APPLICATION

TO STATE LICENSING BOARD FOR THE HEALING ARTS

FOR LICENSE TO PRACTICE

NAME IN FULL (print) Garry Clayton Boyle

Business Address

City State County

Branch of Healing Arts you are to practice M.D. OB-GYN

Date 7-11-79 Phone No. (Office) /

Phone No. (Home) 615-323-3159

Signed [signature]

** PREFERRED MAILING ADDRESS: License fee attached $15.00

Rt 2

Blountville, Tenn 37617

THIS IS THE ONLY NOTICE
YOU WILL RECEIVE.

Nº 6504 M

RENEWAL APPLICATION

FOR CERTIFICATE OF REGISTRATION FOR 1979

STATE LICENSING BOARD FOR THE HEALING ARTS

Public Safety Building
MONTGOMERY, ALABAMA 36130

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

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

Name and Business Address: Gary Clayton Boyle, M. D.
Route 2,
Blountville, Tennessee 37617

License #

Date issued 7/18/79

County

Fee $ 5.00
FOR REMAINDER OF 1979

Signature

FOR CHANGE OF ADDRESS ONLY

RENEWAL APPLICATION NO. 512 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.

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

Name and Mailing Address: Business Address:

GARY C BOYLE
RT 2
BLOUNTVILLE, TN 37617 , 86

LICENSE #: 0008[illegible] ISSUED: 07/1[illegible]/79

☐ The above addresses are correct.

615-323-3159

RENEWAL APPLICATION

NO. 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, Alabama 36130
Phone 205/832-5051

DEC 15 1981

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

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

Name and Mailing Address:

Gary Clayton Boyle, M. D.
Route 2
Blountville, Tennessee 37617

8882 7/18/79

$ 10.00

Business Address: Bristol Obstetrics Gynecology & Family Planning
157 Blountville Highway
Bristol, Tennessee 37620

~~BLOUNTVILLE, TN 37617~~

615-968-2182

☐ The above Addresses are correct.

RENEWAL APPLICATION

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

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

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

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

Name and Mailing Address:

GARY C BOYLE
RT 2
BLOUNTVILLE, TN 37617

Business Address:

157 BLOUNTVILLE HWY
BRISTOL, TN 37620

LICENSE #: 0008882 ISSUED: 07/18/79

☐ The above Addresses are correct.

RENEWAL APPLICATION

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

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

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

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

Name and Mailing Address:

GARY C BOYLE
RT 2
BLOUNTVILLE, TN 37617

Business Address:

SELF
101 NEW KINGSPORT HWY
BRISTOL, TN 37620

LICENSE #: 0008852 ISSUED: 07/18/79

☐ The above Addresses are correct.

RENEWAL APPLICATION

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

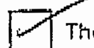
Every physician and osteopath licensed to practice medicine/osteopathy in the State of Alabama shall, on or before the 31st day of December of each year, apply to this Commission for a Certificate of Registration which shall be effective during the calendar year.

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

Name and Mailing Address:
GARY C BOYLE
RT 2
BLOUNTVILLE, TN 37617

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

LICENSE #: 0008882 ISSUED: 07/18/79


The above Addresses are correct.

RENEWAL APPLICATION

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

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

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

Name and Mailing Address:
GARY C BOYLE
RT 2
BLOUNTVILLE, TN 37617

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

LICENSE #: 0008882 ISSUED: 07/18/79

The above Addresses are correct.

RENEWAL APPLICATION

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

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

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

Name and Mailing Address:
GARY C SOYLE
RT 2
BLOUNTVILLE, TN 37617

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

LICENSE #: 0008882 ISSUED: 07/18/79

[✓] The above Addresses are correct.

RENEWAL APPLICATION

FOR A CERTIFICATE OF REGISTRATION TO PRACTICE MEDICINE IN ALABAMA IN 1987
ALABAMA MEDICAL LICENSURE COMMISSION
Post Office Box 887
Montgomery, Alabama 36101-0887
Phone (205) 261-4153

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

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

Name and Mailing Address:
GARY C BOYLE
RT 2
BLOUNTVILLE, TN 37617

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

LICENSE #: 0003662 ISSUED: 07/18/79

☐ The above Addresses are correct.

RENEWAL APPLICATION

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

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

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

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

Name and Mailing Address:	Business Address:
GARY C BOYLE	SELF
RT 2	101 NEW KINGSPORT HWY
BLOUNTVILLE, TN 37617	BRISTOL, TN 37620

LICENSE #: 0008882 ISSUED: 07/18/79

☐ The above Addresses are correct.

RENEWAL APPLICATION

FOR A CERTIFICATE OF REGISTRATION TO PRACTICE MEDICINE IN ALABAMA IN 1989

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

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

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

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

I certify that the above information is correct ______ Signature ______ Date 12/15/88

(Do Not Detach)

RENEWAL APPLICATION

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

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

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

Name and Mailing Address:
GARY C BOYLE
RT 2
BLOUNTVILLE, TN 37617

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

I certify that the above information is correct [signature] MD 10/9/89
Signature Date
(Do Not Detach)

RENEWAL APPLICATION

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

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

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

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

I certify that the above information is correct [signature] 10-25-90
Signature Date

(Do Not Detach)

RENEWAL APPLICATION

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

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

I certify that the above information is correct [signature] 10-8-91
Signature Date

(Do Not Detach)

(Rev. 08/92)

RENEWAL APPLICATION

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

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

Name and Mailing Address
LICENSE #: 0008882 ISSUED: 07/18/79

GARY C BOYLE
RT 2
BLOUNTVILLE, TN 37617

Home Address:
Street 452 Camp Placid Rd
City Blountville
State TN Zip 37617
Business FAX#:( )

☐ Make corrections to mailing address on reverse.

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

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

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

(Check a or b) For CME Certification

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

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

Check One Below If You Answered (b)

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

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

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

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

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

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

I certify that all information on this form is correct [signature] 10-14-92
Signature Date

(Do Not Detach)

(Rev. 08/93)

RENEWAL APPLICATION

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

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

Name & Mailing Address

(Make address corrections in (4) below.)

LICENSE #: 00008882 ISSUED: 7/18/1979

BOYLE GARY CLAYTON
101 NEW KINGSPORT HWY

BRISTOL 37620-

- Every physician and osteopath licensed to practice medicine/osteopathy in the State of Alabama shall, on or before the 31st of December of each year, apply to this Commission for a Certificate of Registration which shall be effective during the calendar year. Ck # 4456 pd 11-12-93
- Renewal Fee: $100.00 - Failure to register and pay the annual registration fee within 30 days after registration becomes due will result in the automatic revocation of the current license without further notice or hearing as provided in §34-24-337, Code of Alabama (1975).

(Check a or b) For CME Certification

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

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

Check One Below If You Answered (b)

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

Within The Past Year:

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

I certify that all information on this form is correct [signature] 11-5-93

Signature Date

License Renewal for 1995
Deadline is December 31, 1994

State of Alabama
Medical Licensure Commission
205/242-4153

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

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.

GARY CLAYTON BOYLE , M.D.
101 NEW KINGSPORT HWY

BRISTOL, TN 37620

Please make corrections or supply information: License # 00008882 Sex: M [✓] F[ ]

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

Office Address:

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

City, State, Zip: BRISTOL, TN 37620

County: Sullivan

Business Phone: (615 968-2182

Fax Number: (615 968-7589

Permission to publish in Roster: Yes [ ] No [X]

Home Address:

452 CAMP PLACID RD

City, State, Zip: BLOUNTVILLE, TN 37617

County: ______

Home Phone: (___) ______
(Will not be published)

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: Bristol Regional Med Ctr City/State: Bristol, TN

Are you licensed in another state: Yes [✓] No [ ] Which ones: [S] [C] [ ] [GA] TN NC

CME Certification: (Check one)

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

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

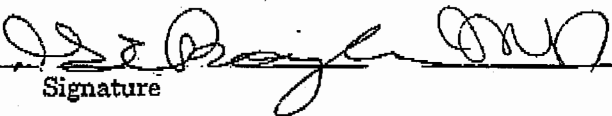
- [] I do not reside in the State of Alabama and do not have a significant portion of my medical practice in Alabama.
- [] I received my initial license to practice medicine in Alabama after June 30th of this calendar year.
- [] I reinstated my license to practice medicine in the State of Alabama after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

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

Within The Past Year:

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

I certify that all information on this form is correct:



Signature

10/19/94

Date

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

Incomplete applications will be returned.

Return with $100.00 renewal fee to:

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

DEADLINE — DECEMBER 31, 1994

License Renewal for 1996
Deadline is December 31, 1995

State of Alabama
Medical Licensure Commission

334/242-4153

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

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

**AADC 377
380
57

Gary Clayton Boyle , M.D.
2901 W State St

Bristol, TN 37620 1677

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 Asian [ ] Other [ ] Social Security #

Office Address:

2901 WEST STATE STREET

City, State, Zip: BRISTOL, TN 37620

(Alabama) County: ______________

Business Phone: (615)968-2182

Fax Number: (615)968-7589

Permission to publish in Roster: Yes [ ] No [X]

Home Address:

452 CAMP PLACID RD

City, State, Zip: BLOUNTVILLE, TN 37617 5303

(Alabama) County: ______________

Home Phone: (615)323-2161
(Will not be published)

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

Specialty: Primary: OBSTETRICS & GYNECOLOGY Board Certified: Yes [ ] No [ ]

Secondary: ______________ Board Certified: Yes [ ] No [ ]

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

Primary Hospital where you have staff privileges:

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

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

CME Certification: (Check one)

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

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

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

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

DEADLINE IS DECEMBER 31, 1995

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

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

I certify that all information on this form is correct.

[signature] 10-19-95

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

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Be sure to correct or supply **ALL** information.
Return with $100.00 renewal fee.
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Failure to register and pay renewal fee will result in the automatic revocation of the current license to practice medicine or osteopathy.

GARY CLAYTON BOYLE MD.
2901 W STATE ST
BRISTOL TN 37620-1718

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 Asian [ ] Other [ ] Social Security # [redacted] Enter SSAN#

Office Address:

2901 WEST STATE STREET

City, State, Zip: BRISTOL, TN 37620

(Alabama) County: ______

Business Phone: (615)968-2182

Fax Number: (615)968-7589

Permission to publish in Roster: Yes [ ] No [X]

Home Address:

452 CAMP PLACID RD

City, State, Zip: BLOUNTVILLE, TN 37617 5303

(Alabama) County: ______

Home Phone: (615)323-2161
(Will not be published)

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: [TN] [GA] [NC] [SC] [ ]

CME Certification: (Check one)

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

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

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

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

DEADLINE IS DECEMBER 31, 1996

		YES	NO
1.	Have you been convicted of a felony or of any offense (felony/misdemeanor) involving the practice of medicine within the past year?	[ ]	[✓]
2.	Has your certificate of qualification or license to practice medicine in any state been suspended, revoked, restricted, curtailed or voluntarily surrendered under threat of suspension or revocation within the past year?	[ ]	[✓]
3.	Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practice, within the past year?	[ ]	[✓]
4.	Have you been denied a certificate of qualification or license to practice medicine in any state or has your application for a certificate of qualification or license to practice medicine been withdrawn under threat of denial within the past year?	[ ]	[✓]
5.	Have you had a judgement rendered against you, or action settled relating to the performance of your professional service within the past year?	[ ]	[✓]
6.	To your knowledge, are you the subject of an investigation by any licensing Board/Agency as of the date of this application within the past year?	[ ]	[✓]
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?	[ ]	[✓]
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?	[ ]	[✓]
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?	[ ]	[✓]
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] Signature   10-21-96 Date

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

Return with $100.00 renewal fee to:

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

License Renewal for 1998
Deadline is December 31, 1997

State of Alabama
Medical Licensure Commission
334/242-4153
P.O. Box 887
Montgomery, Alabama 36101-0887

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.

**************************************3-DIGIT 376
GARY CLAYTON BOYLE , M.D. 33
2901 W STATE ST 218
BRISTOL, TN 37620-1718 9824

Please make corrections or supply information: License 8882 DATE-ISSUED: 7/18/79 Sex: M [X] F [_]
Race: White [X] Black [_] Am. Indian [_] Oriental or Asian [_] Other [_] Social Security #

Office Address:

2901 WEST STATE STREET
City, State, Zip: BRISTOL, TN 37620
(Alabama) County: ______
Business Phone: (~~615~~ 423)968-2182
Fax Number: (~~615~~ 423)968-7589
Permission to publish in Roster: Yes [_] No [X]

Home Address:
452 CAMP PLACID RD

City, State, Zip: BLOUNTVILLE, TN 37617 5303
(Alabama) County: ______
Home Phone: (~~615~~ 423)323-2161
(Will not be published)
Send official mail to: **Business** [✓] address (check one)
Home [ ]

Specialty: Primary: OBSTETRICS & GYNECOLOGY Board Certified: Yes [_] No [✓]
Secondary: ______ Board Certified: Yes [_] No [_]
Form of Practice:[] Solo [X] Partnership (2, 3, or 4) [] Group (5 or more) If Group, give name below:

Primary Hospital where you have staff privileges:
Name: BRISTOL 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:
1. Are you actively engaged in clinical practice? (Check one): Yes [✓] No [ ]
2. Does your practice include the delivery of primary care medical services? (Primary care is defined as: "Basic or general health care focused on the point at which a patient ideally *first* seeks assistance from the medical care system, exclusive of emergency room care."): (Check one): Yes [✓] No [ ]
3. Approximately how many hours per week do you practice the above-defined primary care services? 20

CME Certification: (Check one)

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

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

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

DEADLINE IS DECEMBER 31, 1997

9824

		YES	NO
1.	Have you been convicted of a felony or of any offense (felony/misdemeanor) involving the practice of medicine within the past year?	[ ]	[✓]
2.	Has your certificate of qualification or license to practice medicine in any state been suspended, revoked, restricted, curtailed or voluntarily surrendered under threat of suspension or revocation within the past year?	[ ]	[✓]
3.	Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practice, within the past year?	[ ]	[✓]
4.	Have you been denied a certificate of qualification or license to practice medicine in any state or has your application for a certificate of qualification or license to practice medicine been withdrawn under threat of denial within the past year?	[ ]	[✓]
5.	Have you had a judgement rendered against you, or action settled relating to the performance of your professional service within the past year?	[ ]	[✓]
6.	To your knowledge, are you the subject of an investigation by any licensing Board/Agency as of the date of this application within the past year?	[ ]	[✓]
7.	Within the past year, have you been diagnosed with or have you been treated for bi-polar disorder, schizophrenia, paranoia, or any other psychotic disorder?	[ ]	[✓]
8.	Do you currently have any mental or physical condition or impairment (including, but not limited to, substance abuse, alcohol abuse, or mental, emotional, or nervous disorder or condition) which in any way currently affects, or if untreated could affect, your ability to practice in a competent and professional manner?	[ ]	[✓]
9.	Within the past year, have you ever raised the issue of consumption of drugs or alcohol or the issue of a mental, emotional, nervous, or behavioral disorder or condition as a defense, mitigation, or explanation for your actions in the course of any administrative or judicial proceeding or investigation; any inquiry or other proceeding; or any proposed termination by an educational institution, employer, government agency, professional organization or licensing authority?	[ ]	[✓]
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?	[ ]	[✓]
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?	[ ]	[✓]
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] 10-23-97

Signature Date

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

Return with $100.00 renewal fee to:

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

SERVICE PRINTING CO. (334) 269-0056

License Renewal for 1999
Deadline is December 31, 1998

State of Alabama
Medical Licensure Commission
334/242-4153
P.O. Box 887
Montgomery, Alabama 36101-0887

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

61
1
11434

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: 7/18/79 Sex: M [X] F [_]
Race: White [X] Black [_] Am. Indian [_] Oriental or Asian [_] Other [_] Social Security #

Office Address:

2901 WEST STATE STREET
City, State, Zip: BRISTOL, TN 37620
(Alabama) County: ______________
Business Phone: (423)968-2182
Fax Number: (423)968-7589
Permission to publish in Roster: Yes [_] No [X]

Home Address:

452 CAMP PLACID RD
City, State, Zip: BLOUNTVILLE, TN 37617 5303
(Alabama) County: ______________
Home Phone: (423)323-2161
(Will not be published)
Send official mail to: **Business** [✓] address (check one)
Home [ ]

Specialty: Primary: OBSTETRICS & GYNECOLOGY — Board Certified: Yes [_] No [✓]
Secondary: ______________ — Board Certified: Yes [_] No [_]
Form of Practice: [ ] Solo [X] Partnership (2, 3, or 4) [ ] Group (5 or more) If Group, give name below:

____

Primary Hospital where you have staff privileges:
Name: BRISTOL 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:

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

CME Certification: (Check one)

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

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

DEADLINE IS DECEMBER 31, 1998

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

License #8882 11434 **BOYLE, GARY CLAYTON**

		YES	NO
1.	Have you been convicted of a felony or of any offense (felony/misdemeanor) involving the practice of medicine within the past year?	[ ]	[✓]
2.	Has your certificate of qualification or license to practice medicine in any state been suspended, revoked, restricted, curtailed or voluntarily surrendered under threat of suspension or revocation within the past year?	[ ]	[✓]
3.	Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practice, within the past year?	[ ]	[✓]
4.	Have you been denied a certificate of qualification or license to practice medicine in any state or has your application for a certificate of qualification or license to practice medicine been withdrawn under threat of denial within the past year?	[ ]	[✓]
5.	Have you had a judgement rendered against you, or action settled relating to the performance of your professional service within the past year?	[ ]	[✓]
6.	To your knowledge, are you the subject of an investigation by any licensing Board/Agency as of the date of this application within the past year?	[ ]	[✓]
7.	Within the past year, have you been diagnosed with or have you been treated for bi-polar disorder, schizophrenia, paranoia, or any other psychotic disorder?	[ ]	[✓]
8.	Do you currently have any mental or physical condition or impairment (including, but not limited to, substance abuse, alcohol abuse, or mental, emotional, or nervous disorder or condition) which in any way currently affects, or if untreated could affect, your ability to practice in a competent and professional manner?	[ ]	[✓]
9.	Within the past year, have you ever raised the issue of consumption of drugs or alcohol or the issue of a mental, emotional, nervous, or behavioral disorder or condition as a defense, mitigation, or explanation for your actions in the course of any administrative or judicial proceeding or investigation; any inquiry or other proceeding; or any proposed termination by an educational institution, employer, government agency, professional organization or licensing authority?	[ ]	[✓]
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?	[ ]	[✓]
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?	[ ]	[✓]
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) 10-14-98 (Date)

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

Return with $100.00 renewal fee to:

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

License Renewal for 2000
Deadline is December 31, 1999

State of Alabama
Medical Licensure Commission
334/242-4153
P.O. Box 887
Montgomery, Alabama 36101-0887

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.

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

48
1
11504

Please make corrections or supply information: License **8882** DATE-ISSUED: 7/18/79 Sex: M [X] F [_]
Race: White [X] Black [_] Am. Indian [_] Oriental or Asian [_] Other [_] Social Security # Enter SSAN#

Office Address:
2901 WEST STATE STREET
City, State, Zip: BRISTOL, TN 37620 1718
(Alabama) County: ____________________
Business Phone: (423)968-2182
Fax Number: (423)968-7589
Permission to publish in Roster: Yes [_] No [X]

Home Address:
452 CAMP PLACID RD
City, State, Zip: BLOUNTVILLE, TN 37617 5303
(Alabama) County: ____________________
Home Phone: (423)323-2161
(Will not be published)
Send official mail to: **Business** [✓] address (check one)
Home [ ]

Specialty: Primary: OBSTETRICS & GYNECOLOGY — Board Certified: Yes [_] No [✓]
Secondary: ____________________ — Board Certified: Yes [_] No [_]
Form of Practice: [ ] Solo [X] Partnership (2, 3, or 4) [ ] Group (5 or more) If Group, give name below:

____

Primary Hospital where you have staff privileges:
Name: BRISTOL 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:

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

CME Certification: (Check one)

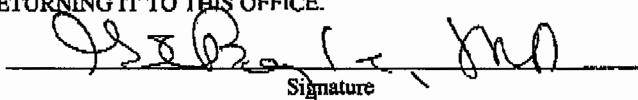
[✓] I hereby certify that I have met the annual minimum continuing education requirement of 12 hours of Category I continuing medical education during the calendar year ending December 31, 1999.
[ ] I certify that I am exempt from the minimum continuing medical education requirements for the following reason:
[ ] I do not reside in the State of Alabama and do not have a significant portion of my medical practice in Alabama.
[ ] I received my initial license to practice medicine in Alabama after June 30th of this calendar year.
[ ] I reinstated my license to practice medicine in the State of Alabama after June 30th of this calendar year.
[ ] I am a resident physician enrolled in a residency training program.
[ ] I am retired from the practice of medicine and have obtained a waiver from the Board of Medical Examiners.

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

		YES	NO
1.	Have you been convicted of a felony or of any offense (felony/misdemeanor) involving the practice of medicine within the past year?	[ ]	[✓]
2.	Has your certificate of qualification or license to practice medicine in any state been suspended, revoked, restricted, curtailed or voluntarily surrendered under threat of suspension or revocation within the past year?	[ ]	[✓]
3.	Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practice, within the past year?	[ ]	[✓]
4.	Have you been denied a certificate of qualification or license to practice medicine in any state or has your application for a certificate of qualification or license to practice medicine been withdrawn under threat of denial within the past year?	[ ]	[✓]
5.	Have you had a judgement rendered against you, or action settled relating to the performance of your professional service within the past year?	[ ]	[✓]
6.	To your knowledge, are you the subject of an investigation by any licensing Board/Agency as of the date of this application within the past year?	[ ]	[✓]
7.	Within the past year, have you been diagnosed with or have you been treated for bi-polar disorder, schizophrenia, paranoia, or any other psychotic disorder?	[ ]	[✓]
8.	Do you currently have any mental or physical condition or impairment (including, but not limited to, substance abuse, alcohol abuse, or mental, emotional, or nervous disorder or condition) which in any way currently affects, or if untreated could affect, your ability to practice in a competent and professional manner?	[ ]	[✓]
9.	Within the past year, have you ever raised the issue of consumption of drugs or alcohol or the issue of a mental, emotional, nervous, or behavioral disorder or condition as a defense, mitigation, or explanation for your actions in the course of any administrative or judicial proceeding or investigation; any inquiry or other proceeding; or any proposed termination by an educational institution, employer, government agency, professional organization or licensing authority?	[ ]	[✓]
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?	[ ]	[✓]
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?	[ ]	[✓]
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

10-18-99
Date

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

Return with $100.00 renewal fee to:

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

SERVICE PRINTING CO. (334) 269-0058

License Renewal for 2001
Deadline is December 31, 2000

State of Alabama
Medical Licensure Commission

334/242-4153

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

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

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

54
1
12162

Please make corrections or supply information: License **8882** DATE-ISSUED: 7/18/79 Sex: M [X] F [_]
Race: White [X] Black [_] Am. Indian [_] Oriental or Asian [_] Other [_] Social Security # [redacted]
Enter SSAN#

Office Address:

2901 WEST STATE STREET

City, State, Zip: BRISTOL, TN 37620 1718

(Alabama) County: ______

Business Phone: (423)968-2182

Fax Number: (423)968-7589

Permission to publish in Roster: Yes [_] No [X]

Home Address:

452 CAMP PLACID RD

City, State, Zip: BLOUNTVILLE, TN 37617 5303

(Alabama) County: ______

Home Phone: (423)323-2161

(Will not be published)

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

Specialty: Primary: OBSTETRICS & GYNECOLOGY — Board Certified: Yes [_] No [_]
Secondary: ______ — Board Certified: Yes [_] No [✓]

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

______

Primary Hospital where you have staff privileges:
Name: BRISTOL 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:

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

CME Certification: (Check one)

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

DEADLINE IS DECEMBER 31, 2000

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

		Yes	No
1.	Have you been convicted of a felony or of any offense (felony/misdemeanor) involving the practice of medicine within the past year?	[ ]	[✓]
2.	Has your certificate of qualification or license to practice medicine in any state been suspended, revoked, restricted, curtailed or voluntarily surrendered under threat of suspension or revocation within the past year?	[ ]	[✓]
3.	Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practice, within the past year?	[ ]	[✓]
4.	Have you been denied a certificate of qualification or license to practice medicine in any state or has your application for a certificate of qualification or license to practice medicine been withdrawn under threat of denial within the past year?	[ ]	[✓]
5.	Have you had a judgement rendered against you, or action settled relating to the performance of your professional service within the past year?	[ ]	[✓]
6.	To your knowledge, are you the subject of an investigation by any licensing Board/Agency as of the date of this application within the past year?	[ ]	[✓]
7.	Within the past year, have you been diagnosed with or have you been treated for bi-polar disorder, schizophrenia, paranoia, or any other psychotic disorder?	[ ]	[✓]
8.	Do you currently have any mental or physical condition or impairment (including, but not limited to, substance abuse, alcohol abuse, or mental, emotional, or nervous disorder or condition) which in any way currently affects, or if untreated could affect, your ability to practice in a competent and professional manner?	[ ]	[✓]
9.	Within the past year, have you ever raised the issue of consumption of drugs or alcohol or the issue of a mental, emotional, nervous, or behavioral disorder or condition as a defense, mitigation, or explanation for your actions in the course of any administrative or judicial proceeding or investigation; any inquiry or other proceeding; or any proposed termination by an educational institution, employer, government agency, professional organization or licensing authority?	[ ]	[✓]
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?	[ ]	[✓]
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?	[ ]	[✓]
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] MD   10-24-00

Signature   Date

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

Return with $125.00 renewal fee to:

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

SERVICE PRINTING CO. (334) 269-0058

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

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.

GARY CLAYTON BOYLE, M.D.
2901 WEST STATE STREET
BRISTOL, TN 37620-1718

Please make corrections or supply information: License: **MD . 00008882** Date-Issued: 07/18/1979 Sex: M [X] F [ ]
Race: White [X] Black [ ] American Indian [ ] Oriental or Asian [ ] Other [ ] Social Security#

Office Address

2901 WEST STATE STREET
BRISTOL, TN 37620-1718

(Alabama) County:

Business Phone: (423) 968-2182

Fax Number: (423) 968-7589

Home Address

452 CAMP PLACID RD
BLOUNTVILLE, TN 37617-5303

(Alabama) County:

Home Phone: (423) 323-2161 (Will not be published)

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:

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

CME Certification: (Check one)

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

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?	[ ]	[X]
2.	Has your certificate of qualification or license to practice medicine in any state been suspended, revoked, restricted, curtailed or voluntarily surrendered under threat of suspension or revocation within the past year?	[ ]	[X]
3.	Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practice, within the past year?	[ ]	[X]
4.	Have you been denied a certificate of qualification or license to practice medicine in any state or has your application for a certificate of qualification or license to practice medicine been withdrawn under threat of denial within the past year?	[ ]	[X]
5.	Have you had a judgement rendered against you, or action settled relating to the performance of your professional service within the past year?	[ ]	[X]
6.	To your knowledge, are you the subject of an investigation by any licensing Board/Agency as of the date of this application within the past year?	[ ]	[X]
7.	Within the past year, have you been diagnosed with or have you been treated for bi-polar disorder, schizophrenia, paranoia, or any other psychotic disorder?	[ ]	[X]
8.	Do you currently have any mental or physical condition or impairment (including, but not limited to, substance abuse, alcohol abuse, or mental, emotional, or nervous disorder or condition) which in any way currently affects, or if untreated could affect, your ability to practice in a competent and professional manner?	[ ]	[X]
9.	Within the past year, have you ever raised the issue of consumption of drugs or alcohol or the issue of a mental, emotional, nervous, or behavioral disorder or condition as a defense, mitigation, or explanation for your actions in the course of any administrative or judicial proceeding or investigation; any inquiry or other proceeding; or any proposed termination by an educational institution, employer, government agency, professional organization or licensing authority?	[ ]	[X]
10.	Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism?	[ ]	[X]
11.	Are you currently engaged in the illegal use of controlled dangerous substances?	[ ]	[ ]
12.	If your answer to the preceding question is yes, are you currently participating in a supervised rehabilitation program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances?	[ ]	[ ]
13.	Have you been, within the past year, convicted of driving under the influence (DUI) or have you been charged with DUI and been convicted of a lesser offense such as reckless driving?	[ ]	[X]
14.	Has your medical training or medical practice been interrupted or suspended for a period longer than 60 days for any reason other than a vacation?	[ ]	[X]

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

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

I certify that all information on this form is correct. [signature] MD
Signature

11-12-01
Date

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

Return with $200.00 renewal fee to:

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

SERVICE PRINTING CO. (334) 269-0058

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**

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.

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

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**

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

Primary specialty:

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

Oct 1, 2014 2:16 PM

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.

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

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**

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

Primary specialty:

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

Oct 1, 2014 2:17 PM

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.

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

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**

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

Primary specialty:

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

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.

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

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**

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If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

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

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

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

2008 Online Renewal Summary

Name: **Gary Clayton Boyle**
License Number: **MD.8882**
Transaction Date: **2007-10-16***
Transaction Number: **VLCF1E21B2E8**
Registration Fee: **300**
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**

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

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

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

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Secondary specialty: **Other**

Are you Board certified in your secondary specialty?

Practice Type: **P**

If Group, provide the Group Name:

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

Hospital Name: **Bristol Regional Medical Center**

Hospital City: **Bristol**

Hospital State:

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 indicated principal county. **null**

Other County1

Other State1

Other County 2

Other State 2

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

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

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

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**

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

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

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

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?

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

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

Other County1

Other State1

Other County 2

Other State 2

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

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

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**

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

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**

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If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

If yes, please explain:

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

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

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