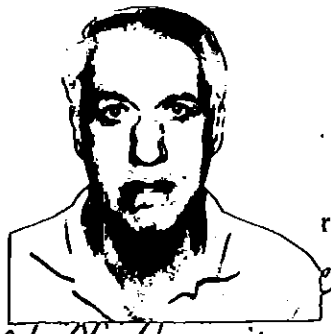
FRAN CAGLE
Notary Public, State of Michigan
County of Macomb
My Commission Expires Sept. 10, 2007
Acting in the County of OAKLAND

My commission expires:

Seal of Notary

Theodore Roumell

1/31/05



"Only the applicant and person authorized by applicant may call regarding the c[illegible] r be given information during the credentialing process."

Specify name of authorized person: Stacy DeGrad[illegible], Amy Sayre, Staff Care, Inc.

April 21, 2005

Kentucky Board of Medical Licensure
Hurstbourne Office Park
310 Whittington Parkway, Suite 1B
Louisville, KY 40222
502-429-8046

To Whom It May Concern:

Only the applicant and person authorized by applicant may call regarding the credentialing of my application or be given information during the credentialing process. I now request that the specific people be changed from Stacy DeGraff and Amy Sayre of Staff Care, Inc. to Jennifer Moorman of Staff Care, Inc. Please give her the information that is necessary to ensure completion of my application on my behalf.

Sincerely,

Theodore Roumell MD

Theodore L. Roumell, MD

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FEB 0 8 2005

K.B.M.L.

Temporary Permit Form

KRS 311.575 provides that Temporary permits may be issued **at the discretion of the Executive Director**, provided the applicant for a full license has a **completed application with all supporting documents** on file with the Board, meets all statutory requirements for licensure, and needs to begin working in Kentucky before the next regularly scheduled meeting of the Board. ***You must request the Temporary Permit by completing this form; it is not automatically issued.***

Temporary Permits will not be issued to an applicant who has a prior history of disciplinary action taken by a licensing jurisdiction or hospital, a criminal record, a history of substance/chemical abuse or any negative or derogatory information. This also includes any malpractice cases in the last ten years in which you paid a settlement of $100,000 or more.

The Temporary Permit **will not be issued until all administrative screening processes are complete.** The Board recommends you submit your **completed** application at least thirty (60) days prior to the time you need your Temporary Permit. (This time may be extended to 60 – 90 days during the months of May, June, and July) The Board also recommends that you **do not make any commitments to accept a position in Kentucky until you have a Temporary Permit *in hand*.**

You may request a Temporary Permit by completing this form and returning it directly to the Board:

Name: Theodore L. Boumell, M.D. (please print), M.D./D.O.

Practice Location in Kentucky: 100 Medical Center Drive
Hazard, KY 41701

Date Temporary Permit Requested: 1-26-05

Address Temporary Permit should be mailed: [redacted]

Please Note: You will not be issued a Temporary Permit to practice in Kentucky without a specific Kentucky practice address listed on this form.

Medical Malpractice Form

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FEB 0 8 2005

K.B.M.L.

Kentucky Board of Medical Licensure
310 Whittington Parkway Suite 1B
Louisville, KY 40222
(502) 429-8046

This form must be completed if you have ever been named as a defendant in a malpractice lawsuit, verdict or settlement. Your application is not complete until this form has been returned to the Board.

THEODORE LOUIS ROVMEHL M.D. 7486514004
Name of Physician *Office Telephone No.*

1050 W. UNIVERSITY ROCHESTER MICHIGAN 48307
Address *City* *State* *Zip*

Malpractice Complaint: *(Include name of patient, age, sex, date of occurrence and location, i.e., office or name and address of hospital.)* 30 yrs ago - Normal Prenatal course & delivery: Mother would not breastfeed assisted. after 5 days - all tests normal - neonatologist stopped respirator. Parents refused post mortem exam to confirm suspected brain stem anomaly. Insurance settled for minimal policy limits. I have no other info.

Patient's Name: _____ *Age:* _____ *Sex:* _____

Date/Place of Occurrence: _____

Indicate you position in case, i.e., resident, primary physician, etc: _____

_____

Filed Against: *( ) Individual Doctor ( ) Group ( ) Hospital*

List names of other defendant-doctors and/or hospitals: _____

_____

Disposition: *( ) Pending ( ) Jury Verdict ( ) Settled*

If there has been a verdict or settlement, please provide the following information:

Legal outcome: _____

Date: _____ *Total Amount Paid (if any):* _____

Amount attributable to you: _____

Send To This Board Copies Of The Complaint, Answer, Release, Settlement Documents, All Other Relevant Legal Documents. I have no documents. This was 30 yrs ago.

On A Separate Sheet, Please Provide A Detailed Explanation Of Background And Medical Issues Involved In The Case.

Signature: Theodore Rovmehl MD *Date:* 1/31/05

→ *A separate report must be completed for each malpractice suit. This form may be duplicated. Please return form(s) and other information to the Board at the above address.*

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FEB 0 8 2005

Form 4

Physicians Name Theodore Boumell, M.D. K.B.M.L. M.D. / D.O.

List all hospitals/clinics other than training where you have practiced medicine within the last five (5) years and send Form 4A to each. ***(This should also include moonlighting and all locum tenens assignments.)***

Dates (From – To)	Hospital/Clinic/Office Name	Complete Address	Indicate Locum Tenens, Moonlighting or Type of Privileges
6/6 – 4/7	FLAGSTAFF MEDICAL CENTER	FLAGSTAFF ARIZONA 86004	
7/1/04 – 7/12/04 4/06	BIXBY MEDICAL CENTER	ADRIAN MICHIGAN 49221	L.T.
6/1/04 – 4/11/04	BIXBY MEDICAL CENTER	ADRIAN MICHIGAN 49221	L.T.
10/12/03 – 10/15/03	WOMANS HEALTH CENTER	TECUMSEH MICHIGAN	L.T.
> 6 yr	CRITTENTON HOSPITAL	ROCHESTER MICHIGAN	ACTIVE STAFF OB-GYN

Form 1

Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, Kentucky 40222

RECEIVED
JAN 28 2005
K.B.M.L.

Verification of Medical Education

••No substitutes will be accepted in lieu of this form••

To Applicant: In applying for a license to practice medicine/osteopathy in the Commonwealth of Kentucky, the Kentucky Board of Medical Licensure requires this form be completed by the Dean or Registrar of the medical school where you graduated. This form must be sent from the reference source to the Board at the above address.

Name: Theodore Roumell, M.D. M.D./D.O. Graduation Date: 1960
(please print)

Address: 1050 W. University Drive, Rochester Hills, MI 48307

See Release
(Signature) M.D./D.O.

****

To Reference Source: Please complete this form, sign, seal and return to the Board (KBML) at the above stated address. Any fees for completion of this form should be collected from the applicant. If you have any additional information that should be considered by this Board (KBML) prior to issuance of a license to this applicant, please provide this information to the Board (KBML) by writing to the above address. Please affix the Seal of the Medical School *or* have the form Notarized by a school official.

It is hereby certified that Theodore L. Roumell
attended the University of Michigan Medical School
located at Ann Arbor, MI for a period of 4 years.
Dates of attendance: 9/20/56 - 6/11/60 Degree: M.D.
Date of graduation: June 11, 1960

Susan K Hayward, Registrar
Signature of Dean or Registrar

Seal of the Medical School

Sworn to and subscribed before me this ____ day of _____, 19___

Seal of Notary

_____
Notary Public

RECEIVED
APR 0 7 2005
K.B.M.L.

RECEIVED
MAY 0 6 2005
K.B.M.L.

Kentucky Board of Medical Licensure
310 Whittington Parkway, #1B
Louisville, KY 40222

Postgraduate Training Verification

Applicant's Authorization: I authorize the release of information from my postgraduate training program listed below to be forwarded to the Kentucky Board of Medical Licensure.

Applicant's signature: See Release

Print or type name: Theodore Rowell, M.D.

Name & Address of Institution: Henry Ford Hospital - 2799 W. Grand Blvd. Detroit MI 48202-2608

Instructions to the Program Director: This form must not be completed more than thirty (30) days prior to the completion of training program if less than two (2) years. Please complete this form, **sign, seal** and return to the Board at the above stated address. Any fees for completion of this form should be collected from the applicant. **Please affix the seal of the hospital or have form notarized by a hospital official.**

Name of Institution: Henry Ford Hospital

If name of Institution was different when applicant attended, please enter name: _____

Enrollment and participation: Our records indicate that Theodore Rowell, MD participated in the following program:

(Type or print applicant's name)

Program type (Internship, Residency, Fellowship)	PGY 1,2,3,4	Department	Dates Attended (Month/Day/Year)		Completed Yes/No	Accredited By: ACGME, AOA, Etc..
OB/GYN Residency	1-4	OB/GYN	7/1/63	3/1/67	yes	ACGME
			/ /	/ /		
			/ /	/ /		
			/ /	/ /		
			/ /	/ /		

RECEIVED RECEIVED
MAY 0 6 2005 APR 0 7 2005
K.B.M.L. K.B.M.L.

Applicant's Name: Theodore Roumell

Unusual circumstances: The following questions apply to unusual circumstances that occurred during any part of the applicant's medical education. Please mark the appropriate response. ****If you answer yes to any of these questions, please enclose an explanation.**

QUESTIONS	Yes	No
1. Did the applicant take any leave of absences or breaks from his/her post-graduate training?	☐	☐
2. Was the applicant ever placed on probation?	☐	☐
3. Was the applicant ever disciplined or under investigation?	☐	☐
4. Were any limitations or special requirements imposed on the applicant because of academic incompetence or disciplinary problems?	☐	☐
5. Was your postgraduate medical training program accredited during the applicant's participation? **If "Yes" answer 5a.**	☐	☐

5a. by: ☒ ACGME ☐ Other: _____

Comments: Review of records - no problems included

Certification: I hereby certify that the above information is correct, to the best of my knowledge.

Program Director's Signature: David A Richardson

Print Name: David A Richardson

Academic Title: Program Director

Telephone: (313 916 1023 Today's Date: 3/27/05

Affix Institutional Seal Here

(If the institution does not have a seal, this form must be notarized.)

RECEIVED

FEB 0 2 2005

K.B.M.L.

Kentucky Board of Medical Licensure
310 Whittington Parkway, #1B
Louisville, KY 40222

Postgraduate Training Verification

Applicant's Authorization: I authorize the release of information from my postgraduate training program listed below to be forwarded to the Kentucky Board of Medical Licensure.

Applicant's signature: _____

Print or type name: _____

Name & Address of Institution: _____

Instructions to the Program Director: This form must not be completed more than thirty (30) days prior to the completion of training program if less than two (2) years. Please complete this form, **sign, seal** and return to the Board at the above stated address. Any fees for completion of this form should be collected from the applicant. **Please affix the seal of the hospital or have form notarized by a hospital official.**

Name of Institution: HealthONE - PSLMC

If name of Institution was different when applicant attended, please enter name: Presbyterian Denver Hospital

Enrollment and participation: Our records indicate that Theodore L. Raunell, MD participated in the following program:

(Type or print applicant's name)

Program type (Internship, Residency, Fellowship)	PGY 1,2,3,4	Department	Dates Attended (Month/Day/Year)		Completed Yes/No	Accredited By: ACGME, AOA, Etc..
Rotating Internship	1		6-24-60	6-24-61	Yes	ACGME
			/ /	/ /		
			/ /	/ /		
			/ /	/ /		
			/ /	/ /		

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Form 2

Applicant's Name: Theodore L. Roumell, MD

Unusual circumstances: The following questions apply to unusual circumstances that occurred during any part of the applicant's medical education. Please mark the appropriate response. ****If you answer yes to any of these questions, please enclose an explanation.**

QUESTIONS	Yes	No
1. Did the applicant take any leave of absences or breaks from his/her post-graduate training?	☐	☒
2. Was the applicant ever placed on probation?	☐	☒
3. Was the applicant ever disciplined or under investigation?	☐	☒
4. Were any limitations or special requirements imposed on the applicant because of academic incompetence or disciplinary problems?	☐	☒
5. Was your postgraduate medical training program accredited during the applicant's participation? **If "Yes" answer 5a.**	☒	☐

5a. by: ☒ ACGME ☐ Other: _____

Comments:

_____

_____

Certification: I hereby certify that the above information is correct, to the best of my knowledge.

Program Director's Signature: _____

Print Name: Gregory J. Gahm, MD

Academic Title: Director, Transitional Internship Program

Telephone: (303-839-6741 Today's Date: 1-28-05

Affix Institutional Seal Here

(If the institution does not have a seal, this form must be notarized.)

JENNIFER M. GRANHOLM
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

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JANET OLSZEWSKI
DIRECTOR

VERIFICATION OF LICENSURE
MICHIGAN BOARD OF MEDICINE
VERIFICATION OF LICENSURE AS OF 02/14/2005

KENTUCKY BOARD OF MEDICAL LICENSURE
310 WHITTINGTON PARKWAY SUITE 15
LOUISVILLE KY 40222

NAME: Theodore L Roumell
ADDRESS: 1050 W University
Rochester, MI 48307-1877

SSN: [redacted]
BIRTHDATE:

TYPE: Medical Doctor
LICENSE NUMBER: 4301024386 **STATUS:** Active
OBTAINED BY: Michigan Examination

ORIGINAL DATE: 06/26/1961
EXPIRATION DATE: 01/31/2006

EXAM DATE	EXAM	SCORES
06/08/1960	Physiology	92
06/08/1960	Pathology	93
06/08/1960	Medical Jurisprudence	45
06/08/1960	Eye, Ear, Nose and Throat	45
06/08/1960	Anatomy, Gross Microscopic & Neuro	79
06/08/1960	Biological Chemistry	45
06/08/1960	Bacteriology, Microbiology & Immun	41
06/08/1960	Medicine Incl. Dermatology	78
06/08/1960	Preventive Medicine & Public Health	42
06/08/1960	Obstetrics & Gynecology	42.5
06/08/1960	Materia Medica, Pharm & Therapeutics	85
06/08/1960	Surgery Incl. Anesth. & Radiology	85
06/08/1960	Neurology & Psychiatry	40
06/08/1960	Pediatrics	37.5

DISCIPLINARY ACTION NONE

OPEN FORMAL COMPLAINTS NONE

CAROLYN F. PARKINSON

BUREAU OF HEALTH PROFESSIONS
611 W. OTTAWA • P.O. BOX 30670 • LANSING, MICHIGAN 48909-8170
www.michigan.gov • (517) 335-0918

Arizona Medical Board
Physician Profile

Printed: 1/27/2005 11:50:02 AM from http://www.azmdboard.org

General Information

Theodore L. Roumell MD
1050 W University Dr
Rochester Michigan 48307-1877
Phone: 248-651-4004

License Number: 28481
License Status: Active
License Date: 7/7/2000
License Renewed: 9/15/2003
Renew By: 08/2005
License Expires: 12/2005

Education and Training (a)

Medical School: UNIVERSITY OF MICHIGAN MEDICAL SCHOOL
ANN ARBOR, MI
Graduation Date: 6/11/1960

Internship: 6/24/1960 - 6/24/1961 (Intern)
DENVER HEALTH MEDICAL CENTER
DENVER, COLORADO

Residency: 7/1/1963 - 3/30/1967 (Intern)
HENRY FORD HEALTH SYSTEM
DETROIT, MICHIGAN

(b) Area of Interest: Obstetrics & Gynecology (ABMS Board Certified)

Board Investigations and Actions

BOARD ACTIONS: 0
(c) OPEN INVESTIGATIONS: 0
NON DISCIPLINARY ACTIONS: 0

Malpractice/Criminal Information

CRIMINAL CONVICTIONS / "NO CONTEST" PLEAS: 0
(e) MALPRACTICE CASES RESULTING IN PAYMENT: 0

(a) Information up to the date of initial licensure is verified by the Board. Information provided by the physician after this date is not verified by the Board.

(b) The Board does not verify current specialties. For more information please see the American Board of Medical Specialties website at: http://www.abms.org to determine if the physician has earned a specialty certification from this private agency.

(c) Open investigations represent unproven allegations - Upon investigation many complaints are found to be without merit and dismissed.

(d) Advisory Letters and Physician Responses to the Advisory Letters are only available on-line for a 5 year period from date of

Alison Markow
Business Operations

Issuance by the Board.

(e) The settlement of a medical malpractice action may occur for a variety of reasons that do not necessarily reflect negatively on the professional competence or conduct of the doctor. A payment in settlement of a medical malpractice action does not create any presumption that medical malpractice occurred.

(f) Prior to 1999, "Advisory Letters" were known as "Letters of Concern"

State of California Department of Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM
1426 HOWE AVE, SUITE 54
SACRAMENTO CA 95825-3236
TELEPHONE: (916) 263-2382
FAX: (916) 263-2944

www.caldocinfo.ca.gov

February 2, 2005

KENTUCKY BOARD OF MEDICAL LICENSURE
HURSTBOURNE OFFICE PARK
310 WHITTINGTON PKWY STE 1B
LOUISVILLE KY 40222-4916

To Whom It May Concern:

In response to your inquiry a standard search of available records in this office has been performed. The following indicates the results of that search:

Physician:	THEODORE L ROUMELL
License No.:	C 27076
Issued:	May 19, 1965
Exam Type:	A written examination
Expiration Date:	August 31, 2005
Status:	Renewed/current

If a discipline status is listed, you may obtain information concerning this action by contacting the Board's Enforcement Program, Central File Room, 1426 Howe Avenue, Sacramento, CA 95825-3236 or by faxing your request to the Central File Room at (916) 263-2420.

Joyce E. Hadnot
Acting Chief, Licensing Program

SEAL

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FEB 25 2005
K.B.M.L.

February 22, 2005

Office: 469-524-1628
Fax: 469-524-1505

LicenseSTAT
Stacy DeGraaf
KY Board of Medical Licensure
310 Whittington Parkway, Ste. 1B
Louisville, KY 40222

RE: Theodore L Roumell, MD

In response to your recent request regarding the status of your privileges at Crittenton Hospital Medical Center, please be advised that due to the large volume of reference requests, Crittenton Hospital Medical Center has chosen to expedite this process by providing the following information:

Original Appointment:	**5/2/1967 - present**
Current Status:	**Active Voting**
Termination Date:	
Specialty:	**Obstetrics and Gynecology**
Department:	**Obstetrics And Gynecology**

A review of this physician's file indicates no adverse actions with regard to professional ethics, disciplinary actions, clinical abilities or health status.

Should you require any additional information, please do not hesitate to contact me directly at (248) 652-5232.

Sincerely,

Cheryl Hung

Credentialing Coordinator

RECEIVED

MAR 10 2005

K.B.M.L.

Form 2A

Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, Kentucky 40222

Hospital, Clinic, Facility Affiliation Form

To Applicant: In applying for a license to practice medicine in the Commonwealth of Kentucky, the Kentucky Board of Medical Licensure requires this form to be completed by an administrator or chairperson in each facility where you have practiced medicine during the five (5) years preceding your application. My signature below is your authority to release any and all information in your files, favorable or otherwise regarding myself.

Name: Theodore Roumell M.D./D.O. See attached release
(Please print) (Signature)

Name and Address of Facility: Bixby Medical Center, Adrian, MI

****

To Reference Source: Please complete this form, sign, and return directly to the Board at the above stated address. The processing time for licensure depends on timely receipt of critical forms such as this. All applicants have signed a general release, which relieves anyone of liability for information furnished in good faith. ***No Substitutions will be accepted in lieu of this form. All other forms submitted will be returned.***

1. Position and Department of the above applicant? Locum Tenen - OB/GYN
2. Affiliation Dates: From 4/4/04 To 4/4/06
3. Were any limitations imposed on this physician? NO If *"Yes"*, please explain briefly and attach certified copies of any documentation pertaining to such action. _____
4. Were privileges ever revoked, suspended, restricted, limited, reprimanded, placed on probation or otherwise disciplined? NO If *"Yes"*, please explain briefly and attach certified copies of any documentation pertaining to such action. _____
5. Was the above physician terminated from employment? NO If yes, please explain in detail.

Derogatory Information, if any: _____

Comments, if any: only provided locum tenen coverage

Signature, Date, Title Kathy Raines, 3/9/05, Med Staff Coord
Printed Name KATHY RAINES
Facility Bixby Medical Center
Address 818 Riverside Ave
Adrian Mi 49221
Phone Number 517.265.0429

Affix Seal Here
(If no seal, so indicate)

Medical Staff Coordinator

Form 4A

Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, Kentucky 40222

Hospital/Clinic/Facility Affiliation Form

To Applicant: In applying for a license to practice medicine in the Commonwealth of Kentucky, the Kentucky Board of Medical Licensure requires this form to be completed by an administrator or chairperson in each facility where you have practiced medicine during the five (5) years preceding your application. My signature below is your authority to release any and all information in your files, favorable or otherwise regarding myself.

Name: Theodore Roumell, M.D. M.D./D.O. See Release
(Please print) (Signature)

Address: Rochester Hills MI

****

To Reference Source: Please complete this form, sign and return to the Board at the above stated address. The processing time for licensure depends on timely receipt of critical forms such as this. All applicants have signed a general release, which relieves anyone of liability for information furnished in good faith. ***No Substitutions will be accepted in lieu of this form. All other forms submitted will be returned.***

1. What privileges were extended to the applicant? Full OB-Gyn
2. Affiliation Dates: From 10/02/03 To 10/05/03
3. Were any limitations imposed on such privileges? NO If *"Yes"*, please explain briefly and attach certified copies of any documentation pertaining to such action. _____
4. Were privileges ever revoked, suspended, restricted, limited, reprimanded, placed on probation or otherwise disciplined? NO If *"Yes"*, please explain briefly and attach certified copies of any documentation pertaining to such action. _____

Derogatory Information, if any: _____

Comments, if any: _____

Signature Dr Michael Sammarco
Title Every Womans Health Center
Hospital Herrick Hospital
Seal of Hospital Practice Address 501 E Cummins
(If no seal, so indicate) Tecumseh MI 49286
Date 4/02/05

Form 4A

Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, Kentucky 40222

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MAR 21 2005
K.B.M.L.

Hospital/Clinic Affiliation Form

To Applicant: In applying for a license to practice medicine in the Commonwealth of Kentucky, the Kentucky Board of Medical Licensure requires this form to be completed by the hospital administration in each hospital/clinic where you have practiced medicine during the five (5) years preceding your application. My signature below is your authority to release any and all information in your files, favorable or otherwise regarding myself.

Name: Theodore Roumell (M.D./D.O.) _____
(Please print) (Signature)

Address: _____

****

To Reference Source: Please complete this form, sign and return to the Board at the above stated address. The processing time for licensure depends on timely receipt of critical forms such as this. All applicants have signed a general release, which relieves anyone of liability for information furnished in good faith. ***No Substitutions will be accepted in lieu of this form. All other forms submitted will be returned.***

1. What privileges were extended to the applicant? Locum Tenens
2. Affiliation Dates: From 6/6/04 To 6/7/04
3. Were any limitations imposed on such privileges? NO If ***"Yes"***, please explain briefly and attach certified copies of any documentation pertaining to such action. _____
4. Were privileges ever revoked, suspended, restricted, limited, reprimanded, placed on probation or otherwise disciplined? NO If ***"Yes"***, please explain briefly and attach certified copies of any documentation pertaining to such action. _____

Derogatory Information, if any: _____

Comments, if any: _____

Seal of Hospital
(If no seal, so indicate)

Signature Susan Peters
Title Medical Staff Services Asst.
Hospital Flagstaff Medical Center
Address 1200 N. Beaver
Flagstaff, AZ 86001
Date 3-15-05

Northern Arizona Healthcare
Flagstaff Medical Center

1200 North Beaver Street
Flagstaff, Arizona 86001
928-779-3366
www.nahealth.com

March 9, 2005

Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, Kentucky 40222

Re: **Theodore L. Roumell, MD**
Primary Specialty: OB/GYN

To Whom It May Concern:

Theodore L. Roumell, MD was a Locum Tenens physician at Flagstaff Medical Center during the time period of 6/6/2004 – 6/7/2004, covering in the area of OB/GYN.

Sincerely,

Susan Peters
Medical Staff Services
(928) 214-3501

Form 4A

Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, Kentucky 40222

Hospital/Clinic/Facility Affiliation Form

To Applicant: In applying for a license to practice medicine in the Commonwealth of Kentucky, the Kentucky Board of Medical Licensure requires this form to be completed by an administrator or chairperson in each facility where you have practiced medicine during the five (5) years preceding your application. My signature below is your authority to release any and all information in your files, favorable or otherwise regarding myself.

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Name: Theodore Bourret, M.D. M.D./D.O. See Release
(Please print) (Signature)

Address: Rochester Hills, MI

****

To Reference Source: Please complete this form, sign and return to the Board at the above stated address. The processing time for licensure depends on timely receipt of critical forms such as this. All applicants have signed a general release, which relieves anyone of liability for information furnished in good faith. ***No Substitutions will be accepted in lieu of this form. All other forms submitted will be returned.***

1. What privileges were extended to the applicant? Locum Tenen. - OB
2. Affiliation Dates: From 4/4/04 To 4/4/06
3. Were any limitations imposed on such privileges? NO If *"Yes"*, please explain briefly and attach certified copies of any documentation pertaining to such action. _____
4. Were privileges ever revoked, suspended, restricted, limited, reprimanded, placed on probation or otherwise disciplined? NO If *"Yes"*, please explain briefly and attach certified copies of any documentation pertaining to such action. _____

Derogatory Information, if any: NONE

Comments, if any: _____

Signature Kathryn Bevins
Title ~~Medical Staff Coordinator~~
Hospital Bixby Medical Center
Address 818 Riverside Ave
Adrian, MI 49221
Date 2.23.05

Seal of Hospital
(If no seal, so indicate)

Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, KY 40222

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FEB 17 2005
K.B.M.L.

Reference Form

To applicant: The Kentucky Board of Medical Licensure requires completion of two (2) Reference Forms from reference sources. These forms must be sent from the reference source to the Board at the above address.

In addition, the forms must meet the following criteria:

(a) Recent (no older than 6 months)
(b) Original signature
(c) Sent by licensed physician familiar with your practice. It is preferable that one be sent by the Program Director for those who recently completed residency training, or the last hospital where staff privileges were held.

Please be sure to indicate your name below for identification purposes.

Name of applicant: Theodore Boumen, M.D.
(Please print)

****

To reference source: Please complete this form, sign and return to the Board at the above stated address. All applicants have signed a general release, which relieves anyone of any liability for information furnished in good faith.

From: JAIME V. ARAGONES, MD
(Full Name – Please Print)
Suite 302, 811 Oakwood, Rochester M. 48307
(Address) (City, State, Zipcode)
Telephone: (248) 6513212

1. How long have you known the applicant? 24 years

2. In what capacity are you acquainted with him/her? as colleague, as member of Hosp. staff

		Yes	No	Not Applicable
3.	Have you ever received reports of poor practice by this physician or have you discussed concerns you had about his/her practice with medical staff officers at a hospital?	☐	☒	☐
4.	Have you ever received reports of poor relationships between this physician and other members of hospital medical staff?	☐	☒	☐
5.	Are you aware of any derogatory information about this physician with respect to his/her ability to practice medicine?	☐	☒	☐

→ Note: If you answer "NO" to questions 10, 11 or 13, please give an explanation.

		Yes	No	Not Applicable
6.	Does he/she have, or has he/she had in the past, any mental or physical illness or personal problems that interfere with his/her medical practice?	☐	☒	☐
7.	Has he/she ever abused alcohol or drugs or shown any signs of chemical dependency?	☐	☒	☐
8.	Are you aware of any lawsuits having to do with his/her medical practice that this physician has either lost or settled out of court?	☒	☐	☐
9.	Are you aware of any restrictions, limitations or other actions of any nature taken against this physician by a hospital or other health related entity?	☐	☒	☐
10.	Does this physician accept medical staff and hospital policies and function willingly according to these policies?	☒	☐	☐
11.	Does he/she enjoy professional respect among his/her colleagues and in the community where he/she practices?	☒	☐	☐
12.	Are you sorry to see this physician leave your community?	☒	☐	☐
13.	Do you recommend him/her for unrestricted medical licensure in Kentucky?	☒	☐	☐

Comments: Well qualified, dependable physician who handles his Responsibilities Well

Signature J Aragones, MD.
Title Past, Chief of Staff
Hospital Crittenton Hospital
Date Feb. 15, 2005

Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, KY 40222

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FEB 17 2005
K.B.M.L.

Reference Form

To applicant: The Kentucky Board of Medical Licensure requires completion of two (2) Reference Forms from reference sources. These forms must be sent from the reference source to the Board at the above address.

In addition, the forms must meet the following criteria:

(a) Recent (no older than 6 months)
(b) Original signature
(c) Sent by licensed physician familiar with your practice. It is preferable that one be sent by the Program Director for those who recently completed residency training, or the last hospital where staff privileges were held.

Please be sure to indicate your name below for identification purposes.

Name of applicant: Theodore Roumell, M.D.
(Please print)

****

To reference source: Please complete this form, sign and return to the Board at the above stated address. All applicants have signed a general release, which relieves anyone of any liability for information furnished in good faith.

From: BARTOL Biocic M.D.
(Full Name – Please Print)
1135 W. University #300, Roch. Hills, MI, 48307
(Address) (City, State, Zipcode)
Telephone: 248, 652-3050

1. How long have you known the applicant? SINCE 1975
2. In what capacity are you acquainted with him/her? MEMBER OF THE OB/GYN DEPT.

		Yes	No	Not Applicable
3.	Have you ever received reports of poor practice by this physician or have you discussed concerns you had about his/her practice with medical staff officers at a hospital?	☐	☑	☐
4.	Have you ever received reports of poor relationships between this physician and other members of hospital medical staff?	☐	☑	☐
5.	Are you aware of any derogatory information about this physician with respect to his/her ability to practice medicine?	☐	☑	☐

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FEB 17 2005
KBML

→ Note: If you answer "NO" to questions 10, 11 or 13, please give an explanation.

		Yes	No	Not Applicable
6.	Does he/she have, or has he/she had in the past, any mental or physical illness or personal problems that interfere with his/her medical practice?	☐	☑	☐
7.	Has he/she ever abused alcohol or drugs or shown any signs of chemical dependency?	☐	☑	☐
8.	Are you aware of any lawsuits having to do with his/her medical practice that this physician has either lost or settled out of court?	☐	☑	☐
9.	Are you aware of any restrictions, limitations or other actions of any nature taken against this physician by a hospital or other health related entity?	☐	☑	☐
10.	Does this physician accept medical staff and hospital policies and function willingly according to these policies?	☑	☐	☐
11.	Does he/she enjoy professional respect among his/her colleagues and in the community where he/she practices?	☑	☐	☐
12.	Are you sorry to see this physician leave community	☑	☐	☐
13.	Do you recommend him/her for unrestricted medical licensure in Kentucky?	☑	☐	☐

Comments: overall good physician

Signature B. Brooke

Title M.D.

Hospital CRITTENTON HOSPITAL

Date 2.16.2005

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FEB 0 8 2005
K.B.M.L.

Form 6

Release and Waiver of Rights Form

I, Theodore Roumell, M.D. hereby authorize the following individuals and entities to release all information (documented, oral or other) about me in their possession to the Kentucky Board of Medical Licensure (KBML) or its agents:

1. All medical/osteopathic schools which I have attended.

2. All hospitals or other health care facilities at which I have ever held staff privileges, whether full or limited, temporary or permanent; and all hospitals or other health care facilities at which I have ever received training.

3. All medical/osteopathic societies, specialty boards, and other medical/osteopathic organizations with which I have been associated.

4. All other state or Canadian licensure boards, federal health agencies, and federal and state drug control agencies.

5. All licensed physicians, nurses or other health care professionals of any state or Canadian province.

6. All attorneys who have participated in civil or criminal actions in which I was named party.

I hereby release the above-named individuals and entities from all liability for the release of information to the Board (KBML) or its agents.

I further authorize the Board (KBML) or any of its duly authorized agents, to make any investigations that they deem necessary to secure information concerning me, which is relevant to the requirements for licensure. I further authorize them to release such information they may now or in the future have, concerning me to (i) any federal, state, county or local governmental entity, (ii) any hospital or other health care facility, or (iii) any other person upon a showing that the release of the information is vital to the health, safety and welfare of the general public.

I hereby make this release and waiver of rights for the purpose of allowing the Board (KBML) to carry out its duties pursuant to my request for a license to practice medicine/osteopathy in the Commonwealth of Kentucky; and further, for the purpose of allowing the Board (KBML) to carry out its duties in regard to my continued licensure.

This release and waiver of rights has no expiration date and shall remain effective during my licensure in the Commonwealth of Kentucky.

Theodore Roumell MD 3/1/05

(Applicant's Signature) (Date)

Theodore Roumell, M.D.

(Print Name)

Sworn to and Subscribed Before Me By the Above Named Applicant on this the 3RD day of FEBRUARY, 2005.

Seal

Fran Cagle

Notary Public

My Commission expires:

FRAN CAGLE
Notary Public, State of Michigan
County of Macomb
My Commission Expires Sept. 10, 2007
Acting in the County of OAKLAND

American Medical Association

Physicians dedicated to the health of America

Division of Survey and Data Resources
515 North State Street
Chicago, Illinois 60610
http://www.ama-assn.org/amaprofiles

AMA Physician Profile

Name and Mailing Address:

THEODORE LOUIS ROUMELL MD
1050 W UNIVERSITY DR
ROCHESTER HLS MI 48307-1877

Primary Office Address:

SAME AS MAILING ADDRESS

Phone: 1-248-651-4004

Birthdate: [redacted]
Birthplace:

Physician's Major Professional Activity: OFFICE BASED PRACTICE

Practice Specialties Self Designated by the Physician*:

Primary Specialty: OBSTETRICS & GYNECOLOGY

Secondary Specialty: UNSPECIFIED

**Self-Designated Practice Specialties/Areas of Practice (SDPS) listed on the AMA Physician Profile do not imply "recognition" or "endorsement" of any field of medical practice by the Association, nor does it imply, certification by a Member Medical Specialty Board of the American Board of Medical Specialties, or that the physician has been trained or has special competence to practice the SDPS.*

AMA membership: NON MEMBER

All Information from this Point Forward is Provided by the Primary Source

Current and/or Historical Medical School:

UNIV OF MI MED SCH, ANN ARBOR MI 48109

Degree Awarded: Yes

Reported Year of Graduation 1960

AMA Physician Profile (continued)

It is mutually agreed between the American Medical Association (AMA) and the requesting organization that this Physician Profile (see reverse) is provided to the requesting organization with the understanding that (1) the information on the Profile will be treated with total confidentiality; (2) that such information is granted solely to the requesting organization and is granted as a non-exclusive limited license, consistent with and limited to the specific purposes set forth on the Physician Profile request form or other agreement; and (3) that no Physician Profile or information contained therein will be sold, provided to, released, copied, extracted or otherwise usurped for use by any other party, entity, organization or government agency. **Disclosure, sale or resale of Physician Profiles or the information contained therein to any third party, whether or not affiliated with the requesting organization, is strictly prohibited except that this prohibition shall not apply with respect to: disclosures required by federal or state government agencies (including, without limitation, disclosure to the physician about whom any such data relates), judicial authorities under court order, federal regulatory bodies with jurisdiction over the requesting organization, or disclosures otherwise required under federal or state law; *provided however,* that if the requesting organization is served with a subpoena or other legal process requiring the production or disclosure of Physician Profiles, then the requesting organization, to the extent reasonably practicable before complying, will promptly notify AMA and permit AMA to intervene and contest disclosure or production time and circumstances permitting.** Upon a breach of any of the foregoing covenants or upon the effective date of any statute, regulation or court decision mandating any disclosure whatsoever of such Profile information by the requesting organization, such license to use and possess the Profile shall be automatically and immediately terminated and the Profile and any information or data contained thereon or, in any way, derived therefrom shall be returned to the AMA immediately, but, in no event, later than 48 hours after such automatic termination.

AMA makes no representations or warranties, either expressed or implied, as to the accuracy, completeness or timeliness of the information contained in Physician Profiles and assumes no responsibility for any errors or omissions contained therein. Furthermore, no warranty, express or implied, is created by providing information through Physician Profiles. The AMA does not endorse in any way the individuals described in the Physician Profiles; and in no event shall the AMA be liable to the requesting organization or anyone else for any decision made or action take in reliance on such information.

American Medical Association

Physicians dedicated to the health of America

Division of Survey and Data Resources
515 North State Street
Chicago, Illinois 60610
http://www.ama-assn.org/amaprofiles

AMA Physician Profile

Current and/or Historical Post Graduate Medical Training Programs Accredited by the Accreditation Council for Graduate Medical Education (ACGME):

Future training dates, as reported by the program, should be interpreted as "in progress" or "current" with projected date of completion. If the training program indicates that training for a physician in a particular specialty was not completed at their institution, the training segment will be identified as "INCOMPLETE TRAINING".

Institution: UNIV OF PITTSBURGH MED CTR — **State:** PENNSYLVANIA
Specialty : FLEXIBLE OR TRANSITIONAL — 06/1960 - 06/1961 (VERIFIED)

Institution: HENRY FORD HOSP — **State:** MICHIGAN
Specialty : OBSTETRICS & GYNECOLOGY — 07/1963 - 02/1967 (VERIFIED)

Note: If you have discrepant information, please submit a Request for Investigation to the AMA so that we may verify the information with the primary source(s). See the last page of this Profile for instructions on how to report a data discrepancy.

Current and/or Historical Medical Licensure:

Jurisdiction	MD/ DO	Date Granted	Expiration Date	Status	License Type	Last Reported
ARIZONA	MD	07/07/2000	12/27/2005	ACTIVE	UNLIMITED	01/24/2005
CALIFORNIA	MD	05/19/1965	08/31/2005	ACTIVE	UNLIMITED	01/10/2005
MICHIGAN	MD	06/26/1961	01/31/2006	ACTIVE	UNLIMITED	01/07/2005

Note: When the specific month and day are unknown, the date will display the default value of "01." Not all licensing boards maintain or provide full date values. Please contact the appropriate licensing board directly for this information.

ECFMG Certfication:

Applicant Number:

Note: The Educational Commission for Foreign Medical Graduates (ECFMG) applicant identification number does not imply current ECFMG certification status. To verify ECFMG status, contact the ECFMG Certification Verification Service in writing at P.O. Box 13679, Philadelphia, PA 19101.

AMA Physician Profile (continued)

It is mutually agreed between the American Medical Association (AMA) and the requesting organization that this Physician Profile (see reverse) is provided to the requesting organization with the understanding that (1) the information on the Profile will be treated with total confidentiality; (2) that such information is granted solely to the requesting organization and is granted as a non-exclusive limited license, consistent with and limited to the specific purposes set forth on the Physician Profile request form or other agreement; and (3) that no Physician Profile or information contained therein will be sold, provided to, released, copied, extracted or otherwise usurped for use by any other party, entity, organization or government agency. **Disclosure, sale or resale of Physician Profiles or the information contained therein to any third party, whether or not affiliated with the requesting organization, is strictly prohibited except that this prohibition shall not apply with respect to: disclosures required by federal or state government agencies (including, without limitation, disclosure to the physician about whom any such data relates), judicial authorities under court order, federal regulatory bodies with jurisdiction over the requesting organization, or disclosures otherwise required under federal or state law; *provided however,* that if the requesting organization is served with a subpoena or other legal process requiring the production or disclosure of Physician Profiles, then the requesting organization, to the extent reasonably practicable before complying, will promptly notify AMA and permit AMA to intervene and contest disclosure or production time and circumstances permitting.** Upon a breach of any of the foregoing covenants or upon the effective date of any statute, regulation or court decision mandating any disclosure whatsoever of such Profile information by the requesting organization, such license to use and possess the Profile shall be automatically and immediately terminated and the Profile and any information or data contained thereon or, in any way, derived therefrom shall be returned to the AMA immediately, but, in no event, later than 48 hours after such automatic termination.

AMA makes no representations or warranties, either expressed or implied, as to the accuracy, completeness or timeliness of the information contained in Physician Profiles and assumes no responsibility for any errors or omissions contained therein. Furthermore, no warranty, express or implied, is created by providing information through Physician Profiles. The AMA does not endorse in any way the individuals described in the Physician Profiles; and in no event shall the AMA be liable to the requesting organization or anyone else for any decision made or action take in reliance on such information.

American Medical Association

Physicians dedicated to the health of America

Division of Survey and Data Resources
515 North State Street
Chicago, Illinois 60610
http://www.ama-assn.org/amaprofiles

AMA Physician Profile

Federal Drug Enforcement Administration:

FEDERAL DEA REGISTRATION INFORMATION WAS LAST REPORTED TO THE AMA ON 12/17/2004. DEA REGISTRATION IS VALID THROUGH 04/30/2005.

Note: Many states require their own controlled substances registration/license. Please check with your state licensing authority for requirement information as the AMA does not maintain this information.

Specialty Board Certification(s)*:

Specialty Board Certification(s) by one or more of the 24 boards recognized by the American Board of Medical Specialties (ABMS) and the American Medical Association (AMA) through the Liaison Committee on Specialty Boards, as reported by the ABMS:

The AMA Physician Profile has been designated by the ABMS as an official "display agent" of the ABMS Specialty Board Certification data. Therefore, the ABMS Board Certification information on the AMA Physician Profile is considered a designated equivalent source in regard to credentialing standards set forth by accrediting bodies such as the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) and National Committee for Quality Assurance (NCQA).

Certifying Board: AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY
Certificate: OBSTETRICS & GYNECOLOGY
Certificate Type: GENERAL

Duration	Effective	Expiration	Occurrence	Last Reported
LIFETIME	01/01/1969		INITIAL	01/13/2005

Note: For certification dates, a default value of "01" appears in the day or month field if data were not provided to AMA. Please contact the appropriate specialty board directly for this information. (**) Indicates an expired certificate.

Medicare/Medicaid Sanction(s):

TO DATE, THERE HAVE BEEN NO SUCH SANCTIONS REPORTED TO THE AMA BY THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.

Other Federal Sanction(s):

TO DATE, THERE HAVE BEEN NO FEDERAL SANCTIONS REPORTED TO THE AMA BY ANY BRANCH OF THE US MILITARY, THE VETERAN'S ADMINSTRATION OR THE US PUBLIC HEALTH SERVICE.

AMA Physician Profile (continued)

It is mutually agreed between the American Medical Association (AMA) and the requesting organization that this Physician Profile (see reverse) is provided to the requesting organization with the understanding that (1) the information on the Profile will be treated with total confidentiality; (2) that such information is granted solely to the requesting organization and is granted as a non-exclusive limited license, consistent with and limited to the specific purposes set forth on the Physician Profile request form or other agreement; and (3) that no Physician Profile or information contained therein will be sold, provided to, released, copied, extracted or otherwise usurped for use by any other party, entity, organization or government agency. **Disclosure, sale or resale of Physician Profiles or the information contained therein to any third party, whether or not affiliated with the requesting organization, is strictly prohibited except that this prohibition shall not apply with respect to: disclosures required by federal or state government agencies (including, without limitation, disclosure to the physician about whom any such data relates), judicial authorities under court order, federal regulatory bodies with jurisdiction over the requesting organization, or disclosures otherwise required under federal or state law; *provided however,* that if the requesting organization is served with a subpoena or other legal process requiring the production or disclosure of Physician Profiles, then the requesting organization, to the extent reasonably practicable before complying, will promptly notify AMA and permit AMA to intervene and contest disclosure or production time and circumstances permitting.** Upon a breach of any of the foregoing covenants or upon the effective date of any statute, regulation or court decision mandating any disclosure whatsoever of such Profile information by the requesting organization, such license to use and possess the Profile shall be automatically and immediately terminated and the Profile and any information or data contained thereon or, in any way, derived therefrom shall be returned to the AMA immediately, but, in no event, later than 48 hours after such automatic termination.

AMA makes no representations or warranties, either expressed or implied, as to the accuracy, completeness or timeliness of the information contained in Physician Profiles and assumes no responsibility for any errors or omissions contained therein. Furthermore, no warranty, express or implied, is created by providing information through Physician Profiles. The AMA does not endorse in any way the individuals described in the Physician Profiles; and in no event shall the AMA be liable to the requesting organization or anyone else for any decision made or action take in reliance on such information.

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AMA Physician Profile

Additional Information:

TO DATE, THERE IS NO ADDITIONAL INFORMATION FOR THIS PHYSICIAN ON FILE.

The content of the AMA Physician Profile is intended to assist with credentialing. Appropriate use of the AMA Physician Masterfile data contained on this Profile by an organization would meet the primary source verification requirements of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the American Accreditation HealthCare Commission/URAC. The Physician Masterfile meets the National Committee for Quality Assurance (NCQA) standards for verification of medical education, post graduate medical training, board certification, DEA status, and Medicare/Medicaid sanctions.

If you note any discrepancies, please log onto our web site and go to the order detail page, select the D following the physician's name and enter the data in question. Or you can mark the issues on a copy of the profile and mail or fax to:

Division of Database Products and Licensing
Attn: Credentialing Products
515 N. State Street
Chicago, IL 60610
800- 665-2882
312 464-5900 (fax)

AMA Physician Profile (continued)

It is mutually agreed between the American Medical Association (AMA) and the requesting organization that this Physician Profile (see reverse) is provided to the requesting organization with the understanding that (1) the information on the Profile will be treated with total confidentiality; (2) that such information is granted solely to the requesting organization and is granted as a non-exclusive limited license, consistent with and limited to the specific purposes set forth on the Physician Profile request form or other agreement; and (3) that no Physician Profile or information contained therein will be sold, provided to, released, copied, extracted or otherwise usurped for use by any other party, entity, organization or government agency. **Disclosure, sale or resale of Physician Profiles or the information contained therein to any third party, whether or not affiliated with the requesting organization, is strictly prohibited except that this prohibition shall not apply with respect to: disclosures required by federal or state government agencies (including, without limitation, disclosure to the physician about whom any such data relates), judicial authorities under court order, federal regulatory bodies with jurisdiction over the requesting organization, or disclosures otherwise required under federal or state law; *provided however,* that if the requesting organization is served with a subpoena or other legal process requiring the production or disclosure of Physician Profiles, then the requesting organization, to the extent reasonably practicable before complying, will promptly notify AMA and permit AMA to intervene and contest disclosure or production time and circumstances permitting.** Upon a breach of any of the foregoing covenants or upon the effective date of any statute, regulation or court decision mandating any disclosure whatsoever of such Profile information by the requesting organization, such license to use and possess the Profile shall be automatically and immediately terminated and the Profile and any information or data contained thereon or, in any way, derived therefrom shall be returned to the AMA immediately, but, in no event, later than 48 hours after such automatic termination.

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Healthcare Integrity and Protection Data Bank
P.O. Box 10832
Chantilly, VA 20153-0832

http://www.npdb-hipdb.com

DCN: 5500000036293301
Process Date: 02/09/2005

RESPONSE TO SELF-QUERY

A. SUBJECT ON WHOM DISCLOSURE IS REQUESTED

Subject Name: ROUMELL, THEODORE
Gender: [redacted]
Date of Birth: [redacted]
Other Name(s) Used:
Organization Name:
Organization Type:
Other, as Specified:
Home or Work Address: [redacted]
City, State, ZIP [redacted]
Country:
Social Security Numbers (SSN): [redacted]
Individual Taxpayer Identification Numbers (ITIN):
Federal Employer Identification Numbers (FEIN):
National Provider Identifiers (NPI):
Drug Enforcement Administration (DEA) Numbers:
Unique Physician Identification Numbers (UPIN):
Professional School(s) & Year(s) of Graduation: UNIVERSITY OF MICHIGAN MEDICAL SCHOOL 1960
Occupation/Field of Licensure (Code): PHYSICIAN (MD) (010)
State License Numbers, State of Licensure: 24386, MI
Other, as Specified:
Specialty:

B. PAYMENT INFORMATION

Payment Type: CREDIT CARD
Account Number: XXXXXXXXXXX[redacted]
Expiration Date: [redacted]
Transaction Date: [redacted]
Transaction Number [redacted]
Total Charge: $8.00

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DCN: 5500000036293301
Process Date: 02/09/2005
Page:2 of 2

C. SEARCH RESULT

Based on the subject identification information provided by you in Section A above, a search of the NPDB has located the following 2 report(s).

Type of Report	Report Number
Medical Malpractice Payment Report	1019902830153000
Medical Malpractice Payment Report	1019902900125000

Recipients should verify that the subject identified in Section A is, in fact, the subject of interest.

Copies of these reports are enclosed for restricted/limited use as prescribed by Title IV of Public Law 99-660, as amended. Recipients should verify that the subject identified in Section B of the report(s) is, in fact, the subject of interest. Information from the NPDB is confidential and must be used solely for the purpose for which it was disclosed. ANY PERSON WHO VIOLATES THE CONFIDENTIALITY PROVISIONS AS SPECIFIED IN TITLE IV IS SUBJECT TO A CIVIL MONEY PENALTY OF UP TO $11,000 FOR EACH VIOLATION. Subjects of reports who obtain information about themselves from the NPDB are permitted to share that information with anyone they choose.

National Practitioner Data Bank
Healthcare Integrity and Protection Data Bank
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Chantilly, VA 20153-0832

http://www.npdb-hipdb.com

DCN: 1019902830153000
Process Date: 11/10/1990

MEDICAL MALPRACTICE PAYMENT REPORT

Report Number 1019902830153000

This report is maintained in: [X] **The National Practitioner Data Bank**

[ ] **The Healthcare Integrity and Protection Data Bank**

The information contained in this report is maintained by the National Practitioner Data Bank for restricted use under the provisions of Title IV of Public Law 99-660, as amended, and 45 CFR Part 60. All information is confidential and may be used only for the purpose for which it was disclosed. For additional information or clarification, contact the reporting entity identified in Section A.

A. REPORTING ENTITY

Entity Name: PHYSICIANS INSURANCE CO OF MICHIGAN
Address: PO BOX 2510
City, State, ZIP: OKEMOS, MI 48864-2510
Entity Internal Report Reference (e.g., claim number):
Name or Office: JEFFREY L. OLSEN
Title or Department: CLAIMS EXAMINER
Telephone: 517-349-6500 EXT.267
Type of Report: INITIAL REPORT

B. SUBJECT IDENTIFICATION INFORMATION (INDIVIDUAL)

Subject Name: ROUMELL, THEODORE L
Other Name(s) Used:
Gender: UNKNOWN
Organization Name: THEODORE L ROUMELL, M.D.P.C.
Work Address: 1050 WEST UNIVERSITY
City, State, ZIP: ROCHESTER, MI 48063
Country:
Home Address:
City, State, ZIP:
Country:
Social Security Numbers (SSN):
Date of Birth: [redacted]
Deceased: NO
Professional School(s) & Year(s) of Graduation: UNIVERSITY OF MICHIGAN MEDICAL SCHOOL 1960
Occupation/Field of Licensure (Code): PHYSICIAN (MD) (010)
State License Number, State of Licensure: 024386, MI
Other, as Specified:
Drug Enforcement Administration (DEA) Numbers:

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Chantilly, VA 20153-0832

http://www.npdb-hipdb.com

DCN: 1019902830153000
Process Date: 11/10/1990

Hospital Affiliation(s):

C. INFORMATION REPORTED

Date of Report: 11/10/1990
Act/Omission Code: SURGERY: IMPROPER PERFORMANCE OF SURGERY (250)
Date of Act/Omission: 09/25/1987
Payment Date: 10/02/1990
Multiple or Single Payment: SINGLE
Amount of This Payment: $10,000.00
Total Amount of Judgment or Settlement:
Payment Result of: SETTLEMENT
Number of Practitioners for Whom Payment Is Made: 1
Relationship of Entity to the Practitioner: INSURANCE COMPANY
Date of Judgment/Settlement:
Adjudicative Case Number:
Adjudicative Body Name:
Court File Number:

Reporter's Description of the Act or Omission: ALLEGED FAILURE TO PROPERLY PERFORM AN ABORTION RESULTING IN INFECTION. 8975-040A

Reporter's Description of the Judgment or Settlement: $10,000 SETTLEMENT.

D. SUBJECT STATEMENT

If the subject identified in Section B of this report has submitted a statement, it appears in this section.

E. REPORT STATUS

Unless one or more boxes below are checked, the subject of this report identified in Section B has not contested this report.

☐ If box is checked, this report has been disputed by the subject identified in Section B.

☐ If box is checked, at the request of the subject identified in Section B, this report is being reviewed by the Secretary of the U.S. Department of Health and Human Services to determine its accuracy and/or whether it complies with reporting requirements. No decision has been reached.

☐ If box is checked, at the request of the subject identified in Section B, this report was reviewed by the Secretary of the U.S. Department of Health and Human Services. The Secretary's decision is shown below:

National Practitioner Data Bank
Healthcare Integrity and Protection Data Bank
P.O. Box 10832
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http://www.npdb-hipdb.com

Date of Initial Report: 11/10/1990

Date of Most Recent Change: 11/10/1990

END OF REPORT

National Practitioner Data Bank
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http://www.npdb-hipdb.com

DISCLOSURE HISTORY

Report Number 1019902830153000

F. DISCLOSURE HISTORY

Recipient(s) of the Current Version of this Report

A copy of this report has been disclosed to the following entity(entities) for limited/restricted use under the statutory provisions specified in this report. Additionally, all active entities who received the earlier version of this report within the three year period prior to the date the correction was filed were mailed a copy of the current version of this report.

Date Released	Entity Name
06/04/1992	CRITTENTON HOSPITAL 1101 W UNIVERSITY DRIVE ROCHESTER, MI 48307 (248) 652-5232
06/03/1991	DETROIT-MACOMB HOSPITAL CORP 7733 EAST JEFFERSON AVENUE DETROIT, MI 48214 (313) 499-4666
07/22/1991	DETROIT-MACOMB HOSPITAL CORP 7733 EAST JEFFERSON AVENUE DETROIT, MI 48214 (313) 499-4666
05/07/1993	DETROIT-MACOMB HOSPITAL CORP 7733 EAST JEFFERSON AVENUE DETROIT, MI 48214 (313) 499-4666

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Chantilly, VA 20153-0832

http://www.npdb-hipdb.com

DISCLOSURE HISTORY

Report Number 1019902830153000

Date Released	Entity Name
10/01/1993	UNIVERSITY OF MICHIGAN MEDICAL STAFF SER 1500 E. MEDICAL CENTER DRIVE F2306 MCHC ANN ARBOR, MI 48109 (734) 936-9879
05/10/1994	CRITTENTON HOSPITAL 1101 W UNIVERSITY DRIVE ROCHESTER, MI 48307 (248) 652-5232
05/15/1995	DETROIT-MACOMB HOSPITAL CORP 7733 EAST JEFFERSON AVENUE DETROIT, MI 48214 (313) 499-4666
06/18/1996	CRITTENTON HOSPITAL 1101 W UNIVERSITY DRIVE ROCHESTER, MI 48307 (248) 652-5232
05/27/1997	ST. JOHN DETROIT RIVERVIEW HOSPITAL MEDICAL AFFAIRS 7733 E. JEFFERSON DETROIT, MI 48214 (313) 499-4666

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DISCLOSURE HISTORY

Report Number 1019902830153000

Date Released	Entity Name
02/27/1998	TENET HEALTHSYSTEM 14001 DALLAS PARKWAY DALLAS, TX 75240 (972) 789-6056
07/17/1998	CRITTENTON HOSPITAL 1101 W UNIVERSITY DRIVE ROCHESTER, MI 48307 (248) 652-5232
06/02/1999	NATIONAL ABORTION FEDERATION 1755 MASSACHUSETTS AVENUE, NW SUITE 600 WASHINGTON, DC 20036 (202) 667-5881
07/14/1999	ST. JOHN DETROIT RIVERVIEW HOSPITAL MEDICAL AFFAIRS 7733 E. JEFFERSON DETROIT, MI 48214 (313) 499-4666
05/25/2001	ST. JOHN DETROIT RIVERVIEW HOSPITAL MEDICAL AFFAIRS 7733 E. JEFFERSON DETROIT, MI 48214 (313) 499-4666

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DISCLOSURE HISTORY

Report Number 1019902830153000

Date Released	Entity Name
07/12/2002	CRITTENTON HOSPITAL 1101 W UNIVERSITY DRIVE ROCHESTER, MI 48307 (248) 652-5232
05/16/2003	ST. JOHN DETROIT RIVERVIEW HOSPITAL MEDICAL AFFAIRS 7733 E. JEFFERSON DETROIT, MI 48214 (313) 499-4666
09/30/2003	BIXBY MEDICAL CENTER 818 RIVERSIDE AVE. ADRIAN, MI 49221 (517) 265-0429
12/15/2003	BIXBY MEDICAL CENTER 818 RIVERSIDE AVE. ADRIAN, MI 49221 (517) 265-0429
03/08/2004	BIXBY MEDICAL CENTER 818 RIVERSIDE AVE. ADRIAN, MI 49221 (517) 265-0429

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DCN: 1019902830153000
Process Date: 02/09/2005

DISCLOSURE HISTORY

Report Number 1019902830153000

Date Released	Entity Name
06/03/2004	FLAGSTAFF MEDICAL CENTER MEDICAL STAFF OFFICE1200 NORTH BEAVER ST 1200 NORTH BEAVER STREET FLAGSTAFF, AZ 86001 (520) 779-3366
07/22/2004	CRITTENTON HOSPITAL 1101 W UNIVERSITY DRIVE ROCHESTER, MI 48307 (248) 652-5232
02/09/2005	PRACTITIONER SELF-QUERY

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http://www.npdb-hipdb.com

DCN: 1019902900125000
Process Date: 02/21/1992

MEDICAL MALPRACTICE PAYMENT REPORT

Report Number 1019902900125000

This report is maintained in: [X] **The National Practitioner Data Bank**

[ ] **The Healthcare Integrity and Protection Data Bank**

The information contained in this report is maintained by the National Practitioner Data Bank for restricted use under the provisions of Title IV of Public Law 99-660, as amended, and 45 CFR Part 60. All information is confidential and may be used only for the purpose for which it was disclosed. For additional information or clarification, contact the reporting entity identified in Section A.

A. REPORTING ENTITY

Entity Name: PHYSICIANS INSURANCE CO OF MICHIGAN
Address: PO BOX 2510

City, State, ZIP: OKEMOS, MI 48864-2510

Entity Internal Report Reference (e.g., claim number):

Name or Office: JEFFREY L. OLSEN
Title or Department: CLAIMS EXAMINER
Telephone: 517-349-6500 EXT.267

Type of Report: INITIAL REPORT

B. SUBJECT IDENTIFICATION INFORMATION (INDIVIDUAL)

Subject Name: ROUMELL, THEODORE L

Other Name(s) Used:

Gender: UNKNOWN

Organization Name: THEODORE L. ROUMELL, M.D. P.C.
Work Address: 1050 WEST UNIVERSITY

City, State, ZIP: ROCHESTER, MI 48063
Country:

Home Address:

City, State, ZIP:
Country:

Social Security Numbers (SSN):

Date of Birth: [redacted]

Deceased: NO

Professional School(s) & Year(s) of Graduation: UNIVERSITY OF MICHIGAN MEDICAL SCHOOL 1960

Occupation/Field of Licensure (Code): PHYSICIAN (MD) (010)

State License Number, State of Licensure: 80167, MI

Other, as Specified:

Drug Enforcement Administration (DEA) Numbers:

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DCN: 1019902900125000
Process Date: 02/21/1992

Hospital Affiliation(s):

C. INFORMATION REPORTED

Date of Report: 02/21/1992
Act/Omission Code: SURGERY: IMPROPER PERFORMANCE OF SURGERY (250)
Date of Act/Omission: 11/16/1987
Payment Date: 10/08/1990
Multiple or Single Payment: SINGLE
Amount of This Payment: $20,000.00
Total Amount of Judgment or Settlement:
Payment Result of: SETTLEMENT
Number of Practitioners for Whom Payment Is Made: 1
Relationship of Entity to the Practitioner: INSURANCE COMPANY
Date of Judgment/Settlement:
Adjudicative Case Number:
Adjudicative Body Name:
Court File Number:

Reporter's Description of the Act or Omission: IT WAS ALLEGED THERE WAS A PERFORATION OF THE ILEUM DURING A TUBAL LIGATIONLEADING TO SUBSEQUENT SURGERIES.

Reporter's Description of the Judgment or Settlement: TOTAL SETTLEMENT AMOUNT OF $30,000 WITH THE HOSPITAL CONTRIBUTING $10,000. 9518-040A

D. SUBJECT STATEMENT

If the subject identified in Section B of this report has submitted a statement, it appears in this section.

E. REPORT STATUS

Unless one or more boxes below are checked, the subject of this report identified in Section B has not contested this report.

[X] If box is checked, this report has been disputed by the subject identified in Section B.

[ ] If box is checked, at the request of the subject identified in Section B, this report is being reviewed by the Secretary of the U.S. Department of Health and Human Services to determine its accuracy and/or whether it complies with reporting requirements. No decision has been reached.

[ ] If box is checked, at the request of the subject identified in Section B, this report was reviewed by the Secretary of the U.S. Department of Health and Human Services. The Secretary's decision is shown below:

National Practitioner Data Bank
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http://www.npdb-hipdb.com

Date of Initial Report: 02/21/1992

Date of Most Recent Change: 02/21/1992

END OF REPORT

National Practitioner Data Bank
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DISCLOSURE HISTORY

Report Number 1019902900125000

F. DISCLOSURE HISTORY

Recipient(s) of the Current Version of this Report

A copy of this report has been disclosed to the following entity(entities) for limited/restricted use under the statutory provisions specified in this report. Additionally, all active entities who received the earlier version of this report within the three year period prior to the date the correction was filed were mailed a copy of the current version of this report.

Date Released	Entity Name
06/04/1992	CRITTENTON HOSPITAL 1101 W UNIVERSITY DRIVE ROCHESTER, MI 48307 (248) 652-5232
05/07/1993	DETROIT-MACOMB HOSPITAL CORP 7733 EAST JEFFERSON AVENUE DETROIT, MI 48214 (313) 499-4666
10/01/1993	UNIVERSITY OF MICHIGAN MEDICAL STAFF SER 1500 E. MEDICAL CENTER DRIVE F2306 MCHC ANN ARBOR, MI 48109 (734) 936-9879
05/10/1994	CRITTENTON HOSPITAL 1101 W UNIVERSITY DRIVE ROCHESTER, MI 48307 (248) 652-5232

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DISCLOSURE HISTORY

Report Number 1019902900125000

Date Released	Entity Name
05/15/1995	DETROIT-MACOMB HOSPITAL CORP 7733 EAST JEFFERSON AVENUE DETROIT, MI 48214 (313) 499-4666
06/18/1996	CRITTENTON HOSPITAL 1101 W UNIVERSITY DRIVE ROCHESTER, MI 48307 (248) 652-5232
05/27/1997	ST. JOHN DETROIT RIVERVIEW HOSPITAL MEDICAL AFFAIRS 7733 E. JEFFERSON DETROIT, MI 48214 (313) 499-4666
02/27/1998	TENET HEALTHSYSTEM 14001 DALLAS PARKWAY DALLAS, TX 75240 (972) 789-6056
07/17/1998	CRITTENTON HOSPITAL 1101 W UNIVERSITY DRIVE ROCHESTER, MI 48307 (248) 652-5232

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DISCLOSURE HISTORY

Report Number 1019902900125000

Date Released	Entity Name
06/02/1999	NATIONAL ABORTION FEDERATION 1755 MASSACHUSETTS AVENUE, NW SUITE 600 WASHINGTON, DC 20036 (202) 667-5881
Date Released	**Entity Name**
07/14/1999	ST. JOHN DETROIT RIVERVIEW HOSPITAL MEDICAL AFFAIRS 7733 E. JEFFERSON DETROIT, MI 48214 (313) 499-4666
Date Released	**Entity Name**
05/25/2001	ST. JOHN DETROIT RIVERVIEW HOSPITAL MEDICAL AFFAIRS 7733 E. JEFFERSON DETROIT, MI 48214 (313) 499-4666
Date Released	**Entity Name**
07/12/2002	CRITTENTON HOSPITAL 1101 W UNIVERSITY DRIVE ROCHESTER, MI 48307 (248) 652-5232
Date Released	**Entity Name**
05/16/2003	ST. JOHN DETROIT RIVERVIEW HOSPITAL MEDICAL AFFAIRS 7733 E. JEFFERSON DETROIT, MI 48214 (313) 499-4666

National Practitioner Data Bank
Healthcare Integrity and Protection Data Bank
P.O. Box 10832
Chantilly, VA 20153-0832

http://www.npdb-hipdb.com

DISCLOSURE HISTORY

Report Number 1019902900125000

Date Released	Entity Name
09/30/2003	BIXBY MEDICAL CENTER 818 RIVERSIDE AVE. ADRIAN, MI 49221 (517) 265-0429
12/15/2003	BIXBY MEDICAL CENTER 818 RIVERSIDE AVE. ADRIAN, MI 49221 (517) 265-0429
03/08/2004	BIXBY MEDICAL CENTER 818 RIVERSIDE AVE. ADRIAN, MI 49221 (517) 265-0429
06/03/2004	FLAGSTAFF MEDICAL CENTER MEDICAL STAFF OFFICE1200 NORTH BEAVER ST 1200 NORTH BEAVER STREET FLAGSTAFF, AZ 86001 (520) 779-3366
07/22/2004	CRITTENTON HOSPITAL 1101 W UNIVERSITY DRIVE ROCHESTER, MI 48307 (248) 652-5232

National Practitioner Data Bank
Healthcare Integrity and Protection Data Bank
P.O. Box 10832
Chantilly, VA 20153-0832

http://www.npdb-hipdb.com

DCN: 1019902900125000
Process Date: 02/09/2005

DISCLOSURE HISTORY

Report Number 1019902900125000

Date Released	Entity Name
02/09/2005	PRACTITIONER SELF-QUERY

National Practitioner Data Bank
Healthcare Integrity and Protection Data Bank
P.O. Box 10832
Chantilly, VA 20153-0832

http://www.npdb-hipdb.com

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FEB 15 2005
K.B.M.L.

DCN: 5500000036293301
Process Date: 02/09/2005

RESPONSE TO SELF-QUERY

A. SUBJECT ON WHOM DISCLOSURE IS REQUESTED

Subject Name: ROUMELL, THEODORE
Gender: [redacted]
Date of Birth: [redacted]
Other Name(s) Used:
Organization Name:
Organization Type:
Other, as Specified:
Home or Work Address: [redacted]
City, State, ZIP: [redacted]
Country:
Social Security Numbers (SSN): [redacted]
Individual Taxpayer Identification Numbers (ITIN):
Federal Employer Identification Numbers (FEIN):
National Provider Identifiers (NPI):
Drug Enforcement Administration (DEA) Numbers:
Unique Physician Identification Numbers (UPIN):
Professional School(s) & Year(s) of Graduation: UNIVERSITY OF MICHIGAN MEDICAL SCHOOL 1960
Occupation/Field of Licensure (Code): PHYSICIAN (MD) (010)
State License Numbers, State of Licensure: 24386, MI
Other, as Specified:
Specialty:

B. PAYMENT INFORMATION

Payment Type: CREDIT CARD
Account Number: [redacted]
Expiration Date: [redacted]
Transaction Date: [redacted]
Transaction Number: [redacted]
Total Charge: $8.00

C. SEARCH RESULT

Based on the subject identification information provided by you in Section A above, a search of the HIPDB has located the following 0 report(s).

Recipients should verify that the subject identified in Section A is, in fact, the subject of interest.

National Practitioner Data Bank
Healthcare Integrity and Protection Data Bank
P.O. Box 10832
Chantilly, VA 20153-0832

http://www.npdb-hipdb.com

DCN: 5500000036293301
Process Date: 02/09/2005

Copies of these reports are enclosed for restricted/limited use as prescribed by Section 1128E of the Social Security Act. Recipients should verify that the subject identified in Section B of the report(s) is, in fact, the subject of interest. Information from the HIPDB is confidential and must be used solely for the purpose for which it was disclosed. Subjects of reports who obtain information about themselves from the HIPDB are permitted to share that information with anyone they choose.

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

JENNIFER M. GRANHOLM
GOVERNOR

JANET OLSZEWSKI
DIRECTOR

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MAR 0 2 2005
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VERIFICATION OF LICENSURE
MICHIGAN BOARD OF MEDICINE
VERIFICATION OF LICENSURE AS OF 02/28/2005

KENTUCKY BOARD OF MEDICINE
310 WHITTINGTON PARKWAY SUITE 1B
LOUISVILLE KY 40222

NAME: Theodore L Roumell
ADDRESS: 1050 W University
Rochester, MI 48307-1877

SSN: [redacted]
BIRTHDATE: [redacted]

TYPE: Medical Doctor
LICENSE NUMBER: 4301024386 **STATUS:** Active
OBTAINED BY: Michigan Examination

ORIGINAL DATE: 06/26/1961
EXPIRATION DATE: 01/31/2006

EXAM DATE	EXAM	SCORES
06/08/1960	Physiology	92
06/08/1960	Pathology	93
06/08/1960	Medical Jurisprudence	45
06/08/1960	Eye, Ear, Nose and Throat	45
06/08/1960	Anatomy, Gross Microscopic & Neuro	79
06/08/1960	Biological Chemistry	45
06/08/1960	Bacteriology, Microbiology & Immun	41
06/08/1960	Medicine Incl. Dermatology	78
06/08/1960	Preventive Medicine & Public Health	42
06/08/1960	Obstetrics & Gynecology	42.5
06/08/1960	Materia Medica, Pharm & Therapeutics	85
06/08/1960	Surgery Incl. Anesth. & Radiology	85
06/08/1960	Neurology & Psychiatry	40
06/08/1960	Pediatrics	37.5

DISCIPLINARY ACTION NONE

OPEN FORMAL COMPLAINTS NONE

CAROLYN F. PARKINSON

Nursing Spectrum NurseWeek
CONTINUING EDUCATION
2002 Renaissance Blvd, Suite 120
King of Prussia, PA 1940
(800) 866-0919 ce@nursingspectrum.com

Nursing Spectrum Division of Continuing Education is accredited as a provider of continuing education in nursing through the American Nurses Credentialing Center's Commission on Accreditation (ANCC); State of Florida Board of Nursing (provider no. FBN 2904); California Board of Registered Nursing (provider no. CEP13213); and American Association of Critical-Care Nurses (AACN, provider no. 0009259).

AACN Category: A KY CHS #1106-1611-M

CERTIFICATE

Kentucky HI Valds Requirement For Healthcare Professionals

Pass Date: 02/11/2005

Contact hou s: 2.0

Licensed in: TP937

You answen d the following questions incorrectly: 2

The correct nswers are: c

RECEIVED
JUN 13 2005
K.B.M.L

Theodore F ournell
1050 W Uni ersity
Rochester, I MI 48307

Robert G. Hess, Jr., RN, PhD
Vice President of
Continuing Education

Do not send this certificate t the Board of Nursing – Keep this certificate for 5 years. Replacement certificate fee is $2.00.

The Federation of State Medical Boards
of the United States, Inc.
PO Box 619850
Dallas, Texas 75261-9850
Telephone: (817) 868-4000
FAX (817) 868-4099

BOARD ACTION SEARCH RECONCILIATION REPORT

February 15, 2005

Kentucky State Bd. of Med. Lic
Attn: C. William Schmidt
Hurstbourne Office Park
310 Whittington Pkwy Ste 1B
Louisville, KY 40222-4916

Re: Board Action Query Dated: February 15, 2005

Your Reference Number:

FSMB Batch Number: BQ1085507

PRACTITIONERS CLEARED WITH NO ACTION AS OF APPLICABLE SEARCH DATE

Name	DOB	School	Yr/Grad	Request ID
Roumell, Theodore	[redacted]	023030	1960	15220907

Please refer to prior clearance reports to determine the search date for each practitioner.

RECEIVED

FEB 18 2005

K.B.M.L.

February 11, 2005

WE HAVE NO UNFAVORABLE INFORMATION REGARDING THE ABOVE NAMED PHYSICIAN

FEB 15 2005

DALE L. AUSTIN
SENIOR VICE PRESIDENT
AND CHIEF OPERATING OFFICER

Federation of State Medical Boards
400 Fuller Wiser Rd., Suite 300
Euless, TX 76039
(817) 868-4000

ATTN: Disciplinary Inquiry Department

Please forward a Disciplinary Inquiry for licensure in the State of Kentucky. The following information should be helpful:

NAME: Theodore Roumell, M.D.
DOB:
SS#:
MEDICAL SCHOOL: University of Michigan, Ann Arbor, MI
DATE OF GRADUATION: 1960
ECFMG#: N/A

Enclosed is a Federal Express air bill and envelope for your convenience in forwarding the document directly to the KY State Board. ***Please seal documents in your own office stationary and forward to the state board. Please use THIS enclosed Fed Ex when sending the requests to the State Medical Boards; we will be tracking it for delivery.***

If you have any questions or require additional information, please do not hesitate to call me at (800) 685-2272, Ext. 1628. Thank you for your help.

Sincerely,

Stacy DeGraaf
Licensing Coordinator

Enclosure

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MAY 19 2005
K.B.M.L.

RECEIVED
FEB 08 2005
K.B.M.L.

Kentucky HIV/AIDS Education
Affidavit of Reasonable Cause

I, Theodore Boumell, M.D., request that the Board (KBML) defer my
(Name)

HIV/AIDS education requirement for initial professional licensure (KRS 214.615) for the following reason,

Please explain in detail: I am pursuing a locum tenens position in your state. I do not live in Kentucky and therefore request an extension to complete the course.

I understand that the deferment is valid for six (6) months from the date of the issuance of my temporary permit to practice medicine and is **not renewable.** I further understand that within this six months I must send to the Board (KBML), a copy of a certificate showing completion of a Kentucky Cabinet for Health Services approved HIV/AIDS course for a full and unrestricted license to be issued.

Signature: Theodore Boumell MD Date: 1/27/05

Printed Name: Theodore Boumell, M.D.

Social Security Number: [redacted]

→ This form must be sent to the Board (KBML) in order for you to receive a six-month extension. Please retain a copy of this affidavit for your records.

Mail this form to the following address:

Medical Licensure Coordinator
Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, KY 40222
(502) 429-8046

RECEIVED

FEB 0 8 2005

CME Form

Name THEODORE L. ROUMELY M.D. K.B.M.L.
(Please Print or Type)

Record of Category I Continuing Medical Education Credits(Last 3 years)
DO NOT PROVIDE DOCUMENTATION

Dates:	Name of Activity/Course	# of Credit Hours
1/01/02-12/31/02	CRITTENTON HOSP. PHYSICIAN EDUCATION	21
YEAR 2002	WAYNE STATE UNIVERSITY SCHOOL OF MEDICINE	44
2003	AEROSPACE MEDICAL EDUCATION DIV.	17.33
2003	WAYNE STATE UNIVERSITY SCH. OF MED.	62
2003	CRITTENTON HOSP. PHYSICIAN EDUC.	28
2004	CRITTENTON HOSP. PHYSICIAN EDUC.	24
2004	WAYNE STATE UNIV. SCH. OF MED	50.5

I attest that the above is valid.

Signature

1/3/05
Date

RECEIVED

MAR 0 2 2006

K.B.M.L.

For Office Use Only: $125.00 [✓] Check # 11589
$175.00 [ ] Check #
$225.00 [ ] Check #

Application for Renewal of Kentucky Medical/Osteopathic License for Year 2006
Registration Fee: $125.00

Late Registration After March 1, but before April 1, may be made by payment of an additional $50.00 fee. After April 1, 2006, you will be imposed an additional $100.00 fee.

All questions on this application must be answered and received with the correct renewal fee. Applications with unanswered questions will be returned to you, which will create a delay in timely processing.

Note: *Intentional false answers or misrepresentation in applying for or procuring a license, registration or reactivation in Kentucky are grounds for disciplinary action, including denial or revocation of license, and are reported to the National Practitioner Data Bank and/or appropriate national professional credentialing organization. You must answer "yes" to any question if the event(s) described in that question has actually occurred. You must answer, "yes" in such circumstances even if you have been advised by an attorney or other person that you may answer "no". You must also answer "yes" in such circumstance even if the record of the event has been sealed or expunged by Court order, or has been designated "confidential" by the body involved. After answering "yes" to the appropriate question(s), you may advise the Board of any additional relevant information pertaining to your answer (i.e., record has been sealed or expunged, record is designated "confidential," attorney has advised that you properly answer "no"). The Board will consider this additional information, along with your answer(s), in determining the appropriate action.*

If you have any question about whether or not you should answer "yes" to a question, you should err in favor of answering "yes", providing an explanation, because any non-disclosure violation will likely result in denial of your application or disciplinary action against your license.

(Please Type or Print)

1) Name: THEODORE L. ROUMELL M.D. 2) KY License No.: 39667

3) Mailing Address: 1050 W UNIVERSITY (Street) ROCHESTER. (City)

MICHIGAN (State or Country) 48307 (Zip Code)

4) Practice Address:

(Note: Primary Practice address appears on the KBML Physician Profile at www.kbml.ky.gov.)

Primary Practice Address 1050 W UNIVERSITY (Street) ROCHESTER (City)

MICHIGAN. (State or Country) 48307 (Zip Code)

5) Office Telephone Number: (248) 651 - 4004

6) E-Mail Address (***For Office Use Only***): —

Application for Registration of Kentucky Medical/Osteopathic License for Year 2006

Name: THEODORE L. BOVMELL M.D. **License No.:** 39667

7) Are you currently practicing in Kentucky? ☐Yes ☒No

8) Please provide KY County and number of hours worked weekly in this county:

(a) County: —

(b) Number of hours worked weekly in this county: —

If you have additional practice counties in Kentucky, please indicate so below:

a) Additional Practice County in KY: —
Number of hours worked weekly in this county: _____

b) Additional Practice County in KY: —
Number of hours worked weekly in this county: _____

9) Do you currently have hospital staff privileges in Kentucky? ☐Yes ☒No

10) Do you currently have a collaborative agreement with an ARNP? ☐Yes ☒No

11) Do you have plans to practice medicine in Kentucky during the year? ☒Yes ☐No

12) Specialty: OB-GYN

13) Type of Practice: LOCUM TENENS ASSIGNMENT

☐ Hospital Based	☐ Resident/Fellow	☐ Military	☐ Retired
☐ Faculty	☐ Private Practice	☐ Research	☐ Semi-Retired
☐ Administrative Medicine	☐ Occupational Medicine	☐ Emergency Medicine	☒ Locum Tenens
			☐ Public Health/Government

Questions (14) and (15) regarding gender and ethnicity are voluntary:

14) Gender [redacted]

15) Race/Ethnicity [redacted]

[redacted] African American	[redacted] Asian	[redacted] Caucasian	[redacted] Hispanic	[redacted] Latino
[redacted] Multiracial	[redacted] Native American	[redacted] Pacific Islander	[redacted] Other	

Application for Registration of Kentucky Medical/Osteopathic License for Year 2006

Name: THEODORE L. ROUMELL MD **License No.:** 39667

1) Since you last registered have you had any license, certificate, registration or other privilege to practice as a health care professional denied, revoked, suspended, probated, restricted, reprimanded, limited, or subjected to any other disciplinary action, by a state medical/osteopathic licensing board, or Federal, or International authority?
☐Yes ☒No

2) Since you last registered have you surrendered such credential, or placed it into an inactive status, to avoid disciplinary action or in connection with or in anticipation of a disciplinary investigation/action by the licensing authority of such jurisdiction?
☐Yes ☒No

3) Since you last registered have you been or are you currently under investigation by any State medical/osteopathic licensing board, Federal or International licensure authority or any drug licensure/enforcement authority?
☐Yes ☒No

4) Since you last registered has the Drug Enforcement Administration (DEA), or any state or International drug licensure/enforcement authority denied, revoked, suspended, restricted, limited, or otherwise disciplined a controlled substance registration certificate issued to you?
☐Yes ☒No

5) Since you last registered have you voluntarily or involuntarily surrendered a medical or osteopathic license, or controlled substance registration certificate issued to you?
☐Yes ☒No

6) Since you last registered has any hospital, hospital medical staff or any other health care entity revoked, suspended, restricted, limited, reprimanded, placed on probation or otherwise disciplined your staff privileges?
☐Yes ☒No

7) Since you last registered have you resigned your privileges or failed to renew privileges at a licensed hospital or from the medical staff of the hospital or any other health care entity, while under investigation or while you were subject to disciplinary proceedings by any of the entities noted above?
☐Yes ☒No

8) Since you last registered are any legal proceedings regarding licensure presently pending against you by any State, Federal or International licensure authority or any drug licensure/enforcement authority?
☐Yes ☒No

9) Since you last registered have you been removed, suspended, expelled or disciplined by any professional medical association or society?
☐Yes ☒No

10) Since you last registered have you been convicted of a felony or misdemeanor by any State, Federal or International court? Are any criminal charges presently pending against you in any of those courts?
☐Yes ☒No

11) Since you last registered to your knowledge, are you the subject of an investigation for a criminal act?
☐Yes ☒No

12) Since you last registered have you had to pay a judgment of $250,000 or greater in a malpractice action or other civil action against your medical practice?
☐Yes ☒No

13) Are you currently in default on any student loan repayment obligations payable to the financial aid programs administered by the Kentucky Higher Education Assistance Authority?
☐Yes ☒No

I hereby state that the information contained in this application is true, accurate and complete to the best of my knowledge and belief. I understand any false information on my application may subject my license to disciplinary action pursuant to the Medical Practice Act.

Applicant Signature: Theodore L. Roumell **Date:** 2/28/06

If you answer "Yes" to questions 1 - 13, please attach a written explanation.

See above exemption

Application for Registration of Kentucky Medical/Osteopathic License for Year 2006

Name: THEODORE L. BOUMBERG **License No.:** 39667

The answers to these questions are exempt from public disclosure under KRS 61.878(1) (a) and KRS 311.619 and shall be subject to inspection only upon order of a court of competent jurisdiction, except that no court shall authorize the inspection by any party of any materials pertaining to civil litigation beyond that which is provided by the Kentucky Rules of Civil Procedure governing pretrial discovery. The answers to these questions may be considered by the Board and may be disclosed in any contested case proceeding, including a Show Cause proceeding, or appeal of a licensing decision based upon them.

"Illegal drug use" means the use of an illegally obtained controlled substance or dangerous drug; the term "illegal drug use" also means the use of a legally obtained controlled substance or dangerous drug which is not taken in accordance with the direction of the licensed health care professional who prescribed the controlled substance or dangerous drug.

If you are currently a participant in the Kentucky Physicians Health Foundation Program (Impaired Physicians Program) or a similar program in another state, make note of your involvement and answer the following questions as they are written.

1) Since you last registered, have you suffered from or been treated for any medical and/or psychiatric condition which might impair your ability to continue to practice medicine?

[redacted]

2) Since you last registered, have you suffered from or been treated for drug or alcohol abuse and/or dependency?

[redacted]

I hereby state that the information contained in this application is true, accurate and complete to the best of my knowledge and belief. I understand any false information on my application may subject my license to disciplinary action pursuant to the Medical Practice Act.

Applicant Signature: [signature] Date: 7/28/06

If You Answer "Yes" To Questions 1 or 2, Please Attach A Written Explanation.

Mail Application to:
Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, KY 40222

Kentucky Board of Medical Licensure

Continuing Medical Education Certification Form

CME Cycle: January 1, 2003 – December 31, 2005

Continuing Medical Education (CME) regulation 201 KAR 9:310 requires all medical and osteopathic physicians maintaining an active Kentucky medical license to obtain 60 hours of CME every three years. Thirty hours in Category 1 accredited by the Accreditation Council on Continuing Medical Education or the American Osteopathic Association and thirty hours may consist of non-supervised personal activities. Two of the total sixty hours must be acquired in a HIV/AIDS course approved by the Kentucky Cabinet for Health and Family Services every ten-year period. Physician who obtained a new license during the CME cycle should refer to the information below for calculating CME hours due.

According to the Continuing Medical Education (CME) regulation 201 KAR 9:310, for each (3) year CME cycle, a licensee shall complete:

(a) A total of sixty (60) hours of CME, if his/her license has been renewed for each year of a CME cycle;
(b) If his/her license has not been renewed for each year of a CME cycle, licensee shall complete twenty (20) hours of CME for each year for which his/her license has been renewed.
(c) A licensee whose initial licensure was granted the first year of the CME cycle for which verification is submitted: completion of (60) hours of CME before the end of the cycle;
(d) A licensee whose initial licensure was granted the second year of the CME cycle for which a verification is submitted: completion of forty (40) hours of CME before the end of the cycle;
(e) A licensee whose initial licensure was granted the third year of the CME cycle for which verification is submitted; completion if twenty (20) hours of CME before the end of the cycle.

You are required to report that you have completed the CME requirements for the years that you have maintained an active medical license in Kentucky during the cycle. If you have not completed the required hours noted above in sections (a) – (e), please complete the **"Request for Extension to Complete Required CME Hours"** which is included with this application. Payment of $100.00 will be required in order to request this extension. **It should be noted that failure to complete this form, pay the extension fee and return with your 2006 renewal application will result in delay of your renewal application being processed.**

Name: THEODORE L. ROUMELL M.D. License Number: 39663

Address: 1050 W UNIVERSITY ROCHESTER MICH 48307

In order to comply with this requirement, please answer the following:

Have you completed your CME requirements for the CME cycle ***1/1/2003 – 12/31/2005***?

☒ Yes ☐ No

Signature _____ Date 2-17-06

Please do not send documentation of your CME hours to the Board unless requested.

Application for Renewal of Kentucky Medical/Osteopathic License for Year 2007

Registration Fee: $150.00

Late Registration After March 1, but before April 1, may be made by payment of an additional $50.00 fee. After April 1, 2007, you will be imposed an additional $100.00 fee. All questions on this application must be answered and received with the correct renewal fee. Applications with unanswered questions will be returned to you, which will create a delay in timely processing.

Note: Intentional false answers or misrepresentation in applying for or procuring a license, registration or reactivation in Kentucky are grounds for disciplinary action, including denial or revocation of license, and are reported to the National Practitioner Data Bank and/or appropriate national professional credentialing organization. You must answer "yes" to any question if the event(s) described in that question has actually occurred. You must answer, "yes" in such circumstances even if you have been advised by an attorney or other person that you may answer "no". You must also answer "yes" in such circumstance even if the record of the event has been sealed or expunged by Court order, or has been designated "confidential" by the body involved. After answering "yes" to the appropriate question(s), you may advise the Board of any additional relevant information pertaining to your answer (i.e., record has been sealed or expunged, record is designated "confidential," attorney has advised that you properly answer "no"). The Board will consider this additional information, along with your answer(s), in determining the appropriate action. If you have any question about whether or not you should answer "yes" to a question, you should err in favor of answering "yes", providing an explanation, because any non-disclosure violation will likely result in denial of your application or disciplinary action against your license.

1) Name:	Theodore L. Roumell
2) KY License No.:	39667
3) Mailing Address:	1050 W. University Rochester, MI 48307
4) Practice Address:	1050 W. University Rochester, MI 48307
5) Office Telephone Number:	2486514004
6) E-mail Address:	[redacted]

Application for Renewal of Kentucky Medical/Osteopathic License for Year 2007

7) Are you currently practicing in Kentucky? No

8) Please provide KY County and number of hours worked weekly in this county:

a) County: Out of State

b) Number of hours worked weekly in this county:

If you have additional practice counties in Kentucky, please indicate so below:

a) Additional Practice County in KY:

Number of hours worked weekly in this county:

b) Additional Practice County in KY:

Number of hours worked weekly in this county:

9) Do you currently have hospital staff privileges in Kentucky? No

10) Do you currently have a collaborative agreement with an Advanced Registered Nurse Practitioner (ARNP)?

No

11) Do you have plans to practice medicine in Kentucky during the year? False

12) Specialty: Obstetrics/Gynecology

13) Type of Practice: Locum Tenens

14) Gender: [redacted]

15) Race/Ethnicity: [redacted]

Application for Renewal of Kentucky Medical/Osteopathic License for Year 2007

1) Since you last registered have you had any license, certificate, registration or other privilege to practice as a health care professional denied, revoked, suspended, probated, restricted, reprimanded, limited, or subjected to any other disciplinary action, by a state medical/osteopathic licensing board, or Federal, or International authority?

No

2) Since you last registered have you surrendered such credential, or placed it into an inactive status, to avoid disciplinary action or in connection with or in anticipation of a disciplinary investigation/action by the licensing authority of such jurisdiction?

No

3) Since you last registered have you been or are you currently under investigation by any State medical/osteopathic licensing board, Federal or International licensure authority or any drug licensure/enforcement authority?

No

4) Since you last registered has the Drug Enforcement Administration (DEA), or any state or International drug licensure/enforcement authority denied, revoked, suspended, restricted, limited, or otherwise disciplined a controlled substance registration certificate issued to you?

No

5) Since you last registered have you voluntarily or involuntarily surrendered a medical or osteopathic license, or controlled substance registration certificate issued to you?

No

6) Since you last registered has any hospital, hospital medical staff or any other health care entity revoked, suspended, restricted, limited, reprimanded, placed on probation or otherwise disciplined your staff privileges?

No

7) Since you last registered have you resigned your privileges or failed to renew privileges at a licensed hospital or from the medical staff of the hospital or any other health care entity, while under investigation or while you were subject to disciplinary proceedings by any of the entities noted above?

No

8) Since you last registered are any legal proceedings regarding licensure presently pending against you by any State, Federal or International licensure authority or any drug licensure/enforcement authority?

No

9) Since you last registered have you been removed, suspended, expelled or disciplined by any professional medical association or society?

No

10) Since you last registered have you been convicted of a felony or misdemeanor by any State, Federal or International court? Are any criminal charges presently pending against you in any of those courts?

No

11) Since you last registered to your knowledge, are you the subject of an investigation for a criminal act?

No

12) Since you last registered have you had to pay a judgment of $250,000 or greater in a malpractice action or other civil action against your medical practice?

No

13) Are you currently in default on any student loan repayment obligations payable to the financial aid programs administered by the Kentucky Higher Education Assistance Authority?

No

Application for Renewal of Kentucky Medical/Osteopathic License for Year 2007

The answers to these questions are exempt from public disclosure under KRS 61.878(1)(a) and KRS 311.619 and shall be subject to inspection only upon order of a court of competent jurisdiction, except that no court shall authorize the inspection by any party of any materials pertaining to civil litigation beyond that which is provided by the Kentucky Rules of Civil Procedure governing pretrial discovery. The answers to these questions may be considered by the Board and may be disclosed in any contested case proceeding, including a Show Cause proceeding, or appeal of a licensing decision based upon them.
"Illegal drug use" means the use of an illegally obtained controlled substance or dangerous drug; the term "illegal drug use" also means the use of a legally obtained controlled substance or dangerous drug which is not taken in accordance with the direction of the licensed health care professional who prescribed the controlled substance or dangerous drug.
If you are currently a participant in the Kentucky Physicians Health Foundation Program (Impaired Physicians Program) or a similar program in another state, make note of your involvement and answer the following questions as they are written.

1) Since you last registered, have you suffered from or been treated for any medical and/or psychiatric condition which might impair your ability to continue to practice medicine?

[redacted]

2) Since you last registered, have you suffered from or been treated for drug or alcohol abuse and/or dependency?

[redacted]

See above exemption

☑ **I hereby state that the information I have provided in this application is true, accurate and complete to the best of my knowledge and belief. I understand that any false information on my application may subject my license to disciplinary action pursuant to the Medical Practice Act. Checking this box serves as my electronic signature. By submitting this application online and checking this box, I waive any claim that my electronic signature is not my actual signature in any disciplinary proceeding based upon an allegation that specific answers in this application are not true. If I refuse to provide this waiver by checking the checkbox, I understand that I must file a paper application which includes my actual signature.**

Application for Renewal of Kentucky Medical/Osteopathic License for Year 2008

Lic. # 39667
Renewal Date: 2/28/2008 8:45:06 PM

Registration Fee: $150.00

Late Registration After March 1, but before April 1, may be made by payment of an additional $50.00 fee. After April 1, 2008, you will be imposed an additional $100.00 fee. All questions on this application must be answered and received with the correct renewal fee. Applications with unanswered questions will be returned to you, which will create a delay in timely processing.

Note: Intentional false answers or misrepresentation in applying for or procuring a license, registration or reactivation in Kentucky are grounds for disciplinary action, including denial or revocation of license, and are reported to the National Practitioner Data Bank and/or appropriate national professional credentialing organization. You must answer "yes" to any question if the event(s) described in that question has actually occurred. You must answer, "yes" in such circumstances even if you have been advised by an attorney or other person that you may answer "no". You must also answer "yes" in such circumstance even if the record of the event has been sealed or expunged by Court order, or has been designated "confidential" by the body involved. After answering "yes" to the appropriate question(s), you may advise the Board of any additional relevant information pertaining to your answer (i.e., record has been sealed or expunged, record is designated "confidential," attorney has advised that you properly answer "no"). The Board will consider this additional information, along with your answer(s), in determining the appropriate action. If you have any question about whether or not you should answer "yes" to a question, you should err in favor of answering "yes", providing an explanation, because any non-disclosure violation will likely result in denial of your application or disciplinary action against your license.

1) Name:	Theodore L. Roumell
2) KY License No.:	39667
3) Mailing Address:	1050 W. University Rochester, MI 48307
4) Practice Address:	1050 W. University Rochester, MI 48307
5) Office Telephone Number:	2486514004
6) E-mail Address:	[redacted]

Application for Renewal of Kentucky Medical/Osteopathic License for Year 2008

Lic. # 39667
Renewal Date: 2/28/2008 8:45:06 PM

7) Are you currently practicing in Kentucky? No

8) Please provide KY County and number of hours worked weekly in this county:

a) County: Out of State

b) Number of hours worked weekly in this county:

If you have additional practice counties in Kentucky, please indicate so below:

a) Additional Practice County in KY:

Number of hours worked weekly in this county:

b) Additional Practice County in KY:

Number of hours worked weekly in this county:

9) Do you currently have hospital staff privileges in Kentucky? No

10) Do you currently have a collaborative agreement with an Advanced Registered Nurse Practitioner (ARNP)?

No

11) Do you have plans to practice medicine in Kentucky during the year? True

12) Specialty: Obstetrics/Gynecology

13) Type of Practice: Locum Tenens

14) Gender: [redacted]

15) Race/Ethnicity: [redacted]

Application for Renewal of Kentucky Medical/Osteopathic License for Year 2008

Lic. # 39667
Renewal Date: 2/28/2008 8:45:06 PM

1) Since you last registered have you had any license, certificate, registration or other privilege to practice as a health care professional denied, revoked, suspended, probated, restricted, reprimanded, limited, or subjected to any other disciplinary action, by a state medical/osteopathic licensing board, or Federal, or International authority?

No

2) Since you last registered, have you surrendered such credential, or placed it into an inactive status, to avoid disciplinary action or in connection with or in anticipation of a disciplinary investigation/action by the licensing authority of such jurisdiction with the exception of the Kentucky Medical Board?

No

3) Since you last registered, have you been or are you currently under investigation by any State medical/osteopathic licensing board, Federal or International licensure authority or any drug licensure/enforcement authority with the exception of the Kentucky Medical Board?

No

4) Since you last registered, has the Drug Enforcement Administration (DEA), or any state or International drug licensure/enforcement authority denied, revoked, suspended, restricted, limited, or otherwise disciplined a controlled substance registration certificate issued to you?

No

5) Since you last registered, have you voluntarily or involuntarily surrendered a medical or osteopathic license with the exception of your Kentucky license, or controlled substance registration certificate issued to you?

No

6) Since you last registered, has any hospital or hospital medical staff removed, suspended, restricted, limited, probated, reprimanded or failed to renew your privileges for cause, or taken any other disciplinary action against your privileges?

No

7) Since you last registered, have you resigned your privileges at any hospital under pressure or investigation or while you were the subject of disciplinary proceedings?

No

Application for Renewal of Kentucky Medical/Osteopathic License for Year 2008

8) Since you last registered, are any legal proceedings regarding licensure presently pending against you by any State, Federal or International licensure authority or any drug licensure/enforcement authority with the exception of the Kentucky Medical Board?

No

9) Since you last registered have you been removed, suspended, expelled or disciplined by any professional medical association or society

No

10) Since you last registered, have you entered a guilty plea, nolo contendere plea or Alford plea, or been convicted, of any felony offense, any misdemeanor offense, or alcohol related offense in any court?

No

11) Since you last registered, have you had to pay a judgment of $250,000 or greater in a malpractice action or other civil action against your medical practice?

No

12) Since you last registered, to your knowledge, have you become the subject of any criminal investigation or are any criminal charges pending against you?

No

13) Are you currently in default on any student loan repayment obligations payable to the financial aid programs administered by the Kentucky Higher Education Assistance Authority?

No

Application for Renewal of Kentucky Medical/Osteopathic License for Year 2008

Lic. # 39667
Renewal Date: 2/28/2008 8:45:06 PM

The answers to these questions are exempt from public disclosure under KRS 61.878(1)(a) and KRS 311.619 and shall be subject to inspection only upon order of a court of competent jurisdiction, except that no court shall authorize the inspection by any party of any materials pertaining to civil litigation beyond that which is provided by the Kentucky Rules of Civil Procedure governing pretrial discovery. The answers to these questions may be considered by the Board and may be disclosed in any contested case proceeding, including a Show Cause proceeding, or appeal of a licensing decision based upon them. "Illegal drug use" means the use of an illegally obtained controlled substance or dangerous drug; the term "illegal drug use" also means the use of a legally obtained controlled substance or dangerous drug which is not taken in accordance with the direction of the licensed health care professional who prescribed the controlled substance or dangerous drug.

If you are currently a participant in the Kentucky Physicians Health Foundation Program (Impaired Physicians Program) or a similar program in another state, make note of your involvement and answer the following questions as they are written.

1) Since you last registered, have you suffered from or been treated for any medical and/or psychiatric condition which might impair your ability to continue to practice medicine?

[redacted]

2) Since you last registered, have you suffered from or been treated for drug or alcohol abuse and/or dependency?

[redacted]

See above exemption

☑ **I hereby state that the information I have provided in this application is true, accurate and complete to the best of my knowledge and belief. I understand that any false information on my application may subject my license to disciplinary action pursuant to the Medical Practice Act. Checking this box serves as my electronic signature. By submitting this application online and checking this box, I waive any claim that my electronic signature is not my actual signature in any disciplinary proceeding based upon an allegation that specific answers in this application are not true. If I refuse to provide this waiver by checking the checkbox, I understand that I must file a paper application which includes my actual signature.**

Application for Renewal of Kentucky Medical/Osteopathic License for Year 2009

Lic. # 39667

Renewal Date/Time: 2/19/2009 10:20:36 PM

The fee to renew a license is $150.00. Registrations taking place after March 1 but before April 1 will be assessed an additional $50 fee per license. After April 1, 2009, you should contact the Board in order to reinstate a license.

Intentional false answers or misrepresentation in applying for or procuring a license, registration or reactivation in Kentucky are grounds for disciplinary action, including denial or revocation of license, and are reported to the National Practitioner Data Bank and/or appropriate national professional credentialing organization. You must answer "yes" to any question if the event(s) described in that question has actually occurred. You must answer, "yes" in such circumstances even if you have been advised by an attorney or other person that you may answer "no". You must also answer "yes" in such circumstance even if the record of the event has been sealed or expunged by Court order, or has been designated "confidential" by the body involved. After answering "yes" to the appropriate question(s), you may advise the Board of any additional relevant information pertaining to your answer (i.e., record has been sealed or expunged, record is designated "confidential," attorney has advised that you properly answer "no"). The Board will consider this additional information, along with your answer(s), in determining the appropriate action.

If you have any question about whether or not you should answer "yes" to a question, you should err in favor of answering "yes" and providing an explanation, because any non-disclosure violation will likely result in denial of your application or disciplinary action against your license.

Note: You cannot change your name through this renewal application.

You will need to notify the Board in writing of a name change. However, you may proceed with your renewal and notify the Board afterwards.

Please verify your mailing address and indicate whether or not it is correct. If the address is incorrect, you may edit it. If you reside outside the United States, please choose "Out-of-Country" in the drop-down selection for State..

Name:	Theodore L. Roumell
KY License No.:	39667
Mailing Address:	1050 W. University Rochester, MI 48307
Practice Address:	1050 W. University Rochester, MI 48307
Office Telephone Number:	2486514004
E-mail Address:	[redacted]

Application for Renewal of Kentucky Medical/Osteopathic License for Year 2009

Lic. # 39667

Renewal Date/Time: 2/19/2009 10:20:36 PM

1) Since you last registered, have you had any license, certificate, registration or other privilege to practice as a health care professional denied, revoked, suspended, probated, restricted, reprimanded, limited, or subjected to any other disciplinary action, by a state medical/osteopathic licensing board, or Federal, or International authority with the exception of the Kentucky Medical Board?

No

2) Since you last registered, have you surrendered such credential, or placed it into an inactive status, to avoid disciplinary action or in connection with or in anticipation of a disciplinary investigation/action by the licensing authority of such jurisdiction with the exception of the Kentucky Medical Board?

No

3) Since you last registered, have you been or are you currently under investigation by any State medical/osteopathic licensing board, Federal or International licensure authority or any drug licensure/enforcement authority with the exception of the Kentucky Medical Board?

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No

6) Since you last registered, has any hospital or hospital medical staff removed, suspended, restricted, limited, probated, reprimanded or failed to renew your privileges for cause, or taken any other disciplinary action against your privileges?

No

7) Since you last registered, have you resigned your privileges at any hospital under pressure or investigation or while you were the subject of disciplinary proceedings?

No

8) Since you last registered, are any legal proceedings regarding licensure presently pending against you by any State, Federal or International licensure authority or any drug licensure/enforcement authority with the exception of the Kentucky Medical Board?

No

9) Since you last registered have you been removed, suspended, expelled or disciplined by any professional medical association or society?

No

10) Since you last registered, have you entered a guilty plea, nolo contendere plea or Alford plea, or been convicted, of any felony offense, any misdemeanor offense, or alcohol related offense in any court?

No

11) Since you last registered, have you had to pay a settlement or judgment of $250,000 or greater in a malpractice action or other civil action against your medical practice?

No

12) Since you last registered, to your knowledge, have you become the subject of any criminal investigation or are any criminal charges pending against you?

No

13) Are you currently in default on any student loan repayment obligations payable to the financial aid programs administered by the Kentucky Higher Education Assistance Authority?

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Application for Renewal of Kentucky Medical/Osteopathic License for Year 2009

Lic. # 39667

Renewal Date/Time: 2/19/2009 10:20:36 PM

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1) Since you last registered, have you suffered from or been treated for any medical and/or psychiatric condition which might impair your ability to continue to practice medicine?

[redacted]

2) Since you last registered, have you suffered from or been treated for drug or alcohol abuse and/or dependency?

[redacted]

See above exemption

Application for Renewal of Kentucky Medical/Osteopathic License for Year 2009

Lic. # 39667

Renewal Date/Time: 2/19/2009 10:20:36 PM

Are you currently retired from the practice of medicine? No

Gender: [redacted]

Race/Ethnicity: [redacted]

Application for Renewal of Kentucky Medical/Osteopathic License for Year 2009

Lic. # 39667

Renewal Date/Time: 2/19/2009 10:20:36 PM

Are you currently practicing in Kentucky? No

Please provide KY County and number of hours worked weekly in this county:

a) County:

b) Number of hours worked weekly in this county:

If you have additional practice counties in Kentucky, please indicate so below:

a) Additional Practice County in KY:

Number of hours worked weekly in this county:

b) Additional Practice County in KY:

Number of hours worked weekly in this county:

Do you currently have hospital staff privileges in Kentucky? Yes

Do you currently have a collaborative agreement with an Advanced Registered Nurse Practitioner (ARNP)? No

Do you have plans to practice medicine in Kentucky during the year? Yes

Specialty: Obstetrics/Gynecology

Type of Practice: Locum Tenens

Application for Renewal of Kentucky Medical/Osteopathic License for Year 2009

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CME Certification

According to the Continuing Medical Education (CME) regulation 201 KAR 9:310, for each (3) year CME cycle, a licensee shall complete:
(a) A total of sixty (60) hours of CME, if his/her license has been renewed for each year of a CME cycle;
(b) If his/her license has not been renewed for each year of a CME cycle, licensee shall complete twenty (20) hours of CME for each year for which his/her license has been renewed.
(c) A licensee whose initial licensure was granted the first year of the CME cycle for which verification is submitted: completion of sixty (60) hours of CME before the end of the cycle;
(d) A licensee whose initial licensure was granted the second year of the CME cycle for which a verification is submitted: completion of forty (40) hours of CME before the end of the cycle;
(e) A licensee whose initial licensure was granted the third year of the CME cycle for which verification is submitted; completion of twenty (20) hours of CME before the end of the cycle.

Have you completed your CME requirements for the CME cycle 1/1/2006-12/31/2008?

Yes

(Note: Continuing Medication Education (CME) regulation 201 KAR 9:310 requires all medical and osteopathic physicians wishing to maintain their Kentucky medical license to obtain 60 hours of CME every three years. The CME cycle for which you are reporting is January 1, 2006 through December 31, 2008. Thirty of these required hours must be in Category 1 accredited by the Accreditation Council on Continuing Medical Education or the American Osteopathic Association and thrity hours may consist of non-supervised personal activities. Two of the total 60 hours must be acquired in a HIV/AIDS course approved by the Kentucky Cabinet for Health and Family Services every ten year period. Please do not send documentation of your CME credits to the Board unless requested.)

Application for Renewal of Kentucky Medical/Osteopathic License for Year 2009

Lic. # 39667

Renewal Date/Time: 2/19/2009 10:20:36 PM

I hereby state that the information I have provided in this application is true, accurate and complete to the best of my knowledge and belief. I understand that any false information on my application may subject my license to disciplinary action pursuant to the Medical Practice Act. Typing my name serves as my electronic signature. By submitting this application online and typing my name, I waive any claim that my electronic signature is not my actual signature in any disciplinary proceeding based upon an allegation that specific answers in this application are not true. If I refuse to provide this waiver by typing my name, I understand that I must file a paper application which includes my written signature.

Theodore L Roumell MD