STATE OF MARYLAND
BOARD OF PHYSICIAN QUALITY ASSURANCE

D39585
LICENSE NUMBER

ENDORSEMENT/FLEX APPLICATION

200-

Control # 2642 NB

1. FOR FLEX EXAM CANDIDATES ONLY
- ☐ COMPONENT 1 ONLY
- ☐ COMPONENT 2 ONLY
- ☐ COMPONENTS 1 & 2

2. BASIS OF APPLICATION

2.1 How Licensed: N
- N-National Boards
- F-FLEX
- R-Reciprocity (State Exam)
- L-LMCC

2.2 If reciprocity or Flex with State of: ☐☐
Use postal abbreviation

BOARD USE ONLY

BD CODE	TRANS CODE	LIC. DUE
A 08	B A	C L

DATE ISSUED	STATUS	YOLR
D 012490	E A	F 88

NOTE

After completing this information return application to the Board of Physician Quality Assurance, 201 W. Preston St., Baltimore, Md. 21201

Remit by Post Office, M.O. or certified check, made payable to the Board of Physician Quality Assurance, the fee indicated on the instruction sheet.

3. NAME

3.1 SURNAME AND GENERATIONAL INDICATORS: HASKELL

3.2 FIRST NAME AND MIDDLE NAME: W. MARTIN

3.3 MAIDEN NAME (will not show on license):

3.4 NAME UNDER WHICH ORIGINALLY LICENSED IF DIFFERENT FROM ABOVE: WILLIAM MUDD MARTIN

3.5 SOCIAL SECURITY NUMBER (used to assure identification): [redacted]

4. ADDRESS

4.1 c/o ADDRESS—IF APPLICABLE:

4.2 STREET ADDRESS: [redacted]

4.3 CITY: [redacted]

4.4 STATE: [redacted]

4.5 ZIP CODE: [redacted]

4.6 FOREIGN COUNTRY (IF APPLICABLE):

TELEPHONE (AC) [redacted]

5. SEX [redacted]
M—Male
F—Female

6. RACE [redacted]
1. WHITE
2. BLACK
3. AMERIND
4. ORIENTAL
5. OTHER

F 1 0 0
EDUC HRS

7. DATE OF BIRTH MONTH [redacted] DAY [redacted] YEAR [redacted]

8. CITIZENSHIP AT BIRTH [redacted] U.S.A. [redacted] CANADA [redacted] OTHER [redacted]

9. UNDER-GRADUATE SCHOOL

NAME: Ohio Wesleyan
LOCATION: Delaware, OH

9.1 LEAVE BLANK:
9.2 YEAR OF GRADUATION: 68
9.3 DEGREE RECEIVED: BA

10. PROFESSIONAL SCHOOL

NAME: University of Alabama Medical College
ADDRESS: 1717 Eleventh Ave. S. Birmingham AL 35233

10.1 LEAVE BLANK: 001002
10.2 YEAR OF GRADUATION: 72
10.3 DEGREE RECEIVED: MD

11. COUNTRY OF MEDICAL SCHOOL
- ☒ U.S.A. ☐ CANADA
- ☐ OTHER—NAME OF COUNTRY:

12. OTHER EXAMS TAKEN

EXAMINATIONS
- ☐ ECFMG
- ☐ VQE/FMGEMS
- ☒ NBME
- ☐ STATE WRITTEN EXAM
- ☐ NONE OF THE ABOVE

MOST RECENT DATE TAKEN (MONTH, YEAR)
/19
/19
/19

13. ACTIVITIES SINCE GRADUATION

76-77

NAME/LOCATION OF PRACTICE OR ACTIVITY	DATES FROM	DATES TO	TYPE OF TRAINING, PRACTICE OR ACTIVITY
University Of Alabama	6 72	6 73 ✓	Anesthesia Internship
Dr. Jack Blair, Fulton AL	6 73	12 73	private practice
Ross Clinic, Birmingham AL	1 74	7-74	private practice
University Of Cincinnati	7-74	12 75 ✓	General Surgery Residency
[illegible] General Hospital, [illegible]	12 75	7-76 ✓	Emergency Room Physician
University of Cincinnati	7-76	6 78 ✓	Family Practice Residency
University Of Cincinnati	7 77	6 78 ✓	Chief Resident

CORRECTED 7/14/87

#13 - ACTIVITIES SINCE GRADUATION (Continued)

Jewish Hospital Cincinnati, OH	6/78	12/79	Emergency Room Director
Self-employed	1/80	present	Private practice

Ohio Wesleyan
Registrar
University Hall, Room 114
61 S. Sandusky Street
Deleware, OH 43015
614-369-4431

University of Alabama
Medical College
1717 Eleventh Ave. S.
Birmingham, AL 35294
205-934-4011
205-934-8222

University of Alabama Hospital
House Staff Office
619 S. 19th Street
Birmingham, AL 35233
ATTN: Cindy Mitchell
205-934-4011

University of Cincinnati
College of Medicine
Mail Location 796
Cincinnati, OH 45267
ATTN: Dr. Andrew Filak
513-558-7391

Dr. Jack Dozier
P.O. Box 8
Fulton, AL 36446
205-636-4823

Tauss Clinic
2124 Fourth Ave. S.
Birmingham, AL 35233
205-323-1661

Marion General Hospital
McKinley Park Drive
Marion, OH 43302
ATTN: Joyce Bailey
614-383-8400

Cincinnati Academy of Medicine
320 Broadway
Cincinnati, OH 45202
513-421-7010

Montgomery County Medical Society
40 South Perry St.
Dayton, OH 45402

American Academy of Family Physicians
P.O. Box 8723
Kansas City, Missouri 64114-0723

Ohio State Medical Board
77 S. High Street
Columbus, OH 43266
614-466-3934

Alabama Medical Licensure Commission
608 S. Hull Street
Suite 110
Montgomery, AL 36104-0946
205-261-4116

14. When do you intend to begin practicing in Maryland? 1990

Where? _____

15. Do you hold a license (current/expired) in any state? Y. If so, list the state and license number for each state. _____

Ohio - 037358, Alabama - 6284

16. Have you ever been charged with violation of any law relative to practice of medicine or relative to any crime (felony)?

NO

17. Have you ever been found guilty in a malpractice suit or settled a malpractice claim? NO

18. Have you ever taken an examination without receiving a license from any medical licensing agency or been denied a license by, or denied the privilege of taking an examination by any medical licensing agency? NO

19. Have you ever been notified by any medical licensing agency or medical society of a complaint against you or of an investigation related to the practice of medicine? NO

20. Have you ever had your medical license revoked, suspended or placed on probation or have you surrendered a (local, state, or federal) permit to prescribe controlled substances? NO

21. Have you ever been discharged from or had a contract voided by any hospital service or training program or had any restrictions or withdrawals of hospital privileges based upon disciplinary action? NO

22. Have you ever had a physical or mental illness requiring professional attention? NO

23. Have you ever been addicted to or treated for an addiction to or abuse of any chemical substance? NO

24. Have you ever been separated from any service of the United States Government for less than honorable cause(s).

NO If yes, _____ Branch: _____ Date of Discharge: _____

_____ Type of discharge

If you answer "yes" to any question 14 through 24, attach a separate page with a complete explanation of each occasion.

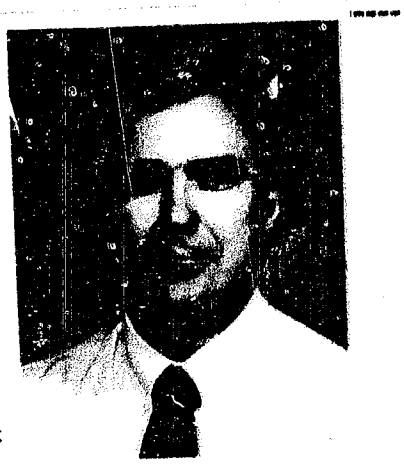
I agree that I will cooperate fully with any request for information, inspection of my medical practice or investigation, including the subpoena of documents or records, incident to my medical practice while licensed in the State of Maryland.

I am aware that, if I become licensed in the State of Maryland, according to Health Occupations Article, Section 14-502, Annotated Code of Maryland, in return for the privilege to practice medicine in the State of Maryland, I consent to submit to an examination if requested by the Board of Physician Quality Assurance.

I certify that the information supplied in this application is true and accurate to the best of my knowledge.

Martin E. Haskell, 13 June 89

Signature Date



AFFIDAVIT OF APPLICANT

MARTIN HASKELL M.D. of Cincinnati, OH being duly sworn says that he is the person referred to in the above application for license to practice Medicine and Surgery in the State of Maryland; and that all statements made in this application are true. The attached photograph bearing my notarial seal is that of the person, here present, making the above application.

Sworn before me this 13th day of June, 19 89

Barbara J. Greenfield
Notary Public

BARBARA J. GREENFIELD
Notary Public, State of Ohio
My Commission Expires May 19, 1993

ENDORSEMENT

BOARD OF PHYSICIAN QUALITY ASSURANCE

4201 Patterson Ave
PO Box 2571

BALTIMORE, MD. 21215-0002

CERTIFICATE OF PRELIMINARY AND MEDICAL EDUCATION AND IDENTIFICATION

PRELIMINARY EDUCATION: The Board reserves the right to make further investigation as it may deem necessary.

I was admitted to the study of medicine upon the following evidence of preliminary Education

Chas Wesleyan University 9/64 - 6/68

Give Dates

MEDICAL EDUCATION:

	Months	Years		Months	Years	Print legal name and location of institution in full on each line
1st Year	9	19 68	to	6	69	University of Alabama
2nd Year	9	19 69	to	6	19 70	University of Alabama
3rd Year	9	19 70	to	6	19 71	University of Alabama
4th Year	9	19 71	to	6	19 72	University of Alabama

I received the Degree of Doctor of Medicine from University of Alabama

at Birmingham, AL June 19 72

(Date of degree)

William Mudd Martin Haskell (Print name in full) William Mudd Martin Haskell (Sign name in full) M.D. (Applicant)

Dated at Columbia, MD June 13 19 89

CERTIFICATION BY MEDICAL SCHOOL:

I hereby certify:

A. The above statements of Applicant to be correct and in accord with the records upon which he as admitted to the degree of Doctor of Medicine and

B. That the photograph hereunto attached, and upon which our official seal has been impressed, is that of the person making this application William Mudd Martin Haskel, M.D.

(If the officer making certification A is unable personally to identify Applicant he will strike out certification B and must not impress seal upon photograph)

James Pittman, M.D.

University of Alabama School of Medicine
July 5, 1989

President
Secretary
Dean
of School
Conferring
Medical Degree

BOARD OF PHYSICIAN QUALITY ASSURANCE
4201 Patterson Ave, PO Box 2571
BALTIMORE, MD. 21215-0002

ENDORSEMENT

764-4777

CERTIFICATE OF PHYSICIANS

We hereby certify that William Mudd Martin Haskell, M.D.

residing in Cincinnati, Ohio, is personally known to us and to the best of our knowledge and belief, he is of good moral character and free from mental defects and drug habits likely to interfere with the proper practice of medicine and surgery. We further certify that the photograph affixed to his application is a recent one and a genuine likeness of William Mudd Martin Haskell
PRINT NAME

_____, M.D.

Signature and address of voucher _____, M.D.

PRINT NAME: Roslyn G Rhoe

173 East McMillan Ave

(date) Cincinnati, OH 45219 6/16/89

Licensed in State of Ohio

Signature and address of voucher _____, M.D.

Print Name: Richard B Grlzer

10496 Montgomery Rd.
Cincinnati OH

(date) 6-20-89

Licensed in State of OHIO

Mailed 8/22/89

BOARD OF PHYSICIAN QUALITY ASSURANCE

ENDORSEMENT

~~REINSTATEMENT~~

4201 Patterson Ave
PO Box 2571
Baltimore, MD 21215-0002

764-4777

(301) ~~383-6000~~

LICENSE VERIFICATION

TO: _____ State Medical Board

JUN 23 1989

I have applied for medical licensure to the Maryland State Board of Medical Examiners. Please fill in the lower portion of this form and mail directly to the Maryland Board. I have given my permission to release this information.

NAME: _____
(Please Print)

Professional School of Graduation _____ Year 72

License Number _____ Date Issued 7/74

Licensed by: Flex ____ Other written examination ____ Reciprocity ____ National Boards X

_____
(Signature)

TO BE COMPLETED BY STATE BOARD:

License is in good standing Yes

License has been revoked No Suspended No

Reason _____

Other Derogatory Information or Pending Charges:

No derogatory information or pending charges

Remarks: None

Date: August 21, 1989 Signed _____
(Authorized Signature)
C.M.E., Records and Renewal

11/83

FORM 846

BOARD OF PHYSICIAN QUALITY ASSURANCE

JUN 27 1989
Endisement
~~REINSTATEMENT~~

4201 Patterson Ave
PO Box 2571
Baltimore, MD 21215-0002

764-4777
(301) ~~383-6209~~

LICENSE VERIFICATION

TO: Alabama State Medical Board
Alabama Medical Licensure Commission
770 S Hull Street, Suite 110
Montgomery, AL 36104-0946

I have applied for medical licensure to the Maryland State Board of Medical Examiners. Please fill in the lower portion of this form and mail directly to the Maryland Board. I have given my permission to release this information.

NAME: William Mark Martin Haskell
(Please Print)

Professional School of Graduation University of Alabama Year 72

License Number 6284 Date Issued 1973

Licensed by: Flex ____ Other written examination ____ Reciprocity ____ National Boards X

Mark Martin Haskell
(Signature)

TO BE COMPLETED BY STATE BOARD:

License is in good standing Yes

License has been revoked No Suspended No

Reason ____

Other Derogatory Information or Pending Charges:

None

Remarks: Leon C. Hamrick, M.D. Exc director

Date: June 27, 1989 Signed LEON C. HAMRICK, M.D.
(Authorized Signature)

Chairman

11/87

NATIONAL BOARD OF MEDICAL EXAMINERS® • 3930 CHESTNUT STREET, PHILADELPHIA, PA 19104

ENDORSEMENT OF CERTIFICATION

NATIONAL BOARD OF MEDICAL EXAMINERS
OF THE
UNITED STATES OF AMERICA

William Mudd Martin Haskell, M. D.

having satisfied all the requirements and having successfully passed the examinations is hereby declared a Diplomate of the National Board of Medical Examiners.

Attest J. D. Myers
Chairman of the Board

Philadelphia, Pa.
July 2, 1973

SEAL

Certificate # 126488

John P. Hubbard
President of the Board

It is certified that the above is a facsimile of the Diplomate Certificate which has been or will be* awarded to the physician named above, who graduated from U Alabama School of Medicine in June 1972 and whose birth date is [redacted]. This physician has successfully completed all examinations required for certification by the National Board of Medical Examiners. The scores obtained by this physician upon which his/her certification is based are as follows:

	Standard Score	Scale Score
PART I passed 06/70		
Anatomy		
Physiology		
Biochemistry		
Pathology		
Microbiology		
Pharmacology		
Behavioral Sciences		
TOTAL TEST (Minimum Passing Score 380/75)		[redacted]
PART II passed 04/72		
Internal Medicine		
Surgery		
Obstetrics and Gynecology		
Public Health and Preventive Medicine		
Pediatrics		
Psychiatry		
TOTAL TEST (Minimum Passing Score 290/75)		[redacted]
PART III passed 03/73		
A General Test of Clinical Competence		
TOTAL TEST (Minimum Passing Score 290/75)		[redacted]
GENERAL AVERAGE (Parts I, II, and III Scale Score)		[redacted]

* For those individuals who have not yet satisfactorily completed one full year of post-M.D. training the date shown on the facsimile is the date which has been certified by the physician's residency program director as the date on which this requirement for certification by the National Board will be fulfilled and such certification will be awarded.

Melanie Valente
Secretary for Certification

SEAL

6-20-89
Date

State of Maryland

RECEIVED
JUN 26 1989

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
BOARD OF PHYSICIAN QUALITY ASSURANCE
4201 PATTERSON AVE • BALTIMORE, MD 21215-2299

Area Code 301-764-4777
TTY FOR DEAF Balto. 383-7555
D.C. Metro 565-0451

DISCIPLINARY INQUIRIES
Federation of State Medical Boards
2630 West Freeway, Suite 138
Fort Worth, Texas 76102-7999

The Board of Physician Quality Assurance requests a disciplinary search concerning the following individual:

William Mudd Martin Haskell
Name

P.O. Box 43222
Address

Cincinnati OH 45243
City, State and Zip

WE HAVE NO UNFAVORABLE INFORMATION REGARDING THE ABOVE NAMED PHYSICIAN ✓

[redacted]
Date of Birth

JUN 27 1989

[redacted]
Social Security Number

Bryant L. Galusha, M.D.
BRYANT L. GALUSHA, M.D.
EXECUTIVE VICE-PRESIDENT

University of Alabama
Medical School of Graduation and Branch Location

1972
Date of Graduation

Please mail the response to the following address:

Board of Physician Quality Assurance
4201 Patterson Ave, PO Box 2571
Baltimore, Maryland 21215-0002

Attention: Endorsement Unit

Signature

AMA PHYSICIAN PROFILE

AMERICAN MEDICAL ASSOCIATION
535 NORTH DEARBORN STREET
CHICAGO, ILLINOIS 60610

DIVISION OF SURVEY AND DATA RESOURCES
DEPARTMENT OF PHYSICIAN DATA SERVICES

DATE: 06-30-89
TIME: 8:03 PM

NAME: HASKELL,WM MUDD MARTIN, M.D.
ADDRESS: [redacted]

BIRTHPLACE: [redacted]
BIRTHDATE: [redacted]
MEMBER OF AMA: NOT MEMBER
MEDICAL SCHOOL
UNIV OF ALABAMA SCH OF MED, BIRMINGHAM AL 35294
YEAR OF GRADUATION: 1972
LICENSES (INITIAL YEAR GRANTED BY STATE):
AL 1973
OH 1974
KY 1980
NATIONAL BOARD CERTIFICATION: 1973
SPECIALTY BOARD CERTIFICATION: AMERICAN BOARD OF FAMILY PRACTICE

PHYSICIAN'S PROFESSIONAL ACTIVITIES: OFFICE BASED PRACTICE
SELF DESIGNATED SPECIALTIES
PRIMARY: OBSTETRICS & GYNECOLOGY
SECONDARY: FAMILY PRACTICE
TERTIARY: UNSPECIFIED

CURRENT MEDICAL TRAINING: NONE REPORTED TO DATE
PRIOR MEDICAL TRAINING: RESIDENT — CINCINNATI OH 45267
HOSPITAL: UNIV CINCINNATI HOSP-MED CTR
DATES OF TRAINING: 07/74-06/76 -- (CONFIRMED)
SPECIALTY: GENERAL SURGERY
SPECIALTY: UNSPECIFIED

HOSPITAL: UNIV CINCINNATI HOSP-MED CTR — CINCINNATI OH 45267
DATES OF TRAINING: 07/76-06/78 -- (CONFIRMED)
SPECIALTY: FAMILY PRACTICE
SPECIALTY: UNSPECIFIED

PRIOR MEDICAL TRAINING: INTERN — BIRMINGHAM AL 35233
HOSPITAL: UNIV AL HOSPS
DATES OF TRAINING: 06/72-06/73 -- (CONFIRMED)
SPECIALTY: UNSPECIFIED
SPECIALTY: UNSPECIFIED

FELLOWSHIP: NONE REPORTED TO DATE

THE FOLLOWING IS HISTORICAL. CHECK WITH PRIMARY SOURCES FOR CURRENT STATUS:

NATIONAL SCIENTIFIC MEDICAL SOCIETIES:
AMERICAN ACADEMY OF FAMILY PHYSICIANS
AMERICAN COLLEGE OF EMERGENCY PHYSICIANS

PROFESSORIAL APPOINTMENT: NONE REPORTED TO DATE

 ****AMA FILES CHECKED 47

IT IS MUTUALLY AGREED BETWEEN THE AMERICAN MEDICAL ASSOCIATION (AMA) AND THE REQUESTING ORGANIZATION, THAT THIS PHYSICIAN PROFILE DATA RELEASED IS PROVIDED TO THE REQUESTING ORGANIZATION WITH THE UNDERSTANDING THAT BY 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 LICENSE, CONSISTENT WITH AND LIMITED TO THE SPECIFIC PURPOSES SET FORTH ON THE PHYSICIAN PROFILE REQUEST FORM; (3) THAT NO PROFILE INFORMATION WILL BE RELEASED, COPIED, EXTRACTED OR OTHERWISE ASSUMED FOR THE USE BY ANY OTHER PARTY, ENTITY, ORGANIZATION OR GOVERNMENT AGENCY; AND (4) THAT UPON A BREACH OF ANY OF THE FOREGOING COVENANT, 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 THEREIN 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.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

BOARD OF PHYSICIAN QUALITY ASSURANCE

4201 PATTERSON AVENUE, P.O. BOX 2571, BALTIMORE, MD. 21215-0002

301-764-4777

TTY FOR DEAF: Balto. 383-7555
D.C. Metro 565-0451

W MARTIN HASKELL MD
PO BOX 43222
CINCINNATI OH 45243

7/11/89
date

DEAR DOCTOR:

WE HAVE RECEIVED YOUR APPLICATION FOR MARYLAND MEDICAL LICENSE. PLEASE FURNISH THIS OFFICE WITH THE FOLLOWING:

____ CERTIFIED CHECK OR MONEY ORDER. (WE ARE RETURNING YOUR APPLICATION AND INCORRECT FEE)

____ PHOTOSTATIC COPY OF DIPLOMA GRANTING MEDICAL DEGREE. (ORIGINAL LANGUAGE)

____ AUTHENTIC TRANSLATION OF DIPLOMA GRANTING MEDICAL DEGREE. (OFFICIAL LETTERHEAD)

____ PHOTOSTATIC COPY OF PERMANENT ECFMG CERTIFICATE.

____ PHOTOSTATIC COPIES OF ALL HOSPITAL CERTIFICATES ATTESTING TO EVERY POST-GRADUATE TRAINING PROGRAM IN WHICH YOU HAVE PARTICIPATED.

____ CERTIFICATE OF PHYSICIANS SIGNED BY TWO LICENSED PHYSICIANS IN ACTIVE PRACTICE IN THE STATE IN WHICH YOU RESIDE.

____ STATEMENT FROM YOUR PROGRAM DIRECTOR GIVING STARTING AND CLOSING DATES OF YOUR CURRENT TRAINING PROGRAM, AND A STATEMENT THAT YOU ARE EXPECTED TO SATISFACTORILY COMPLETE THE PROGRAM.

__X__ PROFESSIONAL AND/OR NON-PROFESSIONAL ACTIVITIES FROM 12/78 TO 1/80.

____ PHOTOSTAT THE LICENSE VERIFICATION FORM AS MANY TIMES AS NECESSARY, FILL IN THE UPPER PORTION OF THE FORM, AND MAIL TO ALL OF THE STATE MEDICAL BOARDS IN WHICH YOU HAVE EVER HELD A LICENSE.

____ SEND CERTIFICATE OF PRELIMINARY AND MEDICAL EDUCATION TO YOUR MEDICAL SCHOOL, WITH INSTRUCTIONS TO RETURN THE FORM DIRECTLY TO THIS OFFICE.

____ TRANSCRIPT OF GRADES FROM THE ____ NATIONAL BOARDS ____ FEDERATION OF STATE MEDICAL BOARDS.

__X__ OTHER PLEASE LET US KNOW IN WRITING WHEN YOUR APPLICATION IS COMPLETE HOW YOU WANT YOUR NAME TO APPEAR ON YOUR LICENSE, SINCE SOME OF YOUR FORMS HAVE YOUR NAME AS WILLIAM MUDD MARTIN HASKELL & ON YOUR APPLICATI[ON] YOU HAVE YOUR NAME AS W. MARTIN - HASKELL.

PLEASE RETURN THIS NOTICE WHEN SUBMITTING THE ABOVE.

VERY TRULY YOURS,

[signature]

ENDORSEMENT UNIT

DHMH 1806
JULY 1984

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

BOARD OF PHYSICIAN QUALITY ASSURANCE

4201 PATTERSON AVENUE, P.O. BOX 2571, BALTIMORE, MD. 21215-0002

301-764-4777

TTY FOR DEAF: Balto. 383-7555
D.C. Metro 565-0451

[redacted]

7/17/89
date

DEAR DOCTOR:

WE HAVE RECEIVED YOUR APPLICATION FOR MARYLAND MEDICAL LICENSE. PLEASE FURNISH THIS OFFICE WITH THE FOLLOWING:

_____ CERTIFIED CHECK OR MONEY ORDER. (WE ARE RETURNING YOUR APPLICATION AND INCORRECT FEE)

_____ PHOTOSTATIC COPY OF DIPLOMA GRANTING MEDICAL DEGREE. (ORIGINAL LANGUAGE)

_____ AUTHENTIC TRANSLATION OF DIPLOMA GRANTING MEDICAL DEGREE. (OFFICIAL LETTERHEAD)

_____ PHOTOSTATIC COPY OF PERMANENT ECFMG CERTIFICATE.

_____ PHOTOSTATIC COPIES OF ALL HOSPITAL CERTIFICATES ATTESTING TO EVERY POST-GRADUATE TRAINING PROGRAM IN WHICH YOU HAVE PARTICIPATED.

_____ CERTIFICATE OF PHYSICIANS SIGNED BY TWO LICENSED PHYSICIANS IN ACTIVE PRACTICE IN THE STATE IN WHICH YOU RESIDE.

_____ STATEMENT FROM YOUR PROGRAM DIRECTOR GIVING STARTING AND CLOSING DATES OF YOUR CURRENT TRAINING PROGRAM, AND A STATEMENT THAT YOU ARE EXPECTED TO SATISFACTORILY COMPLETE THE PROGRAM.

_____ PROFESSIONAL AND/OR NON-PROFESSIONAL ACTIVITIES FROM _____ TO _____.

_____ PHOTOSTAT THE LICENSE VERIFICATION FORM AS MANY TIMES AS NECESSARY, FILL IN THE UPPER PORTION OF THE FORM, AND MAIL TO ALL OF THE STATE MEDICAL BOARDS IN WHICH YOU HAVE EVER HELD A LICENSE.

_____ SEND CERTIFICATE OF PRELIMINARY AND MEDICAL EDUCATION TO YOUR MEDICAL SCHOOL, WITH INSTRUCTIONS TO RETURN THE FORM DIRECTLY TO THIS OFFICE.

_____ TRANSCRIPT OF GRADES FROM THE ____ NATIONAL BOARDS _____ FEDERATION OF STATE MEDICAL BOARDS.

__X__ OTHER PLEASE EXPLAIN TO US IN WRITING THAT YOU HELD AT ONE TIME A LICENSE IN KENTUCKY SINCE THIS WAS NOT INCLUDED ON YOUR APPLICATION, BUT YOUR AMA PHYSICIANS PROFILE INCLUDED IT.

PLEASE RETURN THIS NOTICE WHEN SUBMITTING THE ABOVE.

VERY TRULY YOURS,

ENDORSEMENT UNIT

DHMH 1806
JULY 1984

Martin Haskell, M.D., F.A.A.F.P.
P.O. Box 43222
Cincinnati, Ohio 45243
(513) 271-0002

Clinical Res...
(513) 293-73..

Fellow American Academy
of Family Practice

August 14, 1989

Maryland Board of Physician Quality Assurance
Endorsement Unit
4201 Patterson Avenue
P.O. Box 2571
Baltimore, MD 21215-0002
ATTN: Randi Zipper

Dear Randi Zipper:

As requested in your attached notice, a Kentucky license, number 21067, was issued to me on October 9, 1980. I was not using and, therefore, did not renew this license.

Sincerely,

Martin Haskell, MD

MH/bjg

KENTUCKY BOARD OF MEDICAL LICENSURE

THE MALL OFFICE CENTER
400 SHERBURN LANE, SUITE 222
LOUISVILLE, KENTUCKY 40207

December 18, 1989

TO WHOM IT MAY CONCERN:

Dear Sirs:

We are writing to you at the request of William Mudd Martin Haskell, M. D. who is applying for licensure in your state. We are asked to furnish your Board with the following:

License Number 21067

Date of Issuance 10/9/80

On What Basis Alabama Board

Current Status Inactive

Expiration Date Unavailable

Derogatory Information None

If this office can be of further assistance in this matter, please feel free to contact us.

Sincerely,

C. William Schmidt
Executive Director

SEAL

CWS:sd

State of Maryland

25 JAN 90

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

BOARD OF PHYSICIAN QUALITY ASSURANCE

4201 Patterson Avenue, P.O. Box 2571, Baltimore, MD. 21215-0002

Area Code 301-764-4777

TTY FOR DEAF: Balto. 383-7555
D.C. Metro 565-0451

W. MARTIN HASKELL MD
PO BOX 43222
cincinnati oh 45243

1/11/90

Dear Doctor:

The processing of your application has been completed. Please let us know how you wish to obtain your license:

1. _____ The Board will mail the license to you by certified mail and you, yourself, must claim the packet. It will be sent for "addressee's signature only."

2. ✓ Send the Board a statement, signed by you, bearing the name of the agent, for us to deliver the license to the agent.

Your license will contain your full name even though you do not use your full name in your signature.

PLEASE DETACH AND RETURN THIS FORM TO THE BOARD.

W. Martin Haskell

NAME

Current Address: P.O Box 43222

Cincinnati OH 45243

IF THIS IS A NEW ADDRESS, PLEASE WRITE THE OLD ADDRESS BELOW

the University of Alabama in Birmingham

the Medical Center / UNIVERSITY OF ALABAMA HOSPITALS AND CLINICS

This Certifies That

W. M. Martin Haskell, M. D.

has satisfactorily completed the term of service as

Rotating Anesthesiology Intern

in the University Hospital for the period from

June 22, 1972 to June 22, 1973

Given at Birmingham, Alabama this 22nd day of June, 1973

CHIEF OF SERVICE

CHIEF OF STAFF

ADMINISTRATOR

University of Cincinnati Medical Center

Cincinnati General Hospital

This is to certify that

W. M. Martin Haskell

served in this Hospital as

Junior Resident Surgeon

July 1, 1974, to July 1, 1975

Resident-3 Surgeon

July 1, 1975, to January 5, 1976

IN WITNESS WHEREOF, we have hereunto affixed our names and attached the official seal of the Hospital.

Chairman, Directing Medical Staff

Interim Administrator

W. A. Altemeier

Director of Service

January 5, 1976

University of Cincinnati Medical Center

Cincinnati General Hospital

This is to certify that

William Mudd Martin Haskell

served in this Hospital as

Resident-2 in Family Medicine

July 1, 1976 to July 1, 1977

Chief Resident-3 in Family Medicine

July 1, 1977 to December 31, 1977

Resident-3 in Family Medicine

January 1, 1978 to July 1, 1978

IN WITNESS WHEREOF, we have hereunto affixed our names and attached the official seals of the University and Hospital.

Dean of the College of Medicine

Administrator

Robert Smith M.D.
Professor and Director

July 1, 1978

DO NOT MAIL THIS TO THE BOARD. RETAIN THIS APPLICATION FOR YOUR RECORDS.

Application for renewal of: **Physicians**

1. **License NumberD0039525**Dr. W Martin Haskell

2.	Individual National Provider Identifier NPI: 1215088018 ☐ I do not have an NPI This is the NPI entered in the field for Rendering NPI on a claim (10 digit number) ☒ NPI Information

3. EMAIL ADDRESS: This is your email address on file. If it has changed, please edit below. If you do not have an email address please indicate by checking the checkbox below.

[redacted]

☐ I do not have an email address

Address Changes (Non-Public and Public):
You must submit a Public and Non-Public address. If either address has changed, please correct here.
Your address(es) on the online renewal application is current as of July 1, 2010 . If you requested any changes to your address(es) that are not reflected on this application, please make the change at this time. These changes will be updated in the main database.

4a. Non-Public Address: This address is for Board use only and is **where your license will be mailed**. However, if no public address is listed, this address will also be made available to the public.

Street [redacted]
Street (2)
Street (3)
City
State
If selecting a country other than USA or Canada, please choose "Foreign" as your state
ZipCode
Country United States

4b. Public Address: This address, usually your office, is available to the public and will be posted on the Internet. If you do not designate a public address, your non-public address will be posted on the Internet.

☐ Check if Public Address is the same as your Non-Public address (the address above will be automatically entered below.)

Street Women's Med Group
Street (2) 11250 Lebanon Rd
Street (3)
City Cincinnati
State Ohio
If selecting a country other than USA or Canada, please choose "Foreign" as your state
ZipCode 45241
Country United States

5. Do you give the Maryland Board of Physicians permission to report your date of birth to the Federation of State Medical Boards' Physician Data Center? See instruction ◉ Yes ○ No

CHARACTER AND FITNESS (Question 6)

6. The following questions pertain to the period since July 1, 2008. If this is your first renewal, these questions apply to the period commencing with the date of your initial licensure or reinstatement. Check the box YES or NO next to each question. ***If you answer Yes, provide an explanation at the prompt.***
* All questions must be answered Yes or No.

○ Yes ◉ No
NO

a. Has any licensing or disciplinary board of any jurisdiction (except this licensing board), or any entity of the armed services denied your application for licensure, reinstatement or renewal, or taken any action against your license, including but not limited to reprimand, suspension, revocation, a fine, or nonjudicial punishment, for an act that would be grounds for disciplinary action under Md. Code Ann. Health Occ. §14-404?

○ Yes ◉ No

b. Have any complaints, investigations or charges been brought against you or are any currently pending in any jurisdiction by any licensing or disciplinary board (except this licensing board)

NO or an entity of the armed services?

Yes No
NO

c. Has your application for a medical or health professional license been withdrawn for reasons that would be grounds for disciplinary action under Md. Code Ann. Health Occ. §14-404?

Yes No
NO

d. Has an investigation or charge been brought against you by a hospital, related institution, or alternative health care system that would be grounds for action under Md. Code Ann. Health Occ. §14-404?

Yes No
NO

e. Have you had any denial of application for privileges, failure to renew your privileges, or limitation, restriction, suspension, revocation or loss in privileges in a hospital, related health care facility, or alternative health care system that would be grounds for disciplinary action under Md. Code Ann. Health Occ. §14-404?

Yes No
NO

f. Have you had a plea of guilty, nolo contendere, conviction, or receipt of probation before judgment or other diversionary disposition of any criminal act, excluding traffic violations?

Yes No
NO

g. Have you had a plea of guilty, nolo contendere, conviction, or receipt of probation before judgment or other diversionary disposition for an alcohol or controlled dangerous substance offense, including but not limited to driving while under the influence of alcohol or controlled dangerous substances?

Yes No
NO

h. Are there any pending criminal charges against you in any court of law, excluding minor traffic violations?

Yes No
NO

i. Do you have a physical or mental condition that currently impairs your ability to practice medicine?

Yes No
NO

j. Has the use of drugs and/or alcohol resulted in an impairment of your ability to practice your profession?

Yes No
NO

k. Do you illegally use drugs?

Yes No
NO

l. Have you surrendered or allowed your license to lapse while under investigation by any licensing or disciplinary board of any jurisdiction or an entity of the armed services?

Yes No
NO

m. Have you been named as a defendant in a filing or settlement of a medical malpractice action?

Yes No
NO

n. Has your employment by any hospital, HMO, related health care or other institution, or military entity been terminated for any diciplinary reasons?

Yes No
NO

o. Have you voluntarily resigned from any hospital, HMO, or other health care facility or institution, or military entity while under investigation by that institution for disciplinary reasons?

○ Yes ◉ No

p. Are you in default of a service obligation resulting from your receipt of state or federal funding for your medical education?

NO

○ Yes ◉ No

q. Have you failed to make arrangements to satisfy any state or federal loans that financed your medical education?

NO

CONTINUING MEDICAL EDUCATION (Question 7)

◉ **a. CME met.** I have earned 50 credit hours of Category 1 continuing medical education during the two (2) years prior to this renewal.

○ **b. First Renewal & NPO.** I am exempt from CME during the renewal period because this is my first renewal after initial medical licensure in Maryland and I have completed the Board's New Physician Orientation Program. The New Physician Orientation is for **NEWLY** licensed physicians only. If you were licensed prior to September 30, 2008 or reinstated, this does not apply to you. See New Physician Orientation Program web site. **Your license will not be renewed unless you have completed the orientation.**

○ **c. First Renewal after reinstatement.** I am exempt from CME during the renewal period because this is my first renewal after reinstatement of my medical licensure in Maryland.

PERSONAL AND PROFESSIONAL INFORMATION (Questions 8-17)

8. Ethnicity and Race: (Select all that apply)

[redacted]
Hispanic or Latino
American Indian or Alaska native
Asian
Black or African American
Native Hawaiian or other Pacific Islander
White
Other

---

9. Are you employed by the Federal Government?

○ Yes ◉ No

---

10. Please indicate if you are currently in: a) a residency program accredited by the Accreditation Council for Graduate Medical Education or an internship or residency program approved by the American Osteopathic Association; or b) a fellowship (subspecialty) training program accredited by the ACGME.

If you answer ***Yes*** to either a. or b. you will not be required to complete the Practice Information section (Questions 15-26) of this application.

a. In an accredited/approved internship or residency program?

○ Yes ◉ No

b. In an accredited fellowship (subspecialty) training program?

○ Yes ◉ No

---

11. Which best describes your current area(s) of concentration:

Primary Concentration: Gynecology

Secondary Concentration: None

12. SPECIALTY BOARD CERTIFICATION: List up to two (2) specialty areas only if certified by a recognized board of the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA).

Primary Certification: None

Secondary Certification: None

13. Please indicate below how the hours in your typical work week are allocated. The sum of these hours should reflect the number of hours in your typical work week. Definitions of these categories are listed below.

If you allocate **0 hours per week** to a. Patient Care Related Activities you will not be required to complete the Practice Information section (Questions 15-26) of this application.

Patient Care Related Activities include seeing patients, writing prescriptions, patient-related clinical activities (such as pathologic and radiologic assessments), maintaining patient records, obtaining and reviewing test results, arranging referrals, consulting with other providers about patients, talking with a patient's family members.

Research includes clinical, laboratory, and analytical research

Teaching includes teaching of medical undergraduate & graduate students and other graduate students.

Administration & Other: Administration includes practice management (billing, contract negotiations, personnel, regulatory activities) & management of institutions or programs (health departments, health insurance, hospitals, other health-related institutions or programs); Other

Use whole numbers. No fractional hours. If none enter 0.

a. Patient Care Related Activities	15	hours per week
b. Research	1	hours per week
c. Teaching	1	hours per week
d. Administration & Other	23	hours per week
Total Hours	**40**	hours per week

14. If you indicated in Question 13 that you are not engaged in patient care related activities, do you intend to resume patient care related activities in the next 2 years?

Yes No

PRACTICE INFORMATION (Questions 15-26)

15. Do you plan to discontinue patient care related activities in the next two years?

Yes (●) No

16. Please indicate below the number of practice/office locations at which you routinely deliver patient care for reimbursement.

a. Number of locations in Maryland (if none, enter 0) 0

b. Number of locations outside of Maryland (if none, enter 0) 3
If you have locations outside Maryland, please answer (c) below after you answer (b).

c. Do you routinely treat Maryland patients at your practice/office location(s) outside of Maryland?

Yes (●) No Don't know

17. Please indicate below the number of hospitals at which you currently have admitting privileges.

a. Number of hospitals in Maryland (if none, enter 0) 0

b. Number of hospitals outside of Maryland (if none, enter 0) 1

18. Primary Practice / Office Location Primary Practice / Office Location

Please answer all Primary Practice questions

a. Organization Name: Women's Med Group

b. Street Address: 11250 Lebanon Rd

c. Street2

Enter suite or room number here. (Ex. Suite 101 or Room 101)

d. City: Cincinnati

e. State: Ohio

f. Zip Code: 45241

g. Jurisdiction: Non-Maryland

h. Employer Tax ID: [redacted] What is Employer tax ID?

Enter "None" if you do not have an Employer tax ID

i. Please select one of the following related to the NPI used for billing insurers:

- I use an Organizational NPI for billing. Please Enter > Organizational NPI
- **I use my Individual NPI for billing.**
- I do not bill public or private insurers.

j. You indicated in Question 13a, **15** hours of Patient Care Related Activities during a typical work week.
How many of those Patient Care Related Activity hours in your typical work week are delivered at this practice/office location? 13 Hours

If none, enter 0.

k. Setting: Freestanding Ambulatory Surg Ctr

l. Private/Public: Private-For profit

m. Practice: Single-Specialty Group

Please answer the following regarding staffing at this practice/office location on a typical day.
Definition of mid-level medical providers is listed below.

If none, enter 0; if you don't know the number, enter 999

Number of physicians (MDs, DOs, residents, fellows) including yourself at this location. 2

Number of mid-level medical providers at this location. 1

Mid-level medical providers: nurse practitioners, nurse midwives, nurse anesthetists and physician assistants.

19. Secondary Practice / Office Location

If you have a secondary practice/office location and you've checked the box above, you will see a series of questions that must be completed.

a. Organization Name: Womens Med Center of Indianapolis

b. Street Address: 1201 N Arlington Ave

c. Street2

Enter suite or room number (Ex. Suite 101 or Room 101)

d. City: Cincinnati

e. State: Ohio

f. Zip Code: 45243

g. Jurisdiction: Non-Maryland

h. Employer Tax ID None What is Employer tax ID?

Enter None if you do not have an Employer tax ID

i. Please select one of the following related to the NPI used for billing insurers:

- I use an Organizational NPI for billing. Please Enter > Organizational NPI
- I use my Individual NPI for billing.
- I do not bill public or private insurers.

j. You indicated in Question 13a, **15** hours of Patient Care Related Activities during a typical work week.
How many of those Patient Care Related Activity hours in your typical work week are delivered at this practice/office location? 2 Hours

If none, enter 0.

k. Setting: Free Standing Medical Facility

l. Private/Public: Private-For profit

m. Practice: Single-Specialty Group

Please answer the following regarding staffing at this practice/office location on a typical day. Definition of mid-level medical providers is listed below.

If none, enter 0; if you don't know the number, enter 999

Number of physicians (MDs, DOs, residents, fellows) including yourself at this location. 2

Number of mid-level medical providers at this location. 2

Mid-level medical providers: nurse practitioners, nurse midwives, nurse anesthetists and physician assistants.

20. Information Technology (Primary Practice / Office Location)

Please answer all Primary Practice Information Technology questions

This question is about the use of computers and other forms of information technology, such as hand-held computers, in diagnosing or treating your patients at your primary office/practice location, which you listed in question 18.

Yes / No A. To obtain information about treatment alternatives or recommended guidelines?

Yes / No B. To send prescriptions electronically to a pharmacy?

If you answered **Yes** to 20B, what percentage of prescriptions are submitted electronically? Use whole numbers. %

Yes / No C. To generate reminders for you about preventive services needed for your patients?

Yes / No D. To access patient notes, medication lists, or problem lists?

Yes / No E. For clinical data and image exchanges **WITH OTHER PHYSICIANS**?

Yes / No F. For clinical data and image exchanges **WITH HOSPITALS AND LABORATORIES**?

Yes / No G. To communicate about clinical issues with patients by email?

(●) Yes ( ) No H. To obtain information on potential patient drug interactions with other drugs, allergies, and/or patient conditions?

21. Does your primary office/practice location use electronic MEDICAL RECORDS (not including billing records)?

( ) Yes, all electronic ( ) Yes, part paper and part electronic (●) No ( ) Don't know

21a. If **No,** please indicate your most significant reason for not using electronic medical records.

( ) Capital cost outlays ( ) Risk of privacy breaches ( ) Retiring soon
( ) Overburdened staff (●) Lack of technology standards ( ) Not my decision
( ) Physician resistance to adoption ( ) Intangible benefits

22. Please indicate if you participate in the following private and public insurance programs, and whether you are currently accepting new public insurance program patients.

a. Participate in any PRIVATE insurance plan networks, including PPO, EPO, HMO, etc. ( ) Yes (●) No

b. Participate in the MARYLAND MEDICAL ASSISTANCE PROGRAM (in either the traditional program or a Managed Care Organization) ( ) Yes (●) No

b1. If **Yes**, are you accepting new Maryland Medical Assistance patients? Yes No

c. Participate in the MEDICARE (in either the traditional program or a Medicare Advantage Plan)? ( ) Yes (●) No

c1. If **Yes**, are you accepting new Medicare patients? Yes No

23. Do you offer a sliding fee scale based on ability to pay? (Utilize a standardized fee reduction schedule for low-income)

( ) Yes (●) No ( ) NA

24. Please report the typical number of hours per week you personally provide care to patients on a charity basis (do not include bad debt).

0 hours per week. (●) If none, enter 0

If you are practicing as an adult primary care specialist (internal medicine, family practice, general medicine), answer Q.25. Otherwise skip to Q.26.

25. Do you charge patients an annual fee for participating on your patient panel (sometime called direct, concierge, or retainer-based practice)?

( ) Yes ( ) No

26. Workers Compensation

Workers Compensation coverage: If you employ one or more persons, the Md. Code Ann. Health Occ. §1-202 requires that you verify that you are complying with the Workers' Compensation Law for your renewal to be issued.

I hereby certify:

( ) Not Applicable (Do not complete below)

(●) I do not practice in Maryland.

( ) I do not employ anyone in my practice in Maryland.

( ) I employ one or more persons in my Maryland practice and have the following Workers Compensation coverage.

(●) If you are a Maryland employer you must provide the information requested below.

Insurance Company
Policy Number
Expiration Date

Enter as MM/DD/YYYY Enter as MM/DD/YYYY

PHYSICIANS EMERGENCY CONTACT INFORMATION

27. As part of Maryland's emergency preparedness efforts, the Department of Health and Mental Hygiene has identified the need for certain contact information for licensed physicians in Maryland who may be needed to respond to a catastrophic health emergency. (Public Safety Article, Sec. 14-3A-01 et seq. and Health General Article Section 18-901 et seq. sets forth the powers of the Governor and Secretary of the Department of Health and Mental Hygiene.

*Required Field

Please provide the phone number that should be used in the event of an actual emergency.

Daytime *

Nighttime*

Indicate by checking any box that applies whether you have any particular training and experience regarding the following specific agents:

☐ Chemical ☐ Biological ☐ Radiological

If you are interested in being contacted about training opportunities provided by the Board of Physicians, please visit the Maryland Professional Volunteer Corps website at http://bioterrorism.dhmh.state.md.us/volunteer.htm.

Thank you for your assistance!

APPLICATION PACKET FOR EXEMPTION FROM LICENSE FEE

28. CERTIFICATION AND AUTHORIZATION OF LICENSE APPLICATION

Please check the first 3 boxes to certify and affirm your renewal application.

☑ a. I certify that I have personally reviewed all responses to the items in this application and that the information I have given is true and correct to the best of my knowledge and that any false information provided as part of my application may be cause for the denial of my application.

☑ b. I agree that the Maryland Board of Physicians (the Board) may request any information necessary to process my application for renewal from any person or agency, including but not limited to former and current employers, government agencies, the National Practitioners Data Bank, the Healthcare Integrity and Protection Data Bank, hospitals and other licensing bodies, and I agree that any person or agency may release to the Board the information requested. I also agree to sign any subsequent releases for information that may be requested by the Board.

☑ c. I shall inform the Board, by certified mail, return receipt requested, within 30 days of: (a) action that would be grounds for disciplinary action under Md. Code Ann. Health Occ. §14-404, that occurred at any time during the application period; (b) change in any answer that was originally given in this application.

☐ d. Check Here if you wish to have the option of viewing your completed application online after you renew your license. Otherwise, your application will not be available online for your later viewing. If selected, viewing is available until 12/1/2010.

29. Please provide your electronic signature (type your name) below:

Name Martin Haskell

Today's Date 9/23/2010

Last four digits of Social Security Number:

30. Select a Payment Option here to complete your application.

Please note: Credit cards may be used for online payment only. If you or a 3rd party is sending in payment, it must be by check.

Your renewal fee is:

[redacted] Credit Card [redacted] Send Check [redacted] 3rd Party Check 3rd Party Payer: [redacted]

PAYMENT

APPLICATION COMPLETION INFORMATION:

Date Application Started	9/23/2010
Date Application Submitted	9/23/2010
Confirmation Number	[redacted]
Payment Method	[redacted]
Amount Paid	$512.00

[redacted]

Print

DO NOT MAIL THIS TO THE BOARD. RETAIN THIS APPLICATION FOR YOUR RECORDS.

Application for renewal of: **Physicians**

1. **License Number D0039525** Dr. W Martin Haskell

2.	Individual National Provider Identifier NPI: 1215088018 ☐ I do not have an NPI This is the NPI entered in the field for Rendering NPI on a claim (10 digit number) NPI Information

3. EMAIL ADDRESS: This is your email address on file. If it has changed, please edit below. If you do not have an email address please indicate by checking the checkbox below.

[redacted]

☐ I do not have an email address

Address Changes (Non-Public and Public):
You must submit a Public and Non-Public address. If either address has changed, please correct here.
Your address(es) on the online renewal application is current as of July 1, 2012 . If you requested any changes to your address(es) that are not reflected on this application, please make the change at this time. These changes will be updated in the main database.

4a. Non-Public Address: This address is for Board use only and is **where your license will be mailed**. However, if no public address is listed, this address will also be made available to the public.

Street [redacted]
Street (2)
Street (3)
City
State
If selecting a country other than USA or Canada, please choose "Foreign" as your state
ZipCode
Country United States

4b. Public Address: This address, usually your office, is available to the public and will be posted on the Internet. If you do not designate a public address, your non-public address will be posted on the Internet.

☐ Check if Public Address is the same as your Non-Public address (the address above will be automatically entered below.)

Street Women's Med Group
Street (2) 11250 Lebanon Rd
Street (3)
City Cincinnati
State Ohio
If selecting a country other than USA or Canada, please choose "Foreign" as your state
ZipCode 45241
Country United States

5. Do you give the Maryland Board of Physicians permission to report your date of birth to the Federation of State Medical Boards' Physician Data Center? See instruction ◉ Yes ○ No

CHARACTER AND FITNESS (Question 6)

6. The following questions pertain to the period since July 1, 2010. If this is your first renewal, these questions apply to the period commencing with the date of your initial licensure or reinstatement. Check the box YES or NO next to each question. ***If you answer Yes, provide an explanation at the prompt.***
* All questions must be answered Yes or No.

Yes ◉ No
NO

a. Has any licensing or disciplinary board of any jurisdiction (except this licensing board), or any entity of the armed services denied your application for licensure, reinstatement or renewal, or taken any action against your license, including but not limited to reprimand, suspension, revocation, a fine, or nonjudicial punishment, for an act that would be grounds for disciplinary action under Md. Code Ann. Health Occ. §14-404?

Yes ◉ No

b. Have any complaints, investigations or charges been brought against you or are any currently pending in any jurisdiction by any licensing or disciplinary board (except this licensing board)

NO or an entity of the armed services?

Yes No
NO

c. Has your application for a medical or health professional license been withdrawn for reasons that would be grounds for disciplinary action under Md. Code Ann. Health Occ. §14-404?

Yes No
NO

d. Has an investigation or charge been brought against you by a hospital, related institution, or alternative health care system that would be grounds for action under Md. Code Ann. Health Occ. §14-404?

Yes No
NO

e. Have you had any denial of application for privileges, failure to renew your privileges, or limitation, restriction, suspension, revocation or loss in privileges in a hospital, related health care facility, or alternative health care system that would be grounds for disciplinary action under Md. Code Ann. Health Occ. §14-404?

Yes No
NO

f. Have you had a plea of guilty, nolo contendere, conviction, or receipt of probation before judgment or other diversionary disposition of any criminal act, excluding traffic violations?

Yes No
NO

g. Have you had a plea of guilty, nolo contendere, conviction, or receipt of probation before judgment or other diversionary disposition for an alcohol or controlled dangerous substance offense, including but not limited to driving while under the influence of alcohol or controlled dangerous substances?

Yes No
NO

h. Are there any pending criminal charges against you in any court of law, excluding minor traffic violations?

Yes No
NO

i. Do you have a physical or mental condition that currently impairs your ability to practice medicine?

Yes No
NO

j. Has the use of drugs and/or alcohol resulted in an impairment of your ability to practice your profession?

Yes No
NO

k. Do you illegally use drugs?

Yes No
NO

l. Have you surrendered or allowed your license to lapse while under investigation by any licensing or disciplinary board of any jurisdiction or an entity of the armed services?

Yes No
NO

m. Have you been named as a defendant in a filing or settlement of a medical malpractice action?

Yes No
NO

n. Has your employment by any hospital, HMO, related health care or other institution, or military entity been terminated for any diciplinary reasons?

Yes No
NO

o. Have you voluntarily resigned from any hospital, HMO, or other health care facility or institution, or military entity while under investigation by that institution for disciplinary reasons?

Yes No

p. Are you in default of a service obligation resulting from your receipt of state or federal funding for your medical education?

NO

Yes ◉ No

q. Have you failed to make arrangements to satisfy any state or federal loans that financed your medical education?

NO

CONTINUING MEDICAL EDUCATION (Question 7)

◉ **a. CME met.** I have completed and have been granted credit for at least 50 credit hours of Category 1 continuing medical education activities within the two year period immediately preceding submission of this application for license renewal. *Physician is obliged to obtain requisite documentation of CME activity and maintain documentation for a period of six years for possible inspection by the Board. For additional information on CME, see Maryland Regulations, 10.32.01.09.*

○ **b. First Renewal & NPO.** I am exempt from CME during the renewal period because this is my first renewal after initial medical licensure in Maryland and I have completed the Board's New Physician Orientation Program. The New Physician Orientation is for **NEWLY** licensed physicians only. If you were licensed prior to September 30, 2010 or reinstated, this does not apply to you. See New Physician Orientation Program web site. **Your license will not be renewed unless you have completed the orientation.**

○ **c. First Renewal after reinstatement.** I am exempt from CME during the renewal period because this is my first renewal after reinstatement of my medical licensure in Maryland.

PERSONAL AND PROFESSIONAL INFORMATION (Questions 8-17)

8a. Gender ◉ Male ○ Female

8b. RACE/ETHNIC IDENTIFICATION - PLEASE CHECK ALL THAT APPLY

Are you of Hispanic or Latino origin? (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.) [redacted] Yes [redacted] No

Select one or more of the following racial categories:

[redacted] American Indian or Alaska Native (A person having origins in any of the original peoples of North or South America, including Central America, and who maintains tribal affiliations or community attachment.)

Asian (A person having origin in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.)

Black or African American (A person having origins in any of the black racial groups of Africa.)

Native Hawaiian or other Pacific Islander (A person having origins In the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.)

White (A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.)

Other

9. Are you employed by the Federal Government?

○ Yes ◉ No

10. Please indicate if you are currently in: a) a residency program accredited by the Accreditation Council for Graduate Medical Education or an internship or residency program approved by the American Osteopathic Association; or b) a fellowship (subspecialty) training program accredited by the ACGME.

[redacted] If you answer ***Yes*** to either a. or b. you will not be required to complete the Practice Information section (Questions 15-26) of this application.

a. In an accredited/approved internship or residency program?

○ Yes ◉ No

b. In an accredited fellowship (subspecialty) training program?

○ Yes ◉ No

11a. Which best describes your current area(s) of concentration:

Primary Concentration: Gynecology
Secondary Concentration: None

11b. SPECIALTY BOARD CERTIFICATION: List up to two (2) specialty areas only if certified by a recognized board of the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA).

Primary Certification: Family Medicine
Secondary Certification: None

12. Please select all states (excluding Maryland) where you hold a medical license.

☐ Alabama	☐ Florida	☐ Kentucky	☐ Nebraska	☐ Oklahoma	☐ Utah
☐ Alaska	☐ Georgia	☐ Louisiana	☐ Nevada	☐ Oregon	☐ Vermont
☐ Arizona	☐ Guam	☐ Maine	☐ New Hampshire	☐ Pennsylvania	☐ Virginia
☐ Arkansas	☐ Hawaii	☐ Massachusetts	☐ New Jersey	☐ Puerto Rico	☐ Virgin Islands
☐ California	☐ Idaho	☐ Michigan	☐ New Mexico	☐ Rhode Island	☐ Washington
☐ Colorado	☑ Illinois	☐ Minnesota	☑ New York	☐ South Carolina	☐ West Virginia
☐ Connecticut	☑ Indiana	☐ Mississippi	☐ North Carolina	☐ South Dakota	☐ Wisconsin
☐ Delaware	☐ Iowa	☐ Missouri	☐ North Dakota	☐ Tennessee	☐ Wyoming
☑ District of Columbia	☐ Kansas	☐ Montana	☑ Ohio	☐ Texas	

13a. How many weeks per year do you work? 48

13b. Please indicate below how the hours in your typical work week are allocated. The sum of these hours should reflect the number of hours in your typical work week. Definitions of these categories are listed below.

If you allocate **0 hours per week** to a. Patient Care Related Activities you will not be required to complete the Practice Information section (Questions 15-26) of this application.

Patient Care Related Activities include seeing patients, writing prescriptions, patient-related clinical activities (such as pathologic and radiologic assessments), maintaining patient records, obtaining and reviewing test results, arranging referrals, consulting with other providers about patients, talking with a patient's family members.

Research includes clinical, laboratory, and analytical research

Teaching includes teaching of medical undergraduate & graduate students and other graduate students.

Administration & Other: Administration includes practice management (billing, contract negotiations, personnel, regulatory activities) & management of institutions or programs (health departments, health insurance, hospitals, other health-related institutions or programs); Other

Use whole numbers. No fractional hours. If none enter 0.

a. Patient Care Related Activities	20	hours per week
b. Research	0	hours per week
c. Teaching	0	hours per week
d. Administration & Other	40	hours per week
Total Hours	60	hours per week

14. If you indicated in Question 13 that you are not engaged in patient care related activities, do you intend to resume patient care related activities in the next 2 years?

Yes No

PRACTICE INFORMATION (Questions 15-26)

15. Do you plan to discontinue patient care related activities in the next two years?

◉ Yes ○ No

16. Please indicate below the number of practice/office locations at which you routinely deliver patient care for reimbursement.
    a. Number of locations in Maryland (if none, enter 0) 0
    b. Number of locations outside of Maryland (if none, enter 0) 3
    If you have locations outside Maryland, please answer (c) below after you answer (b).
    c. Do you routinely treat Maryland patients at your practice/office location(s) outside of Maryland?
    ○ Yes ◉ No ○ Don't know

17. Please indicate below the number of hospitals at which you currently have admitting privileges.
    a. Number of hospitals in Maryland (if none, enter 0) 0
    b. Number of hospitals outside of Maryland (if none, enter 0) 0

18. Primary Practice / Office Location Primary Practice / Office Location

Please answer all Primary Practice questions

a. Organization Name: Women's Med Group
b. Street Address: 11250 Lebanon Rd
c. Street2: Enter suite or room number here. (Ex. Suite 101 or Room 101)
d. City: Cincinnati
e. State: Ohio
f. Zip Code: 45241
g. Jurisdiction: Non-Maryland
h. Employer Tax ID: 00 - 0000000 If you do not have an EIN enter 00-0000000
What is Employer tax ID?
i. Please select one of the following related to the NPI used for billing insurers:
    ○ I use an Organizational NPI for billing. Please Enter > Organizational NPI
    ○ I use my Individual NPI for billing.
    ◉ I do not bill public or private insurers.
j. You indicated in Question 13a, **20** hours of Patient Care Related Activities during a typical work week.
How many of those Patient Care Related Activity hours in your typical work week are delivered at this practice/office location? 12 Hours
If none, enter 0.
k. Setting: Freestanding Ambulatory Surg Ctr
l. Private/Public: Private-For profit
m. Practice: Single-Specialty Group

Please answer the following regarding staffing at this practice/office location on a typical day. Definition of mid-level medical providers is listed below.
If none, enter 0; if you don't know the number, enter 999

Number of physicians (MDs, DOs, residents, fellows) including yourself at this location. 3

Number of mid-level medical providers at this location. 0
Mid-level medical providers: nurse practitioners, nurse midwives, nurse anesthetists and physician assistants.

19. Secondary Practice / Office Location

If you have a secondary practice/office location and you've checked the box above, you will see a series of questions that must be completed.

a. Organization Name: Women's Med Group

b. Street Address: 1210 N Arlington Ave

c. Street2: Enter suite or room number (Ex. Suite 101 or Room 101)

d. City: Indianapolis

e. State: Indiana

f. Zip Code: 46219

g. Jurisdiction: Non-Maryland

h. Employer Tax ID: [redacted] If you do not have an EIN enter 00-0000000

What is Employer tax ID?

i. Please select one of the following related to the NPI used for billing insurers:

- I use an Organizational NPI for billing. Please Enter > Organizational NPI
- I use my Individual NPI for billing.
- I do not bill public or private insurers.

j. You indicated in Question 13a, **20** hours of Patient Care Related Activities during a typical work week.
How many of those Patient Care Related Activity hours in your typical work week are delivered at this practice/office location? 8 Hours
If none, enter 0.

k. Setting: Freestanding Ambulatory Surg Ctr

l. Private/Public: Private-For profit

m. Practice: Single-Specialty Group

Please answer the following regarding staffing at this practice/office location on a typical day. Definition of mid-level medical providers is listed below.
If none, enter 0; if you don't know the number, enter 999

Number of physicians (MDs, DOs, residents, fellows) including yourself at this location. 1

Number of mid-level medical providers at this location. 2
Mid-level medical providers: nurse practitioners, nurse midwives, nurse anesthetists and physician assistants.

20-21 Health Information Technology questions has been moved to a seperate section. You are required to complete the Health Information Technology section ONLY if you have a Primary Practice Location.

22. Please indicate if you participate in the following private and public insurance programs, and whether you are currently accepting new public insurance program patients.

a. Participate in any PRIVATE insurance plan networks, including PPO, EPO, HMO, etc. Yes No

b. Participate in the MARYLAND MEDICAL ASSISTANCE PROGRAM (in either the traditional program or a Managed Care Organization) Yes No

b1. If **Yes**, are you accepting new Maryland Medical Assistance patients? Yes No

c. Participate in the MEDICARE (in either the traditional program or a Medicare Advantage Plan)?

Yes No

c1. If **Yes**, are you accepting new Medicare patients? Yes No

23. Do you offer a sliding fee scale based on ability to pay? (Utilize a standardized fee reduction schedule for low-income)

Yes No NA

24. Please report the typical number of hours per week you personally provide care to patients on a charity basis (do not include bad debt).

0 hours per week. If none, enter 0

If you are practicing as an adult primary care specialist (internal medicine, family practice, general medicine), answer Q.25. Otherwise skip to Q.26.

25. Do you charge patients an annual fee for participating on your patient panel (sometime called direct, concierge, or retainer-based practice)?

Yes No

26. Workers Compensation

Workers Compensation coverage: If you employ one or more persons, the Md. Code Ann. Health Occ. §1-202 requires that you verify that you are complying with the Workers' Compensation Law for your renewal to be issued.

I hereby certify:

- Not Applicable (Do not complete below)
- I do not practice in Maryland.
- I do not employ anyone in my practice in Maryland.
- I employ one or more persons in my Maryland practice and have the following Workers Compensation coverage.

If you are a Maryland employer you must provide the information requested below.

Insurance Company

Policy Number

Expiration Date Enter as MM/DD/YYYY Enter as MM/DD/YYYY

HEALTH INFORMATION TECHNOLOGY

Please contact the Maryland Health Care Commission at 410-764-3330 for questions relating to this section.

Electronic Health Record Incentive

Beginning in 2011, physicians that adopt an electronic health record are eligible to receive an incentive either under Medicare or Medicaid. To receive this incentive, a physician must meet certain criteria, which varies depending on which program you choose. The Medicare incentive is up to $44,000 over five years and the Medicaid incentive is up to $63,750 over six years. Physicians are encouraged to learn more about these incentive opportunities by visiting the Centers for Medicare and Medicaid Services website http://www.cms.gov/EHRIncentivePrograms/

This question is about the use of computers and other forms of information technology, such as hand-held computers, in diagnosing or treating your patients at your primary office/practice location, which you listed in
Question 18 - Primary Practice / Office Location Primary Practice / Office Location

1. This question is about the use of computers and other forms of information technology, such as hand-held computers, in diagnosing or treating your patients in your office.

Are you computerized in your office:

a. To obtain information about treatment alternatives or recommended guidelines?

Yes No

b. To send prescriptions electronically to a pharmacy?

○ Yes ◉ No

If you answered Yes to 20B, what percentage of prescriptions are submitted electronically? [ ] %
(Enter Whole number)

c. To generate reminders for you about preventive services needed for your patients?

○ Yes ◉ No

d. To access patient notes, medication lists, or problem lists?

○ Yes ◉ No

e. For clinical data and image exchanges with other physicians?

○ Yes ◉ No

f. For clinical data and image exchanges with hospitals and Laboratories?

○ Yes ◉ No

g. To communicate about clinical issues with patients by email?

○ Yes ◉ No

h. To obtain information on potential patient drug interactions with other drugs, allergies, and/or patient conditions?

◉ Yes ○ No

2. Does your primary office/practice location use electronic MEDICAL RECORDS (not including billing records)?

○ Yes, all electronic ◉ Yes, part paper and part electronic ○ No ○ Don't know

2a. If Yes, what is the name and version of the EHR system?

Other

Other IMS

2b. If **No**, please indicate your most significant reason for not using electronic medical records.

○ Capital cost outlays ○ Lack of technology standards ○ Retiring soon
○ Overburdened staff ○ Intangible benefits ○ Not my decision
○ Risk of privacy breaches

3. Please answer the following Telemedicine question(s)

Telemedicine means, as it relates to the delivery of health care services, the use of interactive audio, video, or other telecommunications of electronic technology by a licensed health care provider to deliver health care service(s) within the scope of practice of the health care provider at a site other than the site at which the patient is located.

3a. Approximately how many times in the last 12 months have you used telemedicine for any purpose? 0
(Enter 0 if you did not use telemedicine)

3b. If you used telemedicine, what are your common uses of telemedicine technology (mark all that apply)?

☐ Second opinion
☐ Diagnosis
☐ Follow-up
☐ Emergency
☐ Chronic disease management
☐ Other (specify) [ ]

PHYSICIANS EMERGENCY CONTACT INFORMATION

27. As part of Maryland's emergency preparedness efforts, the Department of Health and Mental Hygiene has identified the need for certain contact information for licensed physicians in Maryland who may be needed to respond to a catastrophic health emergency. (Public Safety Article, Sec. 14-3A-01 et seq. and Health General Article

Section 18-901 et seq. sets forth the powers of the Governor and Secretary of the Department of Health and Mental Hygiene.

*Required Field

Please provide the phone number that should be used in the event of an actual emergency.
Daytime * [redacted]
Nighttime* [redacted]

Indicate by checking any box that applies whether you have any particular training and experience regarding the following specific agents:
☐ Chemical ☐ Biological ☐ Radiological

If you are interested in being contacted about training opportunities provided by the Board of Physicians, please visit the Maryland Professional Volunteer Corps website at https://mdresponds.dhmh.maryland.gov/.

Thank you for your assistance!

28. CERTIFICATION AND AUTHORIZATION OF LICENSE APPLICATION

☑ a. I certify that I have personally reviewed all responses to the items in this application and that the information I have given is true and correct to the best of my knowledge and that any false information provided as part of my application may be cause for the denial of my application.

☑ b. I agree that the Maryland Board of Physicians (the Board) may request any information necessary to process my application for renewal from any person or agency, including but not limited to former and current employers, government agencies, the National Practitioners Data Bank, the Healthcare Integrity and Protection Data Bank, hospitals and other licensing bodies, and I agree that any person or agency may release to the Board the information requested. I also agree to sign any subsequent releases for information that may be requested by the Board.

☑ c. I shall inform the Board, by certified mail, return receipt requested, within 30 days of: (a) action that would be grounds for disciplinary action under Md. Code Ann. Health Occ. §14-404, that occurred at any time during the application period; (b) change in any answer that was originally given in this application.

☐ d. Check Here if you wish to have the option of viewing your completed application online after you renew your license. Otherwise, your application will not be available online for your later viewing. If selected, viewing is available until 12/1/2012.

29. Please provide your electronic signature (type your name) below:

Name Martin Haskell
Today's Date 9/26/2012
Last four digits of Social Security Number: [redacted]

30. Select a Payment Option here to complete your application.

Please note: Credit cards may be used for online payment only. If you or a 3rd party is sending in payment, it must be by check.

Your renewal fee is:

[redacted] **Credit Card** [redacted] **Send Check** [redacted] **3rd Party Check** **3rd Party Payer:** [redacted]

PAYMENT

APPLICATION COMPLETION INFORMATION:

Date Application Started	9/26/2012
Date Application Submitted	9/26/2012
Confirmation Number	[redacted]
Payment Method	[redacted]
Amount Paid	$514.00

[redacted]