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This is your application to register your professional license for the period indicated in the upper left corner of the application. Registration is require. It you practice your profession or use your professional title within New York State #4% If you do not expect to practice entire indireprofessional title within New York State during the period selected, you may voluntarily place your license on inactive status by checking "NO" to item 2 and resuming the completed application without fee by the beginning of the new period. Please note: If you Decemb fractive, a registration contificate will not be issued and future notices will not be sent to you until you reactivate your registration. Should you later decide to register for practice within New York. you will not be assessed delayed or late registration fees for the period your license was inective. If you do not return this application, either to register or to claim inactive status, your license will be automatically declared not registered. Should you later attempt to register for practice within the State, you may be assessed delayed or late registration feed for each month your license was not प्रज्य स्थ . . registered. INSTRUCTIONS FOR COMPLETING THE APPLICATION 1. Answer all questions. A response of "YES" to any question will not prevent or delay your reregistration . (a) If you answer "YES"; Submit" a list of charges involved for each state and give a brief explanation OF BEST BETTON (b) If you answer "YES", submit a certified copy of the court records for each conviction. Do not creck "YES" for minor traffic violations; charges that were dismissed or acquittmis: For purposes of Item 1(c), section 28.2 of the Rules of the Board of Regents identifies this profession a health profession. (c) If you answer "YES", submit a statement describing the details of the separation. 2. Check "YES", if you plant to practicatin New York State during the period. Registration is required if its practice your profession or use your professional title within New York State. If you do not plan to practice in the State and wish to claim inactive status, check "NO" and return the application without a fee. (see above box for more information.) 3. If you are not currently practicing, enter the month and year you last practiced in New York State 4. Please provide your date of birth.

5. Enter your Social Security Number in Item 5. If you do not have a Social Security Number. you must

7. Licensees who complete, on or after September 1, 1990 an academic program registered by the State Education Department as:fulfilling the educational requirements for licensure are credited with completion of the coursework and do not have to submit a Certificate of Completion nor file for an exemption. The coursework or training must be specifically approved for that purpose by the New York State Education Department; only approved providers can furnish the Certificate of Completion fore required for reregistration; You should return the croy warried STATE EDUCATION DEPARTMENT COPY with regardistration application. If you need to locate a provider, you should call Professional Licensing

6. If you are an employer and hold a Federal Employer Identification Number, you must enter your employe

(The authority to collect, this information is contained in Section 5 of the New York State Tax Law. It

Section 59.12 of the Regulations of the Commissioner of Education provides for exemption from the course requirement in cases where the nature of an individual's practice precludes any contact with envisore If you believe you may qualify for such an exemption, call Professional Lipensing Services to request an exemption application.

8. Please read the important information on the reverse side regarding a NIV/NEV requirement in your profession as the affirmation profession and date the application. If you are registering, the fee must be said with a check or money order made payable to the NEW YORK STATE EXECUTION SERVICES IN U.S. funds only need to the original fee owed, to anyone who submits a bad check for registration or licenses

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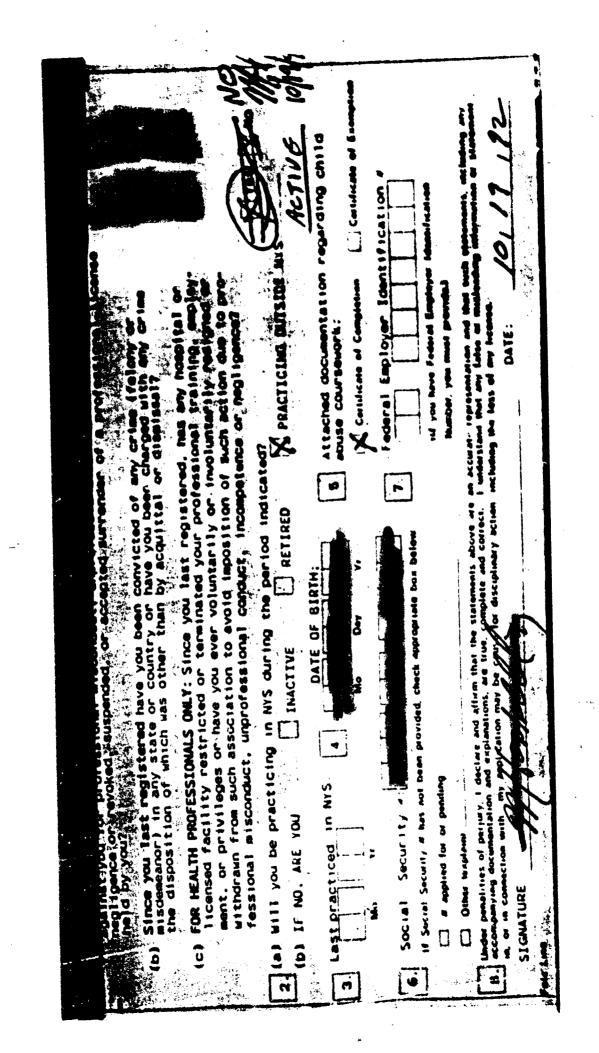
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REGISTRATION APPLICATION

PROFESSION: MEDICINE

PERIOD: 01/01/93 - 12/31/94

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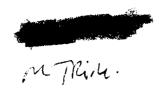
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REGISTRATION RENEWAL DOCUMENT
THE STATE EDUCATION DEPARTMENT
Professional Licerating Services
89 Westwington Avenue
Albany, NY 12234-1000

10/02/03 179138

LIC: HASB

YR: OFF: 04

DOB:

SSN:

HASKELL W MARTIN

CINCINNATI

Name/address change Complete only if change has occurred

Name

Street

City

State/Zip

600

PRESTIFE PARK DUE

PROFESSION: **50 MEDICINE**PERIOD: **03/01/04 - 02/28/06** 

EIN:

Complete and sign reverse side of this application

Cat 6 - 1001

1. Do you wish to register for the period indicated? 2. Since your last registration application, a. Have you been found guilty after trial, or pleaded guilty, no contest, or noto of b. Has any licensing or disciplinary authority revoked, annulled, cancelled, accepted to issue or renew a professional license or certificate held by you now or previous. Are criminal charges pending against you in any court?  d. Are charges pending against you in any jurisdiction for any sort of profession e. Has any hospital or licensed facility restricted or terminated your professions or involuntarily resigned or withdrawn from such association to avoid the imposun professional conduct, incompetency, or negligence?  3. a. Are you under an obligation to pay child support?  b. If you are under such an obligation, do you meet one of the four requirement.	ously, or fined, censured, reprimanded or otherwise disciplined you?.  nal misconduct?  al training, employment, or privileges, or have you voluntarily sition of such action due to professional misconduct,
32444675 891 11032003	DO NOT WRITE IN THIS BOX FOR OFFICIAL USE ONLY
I certify that the statements made in this application and any accompanying do false or misleading information made in connection with my application may remy license; and that the willful failure to register while continuing to practice my Signature	commentation are true, complete and correct. I understand that any misrepresentation or any esult in criminal prosecution and may be cause for disciplinary action, including the loss of profession constitutes professional misconduct.  Business phone (5/3) 272-0002 Date 10/28/03 6

#### 179138HAS8006000060106

REGISTRATION RENEWAL DOCUMENT
THE STATE EDUCATION DEPARTMENT
Professional Licertary Services
59 Washington Avenue
Alberry, NY 12234-1000

10/03/05 LIC: 179138

NME: HASE 06

YR: OFF:

EIN:

PROFESSION: 60 MEDICINE PERIOD: 03/01/06 - 02/29/08

Chi 21P:032204.

Complete and sign reverse side of this application

Name/address change Complete only if change has occurred

Name City

State/Zip

\$ 800

AMOUNT DUE

<ul> <li>b. Has any licensing or disciplina to issue or renew a professional c. Are criminal charges pending:</li> <li>d. Are charges pending against;</li> <li>e. Has any hospital or licensed it or involuntarity resigned or withd unprefessional conduct, incompi 3. a. Are you under an obligation to b. If you are under such an obliga-</li> </ul>	cation, ter trial, or pleaded guilty, no contest, or note of ry authority revoked, annulled, cancelled, acce- license or certificate held by you now or previo- against you in any court? you in any jurisdiction for any sort of profession autity restricted or terminated your professions trawn from such association to avoid the impos- etency, or negligence?	is training, employment, or provides, or have you rotalized you retained you retained you retained you retained you retained you retained you retain you y	Yes	No.
2449752 49 11882885	59000	DO NOT WRITE IN THIS BOX FOR OFFICIAL USE ONLY		



### **Registration Renewal - Transaction Summary**

89 Washington Avenue Albany, NY 12234 518-474-3817

Main Page | Logout

License Number: 179138 Profession

: MEDICINE

Renewal Period: 03/01/2010 through 02/29/2012

We recommend that you print and keep this transaction summary. Thank you for using OP Registration Online.

HASKELL W MARTIN

CINCINNATI OH

Renewal Status: Paid On-line - Renewal Complete

Offices Selected for Renewal:

Address

Fee

L CINCINNATI, OH,

\$ 600

#### Response to Questions:

#### Question

- 1) Have you been found guilty after trial, or pleaded guilty, no contest, or nolo contendere to a crime (felony or misdemeanor) in any court?
- 2) Has any licensing or disciplinary authority revoked, annulled, cancelled, accepted surrender of, suspended, placed on probation, or refused to issue or renew a professional license or certificate held by you now or previously, or fined, censured, reprimanded or otherwise disciplined you?
- 3) Are criminal charges pending against you in any court?
- 4) Are charges pending against you in any jurisdiction for any sort of professional misconduct?
- 5) Has any hospital or licensed facility restricted or terminated your professional training, employment, or privileges, or have you voluntarily or involuntarily resigned or withdrawn from such association to avoid the imposition of such action due to professional misconduct, unprofessional conduct, incompetency, or negligence?
- 6) Are you under an obligation to pay child support?
- 7) Are you a U.S. citizen?

#### License Renewal Payment Details:

Receipt No. Payment Date Amount Paid

:10/13/2009

:\$ 600



Response





# **Registration Renewal - Transaction Summary**

89 Washington Avenue Albany, NY 12234 518-474-3817

Main Page | Logout

License Number: 179138

Profession : MEDICINE

Renewal Period: 03/01/2012 through 02/28/2014

We recommend that you print and keep this transaction summary. Thank you for using OP Registration Online.

HASKELL W MARTIN

CINCINNATI OH

Renewal Status: Paid On-line - Renewal Complete

Offices Selected for Renewal:

Address

Fee

CINCINNATI, OH,

\$ 600

#### Response to Questions:

#### Question

- Response
- 1) Have you been found guilty after trial, or pleaded guilty, no contest, or nolo contendere to a crime (felony or misdemeanor) in any court?
- 2) Has any licensing or disciplinary authority revoked, annulled, cancelled, accepted surrender of, suspended, placed on probation, or refused to issue or renew a professional license or certificate held by you now or previously, or fined, censured, reprimanded or otherwise disciplined you?
- 3) Are criminal charges pending against you in any court?
- 4) Are charges pending against you in any jurisdiction for any sort of professional misconduct?
- 5 ) Has any hospital or licensed facility restricted or terminated your professional training, employment, or privileges, or have you voluntarily or involuntarily resigned or withdrawn from such association to avoid the imposition of such action due to professional misconduct, unprofessional conduct, incompetency, or negligence?
- 6) Are you under an obligation to pay child support?
- 7) Are you a U.S. citizen?

#### License Renewal Payment Details:

Receipt No Payment Date Amount Paid





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8 Name as it appears on dipioma or	other credentials, Cl. 1111-115	Hody Mart	IN HATALL	
4. Have you previously applied for a 10. Have you ever been convicted of a 11. Have you ever been charged with the disposition of which was other 12. Have you ever surrendered your lice unprofessional conduct, incompe 13. Are charges pending against you for incompetence or negligence in a 14. Have we have tall the series of the converted and the converted or t	crime (felony or misdemeanor) a crime (felony or misdemeanor) than by acquittal or dismissal? cense or been tound guilty of protence or negligence in any state or professional misconduct, unpry state or country?	in any state or cour in any state or cou ofessional miscond or country? rofessional conduc	ntry? untry, duct, ct,	
14. Has any hospital or licensed facility employment, or privileges or have from such association to avoid impositions 10-12 your court records and a copy of the answer to guestions.	you ever voluntarily or involunt position of such manner? 4 is "Yes," submit a letter giving a f the "Certificate of Relief from D	arily resigned or w	rithdrawn	e copies of
15. I Wish to be licensed in New York  National Board Exami	State on the basis of: nation (See Licensure Requireme	ents _ Soc 1\/\		
🗔 National Board Exami	nation/Osteopath (See Licensure sing examination in New York S	Requirements S	ec. IV)	
CHAL Date of Field GAS	nination requested (Month and Y	/ear)		
•	r: New York City Area, ilocs, Long Island) ion Licensing Examination (FLE)	Albany Are		
Cove dates and locatio	ns of all FLEX examinations take	n		
Endorsement of licens	n Number (FIN) is: e from another State or Country.			
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August 198* 3th Pathway (Section 6	528 of the Education Law.)		COMPLETE OTH	ER SIDE •

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16. I am a graduate of the following medical program:

	Number of		ATTEND	ANCE	Diploma or Degree Obtained (if school is located
Name of Medical School Attended and Location	Years Attended	Class Completed	Entrance Date	Leaving Date	Outside the United States, attach a copy)
School Univ. of Alabania  Medical Callege 1717 Eleverth Au S. University Staffou Themingham 1235294	4	-50-	१/५४	C/73	Doctor of Medicine

17. I am a licensed physician in the following states or countries:

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			E			
State or Country	Date License Issued	Number	Examination (Date Passed)	Endorsement	Orper	Any Limitations on License
Ohio	1974	037358	Noc'l 7d.	NRME	:33	출시: 4년
Alabama	1973	1999 1400-14	Noul Rd 173	NEME		41.50

#### **AFFIDAVIT**

I hereby certify that I have read the statutory provisions, Rules of the Board of Regents and Regulations of the Commissioner of Education distributed to me by the State Education Department.

Under penalties of perjury, I declare and affirm that the statements made in the application, including accompanying statements and transcripts are true, complete and correct. I understand that any false or misleading information in, or in connection with my application may be cause for denial or loss of licensure.

Signature of Candidate Day



• RETURN TO: Fee Section, Division of Professional Licensing Service
Cultural Education Center, Albany, New York 12230

THE UNIVERSITY OF THE STATE OF NEW OR DEPOSIT ONLY HISED DIVISION OF PROFESSIONAL LICENSING SERVICENDL W THE STATE EDUCATION DEPARTMENT

COULTURAL EDUCATION CENTER ALDANY, NEW YORK 12230"

HARKELL W MARTIN

WHEN RESPONDING - PLEASE IN: CLUDE NAME, ADDRESS, PROFES-SION, SSN, AND A DAY PHONES. 05/25/82 PROFESSION: 40 SOC SEC NO:

THE STATUTORY PROFESSIONAL LICENSING FEES HAVE BEEN AMENCED BY THE MEN YORK STATE LEGICLATURE. ALL FEES RECEIVED ON OR AFTER APRIL 1941 THE NUST BE AT THE NEW RATE. THE FEES YOU SUBMITTED ARE LESS THE AMOUNT SCUTTED UNDER THIS NEW SCHEDULE, AND HE MUST REQUEST STREE ADDITIONAL AND INT FRIDAY HELDING

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PLEASE HAVE YOUR CHECK OR MONEY DRUER PAYABLE TO THE NEWLYORK TTATE EDUCATION DEPARTMENT. NOTE: PAYMENT SUBMITTED FOR OUTSTOE THE MATTER STATES MUST SE MAIN HY CHECK OR DRAFT PAYABLE ON A UNITED BESTEE BASE AND TH SHATED STATES DOSLAND. NOVOTHER FORIMOAN DE CCEPTED AND WILL BE RETURNED. DO NOT SEND CASHING

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> THE SECTION LIVIDIDA DE CHATRESIONAL LIVEUSING LERVILES COLIURAL EDUCATION CENTER ALCANY, REW YORK TELLIO

> > HASKELL

#### FORM 2 MEDICINE

THE UNIVERSITY OF THE STATE OF NEW YORK
THE STATE EDUCATION DEPARTMENT
TYPISION OF PROFESSIONAL STENSING SERVICES

### CANDIDATE EDUCATION AND TRAINING RECORD

### ALL CANDIDATES MUST COMPLETE THIS FORM.



First 3 letters of Last Name

DATE TO. div vi.

	4. PRINT FULL N DETERMINED surname canno	ELIGIB	NE.	đМ	IPC	S Y ORT	OU AN	I W	SH	l IT que	T() ist t	API hat	cor	R C	)N ns 0	YO	UR Inil	UC tials	EN'	SE, d th	IF ne
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**6.** Basis of licensure sought (Form 1, #15) ☑ National Board, □ N.Y.S. Exam.; □ FLex Outside NYS: □ Endorsement **7.** In the spaces below, give an accurate record of your educational preparation.

NUMBER **ATTENDANCE SCHOOLS ATTENDED-Location** Diploma or degree obtained OF Entrance Leaving Ouote titles in original Write names of schools in YEARS Class language and translate. Completed Date **ATTENDED** Class Date original language and translate. **Elementary or Primary School** 4/5,5 (Proof of completion 3 Charless Francis H5.7 need not be submitted Howestown Faces 1115 6-1=8 -1 6 7 Francost to 126 Secondary or High School 6/61 11/10 4 (Proof of completion 7 Mountain Beres to that 4 Same with the need not be submitted Page of the Carlot Carlot St. Tall. 4/11 1.4 12 10. Section 27 20 32 Candidates using form Post Secondary Pre-Proteisional 2A need not verify (Exclusive of Medical School) preprofessional training. 9 : 11-Mir il 1. Chio Weeleyn lund Candidates using Form 2N must arrange that verification of preprofessional training be submitted directly from the school. (See Form 2A or 2N Medical Education (Professional) for verification (List all Medical Schools requirements) Albertachel) 4/72 11 4/1-5 17 grib de gree

Clinical Clerkships were completed in a country other than where your medical school is located, give the dates and location of those clerkships are

The winds

Circlusive Titus Cierkship Dates Ti	8 CClinical Area	Name of Health Care Facility and Address	Medical School In Which Taken/Address
LE TO THE REAL	Constitution of the consti	प्रकार <b>ाष्ट्रक रात</b> ्रक्षण अवस्था । १३८४मा स्ट्रांस	Control of the Contro

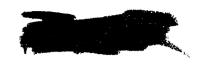
Provide a chronological list or all activities since graduation from professional school to the present. Include vacation periods and periods of employments

FROM WILL DEL		bed in	<u>لتل (</u>	Type of Professional Activity, Including Name and Address of Employer	
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7	77	6	78	Unit of Change Towner Hospital Contribution	
1546	78-	12	79	Emergency Room Director - Jewish Hospital, Cincinnation	
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# 10. Professional Certificates/Other Examinations

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Proficiency ##	Names A	Date Med	dicine Passed	Date I	nglish Passed	Certificate No.
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Fifth	Name and Location of Medic	al School	Name and Lo	cation of F	ospital Inclu	sive Dates of Attendance

Cultural Education Centes, Albamy, New York 12230



ði/01/81 - 12/31/82 NN OK HASS **DOB** SSN FEE PR YR PEN The authority to request personal information from you. FORM 2A MEDICINE

THE UNIVERSITY OF THE STATE OF NEW YORK A RIGHT TO WORK A PROTECTION OF THE STATE EDUCATION DEPARTMENT

THE PRINCIPAL TO SCHOOL PERSONAL CONTRACTOR SHEET AND RESTORMENT OF THE PRINCIPAL PRIN

Graduates of N.Y.S. Registered or LCME According Programs most complete the Sure.

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## CERTIFICATION OF PROFESSIONAL EDUCATION: REGISTERED OR ACCREDITED PROGRAMS

AIQ:20 **CANDIDATE INSTRUCTIONS** ruly or colline of A lete Section L. Enter your name as it appears on your Application (Form 1). and this form to the professional school you attended. See "Licensure Requirements" for additional instruction. Be sure to Include are fee required. cation is not acceptable unless dated after graduation. rate word large recording I L CANDIDATE INFORMATION Sected Security Number of Last Name EINT FULL NAME EXACTLY AS YOU WISH IT TO APPEAR ON YOUR LICENSE, IF DETERMINED ELICIBLE, (IMPORTANT: A request that contains only initials and the me cannot be hunored.) er fait einzige geft fa . man laborate at the abla Mout its #arm 1, #15) → National Board, □ N.Y.S. Exam.; □ FLex Outside NYS; □ Endorsement er or diploma was awarded: School Birmingham, Al (Name) Station: Oir minimum. Date degree was awarded James Herries Sham Mine

CERTIFICATION BY PROFESSIONAL SCHOOL OFFICIAL 
 TO BE MADE ON REVERSE SIDE

12 I I down your house the section with the

#### ECTION II: CERTIFICATION OF EDUCATION

INSTRUCTION TO SCHOOL: Please complete this section, sign the certifying statement, and return the form directly to the Division of Professional Licensing Service. This form will not be accepted if returned by the applicant.

The Control of the Co	Print Name of Institution		
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Doctor of Medicine	11. 11. 14. 15. 15. 15. 15. 15. 15. 15. 15. 15. 15		
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Attach the following to this form:  (1) Official transcript of studies at your institut	tion.  Port the granting of transfer cre	dit.	
Attach the following to this form:  (1) Official transcript of studies at your institut (2) Copies of documentation in your file to sup  Name  (original signature)	tion.  Port the granting of transfer cre	dit.	
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Certification is not acceptable unless dated after graduation.

CHARLE AROUND PROPERTIONAL SCHOOL CHICAE RETURN TO: Division of Professional Licensing Services, Medical Unit, Cultural Education Center, Albany, New York 12230

FORM 2PG1 MEDICINE

### CERTIFICATION OF APPROVED POST

Any certification signed and submitted earlier then one munth prior to the completion of the training period wifl he returned to the hyspital by the division without processing.

. . .

ALL CANDIDATES MUST

#### CANDIDATE INSTRUCTION

Complete Section I. Enter your name as it appears on your Application. (Form 1)

1

- 2. Please send this form to the director of medical education of the hospital(s) in which you completed post graduate training. One form must be submitted to verify each residency.

the form. This form must be sent directly to this office by the your residency does not have a director of medical control of the control of	the hospital in which you did your residency. If the hospital in which you did ical education, the forms may be completed by the department chief.
ECTION & CANDIDATE INFORMATION	
	2. HHS 3. BIRTH
Social Security Number	First 3 letters of Last Name
4. PRINT FULL NAME EXACTLY	AS YOU WISH IT TO APPEAR ON YOUR LICENSE, IF
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surname cannot be honored.)	
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Maria Calaba	
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SECTION IS CERTIFICATION OF POST GRADUATE	
This is to certify that W. Martin Haskell	, M.D.  Physician's Name
a graduate of University of Alabama Med	ical School
•	Medical School d by the Accreditation Council on Graduate Medical Education or the American
can Ostenpathic Association at	of Alabama Hospital
619 South 19th Street, Birmingham,	AL 35233
	ti or ation of Hospitalii
from June 22, 19 <sup>72</sup>	thru June 22, 19 <sup>73</sup> in the clinical area o
Rotating Intern	and that the
above named physician successfully completed this	Clinical Area training on June 22, 1973
accessibility completed this	Date
tf this physician did not successfully complete the po	ost graduate training program, please attach a letter of explanation with this
from AC A. I. a	·
Lam the Silver of White Education or Department of the Avenue of the post-seadurate training indicates	ental Chief of the clinical area. I was the program director for the physician und have carefully read and completed this form and hereby attest that the
statements made herein are strictly true in every respective	ect and are supported by hospital records.
Administrator	5 /31/89
Administrator JAMES E. HO	OON, Ph.D.
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For those individuals who have not yet satisfactorily completed one full year of post. A.D. stall on the facsimile is the date which has been certified by the physician's residency program director as the which this requirement for certification by the National Board will be fulfilled and such

