STATE OF OHIO
STATE MEDICAL BOARD

APPLICATION FOR ENDORSEMENT FOR CERTIFICATE TO PRACTICE MEDICINE AND SURGERY

'79 JUN -6 PM 2 28

OHIO STATE MEDICAL BOARD

SECTION 1: Basic Information

1. Present Legal Name: SCHWARTZ (last) DAVID (first) BRUCE (middle) ( ) (maiden (if applicable))

2. Address: 2705 GATEHOUSE DRIVE EAST (street & number) CINCINNATI (city)
OHIO (state) 45215 (zip code) HAMILTON (country)

Permanent Address: 2705 GATEHOUSE DRIVE EAST (street & number) CINCINNATI (city)
OHIO (state) 45215 (zip code) HAMILTON (country)

Intended place of practice: CINCINNATI (city) OHIO (state) HAMILTON (county)

3. Telephone: Business: 513-872-3100 (area code) Home: 513-821-6447 (area code)

4. Place of Birth NEWARK (city) NEW JERSEY (state) ESSEX (country) Date of Birth 01 (mo.) 08 (day) 52 (year)

5. *Sex: Male (X) Female ( ) *Optional: For statistical purposes only.

6. Immigration or citizenship status:

Indicate which of the following documents you currently possess.

X U.S. Birth Certificate

____ Certificate of Naturalization
Number____ Date Issued____ City/State____

____ Declaration of Intention (issued by the U.S. District Court)
Number____ Date Issued____ City/State____

____ Alien Registration Receipt Card (issued by Dept. of Immigration & Naturalization)
Number____ Date Issued____ City/State____

____ Approved Petition for Immigrant Visa (issued by Dept. of Immigration & Naturalization)
Number____ Date Issued____ City/State____

____ Other, specify____

7. List all names other than the name given above that you have used. Also indicate the time period during which you used the names. If none, write "None."

NONE
name used from: mo./yr. to: mo./yr.

name used from: mo./yr. to: mo./yr.

SECTION 2: Educational Background

1. Preliminary Education

List your high school and college, or equivalent. Give the dates that you attended and the degree that you received, if any.

NAME	ADDRESS	DATE	DEGREE
West Orange High School	West Orange, New Jersey 07052 (Street City State)	9/67-6/70 (from to)	
Cornell University	Ithaca, New York 14850 (Street City State)	9/70-6/74 (from to)	
	(Street City State)	(from to)	

FOR STAFF USE ONLY (Please leave blank)

Preliminary Education Number 57293 Date Issued 6/10/79

2. Medical Background

List the name of your medical school, the complete address, your date of graduation, and the degree that you received. Give the exact degree that appears on your diploma (M.D.; D.O.; M.B.,B.S.; M.B., B.Ch., etc.)

name	address	date	degree
University of Michigan	Ann Arbor, Michigan 48104	May 26, 1978 ✓	M.D.

You must submit a notarized copy of your diploma. If it is not in English, you must supply an original translation which will be returned to you. See the general instructions for a list of acceptable translations.

3. Standard E.C.F.M.G. Certificate

Graduates of foreign medical schools who were not American citizens prior to entering medical school should possess a standard E.C.F.M.G. Certificate if they graduated after 1957. Give the number and date of your certificate if applicable. Attach a notarized copy of your certificate.

Number:________________ Date:________________

SECTION 3: Postgraduate Training

All applicants are required to complete the chart below indicating the dates and hospitals of all postgraduate training. Give the complete address of the hospital where you were employed. Give your position and the department in which you served. Account for the percentage of your time spent in clinical and administrative duties. These two numbers should add up to 100%.

Date mo/yr-mo/yr	Hospital	Complete Address	Position & Department	%Clin.	%Admin.
7/78-6/79	Cincinnati General Hospital	The University of cincinnati Medical Center 231 Bethesda Avenue Cincinnati, Ohio 45267	Obstetrics and Gynecology Resident-1	100	

Total Number of Months in Approved* Training: 12 (on June 30, 1979)
*Approved by AMA, AOA, or in Canada.

Graduates of Foreign Medical Schools are required to complete 24 months of approved training. Submit copies of training certificates issued by the hospital to document training. In addition, have Form 2 completed as indicated in the instructions, if applicable.

SECTION 4: Licensure Information

1. List ALL FLEX and State Board exams which you have taken. Check whether the exam is a FLEX or non-FLEX exam. Indicate the state for which the exam was taken and the month and year the exam was taken. If you took all three days of the FLEX or the entire non-FLEX exam offered, check Full. If you did not take the entire exam, check Partial. If you passed the exam, check Pass. If you failed the exam, check Failed.

State	Mo./Yr.						
		FLEX( )	NON-FLEX( )	FULL( )	PARTIAL( )	PASS( )	FAIL( )
		FLEX( )	NON-FLEX( )	FULL( )	PARTIAL( )	PASS( )	FAIL( )
		FLEX( )	NON-FLEX( )	FULL( )	PARTIAL( )	PASS( )	FAIL( )
		FLEX( )	NON-FLEX( )	FULL( )	PARTIAL( )	PASS( )	FAIL( )
		FLEX( )	NON-FLEX( )	FULL( )	PARTIAL( )	PASS( )	FAIL( )
		FLEX( )	NON-FLEX( )	FULL( )	PARTIAL( )	PASS( )	FAIL( )
		FLEX( )	NON-FLEX( )	FULL( )	PARTIAL( )	PASS( )	FAIL( )

2. List ALL states in which you are or have been fully licensed to practice medicine and surgery. Indicate the license number and the date it was issued. If the license is properly renewed, check YES under current. If the license was not renewed, check NO.

State	Date of Issuance	License Number	Current
			YES ( ) NO ( )
			YES ( ) NO ( )
			YES ( ) NO ( )

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OHIO STATE MEDICAL BOARD

3. Are you eligible for licensure in the country in which you graduated from medical school?
YES(X) NO( ) (NOTE: You do not necessarily have to be licensed there)

4. Field of Specialization

List the field in which you have specialized (Family Medicine, Internal Medicine, Surgery, etc.). Indicate if you are Board Certified and the countries in which you are so certified.

Field	Board Certified	Year Certified	Country
Obstetrics and Gynecology	YES( ) NO(X)		
	YES( ) NO( )		

SECTION 5: Resume

List ALL activities from medical school graduation to the present time. ACCOUNT FOR ALL TIME, WORKING AND NON-WORKING, IN ALL COUNTRIES. Explain what you were doing FOR all non-working time. PLACE ALL ACTIVITIES IN CHRONOLOGICAL ORDER. DO NOT SUBSTITUTE ANY OTHER RESUME FOR THIS FORM.

DATES	HOSPITAL OR UNIVERSITY	COMPLETE ADDRESS	POSITION & DEPARTMENT	%CLIN.	%ADMIN.
7/78-6/79	University of Cincinnati Medical Center	231 Bethesda Avenue Cincinnati, Ohio 45267	Resident-1 Obstetrics and Gynecology	100%	

SECTION 6: General Information

Each of the following questions must be answered with a yes or no answer. Be sure to read each question carefully. All affirmative answers must be thoroughly explained.

1. Has any license entitling you to practice in any foreign country or in any state or territory of the United State been suspended, surrendered, or revoked?
YES( ) NO(X)
If so, give:

STATE_____ DATE_____ CHARGE_____

2. Have you ever been denied any application for licensure in any other state or territory for any reason? YES( ) NO(X)

If so, specify:_____
State or country Reason Date

3. Have you ever been or are you now addicted to the use of drugs or alcohol? YES( ) NO(X

4. Have you ever been convicted of a violation of a federal law, state law, or municipal ordinance other than a minor traffic violation? YES( ) NO(X)

If so, specify:_____
City/State Court Offense

_____
Date Disposition

5. Have you ever found it necessary to surrender your narcotic license? YES( ) NO(X)
If so, specify:_____
Reason Date

6. Physical description of applicant

Color of Hair Brown Color of Eyes Brown Height 5'4"

Build short stature Marks none Weight 145lbs.

7. Photograph and Photoslip

You must submit a recent color photograph. Attach the photoslip enclosed in the application to this photo. Sign and date the back of the photo and print your name. Have each of the physicians who signed your recommendation forms also sign the photoslip.

FORM 3

CERTIFICATE OF RECOMMENDATION

'79 JUN -6 PM 2 28

This form is to be completed by a licensed physician. The recommending physician should be sufficiently acquainted with the applicant as to be able to evaluate and recommend the applicant. This form must be notarized. All questions must be answered. In addition, the recommending physician is strongly urged to include additional comments. This form is not intended to standardize the recommendation or restrict it in any way. However, its form is designed to insure that certain information is included.

I, Tom P. Barden, M.D., a licensed and practicing physician in the state of
Recommending Physician

Ohio, affirm that David B. Schwartz, M.D. has been known to

me personally and professionally for one years and that he/she is of good moral and

ethical character. I offer the following in support of his/her application for full licensure:

I rate his/her medical knowledge and techniques as excellent

His/her command of the English language is excellent

I rate his/her ability to work well with peers and medical staff as excellent

His/her relationship with patients is excellent

In the space below, please add personal comments, evaluation, and recommendation. If more space is required, please attach additional sheets.

I hereby recommend David B. Schwartz, M.D. for full licensure to practice medicine
Applicant

and surgery in Ohio.

Indiana University School of Medicine
Medical School of Graduation of Recommending Physician

Tom P. Barden MD.
Signature of Recommending Physician

Ohio
State of Licensure of Recommending Physician

Tom P. Barden, M.D.
Name of Recommending Physician (Please print)

030722
License No. of Recommending Physician

3445 Observatory Ave; Cincinnati, OH 45208
Address of Recommending Physician

Subscribed and sworn to this 22nd day of May, 1979

Notary Public

(SEAL)

Notary Public, State of Ohio
My Commission Expires June 9, 1982

FORM 3

CERTIFICATE OF RECOMMENDATION

'79 JUN -6 PM 2 28

OHIO STATE MEDICAL BOARD

This form is to be completed by a licensed physician. The recommending physician should be sufficiently acquainted with the applicant as to be able to evaluate and recommend the applicant. This form must be notarized. All questions must be answered. In addition, the recommending physician is strongly urged to include additional comments. This form is not intended to standardize the recommendation or restrict it in any way. However, its form is designed to insure that certain information is included.

I, Allen R. Shade, a licensed and practicing physician in the state of
Recommending Physician

Ohio Ohio, affirm that David B. Schwartz has been known to
me personally and professionally for 2 two years and that he/she is of good moral and
ethical character. I offer the following in support of his/her application for full licensure:

I rate his/her medical knowledge and techniques as excellent excellent

His/her command of the English language is excellent excellent

I rate his/her ability to work well with peers and medical staff as excellent excellent

His/her relationship with patients is outstanding outstanding

In the space below, please add personal comments, evaluation, and recommendation. If more space is required, please attach additional sheets.

I hereby recommend David B. Schwartz for full licensure to practice medicine
Applicant

and surgery in Ohio.

Ohio State University
Medical School of Graduation of Recommending Physician

Ohio Ohio
State of Licensure of Recommending Physician

Ohio 025107
License No. of Recommending Physician

Allen R. Shade M.D.
Signature of Recommending Physician

Allen R. Shade, M.D.
Name of Recommending Physician (Please print)

U.C.Medical Center- Dept. of Ob/Gyn
231 Bethesda Avenue # 4555
Cincinnati, Ohio 45267
Address of Recommending Physician

Subscribed and sworn to this 23 day of May, 19 79

Notary Public

(SEAL)

IvaDean Lair
Notary Public, State of Ohio
My Commission Expires June 9, 1982

NATIONAL BOARD OF MEDICAL EXAMINERS • 3930 CHESTNUT STREET, PHILADELPHIA, PENNA. 19104

ENDORSEMENT OF CERTIFICATION

NATIONAL BOARD OF MEDICAL EXAMINERS
OF THE
UNITED STATES OF AMERICA

DAVID BRUCE SCHWARTZ, 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: WILLIAM B. HOLDEN
Chairman of the Board

Philadelphia, Pa.
07/02/79

SEAL

EDITHE J. LEVIT
President of the Board

Cert. # 195151

It is certified that the above is a copy of the Diplomate Certificate issued to the named physician, a graduate of UNIV OF MICHIGAN MED SCH in MAY 1978, whose birth date is 01/08/1952, following successful completion of all examinations required for Certification by the National Board of Medical Examiners.

The grades obtained are as follows:

	Standard* Score	Scale Score
PART I passed 05/76		
Anatomy, incl. histology and embryology	390	75
Physiology	510	81
Biochemistry	510	81
Pathology	495	80
Microbiology, incl. immunology	490	80
Pharmacology and Materia Medica	515	82
Behavioral Sciences	390	75
(Minimum Passing Grade 380/75) TOTAL GRADE/AVERAGE**	470	79
Part II passed 09/77		
Internal medicine and the medical specialties	355	75
Surgery and the surgical specialties	340	75
Obstetrics and Gynecology	455	80
Public Health and Preventive Medicine	480	81
Pediatrics	435	79
Psychiatry	300	72
(Minimum Passing Grade 290/75) TOTAL GRADE/AVERAGE**	365	76
PART III passed 03/79		
A General Test of Clinical Competence		
(Minimum Passing Grade 290/75) AVERAGE	410	78.8
GENERAL AVERAGE (Parts I, II, and III)		77.9 (Scale Score)

*Examinations taken since June 1971 are reported with both Standard and Scale Score Equivalents.

**Since 1966 National Board criteria for certification are based upon candidate's Total Grade in Part I, Part II, and Part III, and not scores of individual subjects within each Part.

Ann K. Heverling
Secretary for Certification
05/04/79
Date

SEAL

FORM 4

CERTIFIED COPY OF STATE LICENSE OR CERTIFICATE

(DO NOT COMPLETE UNLESS LICENSE IS CURRENTLY RENEWED)

(A verbatim copy to follow here, over Seal of State Licensing Board, certified to by the Secretary, President, or Executive Secretary thereof.)

'79 JUN -6 PM 2 28

OHIO STATE
MEDICAL BOARD

I hereby certify that the above is a verbatim copy of license no. _____,

issued to Dr. _____ by the _____ on the _____
(Name of State Board)

day of _____, 19_____.

_____
Secretary, President, or Executive Secretary

(Seal)

8 CERTIFICATE AND RECOMMENDATION OF SECRETARY, PRESIDENT, OR EXECUTIVE SECRETARY

(DO NOT COMPLETE UNLESS LICENSE IS CURRENTLY RENEWED)

Acting in behalf of the _____
(Name of State Board)

I do hereby certify that Dr. _____ was on the _____ day of _____

19_____, granted a license to practice osteopathic medicine and surgery in the State of

_____ on the basis of _____
(State Board examination, National Boad of Examiners, or reciprocity/endorsement)

(Include Grades) _____

_____

_____

_____

_____

and received an average of _____ percent.

I do hereby certify that the applicant does hold a current, valid license in this state.

(Seal)

_____ _____
(Date) Secretary, President, or Executive Secretary

I certify that this is a true copy of the original document.

Shirley D. Martin

Shirley D. Martin

Universitatis Reipublicae Michiganensium

PROCURATORES OMNIBUS HAS LITERAS PERLECTURIS

Salutem

Sciatis **David Bruce Schwartz** ingenuis moribus nobis a Collegii Medicinae et Chirurgiae Professoribus commendatum, et qui in studio et disciplina scientiaque Medicinae et Chirurgiae Artium bene probatus sit, gradu

Doctoris in Arte Medica

nos ornavisse, cujus in rei testimonium has literas Praesidis et Secretarii et Professorum in unum manusque gerentes, sigilloque Universitatis signatas, in manus ejusdem dedimus.

Datum ex aedibus Universitatis die vicesimo sexto Maii anno salutis millesimo nongentesimo septuagesimo octavo Annoque Universitatis Reipublicae Michiganensium centesimo sexagesimo

R. L. Kennedy Secretarius

R. W. Fleming Praeses

Professores

John A. Gronvall, M.D.

THE UNIVERSITY OF MICHIGAN
MEDICAL SCHOOL
ANN ARBOR, MICHIGAN 48104

OFFICE OF THE DEAN

May 30, 1979

The University of Michigan Medical School diploma, as translated into the English language, reads as follows:

From the Regents to anyone reading this letter: Greetings!

Be advised that we have awarded the degree of Doctor of Medicine to DAVID BRUCE SCHWARTZ recommended to us in the usual manner by the professors of the College of Medicine and Surgery (Medical School) as a person well-qualified in the study, discipline and science of Medicine and Surgery.

In proof of this we have given to (him/her) this letter, bearing signatures of the President, the Secretary, and the professors.

Done on the premises of the University on the

26 day of May 1978

Frances D French

Frances D. French
Director of Academic Services

FDF/ks

(SEAL)

H.D.

SCREENING INFORMATION
(MEDICAL AND OSTEOPATHIC APPLICANTS ONLY)

PLEASE BE ADVISED THAT ALL MATERIALS SUBMITTED TO THE BOARD WILL BE THOROUGHLY INVESTIGATED AND INDIVIDUALS WILL BE CONTACTED REGARDING YOUR APPLICATION AS THE BOARD DEEMS NECESSARY PRIOR TO YOUR POSSIBLE LICENSURE IN OHIO.

Complete all items fully and return to the State Medical Board of Ohio promptly.

1. Name SCHWARTZ (Last) DAVID (First) BRUCE (Middle) PLACE OF BIRTH NEWARK (City) NEW JERSEY (State) ESSEX (Country)

ADDRESS 3705 GATEHOUSE DRIVE EAST DATE OF BIRTH 1 (Month) 8 (Day) 52 (Year)

CINCINNATI OHIO

HOME PHONE NUMBER 513 821 6447 (Area Code) BUSINESS PHONE NUMBER 513 872 4796 (Area Code)

*SEX: MALE (X) FEMALE ( ) *OPTIONAL: For statistical purposes only.

2. IMMIGRATION OR CITIZENSHIP STATUS Check the item which applies to you (if more than one applies, indicate the most recent one obtained)

4/30/79 MTA

X U.S. Birth Certificate
___ Certificate of Naturalization
___ Declaration of Intention
___ Alien Registration Receipt Card
___ Approved Petition for Permanent Visa
___ Other; Specify_____

3. MEDICAL EDUCATION

Name of Medical School UNIVERSITY OF MICHIGAN Degree M.D. (M.D., D.O., M.B.B.S., etc.)

Address of Medical School ANN ARBOR (Street) MICHIGAN (City) (State) Date of Graduation 6 (Mo.) 3 (Day) 78 (Year)

48104 (Zip Code) USA (Country)

5/16/79 MTA
AMA ✓ 5/14/79
Fed ✓ 5/15/79 NB
Pa 5/16/79 MTA

4. E.C.F.M.G. CERTIFICATE Standard ( ) Interim ( )

Number_____ Date_____

5. LICENSE List all states in which you have been licensed to practice medicine and surgery and the date the licenses were issued. Place a check beside "Yes" if your license is current.

State	Date Issued	Current (Yes or No)
OHIO (TEMPORARY)	7/1/79	Yes (✓) No ( )
		Yes ( ) No ( )
		Yes ( ) No ( )
		Yes ( ) No ( )

Schwartz, Bruce

6. LICENSURE EXAMS

a) Are you a diplomate of the National Board of Medical Examiners? Yes (✓) No ( ) If so, specify year 1979 (Mailed to you 5/7/79.
Are you a diplomate of the National Board of Examiners for Osteopathic Physicians and Surgeons. Yes ( ) No ( ) If so, specify year _____

b) List all FLEX exams which you have taken. Indicate whether you took all three days (place an "X" next to Full) or whether you took only part of the exam (place an "X" next to Partial)

STATE	DATE (Mo./Yr.)				
		FULL ( )	PARTIAL ( )	PASS ( )	FAIL ( )
		FULL ( )	PARTIAL ( )	PASS ( )	FAIL ( )
		FULL ( )	PARTIAL ( )	PASS ( )	FAIL ( )
		FULL ( )	PARTIAL ( )	PASS ( )	FAIL ( )
		FULL ( )	PARTIAL ( )	PASS ( )	FAIL ( )
		FULL ( )	PARTIAL ( )	PASS ( )	FAIL ( )
		FULL ( )	PARTIAL ( )	PASS ( )	FAIL ( )

RECEIVED MAY 14 1979 STATE MEDICAL BOARD

c) List all other State Board exams taken. Indicate whether you took a full (place an "X" next to Full) or whether you took only part of the exam (place an "X" next to Partial). Also give the month and year when you took the exam.

STATE	DATE (Mo./Yr.)				
_____		FULL ( )	PARTIAL ( )	PASS ( )	FAIL ( )
_____		FULL ( )	PARTIAL ( )	PASS ( )	FAIL ( )

7. TRAINING

Total number of months of AMA or AOA approved training in the U.S. 11. Will complete 1 year 6/30/79
Total number of months of approved training in Canada. _____

List below the most recent hospitals and the complete addresses where you have worked or trained. Please specify dates and position served at each hospital.

All addresses must be complete with street number, street, apartment if applicable, city, state, zip code, and country if not in U.S. You will be responsible for any delays in your application due to failure to include full addresses, including zip code.

DATE mo/yr-mo/yr	HOSPITAL	COMPLETE ADDRESS (Street, City, State, Zip Code)	POSITION
7/1/78 - 7/1/79	CINCINNATI GENERAL HOSPITAL	GOODMAN STREET CINCINNATI OHIO	RESIDENT
	* THE CHRIST HOSPITAL	AUBURN AVE CINCINNATI OHIO	RESIDENT

8. WAIVER OF APPLICANT

STATE OF OHIO

COUNTY OF HAMILTON ss:

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the State Medical Board of Ohio any information, files, or records requested by the Board in connection with this application. I further authorize the State Medical Board of Ohio to release to the organizations, individuals or groups listed above any information which is material to my application.

Del B Lee MD
(Signature of Affiant)

Subscribed and sworn to this 11th day of May, 19 79

Edith Banks
(Signature of Official Administering Oath)

1-9-84
(Date Commission Expires)

EDITH BANKS
Notary Public, State of Ohio
My Commission Expires

Must be sworn to before a notary public or other person authorized to administer oaths.

SECTION 7: Affidavit of Applicant

'79 JUN -6 PM 2 28

STATE OF OHIO

SS: OHIO STATE MEDICAL BOARD

COUNTY OF HAMILTON

Before me, personally appeared DAVID B. SCHWARTZ M.D.
(Affiant)

who being duly sworn says that he is the person referred to in the foregoing application for license to practice medicine and surgery in the State of Ohio; that the statements therein and the documents attached thereto are strictly true in every respect, and that he has read and understands this Affidavit.

David B Schwartz MD
(Signature of Affiant)

Subscribed and sworn to this 23rd day of May, 19 79

(SEAL)

Edith Banks
(Signature of Official Administering Oath)

EDITH BANKS
Notary Public
My Commission Expires 1-9-84
(Date Commission Expires)

*Must be sworn to before a notary public or other person authorized to administer oaths.

025-655 7/12/79

FOR BOARD USE ONLY

NAME: SCHWARTZ, DAVID BRUCE

CERTIFICATE NO. 43762 DATE ISSUED 7/12/79

ENDORSEMENT - MEDICINE AND SURGERY

FILED 5/16, 19 79

FEE $150.00

307-346-7-79 pc 239 aut 160.00

ama-ok

Rec-Ok ~~6/14/79 VS~~

Ack. card sent 6/14 '79 V.S.I.

DETERMINATION:

Bd. Meeting 7/11/79

BOARD ACTION:

Bd. Approved

M.D.

University of Cincinnati Medical Center

College of Medicine
231 Bethesda Avenue
Cincinnati, Ohio 45267

DEPARTMENT OF OBSTETRICS AND GYNECOLOGY
TELEPHONE (513) 872-4796

'79 APR 27 AM 12 15

OHIO STATE
MEDICAL BOARD

4/30/79
UNTA

April 22, 1979

Mr. William J. Lee, Jr.
Administrator, State Medical Board
180 E. Broad Street Suite #1006
Columbus, Ohio 43215

Dear Mr. Lee:

Please send the necessary application form for a permanent Ohio license to practice medicine. I graduated from the University of Michigan Medical School in June, 1978 and currently have a temporary Ohio license #14262 which expires July 1, 1979. I have passed National Boards Parts I, II, and III.

Please send the application to the following address:

David B. Schwartz, M.D.
2705 Gatehouse Drive East
Cincinnati, Ohio 45215

Thank you.

Sincerely yours,

David B. Schwartz, M.D.

Schwartz, David B.

PS Form 3811, Apr. 1977

RETURN RECEIPT, REGISTERED, INSURED AND CERTIFIED MAIL

● SENDER: Complete items 1, 2, and 3. Add your address in the "RETURN TO" space on reverse.

1. The following service is requested (check one).
   - ☐ Show to whom and date delivered ..... ¢
   - ☐ Show to whom, date, and address of delivery ..... ¢
   - ☐ RESTRICTED DELIVERY Show to whom and date delivered ..... ¢
   - ☐ RESTRICTED DELIVERY Show to whom, date, and address of delivery ..... $
   - (CONSULT POSTMASTER FOR FEES)

2. ARTICLE ADDRESSED TO:
   David Bruce Schwartz

3. ARTICLE DESCRIPTION:

REGISTERED NO.	CERTIFIED NO.	INSURED NO.
	SOS 758	

(Always obtain signature of addressee or agent)

I have received the article described above.
SIGNATURE ☐ Addressee ☐ Authorized agent
X Abby Schwartz

DATE OF DELIVERY 10-22-79

POSTMARK: CINCINNATI OH SEP 27 1979 USPS

5. ADDRESS (Complete only if requested)
2705 GATEHOUSE
CINTI OHIO 45215

6. UNABLE TO DELIVER BECAUSE:

CLERK'S INITIALS

☆GPO: 1977—O—249-595

PS Form 3800, Apr. 1976

No. 508758

RECEIPT FOR CERTIFIED MAIL

NO INSURANCE COVERAGE PROVIDED—
NOT FOR INTERNATIONAL MAIL

(See Reverse)

SENT TO
David Bruce Schwartz
STREET AND NO.
2705 Gatehouse DR E
P.O., STATE AND ZIP CODE
Cincy OH 45215

POSTAGE		$
CONSULT POSTMASTER FOR FEES — CERTIFIED FEE		¢
OPTIONAL SERVICES — SPECIAL DELIVERY		¢
OPTIONAL SERVICES — RESTRICTED DELIVERY		¢
OPTIONAL SERVICES — RETURN RECEIPT SERVICE — SHOW TO WHOM AND DATE DELIVERED		¢
OPTIONAL SERVICES — RETURN RECEIPT SERVICE — SHOW TO WHOM, DATE, AND ADDRESS OF DELIVERY		¢
OPTIONAL SERVICES — RETURN RECEIPT SERVICE — SHOW TO WHOM AND DATE DELIVERED WITH RESTRICTED DELIVERY		¢
OPTIONAL SERVICES — RETURN RECEIPT SERVICE — SHOW TO WHOM, DATE AND ADDRESS OF DELIVERY WITH RESTRICTED DELIVERY		¢
TOTAL POSTAGE AND FEES		$

POSTMARK OR DATE
Cert.
OCT 10 1979

UNITED STATES POSTAL SERVICE
OFFICIAL BUSINESS

SENDER INSTRUCTIONS
Print your name, address, and ZIP CODE in the space below.
- Complete items 1, 2, and 3 on the reverse.
- Moisten gummed ends and attach to front of article if space permits. Otherwise affix to back of article.
- Endorse article "Return Receipt Requested" adjacent to number.

CINCINNATI OH PM OCT 12 1979

PENALTY FOR PRIVATE USE TO AVOID PAYMENT OF POSTAGE, $300

ALWAYS USE ZIP CODE

U.S. MAIL

RETURN TO

OHIO STATE MEDICAL BOARD
SUITE 1000
(Name of Sender)
180 EAST BROAD STREET
(Street or P.O. Box)
COLUMBUS, OHIO 43215
(City, State, and ZIP Code)

STICK POSTAGE STAMPS TO ARTICLE TO COVER FIRST CLASS POSTAGE, CERTIFIED MAIL FEE, AND CHARGES FOR ANY SELECTED OPTIONAL SERVICES. (See front)

1. If you want this receipt postmarked, stick the gummed stub on the left portion of the address side of the article, **leaving the receipt attached**, and present the article at a post office service window or hand it to your rural carrier. (no extra charge)
2. If you do not want this receipt postmarked, stick the gummed stub on the left portion of the address side of the article, date, detach and retain the receipt, and mail the article.
3. If you want a return receipt, write the certified-mail number and your name and address on a return receipt card, Form 3811, and attach it to the front of the article by means of the gummed ends if space permits. Otherwise, affix to back of article. Endorse front of article **RETURN RECEIPT REQUESTED** adjacent to the number.
4. If you want delivery restricted to the addressee, or to an authorized agent of the addressee, endorse **RESTRICTED DELIVERY** on the front of the article.
5. Enter fees for the services requested in the appropriate spaces on the front of this receipt. If return receipt is requested, check the applicable blocks in Item 1 of Form 3811.
6. Save this receipt and present it if you make inquiry.

☆ GPO 1978 -256-915

STATE OF OHIO
THE STATE MEDICAL BOARD
Suite 1006
180 East Broad Street
Columbus, Ohio 43215

'79 MAY 21 PM 2 39

OHIO STATE
MEDICAL BOARD

Federation of State Medical Boards
of the United States

PREV COPIES
ANS
FILE
FORM LETTER
CHECK
BY

Mrs. Fisher
Federation of State Medical Boards
of the United States, Inc.
1612 Summit Avenue
Fort Worth, TX 76102

Dear Mrs. Fisher:

The following physician has applied for endorsement licensure in Ohio based upon National Boards.

SCHWARTZ, David Bruce

Please indicate whether you have any derogatory information in your files. Thank you for your cooperation.

Sincerely,

Joan Elsman

Joan Elsman (Mrs.)
Chief, Endorsement and
Temporary Licensure

Derogatory Information:

We have no unfavorable
information regarding
the above named physician.

Harold Harvey, Jr., M.D.

Date MAY 18 1979

Urgent - licensure Pending
Thank You!

STATE OF OHIO
THE STATE MEDICAL BOARD
180 EAST BROAD STREET, SUITE 1006, COLUMBUS, OHIO 43215

DATE June 14, 1979

(7/78 - 6/79)

Dear Doctor,

Dr. David B. Schwartz who was a Resident in Ob/Gyn is applying for licensure in the State of Ohio. We would appreciate your assistance in filling out the following evaluation so that we can process his/her papers for licensure. Your immediate attention to this matter will be greatly appreciated by the doctor as well as by us. Thank you for your time and assistance.

(1) How long have you known the doctor? 1 year

(2) What was/is your supervisory capacity? Professor & Chairman of Department

(3) At what hospital? University of Cincinnati Medical Center

(4) How would you rate this doctor's medical knowledge and techniques? Adequate

(5) In your opinion, is this doctor a person of good moral and ethical character? Yes

(6) Does this doctor work well with peers and medical staff? Yes

(7) Does he/she relate well to patients? Yes

(8) How is his/her command of the English language? (If applicable) N.A.

(9) Would you recommend this doctor for licensure? Yes

Additional comments, please: (If needed, an extra sheet of paper may be used)

A Eleeds
Signature of Doctor

Professor & Chairman
Position

'79 JUN 20 PM12 10
OHIO STATE MEDICAL BOARD

Sincerely,

Joan Elsman

(Mrs.) Joan Elsman
Chief,
Endorsement and Temporary Licensur

4374

STATE OF OHIO
THE STATE MEDICAL BOARD
180 EAST BROAD STREET, SUITE 1006, COLUMBUS, OHIO 43215

DATE May 16, 1979

'79 MAY 18 AM 10 OHIO STATE MEDICAL BOARD HOUSE STAFF AFFAIRS

Dear Doctor,

Dr. DAVID BRUCE SCHWARTZ who was a resident, 7/78- Date
is applying for licensure in the State of Ohio. We would appreciate your assistance in filling out the following evaluation so that we can process his/her papers for licensure. Your immediate attention to this matter will be greatly appreciated by the doctor as well as by us. Thank you for your time and assistance.

(1) How long have you known the doctor? 6/30/78

(2) What was/is your supervisory capacity? Associate Dean for Clinical & House Staff Affairs

(3) At what hospital? University of Cincinnati Medical Center (Cincinnati General Hospital)

(4) How would you rate this doctor's medical knowledge and techniques? very good

(5) In your opinion, is this doctor a person of good moral and ethical character? yes

(6) Does this doctor work well with peers and medical staff? yes

(7) Does he/she relate well to patients? yes

(8) How is his/her command of the English language? (If applicable) not applicable

(9) Would you recommend this doctor for licensure? yes

Additional comments, please: (If needed, an extra sheet of paper may be used)

While in training at our medical center Dr. David Bruce Schwartz was rated on his professional ability, energy, reliability, originality and cooperation. He was ratedvery good in these categories.

'79 JUL 31 PM 2 23 OHIO STATE MEDICAL BOARD

Kenneth W. Lowe, J.
Signature of Doctor
Associate Dean for
Clinical & House Staff Affairs
Position

Sincerely,

Joan Elsman

(Mrs.) Joan Elsman
Chief,
Endorsement and Temporary Licensure

SENDER:

- Complete items 1 and/or 2 for additional services.
- Complete items 3, and 4a & b.
- Print your name and address on the reverse of this form so that we can return this card to you.
- Attach this form to the front of the mailpiece, or on the back if space does not permit.
- Write "Return Receipt Requested" on the mailpiece below the article number.
- The Return Receipt will show to whom the article was delivered and the date delivered.

I also wish to receive the following services (for an extra fee):

1. ☐ Addressee's Address
2. ☐ Restricted Delivery

Consult postmaster for fee.

3. Article Addressed to:

DAVID BRUCE SCHWARTZ
3120 BURNET AVE
CINCINNATI OH 45229

4a. Article Number

4b. Service Type

- ☐ Registered
- ☐ Insured
- ☒ Certified
- ☐ COD
- ☐ Express Mail
- ☒ Return Receipt for Merchandise

7. Date of Delivery 4-27-93

5. Signature (Addressee)

6. Signature (Agent) Michelle Mercer

8. Addressee's Address (Only if requested and fee is paid)

PS Form 3811, December 1991 ☆ U.S.G.P.O.: 1992-307-530 **DOMESTIC RETURN RECEIPT**

Is your RETURN AD on the reverse side?

Thank you for using Return Receipt Service.

UNITED STATES POSTAL SERVICE

Official Business

PENALTY FOR PRIVATE USE TO AVOID PAYMENT OF POSTAGE, $300

U.S. MAIL

93 APR 20 AM 11:48

STATE MEDICAL BOARD
OF OHIO

Print your name, address and ZIP Code here

STATE MEDICAL BOARD
77 SOUTH HIGH STREET
17TH FLOOR
COLUMBUS OH 43266-0315

STATE MEDICAL BOARD OF OHIO
77 South High Street, 17th Floor • Columbus, Ohio 43266-0315 • (614) 466-3934

JUN 3 0 1993

David B. Schwartz, M.D.
3120 Burnet Ave.
Cincinnati, OH 45229

Dear Doctor:

Thank you for your prompt response to our request for audit material.

The results of this audit confirm that the continuing medical education materials you submitted for relicensure did indeed meet the Board's requirements.

The current and subsequent registration periods will end July 1, 1994, and July 1 of each even numbered year thereafter. It will be necessary to complete 100 credits with 40 being in Category I during each registration period. Licenses will expire on September 30 of each even numbered year. Please keep the Board informed of any address change.

Again, thank you for your cooperation.

Very truly yours,

Carla S. O'Day, M.D.
Secretary
State Medical Board of Ohio

CSO:jdc

Revised 04/05/93

SCHWARTZ

92

CERTIFICATION LOG OF CONTINUING MEDICAL EDUCATION FOR THE PERIOD OF JANUARY 1, 1991 - SEPTEMBER 30, 1992

I certify the following to be true and correct. This form must be completed, signed and returned.

SIGNATURE	DATE	OHIO CERTIFICATE NUMBER
MD	4/28/93	043742

NAME (Last)	(First)	(Middle)	(Suffix, Jr., II)
SCHWARTZ	DAVID	BRUCE	

ADDRESS (Number & street)	(City)	(State)	(Zip code)
3120 BURNET AVENUE	CINCINNATI	OH	45229

CATEGORY I

PLEASE ATTACH DOCUMENTATION

75 CREDIT REQUIREMENT
At least *30 credits* must be earned in Category I. Please list Category II credits on reverse side.

Name of Sponsor	Location (City & State)	Description	Date	Credits
Examples: Ohio State University Hosp.	Columbus, Ohio	Pediatric Grand Rounds	12/01/91 thru 12/31/91	4
Christ Hospital	Cincinnati, Ohio	Surgery Residency	07/01/91 thru 06/30/92	50
ACOG COMPUTER PRINTOUT	ID # CB 0217900		4/91 - 12/91	37
UNIV OF CINTI COMPUTER PRINTOUT	ID # 1S2440347			9
JEWISH HOSPITAL	CINCINNATI OHIO	OB ROUNDS		5

Revised 01/13/93

OVER

CATEGORY II

A Maximum of *45 credits* may be earned in this Category.

Name of Sponsor	Location (City & State)	Description	Date	Credits
Examples: Riverside Hospital	**Toledo, Ohio**	**Internal Medicine Staff Meeting**	**10/21/91**	**8**
Self Instruction		**American Journal of Opthalmology**	**01/92 thru 09/92**	**60+**
MEDICAL STUDENT TEACHING - PRECEPTOR 4th yr STUDENT	UNIVERSITY OF CINCINNATI	MED STUDENT PRECEPTORSHIP - SPENDS ONE MONTH DONE FOR 2/92 6/92	2/1/92 - 2/28/92 6/1/92 - 6/30/92	100+ 100+
SELF INSTRUCTION		JOURNAL OF OB-GYN		12
		FERTILITY & STERILITY		12
MED STUDENT PRECEPTOR. 1ST yr STUDENT				9

THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

PROGRAM FOR CONTINUING PROFESSIONAL DEVELOPMENT

ACOG COGNATE PROGRAM

409 12th Street, S.W.
Washington, D.C. 20024-2188
(800) 673 8444 • (202) 863 2402

TRANSCRIPT

ACOG ID NUMBER	CR-0217900

PAGE NO 1

DAVID BRUCE SCHWARTZ M.D.
JEWISH HOSP PROF BLDG
3120 BURNETT AVE, #204
CINCINNATI OH 45229-3087

COGNATES REPORTED THROUGH MAR 15 1992 DATE OF ISSUE 04/15/92

FINDER # (ACOG USE ONLY)	ACTIVITY DATE	CODE	CME ACTIVITY	CYCLE	CREDITED COGNATES	ADDITIONAL COGNATES	TOTAL AWARD COGNATES CAT I	CAT II	CAT III
00126-000	12/31/89	07	ACOG UPDATE TAPES	14	3	0	3	0	0
11029-004	09/30/90	01	POSTGRAD COURSE/SPECIALTY MEET	17	2	0	2	0	0
01023-000	10/06/90	01	POSTGRAD COURSE/SPECIALTY MEET	17	17	0	19	0	0
11029-006	12/31/90	06	HOSPITAL TRAINING SESSION	17	2	0	21	0	0
11029-005	04/18/91	01	POSTGRAD COURSE/SPECIALTY MEET	17	1	0	22	0	0
10520-000	04/26/91	01	POSTGRAD COURSE/SPECIALTY MEET	17	6	0	28	0	0
11008-000	09/21/91	01	POSTGRAD COURSE/SPECIALTY MEET	17	20	0	48	0	0
11029-000	10/15/91	01	POSTGRAD COURSE/SPECIALTY MEET	17	1	0	49	0	0
11029-003	10/17/91	01	POSTGRAD COURSE/SPECIALTY MEET	17	1	0	50	0	0
11029-001	10/18/91	01	POSTGRAD COURSE/SPECIALTY MEET	17	1	0	51	0	0
11029-002	10/20/91	01	POSTGRAD COURSE/SPECIALTY MEET	17	1	0	52	0	0
20205-000	12/31/91	07	ACOG UPDATE TAPES	17	6	0	58	0	0

SUMMARY OF COGNATES FOR PRIMARY CYCLE 14

REPORTING YEARS	CAT. I	CAT. II	CAT. III	TOTAL
87	0	0	0	0
88	0	0	0	0
89	3	0	0	3

TOTAL COGNATES THIS CYCLE 3

SUMMARY OF COGNATES FOR SECONDARY CYCLE 17

REPORTING YEARS	CAT. I	CAT. II	CAT. III	TOTAL
90	21	0	0	21
91	37	0	0	37
92	0	0	0	0

TOTAL COGNATES THIS CYCLE 58

CONTINUING EDUCATION
TRANSCRIPT

PARTICIPANT SCHWARTZ, DAVID B. ID.NUMBER Redaction

COURSE ORIGIN	DEPT-DIV/CO NO.	ICDA NO.	CODE	DATE	HOURS	PROGRAM / TITLE DESCRIPTION	CTY
3 1	45	75	302.70	1/17/91	1.00	CINTI. OB/GYN SOCIETY MEETING	
3 1	45	00	V 25.	1/31/91	1.00	NORPLANT: FACT OR FICTION	
3 1	45	34	V 25.	3/15/91	1.00	NORPLANT	
3 1	45	00	733.00	4/26/91	6.50	TREATMENT & EVAL. OF OSTEOPOROSIS	
3 1	45	34	183.0	5/17/91	1.00	OVARIAN CANCER SCREENING	
3 1	45	00	629.9	9/19/91	7.00	RECENT ADVANCES IN OB/GYN	
3 1	45	00	629.9	9/20/91	7.00	RECENT ADVANCES IN OB/GYN	
3 1	00	34	V 62.89	10/08/91	1.00	OHIO'S LIVING WILL ACT	
3 1	45	00	615.9	10/10/91	1.00	LONG-TERM MGT. OF ENDOMETRIOSIS	
3 1	45	34	V 26.	10/18/91	1.00	OVULATION INDUCTION	
3 1	45	00	079.8	11/07/91	1.00	CHLAMYDIA & BETA STREP INFECTIONS	
3 1	45	00	V 22.2	12/12/91	1.00	PERINEAL MGT. - A RANDOMIZED TRIAL	
3 1	45	00	V 25.01	2/20/92	1.00	USE OF THE PILL/VARIOUS AGE GROUPS	
3 1	45	00	633.9	4/30/92	1.00	ECTOPIC PREGNANCIES IN THE 1990'S	
3 1	45	00	617.9	5/07/92	1.00	ASPECTS OF ENDOMETRIOSIS	

32.50 IS TOTAL OF CREDIT HOURS

University of Cincinnati
Medical Center

College of Medicine

Office of the Dean

231 Bethesda Avenue (ML 555)
Cincinnati, Ohio 45267-0555
Phone (513) 558-7391

April 10, 1992

David Schwartz, MD
3120 Burnet Avenue, #204
Cincinnati, OH 45229

Dear Dr. Schwartz,

The 1991 Clinical Opportunities Program for our freshmen medical students is over. On behalf of the College of Medicine, I sincerely thank you and your staff for providing our students with this unique and enriching experience. Some aspects of medicine are best taught outside the classroom, and you have contributed to a more well-rounded education by permitting the student to experience your practice setting. We are very fortunate that we are one of the few schools in this country that can offer this clinical exposure so early in the student's training, and we could not have done it without you.

This letter confirms your participation as a preceptor in Winter Quarter 1992 for first year student Danielle O'Neil. Students are required to spend a minimum of 9 hours with their preceptor, so your precepting time for the Introduction to Clinical Practice course totals 9 hours.

I've enclosed a copy of the evaluation that your student completed about the experience with you. I ask that you share this information with other preceptors in your office with whom the student worked.

We are pleased to have you as an instructor in our Clinical Opportunities course and hope you will continue to work with us in the future.

Sincerely,

Peg Butorac
Clinical Opportunities Coordinator

enc.

ID# STAFF MEMBER NAME

1X0895 Schwartz, David M.D.

Type	Local	A*A	From	To	Hours	Sponsor or Description of Activity
InDire	Cat-1	1-Acc	01/30/91	01/30/91	1.00	JEWISH HOSPITAL OF CINCINNATI, OHIO TUMOR BOARD
Direct	Cat-1	1-Acc	03/15/91	03/15/91	1.00	JEWISH HOSPITAL, CINCINNATI, OHIO NORPLANT
InDire	Cat-1	1-Acc	05/17/91	05/17/91	1.00	JEWISH HOSPITAL OF CINCINNATI, CINCINNATI, OHIO OVARIAN CANCER SCREENING
InDire	Cat-1	1-Acc	09/20/91	09/20/91	1.00	JEWISH HSP. - CINCINNATI, OHIO DEPT. OF OB/GYN-OVULATION INDUCTION
None	Cat-1	1-Acc	10/08/91	10/08/91	1.00	The Jewish Hospital of Cincinnati Ohio's Living Will Act

	Local				A*A		Local	A*A
	Cat-1	Cat-2	Cat-3	Cat-4	1-Acc	2-Non	Total	Total
CME Credit Hours:	5.00	0.00	0.00	0.00	5.00	0.00	5.00	5.00

STATE MEDICAL BOARD OF OHIO

77 South High Street, 17th Floor • Columbus, Ohio 43266-0315 • (614) 466-3934

DAVID BRUCE SCHWARTZ
3120 BURNET AVE
CINCINNATI OH 45229

Dear Doctor:

Upon renewal of your Ohio license to practice medicine and surgery, as of October 1, 1992, you certified that during the last registration period (January 1, 1991 - September 30, 1992) you had completed the requisite hours of Continuing Medical Education as certified by the Ohio State Medical Association and approved by the Board.

At this time, as a result of your being randomly selected for audit, it will be necessary for you to complete the enclosed log of Continuing Medical Education. It will also be necessary for you to provide the Board with documentation that you have actually completed at least 30 hours of Category I CME as certified on your license renewal application. Certificates of attendance, hospital printouts and accredited organization printouts are acceptable documentation, copies of which must be enclosed with your log. Those individuals desiring CME credits for their residency training program must submit either a copy of their certificate or a letter from the training program director giving the dates that they were in the program.

Up to forty-five hours of Category II credits may be listed on the reverse side of the log, but no documentation need be provided.

It is important you understand that under Ohio law it is your responsibility to document your CME participation, and, further that a failure to comply with the audit requirements can result in revocation or suspension of your license to practice in Ohio.

Please return the above requested material to the State Medical Board of Ohio within three weeks of receipt of this letter. The result of your log audit will be made available to you in the near future.

Thank you for your cooperation.

Sincerely,

Carla S. O'Day, M.D.
Secretary
State Medical Board of Ohio

CSO:jdc

Enclosures

CERTIFIED MAIL #
RETURN RECEIPT REQUESTED

Revised 04/05/93

STATE OF OHIO STATE MEDICAL BOARD

65 SOUTH FRONT ST. SUITE 510 COLUMBUS, OHIO 43215

I CERTIFY, UNDER PENALTY OF THE LOSS OF MY RIGHT TO PRACTICE MEDICINE AND SURGERY IN THE STATE OF OHIO, THAT I HAVE COMPLETED DURING THE LAST BIENNIUM THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE OHIO STATE MEDICAL ASSN AND IF ALLOWED BY THE STATE MEDICAL BOARD AND HEREBY MAKE APPLICATION FOR RENEWAL.

(SIGNATURE OF APPLICANT) (DATE) 10/8/84

APPLICATION FOR BIENNIAL LICENSE RENEWAL TO PRACTICE AS A

DOCTOR OF MEDICINE

IDENTIFICATION NUMBER 25-04-3742

DAVID BRUCE SCHWARTZ
[redacted] FLAGSTAFF DR
CINCINNATI OH 45215

OF 0345 F

MD & DO SPECIALTY CODES

SPECIALTY CODES CURRENTLY ON RECORD → 39

IF NECESSARY TO CORRECT, ENTER ALL SPECIALTY CODE NUMBERS → [ ] [ ]

(SEE LIST ON ENCLOSED CARD) (LIMIT OF 2)

AMOUNT DUE $100.00 DATE DUE 12/15/84

INSTRUCTIONS

1. DO NOT FOLD OR STAPLE THIS CARD.
2. REVERSE SIDE MUST BE COMPLETED.
3. MAKE CHECK OR MONEY ORDER PAYABLE TO: TREASURER, STATE OF OHIO
4. PUT IDENTIFICATION NUMBER ON CHECK.
5. MARK CORRECT SPECIALTY CODE(S) BELOW.
6. SEND PAYMENT (DO NOT SEND CASH) AND THIS APPLICATION IN ENCLOSED ENVELOPE TO: TREASURER, STATE OF OHIO BOX 2438 COLUMBUS, OHIO 43216

REPORT ANY CHANGE OF ADDRESS OF RECORD

(PLEASE PRINT)

LAST NAME FIRST NAME INITIAL

STREET ADDRESS

CITY STATE ZIP CODE

COUNTY

TO RECEIVE YOUR RENEWAL CARD BY DECEMBER 31ST, RETURN THIS APPLICATION AND FEE BY DUE DATE.

THE ADDRESS SHOWN ON THE FRONT OF THIS CARD WILL BE MAINTAINED AS YOUR ADDRESS OF RECORD WITH THE BOARD.

PRINCIPAL PRACTICE ADDRESS — IF DIFFERENT FROM THAT SHOWN ON FRONT
(PLEASE PRINT)

LAST NAME FIRST NAME INITIAL

STREET ADDRESS

CITY STATE ZIP CODE

COUNTY

SOCIAL SECURITY NUMBER _____

SECTION 4731.281, OHIO REVISED CODE REQUIRES THAT A RESPONSE BE GIVEN TO THE FOLLOWING QUESTION. PLEASE MARK THE CORRECT BOX.

SINCE YOU LAST RENEWED YOUR OHIO MEDICAL LICENSE, HAVE YOU BEEN CONVICTED OF OR PLEAD NOLO CONTENDERE TO:

YES	NO	
☐	☐	a.) a felony,
☐	☐	b.) a misdemeanor committed in the course of your practice, or
☐	☐	c.) a federal or state law regulating the possession, distribution or use of any drug?

AT ANY TIME SINCE THE LAST RENEWAL OF YOUR CERTIFICATE HAVE YOU:

YES	NO		YES	NO	
☐	☐	1). Been addicted to or dependent upon alcohol or any chemical substance?	☐	☐	3). Surrendered or consented to limitation of your license to practice medicine, or state or federal privileges to prescribe controlled substances?
☐	☐	2). Had any disciplinary action taken or initiated against you by a state licensing agency?	☐	☐	4). Had any hospital privileges suspended or revoked?

.1456

STATE MEDICAL BOARD OF OHIO

65 SOUTH FRONT ST., SUITE 510 COLUMBUS, OHIO 43215

I CERTIFY, UNDER PENALTY OF THE LOSS OF MY RIGHT TO PRACTICE MEDICINE AND SURGERY IN THE STATE OF OHIO, THAT I HAVE COMPLETED DURING THE LAST BIENNIUM THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE OHIO STATE MEDICAL ASSN AND APPROVED BY THE STATE MEDICAL BOARD AND HEREBY MAKE APPLICATION FOR RENEWAL.

(SIGNATURE OF APPLICANT) (DATE)

APPLICATION FOR BIENNIAL LICENSE RENEWAL TO PRACTICE AS A DOCTOR OF MEDICINE

IDENTIFICATION NUMBER 35-04-3742

1 DAVID BRUCE SCHWARTZ
668 FLAGSTAFF DR
CINCINNATI OH 45215

MD & DO SPECIALTY CODES
ENTER ALL SPECIALTY CODES 39 (SEE LIST ON ENCLOSED CARD) (LIMIT OF 3)

AMOUNT DUE $100.00 DATE DUE 11/15/86

EDM-14940

INSTRUCTIONS

1. DO NOT FOLD OR STAPLE THIS CARD.
2. REVERSE SIDE MUST BE COMPLETED.
3. MAKE CHECK OR MONEY ORDER PAYABLE TO: TREASURER, STATE OF OHIO
4. PUT IDENTIFICATION NUMBER ON CHECK.
5. MARK CORRECT SPECIALTY CODE(S) BELOW.
6. SEND PAYMENT (DO NOT SEND CASH) AND THIS APPLICATION IN ENCLOSED ENVELOPE TO:

TREASURER, STATE OF OHIO
BOX 2438 COLUMBUS, OHIO 43216

REPORT ANY CHANGE OF ADDRESS OF RECORD
(PLEASE PRINT)

LAST NAME FIRST NAME INITIAL

3120 Burnet Ave
STREET ADDRESS

45229
CITY STATE ZIP CODE

Hamilton
COUNTY

TO RECEIVE YOUR RENEWAL CARD BY DECEMBER 31ST, RETURN THIS APPLICATION AND FEE BY NOVEMBER 15

THE ADDRESS SHOWN ON THE FRONT OF THIS CARD WILL BE MAINTAINED AS YOUR ADDRESS OF RECORD WITH THE BOARD.

PRINCIPAL PRACTICE ADDRESS – IF DIFFERENT FROM THAT SHOWN ON FRONT
(PLEASE PRINT)

LAST NAME FIRST NAME INITIAL

STREET ADDRESS

CITY STATE ZIP CODE

COUNTY

SOCIAL SECURITY NUMBER

SECTION 4731.281, OHIO REVISED CODE REQUIRES THAT A RESPONSE BE GIVEN TO THE FOLLOWING QUESTION. PLEASE MARK THE CORRECT BOX.

SINCE YOU LAST RENEWED YOUR OHIO MEDICAL LICENSE, HAVE YOU BEEN FOUND GUILTY OR PLEAD GUILTY OR NO CONTEST TO:

YES	NO	
☐	☐	a.) a felony.
☐	☐	b.) a misdemeanor committed in the course of your practice, or
☐	☐	c.) a federal or state law regulating the possession, distribution or use of any drug?

EDM-14946-B

AT ANY TIME SINCE THE LAST RENEWAL OF YOUR CERTIFICATE HAVE YOU:

YES	NO		YES	NO	
☐	☐	1.) Been addicted to or dependent upon alcohol or any chemical substance?	☐	☐	3.) Surrendered or consented to limitation upon a license to practice medicine, or state or federal privileges to prescribe controlled substances?
☐	☐	2.) Had any disciplinary action taken or initiated against you by a state licensing agency?	☐	☐	4.) Had any hospital privileges suspended or revoked?

STATE MEDICAL BOARD OF OHIO

MEDICINE

I CERTIFY, UNDER PENALTY OF THE LOSS OF MY RIGHT TO PRACTICE AND SURGERY IN THE STATE OF OHIO, THAT I HAVE COMPLETED DURING THE LAST BIENNIUM THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE OHIO STATE MEDICAL ASSN AND APPROVED BY THE STATE MEDICAL BOARD AND HEREBY MAKE APPLICATION FOR RENEWAL.

(SIGNATURE OF APPLICANT) 9/20/88 (DATE)

INSTRUCTIONS

1. DO NOT FOLD OR STAPLE THIS CARD
2. REVERSE SIDE MUST BE COMPLETED
3. MAKE CHECK OR MONEY ORDER PAYABLE TO TREASURER, STATE OF OHIO
4. PUT IDENTIFICATION NUMBER ON CHECK
5. UPDATE SPECIALTY IF NEEDED
6. SEND PAYMENT (DO NOT SEND CASH) AND THIS APPLICATION IN ENCLOSED ENVELOPE TO TREASURER, STATE OF OHIO, BOX 2438, COLUMBUS, OHIO 43216

APPLICATION FOR BIENNIAL LICENSE RENEWAL TO PRACTICE AS A: DOCTOR OF MEDICINE

IDENTIFICATION NUMBER 35-04-3742

Q1-00223-OF

DAVID BRUCE SCHWARTZ
3120 BURNET AVE
CINCINNATI OH 45229

MD & DO SPECIALTY CODES		AMOUNT DUE	DATE DUE
SPECIALTY CODES CURRENTLY ON RECORD: 30		$100.00	11/01/88
IF NECESSARY TO CORRECT, ENTER ALL SPECIALTY CODE NUMBERS (SEE LIFE ON ENCLOSED CARD)	(LIMIT OF 3)		

REPORT ANY CHANGE OF ADDRESS OF RECORD
(PLEASE PRINT)

LAST NAME FIRST NAME INITIAL

STREET ADDRESS

CITY STATE ZIP CODE

COUNTY

TO RECEIVE YOUR RENEWAL CARD BY DECEMBER 31ST, RETURN THIS APPLICATION AND FEE BY NOVEMBER 1

THE ADDRESS SHOWN ON THE FRONT OF THIS CARD WILL BE MAINTAINED AS YOUR ADDRESS OF RECORD WITH THE BOARD.

PRINCIPAL PRACTICE ADDRESS—IF DIFFERENT FROM THAT SHOWN ON FRONT
(PLEASE PRINT)

LAST NAME FIRST NAME INITIAL

STREET ADDRESS

CITY STATE ZIP CODE

COUNTY

SECTION 4731.281, OHIO REVISED CODE REQUIRES THAT A RESPONSE BE GIVEN TO THE FOLLOWING QUESTION. PLEASE MARK THE CORRECT BOX.

SINCE YOU LAST RENEWED YOUR OHIO MEDICAL LICENSE, HAVE YOU BEEN FOUND GUILTY OR PLEAD GUILTY OR NO CONTEST TO:

YES	NO	
☐	☐	a.) a felony
☐	☐	b.) a federal or state law regulating the possession, distribution or use of any drug?

SOCIAL SECURITY NUMBER _____

AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION FOR RENEWAL OF YOUR CERTIFICATION HAVE YOU:

YES	NO	
☐	☐	1.) Been addicted to or dependent upon alcohol or any chemical substance? You may answer no to this question if you have successfully completed treatment at a program approved by this Board and have subsequently adhered to all statutory requirements as contained in Section 4731.224, O.R.C., and related provisions; or are currently enrolled in a Board approved program.
☐	☐	2.) Had any disciplinary action taken or initiated against you by a state licensing agency?
☐	☐	3.) Surrendered or consented to limitation upon a license to practice medicine by any state or federal privileges to prescribe controlled substances?
☐	☐	4.) Had any clinical privileges suspended or revoked for other than failure to maintain records or attend staff meetings.

QT-00224-OB

DETACH HERE AND REMIT THIS PORTION WITH FEE

STATE MEDICAL BOARD OF OHIO

77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 43266 0315

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED DURING THE LAST BIENNIUM THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE OHIO STATE MEDICAL ASSOCIATION AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.

X _____ 9-27-90

(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER:	AMOUNT DUE	DATE DUE
35-04-3742	$160.00	11/01/90

DAVID BRUCE SCHWARTZ, M.D.
3120 BURNET AVE
CINCINNATI OH 45229

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

39 OBSTETRICS & GYNECOLOGY

☐ SPECIALTY CODE(S) CORRECT AS LISTED

IF THE SPECIALTY CODE(S) ARE IN ERROR, ENTER ALL SPECIALTY CODE NUMBERS. CODE1 CODE2 CODE3

CHANGE OF ADDRESS

STREET

STREET

CITY STATE ZIP CODE

COUNTY

:96969696 21: 0935043742 21" "00000160000"

PRINCIPAL PRACTICE ADDRESS - IF DIFFERENT FROM THE ADDRESS SHOWN ON FRONT:

Street

Street

City State Zip Code

County

HAVE YOU BEEN FOUND GUILTY OF, OR PLEAD GUILTY OR NO CONTEST TO :

YES	NO	
☐	☐	A.) A felony
☐	☐	B.) A federal or state law regulating the possession, distribution or use of any drug?

AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION FOR RENEWAL OF YOUR CERTIFICATE HAVE YOU :

YES	NO	
☐	☐	1.) Been addicted to or dependent upon alcohol or any chemical substance? You may answer "no" to this question if you have successfully completed treatment at a program approved by this board and have subsequently adhered to all statutory requirements as contained in section 4731.224, O.R.C., and related provisions, or you are currently enrolled in a board approved program. Any questions concerning approval can be directed to the board offices.
☐	☐	2.) Had any disciplinary action taken or initiated against you by any state licensing board?
☐	☐	3.) Surrendered, or consented to limitation upon: a) A license to practice medicine; OR b) State or federal privileges to prescribe controlled substances?
☐	☐	4.) Had any clinical privileges suspended or revoked for reasons other than failure to maintain records or attend staff meetings?

Redaction

SOCIAL SECURITY NUMBER
(Optional for purposes of Identification)

DETACH HERE AND REMIT THIS PORTION WITH FEE

STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 43266 - 0315

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED DURING THE LAST BIENNIUM THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE **OHIO STATE MEDICAL ASSOCIATION** *AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.*

X _____
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-04-3742	$160.00	07/01/92

DAVID BRUCE SCHWARTZ,M.D.
3120 BURNET AVE
CINCINNATI OH 45229

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

39 OBSTETRICS & GYNECOLOGY

☐ SPECIALTY CODE(S) CORRECT AS LISTED

IF THE SPECIALTY CODE(S) ARE IN ERROR, ENTER ALL SPECIALTY CODE NUMBERS. CODE1 CODE2 CODE3

CHANGE OF ADDRESS

STREET
STREET
CITY STATE ZIP CODE
COUNTY

:969696962: 0935043742 :00000160000:

PRINCIPAL PRACTICE ADDRESS - IF DIFFERENT FROM THE ADDRESS SHOWN ON FRONT.

Street
Street
City State Zip Code
County

HAVE YOU BEEN FOUND GUILTY OF, OR PLED GUILTY OR NO CONTEST TO :

YES NO
☐ ☐ *A.) A felony or misdemeanor.*
☐ ☐ *B.) A federal or state law regulating the possession, distribution or use of any drug?*

AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION FOR RENEWAL OF YOUR CERTIFICATE HAVE YOU :

YES NO
☐ ☐ *1.) Been addicted to or dependant upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse? You may answer "no" to this question if you have successfully completed treatment at a program approved by this board and have subsequently adhered to all statutory requirements as contained in section 4731.224, O.R.C., and related provisions, or you are currently enrolled in a board approved program. Any questions concerning approval can be directed to the board offices.*
☐ ☐ *2.) Had a license denied by or had any disciplinary action taken or initiated against you by any state licensing board other than the State Medical Board of Ohio?*
☐ ☐ *3.) Surrendered, or consented to limitation upon: a) A license to practice medicine; OR b) State or federal privileges to prescribe controlled substances?*
☐ ☐ *4.) Had any clinical privileges suspended, limited or revoked for reasons other than failure to maintain records or attend staff meetings?*

Redaction
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SOCIAL SECURITY NUMBER
(Optional for purposes of Identification)

DETACH HERE AND REMIT THIS PORTION WITH FEE

STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 43266 - 0315

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 1992-1994 BIENNIUM THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE OHIO STATE MEDICAL ASSOCIATION AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.

X [signature] 3/29/94

(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-04-3742	$250.00	05/01/94

DAVID BRUCE SCHWARTZ,M.D.
3120 BURNET AVE
CINCINNATI OH 45229

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

OBG OBSTETRICS & GYNECOLOGY

☑ SPECIALTY CODE(S) CORRECT AS LISTED

IF CORRECTIONS ARE NECESSARY, PLEASE ENTER ALL SPECIALTY CODES. CODE1 CODE2 CODE3

REPORT ANY CHANGE OF ADDRESS

STREET

STREET

CITY STATE ZIP CODE

COUNTY

⑆969696962⑆ 0935043742⑈ ⑈0000025000⑈

PRINCIPAL PRACTICE ADDRESS - IF DIFFERENT FROM THE ADDRESS SHOWN ON FRONT:

Street

Street

City State Zip Code

County

TAX BATCH P-DATE REC# MC# AMOUNT BATCHDATE ACCOUNT #

AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION FOR RENEWAL OF YOUR CERTIFICATE HAVE YOU :

YES ☐ NO ☑ 1.) Been found guilty of, or pled guilty or no contest to a felony or misdemeanor.

YES ☐ NO ☑ 2.) Been found guilty of, or pled guilty or no contest to a federal or state law regulating the possession, distribution or use of any drug?

YES ☐ NO ☑ 3.) Been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse? You may answer "no" to this question if you have successfully completed treatment at a program approved by this board and have subsequently adhered to all statutory requirements as contained in sections 4731.224 and 4731.25 O.R.C., and related provisions, or you are currently enrolled in a board approved program. Any questions concerning approval can be directed to the board offices.

YES ☐ NO ☑ 4.) Had malpractice insurance cancelled or limited for other than failure to pay premiums?

YES ☐ NO ☑ 5.) Had any disciplinary action taken or initiated against you by any state licensing board other than the State Medical Board of Ohio?

YES ☐ NO ☑ 6.) Surrendered, or consented to limitation upon: a) A license to practice medicine; OR b) State or federal privileges to prescribe controlled substances?

YES ☐ NO ☑ 7.) Had any clinical privileges suspended, restricted or revoked for reasons other than failure to maintain records or attend staff meetings?

YES ☐ NO ☑ 8.) After January 14, 1993, referred a patient, or participated in an arrangement or scheme for referral of a patient, for clinical laboratory services to a person or facility in which either you or a member of your immediate family has an ownership or investment interest, or any compensation arrangement?

[redacted]

SOCIAL SECURITY NUMBER
(Optional for purposes of identification)

DETACH HERE AND REMIT THIS PORTION WITH FEE

STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 43266 - 0315

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 1994-1996 BIENNIUM THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE OHIO STATE MEDICAL ASSOCIATION *AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.*

X [signature] 3/1/96

(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-04-3742	$250.00	05/01/96

DAVID BRUCE SCHWARTZ,M.D.
3120 BURNET AVE
CINCINNATI OH 45229

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

OBG OBSTETRICS & GYNECOLOGY

☐ SPECIALTY CODE(S) CORRECT AS LISTED

IF CORRECTIONS ARE NECESSARY, PLEASE ENTER ALL SPECIALTY CODES. CODE1 CODE2 CODE3

REPORT ANY CHANGE OF ADDRESS

STREET

STREET

CITY STATE ZIP CODE

COUNTY

⑆969696962⑆ 093504374 2⑈ ⑈0000025000⑈

PRINCIPAL PRACTICE ADDRESS - IF DIFFERENT FROM THE ADDRESS SHOWN ON FRONT:

Street

Street

City State Zip Code

County

AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION FOR RENEWAL OF YOUR CERTIFICATE HAVE YOU :

1.) Been found guilty of, or pled guilty or no contest to a felony or misdemeanor. YES ☐ NO ☑

2.) Been found guilty of, or pled guilty or no contest to a federal or state law regulating the possession, distribution or use of any drug? YES ☐ NO ☑

3.) Been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse? You may answer "no" to this question if you have successfully completed treatment at a program approved by this board and have subsequently adhered to all statutory requirements as contained in sections 4731.224 and 4731.25 O.R.C., and related provisions, or you are currently enrolled in a board approved program. Any questions concerning approval can be directed to the board offices. YES ☐ NO ☑

4.) Had malpractice insurance cancelled or limited for other than failure to pay premiums? YES ☐ NO ☑

5.) Had any disciplinary action taken or initiated against you by any state licensing board other than the State Medical Board of Ohio? YES ☐ NO ☑

6.) Surrendered, or consented to limitation upon: a) A license to practice medicine; OR b) State or federal privileges to prescribe controlled substances? YES ☐ NO ☑

7.) Had any clinical privileges suspended, restricted or revoked for reasons other than failure to maintain records or attend staff meetings? YES ☐ NO ☑

8.) Referred a patient, or participated in an arrangement or scheme for referral of a patient, for clinical laboratory services to a person or facility in which either you or a member of your immediate family has an ownership or investment interest, or any compensation arrangement? YES ☐ NO ☑

SOCIAL SECURITY NUMBER (Optional for purposes of identification)

[redacted]

833 00088 040196 0005 3 250.00 032096 935043742
TAX BATCH P.DATE SEQ# MC# AMOUNT BATCHDATE ACCOUNT #

DETACH HERE AND REMIT THIS PORTION WITH FEE

STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 43266 - 0315

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 1996-1998 BIENNIUM THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE OHIO STATE MEDICAL ASSOCIATION AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.

X _____ 9/28/98
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-04-3742-S	$179.00	05/01/98

DAVID BRUCE SCHWARTZ,M.D.
3120 BURNET AVE
CINCINNATI OH 45229

32-2-16 9191 # 204.00 10-6-98

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

OBG OBSTETRICS & GYNECOLOGY

☐ SPECIALTY CODE(S) CORRECT AS LISTED

IF CORRECTIONS ARE NECESSARY, PLEASE ENTER ALL SPECIALTY CODES. CODE1 CODE2 CODE3

REPORT ANY CHANGE OF ADDRESS

STREET
STREET
CITY STATE ZIP CODE
COUNTY

:96969696 21: 0935043742 11" "00000179000"

PRINCIPAL PRACTICE ADDRESS - IF DIFFERENT FROM THE ADDRESS SHOWN ON FRONT:

Street 2123 AUBURN AVE
Street
City CINCINNATI State OH Zip Code 45219
County HAMILTON

AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION FOR RENEWAL OF YOUR CERTIFICATE HAVE YOU :

YES ☐ NO ☐ 1.) Been found guilty of, or pled guilty or no contest to a felony or misdemeanor.

YES ☐ NO ☐ 2.) Been found guilty of, or pled guilty or no contest to a federal or state law regulating the possession, distribution or use of any drug?

YES ☐ NO ☐ 3.) Been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse? You may answer "no" to this question if you have successfully completed treatment at a program approved by this board and have subsequently adhered to all statutory requirements as contained in sections 4731.224 and 4731.25 O.R.C., and related provisions, or you are currently enrolled in a board approved program. Any questions concerning approval can be directed to the board offices.

YES ☐ NO ☐ 4.) Had malpractice insurance cancelled or limited for other than failure to pay premiums?

YES ☐ NO ☐ 5.) Had any disciplinary action taken or initiated against you by any state licensing board other than the State Medical Board of Ohio?

YES ☐ NO ☐ 6.) Surrendered, or consented to limitation upon: a) A license to practice medicine; OR b) State or federal privileges to prescribe controlled substances?

YES ☐ NO ☐ 7.) Had any clinical privileges suspended, restricted or revoked for reasons other than failure to maintain records or attend staff meetings?

YES ☐ NO ☐ 8.) Referred a patient, or participated in an arrangement or scheme for referral of a patient, for clinical laboratory services to a person or facility in which either you or a member of your immediate family has an ownership or investment interest, or any compensation arrangement?

SOCIAL SECURITY NUMBER
(Optional for purposes of identification.)
Redaction

DETACH HERE AND REMIT THIS PORTION WITH FEE

STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 43266 - 0315

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 1998-1999 REGISTRATION PERIOD THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE
OHIO STATE MEDICAL ASSOCIATION
AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.

X _____
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-04-3742-S	$305.00	10/01/99

DAVID BRUCE SCHWARTZ,M.D.
2123 AUBURN AVE
SUITE 528
CINCINNATI OH 45219

I wish to apply for Emeritus status: ☐

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

OBG OBSTETRICS & GYNECOLOGY

☐ SPECIALTY CODE(S) CORRECT AS LISTED

IF CORRECTIONS ARE NECESSARY, PLEASE ENTER ALL SPECIALTY CODES. CODE1 CODE2 CODE3

REPORT ANY CHANGE OF ADDRESS

STREET
STREET
CITY STATE ZIP CODE
COUNTY

:96969696 21: 0935043742 11 "00000305000"

PRINCIPAL PRACTICE ADDRESS - IF DIFFERENT FROM THE ADDRESS SHOWN ON FRONT: THIS ADDRESS MUST BE ENTERED AT EACH RENEWAL.

Street
Street
City State Zip Code
County

AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION FOR RENEWAL OF YOUR CERTIFICATE HAVE YOU :

1.) Been found guilty of, or pled guilty or no contest to, or received treatment in lieu of conviction of, a felony or misdemeanor? YES ☐ NO ☐

2.) Been found guilty of, or pled guilty or no contest to a federal or state law regulating the possession, distribution or use of any drug? YES ☐ NO ☐

3.) Been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse? You may answer "no" to this question if you have successfully completed treatment at a program approved by this board and have subsequently adhered to all statutory requirements as contained in sections 4731.224 and 4731.25 O.R.C., and related provisions, or you are currently enrolled in a board approved program. Any questions concerning approval can be directed to the board offices. YES ☐ NO ☐

4.) Had malpractice insurance cancelled or limited for other than failure to pay premiums? YES ☐ NO ☐

5.) Been notified by any board, bureau, department, agency, or other body including those in Ohio, other than this board, of any investigation concerning you, or any charges, allegations or complaints filed against you? YES ☐ NO ☐

6.) Surrendered, or consented to limitation in any jurisdiction: a) A license to practice medicine;OR b) State or federal privileges to prescribe controlled substances? YES ☐ NO ☐

7.) Had any clinical privileges or other authority to practice suspended,restricted or revoked for reasons other than failure to maintain records or attend staff meetings? YES ☐ NO ☐

SOCIAL SECURITY NUMBER
(Optional for purposes of identification)

State Medical Board of Ohio

77 S. High Street, 17th Floor • Columbus, Ohio 43266-0315 • 614/ 466-3934 • Website: www.state.oh.us/med/

Date: August 11, 1999

DAVID B. SCHWARTZ, M.D.
2123 AUBURN AVE
SUITE 528
CINCINNATI, OH 45219

Dear Doctor:

Please be advised that in reviewing your renewal application card for your Ohio license, we find that you failed to answer the following question(s). To continue processing your renewal, answer each checked question below:

AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION FOR RENEWAL OF YOUR CERTIFICATE HAVE YOU:
(only those questions marked with a ✓ apply to you)

		YES	NO
☐	1.) *Been found guilty of, or pled guilty or no contest to, or received treatment in lieu of conviction of, a felony or misdemeanor?*	☐	☑
☐	2.) *Been found guilty of, or pled guilty or no contest to a federal or state law regulating the possession, distribution or use of any drug?*	☐	☑
☐	3.) *Been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse? You may answer "NO" to this question if you have successfully completed treatment at a program approved by this board and have subsequently adhered to all statutory requirements as contained in sections 4731.224 and 4731.25, O.R.C., and related provisions, or you are currently enrolled in a board approved program. Any questions concerning approval can be directed to the board offices.*	☐	☑
☐	4.) *Had malpractice insurance canceled or limited for other than failure to pay premiums?*	☐	☐
☐	5.) *Been notified by any board, bureau, department, agency, or other body including those in Ohio, other than this board, of any investigation concerning you, or any charges, allegations or complaints filed against you?*	☐	☑
☐	6.) *Surrendered, or consented to limitation in any jurisdiction: a) a license to practice medicine; OR b) State or federal privileges to prescribe controlled substances?*	☐	☐
☐	7.) *Had any clinical privileges suspended, restricted or revoked for reasons other than failure to maintain records or attend staff meetings?*	☐	☐
☑	**YOU DID NOT ANSWER ANY OF THE QUESTIONS. ANSWER EACH QUESTION (1 - 7) ABOVE.**		

OVER ⇨

I certify, that the information provided is true and correct.

Signature of Applicant 8/13/99 Date

Upon completion of this form, return directly to the Board. If your response is not received in this office by October 1, 1999, your Ohio license will lapse by action of law.

Should you have any questions concerning this information, please contact me at the address indicated on the other side.

Sincerely,

Debra L. Jones, Chief
C.M.E., Records and Renewal

DLJ:jdc

DETACH HERE AND REMIT THIS PORTION WITH FEE

STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 43215 - 6127

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 1999-2001 REGISTRATION PERIOD THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE OHIO STATE MEDICAL ASSOCIATION AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT. 7/5/01

X _____
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-04-3742-S	$305.00	10/01/01

DAVID BRUCE SCHWARTZ,M.D.
2123 AUBURN AVE
SUITE 528
CINCINNATI OH 45219

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

OBG OBSTETRICS & GYNECOLOGY

☑ SPECIALTY CODE(S) CORRECT AS LISTED

IF CORRECTIONS ARE NECESSARY, PLEASE ENTER ALL SPECIALTY CODES. CODE1 CODE2 CODE3

RESIDENCE ADDRESS-THIS MUST BE ENTERED AT EACH RENEWAL.

668 FLAGSTAFF DRIVE
STREET
STREET
CINCINNATI OHIO OH 45215
CITY STATE ZIP CODE
HAMILTON
COUNTY

:96969696 21: 093504374 21" "00000 30500"

PRINCIPAL PRACTICE ADDRESS - THIS ADDRESS MUST BE ENTERED AT EACH RENEWAL.

☐ Check this Box if you have NO principal Practice address.

2123 Auburn Ave
Street
Street
Cincinnati OH 45219
City State Zip Code
Hamilton
County

AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION FOR RENEWAL OF YOUR CERTIFICATE :

YES NO
☐ ☑ 1.) Have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?

YES NO
☐ ☑ 2.) Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse? **You may answer "NO" to this question if** you have successfully completed treatment at a program approved by this board and have subsequently adhered to all statutory requirements as contained in sections 4731.224 and 4731.25 O.R.C., and related provisions, or you are currently enrolled in a board approved program. Any questions concerning approval can be directed to the board offices.

YES NO
☐ ☑ 3.) Have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?

YES NO
☐ ☑ 4.) Has any board, bureau, department, agency, or other body, including those in Ohio, **other than this board**, filed any charges, allegations or complaints against you?

YES NO
☐ ☑ 5.) Have you surrendered, or consented to limitation of, or to reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction? You may answer "NO" to this question if the only such surrender or consent was given to this board.

YES NO
☐ ☑ 6.) Have you had any clinical privileges or other similar institutional authority suspended, restricted or revoked for reasons **other than failure to maintain records on a timely basis or to attend staff meetings?**

Redaction

DETACH HERE AND REMIT THIS PORTION WITH FEE

STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 43215 - 6127

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 2001 - 2003 REGISTRATION PERIOD THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE
OHIO STATE MEDICAL ASSOCIATION
AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.

X _____
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE	$50 Late Fee Due After
35-04-3742-S	$305.00	10/01/03	01/01/04

DAVID BRUCE SCHWARTZ,M.D.
668 FLAGSTAFF DRIVE
CINCINNATI OH 45215

MD & DO SPECIALTY CODES CURRENTLY ON RECORD
OBG OBSTETRICS & GYNECOLOGY

☑ SPECIALTY CODE(S) CORRECT AS LISTED

IF CORRECTIONS ARE NECESSARY, PLEASE ENTER ALL SPECIALTY CODES. CODE1 ~~OBG~~ CODE2 CODE3

RESIDENCE ADDRESS-THIS MUST BE ENTERED AT EACH RENEWAL
668 FLAGSTAFF DRIVE
STREET
CINCINNATI
STREET
CINCINNATI OH 45215
CITY STATE ZIP CODE
HAMILTON
COUNTY

0935043742 30500

AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION FOR RENEWAL OF YOUR CERTIFICATE :

1.) *Have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?* YES ☐ NO ☒

2.) *Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse?* ***You may answer "NO" to this question*** *if you have successfully completed treatment at, or are currently enrolled in, a program approved by this Board and have adhered to all statutory requirements during and subsequent to treatment. You must answer "YES" if you have ever relapsed. Any questions concerning program approval or concerning this question can be directed to the board offices.* YES ☐ NO ☒

3.) *Have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?* YES ☐ NO ☒

4.) *Has any board, bureau, department, agency, or other body, including those in Ohio,* ***other than this board****, filed any charges, allegations or complaints against you?* YES ☐ NO ☒

5.) *Have you surrendered, or consented to limitation of, or to reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction? You may answer "NO" to this question if the only such surrender or consent was given to this board.* YES ☐ NO ☒

6.) *Have you had any clinical privileges or other similar institutional authority suspended, restricted or revoked for reasons* ***other than failure to maintain records on a timely basis or to attend staff meetings?*** YES ☐ NO ☒

PRINCIPAL PRACTICE ADDRESS - THIS ADDRESS MUST BE ENTERED AT EACH RENEWAL.
☐ *Check this Box if you have NO principal Practice address.*

2122 AUBURN AVE ST 404
Street
Street
CINCINNATI OH 45219
City *State* *Zip Code*
HAMILTON
County

REQUIRED: Redaction
SOCIAL SECURITY NUMBER

Date Posted: 8/28/2005 7:08:10 PM

Please review all information you have provided. Click on the "Review" button to change any information given or click on the "I Agree" button to verify that all information posted below is correct and to proceed to payment options.

Please note that knowingly providing false information may result in denial of registration.

Address Information

BUSINESS ADDRESS	2123 AUBURN AVE SUITE 320 CINCINNATI, OH 45219 Hamilton County 513-241-4223

License Information

License Number	35.043742
License Name	DAVID SCHWARTZ
Email Address	

Fees

Relicensure Fee	$305.00
	========
Total Fees	**$305.00**

Specialty Codes

1. Please select one specialty from the field below
   ..... OBSTETRICS & GYNECOLOGY
2. Please select one specialty from the field below, if applicable.
   ..... *{not Answered}*
3. Please select one specialty from the field below, if applicable.

. . . . . *{not Answered}*

CME-Physicians

1. Have you met the above CME requirements for your license?

. . . . . YES

Discipline

1. Have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?

. . . . . NO

2. Have you surrendered, consented to limitation of, or to suspension, reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction other than Ohio?

. . . . . NO

3. Have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?

. . . . . NO

4. Has any board, bureau, department, agency, or any other body, including those in Ohio **other than this board,** filed any charges, allegations or complaints against you?

. . . . . NO

5. Have you had any clinical privileges or other similar institutional authority suspended, restricted or revoked for reasons **other than failure to maintain records on a timely basis or to attend staff meetings?**

. . . . . NO

6. Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse?

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Social Security Number

1.

. . . . . Redaction

Nurse Collaboration Info

1. Are you currently in a collaboration agreement with any Clinical Nurse Specialists, Certified Nurse-Midwives or Certified Nurse Practitioners?

   . . . . . NO

2. List the name/names and type of licensure for each nurse with whom you are collaborating. **For example: Jane Doe, CNP; Mary Smith, CNS.**

   . . . . . *{not Answered}*

I understand that submitting a false, fraudulent, or forged statement or document or omitting a material fact in obtaining licensure may be grounds for disciplinary action against my license.

Under penalty of law, I hereby swear or affirm that the information I have provided in the application is complete and correct, and that I have complied with all criteria for applying on line.

Date Posted: 7/9/2007 12:22:08 PM

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License Information

License Number	35.043742
License Name	DAVID SCHWARTZ
Email Address	dbdoc8@aol.com

Fees

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	========
Total Fees	**$305.00**

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Date Posted: 7/9/2009 1:40:35 PM

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Date Posted: 7/13/2011 3:46:36 PM

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Please note that knowingly providing false information may result in denial of registration.

Address Information

CREDENTIAL MAIL ADDRESS
668 FLAGSTAFF DRIVE
CINCINNATI, OH 45215
Hamilton County
(513) 241-4223
dbdoc8@aol.com

License Information

License Number 35.043742
License Name DAVID SCHWARTZ

Fees

Relicensure Fee $305.00

========

Total Fees **$305.00**

Medical Board Correspondence Email

1. **Did you provide a Credential email address? Please note this information is a public record.**

. . . . . YES

Specialty Codes

1. Please select one specialty from the field below

. . . . . OBSTETRICS & GYNECOLOGY

2. Please select one specialty from the field below, if

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. . . . . *{not Answered}*

Ohio Employment

1. Do you practice in Ohio?

. . . . . YES

Ohio Workforce Questions

1. "Clinical" - direct patient care

. 60-64

2. "Research" - study of a treatment, procedure or medication done in a medical setting or for a medical purpose

. 1-4

3. "Administration" - activities related generally to patient care other than direct contact with a patient (e.g. recordkeeping, clerical tasks, chart review, prior authorizations with insurers, claims, billing issues, etc.)

. 1-4

4. "Education" - preceptor, mentor, etc.

. 1-4

5. "Volunteering" - providing medical and medical-related services at no cost

. 5-9

6. "Other" - medical professional activities not included in above categories

. 0

Clinical - Practice setting

1. Enter the number of hours per week spent in "Office/Clinic/Ambulatory care" (out-patient care).

. 40-44

2. Enter the number of hours per week spent in "Hospital (in-patient care)".

. 10-14

3. Enter the number of hours per week spent in "Emergency Room".

. 0

4. Enter the number of hours per week spent in "Urgent Care".

. 0

5. Enter the number of hours perweek spent in "Other".

. 5-9

Workforce Counties

1. Enter the first zip code:

. 45219

2. Enter the first county:

. . . . . Hamilton

3. Enter the second zip code:

. . . . . *{not Answered}*

4. Enter the second county:

. . . . . *{not Answered}*

5. Enter the third zip code:

. . . . . *{not Answered}*

6. Enter the third county:

. . . . . *{not Answered}*

Practice Arrangement (size)

1. Solo practitioner

. . . . . YES

2. Single-specialty Group

. . . . . N/A

3. Multi-specialty Group

. . . . . N/A

4. Employee of a clinical facility or hospital? (Clinical facility is an urgent care, industrial clinic or similar entity)

. . . . . NO

Workforce Language Question

1. Do practitioners or staff in your practice communicate in sign language or in a language other than spoken English?

. . . . . NO

ABMS Certified

1. Are you certified by an ABMS Board?

. . . . . YES

ABMS Specialty

1. Choose specialty from the dropdown list.
. . . . . Obstetrics and Gynecology
2. Choose specialty from the dropdown list.
. . . . . *{not Answered}*
3. Choose specialty from the dropdown list.
. . . . . *{not Answered}*

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Date Posted: 10/7/2013 11:12:18 AM

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CREDENTIAL MAIL ADDRESS	2123 Auburn Ave Suite 320 CINCINNATI, OH 43219 Hamilton County United States of America (513) 241-4223 dbdoc8@aol.com
MAIN	1134 Fort View Place CINCINNATI, OH 45202 Hamilton County United States of America (513) 522-9779 dbdoc8@aol.com

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License Name	DAVID SCHWARTZ

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. 50-54

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. 0

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. 5-9

4. "Education" - preceptor, mentor, etc.

. 5-9

5. "Volunteering" - providing medical and medical-related services at no cost

. 1-4

6. "Other" - medical professional activities not included in above categories

. 1-4

Clinical - Practice setting

1. Enter the number of hours per week spent in "Office/Clinic/Ambulatory care" (out-patient care).

. 35-39

2. Enter the number of hours per week spent in "Hospital (in-patient care)".

. 10-14

3. Enter the number of hours per week spent in "Emergency Room".

. 0

4. Enter the number of hours per week spent in "Urgent Care".

. 0

5. Enter the number of hours per week spent in "Other".

. 10-14

Workforce Counties

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. 45219

2. Enter the first county:

. . . . . Hamilton

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. . . . . *{not Answered}*

4. Enter the second county:

. . . . . *{not Answered}*

5. Enter the third zip code:

. . . . . *{not Answered}*

6. Enter the third county:

. . . . . *{not Answered}*

7. Do you have more than one practice location?

. . . . . NO

Practice Arrangement (size)

1. Solo practitioner

. . . . . YES

2. Single-specialty Group

. . . . . N/A

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. . . . . Obstetrics and Gynecology

2. Choose specialty from the dropdown list.

. . . . . *{not Answered}*

3. Choose specialty from the dropdown list.

. . . . . *{not Answered}*

NPI number

1. Please enter your current NPI number

. 1215903737

DEA number

1. Please enter your DEA number

. . . . . AS8905791

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