APPLICATION ·

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

NAME IN FULL (print)	ry C/co	y Low	13041	<u> </u>
Business Address	\			
City	State		_County	
Branch of Healing Arts you ar	re to practice	ND	DB-GVN	
Date 7-11-79	Phone No.	(Office)		
		(Home) _6/5	<u>- 323-3/5</u>	<u>-</u> q
Signed Obt C	- Chill			
** PREFERRED MAILING ADDRES	SS:	License fee a	attached \$15.0	0
R+ 2		-		
Blouater.lle	Tenn	37617	>	
	`	- ,		

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 <u>additional</u> \$20.00 penalty for reinstatement of your license.

Name and

Cary Clayton Bowle, M. D.

Business

Moute 2

Address

Blountville: Tennossee 37617

License #

Date issued 7/18/79

County



Fee s 5.00

FOR REMAINDER OF

Signature

FOR CHANGE OF ADDRESS ONLY

NO. 5/2

M

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

STATE LICENSING BOARD FOR THE HEALING ARTS

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

JAN 23 1980

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.

HENEWAL 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:

GARY C BOYLE RT 2 BLOUNTVILLE: TN 37617

» 38

LICENSE #: OCCS682

ISSUED: 07/18/79

The above addresses are correct.

615-323-3159

546

M

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

STATE LICENSING BOARD FOR THE HEALING ARTS 908 S. Hull Street, Room 110 Montgomery, Alebama 36130 Phone 205/832-5051

DEC 1 5 1981

this Board for a Certificate of Reg RENEWAL FEE \$10.00 IF	istration which shall be effective dur	State of Alabama shall on or before the 31st day of December of each year apply ing the calendar year. ALTY OF \$20,00 PLUS THE \$10.00 RENEWAL FEE WILL BE CHARGED. RETURN ENTI	
Name and Mailing A	ddress:	Business Address: a Family Planner 157 Blountville Highway	Soll
Gary Clayton Bo Route 2	yle, M. D.	Bristol, Tennessee 37620	Ò
Blountville, Te	nnessee 37617	FLOUNTVILLE, TN 37617	
3882	7/18/79	615-968-218	2
	\$ 10.00	The above Addresses are correct.	



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

ALABAMA MEDICAL LICENSURE COMMISSION 908 South Huli Street, Room 110 Montgomery, Alabama 36104 Phone 205/832-5051

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

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

Name and Mailing Address:

Business Address:

GARY C BOYLE RT 2 BLOUNTVILLE, TN 37617

157 ELOUNTVILLE HWY BRISTOL, TN 37620

LICENSE #: 0008882

ISSUED: 07/18/79



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

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

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

Name and Mailing Address:

GARY C BOYLE RT 2

37617

LICENSE #: 0008882

BLOUNTVILLE, TN

Business Address:

SELF 101 NEW KINGSPORT HWY BRISTOL, TN 37620

ISSUED: 07/18/79

FOR A CERTIFICATE OF REGISTRATION TO PRACTICE MEDICINE IN ALABAMA IN 1984
ALABAMA MEDICAL LICENSURE COMMISSION
Post Office Box 887
Montgomery, Alabama 36101

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:

GARY C BOYLE RT 2 SECUNTVILLE, TN 37617

LICENSE #: \$008882

ISSUED: 07/18/79

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 36101-0867 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:
GARY C BOYLE
RT 2
BLOUNTVILLE, TN 37617

LICENSE #: 0008882 ISSUED: 07/18/79

Business Address:

SELF 101 NEW KINGSPORT HWY 8RISTOL, 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 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: GARY C SOYLE

RT 2

BLOUNTVILLE, TN 37c17

LICENSE #: 0008882

ISSUED: 07/18/79

Business Address:

SELF 101 MEW 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 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: RT 2 BLOUNTVILLE, TN 37517

LICENSE #1 0003852

ISSUED: 07/18/79

Business Address: SELF

101 NEW KINGSPORT HWY BRISTOL, TN 37620



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

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

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

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

Name and Mailing Address;

SARY C BOYLE

4° Z

DECUNTVILLE, TN 37617

LICENSE OF OCC8882

ISSUED: 07/18/79

Business Address:

SELF

IOI NEW KINGSPORT HWY

DRISTOL, TN 37620

	FOR A CERTIFICATE OF REGISTRATION TO PRACT ALABAMA MEDICAL LICENSUF		989
	Post Office Box		
, 4	Montgomery, Alabama 36		
C-14-	Phone (205) 261-4		
Every physician and December of each w	osteopath licensed to practice medicine/osteopathy in rear, apply to this Commission for a Certificate of Registra	the State of Alabama shall, on or l	before the 31st day of
	E: \$50.00 / Fallure to register and pay the		
	pecomes due will result in the automatic revo		e without further
	aring as provided in § 34-24-337, Code of A		
	d Mailing Address:	Business Address:	
GARY (C BOYLE	SELF	
RT 2		101 NEW KINGSPORT HWY	
ELQUN.	TVILLE, TN 37617	BRISTOL, TN 37620	
LICENS	SE #: 0008882	4	
	If your addresses are different from those shown,	, make corrections on back:	
	/ITHIN THE FAST YEAR:		YES NO
٦.	Have you been convicted of a felony or of any offense (felony) medicine.	misdemeshor) involving the practice of	<u> </u>
2.	His vour continuate of qualifications or timensemboractice me- revoked, restricted, curtailed or voluntarily surrendered under t		
3.	Have your staff privileges at any hospitel or health care facilit limited or placed under conditions restricting your practice?	y been revoked, suspended, curtailed,	
4.	Have you been denied a certificate of qualification or a license	e to practice medicine in any state or	
	has your application for a certificate of qualification or license under threat or claim?	to practice raedicine been withdrawn	
5.	Are you now or have you been addicted to the use of alcohol or	controlled substances?	
5.	Pave you been diagnosed and/or treated for a mental illness?		
7.	Have you had a judgement rendered against you, or action settle professional service?	ed relating to the performance of your	
ŧ.	To your knowledge, are you the subject of an investigation by a date of this renewal application?	eny licensing Board/Agency as of the	
	I certify that the above information is correct	21 <u>51(X//G)</u>	88

(Do Not Detach)

FOR A CERTIFICATE OF REGISTRATION TO PRACTICE MEDICINE IN ALABAMA IN 1990 ALABAMA MEDICAL LICENSURE COMMISSION

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

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

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

Name and Mailing Address:

GARY C BOYLE

RT 2

KI Z

BLOUNTVILLE, TN 37617

Business Address:

101 NEW KINGSPORT HWY

BRISTOL, IN 37620

LICENSE #: 0008882

ISSUED: 07/18/79

	If your addresses are different from those shown, make corrections on back:		
W	THIN THE PAST YEAR:	YEŞ	NO
1.	Have you been convicted of a felony or of any offense (felony/misdemeenor) involving the practice of medicine.		_
2.	Has your certificate of qualifications or license to practice modicine in any state been suspended, revoked, restricted, curtailed or voluntarily surrendered under threat of suspension or revocation?		_
3.	Have your staff privileges at any hospital or health cars facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practice?		
4.	Have you been denied a certificate of qualification or a license to practice medicine in any state or has your application for a certificate of qualification or license to practice medicine been withdrawn under threat or claim?		_
5.	Are you now or have you been addicted to the use of alcohol or controlled substances?		_
6.	Have you been diagnosed and/or treated for a mental illness?		
7.	Have you had a judgement rendered against you, or action settled relating to the performance of your professional service?		_
8.	To your knowledge, are you the subject of an investigation by any licensing Board/Agency as of the date of this renewal application?		
	I certify that the above information is correct Signature Date	<i>?</i>	
	(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 osteopath licensed to practice medicine/osteopathy in the State of Alabama shall, on or before the 31st day of December of each year, apply to this Commission for a Certificate of Registration which shall be effective during the calendar year.

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

Name and Mailing Address:

Business Address:

GARY C BOYLE RT 2 SELF

101 NEW KINGSPORT HWY

BLOUNTVILLE, TN 37617

BRISTOL, TN 37620

LICENSE #: 0008882

ISSUED: 07/18/79

If your addresses are different from those shown, make corrections on back: WITHIN THE PAST YEAR: YES. Have you been convicted of a follony or of any offense (fellony/misdemeanor) involving the practice of medicino. Has your certificate of qualifications or license to practice medicine in any state been suspended, revoked, restricted, curtailed or voluntarily surrendered under threat of suspension or revocation? 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? Have you been diagnosed and/or treated for a mental iffness? Have you had a judgement rendered against you, or action settled relating to the performance of your 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 Signature

(Do Not Detach)

FOR A CERTIFICATE OF REGISTRATION TO PRACTICE MEDICINE IN ALABAMA IN 1992 ALABAMA MEDICAL LICENSURE COMMISSION

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

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

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

Name and Mailing Address:

GARY C BOYLE

RT 2

BLOUNTVILLE, TN 37617 1 Business Address:

lol NEW KINGSPORT HWY

BRISTOL, TN 37620

LICENSE #: 0008882

ISSUED: 07/18/79

If your addresses are different from those shown, make corrections on back." WITHIN THE PAST YEAR:

YES Have you been convicted of a falony or of any offense (felony/misdemeasor) involving the practice of

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

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 of has your application for a certificate of qualification or license to practice medicine been withdrawn under threat or claim?

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

6. Have you been diagnosed and/or treeted for a mental illness?

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 by any licensing Board/Agency as of the date of this renewal application?

I certify that the above information is correct

Signature (Do Not Detach)

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 #: 0008882 ISSUED: 07/18/79 GARY C 80YLE RT 2 BLOUNTVILLE, TN 97817 Make corrections to mailing address on reverse. Check if you authorize your FAX# to be published in a directory that Commission for a Certificate of Registration which shall be effective during the calendar year. B Renewal Feet \$75.00 -/ Failure to register and pay the annual registration fee within 30 days after registration beodynes dup will result in the automatic revocation of the ourrent license without further notice or hearing the provided in \$34-24-337, Code of Alabama (1875). (Check a or b) For CME Certification I hereby certify that I have met the annual minimum continuing medical education during the calendar year ending December 31, 1992 I certify that I am exempt from the minimum continuing medical education during the calendar year ending December 31, 1992 I certify that I am exempt from the minimum continuing medical education of the minimum continuing medical education of minimum continuing medical	•	110110 (200) 242 4100		
State	LICENSE #: 0008882 ISSUED: 07/18	3/79	0,	· . D {
Every physician and osteopsth licensed to practice medicine/osteopsthy in the State of Alabama shall, on or before the 31st of December of each year, apply to this Commission for a Certificate of Registration which shall be effective during the calendar year. Renewal Feet \$75.00 - Failure to register and pay the annual registration fee within 30 days after registration becomes due will result in the automatic revocation of the current license without further notice or hearing as provided in § 34-24-337, Code of Alabama (1975). Check a or b) For CME Certification	GARY C BOYLE RT 2 BLOUNTVILLE, TN 37617	Street #52 Cono City Blown Zi State Zi Business FAX#:()	٢	
## Renewal Fee/ \$75.00 Failure to register and pay the annual 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 sprovided in § 34-24-337, Code of Alabama (1975). ## Renewal Fee/ \$75.00 Failure to register and pay the annual registration which shall be effective during the automatic revocation of the current license without further notice or hearing sprovided in § 34-24-337, Code of Alabama (1975). ## Within The Past Year: Yes No ## No ## No I hereby certify that I have met the annual minimum continuing aducation requirement for 12 hours of Category I continuing medical education during the calendar year ending become form the following reason: ## Check One Below If You Answered (b)	Make corrections to mailing address on reverse.	☐ Check if you authorize your FAX# to be publi	shed in	a directory
registration becomes due/will result in the automatic revocation of the current license without further notice or hearing as provided in § 34-24-337. Code of Alabama (1975). (Check a or b) For CME Certification a) I hereby certify that I have met the annual minimum continuing aducation requirement of 12 hours of Catagory I continuing medical education during the calendar year ending December 31, 1992. b) I certifity that I am exempt from the minimum continuing medical education requirement for the following reason: Check One Below If You Answered (b) I do not reside in the State of Alabama and do not have a significant portion of my medical practice in Alabama after June 30th of this calendar year. I received my initial license to practice medicine in Alabama after June 30th of this calendar year. I am retired from the practice of medicine and have obtained a waiver from the Board of Medical Examiners. I am a residency training program. I certify that all information on this form is correct. I certify that all information on this form is correct. I certify that all information on this form is correct. I certify that all information on this form is correct. I certify that all information on this form is correct. I certify that all information on this form is correct. I certify that all information on this form is correct. I certify that all information on this form is correct. I certify that all information on this form is correct. I certify that all information on this form is correct. I certify that all information on this form is correct. I certify that all information on this form is correct. I certify that all information on this form is correct. I certify that all information on this form is correct. I certify that all information on this form is correct. I certify that all information on this form is correct. I certify that all information on this form is correct. I certify that all information on this form is correct. I certificate of a felony or of any offence condicine or conu	31st of December of each year, apply to this Co	ctice medicine/osteopathy in the State of Alabama shall, on minission for a Certificate of Registration which shall be d	or befo effective	gre the during
a) I hereby certify that I have met the annual minimum continuing education requirement of 12 hours of Category I continuing medical education during the calendar year ending December 31, 1992. b) I certify that I am exempt from the minimum continuing medical education requirement for the following reasont Check One Below If You Answered (b) 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 halabama after June 30th of this calendar year. I reinstated my license to practice medicine in the State of Alabama after June 30th of this calendar year. I am retired from the practice of medicine and have obtained a waiver from the Board of Medical Examiners. I am a resident physician enrolled in a residency training program I certify that all information on this form is correct 1 certify that all information on this form is correct 1. Have you been convicted of a felony or of any offense (felony/misdemeanor) involving the practice of medicine? 2. Has your certificate of qualification or license to practice medicine in any state been suspended revoked, restricted, curtailed or voluntarily surrendered under treated for suspension or revocation? 3. Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed limited or placed under conditions restrictate of qualification or license to practice medicine in any state or has your application for 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 in any state or has your application for 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 in any state or has your application for a certificate of qualification or license to practice medicine in any state or has your application for a certi	registration becomes due will result in th	e automatic revocation of the current license w	30 day: ithout	s after further
annual minimum continuing aducation requirement of 12 hours of Category I continuing medical education during the calendar year ending December 31, 1992. 1 certify that I am exempt from the minimum continuing medical education requirement for the following reason: Check One Below If You Answered (b) I do not reside in the State of Alabama and do not have a significant portion of my medical practice in Alabama after June 30th of this calendar year. I received my initial license to practice medicine in Alabama after June 30th of this calendar year. I reinstated my license to practice medicine in the State of Alabama after June 30th of this calendar year. I am retired from the practice of medicine and have obtained a waiver from the Board of Medical Examiners. I am a resident physician enrolled in a residency training program I certify that all information on this form is correct I certify that all information on this form is correct I certify that all information on this form is correct I certify that all information on this form is correct I certify that all information on this form is correct I certify that all information on this form is correct I certify that all information on this form is correct I certify that all information on this form is correct I certificate of qualification or license to practice medicine in any state been suspended, curtailed or voluntarity surrendered under threat of suspension or revocation? 2 has your certificate of qualification or license to practice medicine in any state or health care facility been revoked, restricted, curtailed, limited or voluntarity surrendered under threat of suspension or revocation? 2 have your staff privileges at any hospital or health care facility been revoked, curtailed, limited or placed under conditions restricted or placed under conditions or incense to practice medicine in any state been suspended or voluntaries or	(Check a or b) For CME Certification	Within The Past Year:	Yes	No
under threat of suspension or revocation? 3. Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practice? 4. Have you been denied a certificate of qualification or license to practice medicine in Alabama after June 30th of this calendar year. 5. I reinstated my license to practice medicine in the State of Alabama after June 30th of this calendar year. 6. Have you been denied a certificate of qualification or license to practice medicine in Alabama after June 30th of this calendar year. 6. 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? 7. Are you now or have you been addicted to the use of alcohol or controlled substances? 8. 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 in the State of Alabama after June 30th of this calendar year. 6. 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 in any state or has your application or controlled substances? 8. Have you been denied a certificate of qualification or license to practice medicine in any state or has your application or license to practice medicine in any state or has your application or license to practice medicine in any state or has your application or license to practice medicine in any state or has your application or license to practice medicine in any state or has your application or license to practice medicine in any state or has your application or license to practice. 8. Have you been denied a certificate of qualification or license to practice medicine in any state or has your applicati	annual minimum continuing education requirement of 12 hours of Category I continuing medical education during the calendar year ending December 3.1.	offense (felony/misdemeanor) involving the practice of medicine? 2 Has your certificate of qualification or license to practice medicine in any state been suspended.		
do not reside in the State of Alabama and do not have a significant portion of my medical practice in Alabama I received my initial license to practice medicine in Alabama after June 30th of this calendar year. I reinstated my license to practice medicine in the State of Alabama after June 30th of this calendar year. I am retired from the practice of medicine and have obtained a waiver from the Board of Medical Examiners. I am a resident physician enrolled in a residency training program I certify that all information on this form is correct 4. Have you been denied a certificate of qualification or license to practice medicine in any state or has your application for a certificate of qualification or license to practice medicine been withdrawn under threat of denial? 5. Are you now or have you been addicted to the use of alcohol or controlled substances? 6. Have you been denied a certificate of qualification or license to practice medicine in any state or has your application or license to practice medicine in any state or has your application for a certificate of qualification or license to practice medicine been withdrawn under threat of denial? 5. Are you now or have you been addicted to the use of alcohol or controlled substances? 6. Have you been 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? 7. Are you now or have you been addicted to the use of alcohol or controlled substances? 8. 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? 7. Are you now or have you been addicted to the use of alcohol or controlled substances? 8. To your knowledge, are you the subject of an investigation by any licensing Board/Agency as of the license to practice medicine been wit	minimum continuing medical education requirement for the following reason:	under threat of suspension or revocation? 3. Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your		
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June 30th of this calendar year. I am retired from the practice of medicine and have obtained a waiver from the Board of Medical Examiners. I am a resident physician enrolled in a residency training program I certify that all information on this form is correct I may retired from the practice of medicine and have obtained a waiver professional service? 7. Have you had a judgement rendered against you, or action settled relating to the performance of your professional service? 8. To your knowledge, are you the subject of an investigation by any licensing Board/Agency as of the date of this application?	this calendar year,	of alcohol or controlled substances? 6. Have you been diagnosed and/or treated for a mental		
residency training program investigation by any licensing Board/Agency as of the date of this application? Certify that all information on this form is correct 10-14-9-2	June 30th of this calendar year. I am retired from the practice of medicine and have obtained a waiver.	7. Have you had a judgement rendered against you, or action settled relating to the performance of your	THE STREET	_
		investigation by any licensing Board/Agency as of the		_
	I certify that all information on this form	, — , — , — , — , — , — , — , — , — , —	/o- Date	<u>-14-</u> 97

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

Name & Mailing Address (Make address corrections in (4) below.) LICENSE #: 00008882 ISSUED: 7/18/ BOYLE GARY CLAYTON 101 NEW KINGSPORT HWY BRISTOL 37620-	■ Every physician and osteopath licensed to medicine/osteopathy in the State of Alabama shall, on the 31st of December of each year, apply to this C for a Certificate of Registration which shall be effect the calendar year. ■ Renewal Fee: \$100.00 - Failure to register and pay registration fee within 30 days after registration becault in the automatic revocation of the curre without further notice or hearing as provided in \$300.00 of Alabama (1975).	commission tive during the annuationes during the annuationes during the annuation to the annual to	se set 7-7-7 su e.
(Check a or b) For CME Certification	Within The Past Year:	Yes N	lo
a). I hereby certify that I have met the annual minimum continuing education requirement of 12 hours of Calegory I continuing medical	1. Have you been convicted of a felony or of any offens (felony/misdemeanor) involving the practice of medicine?		
education during the calendar year ending December 31, 1993. b)	2. Has your certificate of qualification or license to practic medicine in any state been suspended, revoked, restricted curtailed or voluntarily surrendered under threat of suspension or revocation?	d, on	
the following reason: Check One Below If You Answered (b)	3. Have your staff privileges at any hospital or health care facilit been revoked, suspended, curtailed, limited or placed under 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. Mave you been denied a certificate of qualification or licens to practice medicine in any state or has your application for certificate of qualification or license to practice medicin been withdrawn under threat of denial?	а	
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?		_
I reinstated my license to practice medicine in the State of Alabama after June 30th of this calendar year.	 Have you been diagnosed and/or treated for a mental illnes and/or serious physical illness? Have you had a judgement rendered against you, or action 	. □. [n ·	
I am retired from the practice of medicine and have obtained a waiver from the Board of Medical Examiners.	settled relating to the performance of your professions service?		
l am a resident physician enrolled in a residency training program.	To your knowledge, are you the subject of an investigation be any licensing Board/Agency as of the date of this application?		12
I certify that all information on this form is o	correct Signature		7.7
作。			-

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



OVER

GARY CLAYTON BOYLE, 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.

Please make corrections or supply information: Li	cense # 00008882 Sex: M [V F]]
Race: White [Black] Am. Indian [Oriental or Asian [- <u> </u>
Office Address:	Home Address:
2901 W. State St.	452 CAMP PLACID RD
City, State, Zip: BRISTOL, TN 37620	City, State, Zip: BLOUNTVILLE, TN 37617
County: <u>Sullivan</u>	County:
Business Phone: (LIS 968 318 2)	Home Phone: () (Will not be published)
Fax Number: (615) 968-7589	
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 (5 or more) If Group, give name:
Primary Hospital where you have staff privileges:	
Name: 15 ristal Regional Med CX	City/State: Bristol 20
Name: Stal Regional Med CXC Are you licensed in another state: Yes [V No [] Which one	S. BULLET TO NE
CME Certification: (Check one)	
I hereby certify that I have met the annual minimum continui medical education during the calendar year ending December	ng education requirement of 12 hours of Category I continuing 31, 1994.
[] I certify that I am exempt from the minimum continuing med	ical education requirement for the following reason:
 ☐ I do not reside in the State of Alabama and do not have a si ☐ I received my initial license to practice medicine in Alabam ☐ I reinstated my license to practice medicine in the State of A ☐ I am a resident physician enrolled in a residency training pr ☐ I am retired from the practice of medicine and have obtained 	a after June 30th of this calendar year. Alabama after June 30th of this calendar year. ogram.

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

Wit	thin The Past Year:	Yes	No
1.	Have you been convicted of a felony or of any offense (felony/misdemeanor) involving the practice of medicine?		</td
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?	п -	
3.	Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practice?	n	9/
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?	D	
5.	Are you now or have you been addicted to the use of alcohol or controlled substances?	<u> </u>	D
6.	Have you been diagnosed and/or treated for a mental illness and/or serious physical illness?		
7.	Have you had a judgement rendered against you, or action settled relating to the performance of your professional service?	=	
8.	To your knowledge, are you the subject of an investigation by any licensing Board/Agency as of the date of this application?	Ħ	

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

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:	License 8882	DATE-ISSUED: 07/18/79 Sex: M [X] F[]
Race: White [X] Black [] Am. Indian [] Oriental or A	sian ∐ Other ∐ So	cial Security #
Office Address:	Home Addres	ss:
2901 WEST STATE STREET	452 CAMP PL	ACID RD
City, State, Zip: BRISTOL, TN 37620	City, State, Zip	: BLOUNTVILLE, TN 37617 5303
(Alabama) County:	(Alabama) Cou	nty:
Business Phone: (615)968-2182	Home Phone:	(615)323-2161
Fax Number: (615)968-7589 Permission to publish in Roster: Yes [_] No [X]	Send official m	(Will not be published) ail 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) []		_
		<u> </u>
Primary Hospital where you have staff privileges:	Group (5 or more) If (
Form of Practice: [] Solo [X] Partnership (2, 3, or 4) [] Primary Hospital where you have staff privileges: Name: BRISTOL REGIONAL MED Are you licensed in another state: Yes [X] No [] Wh	Group (5 or more) If (Group, give name below:
Primary Hospital where you have staff privileges: Name: BRISTOL REGIONAL MED	Group (5 or more) If (Group, give name below:
Primary Hospital where you have staff privileges: Name: BRISTOL REGIONAL MED Are you licensed in another state: Yes [X] No [] Wh	Group (5 or more) If C City/St. Ich ones: [TN] [GA] [N	eroup, give name below:
Primary Hospital where you have staff privileges: Name: BRISTOL REGIONAL MED Are you licensed in another state: Yes [X] No [] Whi CME Certification: (Check one)	Group (5 or more) If C City/St ich ones: [TN] [GA] [N continuing education re ecember 31, 1995.	ete: BRISTOL, TN C] [SC] [] equirement of 12 hours of Category I continu

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 be 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 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?	e in	
5.	Are you now or have you been addicted to the use of alcohol or controlled substances within the past year?		
6.	Have you been diagnosed and/or treated for a mental illness and/or serious physicillness?	cal 🗆	
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, PATTACH A DETAILED EXPLANATION WITH YOUR APPLICATION UPO RETURNING IT TO THIS OFFICE.		
I ce	certify that all information on this form is correct.		
	DEBoyle MA	10-19-	- 45
	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:

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

License Renewal for 1997 Deadline is December 31, 1996

State of Alabama Medical Licensure Commission

334/242-4153

P.O. Box 887

Montgomery, Alabama 36101-0887



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



Please make corrections or supply information: Lic	conse 8882 DATE-ISSUED: 07/18/79 Sex: M[X] F []
Race: White [X] Black [] Am-Indian-[]-Oriental or Asian []	
Office Address:	Home Address:
2901 WEST STATE STREET	452 CAMP PLACID RD
City, State, Zip: BRISTOL, TN 37620	City, State, Zip: BLOUNTVILLE, TN 37617 5303
(Alabama) County:	(Alabama) County:
Business Phone: (615)968-2182	Home Phone: (615)323-2161
Fax Number: (615)968-7589	(Will not be published)
Permission to publish in Roster: Yes [_] No [X]	Send official mail to: Business [] address (check one) Home []
Speciality: Primary: OBSTETRICS & GYNECOLOGY	Board Certified: Yes [] No []
Secondary:	Board Certified: Yes [] No []
Form of Practice: [] Solo [X] Partnership (2, 3, or 4) [] Group (5	or more) If Group, give name below:
Primary Hospital where you have staff privileges:	
Name: BRISTOL REGIONAL MED	City/State: BRISTOL, TN
Are you licensed in another state: Yes [X] No [_] "Which ones:	[IN] [GA] [NC] tsc] []
CME Certification: (Check one)	
I hereby certify that I have met the annual minimum continuing continuing medical education during the calendar year ending I	
[] I certify that I am exempt from the minimum continuing medic	al education requirement for the following reason:
 I do not reside in the State of Alabama and do not have a sig I received my initial license to practice medicine in Alabama I reinstated my license to practice medicine in the State of Al I am a resident physician enrolled in a residency training pro I am retired from the practice of medicine and have obtained 	after June 30th of this calendar year. labama after June 30th of this calendar year. gram.
Complete both sides including signature. Supply	or correct all information. OVER

DEADLINE IS DECEMBER 31, 1996

			YE\$	NO
1.	Have you bee	convicted of a felony or of any offense (felony/misdemeanor) involving the practice of medicine within the past year?	Ė	1
2.		ficate of qualification or license to practice medicine in any state been suspended, revoked, restricted, curtailed or irrendered under threat of suspension or revocation within the past year?	[]	ĮŢ
3.		aff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under stricting your practice, within the past year?	[]	[]
4.		n denied a certificate of qualification or license to practice medicine in any state or has your application for a qualification or license to practice medicine been withdrawn under threat of denial within the past year?	[]	[]
5.	Have you had within the pa	a judgement rendered against you, or action settled relating to the performance of your professional service st year?	[]	17
6.	To your know within the pa	ledge, are you the subject of an investigation by any licensing Board/Agency as of the date of this application at year?	()	W
7.	_	st year, have you been diagnosed with or have you been treated for bi-polar disorder, schizophrenia, paranoia, sychotic disorder?	[]	[,]
8.	alcohol abuse	ntly have any mental or physical condition or impairment (including, but not limited to, substance abuse, , or mental, emotional, or nervous disorder or condition) which in any way currently affects, or if untreated your ability to practice in a competent and professional manner?	[]	i T
9.	nervous. or b	st year, have you ever raised the issue of consumption of drugs or alcohol or the issue of a mental, emotional, chavioral disorder or condition as a defense, mitigation, or explanation for your actions in the course of any conjudicial proceeding or investigation; any inquiry or other proceeding; or any proposed termination by an astitution, employer, government agency, professional organization or licensing authority?	[]	1
10.	Have you eve	r been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism?	[]	1/1
11.	Are you curr	ently engaged in the illegal use of controlled dangerous substances?	[]	[]
12.		to the preceding question is yes, are you currently participating in a supervised rehabilitation programs or you in order to assure that you are not engaging in the illegal use of controlled dangerous substances?	[]	[]
13.		n, within the past year, convicted of driving under the influence (DUI) or have you been charged with a convicted of a lesser offense such as reckless driving?	[]	[,]
14.	Has your me other than a	dical training or medical practice been interrupted or suspended for a period longer than 60 days for any reason recation?	[]	[/
	Rather, it me	crently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. ans recently enough so that the condition referred to may have an ongoing impact on one's functioning as a physician at to a physician, or within the past two years.		
		VE ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, PLEASE ATTACH A DETAILED EXPLANATION R APPLICATION UPON RETURNING IT TO THIS OFFICE.		
I certify	that all inform	ation on this form is correct. Signature Date	-94	

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

Return with \$100.00 renewal fee to:

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

License Renewal for 1998 Deadline is December 31, 1997

GARY CLAYTON BOYLE, M.D.

State of Alabama Medical Licensure Commission

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

Return with \$100.00 renewal fee.

334/242-4153

33

P.O. Box 887

Montgomery, Alabama 36101-0887



2901 W STATE ST BRISTOL, TN 37620-1718 hilliaddhaddhaadhaallhaddadaalad	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: Ruce: White [X] Black [_] Am. Indian [_] Oriental or	
Office Address:	Home Address:
	452 CAMP PLACID RD
2901 WEST STATE STREET	
City, State, Zip: BRISTOL, TN 37620	City, State, Zip: BLOUNTVILLE, TN 37617 5303
(Alabama) County:	(Alabama) County:
(Alabama) County: Business Phone: (415)968-2182	(Alabama) County: Home Phone: (615)323-2161
Fax Number: (615)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 Secondary:	Board Certified: Yes [_] No [_] 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 REGIONAL MED Are you licensed in another state: Yes [X] No [] white Primary Care Information: 1. Are you actively engaged in clinical practice? (Check one 2. Does your practice include the delivery of primary care in care focused on the point at which a patient ideally first se room care."): (Check one): Yes [] No [] 3. Approximately how many hours per week do you practice CME Certification: (Check one) [I hereby certify that I have met the annual minimum continuing medical education during the calendar year end [] I certify that I am exempt from the minimum continuing medical in the State of Alabama and do not have a [] I received my initial license to practice medicine in Alabama and the state of I I am a resident physician enrolled in a residency training [] I am retired from the practice of medicine and have obtain	e): Yes [No [] ledical services? (Primary care is defined as: "Basic or general health eeks assistance from the medical care system, exclusive of emergency in the above-defined primary care services?

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

OVER

		1 53	HU
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?	[]	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?	[]	[7
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?	[]	(<u>/</u>
5.	Have you had a judgement rendered against you, or action settled relating to the performance of your professional service within the past year?	[]	[/J
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/
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 educational institution, employer, government agency, professional organization or licensing authority?	. []	[/
ιο.	Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism?	[]	[/]
11.	Are you currently engaged in the illegal use of controlled dangerous substances?	[·]	سيرا
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?	(1	[/
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?	[]	
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?	[]	[1
	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. that all information on this form is correct. Signature Signature	۹,	フ

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

Return with \$100.00 renewal fee to:

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

License Renewal for 1999 Deadline is December 31, 1998

State of Alabama Medical Licensure Commission

334/242-4153

P.O. Box 887

Montgomery, Alabama 36101-0887



GARY CLAYTON BOYLE, M.D. 2901 W STATE ST BRISTOL TN 37620-1718

Herbelden der bereite bereite bereiteten der bei bereiteten der bereiteten der bereiteten der besteht bei der

Complete **BOTH** sides including signature.

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

Return with \$100.00 renewal fcc.

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: Lie Race: White [X] Black [_] Am. Indian [_] Oriental or Asia	
Office Address:	Home Address:
	452 CAMP PLACID RD
2901 WEST STATE STREET	
City, State, Zip: BRISTOL, TN 37620	City, State, Zip: BLOUNTVILLE, TN 37617 5303
(Alabama) County:	(Alabama) County:
Business Phone: (423)968-2182	Home Phone: (423)323-2161
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 Secondary: Form of Practice:[] Solo [X] Partnership (2, 3, or 4) []	Board Certified: Yes [] No [] Board Certified: Yes [] No []
room care."): (Check one): Yes [] No [] 3. Approximately how many hours per week do you practice the a CIME Certification: (Check one) [] I hereby certify that I have met the annual minimum continuing continuing medical education during the calendar year ending [] 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 signif [] I received my initial license to practice medicine in Alabama a [] I reinstated my license to practice medicine in the State of Alal [] I am a resident physician enrolled in a residency training programment.	es [/] No [] 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? geducation requirement of 12 hours of Category I December 31, 1998. al education requirements for the following reason: ficant portion of my medical practice in Alabama, fiter June 30th of this calendar year, pama after June 30th of this calendar year, ann.
[] I am retired from the practice of medicine and have obtained a DEADLINE IS D	waiver from the Board of Medical Examiners. PECEMBER 31, 1998

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

OVER

			110
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?	()	1/
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?	[]	1,7
5.	Have you had a judgement rendered against you, or action settled relating to the performance of your professional service within the past year?	ι)	11
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?	ι)	()
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?	1]	17
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?	[]	[7
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?	[1	13
10.	Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism?	[]	17
13.	Are you currently engaged in the illegal use of controlled dangerous substances?	[]	[1
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?	[]	11
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?	[]	[1
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?	[]	17
	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.		. 13

Signature

Complete both sides, including signature.

Be sure to supply all information. Incomplete applications will be returned.

Return with \$100.00 renewal fee to:

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

I certify that all information on this form is correct.

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



GARY CLAYTON BOYLE, M.D. 2901 W STATE ST BRISTOL, TN 37620-1718 Complete **BOTH** sides including signature. Be sure to correct or supply **ALL** information. Return with \$100.00 renewal fee.

48 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.

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Please make corrections or supply information: Lice	
Race: White [X] Black [] Am. Indian [] Oriental or Asian	Enter SAN#
Office Address:	Home Address:
	452 CAMP PLACID RD
2901 WEST STATE STREET	
City, State, Zip: BRISTOL, TN 37620 1718	City, State, Zip: BLOUNTVILLE, TN 37617 5303
=(Alabama) County:	(Alabama) County:
Business Phone: (423)968-2182	Home Phone: (423)323-2161
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
Secondary:Form of Practice: [] Solo [X] Partnership (2, 3, or 4) [] C	Board Certified: Yes [] No []
Form of Practice: [] Solo [X] Partnership (2, 3, or 4) [] C	broup (5 or more) If Group, give name below:
	nes: [TN][GA] [NC] [SC] [VA]
Yes [] Go to Question 3 No [] Do NOT answer question 3. Approximately how many hours per week do you practice the aleanswered YES to questions 1 and 2 above.) Approximately	pove-defined primary care services in Alabama? Only answer if you hours per week.
Thereby certify that I have met the annual minimum continuing continuing medical education during the calendar year ending Do I certify that I am exempt from the minimum continuing medica I do not reside in the State of Alabama and do not have a significant of I received my initial license to practice medicine in Alabama affiliar in I reinstated my license to practice medicine in the State of Alabama in I am a resident physician enrolled in a residency training program I I am retired from the practice of medicine and have obtained a complete both sides including signature.	ecember 31, 1999. I education requirements for the following reason: cant portion of my medical practice in Alabama. ter June 30 th of this calendar year. ama after June 30 th of this calendar year. on. waiver from the Board of Medical Examiners.
- Compact Dans asked machines of agreement authory or	

		YES	NO
l.	Have you been convicted of a felony or of any offense (felony/misdemeanor) involving the practice of medicine within the past year?	[]	U
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?	[]	Į.
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
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
5.	Have you had a judgement rendered against you, or action settled relating to the performance of your professional service within the past year?	[]	L}
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?	[]	17
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?	[]	1/1
- 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?	[]	1-1
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?	1]	14
10.	Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voycurism?	[]	4
ш.	Are you currently engaged in the illegal use of controlled dangerous substances?	[]	4
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?	ΙÌ	[.]
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?	()	[-]
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?	[]	1
	The term "currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the condition referred to may have an ongoing impact on one's functioning as a physician or an assistant to a physician, or within the past two years.		
	IF YOU HAVE ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, PLEASE ATTACH A DETAILED EXPLANATION WITH YOUR APPLICATION UPON RETURNING IT TO THIS OFFICE.		
I certify	that all information on this form is correct. Compare Compare Compare	1-9	9
	 Complete both sides, including signature. Be sure to supply all information. 		

Incomplete applications will be returned.

Return with \$100.00 renewal fee to:

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

License Renewal for 2001 Deadline is December 31, 2000

State of Alabama Medical Licensure Commission

334/242-4153

P.O. Box 887

Montgomery, Alabama 36101-0887



BOYLE, GARY CLAYTON

******** AUTO**MIXED AADC 360 GARY CLAYTON BOYLE, M.D. 2901 W STATE ST BRISTOL, TN 37620-1718

fakdiddlashllaaalladadladabbahdalal

License #8882

54 12162 in the automatic revocation of the current license to

Incomplete applications will be returned. Failure to register and pay renewal fee will result

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

practice medicine or osteopathy.

Return with \$125.00 renewal fee.

Please make corrections or supply information: Lie Race: White [X] Black [_] Am. Indian [_] Oriental or Asia	
Office Address:	Home Address:
	452 CAMP PLACID RD
2901 WEST STATE STREET	: ·
City, State, Zip: BRISTOL, TN 37620 1718	City, State, Zip: BLOUNTVILLE, TN 37617 5303
(Alabama) County:	(Alabama) County:
Business Phone: (423)968-2182	Home Phone: (423)323-2161
Pax Number: (423)968-7589	(Will not be published)
Permission to publish in Roster: Yes [] No [X]	Send official mail to: Business [] address (check one)
Specialty: Primary: OBSTETRICS & GYNECOLOGY Secondary:	Board Certified: Yes No No Board Certified: Yes No No
Form of Practice: [] Solo [X] Partnership (2, 3, or 4) []	Group (5 or more) If Group, give name below:
Name: BRISTOL REGIONAL MED City/State: BRISTOI Are you licensed in another state: Yes [X] No [] which Primary Care Information: 1. Are you actively engaged in clinical practice in the State of Al	ones: [TN][GA] [NC] [SC] [VA]
gatekeeper' health care focused on the point at which a patient ide cmergency care situation.")	al services in Alabama? (Primary care is defined as: "Basic or general cally first seeks assistance from the medical care system, exclusive of a
Yes [] Go to Question 3 No [] Do NOT answer question	
	above-defined primary care services in Alabama? Only answer if you hours per week.
CME Certification: (Check one)	nous per wook.
hereby certify that I have met the annual minimum continuin	
continuing medical education within the past two calendar year	
[] I certify that I am exempt from the minimum continuing medic	
Fig. [3] I do not reside in the State of Alabama and do not have a sign [3] Treceived my initial license to practice medicine in Alabama a	
1 [3] A received my initial idense to practice medicine in the State of Ala	
1 I am a resident physician enrolled in a residency training prog	
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	OECEMBER 31, 2000 or correct all information. OVER

12162

		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?	[]	1
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 ficense 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?	[]	L/
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?	[]	H
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?	[]	17
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?	[]	H
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?	[]	H
10.	Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism?	[]	[]/
11.	Are you currently engaged in the illegal use of controlled dangerous substances?	[]	W
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?	П	[]
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?	[]	
	The term "currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the condition referred to may have an ongoing impact on one's functioning as a physician or an assistant to a physician, or within the past two years.		

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

I certify that all information on this form is correct.

Signature WN

10-24-00

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

Return with \$125.00 renewal fee to:

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

License Renewal for 2002 Deadline is December 31, 2001

State of Alabama Medical Licensure Commission

334/242-4153

P.O. Box 887

Montgomery, Alabama 36101-0887



GARY CLAYTON BOYLE, M.D. 2901 WEST STATE STREET BRISTOL, TN 37620-1718 Complete BOTH sides including signature. Be sure to correct or supply ALL information. Return with \$200.00 renewal fee. Incomplete applications will be returned. Failure to register and pay renewal fee will result in the automatic revocation of the current license to practice medicine or osteopathy.

Please make corrections or supply information: License: MC Race: White [X] Black [] American Indian [] Or	D. 00008882 Date-Issued: 07/18/1979 Sex: M [X] F [] iental or Asian [] Other [] Social Security#
Office Address	Home Address
2901 WEST STATE STREET BRISTOL, TN 37620-1718	452 CAMP PLACID RD BLOUNTVILLE, TN 37617-5303
(Alabama) County:	(Alabama) County:
Business Phone: (423) 968-2182	Home Phone: (423) 323-2161 (Will not be published)
Fax Number: (423) 968-7589	
Permission to publish in Roster: Yes [X]	Send official mail to:Business [X] address (check one) Home [] address
Specialty: Primary: OBSTETRICS & GYNECOLOGY	Board Certified: Yes [] No []
Secondary:	Board Certified: Yes [] No []
Form of Practice: [X] Solo [] Partnership (2, 3, or 4) []	Group If Group give Group Name below:
Primary Hospital where you have staff privileges:	
Name: BRISTOL REGIONAL MED	City/State: BRISTOL, TN
Are you licensed in another state: Yes [X] No []	Which ones: [TN] [GA] [NC] [SC] [VA]
Primary Care Information:	
 Are you actively engaged in clinical practice in the State 	
Yes [] Go to Question 2 No [X] Do NOT ar	nswer questions 2 and 3 below. Skip to CME Certification questions.
	medical services in Alabama'? (Primary care is defined as: "Basic or general entitle deally first seeks assistance from the medical care system, exclusive of
an emergency care situation.")	
Yes [] Go to Question 3 No [] Do NOT ans	wer question 3 below. Skip to the CME Certification questions.
Approximately how many hours per week do you practi Answered YES to questions 1 and 2 above. Approximately	ice the above-defined primary care services in Alabama? Only answer if yo : 0 hours per week.
CMF Certification: (Check one)	
I hereby certify that I have met the annual minimum continuir	ag education requirement of 24 hours of Category I
continuing medical education within the past two calendar ye	
[] I certify that I am exempt from the minimum continuing media	cal 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.
1 received my initial license to practice medicine in Alaba	ama after June 30" of this calendar year.
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 obta 	program. ined a waiver from the Board of Medical Examiners.
[1] and found from the problem of the distribute and have obtain	AND A TOTAL TOTAL COURS OF THEMSEL BASEFILLION
DEADLINE IC DECEME	ALD 24 2004 - TOURS OF THE STANKE

MD . 00008882

DEADLINE IS DECEMBER 31, 2001

BOYLE, GARY **CLAYTON**

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?		H
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?	[]	W
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?	[]	W
5.	Have you had a judgement rendered against you, or action settled relating to the performance of your professional service within the past year?	[]	11
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?	[]	N
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?	[]	H
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?	[]	H
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	LJ'
O.	Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism?	[]	W
1.	Are you currently engaged in the illegal use of controlled dangerous substances?	[]	[]
.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?	[]	[]
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?	[]	H
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?	[]	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.		
P YC	OU HAVE ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, PLEASE ATTACH A DETAILED EXPLANATE A YOUR APPLICATION UPON RETURNING IT TO THIS OFFICE.	TION	
certif	y that all information on this form is correct. Signature Date	2-6)/

♦ Complete both sides, including signature.

♦ Be sure to correct or supply all information.

Incomplete applications will be returned.

Return with \$200.00 renewal fee to:

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



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

2003 Online Renewal Summary

Name: Gary Clayton Boyle

Transaction Date: 2002-10-24*

Registration Fee: 200

License Number: MD.8882

Transaction Number: null

Date of Birth: 1948-02-23

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

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

To your knowledge, are you the subject of an investigation by any licensing Board/Agency as of the date of this application within the past year? **N**

Oct 1, 2014 2:16 PM

If yes, please explain:

Within the past year, have you been diagnosed with or have you been treated for bi-polar disorder, schizophrenia, paranoia, or any other psychotic disorder? **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? **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, 2003. **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: 4239682182

Practice Address: 2901 WEST STATE STREET

Home Telephone: 4233232161

Home Address: 452 CAMP PLACID RD

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.



2004 Online Renewal Summary

Name: Gary Clayton Boyle

Transaction Date: 2003-10-31*

Registration Fee: 200

License Number: MD.8882

Transaction Number: null

Date of Birth: 1948-02-23

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

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

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: (423) 323-2161

Home Address: 452 CAMP PLACID RD

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: Gary Clayton Boyle

Transaction Date: 2004-12-30*

Registration Fee: 200

License Number: MD.8882

Transaction Number: null

Date of Birth: 1948-02-23

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

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

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? $\bf N$

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: N

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: (423) 323-2161

Home Address: 452 CAMP PLACID RD

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: Gary Clayton Boyle

Transaction Date: 2005-11-30*

Registration Fee: 200

License Number: MD.8882

Transaction Number: null

Date of Birth: 1948-02-23

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

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

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: (423) 323-2161

Home Address: 452 CAMP PLACID RD

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: Gary Clayton Boyle

Transaction Date: 2006-10-09*

Registration Fee: 200

License Number: MD.8882

Transaction Number: VQEF0BEE212C

Date of Birth: 1948-02-23

* - 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? yes

Secondary specialty:
Are you Board certified in your secondary specialty?
Practice Type: Partnership (2,3 or 4)
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: yes
TN
sc
GA .
NC .
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?

Does the nurse practitioner/midwife practice at a site other than your office?

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?

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.

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 2006 and have supporting documentation if audited. **Y**

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

Exempt Reason

Practice Telephone: (423) 968-2182

Practice Address: 2901 WEST STATE STREET

Home Telephone: (423) 323-2161

Home Address: 452 CAMP PLACID RD

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: Gary Clayton Boyle

Transaction Date: 2007-10-16*

Registration Fee: 300

License Number: MD.8882

Transaction Number: VLCF1E21B2E8

Date of Birth: 1948-02-23

* - 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: 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:
Are you licensed in another State: Y
TN
sc
GA
NC
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?

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: (423) 323-2161

Home Address: 452 Camp Placid Rd

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**



2009 Online Renewal Summary

Name: Gary Clayton Boyle

Transaction Date: 2008-11-24*

Registration Fee: 300

License Number: MD.8882

Transaction Number: VXHF3A17B36E

Date of Birth: 1948-02-23

* - 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

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
NC .
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

Secondary specialty:

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?

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: (423) 323-2161

Home Address: 452 Camp Placid Rd

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: Gary Clayton Boyle

Transaction Date: 2009-10-21*

Registration Fee: 300

License Number: MD.8882

Transaction Number: VUJF4B837004

Date of Birth: 1948-02-23

* - 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
NC
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)

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: (423) 323-2161

Home Address: 452 Camp Placid Rd

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**