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

Name in full (print) Wesley F. Adams Tr
Business address 248 Midwag 57
City
Branch of Healing Arts you are to practice
\$15.00 license fee attached.
Date 10/11/28 197 Signed Misley J. Solomy J. M.
** PREFERRED MAILING ADDRESS:
Coming to Bermingham January - 1001 17th Street South B'ham, ala 35205

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

License #

Date issued 10/23/78

County

Fee \$ 5.00

FOR PEMAINDER OF 1978

V ---g----

FOR CHANGE OF ADDRESS ONLY

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 299 Midway Street Address Bristol, Tennessee 57620

License #

8592

Date issued

10/18/73

County

Fee

0 10.00

FOR CHANGE OF ADDRESS ONLY DEC 27 1978

NO.

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

M

RE	NEWAL API	PLICATION OR A CERTIFICATE OF REGISTRATION TO PRACTICE N	NO. MEDIÇINE IN ALABAMA IN 1981.	3	<i>о</i> м
		STATE LICENSING BOARD FOR THE 908 S. Hull Street, Room 110 Montgomery, Alabama 36130 Phone 205/832-5051)	9	1981
this E	Board.for a Certificate of	ctice any branch of the Healing Arts in the State of Alabama shof Registration which shall be effective during the calendar ye IF NOT RECEIVED BY JANUARY 31st, <u>A PENALTY OF \$20,00 PLU</u>	ar.		
	Name and Maili	ng Address:	Buşiness Address:		
PC.	Wesley Fraz 249 Midway Bristol, Te	sier Adams, W. D. Street 157 Blountville Highway ennessee 37620	157 Blownfuelle 249 MIDNAY ST BRISTOL, TN 37620	Heg	peway
	8592	10/18/78			
	<u> </u>	\$ 10.00	The above Addresses are corr	rect.	

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 auto-

matic revocation of the current license without further notice or hearing as provided in Act. No. \$1-218, Code of Alabama, Section 12.

Name and Mailing Address:

Business Address:

WESLEY F ADAMS 157 BLOUNTVILLE HWY BRISTOL, TN 37620

157 BLOUNTVILLE HWY BRISTOL, TN 37620

LICENSE #: 0008592

ISSUED: 10/18/78

346

- p. (

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 affective 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 resocation 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 KINGSPORT HWY BRISTOL, TN 37620

LICENSE #: 0008592

101 NEW KINGSPORT HWY BRISTOL, TN 37620

ISSUED: 10/18/78

The above Addresses are correct.

Business Address:

SELF

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 KINGSPORT HWY
BRISTOL, TN 37620

LICENSE #: 0008592

ISSUED: 10/18/78

Business Address:

SELF 101 NEW KINGSPORT HWY BRISTOL, TN 37620

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

LICENSE #: 0008592

ISSUED: 10/18/78

Business Address:

SELF 101 NEW KINGSPORT HWY BRISTOL, TN 37620

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 esteopath licensed to practice medicine/esteopathy 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

LICENSE #: 0008592

ISSUED: 10/18/78

Business Address:

SELF 101 NEW KINGSPORT HWY BRISTOL, TN 37620

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 KINGSPORT HWY BRISTOL, TN 37620

LICENSE ## 0008592

ISSUED: 10/18/78

Business Address:

SELF 101 NEW KINGSPORT HWY BRISTOL, TN 37620

FOR A CERTIFICATE OF REGISTRATION TO PRACTICE MEDICINE IN ALABAMA IN 1988 . -

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 LOI NEW KINGSPORT HWY BRISTOL, IN 37620

LICENSE #: 0008592

I55UED: 10/18/78

Business Address: SELF 101 NEW KINGSPORT HWY BRISTOL; TN 37620

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).

Business Address:

Name and Mailing Address:

8592

101878

WESLEY FRAZIER ADAMS MD 101 NEW KINGSPORT HWY

BRISTOL

37620

	· · · · · · · · · · · · · · · · · · ·		
W	ITHIN THE PAST YEAR:	YES	NO /
1.	Mave you been convicted of a falony or of any offense (felony/misdemeanor) involving the practice of medicine.		<u> </u>
·- - 2. ·	Hes-your existificate of qualifications or Hoense to practice medicine in any state been suspended, revoked, restricted, curtailed or voluntarily surrendered under threat of suspension or revocation?		<u>~</u>
3,	Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practice?		\checkmark
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?		<u>\(\) \(\) \(\) \(\)</u>
5.	Are you now or have you been addicted to the use of alcohol or controlled substances?	Russe-	1/
5.	Have you been diagnosed and/or treated for a mental illness?		<u>~</u> ,
7.	Have you had a judgement rendered against you, or action settled relating to the performance of your professional service?		<u> </u>
В.	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 N. 7. William 12/27/88		
	(Do Not Detach)		

FOR A CERTIFICATE OF REGISTRATION TO PRACTICE MEDICINE IN ALABAMA IN 1990
ALABAMA MEDICAL LICENSURE COMMISSION
Port Office Box 887

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:

WESLEY F ADAMS 101 NEW KINGSPORT HWY BRISTOL, TN 37620

SELF 101 NEW KINGSPORT HWY BRISTOL, TN 37620

LICENS	E #: 0008592 ISSUED: 10/18/78 -		
	If your addresses are different from those shown, make corrections on back:		
<u>W1</u>	THIN THE PAST YEAR:	YES	NO /
1.	Have you been convicted of a felony or of any offensa (felony/misdemaanor) involving the practice of medicine.		
2.	Has your <u>certificate of qualifications</u> or ligense to practice medicine in any state been suspended, revoked, restricted, curtailed or voluntarily surrendered under threat of suspension or revocation?	·	<u>-i_</u>
3.	Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practice?		<u> </u>
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?		<u>\(\nu_{\ell}\)</u>
5.	Are you now or have you been addicted to the use of alcohol or controlled substances?		2/
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?	***	1
	I certify that the above information is correct // Signature Date -		
	(Do Not Detach)		

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 esteopath licensed to practice medicine/esteopathy 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

ISSUED: 10/18/78 LICENSE #: 0008592 If your addresses are different from those shown, make corrections on back: WITHIN THE PAST YEAR: YES Have you been convicted of a felony or of any offense (felony/misdemeaner) involving the practice of medicine. 2. Her your certificate_of_qualifications or license to practice_medicine in any state_bean suspended revoked, restricted, curtailed or voluntarily surrendered under throat of suspension or revocation? Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practice? 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? B. Have you been diagnosed and/or treated for a mental illimass? Have you had a judgement rendered against you, or action settled relating to the performance of your professional service? To your knowledge, are you the subject of an investigation date of this renewal application? I certify that the above information is correct Date Signaturé

(Do Not Detach)

FOR A CERTIFICATE OF REGISTRATION TO PRACTICE MEDICINE IN ALABAMA IN 1992

Post Office Box 887

Montgomery, Alabama 36101-0887

Phone (205) 261-4153

OCT 1 1 1991

Every physician and osteopath licensed to practice medicine/osteopathy in the State of Alabama shall, on or before the 3-1st_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:

101 NEW KINGSPORT HWY

BRISTOL, TN 37620

LICENSE #: 0008592 I

ISSUED: 10/18/78

	it you accreases are different from those shown, make confections on pack:		
W	THIN THE PAST YEAR	YES	NO _
1.	Have you been convicted of a felony or of any offense (felony/misdemesnor) involving the practice of medicine.		<u>1</u>
-2-	'Hes 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?		1
3.	Here your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, ilmited 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?	_	4
5.	Are you now or have you been addicted to the use of alcohol or controlled substances?		4
6.	Have you been diagnosed and/or treated for a mental Illness?		4
7.	Have you had a judgement rendered against you, or action scittled relating to the performance of your professional service?		<u>~</u>
8.	To your knowledge, are you the subject of an investigation by any licensing Board/Agency as of the date of this renewal application?		1/
	I certify that the above information is correct	181	

Signature (Do Not Detach)

Dete

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	Home Address:
WESLEY F ADAMS 101 NEW KINGSPORT HWY BRISTOL, TN 37620	Street Zip 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/osteopath state of December of each year, apply to this Commission for a Certithe calendar year.	pathy in the State of Alabama shall, on or before the ifficate of Registration which shall be effective during
Renewal Fee: \$75.00 - Failure to register and pay the registration becomes due will result in the automatic revonotice or hearing as provided in § 34-24-337, Code of Ala	cation of the current license without further
(Check a or b) For CME Certification Within The Past	Year: Yes No
annual minimum continuing education offense (felony/m	convicted of a felony or of any nisdemeanor) involving the practice of
1992. practice medicin revoked, restricte	icate of qualification or license to be in any state been suspended, ad, curtailed or voluntarily surrendered suspension or revocation?
minimum continuing medical education 3. Have your staff requirement for the following reason:	privileges at any hospital or health een revoked, suspended, curtailed, d under conditions restricting your
I do not reside in the State of Alabama 4. Have you been of and do not have a significant portion of my medical practice in Alabama. 4. Have you been of license to practice application for a	denied a certificate of qualification or ce medicine in any state or has your certificate of qualification or license cine*been withdrawn under threat of
I received my initial license to practice denial? medicine in Alabama after June 30th of this calendar year. 5. Are you now or	have you been addicted to the use
reinstated my license to practice 6. Have you been d	diagnosed and/or treated for a mental ious physical illness?
	judgement rendered against you, or elating to the performance of your
I am a resident physician enrolled in a investigation by a residency training program. 8. To your knowled in a investigation by a date of this appliance.	A .
I certify that all information on this form is correct	N.A. Solam Jan 10/14/82
(Do_Not_Detach)	wi

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

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

Name & Mailing Address Make address corrections in (4) below) LICENSE #: 00008592 ISSUED: 10/18 ADAMS WESLEY FRAZIER 101 NEW KINGSPORT HWY BRISTOL 37620-	■ Every physician and osteopath licensed to medicine/osteopathy in the State of Alabama shall, on o the 31st of December of each year, apply to this Co for a Certificate of Registration which shall be effective the calendar year. (*** 4468** + 64.5-53**) ■ Renewal Fee: \$100.00** - Failure to register and pay the registration fee within 30 days after registration becowill result in the automatic revocation of the current without further notice or hearing as provided in \$34.00 code of Alabama (1975).	or beformissive du	iore sion ring nual due ense
(Check a or b) For CME Certification	Within The Past Year:	es/	No
a) / I hereby certify that I have met the annual minimum continuing education requirement of 12 hours of Category I continuing medical	Have you been convicted of a felony or of any offense (felony/misdemeanor) involving the practice of medicine?		
education during the calendar year ending December 31, 1993.	2. Has your certificate of qualification or license to practice medicine in any state been suspended, revoked, restricted, ourtailed or voluntarily surrendered under threat of suspension		
I certifive that I am exempt from the minimum continuing medical education requirement for the following reason:	or revocation? 3 Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under		₽′
Check One Below If You Answered (b)	conditions restricting your practice?		
I do not reside in the State of Alabama and do not have a significant portion of my medical practice in Alabama.	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?		₽′
I received my initial license to practice medicine in Alabama after June 30th of this calendar year.	5. Are you now or have you been addicted to the use of alcohol or controlled substances?		<u>P</u>
I reinstated my license to practice medicine in the State of Alabama after June 30th of this	6. Have you been diagnosed and/or treated for a mental illness and/or serious physical illness?		
calendar year. 1 am retired from the practice of medicine and have obtained a waiver from the Board of Medical Examiners.	7. Have you had a judgement rendered against you, or action settled relating to the performance of your professional service?		区
I am a resident physician enrolled in a residency training program.	8. To your knowledge, are you the subject of an investigation by any licensing Board/Agency as of the date of this application?		<u>□</u> ! !~?
I certify that all information on this form is o	correct M.T. Holam 7 MP 11	111	25
•	Signature //	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



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

BRISTOL, TN 37620

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.

riease make corrections or supply information:				
Race: White W Black Man. Indian Oriental or Asian	Other Social Security #			
Office Address:	Home Address:			
2901 W. STORE ST.	220 SKYLINE DR			
City, State, Zip: BRISTOL, TN 37620	City, State, Zip: BRISTOL, TN 37620			
County: 54.///uan	County:			
Business Phone: 6 15 968 2182	Home Phone: () (Will not be published)			
Fax Number: (615) 868 7588	(Will not be published)			
Permission to publish in Roster: Yes [] No [X]	Send official mail to Business or Home address (circle one)			
Specialty: Primary: OB/GYN	Board Certified: Yes [] No [X]			
Secondary:	Board Certified: Yes [] No [X]			
Form of Practice: Solo Partnership (2, 3 or 4) Group	o (5 or more) If Group, give name:			
Primary Hospital where you have staff privileges: Name: D(15tol Recional Med C+C	City/State:			
Are you licensed in another state: Yes No No Which ones: 59 G- []				
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 m	nedical 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

Wi	thin The Past Year:	Yes	N_0
ĭ.	Have you been convicted of a felony or of any offense (felony/misdemeanor) involving the practice of medicine?	п	•
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?	В	2
3.	Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practice?	a	
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?	п	D/
5.	Are you now or have you been addicted to the use of alcohol or controlled substances?		9
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?	=	(IZ
8.	To your knowledge, are you the subject of an investigation by any licensing Board/Agency as of the date of this application?	-	5

I certify that all information on this form is correct:

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

Complete BOTH sides including signature.

practice medicine or osteopathy.

334/242-4153

P.O. Box 887

Montgomery, Alabama 36101-0887



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

Bristol, TN 37620 1677

Please make corrections or supply information: L	
Race: White X Black Am. Indian Oriental or Asia	n [] Other [] Social Security
Office Address:	Home Address:
2901 WEST STATE STREET	220 SKYLINE DR
City, State, Zip: BRISTOL, TN 37620	City, State, Zip: BRISTOL, TN 37620 4141
(Alabama) County:	(Alabama) County:
Business Phone: (615)968-2182	Home Phone:
Fax Number: (615)868-7589	(Will not be published)
Permission to publish in Roster: Yes [_] No [X]	Send official mail to:Business (sheck one Home)
Specialty: Primary: OBSTETRICS & GYNECOLOGY	Board Certified: Yes [_] No [⊴
Secondary:	Board Certified: Yes [] No []
Form of Practice: [] Solo [X] Partnership (2, 3, or 4) [] G	roup (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 [X] No [_] Which	ones: [GA] [SC] [TN] [] []
CME Certification: (Check one)	
I hereby certify that I have met the annual minimum comedical education during the calendar year ending Dec	ntinuing education requirement of 12 hours of Category I contember 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 [] I received my initial license to practice medicine in Ala [] I reinstated my license to practice medicine in the State [] I am a resident physician enrolled in a residency training [] I am retired from the practice of medicine and have of	te of Alabama after June 30th of this calendar year. ng program.

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?		
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?		
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?	:	
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?		P
5.	Are you now or have you been addicted to the use of alcohol or controlled substances within the past year?		0
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 within the past year?		
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?		
	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 co	ertify that all information on this form is correct.	10/1	6/05
	Signature	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:

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.



Please make corrections or supply information: Licen	nse 8592 DATE-ISSUED: 10/18/78 Sex: M[X] F[]			
Race: White [X] Black [.] Am. Indian [.] Oriental or Asian [.]	Other [_] Social Security #			
Office Address:	Home Address:			
2901 WEST STATE STREET	220 SKYLINE DR			
City, State, Zip: BRISTOL, TN 37620	City, State, Zip: BRISTOL, TN 37620 4141			
(Alabama) County:	(Alabama) County:			
Business Phone: (615)968-2182 423 Fax Number: (615)868-7589	Home Phone: () (Will not be published)			
Permission to publish in Roster: Yes [] No [X]	Send official mail to: Business [] address (check onc) Home []			
Speciality: Primary: OBSTETRICS & GYNECOLOGY	Board Certified: Yes [_] No [_]			
Secondary:	Board Certified: Yes [] No []			
Form of Practice: [] Solo [X] Partnership (2, 3, or 4) [] Group (5 o	т 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 [X] No [] Which ones: [GA] [SC] [TN] [] []				
CME Certification: (Check one)				
I hereby certify that I have met the annual minimum continuing e continuing medical education during the calendar year ending Dec	ducation requirement of 12 hours of Category I cember 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 signif ☐ I received my initial license to practice medicine in Alabama af ☐ I reinstated my license to practice medicine in the State of Alab ☐ I am a resident physician enrolled in a residency training progr ☐ I am retired from the practice of medicine and have obtained a	ter June 30th of this calendar year. sama after June 30th of this calendar year. am.			
Complete both sides including signature. Supply of	r correct all information. OVER			

DEADLINE IS DECEMBER 31, 1996

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? [] 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? [] 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? [] 5. Have you had a judgement rendered against you, or action settled relating to the performance of your professional service within the past year? [] 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, have you been diagnosed with or have you been treated for bi-polar disorder, schizophrenia, paranoia, or any other psychotic disorder? [] 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? [] 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? [] 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]	M
voluntarily surrendered under threat of suspension or revocation within the past year? [] 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? [] 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? [] 5. Have you had a judgement rendered against you, or action settled relating to the performance of your professional service within the past year? [] 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? [] 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? [] 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? [] 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		
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certificate of qualification or license to practice medicine been withdrawn under threat of denial within the past year? [1] [2] [3] [4] [5] [5] [6] [6] [7] [6] [7] [7] [8] [8] [9] [0] [9] [0] [0] [0] [0] [0	}	M
within the past year? 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? 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? 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? 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]	M
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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]	M
educational institution, employer, government agency, professional organization or licensing authority?]	M
0. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism?]	M
1. Are you currently engaged in the illegal use of controlled dangerous substances?]	M
2. 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?	J	()
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?	1	M
4. 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?] ,	M
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.	6	
certify that all information on this form is correct. Signature Date	_	

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

Return with \$100.00 renewal fee to:

License Renewal for 1998 Deadline is December 31, 1997

WESLEY FRAZIER ADAMS, M.D.

State of Alabama Medical Licensure Commission

Complete BOTH sides including signature. Be sure to correct or supply ALL information.

Incomplete applications will be returned.

Return with \$100.00 renewal fee.

334/242-4153

P.O. Box 887

218

Montgomery, Alabama 36101-0887



2901 W STATE ST ... Failure to register and pay renewal fee will result 9823 BRISTOL, TN 37620-1718 in the automatic revocation of the current license to practice medicine or osteopathy. Lallajan (allanda) (18 a.c. a. 18 a.c. land (18 a.c. lalla) (18 a.c. lalla) Please make corrections or supply information: License 8592 DATE-ISSUED: 10/18/78 Sex: M [X] F [_] Race: White X | Black [] Am. Indian [] Oriental of Asian [] Other [] Social Security Home Address: Office Address: 220 SKYLINE DR 2901 WEST STATE STREET City, State, Zip: BRISTOL, TN 37620 4141 City, State, Zip: BRISTOL, TN 37620 (Alabama) County: _____ (Alabama) County: ___ Business Phone: (423)968-2182 Home Phone: (____) (Will not be published) Fax Number: (423)868-7589 Send official mail to: Business [] address (check one) Permission to publish in Roster: Yes [_] No [X] Home [] Board Certified: Yes [] No [] Specialty: Primary: OBSTETRICS & GYNECOLOGY Board Certified: Yes [_] No [_] Secondary: Form of Practice: [] Solo [X] 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 [X] No [] which ones: [GA] [SC] [TN] [] Primary Care Information: 1. Are you actively engaged in clinical practice? (Check one): Yes Mo [] 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 [V] No [] 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 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

		YES	NO
I.	Have you been convicted of a felony or of any offense (felony/misdemeanor) involving the practice of medicine within the past year?	[]	[4
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?	[]	[Y
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?	. 1 1	[v]
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?	[]	М
5.	Have you had a judgement rendered against you, or action settled relating to the performance of your professional service within the past year?	[]	W
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?	[]	M
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?	[]	i.J
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?	. []	i./
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?	[]	M
10.	Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism?	[]	(lg/
i1.	Are you currently engaged in the illegal use of controlled dangerous substances?	[]	[U
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?	[]	И
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?	[]	U/
	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.		
l certify	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. That all information on this form is correct. Value	97	

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

Return with \$100.00 renewal fee to:

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



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

Inthinallandillandilladadiladidadiladid

	Complete BOTH sides including signature.
1	Be sure to correct or supply ALL information.
	Return with \$100.00 renewal fee.
1433	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.

Race: White [X] Black [] Am. Indian [] Oriental or Asia	tense 8592 DATE-ISSUED, 10/18/78 Sex: M [X] F []
Office Address:	Home Address:
	220 SKYLINE DR
2901 WEST STATE STREET	
City, State, Zip: BRISTOL, TN 37620	City, State, Zip: BRISTOL, TN 37620 4141
(Alabama) County:	(Alabama) County:
Business Phone: (423)968-2182	Home Phone: ()
Fax Number: (423)\$468-7589	(Will not be published)
Permission to publish in Roster: Yes [_] No [X]	Send official mail to: Business [address (check one) Home []
Specialty: Primary: OBSTETRICS & GYNECOLOGY	Board Certified: Yes 🔝 No 🗹
Secondary: Form of Practice: [] Solo [X] Partnership (2, 3, or 4) []	Board Certified: Yes [] No []
Primary Hospital where you have staff privileges: Name: BRISTOL REGIONEL MED CTR City/State; BRI Are you licensed in another state: Yes [X] No [] which Primary Care Information:	ones: [GA] [SC] [TN] [] []
 Are you actively engaged in clinical practice? (Check one): 1 Does your practice include the delivery of primary care medic care focused on the point at which a patient ideally first seeks room care."): (Check one): Yes [J] No [] Approximately how many hours per week do you practice the CME Certification: (Check one) I hereby certify that I have met the annual minimum continuin 	al services? (Primary care is defined as: "Basic or general health assistance from the medical care system, exclusive of emergency above-defined primary care services?
continuing medical education during the calendar year ending t	December 31, 1998.
[] I certify that I am exempt from the minimum continuing medic	al education requirements for the following reason:
[] I do not reside in the State of Alabama and do not have a signi [] I received my initial license to practice medicine in Alabama a [] I reinstated my license to practice medicine in the State of Ala [] I am a resident physician enrolled in a residency training prog [] I am retired from the practice of medicine and have obtained a	ofter June 30th of this calendar year, bama after June 30th of this calendar year, ram. I waiver from the Board of Medical Examiners,
DEADLINE IS I	DECEMBER 31, 1998

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

OVER

		I ES	NO
1.	Have you been convicted of a felony or of any offense (felony/misdemeanor) involving the practice of medicine within the past year?	[]	M
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?	Lj	W
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?	[]	. M
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?	1]	M
5.	Have you had a judgement rendered against you, or action settled relating to the performance of your professional service within the past year?	[]	W
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?	1 1	M
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?	[]	W
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?	[]	IJ∕
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?	ιl	М
0.	Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism?	[]	M
1.	Are you currently engaged in the illegal use of controlled dangerous substances?	`{ }	М
.2.	If your answer to the preceding question is yes, are you currently participating in a supervised rehabilitation program	[]	[]
3.	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?	[]	w
4,	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?	1)	ſ√
	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.	16	د ـــ
certify	that all information on this form is correct. M. f. Adam M. D. Date	<u>/</u> /2	j

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

Return with \$100.00 renewal fee to:

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



WESLEY FRAZIER ADAMS, M.D. 2901 W STATE ST BRISTOL, TN 37620-1718 Be sure to correct or supply ALL information.
Return with \$100.00 renewal fee.
Incomplete applications will be returned.

Complete BOTH sides including signature.

Failure to register and pay renewal fee will result.

in the automatic revocation of the current license to practice medicine or osteopathy.

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distribution of the second of	OFOO
Please make corrections or supply information: Lie	
Race: White [X] Black [] Am. Indian [] Oriental or Asia	in [] Other [] Social Security #
Office Address:	Home Address:
	220 \$KYLINE DR
2901 WEST STATE STREET	
City, State, Zip: BRISTOL, TN 37620	City, State, Zip: BRISTOL, TN 37620 4141
(Alabama) County:	(Alabama) County:
Business Phone: (423)968-2182	Home Phone: ()
Fax Number: (423)968-7589	(Will not be published)
Permission to publish in Roster: Yes [] No [X]	Send official mail to: Business [] address (check one) Home []
Specialty: Primary: OBSTETRICS & GYNECOLOGY	Board Certified: Yes [] No [
Secondary:	Board Certified: Yes [] No []
Form of Practice: [] Solo [X] 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: BRIST Are you licensed in another state: Yes [X] No [] which the Primary Care Information: The You actively engaged in clinical practice in the State-of-Ale	ones: [GA][SC] [TN] [] []
Yes [] Go to Question 2 No Do NOT answer question 2. Does your practice include the delivery of primary care medical gatekeeper health care focused on the point at which a patient identification of the point at which are patient identification of the patient	ons 2 and 3 below. Skip to CME Certification questions. al services in Alabama? (Primary care is defined as: "Basic or general ally first seeks assistance from the medical care system, exclusive of an
	on 3 below. Skip to CME Certification questions. above-defined primary care services in Alabama? Only answer if you hours per week.
hereby certify that I have met the annual minimum continuing continuing medical education during the calendar year ending I	December 31, 1999.
[] I certify that I am exempt from the minimum continuing medic [] I do not reside in the State of Alabama and do not have a signi	
I I received my initial license to practice medicine in Alabama a	
[14] I reinstated my license to practice medicine in the State of Alai [15] I am a resident physician enrolled in a residency training progr	
[] I am retired from the practice of medicine and have obtained a	
Complete both sides including signature. Nipply D	

		YES	NC
1.	Have you been convicted of a felony or of any offense (felony/misdemeanor) involving the practice of medicine within the past year?	[]	M
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?	1 1	K.
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?	[]	
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?	[]	
5 .	Have you had a judgement rendered against you, or action sculed relating to the performance of your professional service within the past year?	[]	M
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?	[]	M
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?	[]	N
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?	[]	M
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?	[]	М
10.	Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism?	[]	M
11.	Are you currently engaged in the illegal use of controlled dangerous substances?	[]	M
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?	[]	M
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?	[]	M
	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.		-
certify	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. y that all information on this form is correct. Signature Date	199	

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

Return with \$100.00 renewal fee to:

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



WESLEY FRAZIER ADAMS M.D. 54
2901 W STATE ST 1
BRISTOL, TN 37620-1718 12161

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.

Complete BOTH sides including signature.

Please make corrections or supply information: Lic Race: White [X] Black [Am. Indian [] Oriental or Asia	
Office Address:	Home Address:
	220 SKYLINE DR
2901 WEST STATE STREET	
City, State, Zip: BRISTOL, TN 37620	City, State, Zip: BRISTOL, TN 37620 4141
(Alabama) County:	(Alabama) County:
-Business Phone: (423)968-2182	Home Phone: ()
Fax Number: (423)968-7589	(Will not be published)
Permission to publish in Roster: Yes [_] No [X]	Send official mail to: Business [V] address (check one) Home []
Specialty: Primary: OBSTETRICS & GYNECOLOGY	Board Certified: Yes 🔝 No 🗹
Form of Practice: Solo X Partnership (2, 3, or 4)	Board Certified: Yes [] No []
Form of Practice: [] Solo [X Partnership (2, 3, or 4) []	Group (5 or more) If Group, give name below:
Vi	
Primary Hospital where you have staff privileges:	OTTO TAI
Name: BRISTOL REGIONEL MED CTR City/State: BRIST Are you licensed in another state: Yes [X] No [] which of	
Primary Care Information:	
L. Are you actively engaged in clinical practice in the State of Ala	
Yes [] Go to Question 2 No [] Do NOT answer question	ns 2 and 3 below. Skip to CME Certification questions. Il services in Alabama? (Primary care is defined as: "Basic or general
'gatekeeper' health care focused on the point at which a patient idea	ally first seeks assistance from the medical care system, exclusive of an
emergency care situation.")	
Yes [] Go to Question 3 No [] Do NOT answer question	n 3 below. Skip to CME Certification questions.
answered YES to questions 1 and 2 above.) Approximately	above-defined primary care services in Alabama? Only answer if you hours per week
- CME Certification: (Check one)	notes por Front.
I liereby certify that I have met the annual minimum continuing	
continuing medical education within the past two calendar year	
I Country that I am exempt from the minimum continuing medic	
[6] I do not reside in the State of Alabama and do not have a signi	
Fig. 1 received my limital incense to practice inedictine in the State of Alal	hama after June 30th of this calendar year.
[] Lam a resident physician enrolled in a residency training progr	
[] I am retired from the practice of medicine and have obtained a	
DEADLINE IS D Complete both sides including signature. Supply	ECEMBER 31, 2000 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?	[]	M
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?	[]	M
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?	[].	M
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?	[]	M
5.	Have you had a judgement rendered against you, or action settled relating to the performance of your professional service within the past year?	[]	М
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?	[]	Ŋ
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?	[]	M
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?	[]	. Th
9.	Within the past year, have you over 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?	[]	ξĺ
10.	Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism?	[]	IJ
11.	Are you currently engaged in the illegal use of controlled dangerous substances?	[]	M
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?	[]	[4]
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?	[]	M
	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 EXPLANATI YOUR APPLICATION UPON RETURNING IT TO THIS OFFICE.	<i>f</i> '	
I certify	that all information on this form is correct. Mesley Fragein Solvanth. M.D. 10/23	/00)
	/ Signature // 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:

RENEW ONLINE AT http://renewal.albme.org

Registration-ID: 178694
State of Alabama

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 medicing or osteopathy.

	practice medicine or osteopatny.
Please make corrections or supply information: License: MD	0.00008592 Date-Issued: 01/11/1948 Sex: M[X] F[]
Race: White [X] Black [] American Indian [] Orio	iental or Asian [] Other [] Social Security#
Office Address	Home Address
2901 WEST STATE STREET	220 SKYLINE DR
City, State, Zip: BRISTOL, TN 37620	City, State, Zip: BRISTOL, TN 37620-4141
(Alabama) County: UNREPORTED	(Alabama) County: UNREPORTED
Business Phone: (423) 968-2182	Home Phone: (Will not be published)
Fax Number: (423) 968-7589	
Permission to publish in Roster: Yes [X] Specialty: Primary: OBSTETRICS & GYNECOLOGY No []	Send official mail to: Business [X] address (check one) Home [] Board Certified: Yes [
Secondary: Form of Practice: [] Solo [1 Partnership (2, 3, or 4) [] G	Board Certified: Yes [] No [✓] Group If Group give Group Name below:
Primary Hospital where you have staff privileges: Name: Are you licensed in another state: Yes [X] No [City/State: , [] Which ones: [GA] [[] []
 Does your practice include the delivery of primary care rigatekeeper' health care focused on the point at such a patie an emergency care situation.") Yes [] Go to Question 3 No [] Do NOT ans 	swer questions 2 and 3 below. Skip to CME Certification questions. medical services in Alabama? (Primary care is defined as: "Basic or genera ent ideally first seeks assistance from the medical care system, exclusive of swer question 3 below. Skip to the CME Certification questions. See the above-defined primary care services in Alabama? Only answer if you
CME Certification: (Check one) [V] I hereby certify that I have met the annual minimum continuing continuing medical education within the past two calendar yea is certify that I am exempt from the minimum continuing medical is certify that I am exempt from the minimum continuing medical is I do not reside in the State of Alabama and do not have a is I received my initial license to practice medicine in Alabama is I reinstated my license to practice medicine in the State of it is I am a resident physician enrolled in a residency training is I am retired from the practice of medicine and have obtain	ars ending December 31, 2001. all education requirements for the following reason: a significant portion of my medical practice in Alabama. ma after June 30 th of this calendar year. of Alabama after June 30 th of this calendar year. program.

DEADLINE IS DECEMBER 31, 2001

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?	[]	W
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?	l J	Ŋ
3.	Have your stuff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practice, within the past year?	[]	M
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?	[]	M
5.	Have you had a judgement rendered against you, or action settled relating to the performance of your professional service within the past year?		ŀď
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?	[]	[4]
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?	IJ	[4]
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?	[]	[v]
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?	[]	IJ
0.	Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voycurism?	[]	L.
11.	Are you currently engaged in the illegal use of controlled dangerous substances?	[]	V
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?	[]	М
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?	IJ	U
	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.		
	OU HAVE ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, PLEASE ATTACH A DETAILED EXPLANATE YOUR APPLICATION UPON RETURNING IT TO THIS OFFICE.	,	
certif	fy that all information on this form is correct. MF-below M.P. 12/10/6 Signature Date	2/	
	Signatury 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:

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.

	practice medicine or osteopathy.		
Please make corrections or supply informat	ion: License: MD . 00008592 Date-Issued: 10/18/1978 Sex: M[X] F[]		
Race: White [X] Black [] American	Indian [] Oriental or Asian [] Other [] Social Security		
Office Address	Home Address		
2901 WEST STATE STREET	220 SKYLINE DR		
City, State, Zip: BRISTOL, TN 37620	City, State, Zip: BRISTOL, TN 37620-4141		
(Alabama) County:	(Alabama) County:		
Business Phone: (423) 968-2182	Home Phone: (Will not be published)		
Fax Number: (423) 968-7589			
Permission to publish in Rose Specialty: Primary: OBSTETRICS & GYNECO Secondary: Form of Practice: [] Solo [✓ Partnership	Home []		
 Does your practice include the delive 'gatekeeper' health care focused on the gan emergency care situation.") Yes [] Go to Question 3 N 3. Approximately how many hours per Answered YES to questions 1 and 2 about the Certification: (Check one) [] I hereby certify that I have met the annual continuing medical education within the part of I lide not reside in the State of Alabam 	practice in the State of Alabama? [X] Do NOT answer questions 2 and 3 below. Skip to CME Certification questions. ery of primary care medical services in Alabama? (Primary care is defined as: "Basic or general point at such a patient ideally first seeks assistance from the medical care system, exclusive of o [] Do NOT answer question 3 below. Skip to the CME Certification questions, week do you practice the above-defined primary care services in Alabama? Only answer if you we. Approximately: ① hours per week. minimum continuing education requirement of 24 hours of Category I ast two calendar years ending December 31, 2002. m continuing medical education requirements for the following reason: a and do not have a significant portion of my medical practice in Alabama.		
[] I reinstated my license to practice me [] I am a resident physician enrolled in a	cine and have obtained a waiver from the Board of Medical Examiners.		
NP AAAAEAA	DEADLINE IS DECEMBER 31, 2002		

MD . 00008592

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?	[]	M
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?	l]	u'
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?	[]	4
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?	IJ	М
5.	Have you had a judgement rendered against you, or action settled relating to the performance of your professional service within the past year?	[]	U
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?	[]	¥
7.	Within the past year, have you been diagnosed with or have you been treated for hi-polar disorder, schizophrenia, paranoia, or any other psychotic disorder?	[]	W
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?	[]	M'
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?	[]	M²
10.	Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism?	[]	M
lI.	Are you currently engaged in the illegal use of controlled dangerous substances?	[]	M
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?	[]	M
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?	[]	W
	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.		
F YOU	U HAVE ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, PLEASE ATTACH A DETAILED EXPLANAT YOUR APPLICATION UPON RETURNING IT TO THIS OFFICE.	TION	
certify	that all information on this form is correct. M.F. bloom M.D. 10/38/	104	

- ♦ 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:



2004 Online Renewal Summary

Name: Wesley Frazier Adams

Transaction Date: 2003-10-31*

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? $\bf N$

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? $\bf N$

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**

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

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.



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? \mathbf{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**

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

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

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.



2006 Online Renewal Summary

Name: Wesley Frazier Adams

Transaction Date: 2005-12-29*

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? $\bf N$

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**

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

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

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.



2007 Online Renewal Summary

Name: Wesley Frazier Adams

Transaction Date: 2006-12-19*

Registration Fee: 200

License Number: MD.8592

Transaction Number: VXHF0D5E96C8

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**

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

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? ves

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



2008 Online Renewal Summary

Name: Wesley Frazier Adams

Transaction Date: 2007-12-04*

Registration Fee: 300

License Number: MD.8592

Transaction Number: VPFF1E2F5E28

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**

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

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 indicate 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

Hue

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**



2009 Online Renewal Summary

Name: Wesley Frazier Adams

Transaction Date: 2008-11-24*

Registration Fee: 300

License Number: MD.8592

Transaction Number: VREF2FF12746

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**

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

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**



2010 Online Renewal Summary

Name: Wesley Frazier Adams

Transaction Date: 2009-10-21*

Registration Fee: 300

License Number: MD.8592

Transaction Number: VTJF4BA7EBCB

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**

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 ves. 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

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



2011 Online Renewal Summary

Name: Wesley Frazier Adams

Transaction Date: 2010-10-13*

Registration Fee: 300

License Number: MD.8592

Transaction Number: VQEF5F911F92

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

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 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 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.

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.



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

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 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 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? 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.

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

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