

STATE OF DELAWARE
APPLICATION FOR LICENSE TO PRACTICE MEDICINE AND SURGERY

Ch # 431-169
 Ch # 432-90

SECTION I: BASIC INFORMATION

Present Legal Name: TAYLOR WARREN IRVING CLARK
(last name) (first name) (middle) (maiden name)

Permanent Mailing Address: DELYN MAWRE PA DELAWARE 19010-2070
(city) (state) (county) (zip code)

Current Address (if different from above): _____
(city) (state) (county) (zip code)

Current Telephone: _____
(daytime) (home)

Have you ever sought or been granted a medical or osteopathic license under another name?
 Yes No

If yes, indicate other name(s) used: _____

DATE OF BIRTH: _____
(month) (day) (year)

PLACE OF BIRTH: _____ Social Security No.: _____
(State or Foreign Country)

Race or Color (Check only one):
 White Black American Indian Oriental or Asian
 Other (specify) _____

If not born in the United States, are you a naturalized citizen, or have you filed a petition for nationalization, or are you a lawful permanent resident of the United States?

SECTION II: EDUCATIONAL BACKGROUND:

Pre-medical or pre-osteopathic education:

SCHOOL	LOCATION	DATES	DEGREES
COLLEGE OF EMPORIA	EMPORIA, KS.	1962-66	B.S.

OTHER PROFESSIONAL EDUCATION:

MEDICAL OR OSTEOPATHIC EDUCATION:

SCHOOL	LOCATION	DATES	DEGREES
KANSAS CITY COLL. OF OSTEOPATHY & SURG.	KANSAS CITY MO.	1966-70	D.O.

POSTGRADUATE MEDICAL OR OSTEOPATHIC EDUCATION:

HOSPITAL/INSTITUTION	LOCATION	DATES
INTERNSHIP: METROPOLITAN HOSP.	201 N. 5TH ST. PHILA PA	1970-71
RESIDENCY: METROPOLITAN HOSP.	same	1971-75

FELLOWSHIPS, etc:

What are your areas or fields of medical specialization?

AREA/FIELD	BOARD CERTIFIED?	BOARD ELIGIBLE?
OBSTETRICS & GYN/OB/GYN SURGERY	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

If you are a foreign medical graduate, do you hold a permanent ECFMG certificate?
 YES NO If yes, number: _____

LIST THE MEDICAL/OSTEOPATHIC OR PUBLIC HEALTH ORGANIZATIONS OF WHICH YOU ARE A MEMBER:

AMERICAN OSTEOPATHIC ASSOCIATION

PENNSYLVANIA OSTEOPATHIC MEDICAL ASSOCIATION

SECTION III: GENERAL BACKGROUND

Have you ever been examined by FLEX (National Board) or State Boards? (Circle one)
 YES NO If yes, LOCATION: PHILA. PA. DATE: 1970

Have you ever failed a licensing exam? NO If yes, give details: _____

Have you ever been convicted of a felony or been convicted of drug addiction? YES NO

Have you ever been convicted of violating the Medical or Osteopathic Practice Act of another state? YES NO

Have you ever been engaged in the practice of medicine or osteopathy without a license? YES NO

Have you ever been refused a narcotic license or had such a license modified or suspended or cancelled, or have you prescribed narcotic drugs unlawfully? YES NO

Have you ever willfully violated the confidence of a patient? YES NO

Have you ever been convicted of fraud? YES NO

If yes to any of the above, explain circumstances and outcome: _____

Are you now, or have you ever been dependent upon the use of alcohol, stimulants, or habit-forming drugs or been treated or disciplined or their use? NO If yes, explain circumstances and outcome: _____

Are you physically and mentally capable of engaging in the practice of medicine and surgery according to generally accepted standards, and would you submit to an examination to determine such capability as the Board may deem necessary? YES
Have you had either mental or physical illness which interfered with your practice for over a month? NO If so, please describe: _____

Have you ever had a medical or osteopathic license denied, revoked, suspended, or limited or been under probation? () YES () NO

If yes, explain circumstances and outcome: _____

Have you ever had any action taken against you by the Narcotics Bureau of the Treasury Department or the Drug Enforcement Agency of the Department of Justice or the State Narcotic Agency in this country or any other country? () YES () NO If yes, explain circumstances and outcome: _____

Have you ever had a disciplinary action taken against you by a Medical or Osteopathic Society? NO If yes, please explain on a separate sheet.

Have you ever had a change in hospital privileges as a result of a disciplinary action taken by a hospital? NO If yes, please explain on a separate sheet.

Has a settlement ever been made or a verdict rendered against you in a malpractice action? YES If yes, please explain and report the ultimate disposition of the case on a separate sheet.

Are there any charges pending or are you under investigation regarding a felony or misdemeanor or unprofessional conduct, or professional misconduct, or malpractice? NO If yes explain on a separate sheet.

Have you ever been granted medical licensure by a State or Territory?

() YES () NO If yes, please list:

STATE OR TERRITORY	LICENSE NUMBER	EFFECTIVE DATE
PENNA	OS 2825 L.	1921
NEW JERSEY	M.D. 54-163	1991
MARYLAND	H-41303	1991
NEW YORK	1820311	1971
FLORIDA	0002981	
MISSISSIPPI } NEVER USED & ARE INACTIVE		
KENTUCKY }		

LIST LOCATIONS AND DATES OF MEDICAL OR OSTEOPATHIC EXPERIENCE, INCLUDING PRESENT:

LOCATION	HOSPITAL PRIVILEGES	DATES	NAME OF CHIEF OF SERVICE (note if Public Health or Government)
PHILA PA	HOSP PCOM	1975-PRESENT	
SPRINGFIELD DEL. CO.	SPRINGFIELD HOSP	1985-1990	
PHILA PA	PARKVIEW HOSP	1990-PRESENT	
PHILA PA	GERMANTOWN HOSP	1992-PRESENT	

ARMED SERVICES EXPERIENCE, IF APPLICABLE: _____

Resume of other medical or osteopathic experience (Please be sure all years are accounted for since medical school): _____

ADDRESS OF PRESENT PRACTICE:

ADDRESS 2 PENN BLVD TELEPHONE 844 8570
CITY PHILA STATE PA ZIP 19144

If this license is granted, do you intend to change the location of your practice or activity? () YES () NO

If yes, give location and date of intended establishment of practice:

LOCATION ACTIVITY D CHANGE DATE _____
Why are you applying for a Delaware license? TO ASSIST PHYSICIANS IN ESTABLISHING DR. - ASSIST IN HULLDAY, USEREND, ROYERAGE IN OBSTETRICS & GYNICOLOGY.

ACADEMIC APPOINTMENTS:

WHERE YEAR

(list or attach)
ASSOCIATE PROF DEPT OF OB-GYN; PHILA COLL OF OSTEOPATHIC MEDICINE, 1975-PRESENT.

AUTHOR OF PAPERS (list or attach): _____

IS THIS AN APPLICATION FOR RECIPROCIITY? () YES () NO

I received the degree of Doctor of Osteopathy (Circle one) from the UNIVERSITY OF OSTEOPATHY College.

located at 7105 INDEPENDENCE AVE H.C.M.O. on the 21 day of MAY 1990

I am the person named in the diploma submitted and am the lawful possessor of same.

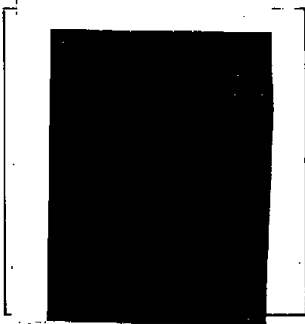
The photograph submitted is a true likeness of myself and was taken within sixty days prior to the date of this application.
Date 8/18/93 WARREN T. TAYLOR MD (Name in full)
County of Phila State of PA In Phila in said county on this 4th day of AUGUST 1993. WARREN T. TAYLOR MD personally appeared before me, has been duly sworn, deposes, and says that he has read carefully and truthfully answered the above questions.

NOTARIAL SEAL
PATRICIA BLEWITT, Notary Public
City of Philadelphia, Phila. County
My Commission Expires Aug. 29, 1994

Patricia Blewitt
Notary Public

My commission expires _____

Note: Passport-size photograph mounted on the thinnest paper obtainable. After pasting, place under weight till dry to insure smooth surface.



SECTION IV: CERTIFICATIONS AND AFFIDAVIT (copy of certificate of medical school diploma must be submitted in addition to certification.)

CERTIFICATE OF MEDICAL OR OSTEOPATHIC EDUCATION

It is hereby certified that _____ of _____ matriculated in _____ at _____ Date _____ attended _____ course of lectures of _____ months each, and received a diploma from _____ conferring the degree of Doctor of Medicine or Osteopathic Medicine.

(Date) TO BE SENT DIRECTLY TO THE BOARD BY THE UNIVERSITY
(President, Secretary or Dean) WARREN T. TAYLOR MD

(Seal)

*** CERTIFICATE OF POSTGRADUATE MEDICAL OR OSTEOPATHIC EDUCATION OR EQUIVALENT DOCUMENTS**

This certifies that Dr. _____ has rendered satisfactory and continuous service as an intern or resident in the _____ (Department) in _____ Hospital at _____ from _____ to _____ Date _____ Chief Administrative Officer of Hospital

If postgraduate education in more than one institution, additional signature and certification required:
This certifies that Dr. _____ has rendered satisfactory and continuous service as an intern or resident in the _____ (Department) in _____ Hospital at _____ from _____ to _____ Date _____ Chief Administrative Officer of Hospital

This certifies that Dr. _____ has rendered satisfactory and continuous service as an intern or resident in the _____ (Department) in _____ Hospital at _____ from _____ to _____ Date _____ Chief Administrative Officer of Hospital

* METROPOLITAN HOSPITAL IS NOW IN RECEIVERSHIP AND APPROPRIATE DOCUMENTATION IS BEING SENT DIRECTLY TO YOU BY THE AMERICAN OSTEOPATHIC ASSOCIATION IN CHICAGO.
WARREN T. TAYLOR MD
(to be completed if previously certified or licensed by another state)

**CERTIFICATE OF SECRETARY OF STATE BOARD ISSUING ORIGINAL LICENSE
AND ATTACH CERTIFICATION OF NATIONAL BOARD, FLEX, ECFMG, AND STATE BOARD SCORES**

I, _____ Secretary of the _____
_____, certify that _____
was granted Certificate No. _____ to practice medicine or osteopathic in the State of _____
on the _____ day of _____, 19____, based on written examination, and that said certificate has never
been revoked.

(SEAL OF STATE BOARD)

Secretary

Place _____ Date _____

RECOMMENDATION FROM CHIEF OF STAFF OR CHIEF OF SERVICE

I, _____ a licensed and practicing physician in the State
of _____, affirm that _____
(Full name of applicant)
has been known to me personally and professionally for the period of _____ years, and that he/she is an ethical practitioner
and is of good moral and professional character. I hereby recommend said applicant for a license to practice medicine or
osteopathy in the State of Delaware.

Signed _____
(Must be acknowledged before a Notary Public)

(SEAL)

Title _____

Medical license number and State _____

Date _____
Notary Public

Commission expires _____

RECOMMENDATION FROM MEDICAL SOCIETY

I, _____ Secretary of the _____ Medical Society,
Located in _____, _____, affirm that
(Full name of applicant)
_____ is a member in good standing of the
_____ Medical Society and that he/she is an ethical
practitioner and is of good moral and professional character. I hereby recommend said applicant for a license to practice
medicine or osteopathy in the State of Delaware.

Signed _____
(Must be acknowledged before a Notary Public)

(SEAL)

Medical license number and State _____

Date _____
Notary Public

Commission expires _____

Kansas City College of Osteopathy and Surgery

To all persons to whom these presents may come, Greeting:

Be it known that

Warren Irving Taylor

Having satisfied the requirements for the degree of

Doctor of Osteopathy

And having been recommended by the faculty is
now admitted to that degree with all the rights and privileges
and immunities thereto appertaining

In Witness Whereof, we the trustees of this College have caused our
Corporate Seal and the proper signatures to be hereunto affixed.

Given at Kansas City, Missouri, on the twenty-first day of May, in the
year of our Lord one thousand nine hundred seventy.



President of the Board of Trustees

Secretary of the Board of Trustees

Rudolph S. Bremen
President of the College

R. Davis, D.O.
Dean of the College





State of Missouri

Mel Carnahan, Governor

Department of Economic Development
Division of Professional Registration

State Board of Registration for the Healing Arts

P.O. Box 4
Jefferson City, Missouri 65102
Telephone 314/751-0098
FAX: 314/751-3166

September 19, 1993

Gayle Melvik
Delaware Board of Medical Practice
Margaret O'Neill Building, 2nd Floor
Federal & Courts Sts.
Dover, DE 19903


SEP 27 '93

To Whom it May Concern:

I am writing to certify that Warren Taylor, M.D., a licensed physician was granted State license number MD32898 to practice in the State of Missouri on the 20th day of July, 1970. The license expired sometime before 1980 due to nonrenewal.

I further certify that the license is in good standing with this office.

Thank you for your inquiry and if we may be of further assistance please do not hesitate to contact our office.

Sincerely,

Sara Perrigo
Secretary

/sp

STATE SEAL

DATE: 09/10/1993

DCOGGINS

LICENSURE VERIFICATION

This is to certify that the records of the
BD OF OSTEOPATHIC MEDICINE
indicate that the person listed below was issued a
license in the State of Florida for the occupation of
OSTEOPATH

Name: TAYLOR, WARREN I

License No.: 0002981

Type of License: LICENSE

Method of Licensure:

Original Licensure Date: 07/01/1971

Expiration Date: 01/31/1994

Current Status of License: ACTIVE

SEP 27 1993

Complaints against licensee = Yes No

State of Florida
Department of Professional Regulation
Board of Osteopathic Medical Examiners
A copy of this request is being forwarded
to our Legal Section for research and
response regarding the existance of any
derogatory information on this individual.

Melissa Coggins

Department of Professional Regulation
Board of Osteopathic Medicine
1940 North Monroe Street
Tallahassee, Florida 32399-0757



DEPARTMENT OF BUSINESS & PROFESSIONAL REGULATION

Lawton Chiles
Governor

September 22, 1993

Delaware Board of Medical Practice
Margaret O'Neill Building, 2nd Floor
Federal & Court Streets
Dover, DE 19903

SEP 27 1993

RE: Warren I. Taylor

To Whom It May Concern:

Your request for information has been forwarded to my office for response regarding the disciplinary history of the above-referenced physician.

A search of the Department of Business and Professional Regulation computer files reveals no past or pending disciplinary action against the referenced licensee.

If I can be of further assistance, please feel free to contact me.

Sincerely,

A handwritten signature in cursive script that reads "Sarah Wachman".

Sarah Wachman
Agency Clerk

SW:pc

DIVISION OF REGULATION
AGENCY CLERK

NORTHWOOD CENTRE • 1940 NORTH MONROE STREET • TALLAHASSEE, FLORIDA 32399-0782

Telephone (904) 921-0342 • Fax (904) 487-9622

Royce E. Dawson, M.D.
President



Telephone (502) 429-8046
Fax (502) 429-9923

KENTUCKY BOARD OF MEDICAL LICENSURE

HURSTBOURNE OFFICE PARK
310 Whittington Parkway, Suite 1B
Louisville, Kentucky 40222

FROM: C. William Schmidt, Executive Director

RE: Warren I. Taylor, M.D.

DATE: 09-01-93

SEP 7 1993

TO WHOM IT MAY CONCERN:

In response to your recent inquiry as to whether or not the above mentioned physician holds a medical license in Kentucky, please be advised of the following:

Held Kentucky License number:

01794

Date of Issuance:

7-1-71

Basis of Licensure:

KY State Exam

Current Status* Inactive due to non-payment of annual fees

Expiration date:

None

Derogatory Information:

None

* Licensure in Kentucky is permanent. Annual renewal is due by March 01 of each year.

CWS/tec

AMA PHYSICIAN PROFILE

AMERICAN MEDICAL ASSOCIATION
515 NORTH STATE STREET
CHICAGO, ILLINOIS 60610

DIVISION OF SURVEY AND DATA RESOURCES
DEPARTMENT OF PHYSICIAN DATA SERVICES

DATE: 08-19-93
TIME: 8:30 PM

NAME: TAYLOR, WARREN I, D.O.

ADDRESS: [REDACTED]
UPPER DARBY PA 19083

BIRTHPLACE: [REDACTED]

BIRTHDATE: [REDACTED]

MEMBER OF AMA: NON-MEMBER

MEDICAL SCHOOL: 028-78

UNIV OF HLTH SCI, COLL OF OSTEO MED, KANSAS CITY MO 64124

YEAR OF GRADUATION: 1970

LICENSES (INITIAL YEAR GRANTED BY STATE):

PA 1971

NJ 1989

NY 1990

MD 1991

NATIONAL BOARD CERTIFICATION: NONE REPORTED TO DATE

SPECIALTY BOARD CERTIFICATION: NONE REPORTED TO DATE

PHYSICIAN'S-PROFESSIONAL ACTIVITIES: NOT CLASSIFIED

SELF DESIGNATED SPECIALTIES

PRIMARY: UNSPECIFIED

SECONDARY: UNSPECIFIED

TERTIARY: UNSPECIFIED

CURRENT MEDICAL TRAINING: NONE REPORTED TO DATE

PRIOR MEDICAL TRAINING: NONE REPORTED TO DATE

FELLOWSHIP: NONE REPORTED TO DATE

THE FOLLOWING IS HISTORICAL. CHECK WITH PRIMARY SOURCES FOR CURRENT STATUS:

NATIONAL SCIENTIFIC MEDICAL SOCIETIES: NONE REPORTED TO DATE

PROFESSORIAL APPOINTMENT: NONE REPORTED TO DATE

COPYRIGHT 1993 AMERICAN MEDICAL ASSOCIATION. SEE REVERSE. ****AMA FILES CHECKED

AMA Physician Profile (continued)

It is mutually agreed between the American Medical Association (AMA) and the requesting organization that this Physician Profile (see reverse) is provided to the requesting organization with the understanding that (1) the information on the Profile will be treated with total confidentiality; (2) that such information is granted solely to the requesting organization and is granted as a non-exclusive limited license, consistent with and limited to the specific purposes set forth on the Physician Profile request form; (3) that no Profile information will be released, copied, extracted or otherwise usurped for the use by any other party, entity, organization or government agency; and (4) that upon a breach of any of the foregoing covenants or upon the effective date of any statute, regulation or court decision mandating any disclosure whatsoever of such Profile information by the requesting organization, such license to use and possess the Profile shall be automatically and immediately terminated and the Profile and any information or data contained thereon or, in any way, derived therefrom shall be returned to the AMA immediately, but, in no event, later than 48 hours after such automatic termination.

National Board of Osteopathic Medical Examiners

2700 River Road, Suite 407, Des Plaines, Illinois 60018 (708) 635-9955

TRANSCRIPT

<u>Part I passed</u>	Scaled Score*1	Standard Score*2
Anatomy	79	
Physiology	80	
Biochemistry	78	
Pharmacology	76	
Pathology	77	
Microbiology	71	
Osteopathic Principles	78	
Scaled Score Average OR Minimum Total Passing Score 75/400		77

<u>Part II passed</u>		
Surgery	77	
Obstetrics & Gynecology	75	
Psychiatry	80	
Community Medicine & Medical Humanities*3	78	
Pediatrics	79	
Internal Medicine	70	
Medical Jurisprudence*3	79	
Osteopathic Principles	N/A	
Scaled Score Average OR Minimum Total Passing Score 75/400		77

<u>Part III passed</u>	
General Test of Clinical Competence	85
Scaled Score Average OR Minimum Total Passing Score 75/350	


- *1 Examinations taken prior to February 1987 are reported as scaled scores.
*2 Beginning in 1987 NBOME criteria for certification are based upon candidate's total score in Part I, Part II and Part III and not scores of individual subjects within each Part.
*3 Prior to March 1990, Part II included the areas of 'Preventive Medicine and Public Health' and 'Medical Jurisprudence'. Currently, those are combined in the area of 'Community Medicine and Medical Humanities'.

I, Joseph F. Smoley, Ph.d., Executive Director of the National Board of Osteopathic Medical Examiners, Inc., do hereby certify the above to be a true report of the record of

Warren Irving Taylor, D.O.

awarded Diplomate Certificate No. 1458 on July 1, 1971.

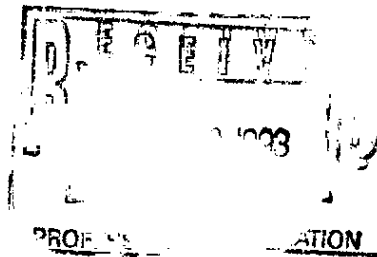
August 31, 1993
Date Prepared



Joseph F. Smoley, Ph.D.
Executive Director

THE UNIVERSITY OF THE STATE OF NEW YORK
THE STATE EDUCATION DEPARTMENT
DIVISION OF PROFESSIONAL LICENSING SERVICES
CUSTOMER SERVICE UNIT
CULTURAL EDUCATION CENTER
ALBANY, NEW YORK 12230

DATE 08/23/93



TO WHOM IT MAY CONCERN:

YOU HAVE INQUIRED AS TO WHETHER OR NOT A LICENSE TO PRACTICE
MEDICINE IN NEW YORK STATE HAS
EVER BEEN ISSUED TO: TAYLOR WARREN IRVING

THIS PERSON IS LICENSED AND IS CURRENTLY REGISTERED. OUR RECORDS
INDICATE THE ADDRESS BELOW:

[REDACTED] BRYN MAWR

PA 19010-0000

LICENSE NUMBER: 182031 LICENSURE DATE: 05/09/90.
CURRENT REGISTRATION EXPIRES: 12/31/94.

THIS LICENSE IS IN GOOD STANDING

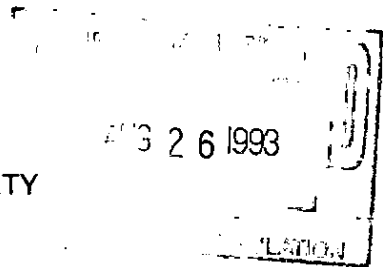
Clairie Alston
VERIFICATION CLERK



State of New Jersey

DEPARTMENT OF LAW AND PUBLIC SAFETY
DIVISION OF CONSUMER AFFAIRS
BOARD OF MEDICAL EXAMINERS

28 WEST STATE STREET
TRENTON, NEW JERSEY 08608
609 - 292 - 4843



ROBERT J. DEL TUFO
ATTORNEY GENERAL

EMMA N. BYRNE
DIRECTOR

AUGUST 20, 1993

STATE OF DELAWARE
DEPT OF ADMINISTRATION SERVICED
DIVISION OF PROFESSIONAL REGULATION
MARGARET O'NEILL BLDG
P.O. BOX 1401
DOVER, DE 19903

RE: WARREN I TAYLOR, D.O.
LICENSE #54163
ISSUED: 11/29/89
EXPIRATION: 6/30/95

TO WHOM IT MAY CONCERN:

The New Jersey State Board of Medical Examiners has been requested by the above captioned to forward a letter of good standing regarding the physician's license to practice medicine and surgery in the State of New Jersey.

Please be advised that the records of this office reflect that the above captioned is licensed to practice medicine and surgery in the State of New Jersey and holds the above noted New Jersey medical license. This physician is currently registered in accordance with New Jersey State Law and his/her file reveals no derogatory information.

Very truly yours,

Charles A. Janousek
Charles A. Janousek
Executive Director

CAJ/ly

MARYLAND BOARD OF PHYSICIAN QUALITY ASSURANCE
P.O. Box 2571
4201 Patterson Avenue
Baltimore, MD 21215-0095

19-AUG-1993

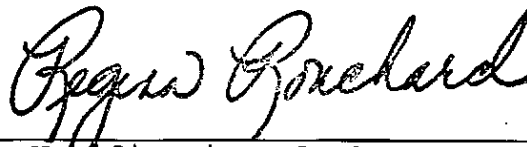
Requested by: DE. DIV. OF PROF. REGULATION

This is to verify that the records of the Board of Physician Quality Assurance indicate the following information regarding:

TAYLOR, WARREN I
[REDACTED]
BRYN MAWR, PA 19010

License number	: H0041303
Date issued	: 02/11/91
Current status	: Active
Expiration date	: September 30, 1995
Medical school code	:
Licensed by	: National Board Cert
Specialty	:
Disciplinary actions	: NONE ON RECORD

- Details of disciplinary action will be made available by photocopy from the public file upon written request only and with a signed release from the physician.
- See attached



Verification Clerk

AUG 19 1993

Date

This is a computer generated form which is acceptable by other States. Licensing examination scores should be requested directly from the examining authority.

Osteopathic Medical Center of Philadelphia
4150 City Avenue, Philadelphia, Pennsylvania 19131-1696

(215) 871-1144

Department of Obstetrics & Gynecology
Saul Jeck, D.O., FACOOG
Professor and Chairman

Osteopathic

August 17, 1993

State of Delaware
Department of Administrative Services
Division of Professional Regulation
Margaret M. O'Neill Bldg.
P.O. Box 1401
Dover, Delaware 19903

Att. Gayle L. Melvin

RE: Warren Taylor, D.O.

Dear Sir:

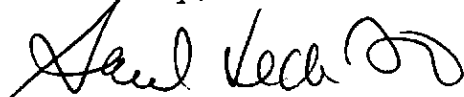
It is with a great deal of pleasure that I recommend Warren Taylor for the position that he seeks with your institution.

I have known Warren for the past 20 years and during that time he has earned himself a fine reputation as being a competent and skilled physician who has always provided his patients with the finest health care.

Warren is a caring physician who has served on the staff at the Phila. College of Osteopathic medicine as an Associate Professor of Obstetrics and Gynecology. In this capacity, he has contributed to the education of the students, interns, and OB/GYN residents.

I know that he will be an asset to your institution, and I therefore recommend him without reservation.

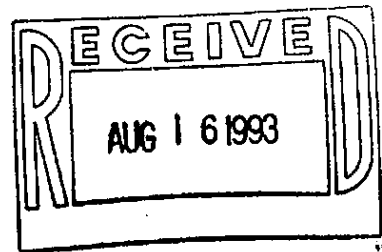
Sincerely,



Saul Jeck, D.O. FACOOG
Chairman, OB/GYN Dept.



STATE OF DELAWARE
 DEPARTMENT OF ADMINISTRATIVE SERVICES
 BOARD OF MEDICAL PRACTICE
 MARGARET O'NEILL BUILDING
 P.O. Box 1401
 DOVER, DELAWARE 19903



TELEPHONE: (302) 736-4522

DISCIPLINARY INQUIRIES

Federation of State Medical Boards
 2630 West Freeway, Suite 138
 Fort Worth, Texas 76102-7999

The Delaware Board of Medical Practice requests a disciplinary search concerning the following individual:

Taylor, Warren Irving
 Name

[Redacted]
 Address

Bryn Mawr, PA 19010-2020
 City, State and Zip

[Redacted]
 Date of Birth

[Redacted]
 Social Security Number

Kansas City College of Osteopathy and Surgery,
 Medical School of Graduation and Branch Location

1970
 Date of Graduation Kansas City, Missouri

Please mail the response to the following address:

Delaware Board of Medical Practice
O'Neill Bldg., P.O. Box 1401
Dover, DE 19903

WE HAVE NO UNFAVORABLE INFORMATION
 REGARDING THE ABOVE NAMED PHYSICIAN

AUG 19 1993

ATTENTION: Rosemarie S. Vanderhoof

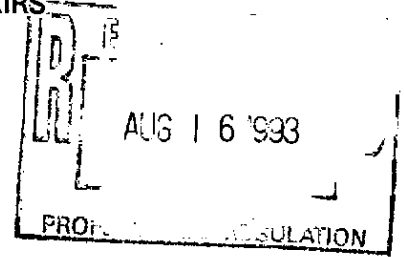
James R. Winn, M.D.
 JAMES B. WINN, M.D.
 EXECUTIVE VICE-PRESIDENT

Rosemarie S. Vanderhoof
 Signature



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS

P.O. BOX 2649
HARRISBURG, PA 17105-2649



WARREN I TAYLOR

[REDACTED]
BRYN MAWR PA 19010

AUGUST 09, 1993

STATE BOARD OF OSTEOPATHIC MEDICINE

WARREN I TAYLOR

OSTEOPATHIC PHYSICIAN AND SURGEON

TO WHOM IT MAY CONCERN:

THIS IS TO CERTIFY THAT THE ABOVE NAMED PERSON IS LICENSED IN THE COMMONWEALTH OF PENNSYLVANIA, DEPARTMENT OF STATE, STATE BOARD OF OSEOPATHIC MEDICINE.

THE RECORDS OF THE PENNSYLVANIA STATE BOARD OF OSTEOPATHIC MEDICINE SHOW NO DEROGATORY INFORMATION AGAINST THIS LICENSE.

ORIGINAL LICENSURE DATE: JULY 19, 1971
EXPIRATION DATE: OCTOBER 31, 1994
LICENSE NUMBER: OS-002825-L

George L. Shevlin

George L. Shevlin
Commissioner



STATE OF DELAWARE
 DEPARTMENT OF ADMINISTRATIVE SERVICES
 BOARD OF MEDICAL PRACTICE
 MARGARET O'NEILL BUILDING
 P.O. BOX 1401
 DOVER, DELAWARE 19903

REC'D
 AUG 9 1993

HEALTH BOARDS DIVISION
 (302) 739-4522
 TELEPHONE: (302) 736-4722

VERIFICATION FROM STATE IN WHICH APPLICANT ACTIVELY PRACTICES

Please complete Section I listing ALL states in which you have been licensed to practice Medicine or Osteopathy. Forward to the State in which you hold a current license for their completion of Section II. Place photograph on back of form.

SECTION I

I certify that I have been licensed to practice Medicine or Osteopathy in the following States during the time indicated below:

NAME OF STATE

<u>PENNSYLVANIA</u>	from <u>1971</u>	until <u>PRESENT</u>
	(Year of Licensure)	
<u>NEW JERSEY</u>	from <u>1991</u>	until <u>PRESENT</u>
<u>MARYLAND</u>	from <u>1991</u>	until <u>PRESENT</u>
<u>NEW YORK</u>	from <u>1990</u>	until <u>PRESENT</u>
<u>FLORIDA</u>	from <u>1971</u>	until <u>PRESENT</u>

I also certify that I am currently actively practicing medicine or osteopathy in the following State: PENNSYLVANIA
 (Name of State)

DATE: August 4, 1993

WARREN I. TAYLOR D.O.
 Applicant's Name (Please Print)

Warren I. Taylor D.O.
 Applicant's Signature

SECTION II - FOR COMPLETION BY STATE IN WHICH APPLICANT HOLDS A CURRENT LICENSE

I hereby certify that: WARREN I. TAYLOR NISC# 000528251

- A. The applicant is licensed to practice medicine or osteopathy in DELAWARE
 Name of State
- B. To my knowledge, the applicant is licensed to practice medicine or osteopathy in the other states listed above.
- C. Applicant has not been disciplined by this licensing Board or to my knowledge by licensing Boards in other States. (If not the case, please list circumstances surrounding disciplinary action on separate sheet.)

(OVER)

BOARD OF ELECTRICAL EXAMINERS
REAL ESTATE COMMISSION
BOARD OF PILOT COMMISSIONERS
BOARD OF ACCOUNTANCY
REGISTRATION FOR PROFESSIONAL LAND SURVEYORS
BOARD OF EXAMINERS OF ARCHITECTS
BOARD OF CHIROPRACTIC EXAMINERS
BOARD OF COSMETOLOGY & BARBERING
BOARD OF DENTAL EXAMINERS
BOARD OF MEDICAL PRACTICE
BOARD OF NURSING
BOARD OF EXAMINERS IN OPTOMETRY
BOARD OF PHARMACY
EXAMINING BOARD OF PHYSICAL THERAPY
BOARD OF PODIATRY
BOARD OF ADULT ENTERTAINMENT
COUNCIL ON REAL ESTATE APPRAISERS
GOVERNOR'S MAGISTRATE
SCREENING COMMITTEE



PRIVATE EMPLOYMENT AGENCIES
ATHLETIC COMMISSION
GAMING CONTROL BOARD
BOARD OF REGISTRATION GEOLOGISTS
BOARD OF LANDSCAPE ARCHITECTURE
DEADLY WEAPONS DEALERS
BOARD OF EXAMINERS OF PSYCHOLOGISTS
BOARD OF FUNERAL SERVICES
BOARD OF VETERINARY MEDICINE
BOARD OF EXAM. OF NURSING HOME ADMIN.
BOARD OF EXAM. OF SPEECH PATHOLOGY &
AUDIOLOGY
BOARD OF SOCIAL WORK EXAMINERS
BOARD OF PROFESSIONAL COUNSELORS OF
MENTAL HEALTH
BOARD OF OCCUPATIONAL THERAPY
PHYSICIAN ASSISTANT ADVISORY COUNCIL
COMMITTEE ON MASSAGE/
BODYWORK PRACTICE

STATE OF DELAWARE
DEPARTMENT OF ADMINISTRATIVE SERVICES
DIVISION OF PROFESSIONAL REGULATION
MARGARET M. O'NEILL BUILDING
P.O. Box 1401
DOVER, DELAWARE 19903

OFFICE OF THE
DIRECTOR

TELEPHONE: (302) 739 - 4522

Date: 8-10-93

Dear Dr. Taylor:

This office is in receipt of your application to practice medicine and surgery in the State of Delaware. In order to complete your application you must submit the following documentation:

1. Copy of medical school diploma and verification of medical school education from institution.
2. Verification of Post Graduate Training.
3. Recommendation from Chief of Staff or Chief of Service.
4. Verification of licensure from States where licensure has been granted. *Pennsylvania, New Jersey, Maryland, New York, Florida, Missouri & Kentucky*
5. Check made payable to the State of Delaware in the amount of \$179.00.
6. State Board Scores, National Board Scores or FLEX Scores.
7. Other: _____

Your prompt response will enable this office to begin processing your application for licensure.

Sincerely,

Gayle L. Melvin

Gayle L. Melvin
Administrative Assistant

Metropolitan Hospital

an Osteopathic Institution
Philadelphia, Pennsylvania

This is to Certify that

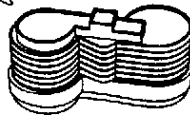
Warren Irving Taylor, D. O.

has faithfully and satisfactorily performed the duties of
Resident in Obstetrics and Gynecology
in this Hospital from July 1, 1974 to June 30, 1975.



David Selverman, M.D., F.A.C.S.
President, Board of Directors

Henry Hobbs, D.O.
Chairman, Medical Staff



Robert A. ...
Medical Director

Wayne G. ...
Executive Director

Metropolitan Hospital

an Osteopathic Institution
Philadelphia, Pennsylvania

This is to Certify that
Warren J. Taylor, D. O.
has faithfully and satisfactorily performed the duties of
Resident Intern
in this Hospital from July 1, 1970 to June 30, 1971
the end of his term.

David Seligman, D.O. F.A.C.S.
President, Board of Directors

Roscoe W. Lewis, D. O.
Medical Director

Paul Barsky, D.O. F.A.C.O.E.
Chief of Staff

John R. McJannet
Superintendent





STATE OF DELAWARE
 DEPARTMENT OF ADMINISTRATIVE SERVICES
 BOARD OF MEDICAL PRACTICE
 MARGARET O'NEILL BUILDING
 P.O. BOX 1401
 DOVER, DELAWARE 19903

AUG 16 1993

(302) 738-4522
 TELEPHONE (302) 738-4722

VERIFICATION OF MEDICAL SCHOOL DEGREE

TO BE FILLED OUT BY APPLICANT:

I certify that I attended the following Medical or Osteopathic Schools during the times indicated below:

DATES	NAME OF INSTITUTION & LOCATION
1st year: from <u>Sept.</u> , 19 <u>66</u> to <u>May/NE</u> , 19 <u>67</u>	KANSAS CITY COLLEGE OF OSTEOPATHY & SURGERY NEW NAME - PRESENTLY IS UNIV. HEALTH SCIENCES
2nd year: from <u>Sept</u> , 19 <u>67</u> to <u>June</u> , 19 <u>68</u>	
3rd year: from <u>Aug</u> , 19 <u>68</u> to <u>May/NE</u> , 19 <u>69</u>	
4th year: from <u>May</u> , 19 <u>69</u> to <u>May</u> , 19 <u>70</u>	

I received a Degree of Doctor of Medicine or Doctor of Osteopathy from
KANSAS CITY COLL. OF OSTEOPATHY & SURGERY at 2105 INDEPENDENCE AVE
 (Name of School) KANSAS CITY MISSOURI (Location)
 on MAY 21, 1970, 19 .
 (Date of Degree)

Social Security Number [REDACTED]
 Date 8/4/93
 Signature of Applicant MORRIS J. TAYLOR, D.O.



I hereby certify that:
 A. The above statements of the applicant are correct and in accord with the records upon which he was admitted to the degree of Doctor of Medicine or Doctor of Osteopathy.

8. The photograph hereunto attached and upon which our official seal has been impressed is that of the person making the application,

WARREN E. TAYLOR D.O.

(Name of Applicant)

Applicant must secure recent photograph here:



If officer is unable to identify applicant from photograph, strike through 8 and do not impress photograph with seal.

President
Secretary
Dean


Stephen M. Payson, M.S.

of UHS-College of Osteopathic Medicine
Name of School Confirming Degree

Associate Dean for Student Affairs

Date: August 10, 1993

Please return to:

Delaware Board of Medical Practice
Margaret O'Neill Building, P.O. Box 1401
Dover, Delaware 19903



American Osteopathic Association

DEPARTMENT OF EDUCATION
DIVISION OF POSTDOCTORAL TRAINING

August 5, 1993

State Board of Medical Practice
Margaret O'Neill Building
Post Office Box 1401
Dover, Delaware 19903

AUG 9 1993

Re: Warren I. Taylor, D.O.
(AOA #29306)

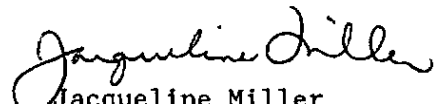
To whom it may concern:

Dr. Warren I. Taylor has asked us to contact you since the institution at which he completed his internship and residency in obstetrics/gynecology -- Metropolitan Hospital (Philadelphia, Pennsylvania) -- is no longer in operation under that name.

Dr. Taylor is a member in good standing of the American Osteopathic Association. This is to verify that he completed a traditional rotating osteopathic internship at Metropolitan Hospital (Philadelphia, Pennsylvania) during the period July 1, 1970 through June 30, 1971, and completed a residency in obstetrics/gynecology at that same facility during the period July 1, 1971 through June 30, 1975.

The American Osteopathic Association is the official repository of internship and residency contracts and biographical training records of osteopathic physicians. If we can provide any further information, please contact us.

Sincerely yours,


Jacqueline Miller
Administrator, Division
of Postdoctoral Training

Copy to Warren I. Taylor, D.O.


Bryn Mawr, Pennsylvania 19010-2020

National Board of Examiners
For
Osteopathic Physicians and Surgeons
of the
United States of America

Warren Irving Taylor, D.O.

having satisfied all the requirements and having successfully
passed the examinations is hereby declared a

Diplomate of the National Board of Examiners

For Osteopathic Physicians and Surgeons



Spencer J. Brasfield, D.O.
President of the Board

Certificate No. 1458

Date July 1, 1971

Wesley L. Hawley, D.O., LL.M., J.D.
Secretary of the Board

AUG. 4, 1993

I HAVE HAD TWO SETTLEMENTS MADE IN MY BEHALF.
THE SETTLEMENTS WERE RECOMMENDED TO ME BY
INS. CARRIER AS FRIVOLOUS. I HAVE ALSO BEEN
NAMED IN A CASE & WAS SUBSEQUENTLY DROPPED WITH
NO SETTLEMENT; NO VERDICTS HAVE EVER BEEN MADE
OR RENDERED AGAINST ME; THERE ARE NO CASES
PENDING OR SUSPECTED.

ANDREW S. TAYLOR D.D.

Commonwealth of Pennsylvania



Department of State

State Board of Osteopathic Examiners

To All To Whom These Presents Shall Come Greeting:

Warren Irving Taylor

Whereas, It appears that

having given satisfactory evidence of fitness as to age, character, preliminary education, osteopathic instruction and all other matters required by law, and having been found duly qualified for the Practice of Osteopathy and Surgery in the State of Missouri, is hereby in accordance with the provisions of the Act of Assembly approved March 19, A.D. 1909 and subsequent amendments granted this License to Practice

Osteopathy and Surgery

In the Commonwealth of Pennsylvania

Ben F. Caprest D.C.
Harold E. Gordon D.O.
David Rotman D.O.
Abel W. ... D.O.
Leopold ... D.O.
H. C. ... D.O.



In Witness Whereof, We have hereunto set our hands and caused the Seal of the Commissioner of Professional and Occupational Affairs to be affixed at Harrisburg the ... month day of July 19 ...

Stanley H. ... Commissioner

The American Osteopathic Board
of
Obstetrics and Gynecology

This certifies that

Warren I. Taylor, D.O.

*having met all the requirements for Certification by the American Osteopathic
Board of Obstetrics and Gynecology is hereby declared competent to practice
The Specialty of*

Obstetrical-Gynecological Surgery

Signed and sealed this 18th day of July 19 81

A. S. Dyer, D.O., FACOG
Chairman-American Osteopathic Board of
Obstetrics and Gynecology

W. C. Orth, D.O., FACOG
Secretary-Treasurer-American Osteopathic Board
of Obstetrics and Gynecology

(Seal)

No. 443

Edward P. Crowell, D.O.
Executive Secretary-American Osteopathic
Association

HOME PHONE [REDACTED] BUSINESS PHONE SAME

BUSINESS ADDRESS [REDACTED] BRYN MAWR PA 19010-2020
HAVE YOU ACTIVELY PRACTICED MEDICINE (DONE MEDICALLY RELATED WORK) IN DELAWARE WITHIN THE PAST 2 YEARS? YES NO

SOCIAL SECURITY # [REDACTED] DATE OF BIRTH [REDACTED]

SOLO PRACTICE OR GROUP SOLO BOARD CERTIFIED YES NO
AREA OF SPECIALIZATION O.B.-GYNE
LIST HOSPITALS WHERE YOU HAVE PRIVILEGES CROWDER - WESTER MED CTR.
LIST OTHER STATE LICENSES PA, NJ, MD.

PLEASE SIGN THE CERTIFICATION BELOW IF TRUE.
I HEREBY CERTIFY THAT I HAVE COMPLETED, AND ON REQUEST CAN VERIFY, AT LEAST 40 HOURS OF CATEGORY I CONTINUING MEDICAL EDUCATION WITHIN THE PAST 2 YEARS AS REQUIRED BY LAW.

SIGNATURE Warren I. Taylor D.O. DATE 6/25/97

187

APPLICATION FOR RENEWAL

STATE OF DELAWARE
Division of Professional Regulation
P.O. Box 1401
Dover, DE 19903



AMOUNT ENCLOSED
\$ 204.00

PLEASE RETURN THIS PORTION WITH YOUR CHECK

PAY LATE CHARGE
IF NOT RECEIVED BY
DUE DATE
06/30/97

TAYLOR, WARREN I
[REDACTED]
BRYNMAWR, PA 19010

ACTIVITY PHYSICIAN D.O.	RENEWAL FEE <u>\$204.00</u>	LATE CHARGE \$105.00	I.D. NUMBER C2 0004218
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received 6/25/97. W.T. PLEASE X IF ADDRESS CHANGES ON REVERSE SIDE

BIENNIAL LICENSE FEE IS \$160.50 HOWEVER, ALL RENEWALS ARE SUBJECT TO A ONE-TIME REBATE OF \$18.65 FROM THE PREVIOUS LICENSE PERIOD. THE NET FEE DUE 6-30-95 IS \$141.85

Field of practice OBS-GYNE.
Specialty board certified? YES NO
Hospital (s) where you have staff privileges CROZER-CHESTER.

Other states where licensed PA, NJ, MD.
Have you actively practiced medicine (done medically related work) in Delaware within the past 2 years? YES Do you plan to in the next 2 years? YES (If neither, your license will be listed as inactive, though the fee and the CME requirement stays the same)

Please sign certification below if true.
I hereby certify that I have completed, and on request can verify, at least 40 hours of Category I Continuing Medical Education within the past 2 years as required by Law.

Signature Warren I Taylor D.O. Date 4/20/95
Social Security Number [REDACTED] Date of Birth [REDACTED]

STATE OF DELAWARE
Cannon Building, Suite 203
P.O. Box 1401
Dover, DE 19903



05/03/95 AMOUNT ENCLOSED \$141.85
\$0312 28/00 \$141.85
141.85

PLEASE RETURN THIS PORTION WITH YOUR CHECK

PAY LATE CHARGE
IF NOT RECEIVED BY
DUE DATE

TAYLOR, WARREN I
[REDACTED]
BRYNMAWR, PA 19010-2020

06/30/95

0000330

ACTIVITY	RENEWAL FEE	LATE CHARGE	I.D. NUMBER
PHYSICIAN D.O.	\$141.85	\$80.25	C2-0004218

PLEASE X IF ADDRESS CHANGES ON REVERSE SIDE

PLEASE NOTE THE EXPIRATION DATE OF THE NEW LICENSE PERIOD HAS BEEN CHANGED TO MARCH 31, 2001 . THE RENEWAL FEE FOR THE LICENSE HAS BEEN PRORATED ACCORDINGLY, PLUS A \$3.00 REBATE HAS BEEN APPLIED.

HOME PHONE () [REDACTED] BUSINESS PHONE () SAME AS [REDACTED]

BUSINESS ADDRESS 1719 DELAWARE AVE SUITE 200 WILMINGTON, DE.
HAVE YOU ACTIVELY PRACTICED MEDICINE (DONE MEDICALLY RELATED WORK) IN DELAWARE WITHIN THE PAST 2 YEARS? YES NO

SOCIAL SECURITY NUMBER [REDACTED] DATE OF BIRTH [REDACTED]

SOLO PRACTICE OR GROUP SOLO BOARD CERTIFIED YES NO

AREA OF SPECIALIZATION OB-GYN

LIST HOSPITALS WHERE YOU HAVE PRIVILEGES WHESTER-GRODEK-MED CTR. PA.

LIST OTHER STATE LICENSES PA; VA; FLA; MD; MAINE;

PLEASE SIGN THE CERTIFICATION BELOW IF TRUE.
I HEREBY CERTIFY THAT I HAVE COMPLETED, AND ON REQUEST CAN VERIFY AT LEAST 40 HOURS OF CATEGORY I CONTINUING MEDICAL EDUCATION WITHIN THE PAST 2 YEARS AS REQUIRED BY LAW.

SIGNATURE WARREN E. Taylor MD DATE 5/12/99

APPLICATION FOR RENEWAL

299
STATE OF DELAWARE
Division of Professional Regulation
861 SILVER LAKE BOULEVARD
CANNON BUILDING, SUITE 203
DOVER, DELAWARE 19904

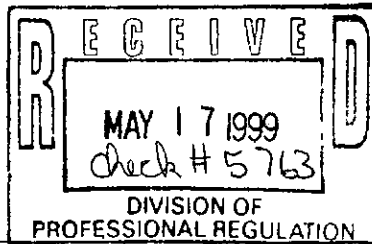


AMOUNT ENCLOSED
\$ 143.00

PLEASE RETURN THIS PORTION WITH YOUR CHECK

TAYLOR, WARREN I
[REDACTED]

BRYNMAWR, PA 19010



PAY LATE CHARGE
IF NOT RECEIVED BY
DUE DATE
6/30/99

ACTIVITY	RENEWAL FEE	LATE CHARGE	I.D. NUMBER
PHYSICIAN D.O.	\$143.00	\$73.00	C2 0004218

PLEASE X IF ADDRESS CHANGES ON REVERSE SIDE

5/27/99

Primary Phone: [redacted] Secondary Phone: [redacted] E-mail: [redacted]

Business Address*: [redacted] Bryn Mawr PA Social Security: [redacted]

Area of Specialization: OB-GYN Board Certified: Yes No Eligible

Since your last license renewal:

- A. Have you had any disciplinary action taken by an appropriate licensing authority in any state or territory? Yes No
- B. Have you voluntarily surrendered your license to practice medicine in any state or territory while under investigation? Yes No
- C. Have you had a felony conviction? Yes No

Are you aware that you have a duty to report to the Board of Medical Practice, in writing, any information you have reason to believe that a licensee is or may be medically incompetent, guilty of unprofessional conduct, or mentally or physically unable to engage safely in the practice of medicine, pursuant to 24 Delaware Code Section 1731A (see attached)? Yes No

Are you aware that there is a separate reporting requirement for malpractice actions and other matters as set forth in 24 Delaware Code Section 1728(c) (see attached)? Yes No

I hereby certify that the above information is true and correct. I also certify that I have completed and can verify at least forty (40) hours of continuing medical education in Category I courses approved by the American Medical Association or the American Osteopathic Association within the past two years, as required by Rule 22.0 of the Board's Rules and Regulations.

Signature: Warren I. Taylor D.O. Date: 2/4/03

*Pursuant to 24 Delaware Code Section 1714, it is the responsibility of the licensee to keep his or her address current with the Division of Professional Regulation.

Disclosure of a social security number is mandatory in accordance with 29 Del. C. § 8807 and 42 U.S.C. § 405 for the purpose of child support obligation enforcement. Disclosure may also occur: 1) to a governmental agency for civil or criminal law enforcement if authorized by law; 2) to a State agency for purposes related to the administration of any tax; or 3) for any purpose permitted or authorized under 42 U.S.C. § 405.

APPLICATION FOR RENEWAL

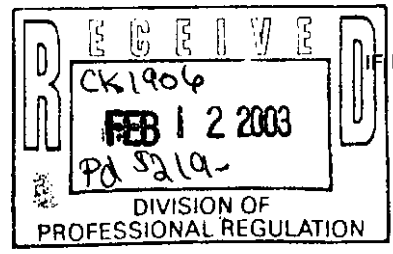
STATE OF ³⁷²DELAWARE
Division of Professional Regulation
861 SILVER LAKE BOULEVARD
CANNON BUILDING, SUITE 203
DOVER, DELAWARE 19904



AMOUNT ENCLOSED
\$ 219.00

PLEASE RETURN THIS PORTION WITH YOUR CHECK

TAYLOR, WARREN I
[redacted]
BRYN MAWR PA 19010



PAY LATE CHARGE
NOT POSTMARKED BY
DUE DATE
March 31, 2003

ACTIVITY Physician D.O.	RENEWAL FEE \$219.00	LATE CHARGE \$109.50	LICENSE NUMBER C2-0004218
----------------------------	-------------------------	-------------------------	------------------------------

FOR NEW ADDRESS, CHECK BOX AND COMPLETE REVERSE

Biennial renewal fee is \$142.00. However, all renewals are subject to a one-time rebate of \$6.00 from the previous license period. The net fee due March 31, 2001 is \$136.00

Primary Phone: [REDACTED] Secondary Phone: _____

Business Address: [REDACTED] BRYN MAWR, PA 19010-7020

Social Security Number: [REDACTED]

Area of Specialization: OB-GYN Board Certified: YES NO Eligible _____

Have you had any disciplinary action taken by an appropriate licensing authority in any state or territory?
YES _____ NO

Have you voluntarily surrendered your license to practice medicine in any state or territory while under investigation?
YES _____ NO

Do you have a felony conviction? YES _____ NO

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT. I ALSO CERTIFY THAT I HAVE COMPLETED, AND UPON REQUEST, CAN VERIFY AT LEAST 40 HOURS OF CATEGORY I CONTINUING MEDICAL EDUCATION APPROVED BY THE AMA OR AOA WITHIN THE PAST 2 YEARS AS REQUIRED BY LAW.

SIGNATURE: WARREN I. TAYLOR, D.O. DATE: 2/12/01

APPLICATION FOR RENEWAL

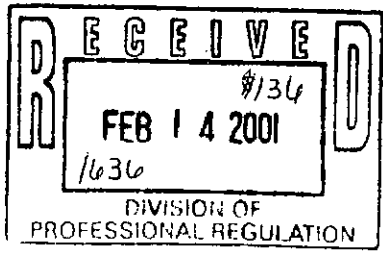
STATE OF DELAWARE
Division of Professional Regulation
P.O. Box 1401
Dover, DE 19903



AMOUNT ENCLOSED
\$ 136.00

PLEASE RETURN THIS PORTION WITH YOUR CHECK

WARREN I TAYLOR
[REDACTED]
BRYNMAWR, PA 19010



PAY LATE CHARGE
IF NOT RECEIVED BY
DUE DATE
03/31/2001

ACTIVITY Physician D.O.	RENEWAL FEE \$136.00	LATE CHARGE \$71.00	I.D. NUMBER C2-0004218
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PLEASE X IF ADDRESS CHANGES ON REVERSE SIDE

BOARD OF ELECTRICAL EXAMINERS
REAL ESTATE COMMISSION
BOARD OF PILOT COMMISSIONERS
BOARD OF ACCOUNTANCY
REGISTRATION FOR PROFESSIONAL LAND SURVEYORS
BOARD OF EXAMINERS OF ARCHITECTS
BOARD OF CHIROPRACTIC EXAMINERS
BOARD OF COSMETOLOGY & BARBERING
BOARD OF DENTAL EXAMINERS
BOARD OF MEDICAL PRACTICE
BOARD OF NURSING
BOARD OF EXAMINERS IN OPTOMETRY
BOARD OF PHARMACY
EXAMINING BOARD OF PHYSICAL THERAPY
BOARD OF PODIATRY
BOARD OF ADULT ENTERTAINMENT
COUNCIL ON REAL ESTATE APPRAISERS
GOVERNOR'S MAGISTRATE
SCREENING COMMITTEE



PRIVATE EMPLOYMENT AGENCIES
ATHLETIC COMMISSION
GAMING CONTROL BOARD
BOARD OF REGISTRATION GEOLOGISTS
BOARD OF LANDSCAPE ARCHITECTURE
DEADLY WEAPONS DEALERS
BOARD OF EXAMINERS OF PSYCHOLOGISTS
BOARD OF FUNERAL SERVICES
BOARD OF VETERINARY MEDICINE
BOARD OF EXAM. OF NURSING HOME ADMIN.
BOARD OF EXAM. OF SPEECH PATHOLOGY &
AUDIOLOGY
BOARD OF SOCIAL WORK EXAMINERS
BOARD OF PROFESSIONAL COUNSELORS OF
MENTAL HEALTH
BOARD OF OCCUPATIONAL THERAPY
PHYSICIAN ASSISTANT ADVISORY COUNCIL
COMMITTEE ON MASSAGE/
BODYWORK PRACTICE

STATE OF DELAWARE
DEPARTMENT OF ADMINISTRATIVE SERVICES
DIVISION OF PROFESSIONAL REGULATION
MARGARET M. O'NEILL BUILDING
P.O. Box 1401
DOVER, DELAWARE 19903

OFFICE OF THE
DIRECTOR

TELEPHONE: (302) 739-4522

9-27-93

Dear Dr. Yayia:

Your completed application for licensure to practice Medicine and Surgery in the State of Delaware has been received by this office.

In order to complete the application process, you must sit for two interviews with the Board Members listed below:

Dr. Thomas Scott - () [REDACTED]

Dr. E Wayne Martz () [REDACTED]

You must contact the two Board Members whose names and telephone numbers are listed above to schedule the interviews. The interviews must be conducted within ninety (90) days of the date of this letter.

If you have any questions concerning the above, please do not hesitate to contact me at (302) 739-4522.

Sincerely,

Gayle L. Melvin

Gayle L. Melvin
Administrative Assistant



DELAWARE HEALTH AND SOCIAL SERVICES
 Division of Public Health
 Office of Controlled Substances
 417 Federal Street • Dover, Delaware 19901
 302-744-4547

BIENNIAL REGISTRATION/RENEWAL APPLICATION

STATE OF DELAWARE UNIFORM CONTROLLED SUBSTANCES ACT
 ACT 16 • 47 SECTION 4732 *Lapsed - Can Renew*

PLEASE TYPE OR PRINT

CSA Number <i>Look up</i> For State Use Only <i>200307</i>	RENEWAL DATE <i>6-30-09</i>	AMOUNT RECEIVED <i>440.00</i>	CHECK NUMBER <i>5683</i>	DATE RECEIVED <i>6-11-07</i>
--	--------------------------------	----------------------------------	-----------------------------	---------------------------------

SECTION A: TO BE COMPLETED BY ALL APPLICANTS

1. APPLICANT'S BUSINESS OR PROFESSIONAL PRACTICE NAME AND LOCATION TO BE REGISTERED (DO NOT USE P.O. BOX) <i>TAYLOR WARREN I D.O. ATLANTIC WOMEN'S MED. 2809 BAYNARD BLVD WASHINGTON, DE 19902</i>	2. NAME AND ADDRESS OF APPLICANT (RESIDENCE) <i>BAYN MAWR PA 19010-2000</i>
--	--

3. (a) D.O.B. <i>[REDACTED]</i>	(b) BUSINESS PHONE: <i>800-456-0369</i>	(c) HOME PHONE: <i>[REDACTED]</i>
---------------------------------	---	-----------------------------------

4. REGISTRATION REQUESTED AS:	1-11 <input checked="" type="checkbox"/> PRESCRIBER OR DISPENSER (\$40.00)	13 <input type="checkbox"/> DISTRIBUTOR (\$100.00)	15 <input type="checkbox"/> LABORATORY (\$40.00)
	12 <input type="checkbox"/> MANUFACTURER (\$100.00)	14 <input type="checkbox"/> RESEARCHER (\$40.00)	16 <input type="checkbox"/> OTHER (\$40.00) SPECIFY

MAKE CHECKS PAYABLE TO "STATE OF DELAWARE"

5. REGISTRATION REQUESTED IN FOLLOWING SCHEDULE(S)	SCHEDULE(S)	<input checked="" type="checkbox"/> I	<input checked="" type="checkbox"/> II	<input checked="" type="checkbox"/> III	<input checked="" type="checkbox"/> IV	<input checked="" type="checkbox"/> V
--	-------------	---------------------------------------	--	---	--	---------------------------------------

NOTE:
 PRESCRIBERS AND DISPENSERS LISTED IN SECTION "B" BELOW MUST COMPLETE ALL SECTIONS EXCEPT "D".
 RESEARCHERS, MANUFACTURERS, DISTRIBUTORS, AND LABORATORIES MUST COMPLETE ALL SECTIONS EXCEPT "B".

SECTION B: PRESCRIBERS AND DISPENSERS

PRESCRIBERS AND DISPENSERS (CHECK CATEGORY)	1. <input type="checkbox"/> M.D. 2. <input checked="" type="checkbox"/> D.O. 3. <input type="checkbox"/> DENTIST 4. <input type="checkbox"/> VETERINARIAN 5. <input type="checkbox"/> PODIATRIST 6. <input type="checkbox"/> PHARMACY - Resident 7. <input type="checkbox"/> HOSPITAL 8. <input type="checkbox"/> CLINIC 9. <input type="checkbox"/> EXEMPT OFFICIAL (NO FEE) (ALSO CK CATEGORY 1-9) <input type="checkbox"/> PHARMACY - Non-resident
---	--

SS # *[REDACTED]* FEDERAL DEA NUMBER *[REDACTED]* DE PRACTICE BOARD NUMBER *C 20009718*

SECTION C:

PRIOR CBS #D0 0350 PRESENT

1. <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	HAS THE APPLICANT BEEN CONVICTED OF A FELONY OR MISDEMEANOR UNDER STATE OR FEDERAL LAW RELATING TO THE MANUFACTURE, DISTRIBUTION, OR DISPENSING OF CONTROLLED SUBSTANCES?	IF THE ANSWER TO QUESTIONS ONE AND/OR TWO IS AFFIRMATIVE, PLEASE ATTACH A LETTER SETTING FORTH THE CIRCUMSTANCES OF SUCH ACTION.	
2. <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	HAS ANY PREVIOUS REGISTRATION HELD BY THE APPLICANT, CORPORATION, FIRM, PARTNER, OR OFFICER OF THE APPLICANT UNDER THE CONTROLLED SUBSTANCES ACT, STATE OR FEDERAL, BEEN SURRENDERED, REVOKED, SUSPENDED, DENIED OR IS IT PENDING SUCH ACTION?		
*3. <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	DOES THE APPLICANT INTEND TO ROUTINELY DISPENSE CONTROLLED SUBSTANCES?		*PRACTITIONERS WHO ROUTINELY DISPENSE OR STORE CONTROLLED SUBSTANCES ARE REQUIRED TO COMPLY WITH SECURITY REQUIREMENTS OF THE STATE AND FEDERAL CONTROLLED SUBSTANCES ACTS. THE PREMISES OF THE APPLICANTS WILL BE INSPECTED TO DETERMINE COMPLIANCE WITH THESE REQUIREMENTS.
*4. <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	DOES THE APPLICANT INTEND TO STORE CONTROLLED SUBSTANCES FOR PATIENT ADMINISTRATION		

SECTION D:

<input checked="" type="checkbox"/> I AM NOT ENGAGED IN THE MANUFACTURE OR DISTRIBUTION OF, OR RESEARCH WITH CONTROLLED DANGEROUS SUBSTANCES LISTED IN SCHEDULES I AND II.	<input type="checkbox"/> I PROPOSE TO MANUFACTURE, DISTRIBUTE OR CONDUCT RESEARCH IN THE INDIVIDUAL CONTROLLED DANGEROUS SUBSTANCES SCHEDULES I AND II WHICH ARE LISTED BELOW.
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(TYPE OR PRINT APPLICABLE SUBSTANCES)

Note: Researchers, manufacturers, distributors, and laboratories must complete Section "D".

The Delaware Controlled Substance Regulations and Statutes may be obtained by accessing the website—<http://www.dhss.delaware.gov/dhss/dph/regs.html#C>. You can also contact the Office of Controlled Substances (Address and phone number on the front of this form).

SECTION E: BUSINESS INFORMATION

1. TYPE OF BUSINESS PROPRIETORSHIP PARTNERSHIP CORPORATION OF DELAWARE
(GIVE STATE OF INC.)
 OTHER (SPECIFY _____)

2. FEDERAL DEA REGISTRATION NUMBERS OF MANUFACTURERS, DISTRIBUTORS, RESEARCHERS, OR LABORATORIES.

3. NAME AND ADDRESS OR PERSON HAVING ADMINISTRATIVE OR MANAGERIAL RESPONSIBILITY FOR REGISTERED LOCATION.

L.T. BRINKLEY
2809 BAYNARD BLVD
WILMINGTON DE 19802

4. NAME AND ADDRESS OF REGISTERED AGENT (IF CORP.) OR NAME AND ADDRESS OF RESIDENT UPON WHOM ORDERS MAY BE SERVED. (IF NON-RESIDENT PROPRIETOR OR PARTNER)

L.T. BRINKLEY
2809 BAYNARD BLVD
WILMINGTON DE 19802

5. LIST NAME, TITLE AND RESIDENCE ADDRESS OF EACH PROPRIETOR, GENERAL PARTNER, CORPORATE OFFICER, (PRESIDENT, SECRETARY, CHIEF EXECUTIVE OFFICER) AND PRINCIPAL SHAREHOLDER(S) (OWNER OF 10% OR MORE OF OUTSTANDING COMMON STOCK).

ATTACH ADDITIONAL SHEETS IF NECESSARY.

NAME AND TITLE

RESIDENCE ADDRESS

Patsy M. Myrce

[REDACTED] WILMINGTON DE 19806

SECTION F: CERTIFICATION

I HEREBY CERTIFY THAT THE FACTS STATED IN THIS APPLICATION, INCLUDING THE STATEMENTS ON THE ATTACHED SCHEDULE, ARE TRUE, COMPLETE AND CORRECT AND THAT APPLICATION IS MADE TO OBTAIN A BIENNIAL REGISTRATION PURSUANT TO THE UNIFORM CONTROLLED SUBSTANCES ACT.

I AGREE TO ABIDE TO THE LAWS OF DELAWARE AND THE FEDERAL GOVERNMENT.

FEE ENCLOSED \$ 40

DATE 6/4/07

SIGNATURE

[Signature]
NAME AND TITLE OF APPLICANT OR OFFICER

BIENNIAL REGISTRATION/RENEWAL APPLICATION
State of Delaware



DELAWARE HEALTH AND SOCIAL SERVICES

DIVISION OF PUBLIC HEALTH
OFFICE OF NARCOTICS AND DANGEROUS DRUGS
P.O. Box 637 • Dover, Delaware 19903-0637

(302) 744-4547

STATE OF DELAWARE UNIFORM CONTROLLED SUBSTANCES ACT
ACT 16 • 47 SECTION 4732

PLEASE TYPE OR PRINT

CSA Number	RENEWAL DATE	AMOUNT RECEIVED	CHECK NUMBER	DATE RECEIVED
For State Use Only 210350	6/30/07	40	2380	12/5/06

SECTION A: TO BE COMPLETED BY ALL APPLICANTS

1. APPLICANT'S NAME AND LOCATION OF PLACE OF BUSINESS OR PROFESSIONAL PRACTICE TO BE REGISTERED (DO NOT USE P.O. BOX) TAYLOR, WARREN I. D.O. ATLANTIC WOMENS MED. 2809 BAYNARD BLVD	2. NAME AND ADDRESS OF APPLICANT (RESIDENCE) TAYLOR, WARREN I. D.O.
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3. (a) D.O.B. [REDACTED]	(b) WORK PHONE: 800-456-0369	(c) HOME PHONE: [REDACTED]
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4. REGISTRATION REQUESTED AS:	1-11 <input checked="" type="checkbox"/> PRESCRIBER OR DISPENSER (\$40.00)	13 <input type="checkbox"/> DISTRIBUTOR (\$100.00)	15 <input type="checkbox"/> LABORATORY (\$40.00)
	12 <input type="checkbox"/> MANUFACTURER (\$100.00)	14 <input type="checkbox"/> RESEARCHER (\$40.00)	16 <input type="checkbox"/> OTHER (\$40.00) SPECIFY

MAKE CHECKS PAYABLE TO "STATE OF DELAWARE"

5. REGISTRATION REQUESTED IN FOLLOWING SCHEDULE(S)	SCHEDULE(S)	<input checked="" type="checkbox"/> I	<input checked="" type="checkbox"/> II	<input checked="" type="checkbox"/> III	<input checked="" type="checkbox"/> IV	<input checked="" type="checkbox"/> V
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NOTE:
PRESCRIBERS AND DISPENSERS LISTED IN SECTION "B" BELOW MUST COMPLETE ALL SECTIONS EXCEPT "D".
RESEARCHERS, MANUFACTURERS, DISTRIBUTORS, AND LABORATORIES MUST COMPLETE ALL SECTIONS EXCEPT "B".

SECTION B: PRESCRIBERS AND DISPENSERS

PRESCRIBERS AND DISPENSERS (CHECK CATEGORY)		
1. <input type="checkbox"/> M.D.	4. <input type="checkbox"/> VETERINARIAN	7. <input type="checkbox"/> HOSPITAL
2. <input checked="" type="checkbox"/> D.O.	5. <input type="checkbox"/> PODIATRIST	8. <input type="checkbox"/> CLINIC
3. <input type="checkbox"/> DENTIST	6. <input type="checkbox"/> PHARMACY - Resident	9. <input type="checkbox"/> EXEMPT OFFICIAL (NO FEE) (ALSO CK CATEGORY 1-9)
	<input type="checkbox"/> PHARMACY - Non-resident	

SS #	FEDERAL DEA NUMBER:	DE PRACTICE BOARD NUMBER 02-0004218 exp. 3/31/10 ISS. 10/5/93
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SECTION C:

1. <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	HAS THE APPLICANT BEEN CONVICTED OF A FELONY OR MISDEMEANOR UNDER STATE OR FEDERAL LAW RELATING TO THE MANUFACTURE, DISTRIBUTION, OR DISPENSING OF CONTROLLED SUBSTANCES?	IF THE ANSWER TO QUESTIONS ONE AND/OR TWO IS AFFIRMATIVE, PLEASE ATTACH A LETTER SETTING FORTH THE CIRCUMSTANCES OF SUCH ACTION.
2. <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	HAS ANY PREVIOUS REGISTRATION HELD BY THE APPLICANT, CORPORATION, FIRM, PARTNER OR OFFICER OF THE APPLICANT UNDER THE CONTROLLED SUBSTANCES ACT STATE OR FEDERAL, BEEN SURRENDERED, REVOKED, SUSPENDED, DENIED OR IS IT PENDING SUCH ACTION?	
3. <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	DOES THE APPLICANT INTEND TO ROUTINELY DISPENSE CONTROLLED SUBSTANCES?	*PRACTITIONERS WHO ROUTINELY DISPENSE OR STORE CONTROLLED SUBSTANCES ARE REQUIRED TO COMPLY WITH SECURITY REQUIREMENTS OF THE STATE AND FEDERAL CONTROLLED SUBSTANCES ACTS. THE PREMISES OF THE APPLICANTS WILL BE INSPECTED TO DETERMINE COMPLIANCE WITH THESE REQUIREMENTS
4. <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	DOES THE APPLICANT INTEND TO STORE CONTROLLED SUBSTANCES FOR PATIENT ADMINISTRATION	

SECTION D:

<input checked="" type="checkbox"/> I AM NOT ENGAGED IN THE MANUFACTURE OR DISTRIBUTION OF, OR RESEARCH WITH CONTROLLED DANGEROUS SUBSTANCES LISTED IN SCHEDULES I AND II.	<input type="checkbox"/> I PROPOSE TO MANUFACTURE, DISTRIBUTE OR CONDUCT RESEARCH IN THE INDIVIDUAL CONTROLLED DANGEROUS SUBSTANCES SCHEDULES I AND II WHICH ARE LISTED BELOW
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(TYPE OR PRINT APPLICABLE SUBSTANCES)

Note: Researchers, manufacturers, distributors, and laboratories must complete Section "D".

The Delaware Controlled Substance Regulations and Statutes may be obtained by accessing the website--www.professionallicensing.state.de.us and proceeding to the Board of Pharmacy. You can also contact the Office of Narcotics and Dangerous Drugs at the address on the front of this form.

SECTION E: BUSINESS INFORMATION

1. TYPE OF BUSINESS PROPRIETORSHIP PARTNERSHIP CORPORATION OF DE
(GIVE STATE OF INC.)

OTHER (SPECIFY _____)

2. FEDERAL DEA REGISTRATION NUMBERS OF MANUFACTURERS, DISTRIBUTORS, RESEARCHERS, OR LABORATORIES. BT5528611

3. NAME AND ADDRESS OR PERSON HAVING ADMINISTRATIVE OR MANAGERIAL RESPONSIBILITY FOR REGISTERED LOCATION.
LUNA K. WASH

4. NAME AND ADDRESS OF REGISTERED AGENT (IF CORP.) OR NAME AND ADDRESS OF RESIDENT UPON WHOM ORDERS MAY BE SERVED.
(IF NON-RESIDENT PROPRIETOR OR PARTNER)
PANSY M. MYRIE [REDACTED] WILM DE. 19806

5. LIST NAME, TITLE AND RESIDENCE ADDRESS OF EACH PROPRIETOR, GENERAL PARTNER, CORPORATE OFFICER, (PRESIDENT, SECRETARY, CHIEF EXECUTIVE OFFICER) AND PRINCIPAL SHAREHOLDER(S) (OWNER OF 10% OR MORE OF OUTSTANDING COMMON STOCK). ATTACH ADDITIONAL SHEETS IF NECESSARY.

NAME AND TITLE	RESIDENCE ADDRESS
<u>PANSY M. MYRIE (DRUGS)</u>	<u>[REDACTED] WILM DE 19806</u>

SECTION F: CERTIFICATION

I HEREBY CERTIFY THAT THE FACTS STATED IN THIS APPLICATION, INCLUDING THE STATEMENTS ON THE ATTACHED SCHEDULE, ARE TRUE, COMPLETE AND CORRECT AND THAT APPLICATION IS MADE TO OBTAIN A BIENNIAL REGISTRATION PURSUANT TO THE UNIFORM CONTROLLED SUBSTANCES ACT.

I AGREE TO ABIDE TO THE LAWS OF DELAWARE AND THE FEDERAL GOVERNMENT

FEE ENCLOSED \$ 40.00 DATE 11/30/06
SIGNATURE [Signature]
NAME AND TITLE OF APPLICANT OR OFFICER _____