



STATE OF TENNESSEE
DEPARTMENT OF HEALTH
DIVISION OF HEALTH LICENSURE AND REGULATION
OFFICE OF HEALTH RELATED BOARDS
665 Mainstream Drive
Nashville, TN 37243
tennessee.gov/health

TENNESSEE BOARD OF MEDICAL EXAMINERS
1-800-778-4123

September 23, 2014

GARY C BOYLE, MD
2901 WEST STATE STREET
BRISTOL TN 37620

TO WHOM IT MAY CONCERN:

The Tennessee Board of Medical Examiners is pleased to furnish the following information from our files:

PROFESSION: Medical Doctor
NAME: GARY C BOYLE
RANK: Medical Doctor
LICENSE NUMBER: MD11935
ISSUE DATE: 06/25/1979
EXPIRATION DATE: 02/29/2016
CURRENT STATUS: Licensed
STATUS DATE: 06/25/1979

COMMENTS: There is no derogatory information in our files concerning this individual. The State of Tennessee only provides the above information. Any other information needed must be obtained from the licensee.

Sincerely,

Board Administrator
Tennessee Board of Medical Examiners

MD/LV1



To expedite the verification process, the above is the standard format used by the Medical Board of Tennessee.

~~0000-0000~~

APPLICATION FOR A CERTIFICATE
UNDER INTERSTATE RECIPROcity AGREEMENT

Fee paid



PAR: _____ Date July 24, 1978

Or Certificate No. 26084 issued by Virginia

Stat: _____ Medical Examiners on the 8th day of August, 19 75

I hereby request a License Certificate to practice Medicine and Surgery in Tennessee and submit the following statement of facts and proof in support of same:

1. Name in full Gary Clayton Boyle Date of birth 2/23/48

2. Place of birth Atlanta, Georgia U.S. Citizen: Yes No

3 Present address 1128 Terrace Circle, North Augusta, South Carolina 29841

4. Intended address in Tennessee Bristol, Tennessee

5. Has your application for examination or license been rejected by any Board of Medical Examiners?
No

If yes, by what Board and for what reason? _____

6. Have you failed an examination before any Board of Medical Examiners? No

If yes, name the Board and give date of examination _____

7. Give names of States in which you are now licensed or have ever been licensed and give dates. _____

Virginia and South Carolina - 1975, North Carolina - 1978

8. Has any State Medical Board revoked or suspended a license certificate issued to you? No

If yes, name the Board and state why such action was taken _____

9. Are you now, or have you ever been directly or indirectly associated with an advertising physician or any advertising medical office? If you have, state when and where No

10. Have you been rejected by a Medical Society? No. If so, why, and by what Society? _____

11. Have you ever been addicted to narcotics or intoxicants, charged with, or convicted of violation of any State or Federal Narcotic or Dangerous Drug laws or of any State or Federal Statute? No

If so, give particulars in a separate letter.

12. Have you ever been convicted of a felony? No. If so, give particulars in a separate letter.

PRELIMINARY AND PRE-MEDICAL EDUCATION

Name of School or College	Date Attended	Certificate or Degree
1. <u>University of Richmond</u>	<u>1966 - 1968</u>	
2. <u>VPI</u>	<u>1968</u>	
3. <u>VCU</u>	<u>1969 - 1970</u>	

5-18-75

MEDICAL EDUCATION

I have spent 8 years in the study of medicine in the institutions below:

Day, Month, Year	Day, Month, Year	Name of School	Location
From <u>9/71</u>	to <u>5/75</u>	<u>University Of Virginia</u>	<u>Charlottesville</u>
From <u>July 1, 1975</u>	to <u>July 1, 1979</u>	<u>Medical College of Georgia</u>	<u>Augusta, Ga.</u>
From _____	to _____		

APR 9 1978

I received the degree of M.D. from the University Of Virginia College located at Charlottesville, Va. on the 18 day of May, 19 75

I am the person named in the diploma and am the lawful possessor of same. The photograph enclosed with this application is a true likeness of myself and was taken within sixty days prior to the date of this application.

Date 3/21/79 Signed Gary Clayton Boyle, M.D. (Name in Full)

Affidavit of applicant Gary Clayton Boyle, M.D.
County of Richmond State of Georgia

On this day March 21, 1979 personally appeared before me _____ who, being duly sworn, deposes and says that he has read carefully, and truthfully answered the above questions.

Marguerite Collier Notary Public

My commission expires July 31, 1979

SEAL

PART II CERTIFICATE OF MEDICAL EDUCATION

It is hereby certified that Gary Clayton Boyle of Richmond, Virginia matriculated in the School of Medicine at the University of Virginia. Date Sept. 1, 1974 attending four courses of lectures of nine months each, and received a diploma from the University of Virginia School of Medicine conferring the degree of Doctor of Medicine May 18, 1975

Carol L. Boyles (Date)
(President, Secretary, or Dean)

SECRETARY FOR STUDENT AFFAIRS

SEAL

Date April 5, 1979

PART III CERTIFICATE OF SECRETARY OF STATE BOARD ISSUING ORIGINAL LICENSE OR NATIONAL BOARD OF MEDICAL EXAMINERS

I, Eugenia K. Dorson Executive Virginia State Board of Medicine Secretary of the Medicine

Board of Medical Examiners, certify that Gary Clayton BOYLE, M D. of North Augusta, South Carolina was granted License Certificate No. 26084 to practice Medicine in the State of Virginia on the 8 day of August, 19 75 based on a written examination before this Board on June 10-11-12, 1975 and prior graduation from Univ. of Virginia on the 18 day of May, 19 75 and that said license certificate has never been revoked. Enclosed photograph is a true likeness of Gary Clayton ROYLE, M. D.

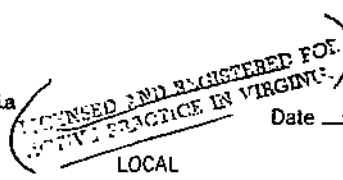
I further certify that the aforesaid in his written examination before this Board obtained a Flex-weighted average of 84.8 per cent, in the following branches:

Subject	Per Cent	Subject	Per Cent
FLEX			
Day I, Anatomy	86	Physiology	83
Biochemistry 64, Pathology 88, Bacteriology & Pharmacology 86.			
Day II, Medicine 86, Surgery 88, Obstetrics and Gynecology 93,			
Public Health and Preventive Medicine 86, Pediatrics 84, Psychiatry 78.			
Day III, Clinical Competence 85.3.			

Acting on behalf of the Virginia State Medicine Board of ~~Medical Examiners~~, I hereby certify to the reputability of Dr. Gary Clayton BOYLE, M. D. based on the records, and recommend him to the Tennessee State Board of Medical Examiners as a fit and proper person to receive a license certificate to practice Medicine and Surgery in Tennessee.

SEAL OF THE BOARD

Place Portsmouth, Virginia



Eugene H. Dorman
Executive (Secretary)

Date April 17, 1979

PART IV LOCAL RECOMMENDATION OF SECRETARY OF LOCAL COUNTY MEDICAL SOCIETY STATE
Date _____

I, _____ Secretary of the _____ Medical Society, certify that _____ is personally known to me, and that he is an ethical practitioner and is of good moral and professional character.

I further certify that the said _____ is engaged in the reputable practice of medicine in the STATE OF _____ : HAVING BEEN A MEMBER OF THIS Society since _____ , and is now in good standing.

(Seal of Society)
Note. If Society has no seal the signature must be acknowledged before a Notary Public.
State of _____
County of _____
Secretary _____
ADDRESS _____

In _____ on the _____ day of _____, 19 _____, before me personally appeared _____ known by me to be the party executing the foregoing instrument, and he being duly sworn, acknowledged said instrument, by him executed, to be his free act and deed.

Notary Public

My commission expires _____
If candidate does not belong to any local, county or state medical society, he must submit two letters of recommendation from licensed physicians who have known him for a substantial length of time.

PLEASE READ INSTRUCTIONS REGARDING COMPLETION OF THIS APPLICATION PAGE 4. APPLICANTS MUST COMPLY WITH ALL INSTRUCTIONS.

TENNESSEE BOARD OF MEDICAL EXAMINERS
350 CAPITOL HILL BUILDING
NASHVILLE, TENNESSEE 37219

REQUIREMENTS FOR A TENNESSEE MEDICAL LICENSE BY RECIPROCITY

This application is not acceptable if any portion herein has been executed and dated prior to ONE YEAR before filing with this board.

RECIPROCITY FEE: \$175.00 payable to the Tennessee Board of Medical Examiners

TEMPORARY PERMITS OR LICENSES ARE NOT ISSUED IN TENNESSEE

Applicants are required to be graduates of medical schools where the curriculum equals that of the Medical Department of the University of Tennessee. Of this matter of reciprocity of licensure, the Board of Medical Examiners shall be the sole judge as to whether or not the applicant holds a certificate from a medical school with the required curriculum.

The Board of Medical Examiners, at its own discretion, may require an applicant to appear in person before he may be certified to the Licensing Board for the Healing Arts for a license to practice medicine in Tennessee.

If you are a FOREIGN MEDICAL GRADUATE, a personal interview with one board member is required prior to certification for licensure. You will be notified as to whom to contact in regard to this interview. A photostatic copy of your medical diploma and a notarized English translation is acceptable in lieu of Part II of the reciprocity application being completed by the medical school. These documents must remain a part of your permanent record in this office. IF YOU HAVE A PERMANENT ECFMG CERTIFICATE, PLEASE SUBMIT A COPY FOR THE BOARD'S EVALUATION OF YOUR APPLICATION. FOREIGN MEDICAL GRADUATES ARE REQUIRED TO HAVE COMPLETED ONE YEAR OF AN APPROVED UNITED STATES TRAINING PROGRAM AND TO SUBMIT EVIDENCE OF COMPLETION OF A PROGRAM. ALSO, A TRANSCRIPT OF YOUR MEDICAL SCHOOL GRADES AND CURRICULUM MUST BE ATTACHED TO YOUR APPLICATION.

Complete all of your part on the application before sending it to the Secretary of the board that granted your original license BY EXAMINATION or to the Secretary of the NATIONAL BOARDS requesting that they execute their Part III on the application.

If you are not a member of a medical society, state the reason in a separate letter and enclose two (2) letters of recommendation as to character, etc., from physicians who are members of their county medical societies and who are personally known to the applicant.

THESE DOCUMENTS MUST BE SUBMITTED TO THIS OFFICE.

1. COMPLETED reciprocity application form
2. Notarized photograph
3. Two letters of recommendation if applicable
4. \$175.00 reciprocity fee

In addition to the above, foreign medical school graduates must submit the following:

5. Copy of ECFMG certificate if applicable
6. Copy of medical diploma if applicable
7. Evidence of completion of one-year approved United States training program
8. Transcript of medical school grades and curriculum

If your papers meet the requirements of the Board of Medical Examiners, you will be promptly certified to the Licensing Board for the Healing Arts as eligible for licensure and for the issuance of your Tennessee medical license. The licensing board issues all licenses for the practice of medicine and surgery and they will require a \$10.00 license fee and an \$11.00 annual registration fee. You will receive further instructions in this regard; therefore, PLEASE DO NOT SEND MONEY TO THE LICENSING BOARD UNTIL YOU ARE INSTRUCTED TO DO SO.

PLEASE SUBMIT ALL DATA TO THIS OFFICE AT THE SAME TIME—NOT SEPARATELY. The process of verification and investigation requires a couple of weeks. Phone or written inquiry during this interval will only result in additional delay.



STATE OF TENNESSEE
BOARD OF MEDICAL EXAMINERS
 DEPARTMENT OF PUBLIC HEALTH STATE OFFICE BUILDING
 BEN ALLEN ROAD
 NASHVILLE, TENNESSEE 37216

May 1, 1979

MAY 9 1979

NC Board of Medical Examiners
 222 N. Person St., #214
 Raleigh, NC 27601

Dear Mr. Paris:

The following physician has made application to this Board for a license to practice medicine in the State of Tennessee:

Gary Clayton Boyle, M.D.

He states on his application that he has a license to practice in your state. We would appreciate the following information. You may be sure that any information given to us will be kept strictly confidential.

Thank you for your assistance.

Very truly yours,

Marvelene Corcoran
 Marvelene Corcoran
 Administrative Assistant

MC/LB/vg

LICENSE NO. 23008 *OK* DATE ISSUED December 12, 1978

 WRITTEN EXAMINATION yes ENDORSEMENT/RECIPROCITY

DEROGATORY INFORMATION: YES no NO

CURRENTLY REGISTERED: yes YES NO

REMARKS:

SIGNED *Betty Joa Perick*
 Asst. Executive Secretary



STATE OF TENNESSEE
BOARD OF MEDICAL EXAMINERS
 DEPARTMENT OF PUBLIC HEALTH STATE OFFICE BUILDING
 BEN ALLEN ROAD
 NASHVILLE, TENNESSEE 37216

May 1, 1979

VA State Board of Medicine
 505 Washington St., #200
 Portsmouth, VA 23704

Dear Ms. Dorson:

The following physician has made application to this Board for a license to practice medicine in the State of Tennessee:

Gary Clayton Boyle, M.D.

He states on his application that he has a license to practice in your state. We would appreciate the following information. You may be sure that any information given to us will be kept strictly confidential.

Thank you for your assistance.

Very truly yours,

Marvelene Corcoran
 Marvelene Corcoran
 Administrative Assistant

MC/LB/vg

LICENSE NO. 26084 ^{OK} DATE ISSUED 8/8/75

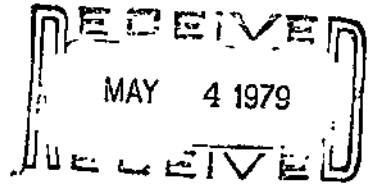
X Flex EXAM WRITTEN EXAMINATION _____ ENDORSEMENT/RECIPROCIITY

DEROGATORY INFORMATION: _____ YES X NO

CURRENTLY REGISTERED: X YES _____ NO

REMARKS: LICENSED AND REGISTERED FOR ACTIVE PRACTICE IN VIRGINIA

SIGNED *Eugenia K. Dorson* ⁽⁶⁵⁾
 Executive Secretary



STATE OF TENNESSEE
BOARD OF MEDICAL EXAMINERS
 DEPARTMENT OF PUBLIC HEALTH STATE OFFICE BUILDING
 BEN ALLEN ROAD
 NASHVILLE, TENNESSEE 37216

May 1, 1979

SC State Board of Medical Examiners
 1315 Blanding Street
 Columbia, SC 29201

Dear Mr. Heyward:

The following physician has made application to this Board for a license to practice medicine in the State of Tennessee:

Gary Clayton Boyle, M.D.

He states on his application that he has a license to practice in your state. We would appreciate the following information. You may be sure that any information given to us will be kept strictly confidential.

Thank you for your assistance.

Very truly yours,

Marvelene Corcoran
 Marvelene Corcoran
 Administrative Assistant

MC/LB/vg

LICENSE NO. 7868

DATE ISSUED 7-1-76

 WRITTEN EXAMINATION

VA '75 ENDORSEMENT/RECIPROCIDY

DEROGATORY INFORMATION:

 YES X NO

CURRENTLY REGISTERED:

 X YES NO

REMARKS:

MAY 1 1979

SIGNED *Marvelene Bryant*
 Secretary II

TENNESSEE DEPARTMENT OF HEALTH
BOARD OF MEDICAL EXAMINERS
MEDICAL DOCTORS
RENEWAL APPLICATION

PLEASE READ INSTRUCTIONS AND ANSWER ALL QUESTIONS ON BACK OF THIS FORM
DO NOT SEPARATE ANY PART OF THIS FORM

Lic./Cert. No: **ND0000011935** Lic./Cert. Status: **ACTIVE**

Expiration Date: **02/29/2000**

File ID: **00013199**

NPI/UPIN#:

Social Sec. No:

GARY C BOYLE MD
2901 WEST STATE STREET
BRISTOL TN 37620-1718



Birth Date: **02/23/1948**

Home Phone: **(423) 323-2161**

Work Phone: **(423) 968-2182**

Name and/or Mailing Address Change

Specialty: **OBSTETRICS & GYNECOLOGY**

Work Address:

BRISTOL TN 37620

Work Address Change

Activity Status: **FULL TIME**
 1 Full Time 3 Not Working
 2 Part Time

STATE REGULATORY FEE \$ **10.00**

RENEWAL

*CK # 9944
00 1-12-00*

TOTAL \$

100.00
110.00

In making this application, I certify that the statements given in this application are true and correct and that I have complied with all renewal requirements and, if applicable, satisfied all continuing education requirements set forth in the Tennessee Code Annotated and the Official Code and Regulations of the State of Tennessee regulating the practice of my profession in Tennessee.

SIGNATURE

DATE

Gary C Boyle MD **1-11-00**

CAREFULLY READ ALL QUESTIONS

Circle YES if the following applies to you:

I have been convicted of a crime and I have not previously notified the Board in writing of that action.

YES

My license has been disciplined in another state and I have not previously notified the Board in writing of that action.

YES

I am currently in poor physical and / or mental health.

YES

IF YOU HAVE ANSWERED YES TO ANY OF THE STATEMENTS PRINTED ABOVE, ATTACH AN EXPLANATION.

If you have been licensed in other states in the past two years, list those states. _____

INSTRUCTIONS

Read all instructions before completing this renewal application.

1. Carefully check all the information printed on this form and neatly print any corrections in the shaded spaces provided.
2. Carefully read all questions on this application form. Circle yes only if the statement(s) applies to you. Do not write NO beside the statement if it does not apply to you.
3. Sign and Date the application and return it in the enclosed self-addressed envelope. DO NOT SEPARATE any part of this form.

If you do not sign and date the application, it WILL be returned to you. Failure to sign and date this application will cause a delay in issuing your renewal certificate.
4. Make your check or money order payable to the Department Of Health. DO NOT SEND CASH.
5. To insure processing by the expiration date, complete the application and submit with check or money order upon receipt of this application.
6. Pursuant to T.G.A. Section 63-1-108, It is the licensee's responsibility to keep the Board apprised of any change of address within thirty days of the change. For the purpose of the Board proving it has sent you your renewal application or license, it is sufficient to send said documentation to the address found in your licensure file.

**TENNESSEE DEPARTMENT OF HEALTH
BOARD OF MEDICAL EXAMINERS
MEDICAL DOCTORS
RENEWAL APPLICATION**

PLEASE READ INSTRUCTIONS AND ANSWER ALL QUESTIONS ON BACK OF THIS FORM
Online Renewal Now Available At www.tennesseeanytime.org/hirs
DO NOT SEPARATE ANY PART OF THIS FORM

Lic./Cert. No: MD0000011935 Lic./Cert. Status: **ACTIVE**

Expiration Date: **02/28/2002**

File ID: 00013199

NPI/UPIN#:

Transaction No: 000082681

**GARY C BOYLE MD
2901 WEST STATE STREET
BRISTOL TN 37620-1718**



Social Sec. No:

Birth Date: **02/23/1948**

Home Phone: (423) 323-2161

Work Phone: (423) 968-2182

Name and/or Mailing Address Change

E-mail:

Specialty:

Activity Status: **FULL TIME**

- 1 Full Time 3 Not Working
 2 Part Time

Work Address:

BRISTOL TN 37620

JAN 30 2002

STATE REGULATORY FEE \$ 10.00

I certify that the statements given in this application are true and correct and that I have complied with all renewal requirements and, if applicable, satisfied all continuing education and competency requirements for the two (2) previous calendar years as set forth in the Tennessee Code Annotated and the Official Compilation Rules and Regulations of the State of Tennessee regulating the practice of my profession.

RENEWAL

150.00

SIGNATURE

Gary C Boyle MD

DATE

1-18-02

TOTAL \$ 160.00

CAREFULLY READ ALL QUESTIONS

Circle YES if the following applies to you:

- I have been convicted of a crime and I have not previously notified the Board in writing of that action. YES
- My license has been disciplined in another state and I have not previously notified the Board in writing of that action. YES
- I am currently in poor physical and / or mental health. YES

IF YOU HAVE ANSWERED YES TO ANY OF THE STATEMENTS PRINTED ABOVE, ATTACH AN EXPLANATION.

If you have been licensed in other states in the past two years, list those states. GA, AL, SC, NC, VA (reaction)

Emergency Phone:

Emergency Fax:

423-968-2182

423-968-7589

INSTRUCTIONS

Read all instructions before completing this renewal application.

- Carefully check all the information printed on this form and neatly print any corrections in the shaded spaces provided.
- Carefully read all questions on this application form. Circle yes only if the statement(s) applies to you. Do not write NO beside the statement if it does not apply to you.
- Sign and Date the application and return it in the enclosed self-addressed envelope. DO NOT SEPARATE any part of this form.
If you do not sign and date the application, it WILL be returned to you. Failure to sign and date this application will cause a delay in issuing your renewal certificate.
- Make your check or money order payable to the Department Of Health. DO NOT SEND CASH.
- To insure processing by the expiration date, complete the application and submit with check or money order upon receipt of this application.
- Pursuant to T.C.A. Section 63-1-108, it is the licensee's responsibility to keep the Board apprised of any change of address within thirty days of the change.

TENNESSEE DEPARTMENT OF HEALTH
BOARD OF MEDICAL EXAMINERS
MEDICAL DOCTORS
RENEWAL APPLICATION

PLEASE READ INSTRUCTIONS AND ANSWER ALL QUESTIONS ON BACK OF THIS FORM
Online Renewal Now Available At www.tennessee.gov/health
DO NOT SEPARATE ANY PART OF THIS FORM

Lic./Cert. No: MD0000011935 Lic./Cert. Status: ACTIVE
File ID: 00013199 NPI/UPIN#:

Expiration Date: 02/29/2004
Transaction No: 000104261

GARY C BOYLE MD
2901 WEST STATE STREET
BRISTOL TN 37620-1718
|||||||

Social Sec. No:
Birth Date: 02/23/1948

Home Phone: (423) 323-2161

Work Phone: (423) 968-2182

Name and/or Mailing Address Change

Activity Status: FULL TIME

- 1 Full Time
- 2 Part Time
- 3 Not Working

E-mail:

Specialty:

Work Address:

BRISTOL TN 37620

Work Address Change

STATE REGULATORY FEE \$	10.00
RENEWAL	225.00
TOTAL \$	235.00

I certify that the statements given in this application are true and correct and that I have complied with all renewal requirements and, if applicable, satisfied all continuing education and competency requirements for the two (2) previous calendar years as set forth in the Tennessee Code Annotated and the Official Compilation Rules and Regulations of the State of Tennessee regulating the practice of my profession.

G. C. Boyle, MD 1-12-04
SIGNATURE DATE

CAREFULLY READ ALL QUESTIONS

Circle YES if the following applies to you:

- I have been convicted of a crime and I have not previously notified the Board in writing of that action. YES
- My license has been disciplined in another state and I have not previously notified the Board in writing of that action. YES
- I am currently in poor physical and / or mental health. YES

IF YOU HAVE ANSWERED YES TO ANY OF THE STATEMENTS PRINTED ABOVE, ATTACH AN EXPLANATION.

If you have been licensed in other states in the past two years, list those states.

Emergency Phone: 4239682182

Emergency Fax: 4239687589

INSTRUCTIONS

Read all instructions before completing this renewal application.

1. Carefully check all the information printed on this form and neatly print any corrections in the shaded spaces provided.
2. Carefully read all questions on this application form. Circle yes only if the statement(s) applies to you. Do not write NO beside the statement if it does not apply to you.
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4. Make your check or money order payable to the Department Of Health. DO NOT SEND CASH.
5. To insure processing by the expiration date, complete the application and submit with check or money order upon receipt of this application.
6. Pursuant to T.C.A. Section 63-1-108, it is the licensee's responsibility to keep the Board apprised of any change of address within thirty days of the change.