130596

State Medical Board of Ohio

30 E. Broad St., 3rd Floor • Columbus, OH 43215-6127 • (614) 466-3934 • Website: http://.med.ohio.gov/

Ohio Addendum to Application

Ohio Training Program

Are you or will you be in an accredited training program in Ohio? ☐ Yes ☑ No
If yes, identify name of training program and location:

Name of Hospital/Training Program _____ City _____ Start Date: ____/____ month/year

Specialty Boards

Name of Specialty Board (If none, enter "N/A")	Year Certified	Country
ABOG	1991 - present	USA

TOEFL IBT

(International Medical School Graduates only)

THE TOEFL, TWE, ECFMG'S ENGLISH EXAM (PRIOR TO 7/1/98), ETC., ARE NOT EQUIVALENT AND CANNOT BE SUBSTITUTED FOR THE TOEFL IBT

Graduates of medical schools located outside the United States and Canada must achieve a score of at least 26 in Speaking and 26 in Listening with a total score of 90 on the TOEFL IBT, regardless of citizenship or country of birth. Prior to July 2006 the Test of Spoken English was required with a minimum score of 40 (between 7/95-7/06) or 230 (prior to 7/95). The following are the only exceptions permitted under Ohio law:

	YES	NO
Have you completed two years of undergraduate college work in the United States?	☐	☐
During the five years immediately preceding the date of your application, have you: (Please note you must be able to answer "YES" to both parts of this question) Held a current medical license (i.e., unrestricted, training certificate, educational permit) in the United States? **AND** Have you been actively practicing medicine (graduate medical education is included) in the United States?	☐	☐
Have you completed a Fifth Pathway program?	☐	☐
Have you passed the Clinical Skills Assessment examination given by ECFMG on or after July 1, 1998?	☐	☐

If you answered **NO** to all of the above questions, you **must** take the TOEFL IBT. Refer to the application instructions for contacting the Educational Testing Service. The Board cannot waive this requirement.

OK KMR 4/16/14

Ohio Addendum to Application

Preliminary Education Form

TO BE COMPLETED BY ALL APPLICANTS

Full Name	Last (Surname)	First	Middle	Suffix (Jr., II)
	GLAZER	Jeffrey	D	

High School or Equivalent

School Name: Waggener H.S

City	State	Country
Lou	KY	USA

Dates Attended — From: MO/YR 8/69 To: MO/YR 3/75

Undergraduate College or Equivalent

School Name: U. of Louisville

City	State	Country
Lou	KY	USA

Dates Attended — From: MO/YR 3/75 To: MO/YR 5/79 — Degree Received: B.A.

School Name: INDIANA University

City	State	Country
Bloomington IN		USA

Dates Attended — From: MO/YR 8/75 To: MO/YR 5/76 — Degree Received:

Medical or Osteopathic School of Graduation

School Name: U. ~~of~~ Louisville School of Medicine

City	State	Country
Louisville	KY	USA

Dates Attended — From: MO/YR 8/79 To: MO/YR 5/83 — Degree Received: M.D.

FOR BOARD USE ONLY

CERTIFICATE OF PRELIMINARY EDUCATION

NO: 128708 DATE ISSUED: APR 16 201

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This is to certify that this applicant has met the preliminary education requirements for study in conformity with the Statutes of Ohio and the regulations of the State Medical Board of Ohio

Ohio Addendum to Application
Additional Information
Medicine or Osteopathic Medicine

If you answer "YES" to any of the following questions, you are required to furnish complete details, including date, place, reason and disposition of the matter. All affirmative answers must be thoroughly explained on a separate sheet of paper. You must submit copies of all relevant documentation, such as court pleadings, court or agency orders, and institutional correspondence and orders. Please note that some questions require very specific and detailed information. Make sure all responses are complete.

(Please place a ☑ in the yes or no box)

		YES	NO
1.	Have you ever been denied staff membership at any hospital, nursing home, clinic, health maintenance organization, or similar institution?	☐	☑
2.	Have you ever been warned, censured, disciplined, had admissions monitored, had privileges limited, had privileges suspended or terminated, been put on probation, or been requested to withdraw from or resign privileges at any hospital, nursing home, clinic, health maintenance organization, or other similar institution in which you have trained, been a staff member, or held privileges, for reasons other than failure to maintain records on a timely basis, or failure to attend staff or section meetings?	☐	☑
3.	Have you ever resigned from, withdrawn from, or terminated, or have you ever been requested to resign from, withdraw from, or otherwise been terminated from, a position with a medical partnership, professional association, corporation, health maintenance organization, or other medical practice organization, either private or public?	☐	☑
4.	Have you ever resigned from, withdrawn from, or have you ever been warned by, censured by, disciplined by, been put on probation by, been requested to withdraw from, dismissed from, been refused renewal of a contract by, or expelled from, a medical school, clinical clerkship, externship, preceptorship, residency, or graduate medical education program?	☐	☑
5.	Have you ever transferred from one graduate medical education program to another?	☐	☑
6.	Have you ever, for any reason, lost specialty board certification in the U.S. or elsewhere, or been denied such certification, or denied examination for such certification?	☐	☑
7.	Has any board, bureau, department, agency or other body, including those in Ohio, in any way limited, restricted, suspended, or revoked any professional license, certificate or registration granted to you; placed you on probation; or imposed a fine, censure or reprimand against you?	☐	☑
8.	Have you ever voluntarily surrendered, resigned, or otherwise forfeited any professional license, certificate or registration issued to you by any board, bureau, department, agency, or other body; or have you ever withdrawn any application for licensure, relicensure, or examination, in any state (including Ohio), territory, province, or country?	☑	☐
9.	Have you ever, for any reason, been denied licensure or relicensure, application for licensure or relicensure, or the privilege of taking an examination, in any state (including Ohio), territory, province, or country?	☐	☑

		YES	NO
10.	Have you ever been requested to appear before any board, bureau, department, agency, or other body, including those in Ohio, concerning allegations against you?	☐	☑
11.	Have you ever entered into an agreement of any kind, whether oral or written, with respect to a professional license, in lieu of or in order to avoid formal disciplinary action, with any board, bureau, department, agency, or other body, including those in Ohio?	☐	☑
12.	Have you ever been notified of any investigation concerning you by any board, bureau, department, agency, or other body, including those in Ohio, with respect to a professional license?	☐	☑
13.	Have you ever been notified of any charges, allegations, or complaints filed against you with any board, bureau, department, agency, or other body, including those in Ohio, with respect to a professional license?	☐	☑
14.	Have you ever been denied or have you ever surrendered a state or federal controlled substance or drug registration; had it revoked, terminated, or restricted in any way; or been warned, reprimanded, or fined by, or been requested to appear before, the responsible agency?	☐	☑
15.	Have you ever pled guilty to, been found guilty of a violation of any law, or been granted intervention or treatment in lieu of conviction regardless of the legal jurisdiction in which the act was committed, other than a minor traffic violation? If yes, submit copies of all relevant documentation, such as police reports, ***certified*** court records and any institutional correspondence and orders. Photocopies will not be accepted.	☐	☑
16	Have you ever been arrested, forfeited collateral, bail, or bond for breach or violation of any law, police regulation, or ordinance other than for a minor traffic violation; been summoned into court as a defendant or had any lawsuit filed against you (other than a malpractice suit)? If yes, submit copies of all relevant documentation, such as police reports, ***certified*** court records and any institutional correspondence and orders. Photocopies will not be accepted.	☐	☑
17.	Have you been a defendant in a legal action involving professional liability (malpractice), or had a professional liability claim paid on your behalf, or paid such a claim yourself? In addition, ask your malpractice insurance carrier(s) to provide a complete claims history report for the last 10 years to the State Medical Board of Ohio. If your current carrier has provided coverage for less than 10 years, ask your previous carrier to submit a claims history report to the Board.	☑	☐
18.	Have you ever been denied professional liability insurance or coverage, or had such insurance or coverage canceled, limited, or restricted in any way?	☐	☑
19.	Have you ever been denied or relinquished participation in any third party reimbursement program, whether governmental or private, including Medicaid and Medicare; or had such participation limited, restricted, suspended, or revoked; or been warned, reprimanded, requested to appear before, or fined by the responsible body?	☐	☑
20.	Have you ever been denied privileges, or had privileges revoked, suspended, restricted, reduced, or terminated by the Department of Defense, the Veteran's Administration, or any of their respective components?	☐	☑

		YES	NO
21.	Have you ever been diagnosed as having, or have you been treated for, pedophilia, exhibitionism, or voyeurism?	☐	☑
22. a)	Within the last ten years, have you been diagnosed with or have you been treated for, bipolar disorder, schizophrenia, paranoia, or any other psychotic disorder?	☐	☑
b)	Have you, since attaining the age of eighteen or within the last ten years, whichever period is shorter, been admitted to a hospital or other facility for the treatment of bipolar disorder, schizophrenia, paranoia, or any other psychotic disorder?	☐	☑

If you answered "YES" to any part of this question, please provide details on a separate sheet, including date(s) of diagnosis or treatment, and a description of your present condition. Include the name, current mailing address, and telephone number of each person who treated you, as well as each facility where you received treatment, and the reason for treatment. Have each treating physician submit a letter detailing the dates of treatment, diagnosis and prognosis.

For purposes of questions 23 and 24 the following phrases or words have the following meaning:

"Ability to practice medicine" is to be construed to include all of the following:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments; and
2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical condition" includes physiological, mental, or psychological conditions or disorders, such as but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

		YES	NO
23.	Do you have, or have you been diagnosed as having, a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? **You may answer "NO" to this question if** you hold a current training certificate to pursue training in Ohio and the only such medical condition is chemical dependency or substance abuse, and you have successfully completed or are currently receiving treatment at a program approved by this board and have adhered to all statutory requirements as contained in Sections 4731.224 and 4731.25, O.R.C., and related provisions. Any questions concerning approval can be directed to the board offices.	☐	☑
a)	Are the limitations or impairment caused by your medical condition reduced or ameliorated because you receive ongoing treatment or received treatment in the past (with or without medication) or participate in a monitoring program? I don't have A medical condition	☐	☑

If you receive such ongoing treatment or participate in such monitoring program the board will make an individualized assessment of the nature, severity, and duration of the risk associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure. Have each treating physician submit a letter detailing the dates of treatment, diagnosis and prognosis.

MEDICAL BOARD
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b)	Are the limitation or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? I don't have A medical condition	☐	☑

"Chemical substances" is to be construed to include alcohol, drugs, or medications including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescribers direction, as well as those used illegally.

		YES	NO
24.	Do you use chemical substance(s) which in any way impair or limit your ability to practice medicine with reasonable skill and safety?	☐	☑
	a) Are the limitations or impairment caused by your use of chemical substances reduced or ameliorated because you receive ongoing treatment (with or without medication) or participate in a monitoring program? Don't use	☐	☑
	If you receive such ongoing treatment or participate in such monitoring program the board will make an individualized assessment of the nature, severity, and duration of the risk associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure. Have each treating physician submit a letter detailing the dates of treatment, diagnosis and prognosis.		
	b) Are the limitation or impairments caused by your use of chemical substances reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? Don't use	☐	☑

For purposes of question 25 the following phrases or words have the following meaning:

"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 use of drugs may have an ongoing impact on one's functioning as a licensee, or within the past two years.

"Illegal use of controlled substances" means the use of controlled substances obtained illegally (e.g. heroin or cocaine) as well as the use of controlled substances which are not obtained pursuant to a valid prescription or not taken in accordance with the direction of a licensed healthcare practitioner.

		YES	NO
25.	Are you currently engaged in the illegal use of controlled substances?	☐	☑
	a) If "YES," are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not using illegal controlled substances.	☐	☐

State Medical Board of Ohio

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Ohio Addendum to Application
Certificate of Recommendation
Medicine or Osteopathic Medicine

I, Sarah C. Cox, currently hold an active license to practice as a
(Recommending physician, print name legibly)

physician in the state of Kentucky, attest that all information I am providing is in conformance with the "Instructions for Completion of Recommendation Form," and provide this recommendation form related to the request for professional licensure by Jeff Glazer.
(Applicant, print name legibly)

Further, the photograph affixed hereto is a genuine likeness of the applicant, who has been personally known to me for 30 years/months.

1. How do you know this applicant? From medical school, professional & personal relationship
2. How would you describe the applicant's medical knowledge? Excellent
3. How would you describe the applicant's clinical technique? Excellent
4. How would you characterize the applicant's relationship with patients? Excellent
5. How would you describe the applicant's ability to work with peers and clinical staff? Excellent
6. Does the applicant possess good moral character? (If no, explain) ☑Yes ☐No
7. Do you recommend this applicant for the professional license being sought? (If no, explain) ☑Yes ☐No
8. Are you aware of any other information (favorable or unfavorable) that could potentially impact this applicant's suitability for professional licensure or the Board's consideration of his/her application? (If yes, explain) ☐Yes ☑No
9. Have you attached additional correspondence or information to this form? ☐Yes ☑No

Signature of Applicant
Date Photo Taken 4, 2014

Sarah C. Cox MD
Signature of Recommending Physician (Name stamps not accepted)

4001 Kresge Way Ste 329 Louisville, Ky 40207
Address (include house number and street, city, state and zip code)

State of Licensure and License Number Ky; 25844

Subscribed and sworn to before me this 17th day of April, 20 14.

Veronica C. Davidson
Notary Public Signature

NOTARY SEAL

9-16-15
Date Commission Expires

RECEIVED
APR 21 2014
STATE MEDICAL BOARD

Eff 4/12

4/15

State Medical Board of Ohio

30 E. Broad St., 3rd Floor • Columbus, OH 43215-6127 • (614) 466-3934 • Website: http://med.ohio.gov

Ohio Addendum to Application
Certificate of Recommendation
Medicine or Osteopathic Medicine

I, DWIGHT PRIDHAM, currently hold an active license to practice as a
(Recommending physician, print name legibly)

physician in the state of KENTUCKY, attest that all information I am providing is in conformance with the "Instructions for Completion of Recommendation Form," and provide this recommendation form related to the request for professional licensure by JEFFREY GLAZER.
(Applicant, print name legibly)

Further, the photograph affixed hereto is a genuine likeness of the applicant, who has been personally known to me for 25 years/months.

1. How do you know this applicant?
Initially through patient referrals, professional meetings, joint surgeries. Eventually personal friendship.
2. How would you describe the applicant's medical knowledge?
Excellent. Stays up to date.
3. How would you describe the applicant's clinical technique?
Excellent, although I have not directly observed in last 5 years (but much direct interaction prior to that).
4. How would you characterize the applicant's relationship with patients?
The patients I have seen, referred by Dr. Glazer, all like him very much. He is friendly but professional.
5. How would you describe the applicant's ability to work with peers and clinical staff?
Very good. Again, friendly and professional.
6. Does the applicant possess good moral character? (If no, explain) ☒Yes ☐No
7. Do you recommend this applicant for the professional license being sought? (If no, explain) ☒Yes ☐No
8. Are you aware of any other information (favorable or unfavorable) that could potentially impact this applicant's suitability for professional licensure or the Board's consideration of his/her application? (If yes, explain) ☐Yes ☒No
9. Have you attached additional correspondence or information to this form? ☐Yes ☒No

Signature of Applicant
Date Photo Taken 4 / 2014

D Pridham MD
Signature of Recommending Physician (Name stamps not accepted)
20 Eastover Ct., Louisville, KY 40206
Address (include house number and street, city, state and zip code)

State of Licensure and License Number KY 25165

Subscribed and sworn to before me this 15 day of April, 2014.

Thelma Bell
Notary Public Signature

NOTARY SEAL

6-20-2016
Date Commission Expires

Eff 4/12

130596

UA UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE

Affidavit and Authorization for Release of Information

Applicant: Send this form to the state board you are applying to. Do not send this to FSMB.

Applicant:

Securely tape or glue a recent (less than 6 month old) front-view 2" x 2" passport-type color photo of yourself in the square below.

Sign this form with attached photo in the presence of a notary public.

Send the notarized form to the board you are applying to for licensure.

DO NOT SEND THIS FORM TO FSMB.

Doing so will cause a delay with your state board application.

I, the undersigned, being duly sworn, hereby certify under oath that I am the person named in this application, that all statements I have made or shall make with respect thereto are true, that I am the original and lawful possessor of and person named in the various forms and credentials furnished or to be furnished with respect to my application, and that all documents, forms, or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

I acknowledge that I have read and understand the Uniform Application for Physician State Licensure and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted under appropriate federal and state laws.

I authorize and request every person, hospital, clinic, government agency (local, state, federal, or foreign), court, association, institution, or law enforcement agency having custody or control of any documents, records, and other information pertaining to me to furnish to the Board any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data, and to permit the Board or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application.

I hereby release, discharge, and exonerate the Board, its agents or representatives, and any person, hospital, clinic, government agency (local, state, federal, or foreign), court, association, institution, or law enforcement agency having custody or control of any documents, records, and other information pertaining to me of any and all liability of every nature and kind arising out of investigation made by the Board.

I will immediately notify the Board in writing of any changes to the answers to any of the questions contained in this application if such a change occurs at any time prior to a license to practice medicine being granted to me by the Board.

I understand my failure to answer questions contained in this application truthfully and completely may lead to denial, revocation, or other disciplinary sanction of my license or permit to practice medicine.

Jeffrey D Glazer
Applicant's signature (must be signed in the presence of a notary)

GLAZER
Applicant's printed last name

Jeffrey
Applicant's printed first name, middle initial, and suffix (e.g., Jr.)

4-8-2014
Date of signature (must correspond to date of notarization)

MEDICAL BOARD
APR 11 2014

Notary

State of Kentucky, County of Jefferson.

I certify that on the date set forth below, the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document.

The statements on this document are subscribed and sworn to before me by the applicant on this 8th day of April, 2014.

Notary Public Signature: Nicholas M. Block

My Notary Commission Expires: June 21, 2014

(NOTARY PUBLIC SEAL)

COMPOSITE STATE BOARD OF MEDICAL EXAMINERS

EXECUTIVE DIRECTOR
LaSharn Hughes, MBA

MEDICAL DIRECTOR
Jim H. McNatt, MD

2 Peachtree St., N.W., 36th Floor • Atlanta, Georgia 30303 • Tel: 404.656.3913 • Fax 404.656.9723
http://www.medicalboard.georgia.gov E-Mail: Medbd@dch.ga.gov

March 25, 2014

RE: **Jeffrey Glazer, MD**

TO WHOM IT MAY CONCERN:

This is to certify that the above has been issued a **Physician** license by the Georgia Medical Board.

It is further certified that:

The license number is **28986** and was issued on **October 09, 1986**

The current license status is **Inactive**

The license expiration date is **December 31, 1993.**

Board Actions A review of public records indicates that no public board orders have been docketed.

Certified this day Tuesday, 25 March, 2014

Composite State Board of Medical Examiners

LaSharn Hughes
Executive Director

LLH/

STATE OF INDIANA

Michael R. Pence

Indiana Professional Licensing Agency
402 W. Washington St. Room W072
Indianapolis, IN 46204
Phone: (317) 232-2980
Fax: (317) 233-4236

Digitally Certified Proof of Licensure

RE: Jeffrey David Glazer

I, Nicholas W. Rhoad, Executive Director of the Indiana Professional Licensing Agency and custodian of the records therein, hereby certify that the attached is the digitally certified proof of licensure, as requested, and as it appears in the files of the Indiana Professional Licensing Agency on the date/time certified.

This digital certification follows the requirements of Indiana's Electronic Digital Signature Act (Indiana Code 5-24-1-1 et seq.) and rules developed by the Indiana State Board of Accounts, 20 IAC 3-1 et seq. to establish a valid digital electronic signature

If you have the need to verify the authenticity of the digital certification as of the date and time stamp below, go to https://secure.in.gov/apps/pla/verify.htm and use our free web service to "Verify an Electronic Certified Record". Simply browse to the location you saved the secure pdf document sent to you and upload to validate.

Nicholas W. Rhoad

Nicholas W. Rhoad, Executive Director
Tue Mar 25 01:37:07 PM EDT 2014

UNITED STATES POSTAL SERVICE
Electronic Postmark

STATE OF INDIANA

Michael R. Pence

Indiana Professional Licensing Agency
402 W. Washington St. Room W072
Indianapolis, IN 46204
Phone: (317) 232-2980
Fax: (317) 233-4236

Official Proof of Licensure
Digitally Certified Record

Personal Information	
Name:	Jeffrey David Glazer
Address:	2325 Cherokee Parkway Louisville, KY 40204
Date of Birth:	05/01/1957

License Information	
Number Issued:	01045854A
License Type:	Physician
Status:	Active
Issue date:	10/24/1996
Expiration Date:	10/31/2015
Obtained By:	Endorsement
Disciplinary Action:	None

This licensee has met ALL requirements for licensure in the State of Indiana - including successfully passing all required exams.

For additional information including questions regarding Disciplinary Action, contact the appropriate Board or Commission at www.in.gov/pla/boards.htm

Digitally Certified on: Tue Mar 25 01:37:07 PM EDT 2014

UNITED STATES POSTAL SERVICE®
Electronic Postmark

Kentucky Board of Medical Licensure

310 Whittington Parkway, Suite 1B
Louisville, Kentucky 40222
Phone (502)429-7150 Fax (502) 429-7158

Name: Jeffrey D. Glazer M.D.
Address: 1025 SOUTH SECOND STREET
City, State, Zip Louisville KY 40203
Phone: (317) 637-4343
License: 25111
Status: Active Physician
Expiration: 2/28/2015 0:00:00
Practice County: Jefferson
***Area of Practice:** Obstetrics/Gynecology
Type of Practice: Public Hth/Gov
Year Licensed in KY: 4/7/1987 0:00:00
Medical School: University of Louisville School of Medicine
Year Graduated: 1983
Board Action: None

*The Board does not verify current specialties. For more information please see the American Board of Medical Specialties website at: http://www.abms.org to determine if the physician has earned a specialty certification from this private agency.

Stephanie L. Simpson
Verification Coordinator

MEDICAL BOARD
APR - 4 2014

UA UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE

Licensure Verification (UA Form #1)

Applicant: Send this form to each board with which you have ever held a license.

RECEIVED
MAR 27 2014
K.B.M.L.

Applicants:

Complete Section 1. In the Authorization area, list the board that needs to verify your license as well as your license number. Type or print legibly.

Send this form and any required fee for this verification to the authorizing board.

Copy this form for multiple licenses.

Section 1: Applicant Information

Last name: GLAZER Suffix: _____

First name: Jeffrey

Middle name: David

Date of birth: 05/01/1957 Social Security number*: [redacted]

**The social security number is to be used for purposes of identification only and may not be used for any other reason.*

In listing the Board information below, please reference http://www.fsmb.org/directory_smb.html.

Name of Board applying to: State Medical Board of OHIO

Board address: 30 E. Broad St. 3rd FLOOR

Board city/state/zip code: Columbus OH 43215

Authorization: I am applying for a license to practice medicine. The Board I am applying to requires that this form be completed by each state or Canadian province in which I hold or have held licenses, whether now current or not. I authorize the licensing agency of the state/province of KY to provide any and all information pertaining to license number 25111 to the Board listed above.

Applicant signature: Jeffrey D Glazer **Date:** 3-25-2014

State Licensing Board or Canadian Province:

Please complete Section 2. Send this form to the board at the address listed in Section 1. Do not send this form to FSMB.

Section 2: Licensure Verification

Name of Licensee: _____
Last First Middle Suffix

License type: _____ License number: _____

Issue date: _____ Expiration date: _____

Is this license current? ☐ Yes ☐ No If not current, please explain: _____

1. Have formal disciplinary proceedings been initiated against applicant's license by a disciplinary authority in your state? ☐ Yes ☐ No ☐ Cannot answer under state law

If yes, please explain: _____

2. Has the applicant ever been warned, censured, placed on probation, formal consent, reprimand, or in any other manner disciplined, or has the applicant's license ever been revoked, suspended, or, in any other manner, limited by a licensing or disciplinary authority in your state?
☐ Yes ☐ No ☐ Cannot answer under state law

If yes, please explain: _____

I CERTIFY THAT to the best of my knowledge and belief, the foregoing is a true, accurate, and complete statement of the record of the individual named on this form.

Signature: _____

AFFIX BOARD SEAL HERE

(If no seal is available, this form must be notarized.)

MEDICAL BOARD

Print name: _____

Title: _____

Date: _____

Email: _____

0057 78

Question 8: I have voluntarily resigned my medical licenses in the states of Georgia, Florida and Indiana, and have recently reapplied and received a renewal of my license in Indiana.

MEDICAL MALPRACTICE CASES AGAINST DR. JEFFREY D. GLAZER

[redacted] v. Jeffrey Glazer M.D. Date of claim: 1/10/2003. Date of closure: May/2003. Outcome: Summary judgment in favor of Dr. Glazer. Case Summary: The patient had her baby delivered by Dr. Glazer who was on call for her obstetrician. The baby did well and she filed a suit four years after delivery, for unknown reasons. She would not answer requests for interrogatories or requests to schedule a deposition, and the courts awarded a summary judgment in my favor.

[redacted] v. Jeffrey Glazer M.D. Date of claim1/6/2006. Date of closure: Feb/2007. Outcome: Dismissal with prejudice. Case summary: The patient underwent a laparoscopic tubal ligation at which time an unrecognized bowel injury occurred. She underwent a bowel resection and made a full recovery. The patient withdrew her claim after discovery.

[redacted] v. Jeffrey Glazer M.D. Date of claim: 6/30/2004 Date of closure: Feb 2011. Outcome: Agreed settlement of $20,000. Case summary: The patient developed diabetic ketoacidosis following a vaginal hysterectomy and may have suffered a myocardial infarction during that episode. The patient had been cleared and followed by both her endocrinologist and cardiologist (she had had previous myocardial infarctions). She made a full recovery and this settlement was made after 7 years.

[redacted] v. Jeffrey Glazer M.D. Date of claim: 3/21/2006. Date of closure: Approximately April 2011. Outcome: Agreed settlement for the limits of my insurance policy for one case ($1 million). Case summary: The patient underwent an abdominal hysterectomy, and had a prolonged slow recovery in the hospital, and when she developed worsening vital signs a large fluid collection was noted on CT scan. She was taken to the operating room where a presumed bowel injury was diagnosed and the patient was given a colostomy. She made a slow recovery but has recovered fully, but lives with her colostomy.

[redacted] v. Jeffrey Glazer M.D. Date of claim 1/22/2008. Date of closure: January/2010. Outcome: Directed verdict in my favor. Case summary: The patient was seen in 2004 with a large ovarian cyst, she underwent laparoscopy with a laparoscopic ovarian cystectomy and made a satisfactory recovery. She had follow up ultrasounds which showed the ovary was present, but when she developed a cyst on the other ovary, she underwent laparoscopy by a different physician. He did not see the ovary that I operated on, and told her it wasn't there. A suit was filed, and in discovery it was noted that the lawyer did not have an expert witness. After much time the lawyer still could not produce an expert witness and the case was dismissed with the above outcome. The lawyer appealed to the Court of Appeals and the Kentucky Supreme Court who affirmed the opinion of the lower courts.

[redacted] vs. Jeffrey D. Glazer M.D. et al. Date of claim July 1996. Date of closure October 1997. Outcome: Out of court Settelment for $124,000. Case Summary: As I was on call for another physician, a baby was born and developed Group B Beta strep sepsis. The baby fully recovered and an out of court settlement was agree upon.

May 21, 2014

Ohio Board of Medicine
30 East Broad Street, 3rd Floor
Columbus, OH 43215

RE: License Certification for Jeffrey David Glazer

To Whom It May Concern:

This is to certify the following information, maintained in the records of the Department of Health, for the above referenced Health Care Practitioner:

PROFESSION:	Medical Doctor
LICENSE NUMBER:	ME44465
ORIGINAL CERTIFICATION:	07/27/1984
EXPIRATION DATE:	12/31/1987
CURRENT STATUS OF LICENSE:	AUTHORITY VOID,
AGENCY ACTION:	No

To expedite the verification process, the above format is the standard format for all healthcare practitioners. If you have questions regarding the status of this license, please call the Customer Contact Center at (850) 488-0595, option 5.

Sincerely,

Ellen Pulido
Licensure Support Services

GREAT SEAL OF THE STATE OF FLORIDA · IN GOD WE TRUST ·

MEDICAL BOARD
MAY 27 2014

State Medical Board of Ohio

30 E. Broad St., 3rd Floor • Columbus, OH 43215-6127 • (614) 466-3934 • Fax (614) 644-1464

Ohio Addendum to Application
EMPLOYER RECOMMENDATION FORM

Dr. Jeffrey Glazer, MD
(PLEASE PRINT APPLICANTS FIRST NAME AND LAST NAME)

is applying for licensure in the State of Ohio. We would appreciate your assistance in filling out the following evaluation so that we can process their application for licensure. To ensure processing of the physicians application, please complete and return this form to the State Medical Board of Ohio at the above address within two (2) weeks. **The form may also be faxed to the Board at (614) 644-1464.** Your immediate attention to this matter will be greatly appreciated by the applicant as well as by us. Thank you for your time and assistance.

Position(s) held: Contract OB/Gyn Physician

Dates of Employment: 17 AUG 2010 - 16 SEPT. 2013

1. How long have you known the applicant? 3 years
2. What is/was your supervisory capacity? n/a
3. At what hospital/clinic? Ireland Army Comm. Hospital, OB/Gyn & L&D
4. How would you rate their medical knowledge and techniques? Excellent
5. In your opinion is the applicant of good moral and ethical character? yes
6. Does the applicant work well with peers and medical staff? yes
7. Does the applicant relate well to patients? yes
8. How is the applicant's command of the English language (if applicable)? Excellent
9. Would you recommend the applicant for licensure? yes

Additional comments (An additional sheet may be added if needed):

Signature of Physician

Todd Albright, LTC, MC (DO)
Name of Physician (Please type or print clearly)

OB/Gyn Physician
Position

502-624-9196
Telephone number (include area code)

sandra.ricke.civ@mail.mil
E-Mail

502-624-0481
Fax number (include area code)

State Medical Board of Ohio

30 E. Broad St., 3rd Floor • Columbus, OH 43215-6127 • (614) 466-3934 • Fax (614) 644-1464

Ohio Addendum to Application
EMPLOYER RECOMMENDATION FORM

Dr. Jeff Glazer (Jeffrey David Glazer)
(PLEASE PRINT APPLICANTS FIRST NAME AND LAST NAME)

is applying for licensure in the State of Ohio. We would appreciate your assistance in filling out the following evaluation so that we can process their application for licensure. To ensure processing of the physicians application, please complete and return this form to the State Medical Board of Ohio at the above address within two (2) weeks. **The form may also be faxed to the Board at (614) 644-1464.** Your immediate attention to this matter will be greatly appreciated by the applicant as well as by us. Thank you for your time and assistance.

Position(s) held: Associate Medical Director

Dates of Employment: September 2013 - present

1. How long have you known the applicant? As above
2. What is/was your supervisory capacity? I am medical director
3. At what hospital/clinic? Planned Parenthood of Indiana + Kentucky
4. How would you rate their medical knowledge and techniques? Very Good → Excellent
5. In your opinion is the applicant of good moral and ethical character? Yes
6. Does the applicant work well with peers and medical staff? Yes
7. Does the applicant relate well to patients? Yes
8. How is the applicant's command of the English language (if applicable)? Primary language
9. Would you recommend the applicant for licensure? Yes - without reservation

Additional comments (An additional sheet may be added if needed): _____

Signature of Physician

John W. Stutsman, MD
Name of Physician (Please type or print clearly)

Medical Director
Position

(317) 637-4343
Telephone number (include area code)

jostutsm@iupui.edu
E-Mail

(317) 637-4344
Fax number (include area code)

Employer Recommendation Form

URGENT LICENSURE PENDING

State Medical Board of Ohio

30 E. Broad St., 3rd Floor • Columbus, OH 43215-6127 • (614) 466-3934 • Website: http://med.ohio.gov/

Dr. Jeffrey D. GLASER
(PLEASE PROVIDE THE FIRST AND LAST NAME OF THE APPLICANT)

is applying for licensure in the State of Ohio. We would appreciate your assistance in filling out the following evaluation so that we can process his/her application for licensure. To ensure processing of the physicians application, please complete and return this form to the State Medical Board of Ohio at the above within two (2) weeks. The form may also be faxed to the Board at (614) 644-1464. Your immediate attention to this matter will be greatly appreciated by the applicant as well as by us. Thank you for your time and assistance.

Position(s) held: STAFF GYNECOLOGIST

Dates of employment: 9-2008- present

(1) How long have you known him/her? 35 YEARS

(2) What is/was your supervisory capacity? SERVICE CHIEF

(3) At what hospital? LOUISVILLE VA

(4) How would you rate his/her medical knowledge and techniques? EXCELLENT

(5) In your opinion is he/she a person of good moral and ethical character? YES

(6) Does he/she work well with peers and medical staff? YES

(7) Does he/she relate well to patients? YES

(8) How is his/her command of the English language if applicable)? FLUENT, NATIVE SPEAKER

(9) Would you recommend him/her for licensure? YES, WITHOUT RESERVATION

Additional comments, please: (f needed, an extra sheet of paper may be used)

Sincerely,
Nicole Weaver
Chief, Licensure

Signature of Physician

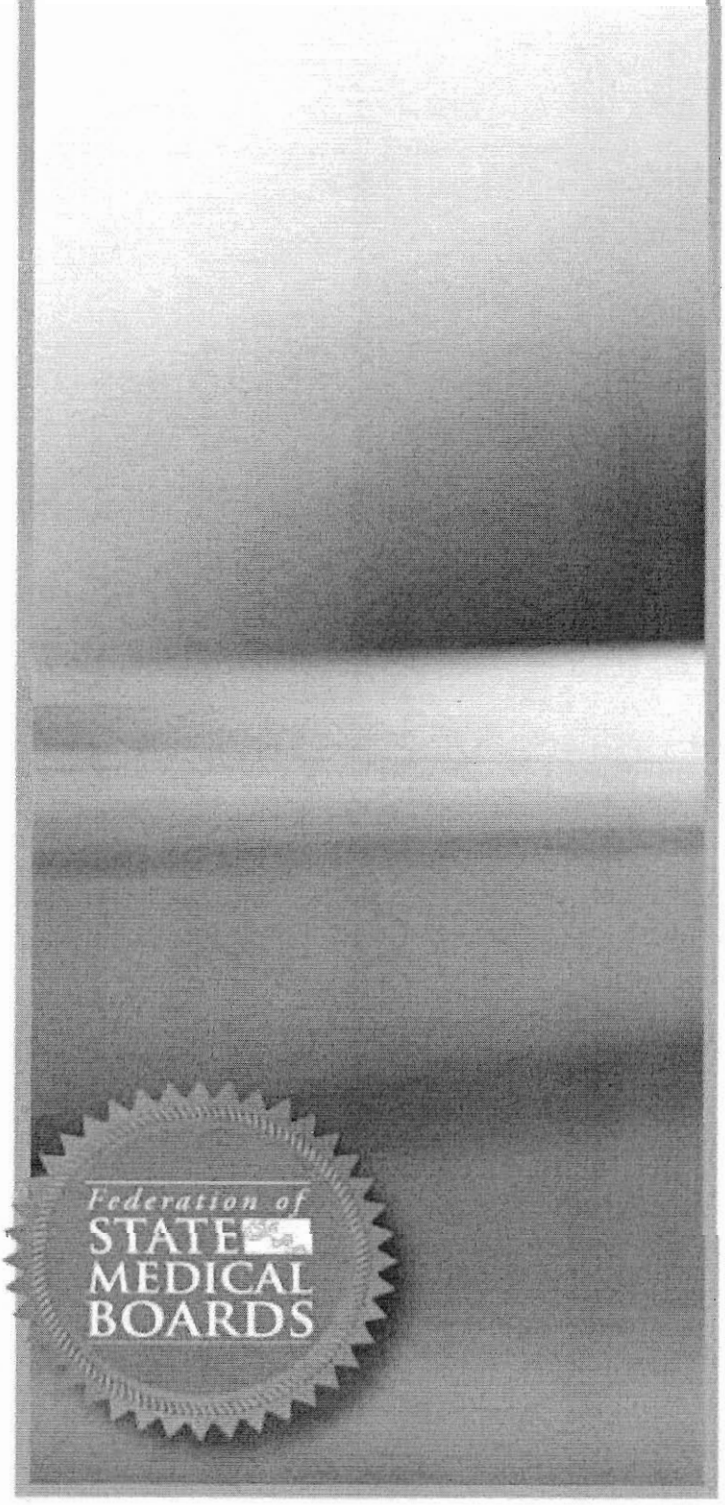
HL SPIELVACK MD
Name of Physician (please type or print clearly)

CLINICAL INFORMATICS
Position

502 · 558 · 2217
Telephone number (include area code)

502 · 287 · 6206
FAX number (include area code)

FCVS | FEDERATION CREDENTIALS VERIFICATION SERVICE



Medical Professional Information Profile

This report provides credentialing information for

Name: **Jeffrey David Glazer**

Social Security Number: [redacted]

Date of Birth: **May 01, 1957**

FID#: **207424185**

Recipient: **OH - State Medical Board of Ohio**

ABOUT THIS PROFILE

The Federation Credentials Verification Service (FCVS) was retained by the above referenced medical professional to verify his/her medical credentials for submission to your agency/organization. Unless noted otherwise, all documents contained in this report were received directly from the issuing institution per written request made by FCVS.

NOTICE: All documents bearing an original Official FCVS seal are certified to be an exact reproduction of the original. Where required, original documents are provided according to the agreements with the institution issuing such document. FCVS maintains all original documents (excluding third-party examination transcripts) in the physician's source file.

This FCVS Medical Professional Information Profile ("Profile") is compiled and provided by the Federation of State Medical Boards of the United States, Inc. (Federation) as a reference source for, and only for, its member boards and other entities authorized by the Federation. The Profile embodies and contains confidential business information because the information, and the format and presentation of that information, comprise trade secrets of the Federation and because the Profile's disclosure would harm the Federation by providing others with an unfair business advantage in competing with the Federation's FCVS services. Further, the form of the Profile and the contents of this Profile, including the compilation of information in this Profile, are the Federation's copyrighted works and proprietary, confidential information and are subject to the protections of United States laws governing copyright, trademark and trade secrets, as well as various state laws protecting the Federation's trade secrets and other intellectual property rights. This Profile and its contents may not be (1) copied, reformatted, modified, published or displayed publicly or (2) used, disclosed, distributed, shared or sold, in whole or part, for any purpose, including use to establish any database or files as a compendium or otherwise, all of which is strictly prohibited without the express written consent of the Federation's CEO.

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FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Credentials Analysis Summary Report

Federation of STATE MEDICAL BOARDS

Note: *Your board may wish to review the unresolved items below marked by an "X"*
Please review the Credentials Analysis Report for further details on the unresolved items

Medical Professional Name: **jeffrey david glazer**
Date of Birth: **May 01, 1957**
Social Security Number: [redacted]
FID: **207424185**

I. FCVS Reports

II. FSMB and Other Reports

III. Identity

A. Certified Birth Certificate OR Copy w/ Cert. of Identification

IV. Medical Education

A. Pre-medical Schools

B. Medical Schools

University of Louisville School of Medicine
1. Medical Education Form and Translation
2. Medical Education Transcript and Translation
3. Medical Education Diploma and Translation

C. Fifth Pathway Program

D. ECFMG Certification

V. Graduate Medical Education

University of Florida Health Science Center
1. GME Form
2. GME Completion Certificate

VI. Licensure Examination History

A. NBME Endorsement of Certification

End of report for: jeffrey david glazer

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FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Medical Professional Information Profile

Federation of STATE MEDICAL BOARDS

Table of Contents

400 FULLER WISER ROAD | SUITE 300 | EULESS, TX 76039 | TEL(817)868-5000 | FAX(817)868-5099

Section I

FCVS Reports

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FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Medical Professional Information Report

Federation of STATE MEDICAL BOARDS

Identity

Medical Professional Name: **Jeffrey David Glazer**

Documentation: Certified Birth Certificate OR Copy w/ Cert. of Identification

Gender: Male

Date of Birth: May 01, 1957

Place of Birth: Louisville, KY, UNITED STATES

Social Security Number: [redacted]

FID: 207424185

Physical Description:
Height: 6 ft. 0 in.
Weight: 200 lbs.
Eye Color: Brown
Hair Color: Brown

Contact Information

Mailing Address:
2325 CHEROKEE PKWY
LOUISVILLE, KY 40204-2215
UNITED STATES

Permanent Address:
2325 CHEROKEE PKWY
LOUISVILLE, KY 40204-2215
UNITED STATES

Telephone Numbers:
Primary: (502) 558-7900
Secondary: N/A
Fax: N/A
Other: N/A

Pre-medical Education

(Provided by Applicant. Not verified with the primary source.)

Institution: **University of Louisville**
Address: Louisville, KY 40292
UNITED STATES
Dates of Attendance: 03/--/1975 To 05/--/1979
Degree Conferred/Issued: Bachelor of Arts

ECFMG

There are none identified or not applicable.

Medical Education

Medical School: **University of Louisville School of Medicine**
Address: Abell Administration Center
323 E Chestnut St
Louisville, KY 40292
UNITED STATES

Dates of Attendance: 08/13/1979 to 05/08/1983
Date Certificate Issued: 05/15/1983
Degree Conferred/Issued: Doctor of Medicine

Unusual Circumstances
Leave of Absence/Extension: **No**
Probation: **No**
Disciplined: **No**
Negative Reports: **No**
Limitations: **No**

Fifth Pathway

There are none identified or not applicable.

Graduate Medical Education

Institution: **University of Florida Health Science Center**
Address: 655 W Eighth St

Jacksonville, FL 32209
UNITED STATES

Training Level: 1 - 3
Program Type: Residency
Specialty: Obstetrics and Gynecology
Dates of Attendance: 07/01/1983 To 06/30/1986
Completed Successfully: Yes
Accreditation: ACGME

Training Level: 4
Program Type: Chief Resident
Specialty: Obstetrics and Gynecology
Dates of Attendance: 07/01/1986 To 06/30/1987
Completed Successfully: Yes
Accreditation: ACGME

Unusual Circumstances
Leave of Absence/Extension: **No**
Probation: **No**
Disciplined: **No**
Negative Reports: **No**
Limitations: **No**

Licensure Examinations

NBME - National Board of Medical Examiners NBME Part I	Date: 06/1981	Passed the Exam
NBME - National Board of Medical Examiners NBME Part II	Date: 04/1982	Passed the Exam
NBME - National Board of Medical Examiners NBME Part III	Date: 03/1984	Passed the Exam

ABMS Verification

A report of the result from a search of the data provided by the American Board of Medical Specialties is enclosed.

Board Action

A report of the results from a search of the Board Action Data Bank is enclosed.

End of report for: jeffrey david glazer FID: 207424185

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Credentials Analysis Report

Federation of STATE MEDICAL BOARDS

The Credentials Analysis Report is a comparative report of a medical professional's credentials as reported to FCVS by the applicant and the primary source (Medical School, Post Graduate Training program, etc.). It will also list particular missing documentation, if any, as outlined in the FCVS Policies and Procedures.

Medical Professional Identification

Medical Professional Name:	**jeffrey david glazer**
Date of Birth:	**May 01, 1957**
Social Security Number:	[redacted]
FID:	**207424185**

Omissions

There are no omissions identified.

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Discrepancies

There are no discrepancies identified.

Miscellaneous Information

There is no miscellaneous information identified.

End of report for: jeffrey david glazer

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Chronology of Activities

Federation of STATE MEDICAL BOARDS

The Chronology of Activities is a comprehensive report of a medical professional's activities as reported to FCVS by the medical-professional applicant.

Medical Professional Name: **jeffrey david glazer**
Date of Birth: **May 01, 1957**
Social Security Number: [redacted]
FID#: **207424185**

Start Date	End Date	Activity	Location	Overlap Explanation	Program Length Explanation
08/1979	05/1983	Medical Education Record	University of Louisville School of Medicine,Abell Administration Center Louisville, KY 40292 UNITED STATES		
06/1983	06/1987	GME Record	University of Florida Health Science Center,655 W Eighth St Jacksonville, FL 32209 UNITED STATES		

End of report for: jeffrey david glazer

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Section II

FSMB and Other Reports

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FPDC | FEDERATION PHYSICIAN DATA CENTER

Board Action Clearance Report

April 21, 2014

Attn:

Re: Board Action Query Dated: April 21, 2014
FSMB Batch Number: BQ2429700

The following is a report of the search results from the Board Action Data Bank as of April 21, 2014 for practitioners submitted as part of the above-referenced batch for which NO board actions were identified.

Provider cleared with No Actions as of April 21, 2014

Name	DOB	School	Yr/Grad	Provider ID
jeffrey david glazer	05/01/1957	018020	1983	246734

License History

Licensing Entity
GEORGIA
INDIANA
KENTUCKY

PLEASE NOTE: The licensure history information contained in these reports is not considered licensure verification but rather an indicator of known states of historical licensure for these individuals. Use of this information should be limited to cross-reference purposes.

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FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

ABMS Verification of Certification

Federation of STATE MEDICAL BOARDS

As of:	**04/21/2014**
Medical Professional Name:	**Jeffrey David Glazer**
Date of Birth:	**5/1/1957**
Year of Graduation:	**(Doctor of Medicine)**
ABMSUID#:	**9007**

Certification

Certification:

Board:	Obstetrics and Gynecology
Specialty:	Obstetrics and Gynecology
Status:	ACT
Initial Certification:	12/07/1990

End of report for Jeffrey David Glazer

All certification information on the ABMS report is based on a search of data shared with the FSMB by the American Board of Medical Specialties. For some physicians the biographic data in the ABMS database is incomplete and is not included in the shared data. FCVS is unable to verify specialty certification on these physicians. FCVS does not follow up with the applicant or ABMS on any missing or discrepant information.

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Section III

Identity

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FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Affidavit and Release

Federation of STATE MEDICAL BOARDS

I, the undersigned, hereby certify under oath that I am the person named in this application, that all statements I have or shall make with respect thereto are true, that I am the original and lawful possessor and person named in the various forms and credentials furnished or to be furnished with respect to my application and that all documents, forms or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

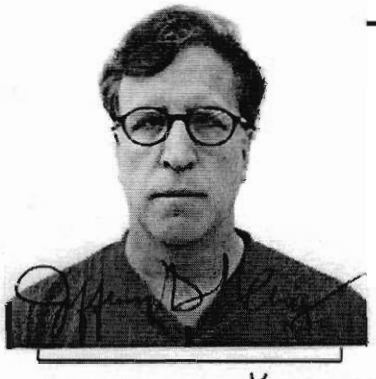
I acknowledge that I have read and understand the "INSTRUCTIONS FOR COMPLETING THE FCVS APPLICATION" and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to me being prosecuted under appropriate federal and state laws.

I authorize and request every person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me to furnish to the Federation Credentials Verification Service any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data and to permit the Federation Credentials Verification Service or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application.

Notary:
The physician has been instructed to sign the front of the photograph. Your seal (or stamp) must be partly upon the photo and partly upon the signature of the applicant.

I, hereby release, discharge and exonerate the Federation Credentials Verification Service, its agents or representatives and any person furnishing information, of any and all liability of every nature and kind arising out of investigation made by the Federation Credentials Verification Service. I authorize the Federation Credentials Verification Service to release information, material, documents, orders or the like relating to me or this application to any entity at my request.

While the FSMB will only use collected personal information for the purposes described on our website and in the FCVS application materials, the FSMB has no control over the entities to which an applicant authorizes the release of FCVS materials. Such entities may include state medical boards, state osteopathic boards, and other entities that may be subject to state and federal public information or open records laws, which might require the release of certain FCVS packet information to the public upon request.



Applicant's Signature (must be signed in the presence of a notary)

GLATER

Applicant's Printed Last Name

7-3-2012

Date of Signature (must correspond to date of notarization)

State of Kentucky, County of Jefferson,
I certify that on the date set forth below the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document. The statements on this document are subscribed and sworn to before me by the applicant on this 3rd day of July, 2012.

Notary Public Signature:

My Notary Commission Expires: 02-28-2015

246734 246734 207424185

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Registrar of Vital Statistics
Certified Copy

THE FACE OF THIS DOCUMENT HAS A COLORED BACKGROUND - NOT A WHITE BACKGROUND

FORM V.S. NO. 2-A
REV. 1-56
FEDERAL SECURITY AGENCY
PUBLIC HEALTH SERVICE
NATIONAL OFFICE VITAL STATISTICS

COMMONWEALTH OF KENTUCKY
DEPARTMENT OF HEALTH
DIVISION OF VITAL STATISTICS
CERTIFICATE OF LIVE BIRTH

FILE NO. 116 57- 22918
REGISTRAR'S NO. 5162

Registration District No. 7 5 5 Primary Registration District No. 2275

1. PLACE OF BIRTH a. COUNTY: Jefferson	2. USUAL RESIDENCE OF MOTHER (Where does mother live?) a. STATE: Kentucky b. COUNTY: Jefferson
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Louisville	c. CITY OR TOWN: Louisville — IS RESIDENCE ON A FARM? YES ☐ NO ☒
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital or institution, give street address or location): Jewish Hospital	d. STREET ADDRESS: 3721 Chevy Chase Road — IS RESIDENCE INSIDE CITY LIMITS? YES ☐ NO ☒

3. CHILD'S NAME (Type or Print) a. (First) Jeffrey b. (Middle) David c. (Last) Glazer

4. SEX	5a. THIS BIRTH	5b. IF TWIN OR TRIPLET (This child born)	6. DATE OF BIRTH (Month) (Day) (Year)
Male	SINGLE ☒ TWIN ☐ TRIPLET ☐	1ST ☐ 2ND ☐ 3RD ☐	May 1 1957
			HOUR 7:28A MCST

FATHER OF CHILD

7. FULL NAME a. (First) Norman b. (Middle) c. (Last) Glazer	8. COLOR OR RACE: White
9. AGE (At time of this birth): 31 YEARS	10. BIRTHPLACE (State or foreign country): Louisville, Kentucky
11a. USUAL OCCUPATION: Physician	11b. KIND OF BUSINESS OR INDUSTRY:

MOTHER OF CHILD

12. FULL MAIDEN NAME a. (First) Georgene b. (Middle) c. (Last) Reilly	13. COLOR OR RACE: White
14. AGE (At time of this birth): 30 YEARS	15. BIRTHPLACE (State or foreign country): Brooklyn, New York

16. CHILDREN PREVIOUSLY BORN TO THIS MOTHER (Do NOT include this child)

a. How many OTHER children are now living?	b. How many OTHER children were born alive but are now dead?	c. How many children were stillborn (born dead after 20 weeks of pregnancy)?
2	-	-

17. INFORMANT: Mrs. Norman Glazer - Mother

I hereby certify that this child was born alive on the date stated above.

18a. ATTENDANT AT BIRTH: M.D. ☒ D.O. ☐ MIDWIFE ☐ OTHER (Specify)
18b. SIGNATURE: Samuel S. [signature], M.D.
18c. ADDRESS: 313 Heyburn Building
18d. DATE SIGNED: May 1, 1957

19. DATE REC'D BY LOCAL REG.: MAY 9 1957
20. REGISTRAR'S SIGNATURE: [signature] Rauh
21. DATE ON WHICH GIVEN NAME ADDED BY (Registrar)

SEAL VERIFIED

THE BACK OF THIS DOCUMENT CONTAINS AN ARTIFICIAL WATERMARK - HOLD AT AN ANGLE TO VIEW

I, Robert N. Hurst III, Registrar of Vital Statistics, hereby certify this to be a true and correct copy of the certificate of birth/death of the person therein named, and that the original certificate is registered under the file number shown. In testimony thereof I have hereunto subscribed my name and caused the official seal of the Office of Vital Statistics to be affixed at Frankfort, Kentucky this 23 day of [illegible], 19 98

246734

Robert N. Hurst III [signature]
Robert N. Hurst III, State Registrar

Section IV

Medical Education

400 FULLER WISER ROAD | SUITE 300 | EULESS, TX 76039 | TEL(817)868-5006 | FAX(817)868-5099

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Verification of Medical Education

Federation of STATE MEDICAL BOARDS

Instruction to the Dean

Please complete both pages of this form, sign date and seal on the front page then return to:

Federation Credentials Verification Service
400 Fuller Wiser Rd
Suite 300
Euless, TX 76039

The individual identified on the attached Authorization for Release of Information, Documents and Records form has authorized your medical school to provide to the Federation Credentials Verification Service (FCVS) any and all information pertaining to their education at your institution.

Please note: If your institution processes transcript requests through another office, FCVS has likely made such a request under separate cover.

If your office also processes transcript requests, please attach the individual's official transcript (which indicates courses taken, dates and hours of attendance, and scores, grades, or evaluation).

Institution Name: University of Louisville School of Medicine

Address Line 1:
University of Louisville School of Medicine

Address Line 2:

City: Louisville **State/Province:** KY **Zip Code (Postal Code):** 40292
Country: US

If name of institution was different when this individual attended, please note this name below:

Premedical Education:
Years of education required for admission to your medical school: 3 yrs.
Credential/degree presented by the applicant for admission to your medical school: Bachelor's

Enrollment and Participation: Our records indicate that Glazer, Jeffrey David
(type/print individual's name: Last, First, Middle, Suffix)
attended our medical school for total of 156 weeks of medical education on the following dates: From: 8 13 79 To: 5 8 83
Month Day Year Month Day Year

This individual
Was awarded the degree of Doctor of Medicine on 5 15 83
Month Day Year
Was NOT awarded a degree because: (please explain - additional page if necessary)

Attestation

Affix Institutional Seal Here

If no seal is available, this form must be notarized.

Watermark
For FCVS internal use only.

ELECTRONIC SEAL VERIFIED

Name: [redacted]
Signature:
Title:
Date of Signature: 8/1/12 **Phone:** 502 852-6183
Fax: 502 852-5871 **Email:** slgary01@louisville.edu

246734 2276 207424185

Unusual Circumstances

1. Do this individual's official records reflect (an) interruption(s) or extension(s) in his/her medical education? ___ YES ___ NO

If Yes, please specify the reason(s) for, indicate the date of the interruptions(s) or extension(s) and check whether the interruption/extension was approved or unapproved:

Personal/Family	From (Mo/Yr)___/___	To (Mo/Yr)___/___	___ Approved	___ Unapproved
Academic remediation	From (Mo/Yr)___/___	To (Mo/Yr)___/___	___ Approved	___ Unapproved
Health	From (Mo/Yr)___/___	To (Mo/Yr)___/___	___ Approved	___ Unapproved
Financial	From (Mo/Yr)___/___	To (Mo/Yr)___/___	___ Approved	___ Unapproved
Participation in joint degree Program (e.g., MD/PhD)	From (Mo/Yr)___/___	To (Mo/Yr)___/___	___ Approved	___ Unapproved
Participation in non-research special study (e.g., fellowship, international experience)	From (Mo/Yr)___/___	To (Mo/Yr)___/___	___ Approved	___ Unapproved
Participation in non-degree research	From (Mo/Yr)___/___	To (Mo/Yr)___/___	___ Approved	___ Unapproved
Other	From (Mo/Yr)___/___	To (Mo/Yr)___/___	___ Approved	___ Unapproved

Please Specify:

2. Do this individual's official records reflect that he/she was ever placed on academic or disciplinary probation during his/her medical education? ___ YES ___ NO

If YES, please select the reason(s) for the probation, indicate the dates of placement on and removal from probation and attach additional documentation to this report:

Academic Probation	From (Mo/Yr)___/___	To (Mo/Yr)___/___
Probation for unprofessional conduct/behavioral	From (Mo/Yr)___/___	To (Mo/Yr)___/___
Probation for other reason	From (Mo/Yr)___/___	To (Mo/Yr)___/___

Please specify a reason:

3. Do this individual's official records reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons by the medical school or parent university? ___ YES ___ NO

If YES, please provide detailed documentation/information about the circumstances and outcome(s):

4. Do this individual's official records reflect that he/she was ever the subject of negative reports for behavioral reasons or an investigation by the medical school or parent university? ___ YES ___ NO

If YES, please provide detailed documentation/information about the circumstances and outcome(s):

___ YES ___ NO

5. Do this individual's official records reflect that there were any limitations or special requirements imposed on the individual because of questions of academic incompetence, disciplinary problems, or any other reason?

If YES, please provide detailed documentation/information about the nature of the limitations or special requirements:

246734 2276 207424185

246734

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Applicant Reported Unusual Circumstances

Federation of STATE MEDICAL BOARDS

Medical School

Medical Professional Name: jeffrey david glazer
University of Louisville School of Medicine

Unusual Circumstances

Did you have any interruption(s) or extension(s) in your medical education?	Yes	**No**
Were you ever placed on probation?	Yes	**No**
Were you ever disciplined or placed under investigation?	Yes	**No**
Were any negative reports for behavioral reasons ever filed by instructors?	Yes	**No**
Were any limitations or special requirements imposed on you because of academic performance, incompetence, disciplinary problems or for any other reason?	Yes	**No**

End of report for: jeffrey david glazer

PROVIDED BY APPLICANT

400 FULLER WISER ROAD | SUITE 300 | EULESS, TX 76039 TEL(817)868-5000 FAX(817)868-5099

UNIVERSITY OF
LOUISVILLE. Louisville, Kentucky 40292

OFFICIAL TRANSCRIPT

(A BLACK AND WHITE TRANSCRIPT IS NOT AN ORIGINAL)

This officially sealed and signed transcript is printed on security paper with the name of the university printed in small red type across the face of the document. A raised seal is not required.

THIS IS A TRUE COPY OF A RECORD ON FILE AT THE UNIVERSITY OF LOUISVILLE.

Scott A. Burke
ACTING REGISTRAR

NAME: GLAZER, JEFFREY DAVID

STUDENT ID: 1170888 BIRTH DATE: MAY 01

DATE PRINTED: 07/24/2012

COURSE NO.	COURSE TITLE	GRADE	EARNED HOURS	HAW/G	QUALITY POINTS
- - - - -	DEGREES AWARDED - - - - -				
DEGREE:	DOCTOR OF MEDICINE				
PLAN:	MEDICINE				
AWARDED:	1983-05-15				
- - - - -	BEGINNING OF SCHOOL OF MEDICINE RECORD - - - - -				
*** SPRING 1983 ***					
PROGRAM:	MEDICAL SCHOOL - DEGREE				
EMED 910	CLINICAL ELECTIVE	P	6.0		
MED 907	CLINICAL ELEC OFF CAMPUS	P	4.0		
OB&G 907	CLINICAL ELEC OFF CAMPUS	P	4.0		
OB&G 907	CLINICAL ELEC OFF CAMPUS	P	4.0		
OPHT 902	OPHTHALMOLOGY	P	1.0		
SURG 902	SURGERY	P	9.0		
SURG 906	CLINICAL ELECTIVE URBAN	P	2.0		
	TERM GPA: 0.000 TERM TOTALS:		30.0	0.0	0.000
	CUM GPA: 0.000 CUM TOTALS:		30.0	0.0	0.000
SCHOOL OF	MEDICINE CAREER TOTALS				
	CUM GPA: 0.000 CUM TOTALS:		30.0	0.0	0.000
- - - - -	End of Transcript - - - - -				

SEAL VERIFIED

246734

2276

UNIVERSITY OF
LOUISVILLE.

OFFICIAL TRANSCRIPT

AUTHENTICITY CONFIRMATION

When photocopied, the word COPY will appear several times in large letters. A black and white transcript is not an original. Alteration of the transcript may be a criminal offense. No official transcript is issued to or for a student indebted to the University. Further authentication can be obtained by calling (502) 852-6522.

FED CRED VERI SVCS
MED BOARD
400 FULLER WISER
STE 300
EULESS, TX 76039

KEY TO TRANSCRIPT

Effective the 1982 Fall Semester, the University of Louisville implemented a new Student Records System and is no longer maintaining record cards. Transcripts for students who were enrolled in the University prior to Fall 1982 consist of copies of two types of records.

With the transition, two major policy changes were implemented.

1. Effective Fall 1982, the student record will show a University GPA within Undergraduate, Graduate, Law, Medical, and Dental levels. All records prior to Fall 1982 show totals applicable to programs. Therefore totals on the previous record may not agree with INITIAL STATISTICS entry on the new record. Old records have not been changed.

2. Effective Fall 1982, the University expresses transfer work in total hours earned only. Previously some colleges exercised selectivity in the transfer of courses applicable to programs and some colleges included grades and quality points. Therefore totals on the previous record may not agree with INITIAL STATISTICS entry on the new record card. Old records have not been changed.

ABBREVIATIONS

HAW/G	Hours attempted with grade
GPA	Grade Point Average
CUM	Cumulative

To arrive at the Grade Point Average, divide Quality Points by Hours attempted with Grade.

The University of Louisville uses the Semester Hour Unit of credit and a 4.0 Grading system.

RELEASE OF INFORMATION

In accordance with the Family Educational Rights and Privacy Act of 1974, this record and information contained therein cannot be released to a third party without the written consent of the student.

GRADES

		Quality Pts
A+		4.0
A	Excellent	4.0
A-		3.7
B+		3.3
B	Above Average	3.0
B-		2.7
C+		2.3
C	Average	2.0
C-		1.7
D+		1.3
D	Below Average	1.0
D-		0.7
F	Failing	0.0

AU	Audit
CR	Credit
H	Honors
I	Incomplete
P	Pass
S	Satisfactory
T	Test Credit
U	Unsatisfactory
W	Withdrawn
WF	Withdrew - Failing
WP	Withdrew - Passing
X	Deferred

GENERAL EDUCATION CODES

The University uses the following codes at the end of the title.

A	Arts
B	Natural Science with Lab
CD1	Understanding Cultural Diversity 1
CD2	Understanding Cultural Diversity 2
H	Humanities
M	Mathematics
OC	Oral Communication
S	Natural Sciences
SB	Social and Behavioral Sciences
SL	Natural Sciences Lab
WC	Written Communication

COURSE NUMBERING SYSTEM

000-100	Non-Degree Credit Beginning Fall, 1998, developmental courses below the 100 level do not count toward earned hours.
101-499	Undergraduate Credit
500-599	May be undergraduate or graduate credit
600-799	Graduate Credit
800-999	Professional Credit Prior to Fall, 1982, Professional School numbers started with 1001.

METROVERSITY

The University of Louisville is a member of the Kentuckiana Metroversity consortium. When students register for courses taught by other member schools, these courses will be designated by a code which indicates the institution.

MBEC	Bellarmine University
MIUS	Indiana University Southeast
MJCC	Jefferson Community and Technical College
MLPS	Louisville Presbyterian Seminary
MSBS	Southern Baptist Seminary
MSPC	Spalding University

The course number and title are also indicated.

ACADEMIC INFORMATION

Information concerning the nature of Academic Dismissals can be obtained with the student's permission from the Office of the University Provost.

The University of Louisville is accredited by the Commission on Colleges of the Southern Association of Colleges and Schools to award associate, bachelor, master, specialist, doctoral, and first professional degrees (D.M.D., J.D., M.D.). Individuals who wish to contact the Commission on Colleges regarding the accreditation status of the university may write the Commission at 1866 Southern Lane, Decatur, Georgia 30033-4097, or call (404) 679-4500.

UNIVERSITY OF LOUISVILLE LOUISVILLE, KENTUCKY 40208

COPIES OF THIS ACADEMIC RECORD ARE VALID ONLY WHEN SIGNATURE AND SEAL ARE AFFIXED

Microfilmed

NO.	SURNAME	FIRST	MIDDLE	SEX	H.S.	LOC.
87421	GLAZER,	Jeffrey	David	M		

MEMORANDA: 3/24/1975: ADMITTED TO A&S

804 Samoa Way, Louisville, Kentucky 40207
HOME ADDRESS

DATE GRADUATED RANK

PARENT OR LEGAL GUARDIAN

ADDRESS

BIRTH DATE 5/1/1957 PLACE Louisville, Kentucky

1170888
Glazer,Jeffrey David

2h634

A - EXCELLENT 4 POINTS PER HOUR
B - GOOD 3 POINTS PER HOUR
C - AVERAGE 2 POINTS PER HOUR
D - POOR 1 POINT PER HOUR
F - FAILURE 0 POINT PER HOUR
WF - WITHDRAWN FAILURE 0 POINT PER HOUR
I - INCOMPLETE
W - WITHDRAWN
WP - WITHDRAWN PASSING
AU - AUDIT
X - DEFERRED
P - CREDIT
H - PASSING WITH HONORS
S - SATISFACTORY
U - UNSATISFACTORY

DEPT.	COURSE NO.	COURSE TITLE	HOURS ATT.	SEM. HRS. EARNED	GRADE	POINTS
		B.A., UNIVERSITY OF LOUISVILLE, 5/13/1979				
		8/13/1979: ADMITTED TO SCHOOL OF MEDICINE				
		"P" or "F" are the only grades issued for Medical School courses. Additional faculty evaluations are conveyed by the Office of the Dean.				
	087421	YEAR 1979-80 MEDICAL				
ANAT	1101	GROSS ANATOMY	7	7	P	0
ANAT	1103	MICROSCOPIC ANATOMY	4	4	P	0
ANAT	1105	HUMAN EMBRYOLOGY	2	2	P	0
ANAT	1155	CORRELATIVE ANATOMY	2	2	P	0
BIOC	1101	BIOCHEMISTRY	7.5	7.5	P	0
CLIN	1101	CLINICAL CORRELATION	4	4	P	0
EMED	1101	BASIC EMERGENCY CARE	0.5	0.5	P	0
IDEP	1104	MEDICAL CELL BIOLOGY	5	5	P	0
IDEP	1115	NEUROSCIENCES	5	5	P	0
IDEP	1128	HUMAN VALUES-MED	1	1	P	0
PHY	1101	HUMAN PHYSIOLOGY	6.5	6.5	P	0
PSY	1159	HUM BHVR-HLTH&DIS	1	1	P	0
		XXXXX 0.00		45.50		0.00

DEPT.	COURSE NO.	COURSE TITLE	HOURS ATT.	SEM. HRS. EARNED	GRADE	POINTS
	087421	YEAR 1980-81 MEDICAL				
ANAT	1285	REVW OF NEUROANATOMY	1	1	P	0
ANES	1262	INTRO ANESTHESIOLOGY	2	2	P	0
C H	1201	INTR-COMMUNITY HLTH	0.5	0.5	P	0
CLIN	1201	CLINICAL CORRELATION	1	1	P	0
FPRA	1201	INTR-FAMILY PRACTICE	1	1	P	0
MBIO	1201	MICROBIO-IMMUNOLOGY	8	8	P	0
MED	1201	CLINICAL DIAGNOSIS	5	5	P	0
MED	1202	PHYSICAL MED REHAB	1	1	P	0
MED	1203	DERMATOLOGY	0.5	0.5	P	0
MED	1275	ENDOCRINE&METAB PROB	3	3	P	0
OB&G	1260	CLIN ASPT REPRO BIOL	2	2	P	0
OPHT	1201	INTR-OPHTHALMOLOGY	1	1	P	0
PATH	1201	PATHOLOGY	12	12	P	0
PATH	1202	LABORATORY MEDICINE	0.5	0.5	P	0
PATH	1283	MED DISEASES-KIDNEY	1	1	P	0
PED	1201	INTR-PEDIATRICS	0.5	0.5	P	0
PHAR	1201	PRIN OF PHARMACOLOGY	7	7	P	0
PSY	1201	BEHAVIORAL SCIENCE	3	3	P	0
PSY	1202	CLIN PSYCHIATRY	1	1	P	0
RADI	1201	CLIN RADIOLOGY	0.5	0.5	P	0
		XXXXX 0.00		51.50		0.00

CONTINUED ON PAGE 2

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Scott A. Burks
UNIVERSITY ACTING REGISTRAR

CONTINUATION FROM PAGE 1 OF THE RECORD OF

DEPT.	COURSE NO.	COURSE TITLE	HOURS ATT.	SEM. HRS. EARNED	GRADE	POINTS
	087421	YEAR 1981-82 MEDICAL				
MED	1301	MEDICINE	10	10	P	0
MED	1401	PRIMARY CARE	10	10	P	0
OB&G	1301	OBSTETRICS & GYN	6.5	6.5	P	0
PED	1301	PEDIATRIC CLERKSHIP	6.5	6.5	P	0
PSY	1301	BASIC CLIN PSY	6.5	6.5	P	0
SURG	1301	SURGERY	9	9	P	0
		XXXXX 0.00		48.50		0.00

GLAZER, JEFFREY D.
403-72-4887 ME

SEAL
VERIFIED

DEPT.	COURSE NO.	COURSE TITLE	HOURS ATT.	SEM. HRS. EARNED	GRADE	POINTS

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UNIVERSITY ACTING REGISTRAR

DEGREE

TRANSCRIPTS:

UNIVERSITY OF LOUISVILLE LOUISVILLE, KENTUCKY 40208

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NO.	SURNAME	FIRST	MIDDLE	SEX	H.S.	LOC.
87421	GLAZER	Jeffrey	David	M	Waggener	Louisville, Kentucky

804 Samoa Way, Louisville, Kentucky 40207
HOME ADDRESS

Norman Glazer
PARENT OR LEGAL GUARDIAN

804 Samoa Way, Louisville, Kentucky 40207
ADDRESS

BIRTH DATE 5/1/1957 PLACE Louisville, Kentucky

DATE GRADUATED 3/5/1975 RANK

MEMORANDA
8/13/1979: ADMITTED TO SCHOOL OF MEDICINE

DEGREE	MAJOR	DATE
B.A.	Biology	5/13/1979

DEGREE MAJOR DATE
STATUS

A - EXCELLENT 4 POINTS PER HOUR
B - GOOD 3 POINTS PER HOUR
C - AVERAGE 2 POINTS PER HOUR
D - POOR 1 POINT PER HOUR
F - FAILURE 0 POINT PER HOUR
WF - WITHDRAWN FAILURE 0 POINT PER HOUR
I - INCOMPLETE
W - WITHDRAWN
WP - WITHDRAWN PASSING
AU - AUDIT
X - DEFERRED
P - CREDIT
H - PASSING WITH HONORS
S - SATISFACTORY
U - UNSATISFACTORY

DEPT.	COURSE NO.	COURSE TITLE	HOURS ATT.	SEM. HRS. EARNED	GRADE	POINTS
		3/24/1975: ADMITTED TO ARTS & SCIENCES MATRICULATED				
	87421	SPR SEM-75 A&S				
ENGL	101	ENGL COMPOSITION I	3	3	P	0
HIST	108	HIST-WORLD CIVIL IV	3	3	B	9
		3.0000 3.00		6.00		9.00
		EARNED INDIANA UNIVERSITY 1975-76				
		INTRO AMER POL	3	3	B	9
		CALC	3	3	A	12
		AMER HIST	-	3	P	-
		EXPERIM CHEM	4	4	CB	10
		PRIN CHEM	3	3	B	9
		QUANT CHEM	3	3	C	6
		PHYS EDUC	1	1	A	4
		INTRO PSYCH	3	3	A	12
		ANIMAL BIOL-LAB	5	5	C	10
		TOTAL	25	28		72
		TOTAL ALLOWED(PRORATED)	25	28		72
	87421	SUM SEM-76 A & S				
CHEM	341	ORGANIC CHEMISTRY I	3	3	B	9
CHEM	342	ORGANIC CHEM II	3	3	C	6
CHEM	343	ORGANIC CHEM LAB I	1	1	B	3
CHEM	344	ORGANIC CHEM LAB II	1	0	W	0
		2.5714 7.00		7.00		18.00
				13		27

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DEPT.	COURSE NO.	COURSE TITLE	HOURS ATT.	SEM. HRS. EARNED	GRADE	POINTS
	087421	FALL SEM-76 A&S				
ARTH	203	INTRODUCTION TO ART	3	0	W	0
BIOL	311	CELLULAR BIOLOGY	4	4	B	12
GEOG	307	GEOG OF U.S. &CANADA	3	3	B	9
PHIL	303	MODERN PHILOSOPHY	3	3	B	9
SPAN	201	INTERMED SPANISH I	3	3	B	9
		3.0000 13.00		13.00		39.00
		23		26		66
		EARNED BY ADVANCED PLACEMENT				
		SPANISH 101-102	-	6	P	-
		TOTAL	-	6		-
		23		32		66
	087421	SPR SEM-77 A&S				
BIOL	312	GENETIC BIOLOGY	4	4	A	16
BIOL	404	UNDERGRAD RESEARCH	3	3	A	12
ENGL	102D	ENGL COMPOSITION II	3	3	A	12
POLS	202	COMPAR POLIT SYSTEMS	3	3	A	12
SPAN	202	INTERMED SPANISH II	3	3	A	12
		4.0000 16.00		16.00		64.00
		39		48		130

DEAN'S SCHOLAR

CONTINUED ON PAGE 2

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Scott A. Burks
UNIVERSITY ACTING REGISTRAR

CONTINUATION FROM PAGE 1 OF THE RECORD OF:

87421 GLAZER, Jeffrey David

DEPT.	COURSE NO.	COURSE TITLE	HOURS ATT.	SEM. HRS. EARNED	GRADE	POINTS
			39	48		130
	087421	FALL SEM-77 A&S				
CHEM	344	ORGANIC CHEM LAB II	1	1	B	3
ECON	202	PRIN-ECCN II-MACRO	3	3	P	0
M L	355	PENNINSULAR SPAN LIT	3	3	B	9
PHYS	105	ELEM ASTRO-SOLAR SYS	3	3	A	12
PHYS	221	FUND OF PHYSICS I	3	3	B	9
PHYS	223	FUND PHYSICS LAB I	1	1	A	4
		3.3636 11.00		14.00		37.00
		DEAN'S LIST 50		62		167
	087421	SPR SEM-78 A&S				
BIOL	112	BIOL OF POPULATIONS	3	3	A	12
HIST	107	HIST-WORLD CIVIL III	3	3	B	9
HUM	200	MASTERPIECE-WLD LIT	3	3	A	12
PHYS	224	FUND-PHYSICS LAB II	1	1	A	4
PHYS	A222	FUND OF PHYSICS II	3	3	A	12
		3.7692 13.00		13.00		49.00
		63		75		216
		ADV. STNDG.	25	28		72
			88	103		288
	087421	FALL SEM-78 A&S				
BIOL	347	COMP VERT ANATOMY	4	4	C	8
BIOL	355	BACTERIOLOGY	4	4	B	12
NATS	320	INTRO COMPUTER SCI	3	3	P	0
POLS	338	NATL SECURITY POL	3	3	A	12
		2.9091 11.00		14.00		32.00
			99	117		320

DEPT.	COURSE NO.	COURSE TITLE	HOURS ATT.	SEM. HRS. EARNED	GRADE	POINTS
			99	117		320
	087421	SPR SEM-79 A&S				
BIOL	A400R	HISTOLOGY	4	4	B	12
M L	358	CONT MEXICAN LIT-TR	3	3	A	12
MUSH	204	INTRO TO MUSIC	3	3	B	9
NATS	402	HIST&PHIL OF SCIENCE	3	3	B	9
P ED	122	BADMINTON	1	1	A	4
		3.2857 14.00		14.00		46.00
		113		131		366

5/13/1979: BACHELOR OF ARTS DEGREE WITH MAJOR IN BIOLOGY AWARDED

SEAL VERIFIED

GENERAL MEMORANDA:

OFFICIAL TRANSCRIPT

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Scott A. Burks

UNIVERSITY ACTING REGISTRAR

DEGREE

11-23-82 TRANSCRIPTS: Indianapolis free

2467334

The University of Louisville

To all to whom these Letters shall come, Greeting:

The trustees of the University on the recommendation of the University faculty and by virtue of the authority vested in them have conferred on

Jeffrey David Glazer

who has satisfactorily pursued the studies and passed the examinations required therefor the degree of

Doctor of Medicine

with all the rights, privileges and honors pertaining thereto.

Given at the University of Louisville in the Commonwealth of Kentucky on the Fifteenth day of May in the year of our Lord the One Thousand Nine Hundred Eighty-third, of the City of Louisville the Two Hundred Fifth, of the Commonwealth of Kentucky the One Hundred Ninety-first, and of the University of Louisville the One Hundred Eighty-fifth.

Chairman of the Board of Trustees

President of the University

Bruce A. Beemer
Registrar of the University

Dean of the School of Medicine

Jeffrey David Glazer
5/15/2013

SEAL OF THE UNIVERSITY OF LOUISVILLE

University of Louisville
School of Medicine
Student Affairs
Louisville, KY 40292

SEAL VERIFIED

2276

Section V

Graduate Medical Education

400 FULLER WISER ROAD | SUITE 300 | EULESS, TX 76039 | TEL(817)868-5000 | FAX(817)868-5099

Federation of STATE MEDICAL BOARDS

Federation Credentials Verification Service (FCVS)

400 Fuller Wiser Road, Suite 300, Euless, TX 76039
Tel: (817) 868-5000 Fax: (817) 868-5099

Verification of Graduate Medical Education

Institution: University of Florida Health Science Center
now known as University of Florida College of Medicine - Jacksonville

Attention: **OBSTETRICS AND GYNECOLOGY**

Specialty: Obstetrics and Gynecology

Affiliated University: University of Florida College of Medicine - Jacksonville

Address: Jacksonville, FL

Verification For:

Name: glazer, jeffrey david

DOB: 05/01/1957

Individual's Name on Record (If different from above):

RECEIVED
AUG 08 2012
By

Program Participation:

Important:
Report Incomplete Training Levels (years) separate from those that were successfully completed.

If the training level (year) is currently in progress report the expected completion date in the "To" field.

Report Internships, Residencies and Fellowships separately.

Use one section per Department/Specialty. If the Department/Specialty is rotating or transitional, please provide a schedule of rotations.

Training Level: 1-3 (e.g., 1, 2, 3, etc.)
☐ Internship ☒ Residency ☐ Chief Residency ☐ Fellowship ☐ Research
Specialty/Subspecialty: 0364N
From: 7 1 83 **To:** 6 3 86
Successfully Completed?: ☒ Yes ☐ No ☐ In Progress
Accredited by: ☒ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Training Level: 4 (e.g., 1, 2, 3, etc.)
☐ Internship ☐ Residency ☒ Chief Residency ☐ Fellowship ☐ Research
Specialty/Subspecialty: 0364N
From: 7 1 86 **To:** 6 30 87
Successfully Completed?: ☒ Yes ☐ No ☐ In Progress
Accredited by: ☒ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Training Level: _____ (e.g., 1, 2, 3, etc.)
☐ Internship ☐ Residency ☐ Chief Residency ☐ Fellowship ☐ Research
Specialty/Subspecialty: _____
From: / / **To:** / /
Successfully Completed?: ☐ Yes ☐ No ☐ In Progress
Accredited by: ☐ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Unusual Circumstances:

Check the correct response. Omitted responses require written explanation.

If necessary, you may continue your explanation on a separate sheet of paper.

SEAL VERIFIED

1. Did this individual ever take a leave of absence or break from his/her training? ☐ Yes ☒ No
2. Was this individual ever placed on probation? ☐ Yes ☒ No
3. Was this individual ever disciplined or placed under investigation? ☐ Yes ☒ No
4. Were any negative reports for behavioral reasons ever filed by instructors? ☐ Yes ☒ No
5. Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason? ☐ Yes ☒ No

Please explain any "Yes" response from above:

_____

_____

Certification:

Affix your institutional seal in this space. If no seal is available, you must have this form notarized.

Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct. The signature line must contain the original signature, or the electronic/typed signature, of the program director (M.D./D.O. only).

Name: Guy I Benrubi MD **Signature:**

Title of Signatory: Chairman (e.g., Program Director) **Date of Signature:** 7-31-2012

Tel: 904-244-3112 Fax: 904-244-3658 E-Mail: guy.benrubi@jax.ufl.edu

Applicant Reported Unusual Circumstances

Graduate Medical Education

Medical Professional Name: jeffrey david glazer
University of Florida Health Science Center
Obstetrics and Gynecology

Unusual Circumstances

Did you have any interruption(s) or extension(s) in your medical education?	Yes	**No**
Were you ever placed on probation?	Yes	**No**
Were you ever disciplined or placed under investigation?	Yes	**No**
Were any negative reports for behavioral reasons ever filed by instructors?	Yes	**No**
Were any limitations or special requirements imposed on you because of academic performance, incompetence, disciplinary problems or for any other reason?	Yes	**No**

End of report for: jeffrey david glazer

PROVIDED BY APPLICANT

Jacksonville Health Education Programs

and

The J. Hillis Miller Health Center of the University of Florida

certify that

Jeffrey David Glazer, M.D.

has completed

36 Months

As A Resident

In The

Department of Obstetrics and Gynecology

Jacksonville, Florida *June 30, 1986*

1853

date June 1, 1987

I hereby, certify that this is a true copy of the original document.

Notary Public

Notary Public, State of
My Commission Expires Dec.

Associate Department Chairman

Dean, College of Medicine

Jacksonville Health Education Programs

and

The J. Hillis Miller Health Center of the University of Florida

certify that

Jeffrey David Glazer, M.D.

has completed

12 Months

As Chief Resident

In The

Department of Obstetrics and Gynecology

Jacksonville, Florida *June 30, 1987*

Date June 1, 1987

I hereby, certify that this is a true copy of the original document.

Notary Public

Notary Public, State of Florida
My Commission Expires Dec. 5, 1987

Associate Department Chairman

Dean, College of Medicine

Section VI

Licensure Examination History

(State Licensing Authorities Only)

400 FULLER WISER ROAD | SUITE 300 | EULESS, TX 76039 | TEL (817) 868-5000 | FAX (817) 868-5099

NATIONAL BOARD OF MEDICAL EXAMINERS® (NBME®)
Endorsement of Certification

This document was prepared by
National Board of Medical Examiners® (NBME®)
3750 Market Street, Philadelphia, PA 19104-3190 - Telephone (215) 590-9700

Recipient: State Medical Board of Ohio
30 E. Broad Street 3rd floor
Columbus, OH 43215-6127

Date: 04/09/2014

Examinee: Jeffrey David Glazer

Examinee ID: 3-280-435-3
Date of Birth: 05/01/1957

NBME Certification Date: 07/02/1984

Certificate#: 280435

It is certified that the physician named above successfully completed the examination, education and training requirements for certification by the NBME as of the certification date shown above. This record shows only passing scores for each NBME Part examination reported on this document. If applicable, results for all USMLE Steps taken by this examinee (and for which scores have been reported to date) are also shown.

NBME PART I

			Total		Individual Subject Scores						
Test Date	Pass/Fail	Score Scale	Score	(Min.Pass)	Anat	Phys	Bioc	Path	Micr	Phar	Beh Sci
06/10/1981	Pass	Three-Digit	385	(380)	375	475	380	480	370	375	355
		Two-Digit	75	(75)	73	79	73	79	72	73	71

NBME PART II

			Total		Individual Subject Scores					
Test Date	Pass/Fail	Score Scale	Score	(Min.Pass)	Med	Surg	ObGyn	Prev	Peds	Psych
04/06/1982	Pass	Three-Digit	465	(290)	465	500	550	425	470	415
		Two-Digit	80	(75)	80	82	85	78	81	78

NBME PART III

			Total	
Test Date	Pass/Fail	Score Scale	Score	(Min.Pass)
03/07/1984	Pass	Three-Digit	420	(290)
		Two-Digit	79.2	(75)

Uniform Application for Physician Licensure

UA Username jeffglazer **Date Submitted** 5/5/2014
FCVS Status Applicant has an FCVS Packet

1. Name: Indicate your full legal name. If your name has changed at any time during your life and you are not using FCVS, you must submit a copy of the legal document (marriage certificate, divorce decree, etc.) supporting your name change.

1. Full Name (use no initials)

Last Name	glazer
First Name	jeffrey
Middle Name	david
Suffix	
Maiden Name	

M.D. [X] **D.O.** [ ]

All other names used

First	Middle	Last	Suffix

2. Address/Phone: Please complete all sections and indicate which address you wish to be used for public access and which is to be used for mailings from the medical board. Each state's law determines whether each address or phone number is a public record in the state in which you are applying. You may wish to contact the licensing authority for that state for further information. Many boards publish the "Public Access" address on their website, therefore you should consider what your preferred address is for these purposes.

2. Address/Phone

Business

[ ] **Public Access**
[X] **Mailing**

Street 2325 CHEROKEE PKWY
City LOUISVILLE **State/Province** KY **Zip Code** 40204-2215
Country USA
Telephone (502) 558-7900
Fax
Email jeffglazer@gmail.com
Alternate Phone

Home

[X] **Public Access**
[ ] **Mailing**

Street 2325 CHEROKEE PKWY
2325 Cherokee Parkway
City LOUISVILLE **State/Province** KY **Zip Code** 40204-2215
Country USA
Telephone 5025587900
Fax
Email jeffglazer@gmail.com
Alternate Phone

3. Identification: If you are not using FCVS, you must submit either a notarized copy of your birth certificate or a notarized copy of your current, valid passport.

3. Identification

05/01/1957	Louisville	Kentucky	USA
Date of Birth (mm/dd/yyyy)	Birth City	Birth State/Province	Birth Country

M	[redacted]	1467415778		
Gender	Social Security Number	NPI	Are you a U.S. Citizen?	[X] Yes [ ] No

Your social security number is required to facilitate reporting to the federal Healthcare Integrity & Protection Data Bank (42 U.S.C. Sections 1320a-7e(b), 5 U.S.C. Section 552a, and 45 C.F.R. pt. 61) and for accurate identification under the federal and state child support enforcement law (42 U.S.C. Section 666 and applicable state law). It may also be used for reporting to the National Practitioner Data Bank (42 U.S.C. Section 11101 and 45 C.F.R. pt. 60) and for other investigative/enforcement purposes in compliance with state laws governing physician discipline or as otherwise required by state or federal law.

The National Provider Identifier (NPI) is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. For more information on the NPI, please go to http://www.cms.hhs.gov/NationalProvidentStand/.

4. Medical School: List all medical schools you have attended, even those from which you did not graduate, in chronological order. Attach an additional sheet if necessary. If you are not using FCVS, you must complete the attached "Medical Education Verification" form and send it to all medical schools you have attended. You must include a copy of your diploma to which the medical school must attach their seal prior to forwarding it to this Board. Additionally, the medical school must provide this Board with an official copy of your transcripts. The medical school must forward all documentation directly to this Board.

4. Medical School

1 **School Name** University of Louisville School of Medicine
Address Health Sciences Center

City Louisville
State/Province KY
ZIP Code 40292
Country USA
Attendance Dates **From (mm/yyyy)** 08/1979 **To (mm/yyyy)** 05/1983
Graduation Date 5/9/1983
Degree MD

5. Fifth Pathway: If you attended a Fifth Pathway program and are not using FCVS, you must complete the attached "Fifth Pathway Verification" form and send it to your medical school and to the institution where you completed your rotations. You must include a copy of your diploma. The medical school and institution must forward all documentation directly to this Board.

5. Fifth Pathway (if applicable)

Medical School Name			
Address			
City			
State/Province			
ZIP Code			
Country			
Attendance Dates	**From (mm/yyyy)**	**To (mm/yyyy)**	**In Progress**
Graduation Date			
Degree			
Institution name where rotations performed			
Address			
City			
State/Province			
ZIP Code			
Country			
Rotation Dates	**From (mm/yyyy)**	**To (mm/yyyy)**	**In Progress**
Certification Date			

6. Postgraduate Training: List **all** postgraduate programs you have attended, even those you did not complete. Attach an additional sheet if necessary. If you are not using FCVS, you must complete the attached "Postgraduate Training Verification" form and send it to **all** postgraduate training programs you have attended. You must submit a copy of your certificate of program completion to this Board. The postgraduate program must forward all documentation directly to this Board.

6. Postgraduate Training

1 **Hospital Name** University of Florida Health Science Center
Hospital Address 655 W Eighth St

City Jacksonville
State/Province Florida
ZIP Code 32209
Country USA

PGY: (e.g., 1, 2, 3, etc.) ☐ **Internship** ☒ **Residency** ☐ **Fellowship** ☐ **Research** ☐ **Other**

Department/Specialty Obstetrics and Gynecology

From: 06 /1983 **To:** 06 /1987 **Successfully Completed?** ☒ **Yes** ☐ **No** **In Progress** ☐

Month Year Month Year

7. Examination History: If you are not using FCVS, you are responsible for contacting the appropriate examination entity and having a certified transcript of your scores sent directly to this Board.

7. Examination History

List each licensure examination, U.S. or international, you have taken (USMLE, NBME, NBOME, LMCC, Etc.).If additional space is necessary, please enclose a separate sheet with your application and include all the information below

Examination	State	Most Recent Date taken(Month/Year)	Passed (P) or Failed (F)		Number of attempts
NBME Part I			[X] P	[ ] F	1
NBME Part II			[X] P	[ ] F	1
NBME Part III		07/1984	[X] P	[ ] F	1

8. ECFMG: If ECFMG is applicable and you are not using FCVS, you are responsible for contacting ECFMG and having a certified "Status Report" forwarded directly to this Board. There is a separate fee for this report. Reports can be obtained through the ECFMG web site at www.ecfmg.org.

8. ECFMG (if applicable)

Certificate Number	Issue Date	Valid Through Date

9. State or Professional Licensure: List all state and Canadian provinces where you currently hold or have ever held any type of medical/osteopathic license. You must also complete the attached "Licensure Verification" form (Form #1) and forward it to all states in which you have held any health care license or certification. The verifying entity must forward all documentation directly to this Board. Some state boards charge a fee for this information. Contact the state board where you hold or held a license to determine their requirements.

9. State Licensure

1	**State/Province**	KY	**Practitioner Type** (MD, DO, etc.)	MD	**Type of License** (Full, Temporary, etc.)		
	License Number	25111	**Status**	Active	**Issue Date**	5/1/1987	
2	**State/Province**	FL	**Practitioner Type** (MD, DO, etc.)	MD	**Type of License** (Full, Temporary, etc.)		
	License Number	44465	**Status**	Inactive	**Issue Date**	7/1/1984	
3	**State/Province**	GA	**Practitioner Type** (MD, DO, etc.)	MD	**Type of License** (Full, Temporary, etc.)		
	License Number	28986	**Status**	Inactive	**Issue Date**		
4	**State/Province**	IN	**Practitioner Type** (MD, DO, etc.)	MD	**Type of License** (Full, Temporary, etc.)		
	License Number	45854	**Status**	Active	**Issue Date**	8/1/2013	
5	**State/Province**	KY	**Practitioner Type** (MD, DO, etc.)	MD	**Type of License** (Full, Temporary, etc.)	Full License	
	License Number	25111	**Status**	Active	**Issue Date**	6/1/1987	

10. Chronology of Activities: List ALL activities (medical, non-medical, and postgraduate training) in chronological order beginning with medical school graduation to the PRESENT date, using **MONTH** and **YEAR**. *For any non-working time, you MUST state on the form exactly what your activities were, such as "vacation" or "seeking employment," as well as your permanent address.* If you worked for a physician-staffing group or did locum tenens, you must list all facilities where you worked and include complete dates and addresses. **DO NOT SUBSTITUTE ANY OTHER RESUME FOR THIS FORM**. Be sure to indicate the percentage of working time spent in clinical administrative duties.

10. Chronology of Activities

Dates: From/To	Practice/Employment
1 From: Month: 08 Year: 1987 To: Month: 12 Year: 2009 In Progress ☐	**Practice/Employment Name** MedifemHealth (or list non-working time as indicated above) **Practice/Employment Address** 2325 Cherokee Pky **City** Louisville **State/Province** Kentucky **ZIP Code** 40204 **Country** USA **Position and Department** PHysiciian **Percent Clinical:** 100% **Percent Administrative:** 0% **Employment** ☒ **Staff Privileges** ☐ **Affiliation** ☐ **Other**

Dates: From/To	Practice/Employment
2 From: Month: 09 Year: 2008 To: Month: Year: In Progress ☒	**Practice/Employment Name** Veterans Administration (or list non-working time as indicated above) **Practice/Employment Address** 800 Zorn Ave **City** Louisville **State/Province** Kentucky **ZIP Code** 40206 **Country** **Position and Department** Physiciian-ACB **Percent Clinical:** 100% **Percent Administrative:** 0% **Employment** ☒ **Staff Privileges** ☒ **Affiliation** ☐ **Other**

Dates: From/To	Practice/Employment
3 From: Month: 08 Year: 2010 To: Month: 07 Year: 2013 In Progress ☐	**Practice/Employment Name** Ft. Knox Dept. of Defense (or list non-working time as indicated above) **Practice/Employment Address** ft Knox, KY **City** Ft. Knox **State/Province** Kentucky **ZIP Code** 40121 **Country** USA **Position and Department** Physiciian-ob/gyn **Percent Clinical:** 100% **Percent Administrative:** 0% **Employment** ☒ **Staff Privileges** ☒ **Affiliation** ☐ **Other**

Dates: From/To	Practice/Employment
4 From: Month: 10 Year: 2013 To: Month: Year: In Progress ☒	**Practice/Employment Name** Planned Parenthood of Indiana and Kentucky (or list non-working time as indicated above) **Practice/Employment Address** 200 S Meridian St Suite 400 **City** Indianapolis **State/Province** Indiana **ZIP Code** 4625 **Country** USA **Position and Department** physiciian **Percent Clinical:** 100% **Percent Administrative:** 0% **Employment** ☐ **Staff Privileges** ☐ **Affiliation** ☐ **Other**

11. Malpractice: List of all claims or suits for medical malpractice made against you. A claim is any formal or informal demand for payment to any person or organization. If you do not have any such claims or suits, this section will be blank. Please have your information available before reviewing this section and contact the state board or FCVS to make changes.

11. Malpractice Liability Claims Information

Name of patient involved: Slater

In which state did the action take place? KY **Case number (if applicable)**

Which court? Circuit
(If private compromise or settled before initiation of civil action, state here)

Current status of claim:

☐ Open (pending) ☐ Closed (settled or judgment) ☒ Dismissed (no money paid out) ☐ Other

Amount of judgement or settlement $ **Amount paid on your behalf $**

Month and year of event precipitating claim: 12/1998

Month and year of lawsuit: 01/2003

Insurance carrier at time: PIE

What is/or was your status? ☒ **Primary defendant** ☐ **Co-defendant** ☐ **Other**

Please provide specifics in reference to the adverse event including the allegations and your role in the event:

Outcome: Summary judgment in favor of Dr. Glazer. Case Summary: The patient had her baby delivered by Dr. Glazer who was on call for her obstetrician. The baby did well and she filed a suit four years after delivery, for unknown reasons. She would not answer requests for interrogatories or requests to schedule a deposition, and the courts awarded a summary judgment in my favor.

Name of patient involved: Wrightson

In which state did the action take place? KY **Case number (if applicable)**

Which court? Circuit
(If private compromise or settled before initiation of civil action, state here)

Current status of claim:

☐ Open (pending) ☐ Closed (settled or judgment) ☒ Dismissed (no money paid out) ☐ Other

Amount of judgement or settlement $ **Amount paid on your behalf $**

Month and year of event precipitating claim: 01/2005

Month and year of lawsuit: 01/2006

Insurance carrier at time: Red Mountain

What is/or was your status? ☒ **Primary defendant** ☐ **Co-defendant** ☐ **Other**

Please provide specifics in reference to the adverse event including the allegations and your role in the event:

Outcome: Dismissal with prejudice. Case summary: The patient underwent a laparoscopic tubal ligation at which time an unrecognized bowel injury occurred. She underwent a bowel resection and made a full recovery. The patient withdrew her claim after discovery.

Name of patient involved: Trulock

In which state did the action take place? KY **Case number (if applicable)**

Which court? Circuit
(If private compromise or settled before initiation of civil action, state here)

Current status of claim:

☐ Open (pending) ☒ Closed (settled or judgment) ☐ Dismissed (no money paid out) ☐ Other

Amount of judgement or settlement $ 20,000.00 **Amount paid on your behalf $** 20,000.00

Month and year of event precipitating claim: 07/2001

Month and year of lawsuit: 02/2004

Insurance carrier at time: Red Mountain

What is/or was your status? ☐ **Primary defendant** ☒ **Co-defendant** ☐ **Other**

Please provide specifics in reference to the adverse event including the allegations and your role in the event:

The patient developed diabetic ketoacidosis following a vaginal hysterectomy and may have suffered a myocardial infarction during that episode. The patient had been cleared and followed by both her endocrinologist and cardiologist (she had had previous myocardial infarctions). She made a full recovery and this settlement was made after 7 years.

Name of patient involved: Smith

In which state did the action take place? KY **Case number (if applicable)**

Which court? Circuit
(If private compromise or settled before initiation of civil action, state here)

Current status of claim:

☐ Open (pending) ☒ Closed (settled or judgment) ☐ Dismissed (no money paid out) ☐ Other

Amount of judgement or settlement $ 1,000,000.00 **Amount paid on your behalf $** 1,000,000.00

Month and year of event precipitating claim: 04/2005

Month and year of lawsuit: 03/2006

Insurance carrier at time: Red Mountain

What is/or was your status? ☐ **Primary defendant** ☒ **Co-defendant** ☐ **Other**

Please provide specifics in reference to the adverse event including the allegations and your role in the event:

The patient underwent an abdominal hysterectomy, and had a prolonged slow recovery in the hospital, and when she developed worsening vital signs a large fluid collection was noted on CT scan. She was taken to the operating room where a presumed bowel injury was diagnosed and the patient was given a colostomy. She made a slow recovery but has recovered fully, but lives with her colostomy.

Name of patient involved: Morgan

In which state did the action take place? KY **Case number (if applicable)**

Which court? Circuit
(If private compromise or settled before initiation of civil action, state here)

Current status of claim:

☐ Open (pending) ☐ Closed (settled or judgment) ☒ Dismissed (no money paid out) ☐ Other

Amount of judgement or settlement $ **Amount paid on your behalf $**

Month and year of event precipitating claim: 07/2005

Month and year of lawsuit: 01/2008

Insurance carrier at time: Red Mountain

What is/or was your status? ☒ **Primary defendant** ☐ **Co-defendant** ☐ **Other**

Please provide specifics in reference to the adverse event including the allegations and your role in the event:

The patient was seen in 2004 with a large ovarian cyst, she underwent laparoscopy with a laparoscopic ovarian cystectomy and made a satisfactory recovery. She had follow up ultrasounds which showed the ovary was present, but when she developed a cyst on the other ovary, she underwent laparoscopy by a different physician. He did not see the ovary that I operated on, and told her it wasn't there. A suit was filed, and in discovery it was noted that the lawyer did not have an expert witness. After much time the lawyer still could not produce an expert witness and the case was dismissed with the above outcome. The lawyer appealed to the Court of Appeals and the Kentucky Supreme Court who affirmed the opinion of the lower courts.

Name of patient involved: Walton

In which state did the action take place? KY **Case number (if applicable)**

Which court? Circuit
(If private compromise or settled before initiation of civil action, state here)

Current status of claim:

☐ Open (pending) ☒ Closed (settled or judgment) ☐ Dismissed (no money paid out) ☐ Other

Amount of judgement or settlement $ 375,000.00 **Amount paid on your behalf $** 125,000.00

Month and year of event precipitating claim: 10/1995

Month and year of lawsuit: 07/1996

Insurance carrier at time: Assurance

What is/or was your status? ☐ **Primary defendant** ☒ **Co-defendant** ☐ **Other**

Please provide specifics in reference to the adverse event including the allegations and your role in the event:

I was on call for another physician, a baby was born and developed Group B Beta strep sepsis. The baby fully recovered and an out of court settlement was agree upon.

State Medical Board of Ohio

30 E. Broad St., 3rd Floor • Columbus, OH 43215-6127 • (614) 466-3934 • Website: http://med.ohio.gov/

7/1/2014

Jeffrey David Glazer, MD
2325 Cherokee Pkwy
Louisville KY 40204-2215

This is to notify you that you are now licensed to practice medicine or osteopathic medicine and surgery in the State of Ohio. The Board approved your request and your license number **123998** was issued on **07/01/2014** and will expire on **01/01/2017**.

Enclosed is your wallet card and wall certificate. The wall certificate, by law, must be displayed in your office or the place where a major portion of your practice is conducted.

Please be advised that verification of your Ohio license must be obtained directly from the Board's website at http://med.ohio.gov in the "Licensee Profile and Status section. The website is updated immediately to reflect newly issued licenses.

The Ohio Medical Board operates a "staggered renewal" system based upon the first letter of your last name at the time of licensure. Enclosed is a chart and information outlining the staggered medical license renewal system and continuing medical education (CME) hours required. Renewal applications are mailed approximately six months prior to the date of expiration. CME information may also be obtained from the Board's website.

SECTION 4731.281, OHIO REVISED CODE REQUIRES WRITTEN NOTICE TO THE BOARD OF ANY CHANGE OF PRINCIPAL PRACTICE ADDRESS OR RESIDENCE ADDRESS WITHIN THIRTY DAYS OF THE CHANGE. *A CHANGE OF ADDRESS FORM IS AVAILABLE ON THE BOARD'S WEBSITE.*

This notice authorizes you to make application for a U.S. Drug Enforcement Administration certificate of registration (controlled substance permit). To make such application, contact:

Drug Enforcement Administration (DEA)
431 Howard St.
Detroit, Michigan 48226
(800) 230-6844
www.deadiversion.usdoj.gov/

Any questions regarding the DEA registration must be directed to the DEA office.

Sincerely,

Nicole Weaver
Nicole Weaver
Chief, Licensure