REGISTRATION APPLICATION

PROFESSION: MEDICINE

REGISTRATION PERIOD: 01/01/95 - 02/29/96

$ 193.00 PAY THIS AMOUNT

Make check or money order payable to New York [redacted] Department."

The University of the State of New York
THE STATE EDUCATION DEPARTMENT
Office of Professional Credentialing
Professional Licensing Services
Cultural Education Center
Albany, NY 12230
(518) 474-3817

READ INSTRUCTIONS ON REVERSE SIDE BEFORE COMPLETING THIS FORM

OFFICE USE ONLY

DATE: 08/01/94
LIC NO: 179138
NM: HAS8
DOB: [redacted]
SSN: [redacted]
FEE: 193
PR: 60 OFF: 1
YR: 95 TYPE: RR
PY:
CA: Y

HASKELL W MARTIN
[redacted]
CINCINNATI OH [redacted]

7

This application may ONLY be used by the person whose name appears above.

1. (a) Since you last registered, has any state other than New York instituted charges against you for professional misconduct, unprofessional conduct, incompetence or negligence or revoked, suspended, or accepted surrender of a professional license held by you?

(b) Since you last registered, have you been convicted of any crime (felony or misdemeanor) in any state or country or have you been charged with any crime the disposition of which was other than acquittal or dismissal?

(c) Since you last registered, 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terminated your professional training, employment, or privileges, or have you voluntarily or involuntarily resigned or withdrawn from such association to avoid imposition of such action due to professional misconduct, unprofessional conduct, incompetence or negligence?

[redacted]

2. Do you wish to register in New York State for the period indicated?
(Registration is required to practice your profession or use your professional title within New York State.)

3. Are you currently practicing in New York State?
If no, provide month and year last practiced. HAVE NOT ESTABLISHED IN N.Y. Mo Yr.

4. Date of Birth: [redacted] Mo. Day Yr.

5. Social Security #: [redacted]
If Social Security # has not been provided, check appropriate box below
☐ number applied for or pending ☐ explanation attached

6. Federal Employer Identification Number: ☐☐—☐☐☐☐☐☐☐
(applicable only if you are an employer required to report employment taxes to the I.R.S.)

7. Your profession must comply with a one-time requirement for two hours of coursework or training in the recognition and reporting of child abuse and maltreatment. Your registration will not be processed until this requirement has been satisfied. Your current status with regard to this requirement is noted to the right. SEE REVERSE SIDE

X or R - Requirement has not been satisfied. You must submit either a Certificate of Completion or Exemption.
Y - Requirement has been satisfied. You do not have to submit any additional information.
E - Exemption has been granted. You do not have to submit any additional information.

CA: Y

8. You must comply with the statutory requirement for completion of approved course work in infection control and barrier precautions to prevent the transmission of HIV and HBV in healthcare settings. Questions may be referred to the Infection Control/Occupational Health Unit of the NYS Department of Health at (518) 473-8815.

9. Under penalties of perjury, I declare and affirm that the statements above are an accurate representation and that such statements, including any accompanying documentation and explanations, are true, complete and correct. I understand that any false or misleading information or statement, on, or in connection with, my application may be cause for disciplinary action, including the loss of my license.

[redacted] (Signature) 9/13/94 (Date)

DECEASED NOTIFICATION

If you are aware that the licensee is deceased, please complete and sign the following statement in order to permit us to change our records and to prevent future correspondence from being mailed.

The licensee whose name appears above is deceased. Approximate date of death was ___/___/___.

_____ (Signature) _____ (Relationship to deceased) ___/___/___ (Date)

FOLD

FOLD

PLS CAT 7 5/94

This is your application to register your professional license for the period indicated in the upper left corner of the application. Registration is required if you practice your profession or use your professional title within New York State.

If you do not expect to practice or use your professional title within New York State during the period indicated, you may voluntarily place your license on inactive status by checking "NO" to item 2 and returning the completed application without fee by the beginning of the new period. Please note: If you become inactive, a registration certificate 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 inactive.

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 fees for each month your license was not 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 each action.
   (b) If you answer "YES", submit a certified copy of the court records for each conviction. Do not check "YES" for minor traffic violations, charges that were dismissed or acquittals.
   For purposes of Item 1(c), section 29.2 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 plan to practice in New York State during the period. Registration is required if you 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 provide an explanation as indicated.

6. If you are an employer and hold a Federal Employer Identification Number, you must enter your employer identification number in the boxes provided.
   (The authority to collect this information is contained in Section 5 of the New York State Tax Law. It will be used for tax administration purposes.)

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 form required for reregistration. You SHOULD return the copy marked STATE EDUCATION DEPARTMENT COPY with your reregistration application. If you need to locate a provider, you should call Professional Licensing Services for assistance.
   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 children. If you believe you may qualify for such an exemption, call Professional Licensing Services to request an exemption application.

8. Please read the important information on the reverse side regarding a HIV/AIDS requirement in your profession

9. Read the affirmation, sign and date the application. If you are registering, the fee must be paid with a check or money order made payable to the NEW YORK STATE EDUCATION DEPARTMENT in U.S. funds only. DO NOT SEND CASH. Section 6502 (7) of the Education Law requires a $25.00 penalty fee be charged, in addition to the original fee owed, to anyone who submits a bad check for registration or licensure. Such replacement fees must be paid by certified check, bank check, or money order. If replacement fees are not submitted within 60 days of the notice of a bad check, section 29.3 (g) of the Regulations of the Commissioner of Education stipulates that the registration may be revoked.

- DECEASED NOTIFICATION: If you are aware that the licensee named on the application is deceased please complete the appropriate information on the front and return using the enclosed envelope
- NAME AND ADDRESS CHANGE: Use the enclosed card ONLY if you are reporting a change of name and or address
- When returning the application, please do not staple, tape or clip any of the materials together. Please print your profession and profession code on the front of the return envelope. The professions and codes are listed on page 4.

REGISTRATION APPLICATION

[redacted]

03/01/96 - 02/28/98

DATE: 10/02/95
[redacted]

- Make check or money order payable to New York State Education D[redacted]
- To help be sure that your registration is processed timely, please mail your [redacted] promptly. Receipt is requested at least 60 days' before the start of the new period shown above.
- This application may ONLY be used by the person whose name appears below.
- Please read instructions on reverse side before completing this form.

FEE: 3[redacted]
PR: 60 OFF: 1[redacted]
YR: 96 TYPE: RE
PY:
CA:

The University of the State of New York
THE STATE EDUCATION DEPARTMENT
Office of the Professions
Professional Licensing Services
Cultural Education Center
Albany, NY 12230
(518) 474-3817

[redacted] MARIE M MARTIN

[redacted] CINCINNATI OH [redacted]

7

- The above address is: [redacted]

1 (a) Since you last registered, has any state other than New York instituted charges against you for professional misconduct, [redacted] negligence, or revoked, suspended, or otherwise limited a professional license held by you?

(b) Since you last registered, have you been convicted of any crime (felony or misdemeanor) in any state or country, or have you been charged with any crime the disposition of which was other than acquittal or dismissal?

(c) Since you last registered, has any hospital or licensed facility restricted or terminated your professional training, employment, or privileges, or have you ever voluntarily or involuntarily resigned or withdrawn from such association to avoid imposition of such action due to professional misconduct, unprofessional conduct, incompetence or negligence?

2 Do you wish to register in New York State for the period indicated?
(Registration is required to practice your profession or use your professional title within New York State.)

3 Are you currently practicing in New York State?
If no, provide month and year last practiced. ____ / ____
Mo. Yr.

4-5 Enter Date of Birth and Social Security Number ONLY if it is missing or incorrect in the OFFICE USE ONLY BOX above.

4 Date of Birth: [redacted]
Mo. Day Yr.

5 Social Security Number: [redacted]
If Social Security number has not been provided, check appropriate box below:
☐ *number applied for or pending* ☐ *explanation attached*

6 Federal Employer Identification Number: [redacted]
(applicable only if you are an employer required to report employment taxes to the I.R.S.)

7 Your profession must comply with a one-time requirement for two hours of coursework or training in the recognition and reporting of child abuse and maltreatment. Your registration will not be processed until this requirement has been satisfied. Your current status with regard to this requirement is noted to the right. *See reverse side for details.*

> [redacted] Exemption has been granted. You do not have to submit any additional information.

8 You must comply with the statutory requirement for completion of approved course work in infection control and barrier precautions to prevent the transmission of HIV and HBV in healthcare settings. Questions may be referred to the Infection Control/Occupational Health Unit of the NYS Department of Health at (518) 473-8815. [redacted]

9 Under penalties of perjury, I declare and affirm that the statements above are an accurate representation and that such statements, including any accompanying documentation and explanations, are true, complete, and correct. I understand that any false or misleading information or statement in, or in connection with, my application may be basis for disciplinary action, including the loss of my license.

[redacted] 11 / 10 / 95
(Signature) (Date)

If you are aware that the licensee is deceased, please complete and sign the following statement in order to permit us to change our license records and to prevent future correspondence from being mailed [redacted]

THE LICENSEE WHOSE NAME APPEARS ABOVE IS DECEASED. Approximate date of death was ____ / ____ / ____.

(Signature) (Relationship to deceased) ____ / ____ / ____ (Date)

FOLD

PLS 99 Cat. for Medicine, 2nd

[redacted] negligence or revoked, suspended, or accepted surrender of a professional license held by you?

(b) Since you last registered have you been convicted of any crime (felony or misdemeanor) in any state or country or have you been charged with any crime the disposition of which was other than by acquittal or dismissal?

(c) FOR HEALTH PROFESSIONALS ONLY: Since you last registered, has any hospital or licensed facility restricted or terminated your professional training, employment, or privileges or have you ever voluntarily or involuntarily resigned or withdrawn from such association to avoid imposition of such action due to professional misconduct, unprofessional conduct, incompetence or negligence?

[redacted] NO

2. (a) Will you be practicing in NYS during the period indicated? ACTIVE

(b) IF NO, ARE YOU ☐ INACTIVE ☐ RETIRED ☒ PRACTICING OUTSIDE NYS

3. Last practiced in NYS Mo Yr

4. DATE OF BIRTH: [redacted] Mo Day Yr

5. Attached documentation regarding child abuse coursework:
☒ Certificate of Completion ☐ Certificate of Exemption

6. Social Security # [redacted]
If Social Security # has not been provided, check appropriate box below
☐ # applied for or pending
☐ Other (explain) _____

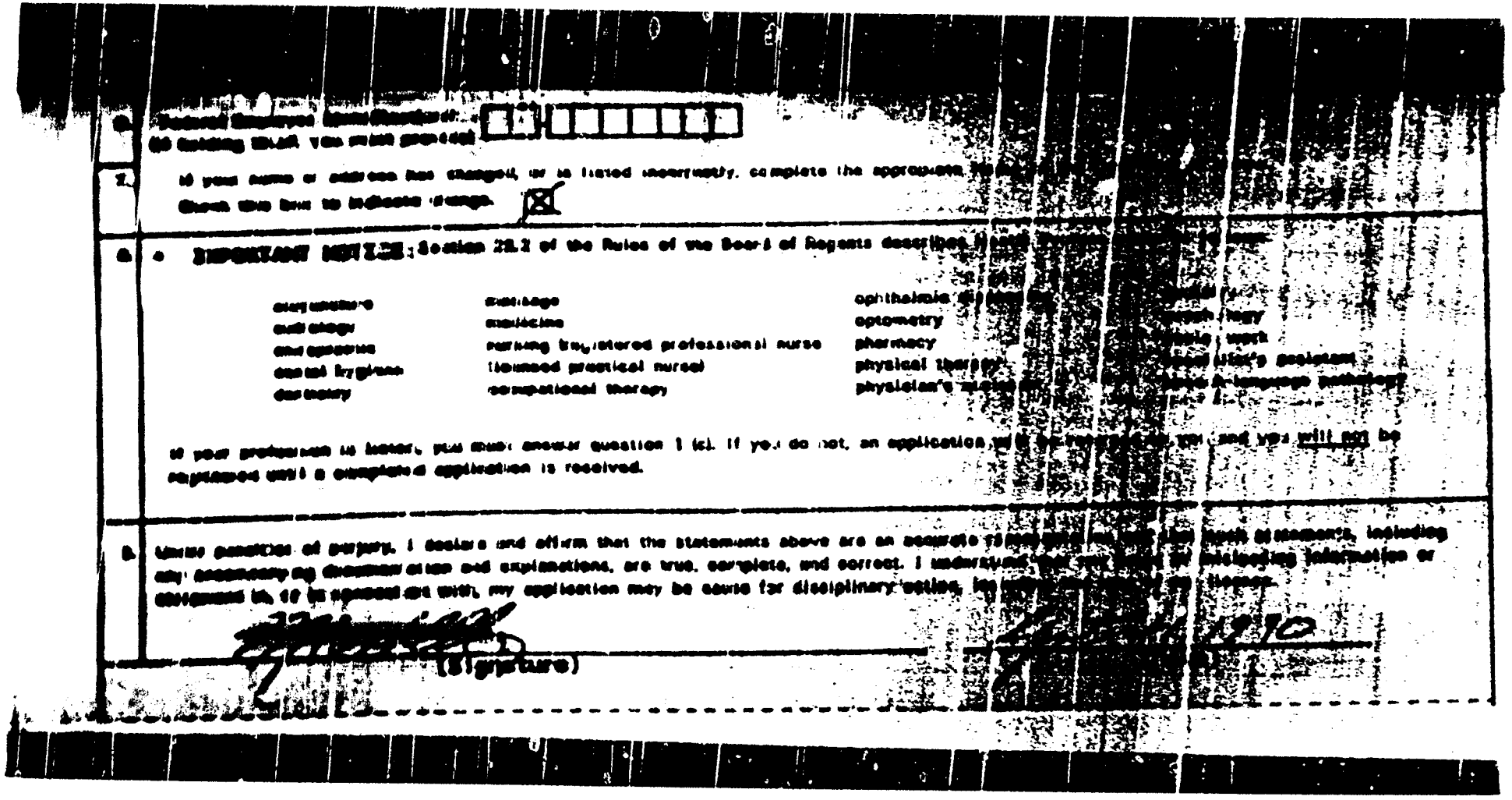
7. Federal Employer Identification #
(If you have Federal Employer Identification Number, you must provide)

8. Under penalties of perjury, I declare and affirm that the statements above are an accurate representation and that such statements, including any accompanying documentation and explanations, are true, complete and correct. I understand that any false or misleading information or statement in, or in connection with, my application may be cause for disciplinary action including the loss of my license.

SIGNATURE [redacted] DATE: 10/19/92

Fold Line

10/19/92



6. [illegible]

7. If your name or address has changed, or is listed incorrectly, complete the appropriate [illegible]. Check this box to indicate change. ☒

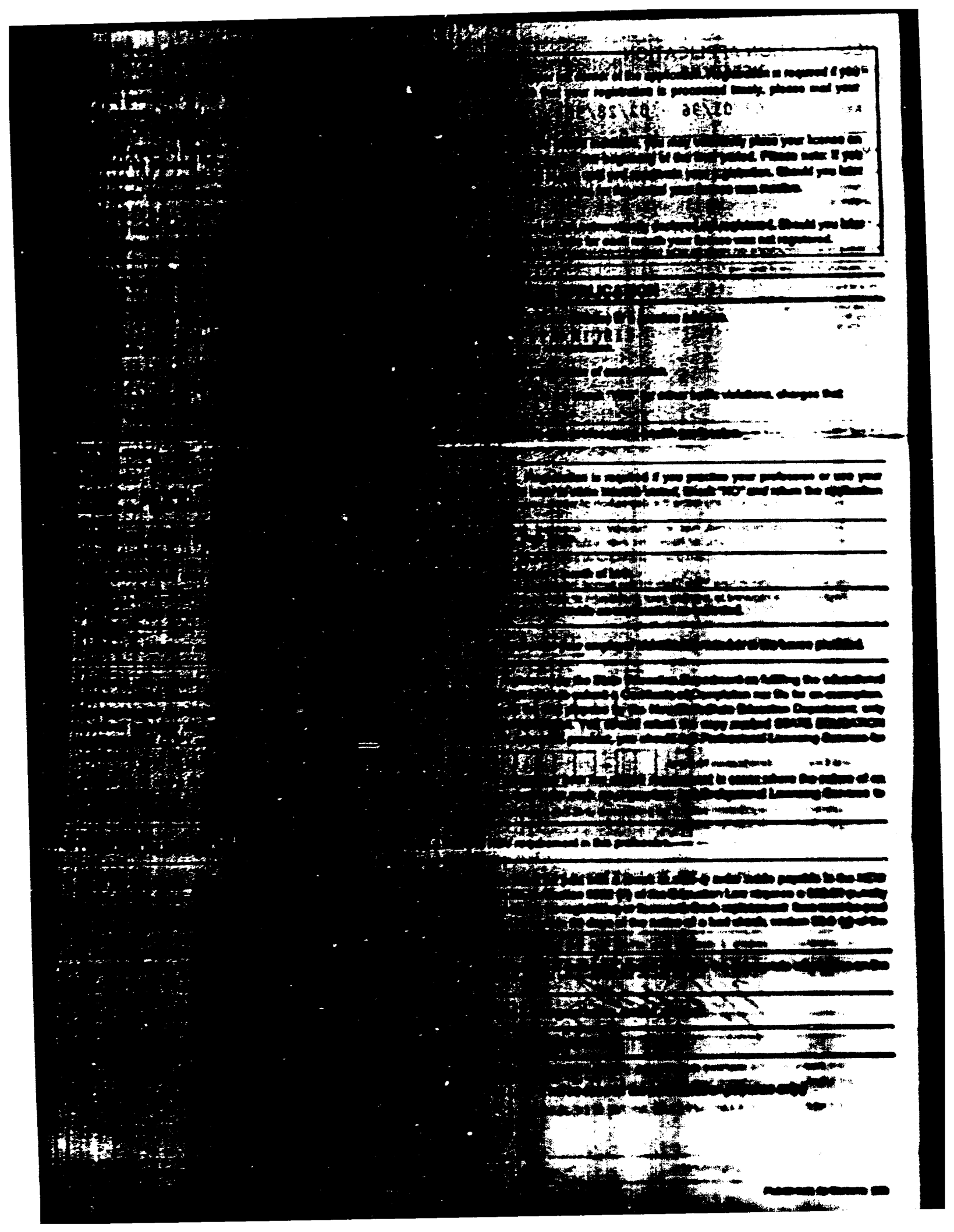
8. • IMPORTANT NOTICE: Section 29.2 of the Rules of the Board of Regents describes [illegible]

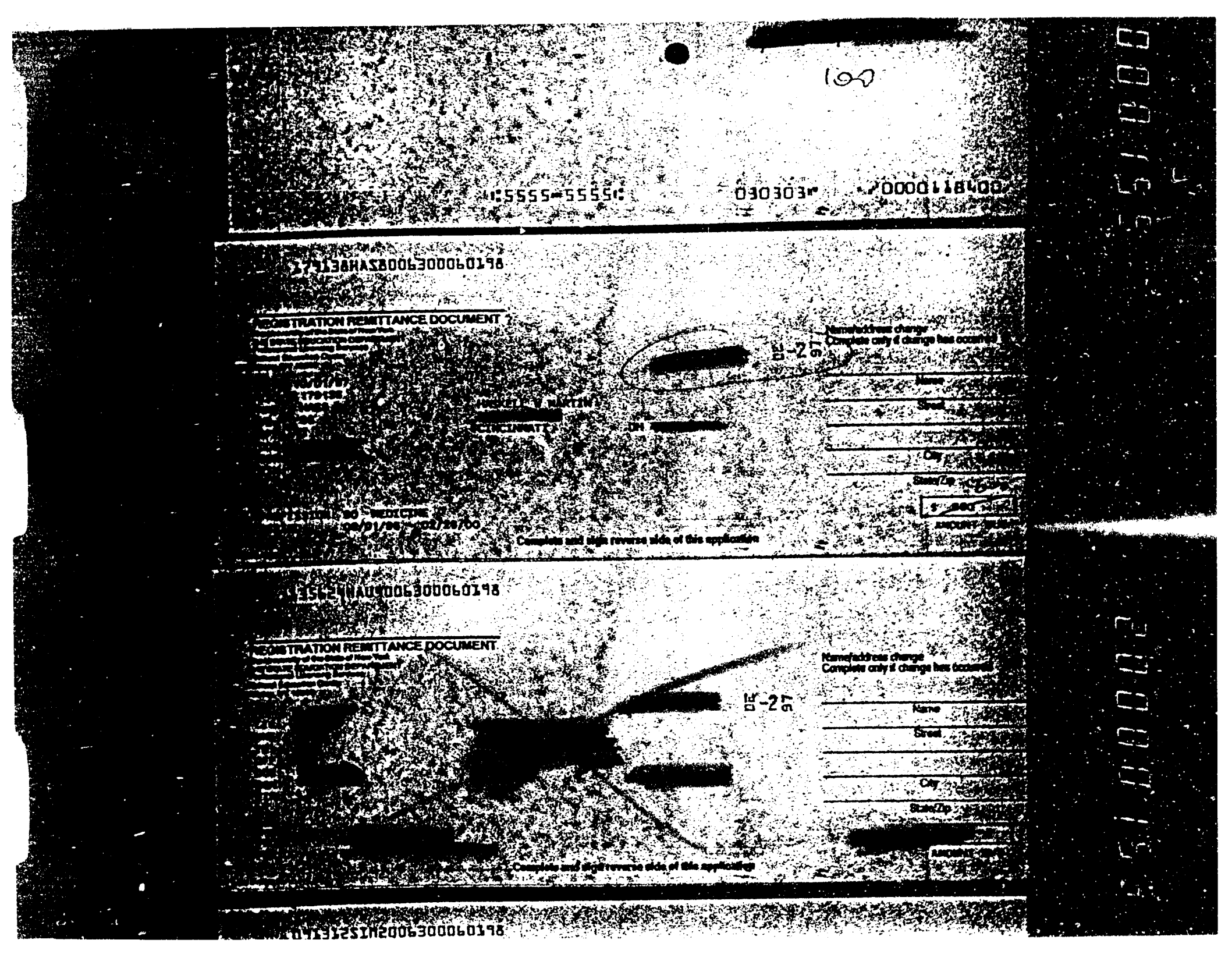
audiology	midwifery	ophthalmic dispensing
audiology	medicine	optometry
chiropractic	nursing (registered professional nurse	pharmacy
dental hygiene	licensed practical nurse)	physical therapy
dentistry	occupational therapy	physician's assistant

If your profession is listed, you must answer question 1 (c). If you do not, an application will be returned to you and you will not be registered until a completed application is received.

9. Under penalties of perjury, I declare and affirm that the statements above are an accurate [illegible] and that such statements, including any accompanying documentation and explanations, are true, complete, and correct. I understand that [illegible] misleading information or statements in or in connection with my application may be cause for disciplinary action, [illegible] thereof.

(Signature)





100

555-5555

030303

0000118400

27313&HAS&006300060198

DE -2 97

Name/address change
Complete only if change has occurred

Name

Street

City

State/Zip

$

Complete and sign reverse side of this application

35-2 HAU 006300060198

DE -2 97

Name/address change
Complete only if change has occurred

Name

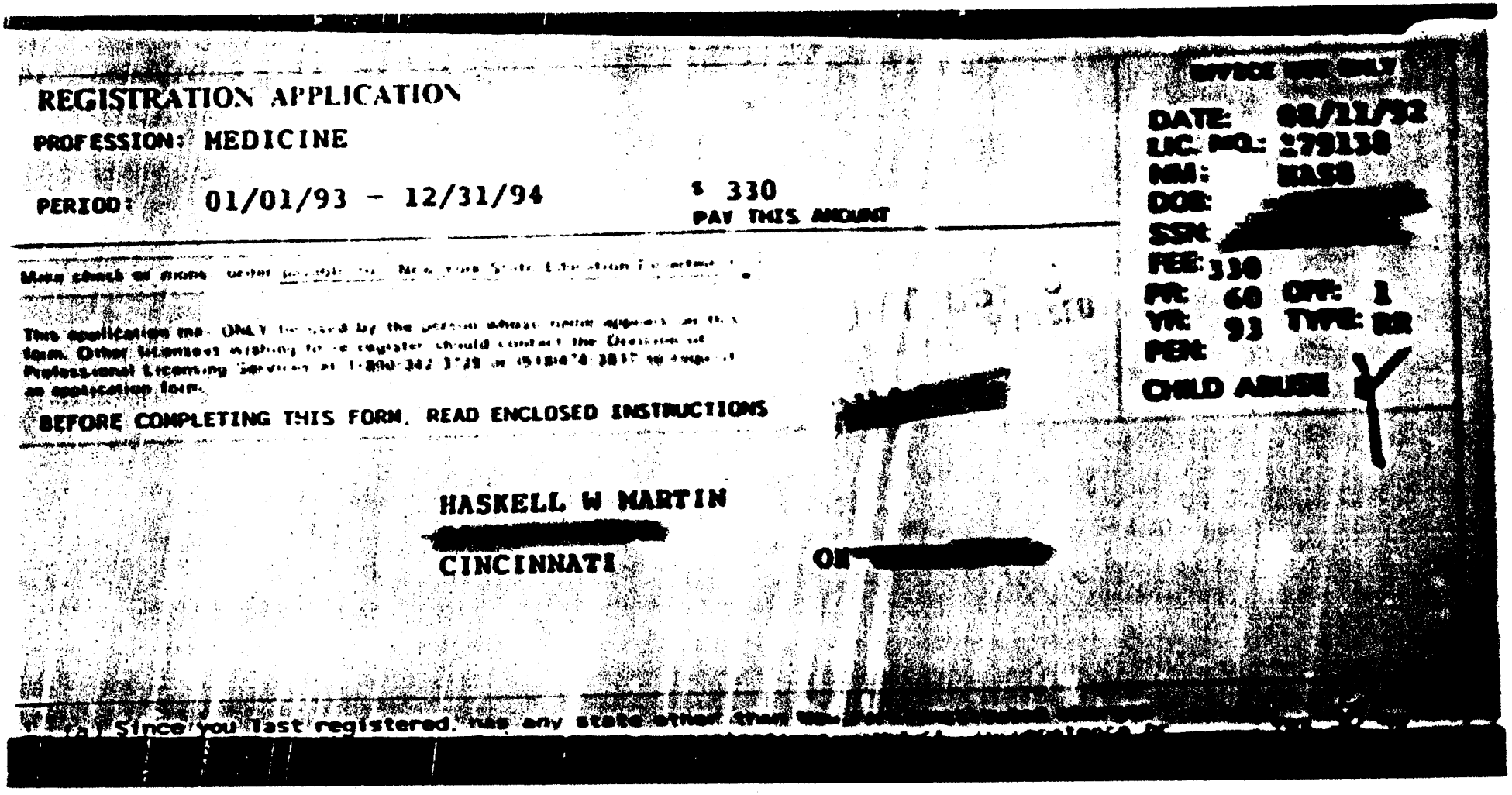
Street

City

State/Zip

Complete and sign reverse side of this application

006300060198



REGISTRATION APPLICATION

PROFESSION: MEDICINE

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

$ 330
PAY THIS AMOUNT

Make check or money order payable to: [illegible]

This application may ONLY be used by the person whose name appears on the form. Other licensees wishing to re-register should contact the Division of Professional Licensing Services at 1-800-342-3718 or (614)466-3834 to request an application form.

BEFORE COMPLETING THIS FORM, READ ENCLOSED INSTRUCTIONS

HASKELL W MARTIN

[redacted]

CINCINNATI OH [redacted]

OFFICE USE ONLY
DATE: 08/11/92
LIC. NO.: 79138
NAME: MASS
DOB: [redacted]
SSN: [redacted]
FEE: 330
PR: 60 OFF: 1
YR: 93 TYPE: MD
PEN:
CHILD ABUSE: Y

Since you last registered, has any state other than [illegible]

[redacted] (Date) [illegible]

[illegible] with any crime (felony or misdemeanor) in any state or country, the disposition of which [illegible]

[illegible] instituted charges against you for professional misconduct, unprofessional conduct, [illegible] revoked, suspended, or accepted surrender of a professional license held by you? [redacted]

[illegible] 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?

Are you under an obligation to pay child support?

If you are under such an obligation, do you meet one of the four requirements listed in the Child Support Law section below?

[illegible] under penalties of perjury, I certify that the statements in this application and any accompanying documentation are true, complete, and correct. I understand [illegible] any misrepresentation made in connection with my application may be cause for disciplinary action, including the loss of my license, and that willful [illegible] [illegible] continuing to practice my profession constitutes professional misconduct.

[redacted] (Date) [illegible]

Yes No

[illegible] with any crime (felony or misdemeanor) in any state or country, the disposition of which [illegible]

[illegible] instituted charges against you for professional misconduct, unprofessional conduct, [illegible] revoked, suspended, or accepted surrender of a professional license held by you? [redacted]

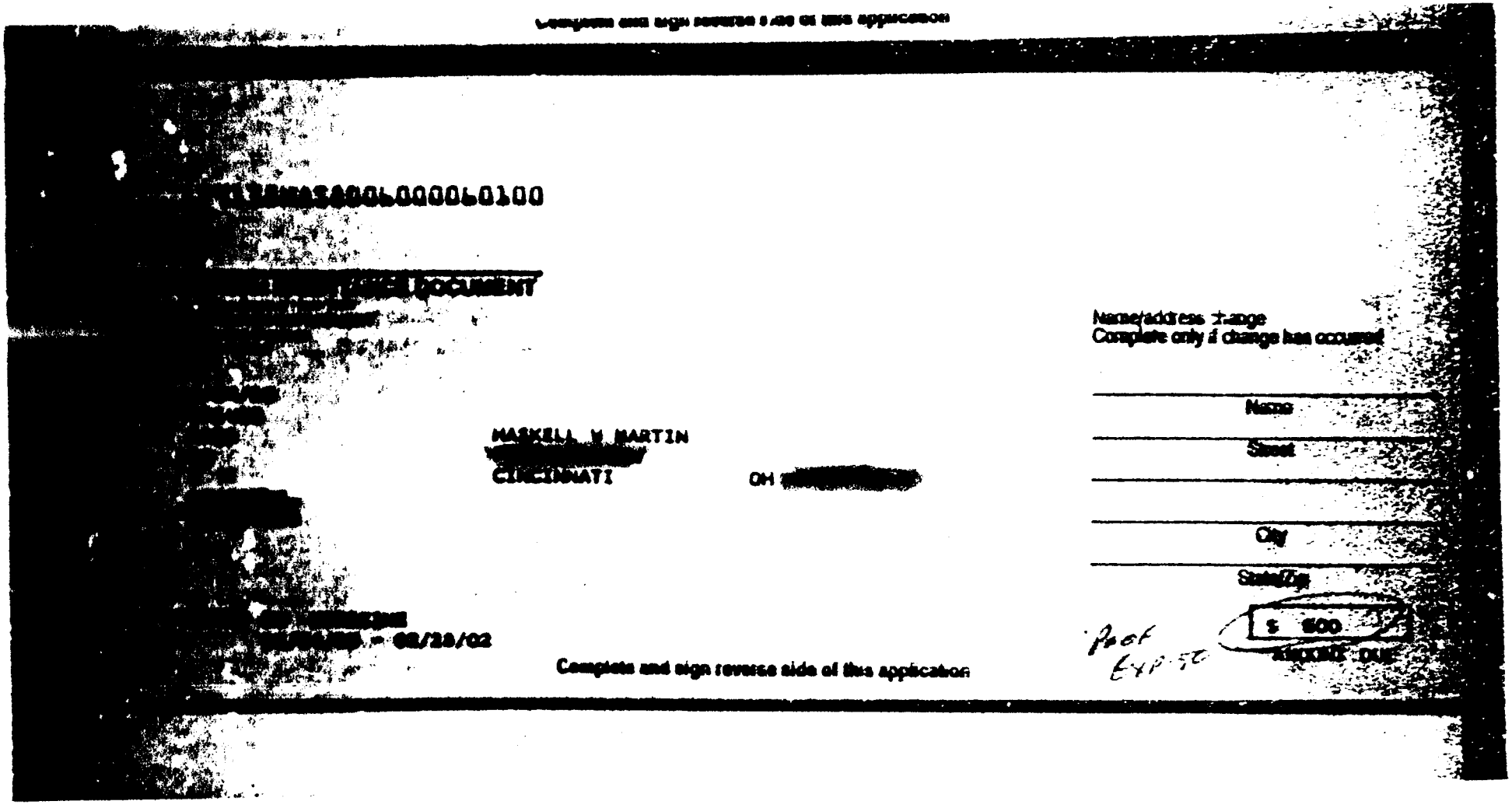
[illegible] any hospital or licensed facility restricted or terminated your professional training, employment, or privileges, or have you voluntarily or involuntarily resigned or withdrawn from such association to avoid the imposition of such action due to professional misconduct, unprofessional conduct, incompetency, or negligence?

Are you under an obligation to pay child support?

If you are under such an obligation, do you meet one of the four requirements listed in the Child Support Law section below?

[illegible] under penalties of perjury, I certify that the statements in this application and any accompanying documentation are true, complete, and correct. I understand [illegible] any misrepresentation made in connection with my application may be cause for disciplinary action, including the loss of my license, and that willful [illegible] register while continuing to practice my profession constitutes professional misconduct.

Signature [illegible] (Date) [illegible]



Complete and sign reverse side of this application

[redacted]000060100

[redacted] DOCUMENT

MASKELL W MARTIN
[redacted]
CINCINNATI OH [redacted]

[redacted] 08/28/02

Complete and sign reverse side of this application

Name/address change
Complete only if change has occurred

Name

Street

City

State/Zip

Prof Exp-50

$ 600

AMOUNT DUE

[redacted] Business phone [redacted] Date 12/[illegible]

X Yes ___ No

[illegible] for the period [illegible]
[illegible]
[illegible] convicted or charged with any crime (felony or misdemeanor) in any state or country, the disposition of which [illegible] acquitted or dismissed?

[redacted]

[illegible] any other state or country [illegible] charges against you for professional misconduct, unprofessional conduct, [illegible] or negligence, or revoked, suspended, or accepted surrender of a professional license held by you?

[illegible] hospital or licensed facility restricted or terminated your professional training, employment, or privileges, or have you [illegible] voluntarily resigned or withdrawn from such an association to avoid the imposition of such action due to professional [illegible], unprofessional conduct, incompetency, or negligence?

[illegible] under an obligation to pay child support?
[illegible] under such an obligation, do you meet one of the four requirements listed in the Child Support Law section below?

[illegible] U.S. citizen or a qualified alien as defined below?

[illegible] 001 0000050000
[illegible] 1999

DO NOT WRITE IN THIS BOX
FOR OFFICIAL USE ONLY

[illegible] of perjury, I certify that the statements in this application and any accompanying documentation are true, complete, and correct. I understand that [illegible] made in connection with any application may be cause for disciplinary action, including the loss of my license, and that willful failure to [illegible] practice my profession constitutes professional misconduct.

[signature] Business phone [redacted]

X Yes ___ No

LIC: [redacted]
NME: [redacted]
YR:
OFF:
DOB:
SSN:
EIN:

PROFESSION: [redacted]
[redacted]

Complete and sign reverse side of this application

Name
Street
City
[redacted]
AMOUNT DUE

[redacted]

179138HAS80060000060102

REGISTRATION RENEWAL DOCUMENT
THE STATE EDUCATION DEPARTMENT
Professional Licensing Services
[redacted]

10/01/01
LIC: 179138
NME: HASS
YR: 02
OFF: 1
DOB: [redacted]
SSN:
EIN:

HASKELL W MARTIN
[redacted]
CINCINNATI OH [redacted]

PROFESSION: MEDICINE
PERIOD: 03/01/02 - 02/28/04

Complete and sign reverse side of this application

Name/address change
Complete only if change has occurred

Name [redacted]
Street [redacted]
[redacted]
City [redacted]
State/Zip [redacted]
$ [redacted]
AMOUNT DUE

3899288UIA80600000060102

REGISTRATION RENEWAL DOCUMENT
THE STATE EDUCATION DEPARTMENT
Professional Licensing Services

Name/address change

...child support?

...under such as d'Aquino, do you meet one of the four requirements listed in the Child Support Law section below?

...U.S. citizen or a qualified alien as defined below?

...

DO NOT WRITE IN THIS BOX
FOR OFFICIAL USE ONLY

...the statements made in this application and any accompanying documentation are true, complete and correct. I understand that any ... misrepresentation made in connection with my application may result in criminal prosecution and may be cause for disciplinary action, ... including but not limited to suspension or revocation of my license to practice my profession constitutes professional misconduct.

...

...Business phone ...

...found guilty after trial, or pleaded guilty, no contest, or nolo contendere to a crime (felony or misdemeanor) in any court?

...licensing or disciplinary authority revoked, annulled, cancelled, accepted surrender of, suspended, placed on probation, or refused ... to renew a professional license or certificate held by you now or previously, or fined, censured, reprimanded or otherwise disciplined you?

...charges pending against you in any court?

...pending against you in any jurisdiction for any sort of professional misconduct?

...hospital or licensed facility revoked or terminated your professional training, employment, or privileges, or have you voluntarily ... resigned or withdrawn from such association to avoid the imposition of such action due to professional misconduct, ... incompetence, unprofessional conduct, malpractice, or negligence?

...under an obligation to pay child support?

...court order an obligation, do you meet one of the four requirements listed in the Child Support Law section below?

...U.S. citizen or a qualified alien as defined below?

...

DO NOT WRITE IN THIS BOX
FOR OFFICIAL USE ONLY

...the statements made in this application and any accompanying documentation are true, complete and correct. I understand that any ... misrepresentation made in connection with my application may result in criminal prosecution and may be cause for disciplinary action, ... including but not limited to suspension or revocation of my license to practice my profession constitutes professional misconduct.

...

...Business phone ...

...found guilty after trial, or pleaded guilty, no contest, or nolo contendere to a crime (felony or misdemeanor) in any court?

...licensing or disciplinary authority revoked, annulled, cancelled, accepted surrender of, suspended, placed on probation, or refused ... to renew a professional license or certificate held by you now or previously, or fined, censured, reprimanded or otherwise disciplined you?

...charges pending against you in any court?

...pending against you in any jurisdiction for any sort of professional misconduct?

[redacted]

M Trick.

179138HAS8006000060104

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

10/02/03
LIC: 179138
NME: HAS8
YR: 04
OFF: 1
DOB: [redacted]
SSN:
EIN:

HASKELL W MARTIN
[redacted]
CINCINNATI OH [redacted]

Name/address change
Complete only if change has occurred

Name
Street
City
State/Zip

$ 600
AMOUNT DUE

PROFESSION: 60 MEDICINE
PERIOD: 03/01/04 - 02/28/06

Complete and sign reverse side of this application

Cat 6 - 1001

	X Yes	No
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 nolo contendere to a crime (felony or misdemeanor) in any court?	[redacted]	
b. 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?		
c. Are criminal charges pending against you in any court?		
d. Are charges pending against you in any jurisdiction for any sort of professional misconduct?		
e. 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?		
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 requirements listed in the Child Support Law section below?		
4. Are you a U.S. citizen or a qualified alien as defined below?		

3244467
891 11032003 [redacted]

DO NOT WRITE IN THIS BOX
FOR OFFICIAL USE ONLY

I certify that the statements made in this application and any accompanying documentation are true, complete and correct. I understand that any misrepresentation or any false or misleading information made in connection with my application may **result in criminal prosecution and** may be cause for disciplinary action, including the loss of my license; and that the willful failure to register while continuing to practice my profession constitutes professional misconduct.

Signature [redacted] Business phone (513) 272-0002 Date 10/28/03

CM-6A (REV)

179138HAS8006000060106

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

10/03/05
LIC: 179138
NME: HAS8
YR: 06
OFF: 1
EIN:

HASKELL W MARTIN
[redacted]
CINCINNATI OH [redacted]

Name/address change
Complete only if change has occurred

Name
Street
City
State/Zip

$ 800
AMOUNT DUE

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

Complete and sign reverse side of this application

Cat 21P-032204

	X Yes	No
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 nolo contendere to a crime (felony or misdemeanor) in any court?	[redacted]	[redacted]
b. 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?		
c. Are criminal charges pending against you in any court?		
d. Are charges pending against you in any jurisdiction for any sort of professional misconduct?		
e. 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?		
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 requirements listed in the Child Support Law section below?		
4. Are you a U.S. citizen or an alien admitted for permanent residence in the U.S.?		

[redacted]

DO NOT WRITE IN THIS BOX
FOR OFFICIAL USE ONLY

I certify that the statements made in this application and any accompanying documentation are true, complete and correct. I understand that any misrepresentation or any false or misleading information made in connection with my application may result in criminal prosecution and may be cause for disciplinary action, including the loss of my license; and that the wilful failure to register while continuing to practice my profession constitutes professional misconduct.

Signature [redacted] Daytime phone [redacted] Date 10/31/05

Cal21R:2/07/04

OFFICE OF THE PROFESSIONS

Registration Renewal - Transaction Summary

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

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
[redacted]
CINCINNATI OH [redacted]

Renewal Status : **Paid On-line - Renewal Complete**

Offices Selected for Renewal:

	Address	Fee
1)	[redacted] CINCINNATI, OH, [redacted]	$ 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?	[redacted]
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?	[redacted]
3) Are criminal charges pending against you in any court?	[redacted]
4) Are charges pending against you in any jurisdiction for any sort of professional misconduct?	[redacted]
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?	[redacted]
6) Are you under an obligation to pay child support?	[redacted]
7) Are you a U.S. citizen?	[redacted]

License Renewal Payment Details:

Receipt No	[redacted]
Payment Date	: 10/13/2009
Amount Paid	: $ 600

OFFICE OF THE PROFESSIONS

Registration Renewal - Transaction Summary

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

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
[redacted]
CINCINNATI OH [redacted]

Renewal Status : **Paid On-line - Renewal Complete**

Offices Selected for Renewal:

	Address	Fee
1)	[redacted] CINCINNATI, OH, [redacted]	$ 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?	[redacted]
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?	[redacted]
3) Are criminal charges pending against you in any court?	[redacted]
4) Are charges pending against you in any jurisdiction for any sort of professional misconduct?	[redacted]
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?	[redacted]
6) Are you under an obligation to pay child support?	[redacted]
7) Are you a U.S. citizen?	[redacted]

License Renewal Payment Details:

Receipt No [redacted]
Payment Date : 11/03/2011
Amount Paid : $ 600

Md 5/24/89 — NR fld Reg, 2A, 2PGT, NB, add #40ER file

FORM 1
MEDICINE

ALL CANDIDATES MUST COMPLETE THIS FORM

THE UNIVERSITY OF THE STATE OF NEW YORK
THE STATE EDUCATION DEPARTMENT
OFFICE OF PROFESSIONAL LICENSING SERVICES

APPLICATION FOR LICENSE AND FIRST REGISTRATION

COMPLETE BOTH SIDES OF THIS APPLICATION

Department Use Only

FEE $ CASH

172965

#53014 - 6-7-89 60

1. [redacted] Social Security Number
2. HAS First 3 letters of Last Name
3. BIRTH DATE [redacted] mo day yr

4. PRINT FULL NAME EXACTLY AS YOU WISH IT TO APPEAR ON YOUR LICENSE, IF DETERMINED ELIGIBLE (IMPORTANT: A request that contains only initials and the surname cannot be honored.)

Last: HASKELL
First: W
Middle: MARTIN

445 LX
☑ 335 ER
☐

N.Y.S. License Number [redacted] 7/25/89 HK

QUALS.
APPROVED

5. ADDRESS (check only one) ☒ permanent address of record ☐ temporary mailing address*

Care of:
Street (Bldg. & Apt. etc.): [redacted]
City: CINCINNATI
State: OHIO ZIP Code: [redacted]

6. TELEPHONE
At home [redacted] area code number
At work [redacted] area code number

7. CITIZENSHIP ● United States ● Alien Lawfully admitted for permanent residence in the United States.
Citizen of _____

8. Name as it appears on diploma or other credentials: William Hoyt Martin HASKELL
9. Have you previously applied for a New York State Medical license or a limited permit
10. Have you ever been convicted of a crime (felony or misdemeanor) in any state or country?
11. Have you ever been charged with a crime (felony or misdemeanor) in any state or country, the disposition of which was other than by acquittal or dismissal?
12. Have you ever surrendered your license or been found guilty of professional misconduct, unprofessional conduct, incompetence or negligence in any state or country?
13. Are charges pending against you for professional misconduct, unprofessional conduct, incompetence or negligence in any state or country?
14. Has any hospital or licensed facility restricted or terminated your professional training, employment, or privileges or have you ever voluntarily or involuntarily resigned or withdrawn from such association to avoid imposition of such manner?

[redacted]

- If the answer to questions 10--14 is "Yes," submit a letter giving a complete explanation as applicable, also include copies of your court records and a copy of the "Certificate of Relief from Disabilities" or your "Certificate of Good Conduct."

15. I wish to be licensed in New York State on the basis of:

☒ National Board Examination (See Licensure Requirements – Sec. IV)
☐ National Board Examination/Osteopath (See Licensure Requirements – Sec. IV)
☐ Admission to the licensing examination in New York State (See Licensure Requirements – Sec. IV)
Give Date of Flex examination requested (Month and Year) _____
Requested exam center: ☐ New York City Area, (incs. Long Island) ☐ Albany Area ☐ Buffalo Area
☐ Acceptance of Federation Licensing Examination (FLEX) taken outside New York State.
Give dates and locations of all FLEX examinations taken. _____
My FLEX identification Number (FIN) is: _____
☐ Endorsement of license from another State or Country.
Name State or Country _____
Other _____
☐ 5th Pathway (Section 6528 of the Education Law.)

August 198*

• COMPLETE OTHER SIDE •

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

Name of Medical School Attended and Location	Number of Years Attended	Class Completed	ATTENDANCE		Diploma or Degree Obtained (if school is located Outside the United States, attach a copy)
			Entrance Date	Leaving Date	
School Univ. of Alabama Medical College 1717 Eleventh Ave S. University Station Birmingham AL 35294	4	MD	9/68	6/72	Doctor of Medicine

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

State or Country	Date License Issued	Number	Basis of Licensure			Any Limitations on License
			Examination (Date Passed)	Endorsement	Other	
Ohio	1974	037358	Nat'l Bd. 1973	NAME		NONE
Alabama	1973	~~NOT~~ 6284	Nat'l Bd 1973	NAME		NONE

'89 MAY 18 1:33

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.

X [redacted] 5/3/89
Signature of Candidate Date

[redacted]

Date of Photograph 5/89

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

F

P2/87

THE UNIVERSITY OF THE STATE OF NEW YORK
THE STATE EDUCATION DEPARTMENT
DIVISION OF PROFESSIONAL LICENSING SERVICES
CULTURAL EDUCATION CENTER
ALBANY, NEW YORK 12230

710 00 3635
ON DEPOSIT ONLY NYSED
CASH NO.: W

JN-7 89

WHEN RESPONDING, PLEASE INCLUDE NAME, ADDRESS, PROFESSION, SSN, AND A DAY PHONE#.
DATE: 05/25/89
PROFESSION: 20
SOC SEC NO: [redacted]

HASKELL W MARTIN
[redacted]
CINCINNATI OH [redacted]

DEAR APPLICANT:

THE STATUTORY PROFESSIONAL LICENSING FEES HAVE BEEN AMENDED BY THE NEW YORK STATE LEGISLATURE. ALL FEES RECEIVED ON OR AFTER APRIL 27, 1989, MUST BE AT THE NEW RATE. THE FEES YOU SUBMITTED ARE LESS THAN THE AMOUNT REQUIRED UNDER THIS NEW SCHEDULE, AND WE MUST REQUEST THE ADDITIONAL AMOUNT SHOWN BELOW:

CURRENT FEE: $175 AMOUNT OBLIGATED: $335
BALANCE DUE: $ 40

PLEASE MAKE YOUR CHECK OR MONEY ORDER PAYABLE TO THE NEW YORK STATE EDUCATION DEPARTMENT. NOTE: PAYMENT SUBMITTED FROM OUTSIDE THE UNITED STATES MUST BE MADE BY CHECK OR DRAFT PAYABLE ON A UNITED STATES BANK AND IN UNITED STATES DOLLARS. NO OTHER FORM CAN BE ACCEPTED AND WILL BE RETURNED. DO NOT SEND CASH.

TO ASSURE PROMPT CREDITING TO YOUR RECORD, PLEASE RETURN THIS FORM ALONG WITH YOUR CHECK OR MONEY ORDER USING THE TWO-WAY ENVELOPE, OR TO THE ADDRESS SHOWN BELOW:

[illegible] SECTION
DIVISION OF PROFESSIONAL LICENSING SERVICES
CULTURAL EDUCATION CENTER
ALBANY, NEW YORK 12230

60
HASKELL W
40 ER
375

FORM 2
MEDICINE

THE UNIVERSITY OF THE STATE OF NEW YORK
THE STATE EDUCATION DEPARTMENT
DIVISION OF PROFESSIONAL LICENSING SERVICES

CANDIDATE EDUCATION AND TRAINING RECORD

ALL CANDIDATES MUST COMPLETE THIS FORM.

1. [redacted] Social Security Number
2. H A S First 3 letters of Last Name
3. BIRTH DATE [redacted] mo. day yr.

4. PRINT FULL NAME EXACTLY AS YOU WISH IT TO APPEAR ON YOUR LICENSE, IF DETERMINED ELIGIBLE. (IMPORTANT: A request that contains only initials and the surname cannot be honored.)

Last: H A S K E L L
First: D
Middle: M A R T I N

5. ADDRESS Street, Bldg. & Apt. etc.
Street: [redacted]
City: C I N C I N N A T I
State: O H I O
ZIP Code: [redacted]

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.

SCHOOLS ATTENDED-Location Write names of schools in original language and translate.	NUMBER OF YEARS ATTENDED	ATTENDANCE				Diploma or degree obtained Quote titles in original language and translate.
		Entrance		Leaving		
		Class	Date	Class Completed	Date	
Elementary or Primary School Chandler Elem.	4	1	9/52	3	6/55	(Proof of completion need not be submitted
Hartman Elem.	3	4	9/55	6	6/58	
Secondary or High School Hartman Elem. to Hoyt	3	7	9/58	9	6/61	(Proof of completion need not be submitted
Withrow High	3	10	9/61	12	6/64	
Post Secondary Pre-Professional (Exclusive of Medical School) Ohio Wesleyan Univ	4	1	9/64	3	6/68	Candidates using Form 2A need not verify preprofessional training. Candidates using Form 2N must arrange that verification of preprofessional training be submitted directly from the school.
Medical Education (Professional) (List *all* Medical Schools Attended) Univ. of Cincinnati	4	1	9/68	4	6/72	(See Form 2A or 2N for verification requirements)

• COMPLETE OTHER SIDE •

August 1987

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

Inclusive Clerkship Dates	Clinical Area	Name of Health Care Facility and Address	Medical School In Which Taken/Address

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

FROM Month	FROM Year	TO Month	TO Year	Type of Professional Activity, Including Name and Address of Employer, Beginning with Date of Graduation from Professional School
7	72	6	73	Univ of Alabama - Anesthesia Internship
6	73	5	75	Private Practice with Dr Jack Dozier, Fulton, AL
7	74	7	74	Private Practice, Thuss Clinic, Birmingham, AL
7	74	12	75	Univ. of Cincinnati - General Surgery Residency
12	75	7	76	Emergency Room Physician, Marion General Hospital, Marion, Ohio
7	76	6	78	Univ of Cincinnati - Family Practice Residency
7	77	6	78	Univ. of Cincinnati - Chief Resident
6	78	12	79	Emergency Room Director - Jewish Hospital, Cincinnati, OH
1	80	Present		Private Practice, Self-Employed

10. Professional Certificates/Other Examinations

MSKP	Date:	Score:	Certificate No.:	
Proficiency Examination	Name:	Date Medicine Passed	Date English Passed	Certificate No.

Specialty Boards (if more space is needed attach on separate sheet).
AMERICAN Board of Family Practice - 1978

Fifth Pathway	Name and Location of Medical School	Name and Location of Hospital	Inclusive Dates of Attendance

80 MAY 18 P1:33

If more space is needed, please attach additional sheets of paper.

Return this Form *together with* Form 1, Form 1D, and fee to:

Fee Section, Division of Professional Licensing Services,
Cultural Education Center, Albany, New York 12230

[redacted]

REGISTRATION APPLICATION PERIOD: 01/01/81 - 12/31/82

$ 330.00
PAY THIS AMOUNT

[illegible]

710.00
FOR DEPOSIT ONLY
UG9 6
RS
#95

□ YES ☒ NO

OFFICE USE ONLY
NYSEB 08/27/90
LIC. NO 179138
NM CHK HAS8
DOB [redacted]
SSN [redacted]
FEE 330
PR 60 OFF 1
YR 91 TYPE RR
PEN

[illegible] M MARTIN

[redacted]

CINCINNATI OH [redacted]

Date of birth [redacted]

Social Security [redacted]

PRIVACY NOTIFICATION: The authority to request personal information from you, [illegible] numbers such as Federal Social Security and Federal Employer [illegible] and the authority to maintain such information is found in Section [illegible] of this information by you is mandatory, and will be used [illegible]

FORM 2A
MEDICINE

THE UNIVERSITY OF THE STATE OF NEW YORK
THE STATE EDUCATION DEPARTMENT
DIVISION OF PROFESSIONAL LICENSING SERVICES

Graduates of N.Y.S. Registered or LCME Accredited Programs must complete this form.

CERTIFICATION OF PROFESSIONAL EDUCATION: REGISTERED OR ACCREDITED PROGRAMS

'89 MAY 19 A10:20

CANDIDATE INSTRUCTIONS

1. Complete Section I. Enter your name as it appears on your Application (Form 1).
2. Send this form to the professional school you attended. See "Licensure Requirements" for additional instruction. Be sure to include any fee required.
3. Certification is not acceptable unless dated after graduation.

SECTION I: CANDIDATE INFORMATION

1. [redacted] Social Security Number
2. H [redacted] First 3 letters of Last Name
3. BIRTH DATE [redacted] mo. day yr.

4. PRINT FULL NAME EXACTLY AS YOU WISH IT TO APPEAR ON YOUR LICENSE, IF DETERMINED ELIGIBLE. (IMPORTANT: A request that contains only initials and the surname cannot be honored.)

Last: HACKELL
First: W.
Middle: MARTIN

5. ADDRESS (Number & Street or P.O. Box): [redacted]
Email: [redacted]
City: CINCINNATI
State: OHIO
ZIP Code: [redacted]

6. Service of licensure sought (Form 1, #15): ☒ National Board, ☐ N.Y.S. Exam.; ☐ FLex Outside NYS; ☐ Endorsement

7. Print name under which degree or diploma was awarded:
William Hudd Martin Hackell
(Name)

8. High School Attended: Shades Valley High School, Birmingham, AL
(Name)

9. Professional school attended: Univ. of Alabama, Birmingham
(Name)
Address: Med. Coll. Univ. Station, Birmingham, AL Date degree was awarded 6/72

• CERTIFICATION BY PROFESSIONAL SCHOOL OFFICIAL •
IS TO BE MADE ON REVERSE SIDE

SECTION 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.

CERTIFICATION BY N.Y.S. REGISTERED OR LCME ACCREDITED MEDICAL SCHOOL

Preprofessional Education:

(1) Satisfactorily completed, prior to matriculation in professional school the following preprofessional education:

Ohio Wesleyan University, Delaware, Ohio
Print Name of Institution

June 1964 — June, 1968
Dates of Attendence — Degree Granted

Professional Education

(1) Was admitted to The University of Alabama School of Medicine, Birmingham, Alabama
Print Name of Medical School

on 09 (Month) 03 (Day) 68 (Year) and on 06 (Month) 04 (Day) 72 (Year)

Satisfactorily completed the program and was awarded the degree of

Doctor of Medicine
Print Name of Degree Awarded

[redacted]

If the applicant was credited with advanced standing based on prior academic work, give institution name and dates of attendence.

Name of Institution:

Dates of Attendence

Attach the following to this form:

(1) Official transcript of studies at your institution.
(2) Copies of documentation in your file to support the granting of transfer credit.

Name [redacted]
(original signature)

Travis J. Tindal, Ed.D.
(Type or print above name

(COLLEGE SEAL)

Title Co-Director, Medical Student Services and Registrar

Medical School The University of Alabama School of Medicine
Birmingham, Alabama

Date May 15, 1989

Certification is not acceptable unless dated after graduation.

RETURN TO: Division of Professional Licensing Services, Medical Unit, Cultural Education Center, Albany, New York 12230

FORM 2PGT
MEDICINE

THE UNIVERSITY OF THE STATE OF NEW YORK
THE STATE EDUCATION DEPARTMENT
DIVISION OF PROFESSIONAL LICENSING SERVICES

ALL CANDIDATES MUST COMPLETE THIS FORM.

CERTIFICATION OF APPROVED POST GRADUATE TRAINING

Any certification signed and submitted earlier than one month prior to the completion of the training period will be returned to the hospital by the division without processing.

CANDIDATE INSTRUCTION

1. Complete Section I. Enter your name as it appears on your Application. (Form 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.
3. If you have completed more than 3 residencies, you may have the director of medical education complete a photocopy of the form.
4. This form must be sent directly to this office by the hospital in which you did your residency. If the hospital in which you did your residency does not have a director of medical education, the forms may be completed by the department chief.

SECTION I: CANDIDATE INFORMATION

1. [redacted] Social Security Number
2. HAS First 3 letters of Last Name
3. BIRTH DATE [redacted]

4. PRINT FULL NAME EXACTLY AS YOU WISH IT TO APPEAR ON YOUR LICENSE, IF DETERMINED ELIGIBLE. (IMPORTANT: A request that contains only initials and the surname cannot be honored.)

Last: HASKELL
First: W
Middle: MARTIN

SECTION II: CERTIFICATION OF POST GRADUATE TRAINING

This is to certify that W. Martin Haskell, M.D. (Physician's Name)

a graduate of University of Alabama Medical School (Medical School)

was enrolled in a residency training program approved by the Accreditation Council on Graduate Medical Education or the American Osteopathic Association at University of Alabama Hospital (Name of Hospital)

619 South 19th Street, Birmingham, AL 35233 (Location of Hospital)

from June 22, (Date) 1972 thru June 22, (Date) 1973 in the clinical area of

Rotating Intern (Clinical Area) and that the

above named physician successfully completed this training on June 22, 1973 (Date)

If this physician did not successfully complete the post graduate training program, please attach a letter of explanation with this form.

I am the ~~Director of Medical Education or Departmental Chief of the clinical area~~ Administrator. ~~I was the program director for the physician named above during the post graduate training indicated and have carefully read and completed this form~~ and hereby attest that the statements made herein are strictly true in every respect and are supported by hospital records.

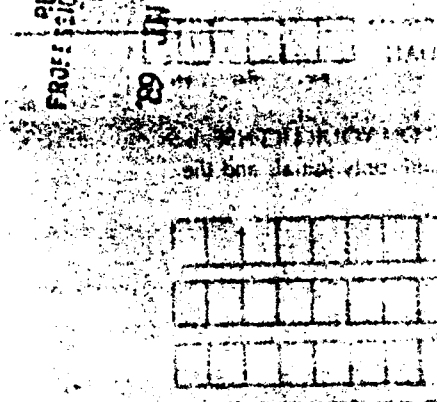
~~Signature of Director/Chief~~ Administrator [redacted] Date 5/31/89

~~Print Name of Director/Chief~~ Administrator JAMES E. MOON, Ph.D.

Print Title Administrator

• RETURN TO: Division of Professional Licensing Services, Medical Unit, Cultural Education Center, Albany, New York 12230

August 1987



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

SEAL

John P. Hubbard
President of the Board

Philadelphia, Pa.
July 2, 1973

Certificate # 126488

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 03-02-1946. 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 [redacted]	06/70		
Anatomy			
Physiology			
Biochemistry			
Pathology			
Microbiology			
Pharmacology			
Behavioral Sciences			
TOTAL TEST (Minimum Passing Score 380/75			
PART II [redacted]	04/72		
Internal Medicine			
Surgery			
Obstetrics and Gynecology			
Public Health and Preventive Medicine			
Pediatrics			
Psychiatry			
TOTAL TEST (Minimum Passing Score 290/75			
PART III [redacted]	03/73		
A General Test of Clinical Competence			
TOTAL TEST (Minimum Passing Score 290/75			
GENERAL AVERAGE (Parts, I, II, and III Scale Score)			

JU 24 P2:47

*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.

[redacted]

SEAL

[redacted]