

APPLICATION TO STATE LICENSING BOARD FOR THE HEALING ARTS  
FOR LICENSE TO PRACTICE

Name in full (print) Wesley F. Adams Jr

Business address 248 Midway St

City Bristol Tenn County \_\_\_\_\_  
37620

Branch of Healing Arts you are to practice Medicine (Ob-Gyn)

\$15.00 license fee attached.

Date 10/1/78 197 \_\_\_\_\_ Signed Wesley F. Adams Jr

\*\* PREFERRED MAILING ADDRESS:

Coming to Birmingham  
January -  
1001 17<sup>th</sup> Street South  
B'ham, Ala. 35205

THIS IS THE ONLY NOTICE  
YOU WILL RECEIVE.

No 6357 M

APPLICATION  
FOR CERTIFICATE OF REGISTRATION FOR 1978  
**STATE LICENSING BOARD FOR THE HEALING ARTS**

Public Safety Building  
MONTGOMERY, ALABAMA 36130

Every person licensed to practice any branch of the Healing Arts in the State of Alabama shall on or before the 31st day of December of each year apply to this Board for a certificate of registration which shall be effective during the next calendar year. The \$10.00 fee must accompany this application. If licensed after July 1st, pay only \$5.00 for remainder of that year

If not paid by January 31st you must pay an additional \$20.00 penalty for reinstatement of your license.

Name and Business Address Wesley Frazier Adams, M. D.  
249 Midway Street  
Bristol, Tennessee 37620

License #

Date issued 10/18/78

County

Fee \$ 5.00

FOR REMAINDER OF 1978

*Wesley F. Adams, M.D.*  
Signature

FOR CHANGE OF ADDRESS ONLY

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THIS IS THE ONLY NOTICE  
YOU WILL RECEIVE.

No. 5781 M

RENEWAL  
APPLICATION  
FOR CERTIFICATE OF REGISTRATION FOR 1979  
STATE LICENSING BOARD FOR THE HEALING ARTS

Public Safety Building  
MONTGOMERY, ALABAMA 36130

Every person licensed to practice any branch of the Healing Arts in the State of Alabama shall on or before the 31st day of December of each year apply to this Board for a certificate of registration which shall be effective during the next calendar year. The \$10.00 fee must accompany this application.

If not paid by January 31st you must pay an additional \$20.00 penalty for reinstatement of your license.

Name and  
Business  
Address

Wesley Frazier Adams, M. D.  
349 Midway Street  
Bristol, Tennessee 37620

License #

8592

Date issued

10/12/73

County

Fee

\$ 10.00

*Wesley F. Adams, M.D.*  
Signature

FOR CHANGE OF ADDRESS ONLY DEC 27 1978

RENEWAL APPLICATION

NO.

29

M

FOR A CERTIFICATE OF REGISTRATION TO PRACTICE MEDICINE IN ALABAMA IN 1980.

STATE LICENSING BOARD FOR THE HEALING ARTS

Public Safety Building  
Montgomery, Alabama 36130  
Phone 205/832-5051

OCT 24 1979

Every person licensed to practice any branch of the Healing Arts in the State of Alabama shall on or before the 31st day of December of each year apply to this Board for a Certificate of Registration which shall be effective during the calendar year.

RENEWAL FEE \$10.00 ... IF NOT RECEIVED BY JANUARY 31st, A PENALTY OF \$20.00 PLUS THE \$10.00 RENEWAL FEE WILL BE CHARGED. RETURN ENTIRE FORM WITH FEE.

Name and Mailing Address:

Business Address:

WESLEY F ADAMS  
249 MIDWAY ST  
BRISTOL, TN 37620

249 MIDWAY ST  
BRISTOL, TN 37620

LICENSE #: 0008592

ISSUED: 10/18/78



The above addresses are correct.

615/968-3033

**RENEWAL APPLICATION**

NO. **30** M

FOR A CERTIFICATE OF REGISTRATION TO PRACTICE MEDICINE IN ALABAMA IN 1981.

**STATE LICENSING BOARD FOR THE HEALING ARTS**

908 S. Hull Street, Room 110  
Montgomery, Alabama 36130  
Phone 205/632-5051

**JAN 9 1981**

Every person licensed to practice any branch of the Healing Arts in the State of Alabama shall on or before the 31st day of December of each year apply to this Board for a Certificate of Registration which shall be effective during the calendar year.

RENEWAL FEE \$10.00 ... IF NOT RECEIVED BY JANUARY 31st, A PENALTY OF \$20.00 PLUS THE \$10.00 RENEWAL FEE WILL BE CHARGED. RETURN ENTIRE FORM WITH FEE.

Name and Mailing Address:

Business Address:

*PC*  
Wesley Frazier Adams, M. D.  
~~249 Midway Street~~ *157 Blountville Highway*  
Bristol, Tennessee 37620

*157 Blountville Highway*  
~~249 MIDWAY ST~~  
BRISTOL, TN 37620

8592

10/18/78

\$ 10.00

The above Addresses are correct.

## RENEWAL APPLICATION

FOR A CERTIFICATE OF REGISTRATION TO PRACTICE MEDICINE IN ALABAMA IN 1982.

### ALABAMA MEDICAL LICENSURE COMMISSION

908 South Hull Street, Room 110  
Montgomery, Alabama 36104  
Phone 205/832-5051

Every physician and osteopath licensed to practice medicine/osteopathy in the State of Alabama shall, on or before the 31st day of December of each year, apply to this Commission for a Certificate of Registration which shall be effective during the calendar year.

**RENEWAL FEE \$50.00** — Failure to register and pay the annual registration fee within 30 days after registration becomes due will result in the automatic revocation of the current license without further notice or hearing as provided in Act. No. 81-218, Code of Alabama, Section 12.

Name and Mailing Address:

WESLEY F ADAMS  
157 BLOUNTVILLE HWY  
BRISTOL, TN 37620

Business Address:

157 BLOUNTVILLE HWY  
BRISTOL, TN 37620

LICENSE #: 0008592

ISSUED: 10/18/78

The above Addresses are correct.

## RENEWAL APPLICATION

FOR A CERTIFICATE OF REGISTRATION TO PRACTICE MEDICINE IN ALABAMA IN 1983

### ALABAMA MEDICAL LICENSURE COMMISSION

908 South Hull Street, Room 110  
Montgomery, Alabama 36104  
Phone 205/832-5051

Every physician and osteopath licensed to practice medicine/osteopathy in the State of Alabama shall, on or before the 31st day of December of each year, apply to this Commission for a Certificate of Registration which shall be effective during the calendar year.

**RENEWAL FEE \$50.00** — Failure to register and pay the annual registration fee within 30 days after registration becomes due will result in the automatic revocation of the current license without further notice or hearing as provided in Act. No. 81-218, Code of Alabama, Section 12.

**Name and Mailing Address:**

WESLEY F ADAMS  
101 NEW KINGSPOUR HWY  
BRISTOL, TN 37620

LICENSE #: 0008592

ISSUED: 10/18/78

**Business Address:**

SELF  
101 NEW KINGSPOUR HWY  
BRISTOL, TN 37620

The above Addresses are correct.

## RENEWAL APPLICATION

FOR A CERTIFICATE OF REGISTRATION TO PRACTICE MEDICINE IN ALABAMA IN 1984  
ALABAMA MEDICAL LICENSURE COMMISSION  
Post Office Box 887  
Montgomery, Alabama 36101  
Phone (205) 832-5051

Every physician and osteopath licensed to practice medicine/osteopathy in the State of Alabama shall, on or before the 31st day of December of each year, apply to this Commission for a Certificate of Registration which shall be effective during the calendar year.

**RENEWAL FEE: \$50.00 -- Failure to register and pay the annual registration fee within 30 days after registration becomes due will result in the automatic revocation of the current license without further notice or hearing as provided in § 34-24-337, Code of Alabama, (1975).**

Name and Mailing Address:

WESLEY F ADAMS  
101 NEW KINGSPOET HWY  
BRISTOL, TN 37620

Business Address:

SELF  
101 NEW KINGSPOET HWY  
BRISTOL, TN 37620

LICENSE #: 0008592

ISSUED: 10/18/78



The above Addresses are correct.



## RENEWAL APPLICATION

FOR A CERTIFICATE OF REGISTRATION TO PRACTICE MEDICINE IN ALABAMA IN 1985  
ALABAMA MEDICAL LICENSURE COMMISSION  
Post Office Box 887  
Montgomery, Alabama 36101-0887  
Phone (205) 261-4153

Every physician and osteopath licensed to practice medicine/osteopathy in the State of Alabama shall, on or before the 31st day of December of each year, apply to this Commission for a Certificate of Registration which shall be effective during the calendar year.

**RENEWAL FEE: \$50.00 -- Failure to register and pay the annual registration fee within 30 days after registration becomes due will result in the automatic revocation of the current license without further notice or hearing as provided in § 34-24-337, Code of Alabama, (1975).**

Name and Mailing Address:

WESLEY F ADAMS  
101 NEW KINGSPORT HWY  
BRISTOL, TN 37620

Business Address:

SELF  
101 NEW KINGSPORT HWY  
BRISTOL, TN 37620

LICENSE #: 0008592

ISSUED: 10/18/78

The above Addresses are correct.

## RENEWAL APPLICATION

FOR A CERTIFICATE OF REGISTRATION TO PRACTICE MEDICINE IN ALABAMA IN 1986  
ALABAMA MEDICAL LICENSURE COMMISSION  
Post Office Box 887  
Montgomery, Alabama 36101-0887  
Phone (205) 261-4153

Every physician and osteopath licensed to practice medicine/osteopathy in the State of Alabama shall, on or before the 31st day of December of each year, apply to this Commission for a Certificate of Registration which shall be effective during the calendar year.

**RENEWAL FEE: \$50.00 -- Failure to register and pay the annual registration fee within 30 days after registration becomes due will result in the automatic revocation of the current license without further notice or hearing as provided in § 34-24-337, Code of Alabama, (1975).**

Name and Mailing Address:

WESLEY F ADAMS  
101 NEW KINGSPOET HWY  
BRISTOL, TN 37620

Business Address:

SELF  
101 NEW KINGSPOET HWY  
BRISTOL, TN 37620

LICENSE #: 0008592

ISSUED: 10/18/78



The above Addresses are correct.

## RENEWAL APPLICATION

FOR A CERTIFICATE OF REGISTRATION TO PRACTICE MEDICINE IN ALABAMA IN 1987  
ALABAMA MEDICAL LICENSURE COMMISSION

Post Office Box 887  
Montgomery, Alabama 36101-0887  
Phone (205) 261-4153

Every physician and osteopath licensed to practice medicine/osteopathy in the State of Alabama shall, on or before the 31st day of December of each year, apply to this Commission for a Certificate of Registration which shall be effective during the calendar year.

**RENEWAL FEE: \$50.00** --- Failure to register and pay the annual registration fee within 30 days after registration becomes due will result in the automatic revocation of the current license without further notice or hearing as provided in § 34-24-337, Code of Alabama, (1975).

Name and Mailing Address:

WESLEY F ADAMS  
101 NEW KINGSPOET HWY  
BRISTOL, TN 37620

Business Address:

SELF  
101 NEW KINGSPOET HWY  
BRISTOL, TN 37620

LICENSE #: 0008592      ISSUED: 10/18/78

The above Addresses are correct.

## RENEWAL APPLICATION

FOR A CERTIFICATE OF REGISTRATION TO PRACTICE MEDICINE IN ALABAMA IN 1988  
ALABAMA MEDICAL LICENSURE COMMISSION

Post Office Box 887  
Montgomery, Alabama 36101-0887  
Phone (205) 261-4153

Every physician and osteopath licensed to practice medicine/osteopathy in the State of Alabama shall, on or before the 31st day of December of each year, apply to this Commission for a Certificate of Registration which shall be effective during the calendar year.

**RENEWAL FEE: \$50.00 --- Failure to register and pay the annual registration fee within 30 days after registration becomes due will result in the automatic revocation of the current license without further notice or hearing as provided in § 34-24-337, Code of Alabama, (1975).**

Name and Mailing Address:

WESLEY F ADAMS  
101 NEW KINGSPOUR HWY  
BRISTOL, TN 37620

Business Address:

SELF  
101 NEW KINGSPOUR HWY  
BRISTOL, TN 37620

LICENSE #: 0008592

ISSUED: 10/18/78

The above Addresses are correct.

# RENEWAL APPLICATION

FOR A CERTIFICATE OF REGISTRATION TO PRACTICE MEDICINE IN ALABAMA IN 1989  
ALABAMA MEDICAL LICENSURE COMMISSION  
Post Office Box 887  
Montgomery, Alabama 36101-0887  
Phone (205) 261-4153

Every physician and osteopath licensed to practice medicine/osteopathy in the State of Alabama shall, on or before the 31st day of December of each year, apply to this Commission for a Certificate of Registration which shall be effective during the calendar year.

**RENEWAL FEE: \$50.00** --- Failure to register and pay the annual registration fee within 30 days after registration becomes due will result in the automatic revocation of the current license without further notice or hearing as provided in § 34-24-337, Code of Alabama, (1975).

Name and Mailing Address:

Business Address:

8592 101878

WESLEY FRAZIER ADAMS MD  
101 NEW KINGSFORT HWY

BRISTOL

TN 37620

~~If your addresses are different from those shown, make corrections on back:~~

WITHIN THE PAST YEAR:

YES NO

1. Have you been convicted of a felony or of any offense (felony/misdemeanor) involving the practice of medicine.  YES  NO
2. ~~Has your certificate of qualifications or license to practice medicine in any state been suspended, revoked, restricted, curtailed or voluntarily surrendered under threat of suspension or revocation?~~  YES  NO
3. Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practice?  YES  NO
4. Have you been denied a certificate of qualification or a license to practice medicine in any state or has your application for a certificate of qualification or license to practice medicine been withdrawn under threat or claim?  YES  NO
5. Are you now or have you been addicted to the use of alcohol or controlled substances?  YES  NO
6. Have you been diagnosed and/or treated for a mental illness?  YES  NO
7. Have you had a judgement rendered against you, or action settled relating to the performance of your professional service?  YES  NO
8. To your knowledge, are you the subject of an investigation by any licensing Board/Agency as of the date of this renewal application?  YES  NO

I certify that the above information is correct

Signature

Date

(Do Not Detach)

# RENEWAL APPLICATION

FOR A CERTIFICATE OF REGISTRATION TO PRACTICE MEDICINE IN ALABAMA IN 1990  
 ALABAMA MEDICAL LICENSURE COMMISSION  
 Post Office Box 887  
 Montgomery, Alabama 36101-0887  
 Phone (205) 261-4153

Every physician and osteopath licensed to practice medicine/osteopathy in the State of Alabama shall, on or before the 31st day of December of each year, apply to this Commission for a Certificate of Registration which shall be effective during the calendar year.

**RENEWAL FEE: \$50.00** --- Failure to register and pay the annual registration fee within 30 days after registration becomes due will result in the automatic revocation of the current license without further notice or hearing as provided in § 34-24-337, Code of Alabama, (1975).

Name and Mailing Address:

WESLEY F ADAMS  
 101 NEW KINGSPORT HWY  
 BRISTOL, TN 37620

Business Address:

SELF  
 101 NEW KINGSPORT HWY  
 BRISTOL, TN 37620

LICENSE #: 0008592 ISSUED: 10/18/78

If your addresses are different from those shown, make corrections on back:

WITHIN THE PAST YEAR:

- |  | YES | NO                                  |
|--|-----|-------------------------------------|
| 1. Have you been convicted of a felony or of any offense (felony/misdemeanor) involving the practice of medicine.  | --- | <input checked="" type="checkbox"/> |
| 2. Has your certificate of qualifications or license to practice medicine in any state been suspended, revoked, restricted, curtailed or voluntarily surrendered under threat of suspension or revocation?                             | --- | <input checked="" type="checkbox"/> |
| 3. Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practice?  | --- | <input checked="" type="checkbox"/> |
| 4. Have you been denied a certificate of qualification or a license to practice medicine in any state or has your application for a certificate of qualification or license to practice medicine been withdrawn under threat or claim? | --- | <input checked="" type="checkbox"/> |
| 5. Are you now or have you been addicted to the use of alcohol or controlled substances?   | --- | <input checked="" type="checkbox"/> |
| 6. Have you been diagnosed and/or treated for a mental illness?  | --- | <input checked="" type="checkbox"/> |
| 7. Have you had a judgement rendered against you, or action settled relating to the performance of your professional services?   | --- | <input checked="" type="checkbox"/> |
| 8. To your knowledge, are you the subject of an investigation by any licensing Board/Agency as of the date of this renewal application?  | --- | <input checked="" type="checkbox"/> |

I certify that the above information is correct

*W. F. Adams* 10/18/89  
 Signature Date

(Do Not Detach)

# RENEWAL APPLICATION

FOR A CERTIFICATE OF REGISTRATION TO PRACTICE MEDICINE IN ALABAMA IN 1991  
 ALABAMA MEDICAL LICENSURE COMMISSION  
 Post Office Box 887  
 Montgomery, Alabama 36101-0887  
 Phone (205) 261-4153

Every physician and osteopath licensed to practice medicine/osteopathy in the State of Alabama shall, on or before the 31st day of December of each year, apply to this Commission for a Certificate of Registration which shall be effective during the calendar year.

**RENEWAL FEE: \$75.00** --- Failure to register and pay the annual registration fee within 30 days after registration becomes due will result in the automatic revocation of the current license without further notice or hearing as provided in § 34-24-337, Code of Alabama, (1975).

Name and Mailing Address:

WESLEY F ADAMS  
 101 NEW KINGSPORT HWY  
 BRISTOL, TN 37620

Business Address:

SELF  
 101 NEW KINGSPORT HWY  
 BRISTOL, TN 37620

LICENSE #: 0008592 ISSUED: 10/18/78

If your addresses are different from those shown, make corrections on back:

WITHIN THE PAST YEAR:

- |  | YES | NO                                  |
|--|-----|-------------------------------------|
| 1. Have you been convicted of a felony or of any offense (felony/misdemeanor) involving the practice of medicine.  | —   | <input checked="" type="checkbox"/> |
| 2. Has your certificate of qualifications or license to practice medicine in any state been suspended, revoked, restricted, curtailed or voluntarily surrendered under threat of suspension or revocation?                             | —   | <input checked="" type="checkbox"/> |
| 3. Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practice?  | —   | <input checked="" type="checkbox"/> |
| 4. Have you been denied a certificate of qualification or a license to practice medicine in any state or has your application for a certificate of qualification or license to practice medicine been withdrawn under threat or claim? | —   | <input checked="" type="checkbox"/> |
| 5. Are you now or have you been addicted to the use of alcohol or controlled substances?   | —   | <input checked="" type="checkbox"/> |
| 6. Have you been diagnosed and/or treated for a mental illness?  | —   | <input checked="" type="checkbox"/> |
| 7. Have you had a judgement rendered against you, or action settled relating to the performance of your professional service?  | —   | <input checked="" type="checkbox"/> |
| 8. To your knowledge, are you the subject of an investigation by any licensing Board/Agency as of the date of this renewal application?  | —   | <input checked="" type="checkbox"/> |

I certify that the above information is correct

*W.F. Adams*  
 Signature Date

(Do Not Detach)

# RENEWAL APPLICATION

FOR A CERTIFICATE OF REGISTRATION TO PRACTICE MEDICINE IN ALABAMA IN 1992  
 ALABAMA MEDICAL LICENSURE COMMISSION  
 Post Office Box 887  
 Montgomery, Alabama 36101-0887  
 Phone (205) 261-4153

**POSTED**  
 OCT 11 1991

Every physician and osteopath licensed to practice medicine/osteopathy in the State of Alabama shall, on or before the 31st day of December of each year, apply to this Commission for a Certificate of Registration which shall be effective during the calendar year.

**RENEWAL FEE: \$75.00** --- Failure to register and pay the annual registration fee within 30 days after registration becomes due will result in the automatic revocation of the current license without further notice or hearing as provided in § 34-24-337, Code of Alabama, (1975).

Name and Mailing Address:

WESLEY F ADAMS  
 101 NEW KINGSFORT HWY  
 BRISTOL, TN 37620

Business Address:

SELF  
 101 NEW KINGSFORT HWY  
 BRISTOL, TN 37620

LICENSE #: 0008592 ISSUED: 10/18/78

If your addresses are different from those shown, make corrections on back:

WITHIN THE PAST YEAR:

- |  | YES | NO |
|--|-----|----|
| 1. Have you been convicted of a felony or of any offense (felony/misdemeanor) involving the practice of medicine.  | —   | ✓  |
| 2. Has your certificate of qualifications or license to practice medicine in any state been suspended, revoked, restricted, curtailed or voluntarily surrendered under threat of suspension or revocation?                             | —   | ✓  |
| 3. Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practice?  | —   | ✓  |
| 4. Have you been denied a certificate of qualification or a license to practice medicine in any state or has your application for a certificate of qualification or license to practice medicine been withdrawn under threat or claim? | —   | ✓  |
| 5. Are you now or have you been addicted to the use of alcohol or controlled substances?   | —   | ✓  |
| 6. Have you been diagnosed and/or treated for a mental illness?  | —   | ✓  |
| 7. Have you had a judgement rendered against you, or action settled relating to the performance of your professional service?  | —   | ✓  |
| 8. To your knowledge, are you the subject of an investigation by any licensing Board/Agency as of the date of this renewal application?  | —   | ✓  |

I certify that the above information is correct

*W.F. Adams*  
 Signature Date 10/7/91

(Do Not Detach)



# RENEWAL APPLICATION

For a certificate of registration to practice medicine in Alabama in 1993

Alabama Medical Licensure Commission  
Post Office Box 887  
Montgomery, Alabama 36101-0887  
Phone (205) 242-4153

Name and Mailing Address

LICENSE #: 0008592 ISSUED: 10/18/78  
WESLEY F ADAMS  
101 NEW KINGSPORT HWY  
BRISTOL, TN 37620

*Ch # 3145  
PA 10-16-92*

Home Address:

Street \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_ Zip \_\_\_\_\_  
Business FAX#:( ) \_\_\_\_\_

Make corrections to mailing address on reverse.

Check if you authorize your FAX# to be published in a directory

■ Every physician and osteopath licensed to practice medicine/osteopathy in the State of Alabama shall, on or before the 31st of December of each year, apply to this Commission for a Certificate of Registration which shall be effective during the calendar year.

■ Renewal Fee: \$75.00 - Failure to register and pay the annual registration fee within 30 days after registration becomes due will result in the automatic revocation of the current license without further notice or hearing as provided in § 34-24-337, Code of Alabama (1975).

(Check a or b) For CME Certification

a)  I hereby certify that I have met the annual minimum continuing education requirement of 12 hours of Category I continuing medical education during the calendar year ending December 31, 1992.

b) \_\_\_\_\_ I certify that I am exempt from the minimum continuing medical education requirement for the following reason:

Check One Below If You Answered (b)

\_\_\_\_\_ I do not reside in the State of Alabama and do not have a significant portion of my medical practice in Alabama.

\_\_\_\_\_ I received my initial license to practice medicine in Alabama after June 30th of this calendar year.

\_\_\_\_\_ I reinstated my license to practice medicine in the State of Alabama after June 30th of this calendar year.

\_\_\_\_\_ I am retired from the practice of medicine and have obtained a waiver from the Board of Medical Examiners.

\_\_\_\_\_ I am a resident physician enrolled in a residency training program.

Within The Past Year:

Yes No

1. Have you been convicted of a felony or of any offense (felony/misdemeanor) involving the practice of medicine? \_\_\_\_\_

2. Has your certificate of qualification or license to practice medicine in any state been suspended, revoked, restricted, curtailed or voluntarily surrendered under threat of suspension or revocation? \_\_\_\_\_

3. Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practice? \_\_\_\_\_

4. Have you been denied a certificate of qualification or license to practice medicine in any state or has your application for a certificate of qualification or license to practice medicine been withdrawn under threat of denial? \_\_\_\_\_

5. Are you now or have you been addicted to the use of alcohol or controlled substances? \_\_\_\_\_

6. Have you been diagnosed and/or treated for a mental illness and/or serious physical illness? \_\_\_\_\_

7. Have you had a judgement rendered against you, or action settled relating to the performance of your professional service? \_\_\_\_\_

8. To your knowledge, are you the subject of an investigation by any licensing Board/Agency as of the date of this application? \_\_\_\_\_

I certify that all information on this form is correct

*W. F. Adams*  
Signature

*10/14/92*  
Date

# RENEWAL APPLICATION

## For a certificate of registration to practice medicine in Alabama in 1994

Alabama Medical Licensure Commission • Post Office Box 887 • Montgomery, Alabama 36101-0887 • Phone (205) 242-4153

### Name & Mailing Address

(Make address corrections in (4) below)

LICENSE #: 00008592      ISSUED: 10/18/1978

ADAMS WESLEY FRAZIER  
101 NEW KINGSPORT HWY

BRISTOL      37620-

■ Every physician and osteopath licensed to practice medicine/osteopathy in the State of Alabama shall, on or before the 31st of December of each year, apply to this Commission for a Certificate of Registration which shall be effective during the calendar year.

*CR# 4408 pd 11-5-93*

■ Renewal Fee: \$100.00 - Failure to register and pay the annual registration fee within 30 days after registration becomes due will result in the automatic revocation of the current license without further notice or hearing as provided in §34-24-337, Code of Alabama (1975).

### (Check a or b) For CME Certification

a)  I hereby certify that I have met the annual minimum continuing education requirement of 12 hours of Category I continuing medical education during the calendar year ending December 31, 1993.

b)  I certify that I am exempt from the minimum continuing medical education requirement for the following reason:

### Check One Below If You Answered (b)

I do not reside in the State of Alabama and do not have a significant portion of my medical practice in Alabama.

I received my initial license to practice medicine in Alabama after June 30th of this calendar year.

I reinstated my license to practice medicine in the State of Alabama after June 30th of this calendar year.

I am retired from the practice of medicine and have obtained a waiver from the Board of Medical Examiners.

I am a resident physician enrolled in a residency training program.

### Within The Past Year:

Yes No

- |   |                          |                                     |
|---|--------------------------|-------------------------------------|
| 1. Have you been convicted of a felony or of any offense (felony/misdemeanor) involving the practice of medicine?   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 2. Has your certificate of qualification or license to practice medicine in any state been suspended, revoked, restricted, curtailed or voluntarily surrendered under threat of suspension or revocation?                             | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 3. Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practice?   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 4. Have you been denied a certificate of qualification or license to practice medicine in any state or has your application for a certificate of qualification or license to practice medicine been withdrawn under threat of denial? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 5. Are you now or have you been addicted to the use of alcohol or controlled substances?  | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 6. Have you been diagnosed and/or treated for a mental illness and/or serious physical illness?   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 7. Have you had a judgement rendered against you, or action settled relating to the performance of your professional service?   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 8. To your knowledge, are you the subject of an investigation by any licensing Board/Agency as of the date of this application?   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

I certify that all information on this form is correct.

*W.F. Adams, Jr. M.D.*  
Signature

*11/1/93*  
Date

License Renewal for 1995  
Deadline is December 31, 1994

State of Alabama  
Medical Licensure Commission

205/242-4153

P.O. Box 887  
Montgomery, Alabama 36101-0887



Complete **BOTH** sides including signature.  
Be sure to correct or supply **ALL** information.  
Return with \$100.00 renewal fee.  
Incomplete applications will be returned.  
Failure to register and pay renewal fee will result in the  
automatic revocation of the current license to practice  
medicine or osteopathy.

WESLEY FRAZIER ADAMS, M.D.  
101 NEW KINGSPORT HWY

BRISTOL, TN 37620

Please make corrections or supply information: License # 00008592 Sex: M  F

Race: White  Black  Am. Indian  Oriental or Asian  Other  Social Security # [REDACTED]

Office Address:

~~101 NEW KINGSPORT HWY~~  
2901 W. State St.

City, State, Zip: BRISTOL, TN 37620

County: Sullivan

Business Phone: (615) 968 2182

Fax Number: (615) 968 7589

Permission to publish in Roster: Yes  No

Specialty: Primary: OB/GYN

Secondary: \_\_\_\_\_

Form of Practice:  Solo  Partnership (2, 3 or 4)  Group (5 or more) If Group, give name: \_\_\_\_\_

Primary Hospital where you have staff privileges:

Name: Bristol Regional Med Ctr

City/State: \_\_\_\_\_

Are you licensed in another state: Yes  No  Which ones:  GA  IL  IN  OH  VA

CME Certification: (Check one)

I hereby certify that I have met the annual minimum continuing education requirement of 12 hours of Category I continuing medical education during the calendar year ending December 31, 1994.

I certify that I am exempt from the minimum continuing medical education requirement for the following reason:

- I do not reside in the State of Alabama and do not have a significant portion of my medical practice in Alabama.
- I received my initial license to practice medicine in Alabama after June 30th of this calendar year.
- I reinstated my license to practice medicine in the State of Alabama after June 30th of this calendar year.
- I am a resident physician enrolled in a residency training program.
- I am retired from the practice of medicine and have obtained a waiver from the Board of Medical Examiners.

Complete both sides including signature. Supply or correct all information.

OVER

**Within The Past Year:**

**Yes No**

1. Have you been convicted of a felony or of any offense (felony/misdemeanor) involving the practice of medicine?  Yes  No
2. Has your certificate of qualification or license to practice medicine in any state been suspended, revoked, restricted, curtailed or voluntarily surrendered under threat of suspension or revocation?  Yes  No
3. Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practice?  Yes  No
4. Have you been denied a certificate of qualification or license to practice medicine in any state or has your application for a certificate of qualification or license to practice medicine been withdrawn under threat of denial?  Yes  No
5. Are you now or have you been addicted to the use of alcohol or controlled substances?  Yes  No
6. Have you been diagnosed and/or treated for a mental illness and/or serious physical illness?  Yes  No
7. Have you had a judgement rendered against you, or action settled relating to the performance of your professional service?  Yes  No
8. To your knowledge, are you the subject of an investigation by any licensing Board/Agency as of the date of this application?  Yes  No

**I certify that all information on this form is correct:**

*M. F. Adam, M.D.*  
\_\_\_\_\_  
Signature

*10/12/94*  
\_\_\_\_\_  
Date

• Complete both sides, including signature.  
• Be sure to correct or supply all information.  
**Incomplete applications will be returned.**

**Return with \$100.00 renewal fee to:  
Medical Licensure Commission  
P.O. Box 887  
Montgomery, AL 36101-0887**

**DEADLINE -- DECEMBER 31, 1994**

**License Renewal for 1996**  
Deadline is December 31, 1995

State of Alabama  
Medical Licensure Commission

334/242-4153

P.O. Box 887

Montgomery, Alabama 36101-0887



Complete **BOTH** sides including signature.

Be sure to correct or supply **ALL** information.

Return with \$100.00 renewal fee.

Incomplete applications will be returned.

Failure to register and pay renewal fee will result in the automatic revocation of the current license to practice medicine or osteopathy.

Wesley Frazier Adams, M.D.  
2901 W State St

\*\*AADC 377  
380  
57

Bristol, TN 37620 1677



Please make corrections or supply information: License **8592** DATE ISSUED: 10/18/78 Sex: M  F

Race: White  Black  Am. Indian  Oriental or Asian  Other  Social Security [REDACTED]

**Office Address:**

2901 WEST STATE STREET

City, State, Zip: BRISTOL, TN 37620

(Alabama) County: \_\_\_\_\_

Business Phone: (615)968-2182

Fax Number: (615)868-7589

Permission to publish in Roster: Yes  No

Specialty: Primary: OBSTETRICS & GYNECOLOGY

Secondary: \_\_\_\_\_

Form of Practice:  Solo  Partnership (2, 3, or 4)  Group (5 or more) If Group, give name below:

**Home Address:**

220 SKYLINE DR

City, State, Zip: BRISTOL, TN 37620 4141

(Alabama) County: \_\_\_\_\_

Home Phone: \_\_\_\_\_

(Will not be published)

Send official mail to: Business  address (check one)  
Home

Board Certified: Yes  No

Board Certified: Yes  No

Primary Hospital where you have staff privileges:

Name: BRISTOL REGIONAL MED CTR

City/State: BRISTOL, TN

Are you licensed in another state: Yes  No  Which ones: [GA] [SC] [TN]

**CME Certification:** (Check one)

I hereby certify that I have met the annual minimum continuing education requirement of 12 hours of Category I continuing medical education during the calendar year ending December 31, 1995.

I certify that I am exempt from the minimum continuing medical education requirement for the following reason:

- I do not reside in the State of Alabama and do not have a significant portion of my medical practice in Alabama.
- I received my initial license to practice medicine in Alabama after June 30th of this calendar year.
- I reinstated my license to practice medicine in the State of Alabama after June 30th of this calendar year.
- I am a resident physician enrolled in a residency training program.
- I am retired from the practice of medicine and have obtained a waiver from the Board of Medical Examiners.

Complete both sides including signature. Supply or correct all information.

**OVER**

**DEADLINE IS DECEMBER 31, 1995**

- |  | Yes                      | No                                  |
|--|--------------------------|-------------------------------------|
| 1. Have you been convicted of a felony or of any offense (felony/misdemeanor) involving the practice of medicine within the past year?   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 2. Has your certificate of qualification or license to practice medicine in any state been suspended, revoked, restricted, curtailed or voluntarily surrendered under threat of suspension or revocation within the past year?                             | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 3. Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practice, within the past year?  | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 4. Have you been denied a certificate of qualification or license to practice medicine in any state or has your application for a certificate of qualification or license to practice medicine been withdrawn under threat of denial within the past year? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 5. Are you now or have you been addicted to the use of alcohol or controlled substances within the past year?  | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 6. Have you been diagnosed and/or treated for a mental illness and/or serious physical illness?  | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 7. Have you had a judgement rendered against you, or action settled relating to the performance of your professional service within the past year?   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 8. To your knowledge, are you the subject of an investigation by any licensing Board/Agency as of the date of this application within the past year?   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

**IF YOU HAVE ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, PLEASE ATTACH A DETAILED EXPLANATION WITH YOUR APPLICATION UPON RETURNING IT TO THIS OFFICE.**

I certify that all information on this form is correct.

Signature

*M. F. Adams J.M.D.*

Date

*10/16/05*

- Complete both sides, including signature.
- Be sure to correct or supply all information.

**Incomplete applications will be returned.**

**Return with \$100.00 renewal fee to:**

**Medical Licensure Commission  
P.O. Box 887  
Montgomery, AL 36101-0887**

License Renewal for 1997  
Deadline is December 31, 1996

State of Alabama  
Medical Licensure Commission

334/242-4153

P.O. Box 887

Montgomery, Alabama 36101-0887



Complete **BOTH** sides including signature.  
Be sure to correct or supply **ALL** information.  
Return with \$100.00 renewal fee.  
Incomplete applications will be returned.  
Failure to register and pay renewal fee will result  
in the automatic revocation of the current license to  
practice medicine or osteopathy.

~~WESLEY FRAZIER ADAMS, M.D.~~  
2901 W STATE ST  
BRISTOL TN 37620-1718

Please make corrections or supply information: License 8592 DATE-ISSUED: 10/18/78 Sex: M  F

Race: White  Black  Am. Indian  Oriental or Asian  Other  Social Security # [REDACTED]  
Enter SSAN#

**Office Address:**

2901 WEST STATE STREET

**Home Address:**

220 SKYLINE DR

City, State, Zip: BRISTOL, TN 37620

City, State, Zip: BRISTOL, TN 37620 4141

(Alabama) County: \_\_\_\_\_

(Alabama) County: \_\_\_\_\_

Business Phone: <sup>423</sup>(615)968-2182

Home Phone: (\_\_\_\_) \_\_\_\_\_

Fax Number: <sup>429</sup>(615)868-7589

(Will not be published)

Permission to publish in Roster: Yes  No

Send official mail to: **Business**  address (check one)  
**Home**

Speciality: Primary: OBSTETRICS & GYNECOLOGY

Board Certified: Yes  No

Secondary: \_\_\_\_\_

Board Certified: Yes  No

Form of Practice:  Solo  Partnership (2, 3, or 4)  Group (5 or more) If Group, give name below:

Primary Hospital where you have staff privileges:

Name: BRISTOL REGIONAL MED CTR

City/State: BRISTOL, TN

Are you licensed in another state: Yes  No  Which ones: [GA] [SC] [TN]

**CME Certification: (Check one)**

I hereby certify that I have met the annual minimum continuing education requirement of 12 hours of Category I continuing medical education during the calendar year ending December 31, 1996.

I certify that I am exempt from the minimum continuing medical education requirement for the following reason:

- I do not reside in the State of Alabama and do not have a significant portion of my medical practice in Alabama.
- I received my initial license to practice medicine in Alabama after June 30th of this calendar year.
- I reinstated my license to practice medicine in the State of Alabama after June 30th of this calendar year.
- I am a resident physician enrolled in a residency training program.
- I am retired from the practice of medicine and have obtained a waiver from the Board of Medical Examiners.

Complete both sides including signature. Supply or correct all information.

**OVER**

**DEADLINE IS DECEMBER 31, 1996**

- |  | YES                      | NO                                  |
|--|--------------------------|-------------------------------------|
| 1. Have you been convicted of a felony or of any offense (felony/misdemeanor) involving the practice of medicine within the past year?   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 2. Has your certificate of qualification or license to practice medicine in any state been suspended, revoked, restricted, curtailed or voluntarily surrendered under threat of suspension or revocation within the past year?   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 3. Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practice, within the past year?  | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 4. Have you been denied a certificate of qualification or license to practice medicine in any state or has your application for a certificate of qualification or license to practice medicine been withdrawn under threat of denial within the past year?   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 5. Have you had a judgement rendered against you, or action settled relating to the performance of your professional service within the past year?   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 6. To your knowledge, are you the subject of an investigation by any licensing Board/Agency as of the date of this application within the past year?   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 7. Within the past year, have you been diagnosed with or have you been treated for bi-polar disorder, schizophrenia, paranoia, or any other psychotic disorder?  | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 8. Do you currently have any mental or physical condition or impairment (including, but not limited to, substance abuse, alcohol abuse, or mental, emotional, or nervous disorder or condition) which in any way currently affects, or if untreated could affect, your ability to practice in a competent and professional manner?   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 9. Within the past year, have you ever raised the issue of consumption of drugs or alcohol or the issue of a mental, emotional, nervous, or behavioral disorder or condition as a defense, mitigation, or explanation for your actions in the course of any administrative or judicial proceeding or investigation; any inquiry or other proceeding; or any proposed termination by an educational institution, employer, government agency, professional organization or licensing authority? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 10. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism?   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 11. Are you currently engaged in the illegal use of controlled dangerous substances?   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 12. If your answer to the preceding question is yes, are you currently participating in a supervised rehabilitation program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances?   | <input type="checkbox"/> | <input type="checkbox"/>            |
| 13. Have you been, within the past year, convicted of driving under the influence (DUI) or have you been charged with DUI and been convicted of a lesser offense such as reckless driving?   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 14. Has your medical training or medical practice been interrupted or suspended for a period longer than 60 days for any reason other than a vacation?   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

The term "currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the condition referred to may have an ongoing impact on one's functioning as a physician or an assistant to a physician, or within the past two years.

**IF YOU HAVE ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, PLEASE ATTACH A DETAILED EXPLANATION WITH YOUR APPLICATION UPON RETURNING IT TO THIS OFFICE.**

I certify that all information on this form is correct.

M. F. Adams, M.D.  
Signature

10/15/86  
Date

- ◆ Complete both sides, including signature.
- ◆ Be sure to supply all information.
- ◆ Incomplete applications will be returned.

Return with \$100.00 renewal fee to:

**Medical Licensure Commission  
P.O. Box 887  
Montgomery, AL 36101-0887**



**License Renewal for 1998**  
**Deadline is December 31, 1997**

**State of Alabama**  
**Medical Licensure Commission**

334/242-4153

P.O. Box 887

Montgomery, Alabama 36101-0887



\*\*\*\*\*3-DIGIT 376

WESLEY FRAZIER ADAMS, M.D.  
2901 W STATE ST  
BRISTOL, TN 37620-1718

33  
218  
9823

Complete **BOTH** sides including signature.  
Be sure to correct or supply **ALL** information.  
Return with \$100.00 renewal fee.  
Incomplete applications will be returned.  
Failure to register and pay renewal fee will result  
in the automatic revocation of the current license to  
practice medicine or osteopathy.

|||||

**Please make corrections or supply information:** License 8592 DATE ISSUED: 10/18/78 Sex: M  F

Race: White  Black  Am. Indian  Oriental or Asian  Other  Social Security [REDACTED]

**Office Address:**

2901 WEST STATE STREET  
City, State, Zip: BRISTOL, TN 37620

(Alabama) County: \_\_\_\_\_

Business Phone: (423)968-2182

Fax Number: (423)868-7589

Permission to publish in Roster: Yes  No

Specialty: Primary: OBSTETRICS & GYNECOLOGY

Secondary: \_\_\_\_\_

Form of Practice:  Solo  Partnership (2, 3, or 4)  Group (5 or more) If Group, give name below:

**Home Address:**

220 SKYLINE DR

City, State, Zip: BRISTOL, TN 37620 4141

(Alabama) County: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_

(Will not be published)

Send official mail to: **Business**  address (check one)

**Home**

Board Certified: Yes  No

Board Certified: Yes  No

Primary Hospital where you have staff privileges:

Name: BRISTOL REGIONAL MED CTR

City/State: BRISTOL, TN

Are you licensed in another state: Yes  No  which ones: [GA] [SC] [TN] [ ] [ ]

**Primary Care Information:**

1. Are you actively engaged in clinical practice? (Check one): Yes  No
2. Does your practice include the delivery of primary care medical services? (Primary care is defined as: "Basic or general health care focused on the point at which a patient ideally *first* seeks assistance from the medical care system, exclusive of emergency room care."); (Check one): Yes  No
3. Approximately how many hours per week do you practice the above-defined primary care services? \_\_\_\_\_

**CME Certification: (Check one)**

- I hereby certify that I have met the annual minimum continuing education requirement of 12 hours of Category I continuing medical education during the calendar year ending December 31, 1997.
- I certify that I am exempt from the minimum continuing medical education requirements for the following reason:

- I do not reside in the State of Alabama and do not have a significant portion of my medical practice in Alabama.
- I received my initial license to practice medicine in Alabama after June 30<sup>th</sup> of this calendar year.
- I reinstated my license to practice medicine in the State of Alabama after June 30<sup>th</sup> of this calendar year.
- I am a resident physician enrolled in a residency training program.
- I am retired from the practice of medicine and have obtained a waiver from the Board of Medical Examiners.

Complete both sides including signature. Supply or correct all information.

**OVER**

**DEADLINE IS DECEMBER 31, 1997**

9823

- |  | YES | NO  |
|--|-----|-----|
| 1. Have you been convicted of a felony or of any offense (felony/misdemeanor) involving the practice of medicine within the past year?   | [ ] | [X] |
| 2. Has your certificate of qualification or license to practice medicine in any state been suspended, revoked, restricted, curtailed or voluntarily surrendered under threat of suspension or revocation within the past year?   | [ ] | [X] |
| 3. Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practice, within the past year?  | [ ] | [X] |
| 4. Have you been denied a certificate of qualification or license to practice medicine in any state or has your application for a certificate of qualification or license to practice medicine been withdrawn under threat of denial within the past year?   | [ ] | [X] |
| 5. Have you had a judgement rendered against you, or action settled relating to the performance of your professional service within the past year?   | [ ] | [X] |
| 6. To your knowledge, are you the subject of an investigation by any licensing Board/Agency as of the date of this application within the past year?   | [ ] | [X] |
| 7. Within the past year, have you been diagnosed with or have you been treated for bi-polar disorder, schizophrenia, paranoia, or any other psychotic disorder?  | [ ] | [X] |
| 8. Do you currently have any mental or physical condition or impairment (including, but not limited to, substance abuse, alcohol abuse, or mental, emotional, or nervous disorder or condition) which in any way currently affects, or if untreated could affect, your ability to practice in a competent and professional manner?   | [ ] | [X] |
| 9. Within the past year, have you ever raised the issue of consumption of drugs or alcohol or the issue of a mental, emotional, nervous, or behavioral disorder or condition as a defense, mitigation, or explanation for your actions in the course of any administrative or judicial proceeding or investigation; any inquiry or other proceeding; or any proposed termination by an educational institution, employer, government agency, professional organization or licensing authority? | [ ] | [X] |
| 10. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism?   | [ ] | [X] |
| 11. Are you currently engaged in the illegal use of controlled dangerous substances?   | [ ] | [X] |
| 12. If your answer to the preceding question is yes, are you currently participating in a supervised rehabilitation program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances?   | [ ] | [ ] |
| 13. Have you been, within the past year, convicted of driving under the influence (DUI) or have you been charged with DUI and been convicted of a lesser offense such as reckless driving?   | [ ] | [X] |
| 14. Has your medical training or medical practice been interrupted or suspended for a period longer than 60 days for any reason other than a vacation?   | [ ] | [X] |

The term "currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the condition referred to may have an ongoing impact on one's functioning as a physician or an assistant to a physician, or within the past two years.

**IF YOU HAVE ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, PLEASE ATTACH A DETAILED EXPLANATION WITH YOUR APPLICATION UPON RETURNING IT TO THIS OFFICE.**

I certify that all information on this form is correct.

M. F. Adams, Jr. M.D.  
Signature

10/20/97  
Date

- ◆ Complete both sides, including signature.
- ◆ Be sure to supply all information.
- ◆ Incomplete applications will be returned.

Return with \$100.00 renewal fee to:

**Medical Licensure Commission  
P.O. Box 887  
Montgomery, AL 36101-0887**

**License Renewal for 1999**  
**Deadline is December 31, 1998**

**State of Alabama**  
**Medical Licensure Commission**

334/242-4153

P.O. Box 887

Montgomery, Alabama 36101-0887



\*\*\*\*\*AUTO\*\*MIXED AADC 360  
WESLEY FRAZIER ADAMS, M.D.  
2901 W STATE ST  
BRISTOL TN 37620-1718

61 Complete **BOTH** sides including signature.  
1 Be sure to correct or supply **ALL** information.  
11433 Return with \$100.00 renewal fee.  
Incomplete applications will be returned.  
Failure to register and pay renewal fee will result  
in the automatic revocation of the current license to  
practice medicine or osteopathy.

|||||

Please make corrections or supply information: License **8592** DATE ISSUED: 10/18/78 Sex: M  F   
Race: White  Black  Am. Indian  Oriental or Asian  Other  Social Security # [REDACTED]

**Office Address:**

**Home Address:**

2901 WEST STATE STREET  
City, State, Zip: BRISTOL, TN 37620  
(Alabama) County: \_\_\_\_\_  
Business Phone: (423)968-2182  
Fax Number: (423)968-7589

220 SKYLINE DR  
City, State, Zip: BRISTOL, TN 37620 4141  
(Alabama) County: \_\_\_\_\_  
Home Phone: ( ) \_\_\_\_\_  
(Will not be published)

Permission to publish in Roster: Yes  No

Send official mail to: **Business**  address (check one)  
**Home**

Specialty: Primary: OBSTETRICS & GYNECOLOGY  
Secondary: \_\_\_\_\_

Board Certified: Yes  No   
Board Certified: Yes  No

Form of Practice:  Solo  Partnership (2, 3, or 4)  Group (5 or more) If Group, give name below:

**Primary Hospital where you have staff privileges:**

Name: BRISTOL REGIONAL MED CTR City/State: BRISTOL, TN

Are you licensed in another state: Yes  No  which ones: [GA] [SC] [TN] [ ] [ ]

**Primary Care Information:**

1. Are you actively engaged in clinical practice? (Check one): Yes  No
2. Does your practice include the delivery of primary care medical services? (Primary care is defined as: "Basic or general health care focused on the point at which a patient ideally *first* seeks assistance from the medical care system, exclusive of emergency room care.") (Check one): Yes  No
3. Approximately how many hours per week do you practice the above-defined primary care services? \_\_\_\_\_

**CME Certification: (Check one)**

- I hereby certify that I have met the annual minimum continuing education requirement of 12 hours of Category I continuing medical education during the calendar year ending December 31, 1998.
- I certify that I am exempt from the minimum continuing medical education requirements for the following reason:

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- I received my initial license to practice medicine in Alabama after June 30<sup>th</sup> of this calendar year.
- I reinstated my license to practice medicine in the State of Alabama after June 30<sup>th</sup> of this calendar year.
- I am a resident physician enrolled in a residency training program.
- I am retired from the practice of medicine and have obtained a waiver from the Board of Medical Examiners.

**DEADLINE IS DECEMBER 31, 1998**

Complete both sides including signature. Supply or correct all information.

**OVER**

License #8592

11433

ADAMS, WESLEY FRAZIER

YES NO

- 1. Have you been convicted of a felony or of any offense (felony/misdemeanor) involving the practice of medicine within the past year?  YES  NO
- 2. Has your certificate of qualification or license to practice medicine in any state been suspended, revoked, restricted, curtailed or voluntarily surrendered under threat of suspension or revocation within the past year?  YES  NO
- 3. Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practice, within the past year?  YES  NO
- 4. Have you been denied a certificate of qualification or license to practice medicine in any state or has your application for a certificate of qualification or license to practice medicine been withdrawn under threat of denial within the past year?  YES  NO
- 5. Have you had a judgement rendered against you, or action settled relating to the performance of your professional service within the past year?  YES  NO
- 6. To your knowledge, are you the subject of an investigation by any licensing Board/Agency as of the date of this application within the past year?  YES  NO
- 7. Within the past year, have you been diagnosed with or have you been treated for bi-polar disorder, schizophrenia, paranoia, or any other psychotic disorder?  YES  NO
- 8. Do you currently have any mental or physical condition or impairment (including, but not limited to, substance abuse, alcohol abuse, or mental, emotional, or nervous disorder or condition) which in any way currently affects, or if untreated could affect, your ability to practice in a competent and professional manner?  YES  NO
- 9. Within the past year, have you ever raised the issue of consumption of drugs or alcohol or the issue of a mental, emotional, nervous, or behavioral disorder or condition as a defense, mitigation, or explanation for your actions in the course of any administrative or judicial proceeding or investigation; any inquiry or other proceeding; or any proposed termination by an educational institution, employer, government agency, professional organization or licensing authority?  YES  NO
- 10. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism?  YES  NO
- 11. Are you currently engaged in the illegal use of controlled dangerous substances?  YES  NO
- 12. If your answer to the preceding question is yes, are you currently participating in a supervised rehabilitation program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances?  YES  NO
- 13. Have you been, within the past year, convicted of driving under the influence (DUI) or have you been charged with DUI and been convicted of a lesser offense such as reckless driving?  YES  NO
- 14. Has your medical training or medical practice been interrupted or suspended for a period longer than 60 days for any reason other than a vacation?  YES  NO

The term "currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the condition referred to may have an ongoing impact on one's functioning as a physician or an assistant to a physician, or within the past two years.

IF YOU HAVE ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, PLEASE ATTACH A DETAILED EXPLANATION WITH YOUR APPLICATION UPON RETURNING IT TO THIS OFFICE.

I certify that all information on this form is correct.

W. F. Adams, M.D.  
Signature

10/15/98  
Date

- ◆ Complete both sides, including signature.
- ◆ Be sure to supply all information.
- ◆ Incomplete applications will be returned.

Return with \$100.00 renewal fee to:

Medical Licensure Commission  
P.O. Box 887  
Montgomery, AL 36101-0887

**License Renewal for 2000**  
**Deadline is December 31, 1999**

**State of Alabama**  
**Medical Licensure Commission**

334/242-4153  
P.O. Box 887  
Montgomery, Alabama 36101-0887



\*\*\*\*\*AUTO\*\*MIXED AADC 360  
WESLEY FRAZIER ADAMS, M.D.  
2901 W STATE ST  
BRISTOL, TN 37620-1718

48  
1  
11503

Complete BOTH sides including signature.  
Be sure to correct or supply ALL information.  
Return with \$100.00 renewal fee.  
Incomplete applications will be returned.  
Failure to register and pay renewal fee will result  
in the automatic revocation of the current license to  
practice medicine or osteopathy.



Please make corrections or supply information: License **8592** DATE ISSUED: 10/18/78 Sex: M  F

Race: White  Black  Am. Indian  Oriental or Asian  Other  Social Security # [REDACTED]

Enter SSAN#

Office Address:  
  
2901 WEST STATE STREET  
City, State, Zip: BRISTOL, TN 37620  
(Alabama) County: \_\_\_\_\_  
Business Phone: (423)968-2182  
Fax Number: (423)968-7589

Home Address:  
  
220 SKYLINE DR  
  
City, State, Zip: BRISTOL, TN 37620 4141  
(Alabama) County: \_\_\_\_\_  
Home Phone: ( ) \_\_\_\_\_

(Will not be published)

Permission to publish in Roster: Yes  No

Send official mail to: **Business**  address (check one)

**Home**

Specialty: Primary: OBSTETRICS & GYNECOLOGY  
Secondary: \_\_\_\_\_

Board Certified: Yes  No

Board Certified: Yes  No

Form of Practice:  Solo  Partnership (2, 3, or 4)  Group (5 or more) If Group, give name below:

Primary Hospital where you have staff privileges:

Name: BRISTOL REGIONEL MED CTR City/State: BRISTOL, TN

Are you licensed in another state: Yes  No  which ones: [GA] [SC] [TN] [ ] [ ]

**Primary Care Information:**

1. Are you actively engaged in clinical practice in the State of Alabama?

Yes  Go to Question 2 No  Do NOT answer questions 2 and 3 below. Skip to CME Certification questions.

2. Does your practice include the delivery of primary care medical services in Alabama? (Primary care is defined as: "Basic or general gatekeeper" health care focused on the point at which a patient ideally first seeks assistance from the medical care system, exclusive of an emergency care situation.")

Yes  Go to Question 3 No  Do NOT answer question 3 below. Skip to CME Certification questions.

3. Approximately how many hours per week do you practice the above-defined primary care services in Alabama? Only answer if you answered YES to questions 1 and 2 above.) Approximately \_\_\_\_\_ hours per week.

**CME Certification: (Check one)**

I hereby certify that I have met the annual minimum continuing education requirement of 12 hours of Category I continuing medical education during the calendar year ending December 31, 1999.

I certify that I am exempt from the minimum continuing medical education requirements for the following reason:

I do not reside in the State of Alabama and do not have a significant portion of my medical practice in Alabama.

I received my initial license to practice medicine in Alabama after June 30<sup>th</sup> of this calendar year.

I reinstated my license to practice medicine in the State of Alabama after June 30<sup>th</sup> of this calendar year.

I am a resident physician enrolled in a residency training program.

I am retired from the practice of medicine and have obtained a waiver from the Board of Medical Examiners.

Complete both sides including signature. **DEADLINE IS DECEMBER 31, 1999.** Supply or correct all information.

**OVER**

- |  | YES                      | NO                                  |
|--|--------------------------|-------------------------------------|
| 1. Have you been convicted of a felony or of any offense (felony/misdemeanor) involving the practice of medicine within the past year?   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 2. Has your certificate of qualification or license to practice medicine in any state been suspended, revoked, restricted, curtailed or voluntarily surrendered under threat of suspension or revocation within the past year?   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 3. Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practice, within the past year?  | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 4. Have you been denied a certificate of qualification or license to practice medicine in any state or has your application for a certificate of qualification or license to practice medicine been withdrawn under threat of denial within the past year?   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 5. Have you had a judgement rendered against you, or action scotled relating to the performance of your professional service within the past year?   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 6. To your knowledge, are you the subject of an investigation by any licensing Board/Agency as of the date of this application within the past year?   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 7. Within the past year, have you been diagnosed with or have you been treated for bi-polar disorder, schizophrenia, paranoia, or any other psychotic disorder?  | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 8. Do you currently have any mental or physical condition or impairment (including, but not limited to, substance abuse, alcohol abuse, or mental, emotional, or nervous disorder or condition) which in any way currently affects, or if untreated could affect, your ability to practice in a competent and professional manner?   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 9. Within the past year, have you ever raised the issue of consumption of drugs or alcohol or the issue of a mental, emotional, nervous, or behavioral disorder or condition as a defense, mitigation, or explanation for your actions in the course of any administrative or judicial proceeding or investigation; any inquiry or other proceeding; or any proposed termination by an educational institution, employer, government agency, professional organization or licensing authority? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 10. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism?   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 11. Are you currently engaged in the illegal use of controlled dangerous substances?   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 12. If your answer to the preceding question is yes, are you currently participating in a supervised rehabilitation program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances?   | <input type="checkbox"/> | <input type="checkbox"/>            |
| 13. Have you been, within the past year, convicted of driving under the influence (DUI) or have you been charged with DUI and been convicted of a lesser offense such as reckless driving?   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 14. Has your medical training or medical practice been interrupted or suspended for a period longer than 60 days for any reason other than a vacation?   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

The term "currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the condition referred to may have an ongoing impact on one's functioning as a physician or an assistant to a physician, or within the past two years.

IF YOU HAVE ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, PLEASE ATTACH A DETAILED EXPLANATION WITH YOUR APPLICATION UPON RETURNING IT TO THIS OFFICE.

I certify that all information on this form is correct.

M. F. Adams, M.D.  
Signature

10/21/89  
Date

- ◆ Complete both sides, including signature.
- ◆ Be sure to supply all information.
- ◆ Incomplete applications will be returned.

Return with \$100.00 renewal fee to:

Medical Licensure Commission  
P.O. Box 887  
Montgomery, AL 36101-0887

**License Renewal for 2001**  
**Deadline is December 31, 2000**

State of Alabama  
 Medical Licensure Commission

334/242-4153

P.O. Box 887  
 Montgomery, Alabama 36101-0887



Complete **BOTH** sides including signature.  
 Be sure to correct or supply **ALL** information.  
 Return with \$125.00 renewal fee.  
 Incomplete applications will be returned.  
 Failure to register and pay renewal fee will result  
 in the automatic revocation of the current license to  
 practice medicine or osteopathy.

\*\*\*\*\*AUTO\*\*MIXED AADC 360  
 WESLEY FRAZIER ADAMS, M.D.  
 2901 W STATE ST  
 BRISTOL, TN 37620-1718

54  
 1  
 12161



Please make corrections or supply information: License **8592** DATE ISSUED: 10/18/78 Sex: M  F   
 Race: White  Black  Am. Indian  Oriental or Asian  Other  Social Security # XXXXXXXXXX Enter SSAN#

Office Address:  
 2901 WEST STATE STREET  
 City, State, Zip: BRISTOL, TN 37620  
 (Alabama) County: \_\_\_\_\_  
 Business Phone: (423)968-2182  
 Fax Number: (423)968-7589

Home Address:  
 220 SKYLINE DR  
 City, State, Zip: BRISTOL, TN 37620 4141  
 (Alabama) County: \_\_\_\_\_  
 Home Phone: (\_\_\_\_) \_\_\_\_\_  
 (Will not be published)  
 Send official mail to: Business  address (check one)  
 Home   
 Board Certified: Yes  No   
 Board Certified: Yes  No   
 Form of Practice:  Solo  Partnership (2, 3, or 4)  Group (5 or more) If Group, give name below:

Permission to publish in Roster: Yes  No

Specialty: Primary: OBSTETRICS & GYNECOLOGY  
 Secondary: \_\_\_\_\_

Primary Hospital where you have staff privileges:  
 Name: BRISTOL REGIONAL MED CTR City/State: BRISTOL, TN  
 Are you licensed in another state: Yes  No  which ones: [GA] [SC] [TN] [ ] [ ]

**Primary Care Information:**

1. Are you actively engaged in clinical practice in the State of Alabama?  
 Yes  Go to Question 2 No  Do NOT answer questions 2 and 3 below. Skip to CME Certification questions.
2. Does your practice include the delivery of primary care medical services in Alabama? (Primary care is defined as: "Basic or general 'gatekeeper' health care focused on the point at which a patient ideally first seeks assistance from the medical care system, exclusive of an emergency care situation.")  
 Yes  Go to Question 3 No  Do NOT answer question 3 below. Skip to CME Certification questions.
3. Approximately how many hours per week do you practice the above-defined primary care services in Alabama? Only answer if you answered YES to questions 1 and 2 above.) Approximately \_\_\_\_\_ hours per week.

**CME Certification: (Check one)**

- I hereby certify that I have met the annual minimum continuing education requirement of 24 hours of Category I continuing medical education within the past two calendar years ending December 31, 2000.
- I certify that I am exempt from the minimum continuing medical education requirements for the following reason:
- I do not reside in the State of Alabama and do not have a significant portion of my medical practice in Alabama.
- I received my initial license to practice medicine in Alabama after June 30<sup>th</sup> of this calendar year.
- I reinstated my license to practice medicine in the State of Alabama after June 30<sup>th</sup> of this calendar year.
- I am a resident physician enrolled in a residency training program.
- I am retired from the practice of medicine and have obtained a waiver from the Board of Medical Examiners.

**DEADLINE IS DECEMBER 31, 2000**

Complete both sides including signature. Supply or correct all information.

**OVER**

License #8592

12161

ADAMS, WESLEY FRAZIER

- |  | Yes                      | No                                  |
|--|--------------------------|-------------------------------------|
| 1. Have you been convicted of a felony or of any offense (felony/misdemeanor) involving the practice of medicine within the past year?   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 2. Has your certificate of qualification or license to practice medicine in any state been suspended, revoked, restricted, curtailed or voluntarily surrendered under threat of suspension or revocation within the past year?   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 3. Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practice, within the past year?  | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 4. Have you been denied a certificate of qualification or license to practice medicine in any state or has your application for a certificate of qualification or license to practice medicine been withdrawn under threat of denial within the past year?   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 5. Have you had a judgement rendered against you, or action settled relating to the performance of your professional service within the past year?   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 6. To your knowledge, are you the subject of an investigation by any licensing Board/Agency as of the date of this application within the past year?   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 7. Within the past year, have you been diagnosed with or have you been treated for bi-polar disorder, schizophrenia, paranoia, or any other psychotic disorder?  | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 8. Do you currently have any mental or physical condition or impairment (including, but not limited to, substance abuse, alcohol abuse, or mental, emotional, or nervous disorder or condition) which in any way currently affects, or if untreated could affect, your ability to practice in a competent and professional manner?   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 9. Within the past year, have you ever raised the issue of consumption of drugs or alcohol or the issue of a mental, emotional, nervous, or behavioral disorder or condition as a defense, mitigation, or explanation for your actions in the course of any administrative or judicial proceeding or investigation; any inquiry or other proceeding; or any proposed termination by an educational institution, employer, government agency, professional organization or licensing authority? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 10. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism?   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 11. Are you currently engaged in the illegal use of controlled dangerous substances?   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 12. If your answer to the preceding question is yes, are you currently participating in a supervised rehabilitation program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances?   | <input type="checkbox"/> | <input type="checkbox"/>            |
| 13. Have you been, within the past year, convicted of driving under the influence (DUI) or have you been charged with DUI and been convicted of a lesser offense such as reckless driving?   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 14. Has your medical training or medical practice been interrupted or suspended for a period longer than 60 days for any reason other than a vacation?   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

The term "currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the condition referred to may have an ongoing impact on one's functioning as a physician or an assistant to a physician, or within the past two years.

**IF YOU HAVE ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, PLEASE ATTACH A DETAILED EXPLANATION WITH YOUR APPLICATION UPON RETURNING IT TO THIS OFFICE.**

I certify that all information on this form is correct.

*Wesley Francis Adams Jr. M.D.*  
Signature

10/23/00  
Date

- ◆ Complete both sides, including signature.
- ◆ Be sure to correct or supply all information.
- ◆ Incomplete applications will be returned.

Return with \$125.00 renewal fee to:

**Medical Licensure Commission  
P.O. Box 887  
Montgomery, AL 36101-0887**



License Renewal for 2002  
Deadline is December 31, 2001

State of Alabama  
Medical Licensure Commission

334/242-4153

P.O. Box 887

Montgomery, Alabama 36101-0887



**WESLEY FRAZIER ADAMS, M.D.**  
**2901 WEST STATE STREET**  
**BRISTOL, TN 37620**

Complete **BOTH** sides including signature.  
Be sure to correct or supply **ALL** information.  
Return with \$200.00 renewal fee.  
Incomplete applications will be returned.  
Failure to register and pay renewal fee will result  
in the automatic revocation of the current license to  
practice medicine or osteopathy.

Please make corrections or supply information: License: **MD . 00008592** Date-Issued: 01/11/1948 Sex: M  F

Race: White  Black  American Indian  Oriental or Asian  Other  Social Security# XXXXXXXXXX

**Office Address**

2901 WEST STATE STREET  
City, State, Zip: BRISTOL, TN 37620  
(Alabama) County: UNREPORTED  
Business Phone: (423) 968-2182  
Fax Number: (423) 968-7589

**Home Address**

220 SKYLINE DR  
City, State, Zip: BRISTOL, TN 37620-4141  
(Alabama) County: UNREPORTED  
Home Phone: (Will not be published)

Permission to publish in Roster: Yes

Send official mail to: Business  address (check one)  
Home

Specialty: Primary: OBSTETRICS & GYNECOLOGY  
No

Board Certified: Yes

Form of Practice: [ ] Solo  Partnership (2, 3, or 4) [ ] Group If Group give Group Name below:  
Secondary: Board Certified: Yes  No

Primary Hospital where you have staff privileges:

Name:

City/State: ,

Are you licensed in another state: Yes  No  Which ones: [ GA ]  [ ] [ ] [ ]

**Primary Care Information:**

- Are you actively engaged in clinical practice in the State of Alabama?  
Yes  Go to Question 2 No  Do NOT answer questions 2 and 3 below. Skip to CME Certification questions.
- Does your practice include the delivery of primary care medical services in Alabama? (Primary care is defined as: "Basic or general 'gatekeeper' health care focused on the point at such a patient ideally first seeks assistance from the medical care system, exclusive of an emergency care situation.")  
Yes  Go to Question 3 No  Do NOT answer question 3 below. Skip to the CME Certification questions.
- Approximately how many hours per week do you practice the above-defined primary care services in Alabama? Only answer if you Answered YES to questions 1 and 2 above. Approximately: \_\_\_\_\_ hours per week.

**CME Certification: (Check one)**

- I hereby certify that I have met the annual minimum continuing education requirement of 24 hours of Category I continuing medical education within the past two calendar years ending December 31, 2001.
- I certify that I am exempt from the minimum continuing medical education requirements for the following reason:
- I do not reside in the State of Alabama and do not have a significant portion of my medical practice in Alabama.
  - I received my initial license to practice medicine in Alabama after June 30<sup>th</sup> of this calendar year.
  - I reinstated my license to practice medicine in the State of Alabama after June 30<sup>th</sup> of this calendar year.
  - I am a resident physician enrolled in a residency training program.
  - I am retired from the practice of medicine and have obtained a waiver from the Board of Medical Examiners.

**DEADLINE IS DECEMBER 31, 2001**

**ADAMS, WESLEY FRAZIER**

MD . 00008592

Complete both sides including signature. Supply or correct all information.

**OVER**

- |  | Yes                      | No                                  |
|--|--------------------------|-------------------------------------|
| 1. Have you been convicted of a felony or of any offense (felony/misdemeanor) involving the practice of medicine within the past year?   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 2. Has your certificate of qualification or license to practice medicine in any state been suspended, revoked, restricted, curtailed or voluntarily surrendered under threat of suspension or revocation within the past year?   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 3. Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practice, within the past year?  | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 4. Have you been denied a certificate of qualification or license to practice medicine in any state or has your application for a certificate of qualification or license to practice medicine been withdrawn under threat of denial within the past year?   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 5. Have you had a judgement rendered against you, or action settled relating to the performance of your professional service within the past year?   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 6. To your knowledge, are you the subject of an investigation by any licensing Board/Agency as of the date of this application within the past year?   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 7. Within the past year, have you been diagnosed with or have you been treated for bi-polar disorder, schizophrenia, paranoia, or any other psychotic disorder?  | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 8. Do you currently have any mental or physical condition or impairment (including, but not limited to, substance abuse, alcohol abuse, or mental, emotional, or nervous disorder or condition) which in any way currently affects, or if untreated could affect, your ability to practice in a competent and professional manner?   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 9. Within the past year, have you ever raised the issue of consumption of drugs or alcohol or the issue of a mental, emotional, nervous, or behavioral disorder or condition as a defense, mitigation, or explanation for your actions in the course of any administrative or judicial proceeding or investigation; any inquiry or other proceeding; or any proposed termination by an educational institution, employer, government agency, professional organization or licensing authority? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 10. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism?   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 11. Are you currently engaged in the illegal use of controlled dangerous substances?   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 12. If your answer to the preceding question is yes, are you currently participating in a supervised rehabilitation program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances?   | <input type="checkbox"/> | <input type="checkbox"/>            |
| 13. Have you been, within the past year, convicted of driving under the influence (DUI) or have you been charged with DUI and been convicted of a lesser offense such as reckless driving?   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 14. Has your medical training or medical practice been interrupted or suspended for a period longer than 60 days for any reason other than a vacation?   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

The term "currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the condition referred to may have an ongoing impact on one's functioning as a physician or an assistant to a physician, or within the past two years.

IF YOU HAVE ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, PLEASE ATTACH A DETAILED EXPLANATION WITH YOUR APPLICATION UPON RETURNING IT TO THIS OFFICE.

I certify that all information on this form is correct.

M. F. Belam Jr. M.D.  
Signature

12/10/01  
Date

- ◆ Complete both sides, including signature.
- ◆ Be sure to correct or supply all information.
- ◆ Incomplete applications will be returned.

Return with \$200.00 renewal fee to:

**Medical Licensure Commission**  
**P.O. Box 887**  
**Montgomery, AL 36101-0887**

License Renewal for 2003  
Deadline is December 31, 2002

State of Alabama  
Medical Licensure Commission

334/242-4153

P.O. Box 887

Montgomery, Alabama 36101-0887



**WESLEY FRAZIER ADAMS, M.D.**  
2901 WEST STATE STREET  
BRISTOL, TN 37620

Complete **BOTH** sides including signature.  
Be sure to correct or supply **ALL** information.  
Return with \$200.00 renewal fee.  
Incomplete applications will be returned.  
Failure to register and pay renewal fee will result  
in the automatic revocation of the current license to  
practice medicine or osteopathy.

Please make corrections or supply information: License: **MD . 00008592** Date-Issued: 10/18/1978 Sex: M  F

Race: White  Black  American Indian  Oriental or Asian  Other  Social Security: [REDACTED]

**Office Address**

2901 WEST STATE STREET  
City, State, Zip: BRISTOL, TN 37620  
(Alabama) County:  
Business Phone: (423) 968-2182  
Fax Number: (423) 968-7589

**Home Address**

220 SKYLINE DR  
City, State, Zip: BRISTOL, TN 37620-4141  
(Alabama) County:  
Home Phone: (Will not be published)

Permission to publish in Roster: Yes

Send official mail to: Business  address (check one)  
Home

Specialty: Primary: OBSTETRICS & GYNECOLOGY  
Secondary:

Board Certified: Yes  No   
Board Certified: Yes  No

Form of Practice:  Solo  Partnership (2, 3, or 4)  Group If Group give Group Name below:

Primary Hospital where you have staff privileges:  
Name: BRISTOL REGIONEL MED CTR

City/State: BRISTOL, Tennessee

Are you licensed in another state: Yes  No  Which ones:  GA  SC  TN  [ ] [ ]

**Primary Care Information:**

- Are you actively engaged in clinical practice in the State of Alabama?  
Yes  Go to Question 2 No  Do NOT answer questions 2 and 3 below. Skip to CME Certification questions.
- Does your practice include the delivery of primary care medical services in Alabama? (Primary care is defined as: "Basic or general 'gatekeeper' health care focused on the point at such a patient ideally first seeks assistance from the medical care system, exclusive of an emergency care situation.")  
Yes  Go to Question 3 No  Do NOT answer question 3 below. Skip to the CME Certification questions.
- Approximately how many hours per week do you practice the above-defined primary care services in Alabama? Only answer if you Answered YES to questions 1 and 2 above. Approximately: 0 hours per week.

**CME Certification: (Check one)**

- I hereby certify that I have met the annual minimum continuing education requirement of 24 hours of Category I continuing medical education within the past two calendar years ending December 31, 2002.
- I certify that I am exempt from the minimum continuing medical education requirements for the following reason:
- I do not reside in the State of Alabama and do not have a significant portion of my medical practice in Alabama.
  - I received my initial license to practice medicine in Alabama after June 30<sup>th</sup> of this calendar year.
  - I reinstated my license to practice medicine in the State of Alabama after June 30<sup>th</sup> of this calendar year.
  - I am a resident physician enrolled in a residency training program.
  - I am retired from the practice of medicine and have obtained a waiver from the Board of Medical Examiners.

**DEADLINE IS DECEMBER 31, 2002**

MD . 00008592

ADAMS, WESLEY FRAZIER

Complete both sides including signature. Supply or correct all information.

**OVER**

- |  | Yes                      | No                                  |
|--|--------------------------|-------------------------------------|
| 1. Have you been convicted of a felony or of any offense (felony/misdemeanor) involving the practice of medicine within the past year?   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 2. Has your certificate of qualification or license to practice medicine in any state been suspended, revoked, restricted, curtailed or voluntarily surrendered under threat of suspension or revocation within the past year?   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 3. Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practice, within the past year?  | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 4. Have you been denied a certificate of qualification or license to practice medicine in any state or has your application for a certificate of qualification or license to practice medicine been withdrawn under threat of denial within the past year?   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 5. Have you had a judgement rendered against you, or action settled relating to the performance of your professional service within the past year?   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 6. To your knowledge, are you the subject of an investigation by any licensing Board/Agency as of the date of this application within the past year?   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 7. Within the past year, have you been diagnosed with or have you been treated for bi-polar disorder, schizophrenia, paranoia, or any other psychotic disorder?  | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 8. Do you currently have any mental or physical condition or impairment (including, but not limited to, substance abuse, alcohol abuse, or mental, emotional, or nervous disorder or condition) which in any way currently affects, or if untreated could affect, your ability to practice in a competent and professional manner?   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 9. Within the past year, have you ever raised the issue of consumption of drugs or alcohol or the issue of a mental, emotional, nervous, or behavioral disorder or condition as a defense, mitigation, or explanation for your actions in the course of any administrative or judicial proceeding or investigation; any inquiry or other proceeding; or any proposed termination by an educational institution, employer, government agency, professional organization or licensing authority? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 10. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism?   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 11. Are you currently engaged in the illegal use of controlled dangerous substances?   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 12. If your answer to the preceding question is yes, are you currently participating in a supervised rehabilitation program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances?   | <input type="checkbox"/> | <input type="checkbox"/>            |
| 13. Have you been, within the past year, convicted of driving under the influence (DUI) or have you been charged with DUI and been convicted of a lesser offense such as reckless driving?   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 14. Has your medical training or medical practice been interrupted or suspended for a period longer than 60 days for any reason other than a vacation?   | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

The term "currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the condition referred to may have an ongoing impact on one's functioning as a physician or an assistant to a physician, or within the past two years.

IF YOU HAVE ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, PLEASE ATTACH A DETAILED EXPLANATION WITH YOUR APPLICATION UPON RETURNING IT TO THIS OFFICE.

I certify that all information on this form is correct.

M. F. Adams, M.D.  
Signature

10/28/02  
Date

- ◆ Complete both sides, including signature.
- ◆ Be sure to correct or supply all information.
- ◆ Incomplete applications will be returned.

Return with \$200.00 renewal fee to:

**Medical Licensure Commission**  
P.O. Box 887  
Montgomery, AL 36101-0887



Medical Licensure Commission of the State of Alabama  
PO Box 887  
Montgomery, AL 36101

### 2004 Online Renewal Summary

Name: **Wesley Frazier Adams**

License Number: **MD.8592**

Transaction Date: **2003-10-31\***

Transaction Number: **null**

Registration Fee: **200**

Date of Birth: **1948-01-11**

\* - This date reflects the date that the transaction was downloaded into the production system not the date the transaction was processed online.

Have you been convicted of a felony or of any offense (felony/misdemeanor) involving the practice of medicine within the past year? **N**

If yes, please explain:

Has your certificate of qualification or license to practice medicine in any state been suspended, revoked, restricted, curtailed or voluntarily surrendered under threat of suspension or revocation within the past year? **N**

If yes, please explain:

Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practice, within the past year? **N**

If yes, please explain:

Have you been denied a certificate of qualification or license to practice medicine in any state or has your application for a certificate of qualification or license to practice medicine been withdrawn under threat of denial within the past year? **N**

If yes, please explain:

Have you had a judgement rendered against you, or action settled relating to the performance of your professional service within the past year? **N**

If yes, please explain:

To your knowledge, are you the subject of an investigation, or has a formal complaint against your license been filed by any licensing Board/Agency as of the date of this application within the past year? **N**

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If yes, please explain:

Within the past year, have you been diagnosed with or have you been treated for bi-polar disorder, schizophrenia, paranoia, or any other psychotic disorder? **N**

If yes, please explain:

Do you currently\* have any mental or physical condition or impairment (including, but not limited to, substance abuse, alcohol abuse, or mental, emotional or nervous disorder or condition) which in any way currently affects, or if untreated could affect, your ability to practice in a competent and professional manner or, within the past year, have you applied for and/or have you received any payment or other compensation for any mental or physical condition? **N**

If yes, please explain:

Within the past year, have you ever raised the issue of consumption of drugs or alcohol or the issue of a mental, emotional, nervous, or behavioral disorder or condition as a defense, mitigation, or explanation for your actions in the course of any administrative or judicial proceeding or investigation; any inquiry or other proceeding; or any proposed termination by an educational institution, employer, government agency, professional organization or licensing authority? **N**

If yes, please explain:

Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism? **N**

If yes, please explain:

Are you currently\* engaged in the illegal use of controlled dangerous substances? **N**

If yes, please explain:

If your answer to the preceding question is yes, are you currently\* participating in a supervised rehabilitation program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances? **N**

If yes, please explain:

Have you been, within the past year, convicted of driving under the influence (DUI) or have you been charged with DUI and been convicted of a lesser offense such as reckless driving? **N**

If yes, please explain:

Has your medical training or medical practice been interrupted or suspended for a period longer than 60 days for any reason other than a vacation? **N**

If yes, please explain:

\*Note: The term "currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the condition referred to may have an ongoing impact on one's functioning as a physician or an assistant to a physician, or within the past two years.

Primary specialty:

Are you Board certified in your primary specialty? **N**

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Secondary specialty:

Are you Board certified in your secondary specialty? **N**

Practice Type:

Primary Hospital where you have privileges:

Are you licensed in another State: **Y**

Primary Care Information:

Are you actively engaged in clinical practice in the State of Alabama? **N**

Does your practice include the delivery of primary care medical services in Alabama? (Primary care is defined as: "Basic or general 'gatekeeper' health care focused on the point at such a patient ideally first seeks assistance from the medical care system, exclusive of an emergency care situation.") **N**

Approximately how many hours per week do you practice the above-defined primary care services in Alabama? Only answer if you answered YES to questions 1 and 2 above. **0**

CME Certification: I hereby certify that I have met the annual minimum continuing education requirement of 24 hours of Category I continuing medical education within the past two Calendar Years ending December 31, 2004. **Y**

I certify that I am exempt from the minimum CME requirement. **N**

I am exempt from the CME requirement for the following reason: **null**

Practice Telephone: **(423) 968-2182**

Practice Address: **2901 WEST STATE STREET**

Home Telephone:

Home Address: **220 SKYLINE DR**

Public Address: **Practice**

Mail Address: **Practice**

By agreeing with this data and submitting your credit information, you have signed this registration form attesting that the material has been supplied by you, the licensee, and that the information is correct. Knowingly providing false registration information to the Alabama Board of Medical Examiners may result in the loss of your license to practice medicine.

Oct 1, 2014 12:52 PM





Medical Licensure Commission of the State of Alabama  
PO Box 887  
Montgomery, AL 36101

### 2005 Online Renewal Summary

Name: **Wesley Frazier Adams**  
Transaction Date: **2004-12-30\***  
Registration Fee: **200**

License Number: **MD.8592**  
Transaction Number: **null**  
Date of Birth: **1948-01-11**

\* - This date reflects the date that the transaction was downloaded into the production system not the date the transaction was processed online.

Have you been convicted of a felony or of any offense (felony/misdemeanor) involving the practice of medicine within the past year? **N**

If yes, please explain:

Has your certificate of qualification or license to practice medicine in any state been suspended, revoked, restricted, curtailed or voluntarily surrendered under threat of suspension or revocation within the past year? **N**

If yes, please explain:

Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practice, within the past year? **N**

If yes, please explain:

Have you been denied a certificate of qualification or license to practice medicine in any state or has your application for a certificate of qualification or license to practice medicine been withdrawn under threat of denial within the past year? **N**

If yes, please explain:

Have you had a judgement rendered against you, or action settled relating to the performance of your professional service within the past year? **N**

If yes, please explain:

To your knowledge, are you the subject of an investigation, or has a formal complaint against your license been filed by any licensing Board/Agency as of the date of this application within the past year? **N**

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If yes, please explain:

Within the past year, have you been diagnosed with or have you been treated for bi-polar disorder, schizophrenia, paranoia, or any other psychotic disorder? **N**

If yes, please explain:

Do you currently\* have any mental or physical condition or impairment (including, but not limited to, substance abuse, alcohol abuse, or mental, emotional or nervous disorder or condition) which in any way currently affects, or if untreated could affect, your ability to practice in a competent and professional manner or, within the past year, have you applied for and/or have you received any payment or other compensation for any mental or physical condition? **N**

If yes, please explain:

Within the past year, have you ever raised the issue of consumption of drugs or alcohol or the issue of a mental, emotional, nervous, or behavioral disorder or condition as a defense, mitigation, or explanation for your actions in the course of any administrative or judicial proceeding or investigation; any inquiry or other proceeding; or any proposed termination by an educational institution, employer, government agency, professional organization or licensing authority? **N**

If yes, please explain:

Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism? **N**

If yes, please explain:

Are you currently\* engaged in the illegal use of controlled dangerous substances? **N**

If yes, please explain:

If your answer to the preceding question is yes, are you currently\* participating in a supervised rehabilitation program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances? **N**

If yes, please explain:

Have you been, within the past year, convicted of driving under the influence (DUI) or have you been charged with DUI and been convicted of a lesser offense such as reckless driving? **N**

If yes, please explain:

Has your medical training or medical practice been interrupted or suspended for a period longer than 60 days for any reason other than a vacation? **N**

If yes, please explain:

\*Note: The term "currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the condition referred to may have an ongoing impact on one's functioning as a physician or an assistant to a physician, or within the past two years.

Primary specialty:

Are you Board certified in your primary specialty? **N**

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Secondary specialty:

Are you Board certified in your secondary specialty? **N**

Practice Type:

Primary Hospital where you have privileges:

Are you licensed in another State: **Y**

Primary Care Information:

Are you actively engaged in clinical practice in the State of Alabama? **N**

Does your practice include the delivery of primary care medical services in Alabama? (Primary care is defined as: "Basic or general 'gatekeeper' health care focused on the point at such a patient ideally first seeks assistance from the medical care system, exclusive of an emergency care situation.") **N**

Approximately how many hours per week do you practice the above-defined primary care services in Alabama? Only answer if you answered YES to questions 1 and 2 above. **0**

CME Certification: I hereby certify that I have met the annual minimum continuing education requirement of 12 hours of Category I continuing medical education for the Calendar Year 2004. **Y**

I certify that I am exempt from the minimum Continuing Medical Education requirement for the following reason: **N**

I am exempt from the Continuing Medical Education requirement for the following reason: (Reason Response) **null**

Practice Telephone: **(423) 968-2182**

Practice Address: **2901 WEST STATE STREET**

Oct 1, 2014 12:52 PM

Home Telephone:

Home Address: **220 SKYLINE DR**

Public Address: **Practice**

Mail Address: **Practice**

By agreeing with this data and submitting your credit information, you have signed this registration form attesting that the material has been supplied by you, the licensee, and that the information is correct. Knowingly providing false registration information to the Alabama Board of Medical Examiners may result in the loss of your license to practice medicine.



**Medical Licensure Commission of the State of Alabama**  
**PO Box 887**  
**Montgomery, AL 36101**

**2006 Online Renewal Summary**

Name: **Wesley Frazier Adams**

License Number: **MD.8592**

Transaction Date: **2005-12-29\***

Transaction Number: **null**

Registration Fee: **200**

Date of Birth: **1948-01-11**

\* - This date reflects the date that the transaction was downloaded into the production system not the date the transaction was processed online.

Have you been convicted of a felony or of any offense (felony/misdemeanor) involving the practice of medicine within the past year? **N**

If yes, please explain:

Has your certificate of qualification or license to practice medicine in any state been suspended, revoked, restricted, curtailed or voluntarily surrendered under threat of suspension or revocation within the past year? **N**

If yes, please explain:

Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practice, within the past year? **N**

If yes, please explain:

Have you been denied a certificate of qualification or license to practice medicine in any state or has your application for a certificate of qualification or license to practice medicine been withdrawn under threat of denial within the past year? **N**

If yes, please explain:

Have you had a judgement rendered against you, or action settled relating to the performance of your professional service within the past year? **N**

If yes, please explain:

To your knowledge, are you the subject of an investigation, or has a formal complaint against your license been filed by any licensing Board/Agency as of the date of this application within the past year? **N**

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If yes, please explain:

Within the past year, have you been diagnosed with or have you been treated for bi-polar disorder, schizophrenia, paranoia, or any other psychotic disorder? **N**

If yes, please explain:

Do you currently\* have any mental or physical condition or impairment (including, but not limited to, substance abuse, alcohol abuse, or mental, emotional or nervous disorder or condition) which in any way currently affects, or if untreated could affect, your ability to practice in a competent and professional manner or, within the past year, have you applied for and/or have you received any payment or other compensation for any mental or physical condition? **N**

If yes, please explain:

Within the past year, have you ever raised the issue of consumption of drugs or alcohol or the issue of a mental, emotional, nervous, or behavioral disorder or condition as a defense, mitigation, or explanation for your actions in the course of any administrative or judicial proceeding or investigation; any inquiry or other proceeding; or any proposed termination by an educational institution, employer, government agency, professional organization or licensing authority? **N**

If yes, please explain:

Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism? **N**

If yes, please explain:

Are you currently\* engaged in the illegal use of controlled dangerous substances? **N**

If yes, please explain:

If your answer to the preceding question is yes, are you currently\* participating in a supervised rehabilitation program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances? **N**

If yes, please explain:

Have you been, within the past year, convicted of driving under the influence (DUI) or have you been charged with DUI and been convicted of a lesser offense such as reckless driving? **N**

If yes, please explain:

Has your medical training or medical practice been interrupted or suspended for a period longer than 60 days for any reason other than a vacation? **N**

If yes, please explain:

\*Note: The term "currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the condition referred to may have an ongoing impact on one's functioning as a physician or an assistant to a physician, or within the past two years.

Primary specialty:

Are you Board certified in your primary specialty? **N**

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Secondary specialty:

Are you Board certified in your secondary specialty? **N**

Practice Type:

Primary Hospital where you have privileges:

Are you licensed in another State: **Y**

Primary Care Information:

Are you actively engaged in clinical practice in the State of Alabama? **N**

Does your practice include the delivery of primary care medical services in Alabama? (Primary care is defined as: "Basic or general `gatekeeper` health care focused on the point at such a patient ideally first seeks assistance from the medical care system, exclusive of an emergency care situation.") **N**

Approximately how many hours per week do you practice the above-defined primary care services in Alabama? Only answer if you answered YES to questions 1 and 2 above. **0**

CME Certification: I hereby certify that I have met the annual minimum continuing education requirement of 12 hours of Category I continuing medical education for the Calendar Year 2005. **Y**

I certify that I am exempt from the minimum Continuing Medical Education requirement for the following reason: **N**

I am exempt from the Continuing Medical Education requirement for the following reason: (Reason Response) **null**

Practice Telephone: **(423) 968-2182**

Practice Address: **2901 WEST STATE STREET**

Home Telephone:

Home Address: **220 SKYLINE DR**

Public Address: **Practice**

Mail Address: **Practice**

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**Medical Licensure Commission of the State of Alabama**

**PO Box 887**

**Montgomery, AL 36101**

**2007 Online Renewal Summary**

**Name: Wesley Frazier Adams**

**License Number: MD.8592**

**Transaction Date: 2006-12-19\***

**Transaction Number: VXHF0D5E96C8**

**Registration Fee: 200**

**Date of Birth: 1948-01-11**

\* - This date reflects the date that the transaction was downloaded into the production system not the date the transaction was processed online.

Have you been charged with any offense (felony/ misdemeanor) within the past year? **no**

If yes, please explain:

Has your certificate of qualification or license to practice medicine in any state been suspended, revoked, restricted, curtailed or voluntarily surrendered under threat of suspension or revocation within the past year? **no**

If yes, please explain:

Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practice, within the past year? **no**

If yes, please explain:

Have you been denied a certificate of qualification or license to practice medicine in any state or has your application for a certificate of qualification or license to practice medicine been withdrawn under threat of denial within the past year? **no**

If yes, please explain:

Have you had a judgment rendered against you, or action settled relating to the performance of your professional service within the past year? **no**

If yes, please explain:

To your knowledge, are you the subject of an investigation, or has a formal complaint against your license been filed by any licensing Board/Agency as of the date of this application within the past year? **no**

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If yes, please explain:

Within the past year, have you been diagnosed with or have you been treated for bi-polar disorder, schizophrenia, paranoia, or any other psychotic disorder? **no**

If yes, please explain:

Do you currently have any mental or physical condition or impairment (including, but not limited to, substance abuse, alcohol abuse, or mental, emotional, or nervous disorder or condition) which in any way currently affects, or if untreated could affect, your ability to practice in a competent and professional manner or, within the past year, have you applied for and/or have you received any payment or other compensation for any mental or physical condition? **no**

If yes, please explain:

Within the past year, have you raised the issue of consumption of drugs or alcohol or the issue of a mental, emotional, nervous, or behavioral disorder or condition as a defense, mitigation, or explanation for your actions in the course of any administrative or judicial proceeding or investigation; any inquiry or other proceeding; or any proposed termination by an educational institution, employer, government agency, professional organization or licensing authority? **no**

If yes, please explain:

Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism? **no**

If yes, please explain:

Have you engaged in the illegal use of controlled dangerous substances within the past twelve months? **no**

If yes, please explain:

If your answer to the preceding question is yes, are you currently participating in a supervised rehabilitation program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances? **n/a**

If yes, please explain:

Have you been, within the past year, convicted of driving under the influence (DUI) or have you been charged with DUI and been convicted of a lesser offense such as reckless driving? **no**

If yes, please explain:

Has your medical training or medical practice been interrupted or suspended for a period longer than 60 days for any reason other than a vacation? **no**

If yes, please explain:

Note: The term "currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough that the condition referred to may have an ongoing impact on one's functioning as a physician, or within the past two years. **null**

Primary specialty: **GYNECOLOGY (OB/GYN)**

Are you Board certified in your primary specialty? **no**

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Secondary specialty:

Are you Board certified in your secondary specialty?

Practice Type:

If Group, provide the Group Name:

Primary Hospital where you have privileges: (if any) **null**

Hospital Name:

Hospital City:

Hospital State:

Are you licensed in another State: **yes**

**TN**

**SC**

**GA**

Are you actively engaged in clinical practice in the State of Alabama? **no**

What is your principal county of practice in the State of Alabama?

(\*\*indicate state if not in Alabama) **TN**

Other county(ies) of practice? Indicate state, if counties are not in Alabama). Click 'NONE' if you only practice in the indicated principal county. **null**

Other County1

Other State1

Other County 2

Other State 2

Do you have a current collaborative agreement with a nurse or practitioner or midwife? **No**

Does the nurse practitioner/midwife practice at a site other than your office? **No**

Are you employed by the nurse practitioner/midwife or a corporation owned by the nurse practitioner/midwife?

Do you currently conduct office based surgery involving the administration of parenteral medication for analgesia/sedation, general anesthesia or major regional block anesthesia? **yes**

PRIMARY CARE INFORMATION: Primary care is defined as: Basic or general health care focused on the point at which a patient ideally first seeks assistance from the medical care system, exclusive or an emergency situation. **null**

Does your practice include the delivery of primary care medical services in Alabama? **no**

Approximately how many hours per week do you practice the above defined primary care services in Alabama? NOTE: Enter the Average hours worked as a whole number. Do not enter ranges of hours or decimals. **0**

Approximately how many patient encounters (office, hospital, ER, etc.) per week do you have involving the above defined priary care services in Alabama? **0**

CME Certification: I hereby certify that I have met the annual minimum continuing education requirement of 12 hours of Category I continuing medical education for the calendar year 2006 and have supporting documentation if audited. **N**

I certify that I am exempt from the minimum continuing medical education requirements for the following reason: **Y**

Exempt Reason **I do not reside in the State of Alabama and do not have a significant portion of any medical practice in the State of Alabama.**

Practice Telephone: **(423) 968-2182**

Practice Address: **2901 WEST STATE STREET**

Home Telephone:

Home Address: **220 SKYLINE DR**

Public Address: **True**

Mail Address: **True**

By agreeing with this data and submitting your credit information, you have signed this registration form attesting that the material has been supplied by you, the licensee, and that the information is correct. Knowingly providing false registration information to the State of Alabama Medical Licensure Commission may result in the loss of your license to practice medicine. **null**

Oct 1, 2014 12:53 PM



Medical Licensure Commission of the State of Alabama  
PO Box 887  
Montgomery, AL 36101

### 2008 Online Renewal Summary

Name: **Wesley Frazier Adams**

License Number: **MD.8592**

Transaction Date: **2007-12-04\***

Transaction Number: **VFFF1E2F5E28**

Registration Fee: **300**

Date of Birth: **1948-01-11**

\* - This date reflects the date that the transaction was downloaded into the production system not the date the transaction was processed online.

Have you been charged with any offense (felony/ misdemeanor) within the past year? **no**

If yes, please explain:

Has your certificate of qualification or license to practice medicine in any state been suspended, revoked, restricted, curtailed or voluntarily surrendered under threat of suspension or revocation within the past year? **no**

If yes, please explain:

Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practice, within the past year? **no**

If yes, please explain:

Have you been denied a certificate of qualification or license to practice medicine in any state or has your application for a certificate of qualification or license to practice medicine been withdrawn under threat of denial within the past year? **no**

If yes, please explain:

Have you had a judgment rendered against you, or action settled relating to the performance of your professional service within the past year? **no**

If yes, please explain:

To your knowledge, are you the subject of an investigation, or has a formal complaint against your license been filed by any licensing Board/Agency as of the date of this application within the past year? **no**

Oct 1, 2014 12:53 PM

If yes, please explain:

Within the past year, have you been diagnosed with or have you been treated for bi-polar disorder, schizophrenia, paranoia, or any other psychotic disorder? **no**

If yes, please explain:

Do you currently have any mental or physical condition or impairment (including, but not limited to, substance abuse, alcohol abuse, or mental, emotional, or nervous disorder or condition) which in any way currently affects, or if untreated could affect, your ability to practice in a competent and professional manner or, within the past year, have you applied for and/or have you received any payment or other compensation for any mental or physical condition? **no**

If yes, please explain:

Within the past year, have you raised the issue of consumption of drugs or alcohol or the issue of a mental, emotional, nervous, or behavioral disorder or condition as a defense, mitigation, or explanation for your actions in the course of any administrative or judicial proceeding or investigation; any inquiry or other proceeding; or any proposed termination by an educational institution, employer, government agency, professional organization or licensing authority? **no**

If yes, please explain:

Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism? **no**

If yes, please explain:

Have you engaged in the illegal use of controlled dangerous substances within the past twelve months? **no**

If yes, please explain:

If your answer to the preceding question is yes, are you currently participating in a supervised rehabilitation program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances? **n/a**

If yes, please explain:

Have you been, within the past year, convicted of driving under the influence (DUI) or have you been charged with DUI and been convicted of a lesser offense such as reckless driving? **no**

If yes, please explain:

Has your medical training or medical practice been interrupted or suspended for a period longer than 60 days for any reason other than a vacation? **no**

If yes, please explain:

Note: The term "currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough that the condition referred to may have an ongoing impact on one's functioning as a physician, or within the past two years. **null**

Primary specialty: **Gynecology (OB/GYN)**

Are you Board certified in your primary specialty? **Y**

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Secondary specialty: **Other**

Are you Board certified in your secondary specialty?

Practice Type: **P**

If Group, provide the Group Name:

Primary Hospital where you have privileges: (if any) **null**

Hospital Name: **Bristol Regional Medical Center**

Hospital City: **Bristol**

Hospital State: **TN**

Are you licensed in another State:

**TN**

**SC**

**GA**

Are you actively engaged in clinical practice in the State of Alabama? **N**

What is your principal county of practice in the State of Alabama?

(\*\*indicate state if not in Alabama)

Other county(ies) of practice? Indicate state, if counties are not in Alabama). Click 'NONE' if you only practice in the indicated principal county. **null**

Other County1

Other State1

Other County 2

Other State 2

Do you have a current collaborative agreement with a nurse or practitioner or midwife? **N**

Do you currently conduct office based surgery involving the administration of parenteral medication for analgesia/sedation, general anesthesia or major regional block anesthesia? **N**

PRIMARY CARE INFORMATION: Primary care is defined as: Basic or general health care focused on the point at which a patient ideally first seeks assistance from the medical care system, exclusive or an emergency situation. **null**

Does your practice include the delivery of primary care medical services in Alabama? **N**

Approximately how many hours per week do you practice the above defined primary care services in Alabama? NOTE: Enter the Average hours worked as a whole number. Do not enter ranges of hours or decimals.

Approximately how many patient encounters (office, hospital, ER, etc.) per week do you have involving the above defined priary care services in Alabama?

CME Certification: I hereby certify that I have met the annual minimum continuing education requirement of 12 hours of Category I continuing medical education for the calendar year 2007 and have supporting documentation if audited. **yes**

I certify that I am exempt from the minimum continuing medical education requirements for the following reason:

Exempt Reason

Practice Telephone: **(423) 968-2182**

Practice Address: **2901 West State Street**

Home Telephone:

Home Address: **220 Skyline Dr**

Public Address: **True**

Mail Address: **True**

By agreeing with this data and submitting your credit information, you have signed this registration form attesting that the material has been supplied by you, the licensee, and that the information is correct. Knowingly providing false registration information to the State of Alabama Medical Licensure Commission may result in the loss of your license to practice medicine. **null**





**Medical Licensure Commission of the State of Alabama**

**PO Box 887**

**Montgomery, AL 36101**

**2009 Online Renewal Summary**

**Name: Wesley Frazier Adams**

**License Number: MD.8592**

**Transaction Date: 2008-11-24\***

**Transaction Number: VREF2FF12746**

**Registration Fee: 300**

**Date of Birth: 1948-01-11**

\* - This date reflects the date that the transaction was downloaded into the production system not the date the transaction was processed online.

Have you been charged with any offense (felony/ misdemeanor) within the past year? **no**

If yes, please explain:

Has your certificate of qualification or license to practice medicine in any state been suspended, revoked, restricted, curtailed or voluntarily surrendered under threat of suspension or revocation within the past year? **no**

If yes, please explain:

Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practice, within the past year? **no**

If yes, please explain:

Have you been denied a certificate of qualification or license to practice medicine in any state or has your application for a certificate of qualification or license to practice medicine been withdrawn under threat of denial within the past year? **no**

If yes, please explain:

Have you had a judgment rendered against you, or action settled relating to the performance of your professional service within the past year? **no**

If yes, please explain:

To your knowledge, are you the subject of an investigation, or has a formal complaint against your license been filed by any licensing Board/Agency as of the date of this application within the past year? **no**

Oct 1, 2014 12:53 PM

If yes, please explain:

Within the past year, have you been diagnosed with or have you been treated for bi-polar disorder, schizophrenia, paranoia, or any other psychotic disorder? **no**

If yes, please explain:

Do you currently have any mental or physical condition or impairment (including, but not limited to, substance abuse, alcohol abuse, or mental, emotional, or nervous disorder or condition) which in any way currently affects, or if untreated could affect, your ability to practice in a competent and professional manner or, within the past year, have you applied for and/or have you received any payment or other compensation for any mental or physical condition? **no**

If yes, please explain:

Within the past year, have you raised the issue of consumption of drugs or alcohol or the issue of a mental, emotional, nervous, or behavioral disorder or condition as a defense, mitigation, or explanation for your actions in the course of any administrative or judicial proceeding or investigation; any inquiry or other proceeding; or any proposed termination by an educational institution, employer, government agency, professional organization or licensing authority? **no**

If yes, please explain:

Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism? **no**

If yes, please explain:

Have you engaged in the illegal use of controlled dangerous substances within the past twelve months? **no**

If yes, please explain:

If your answer to the preceding question is yes, are you currently participating in a supervised rehabilitation program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances? **n/a**

If yes, please explain:

Have you been, within the past year, convicted of driving under the influence (DUI) or have you been charged with DUI and been convicted of a lesser offense such as reckless driving? **no**

If yes, please explain:

Has your medical training or medical practice been interrupted or suspended for a period longer than 60 days for any reason other than a vacation? **no**

If yes, please explain:

Note: The term "currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough that the condition referred to may have an ongoing impact on one's functioning as a physician, or within the past two years. **null**

Primary specialty: **Gynecology (OB/GYN)**

Are you Board certified in your primary specialty? **Y**

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Secondary specialty:

Are you Board certified in your secondary specialty?

Practice Type: **P**

If Group, provide the Group Name:

Primary Hospital where you have privileges: (if any) **null**

Hospital Name: **Bristol Regional Medical Center**

Hospital City: **Bristol**

Hospital State:

Are you licensed in another State:

**TN**

**SC**

**GA**

Are you actively engaged in clinical practice in the State of Alabama? **N**

What is your principal county of practice in the State of Alabama?

(\*\*indicate state if not in Alabama) **TN**

Other county(ies) of practice? Indicate state, if counties are not in Alabama). Click 'NONE' if you only practice in the indicated principal county. **null**

Other County1

Other State1

Other County 2

Other State 2

Do you have a current collaborative agreement with a nurse or practitioner or midwife?

Do you currently conduct office based surgery involving the administration of parenteral medication for analgesia/sedation, general anesthesia or major regional block anesthesia?

PRIMARY CARE INFORMATION: Primary care is defined as: Basic or general health care focused on the point at which a patient ideally first seeks assistance from the medical care system, exclusive or an emergency situation. **null**

Does your practice include the delivery of primary care medical services in Alabama?

Approximately how many hours per week do you practice the above defined primary care services in Alabama? NOTE: Enter the Average hours worked as a whole number. Do not enter ranges of hours or decimals.

Approximately how many patient encounters (office, hospital, ER, etc.) per week do you have involving the above defined priary care services in Alabama? **0**

CME Certification: I hereby certify that I have met the annual minimum continuing education requirement of 12 hours of Category I continuing medical education for the calendar year 2008 and have supporting documentation if audited. **yes**

I certify that I am exempt from the minimum continuing medical education requirements for the following reason:

Exempt Reason

Practice Telephone: **(423) 968-2182**

Practice Address: **2901 West State Street**

Home Telephone:

Home Address: **220 Skyline Dr**

Public Address: **True**

Mail Address: **True**

By agreeing with this data and submitting your credit information, you have signed this registration form attesting that the material has been supplied by you, the licensee, and that the information is correct. Knowingly providing false registration information to the State of Alabama Medical Licensure Commission may result in the loss of your license to practice medicine. **null**



**Medical Licensure Commission of the State of Alabama**  
**PO Box 887**  
**Montgomery, AL 36101**

**2010 Online Renewal Summary**

Name: **Wesley Frazier Adams**

License Number: **MD.8592**

Transaction Date: **2009-10-21\***

Transaction Number: **VTJF4BA7EBCB**

Registration Fee: **300**

Date of Birth: **1948-01-11**

\* - This date reflects the date that the transaction was downloaded into the production system not the date the transaction was processed online.

Have you been charged with any offense (felony/ misdemeanor) within the past year? **no**

If yes, please explain:

Has your certificate of qualification or license to practice medicine in any state been suspended, revoked, restricted, curtailed or voluntarily surrendered under threat of suspension or revocation within the past year? **no**

If yes, please explain:

Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practice, within the past year? **no**

If yes, please explain:

Have you been denied a certificate of qualification or license to practice medicine in any state or has your application for a certificate of qualification or license to practice medicine been withdrawn under threat of denial within the past year? **no**

If yes, please explain:

Have you had a judgment rendered against you, or action settled relating to the performance of your professional service within the past year? **no**

If yes, please explain:

To your knowledge, are you the subject of an investigation, or has a formal complaint against your license been filed by any licensing Board/Agency as of the date of this application within the past year? **no**

If yes, please explain:

Within the past year, have you been diagnosed with or have you been treated for bi-polar disorder, schizophrenia, paranoia, or any other psychotic disorder? **no**

If yes, please explain:

Do you currently have any mental or physical condition or impairment (including, but not limited to, substance abuse, alcohol abuse, or mental, emotional, or nervous disorder or condition) which in any way currently affects, or if untreated could affect, your ability to practice in a competent and professional manner or, within the past year, have you applied for and/or have you received any payment or other compensation for any mental or physical condition? **no**

If yes, please explain:

Within the past year, have you raised the issue of consumption of drugs or alcohol or the issue of a mental, emotional, nervous, or behavioral disorder or condition as a defense, mitigation, or explanation for your actions in the course of any administrative or judicial proceeding or investigation; any inquiry or other proceeding; or any proposed termination by an educational institution, employer, government agency, professional organization or licensing authority? **no**

If yes, please explain:

Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism? **no**

If yes, please explain:

Have you engaged in the illegal use of controlled dangerous substances within the past twelve months? **no**

If yes, please explain:

If your answer to the preceding question is yes, are you currently participating in a supervised rehabilitation program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances? **n/a**

If yes, please explain:

Have you been, within the past year, convicted of driving under the influence (DUI) or have you been charged with DUI and been convicted of a lesser offense such as reckless driving? **no**

If yes, please explain:

Has your medical training or medical practice been interrupted or suspended for a period longer than 60 days for any reason other than a vacation? **no**

If yes, please explain:

Note: The term "currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough that the condition referred to may have an ongoing impact on one's functioning as a physician, or within the past two years. **null**

Primary specialty: **Gynecology (OB/GYN)**

Are you Board certified in your primary specialty? **Y**

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Secondary specialty:

Are you Board certified in your secondary specialty?

Practice Type: **P**

If Group, provide the Group Name:

Primary Hospital where you have privileges: (if any) **null**

Hospital Name: **Bristol Regional Medical Center**

Hospital City: **Bristol**

Hospital State:

Are you licensed in another State:

**TN**

**SC**

**GA**

Are you actively engaged in clinical practice in the State of Alabama? **N**

What is your principal county of practice in the State of Alabama? **Out of State**

(\*\*indicate state if not in Alabama) **TN**

Other county(ies) of practice? Indicate state, if counties are not in Alabama). Click 'NONE' if you only practice in the indicated principal county. **null**

Other County1

Other State1

Other County 2

Other State 2

Do you have a current collaborative agreement with a nurse or practitioner or midwife? **N**

Do you currently conduct office based surgery involving the administration of parenteral medication for analgesia/sedation, general anesthesia or major regional block anesthesia? **N**

PRIMARY CARE INFORMATION: Primary care is defined as: Basic or general health care focused on the point at which a patient ideally first seeks assistance from the medical care system, exclusive or an emergency situation. **null**

Does your practice include the delivery of primary care medical services in Alabama? **N**

Approximately how many hours per week do you practice the above defined primary care services in Alabama? NOTE: Enter the Average hours worked as a whole number. Do not enter ranges of hours or decimals.

Approximately how many patient encounters (office, hospital, ER, etc.) per week do you have involving the above defined priary care services in Alabama?

CME Certification: I hereby certify that I have met the annual minimum continuing education requirement of 12 hours of Category I continuing medical education for the calendar year 2009 and have supporting documentation if audited. **E**

I certify that I am exempt from the minimum continuing medical education requirements for the following reason:

Exempt Reason 1

Practice Telephone: **(423) 968-2182**

Practice Address: **2901 West State Street**

Home Telephone:

Home Address: **220 Skyline Dr**

Public Address: **TRUE**

Mail Address: **TRUE**

By agreeing with this data and submitting your credit information, you have signed this registration form attesting that the material has been supplied by you, the licensee, and that the information is correct. Knowingly providing false registration information to the State of Alabama Medical Licensure Commission may result in the loss of your license to practice medicine. **null**





**Medical Licensure Commission of the State of Alabama**

**PO Box 887**

**Montgomery, AL 36101**

**2011 Online Renewal Summary**

**Name: Wesley Frazier Adams**

**License Number: MD.8592**

**Transaction Date: 2010-10-13\***

**Transaction Number: VQEF5F911F92**

**Registration Fee: 300**

**Date of Birth: 1948-01-11**

\* - This date reflects the date that the transaction was downloaded into the production system not the date the transaction was processed online.

What is your Practice Address? (No PO Boxes)

Street **2901 West State Street**

City **Bristol**

State **Tennessee**

Zip **37620**

County (If not in Alabama Choose 'Out of State' **Out of State**

Country **United States**

What is your practice Email? **starly94@hotmail.com**

What is your practice Telephone? **(423) 968-2182**

What is your practice Fax? **(423) 968-7589**

What is your Home Address? (No PO Boxes)

Street **220 Skyline Dr**

City **Bristol**

State **Tennessee**

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Zip **37620-4141**

County (If not in Alabama Choose 'Out of State' **Out of State**)

Country **United States**

What is your Home Phone? **423-968-2182**

Please choose which address you would like to be your MAILING ADDRESS. The mailing address will be the address that the Board and Commission will use to mail all communications to the Licensee. (Examples: Renewal Certificates, Renewal Notices, Important Notices from the Board or Commission, etc) **IMPORTANT NOTE:** By law you are required to notify the Board and the Commission of change in address within 15 days of that change. Change of Address can be submitted using the Change of Address form found on the [www.albme.org](http://www.albme.org) website. **Practice**

Please choose which address you would like to be your PUBLIC ADDRESS. The public address will be the address given out if an address is requested. **IMPORTANT NOTE:** If a valid public address is not provided then the mailing address will be given out instead of the public address. By law you are required to notify the Board and the Commission of change in address within 15 days of that change. Change of Address can be submitted using the Change of Address form found on the [www.albme.org](http://www.albme.org) website. **Practice**

Social Security Number 

What is your Primary Specialty? (If None Please Choose None) **Gynecology (OB/GYN)**

Is your Primary Specialty Board Certified? **Yes**

What is your Secondary Specialty? (If None Please Choose None) **None**

Form of Practice: Resident, Intern, Fellowship, Solo, Partnership (2, 3, or 4,) Group **Partnership (2, 3, or 4,)**

What is the name of the Primary Hospital where you have staff privileges? **Bristol Regional Medical Center**

What City is the Primary Hospital where you have staff privileges located? **Bristol**

What State is the Primary Hospital where you have staff privileges located? **Tennessee**

Are you licensed in another state? **Yes**

Which Ones? **Georgia South Carolina Tennessee**

Are you actively engaged in clinical practice in the State of Alabama? **No**

What is your principal county of practice? (If principal county is not in Alabama choose Out of State) **Out of State**

Other counties of practice? Type "None" if you only practice in the indicated principal county. **None**

CME Certification: (Select One) **I hereby certify that I have met the annual minimum continuing education requirement of 25 hours of AMA PRA Category I Credits™ or equivalent continuing medical education for the calendar year 2010 and have supporting documentation if audited.**

Please answer the following questions.

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Have you been charged with any offense (felony/misdemeanor) within the past year? **No**

Has your certificate of qualification or license to practice medicine in any state been suspended, revoked, restricted, curtailed or voluntarily surrendered under threat of suspension or revocation within the past year? **No**

Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practice, within the past year? **No**

Have you been denied a certificate of qualification or license to practice medicine in any state or has your application for a certificate or qualification or license to practice medicine been withdrawn under threat of denial within the past year? **No**

Have you had a judgment rendered against you, or action settled relating to the performance of your professional service within the past year? **No**

To your knowledge, are you the subject of an investigation, or has a formal complaint against your license been filed by any licensing Board/Agency as of the date of this application within the past year? **No**

Within the past year, have you been diagnosed with or have you been treated for bi-polar disorder, schizophrenia, paranoia, or any other psychotic disorder? **No**

Do you currently have any mental or physical condition or impairment (including, but not limited to, substance abuse, alcohol abuse, or mental, emotional, or nervous disorder or condition) which in any way currently affects, or if untreated could affect, your ability to practice in a competent and professional manner or, within the past year, have you applied for and/or have you received any payment or other compensation for any mental or physical condition? **No**

Within the past year, have you raised the issue of consumption of drugs or alcohol or the issue of a mental, emotional, nervous, or behavioral disorder or condition as a defense, mitigation, or explanation for your actions in the course of any administrative or judicial proceeding or investigation; any inquiry or other proceeding; or any proposed termination by an educational institution, employer, government agency, professional organization or licensing authority? **No**

Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, or voyeurism? **No**

Have you engaged in the illegal use of controlled dangerous substances with the past twelve months? **No**

Have you been, within the past year, convicted of driving under the influence (DUI) or have you been charged with DUI and been convicted of a lesser offense such as reckless driving? **No**

Has your medical training or medical practice been interrupted or suspended for a period longer than 60 days for any reason other than a vacation or maternity leave? **No**

The term "currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough that the condition referred to may have an ongoing impact on one's functioning as a physician, or within the past two years.

By agreeing with this data, you are signing this registration form and attesting that the material has been supplied by you, the licensee, and that all information is correct. Knowingly providing false registration information to the Alabama Medical Licensure Commission may result in the loss of your license to practice medicine.



Medical Licensure Commission of the State of Alabama

PO Box 887

Montgomery, AL 36101

## 2012 Online Renewal Summary

Name: **Wesley Frazier Adams**

Transaction Date: **2011-10-19\***

Registration Fee: **300**

License Number: **MD.8592**

Transaction Number: **VTHA7EE01F6B**

Date of Birth: **1948-01-11**

\* - This date reflects the date that the transaction was downloaded into the production system not the date the transaction was processed online.

What is your Practice Address? (No PO Boxes)

Street **2901 West State Street**

City **Bristol**

State **Tennessee**

Zip **37620**

County (If not in Alabama Choose 'Out of State' **Out of State**

Country **United States**

What is your practice Email? **starly94@hotmail.com**

What is your practice Telephone? **(423) 968-2182**

What is your practice Fax? **(423) 968-7589**

What is your Home Address? (No PO Boxes)

Street **220 Skyline Dr**

City **Bristol**

State **Tennessee**

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Zip **37620-4141**

County (If not in Alabama Choose 'Out of State' **Out of State**)

Country **United States**

What is your Home Phone? **423-968-2182**

Please choose which address you would like to be your MAILING ADDRESS. The mailing address will be the address that the Board and Commission will use to mail all communications to the Licensee. (Examples: Renewal Certificates, Renewal Notices, Important Notices from the Board or Commission, etc) IMPORTANT NOTE: By law you are required to notify the Board and the Commission of change in address within 15 days of that change. Change of Address can be submitted using the Change of Address form found on the [www.albme.org](http://www.albme.org) website. **Practice**

Please choose which address you would like to be your PUBLIC ADDRESS. The public address will be the address given out if an address is requested. IMPORTANT NOTE: If a valid public address is not provided then the mailing address will be given out instead of the public address. By law you are required to notify the Board and the Commission of change in address within 15 days of that change. Change of Address can be submitted using the Change of Address form found on the [www.albme.org](http://www.albme.org) website. **Practice**

Social Security Number **[REDACTED]**

What is your Primary Specialty? (If None Please Choose None) **Gynecology (OB/GYN)**

Is your Primary Specialty Board Certified? **Yes**

What is your Secondary Specialty? (If None Please Choose None) **None**

Form of Practice: Resident, Intern, Fellowship, Solo, Partnership (2, 3, or 4,) Group **Partnership (2, 3, or 4,)**

What is the name of the Primary Hospital where you have staff privileges? **Bristol Regional Medical Center**

What City is the Primary Hospital where you have staff privileges located? **Bristol**

What State is the Primary Hospital where you have staff privileges located? **Tennessee**

Are you licensed in another state? **Yes**

Which Ones? **Tennessee South Carolina Georgia**

Are you actively engaged in clinical practice in the State of Alabama? **No**

What is your principal county of practice? (If principal county is not in Alabama choose Out of State) **Out of State**

Other counties of practice? Type "None" if you only practice in the indicated principal county. **None**

CME Certification: (Select One) I hereby certify that I have met the annual minimum continuing education requirement of **25 hours of AMA PRA Category I Credits™** or equivalent continuing medical education for the calendar year 2011 and have supporting documentation if audited.

If you choose I have obtained a retirement waiver or a medical waiver the waiver MUST ALREADY be on file in our office.

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Please answer the following questions.

Have you been charged with any offense (felony/misdemeanor) within the past year? **No**

Has your certificate of qualification or license to practice medicine in any state been suspended, revoked, restricted, curtailed or voluntarily surrendered under threat of suspension or revocation within the past year? **No**

Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practice, within the past year? **No**

Have you been denied a certificate of qualification or license to practice medicine in any state or has your application for a certificate or qualification or license to practice medicine been withdrawn under threat of denial within the past year? **No**

Have you had a judgment rendered against you, or action settled relating to the performance of your professional service within the past year? **No**

To your knowledge, are you the subject of an investigation, or has a formal complaint against your license been filed by any licensing Board/Agency as of the date of this application within the past year? **No**

Within the past year, have you been diagnosed with or have you been treated for bi-polar disorder, schizophrenia, paranoia, or any other psychotic disorder? **No**

Do you currently have any mental or physical condition or impairment (including, but not limited to, substance abuse, alcohol abuse, or mental, emotional, or nervous disorder or condition) which in any way currently affects, or if untreated could affect, your ability to practice in a competent and professional manner or, within the past year, have you applied for and/or have you received any payment or other compensation for any mental or physical condition? **No**

Within the past year, have you raised the issue of consumption of drugs or alcohol or the issue of a mental, emotional, nervous, or behavioral disorder or condition as a defense, mitigation, or explanation for your actions in the course of any administrative or judicial proceeding or investigation; any inquiry or other proceeding; or any proposed termination by an educational institution, employer, government agency, professional organization or licensing authority? **No**

Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, or voyeurism? **No**

Have you engaged in the illegal use of controlled dangerous substances with the past twelve months? **No**

Have you been, within the past year, convicted of driving under the influence (DUI) or have you been charged with DUI and been convicted of a lesser offense such as reckless driving? **No**

Has your medical training or medical practice been interrupted or suspended for a period longer than 60 days for any reason other than a vacation or maternity leave? **No**

The term "currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough that the condition referred to may have an ongoing impact on one's functioning as a physician, or within the past two years.

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