MD

22 JUN 1983

STATE MEDICAL BOARD OF OHIO

23-6-113
6-23-83
85.00 Bud
974

APPLICATION FOR MEDICAL OR OSTEOPATHIC LICENSURE
(ALL RESPONSES MUST BE TYPED)

SECTION 1: Identification Information- Answer All Questions

1. Present Legal Name: Grossman (last) Gerald (first) Evan (middle) _____ (maiden (if applicable))

2. Address: 3400 Hollister Road (street & number)

Cleveland Heights (city) Ohio (state) 44118 (zip code) U.S.A. (country)

Intended place of practice: Cleveland (city) Ohio (state) Cuyahoga (county)

Telephone: Business 216-444-3193 (area code) Home: 216-932-4035 (area code)

Place of Birth: Brooklyn (city) New York (state) U.S.A. (country) Date of Birth: Nov. 23, 1948 (mo. day year)

*Sex: Male (x) Female ( ) *Optional: For statistical purposes only.

Physical description:

Color of Hair Brown Color of Eyes Green Height 5'8"

Build Medium Marks None Weight 145 lbs.

Immigration or citizenship status:

Indicate which of the following documents you currently possess.

X U.S. Birth Certificate

_____ Certificate of Naturalization
Number _____ Date Issued _____ City/State _____

_____ Declaration of Intention (issued by the U.S. District Court)
Number _____ Date Issued _____ City/State _____

_____ Alien Registration Receipt Card (issued by Dept. of Immigration & Naturalization)
Number _____ Date Issued _____ City/State _____

_____ Approved Petition for Immigrant Visa (issued by Dept. of Immigration & Naturalization)
Number _____ Date Issued _____ City/State _____

_____ Other, specify _____

8. List all names other than the name given above that you have used. Also indicate the time period during which you used the names. Be sure to include all names. Failure to do so may result in denial. You must supply the appropriate legal document which authorizes the name change. This may be a court decree or a marriage certificate. Any document in a foreign language must be accompanied by an official, certified translation (original) as outlined in Paragraph (A)(8), Page 1 of General Instructions above.

NOTE: Individuals who retain their maiden name or hyphenate their maiden and married name are requested to be consistent in such usage.

No other names
Name used from: mo./yr. to mo./yr.

Name used from: mo./yr. to mo./yr.

SECTION 2: Educational Background

1. Preliminary Education- Census Blank
You must complete the enclosed census blank in order to apply for your preliminary education number as required by Ohio law.

2. List the names of all medical schools attended, the complete addresses, your date of graduation, and the degree that you received. Give the exact degree that appears on your diploma (M.D., D.O., M.B., B.S., M.B., B.Ch., etc.)

name	address	From: mo/day/yr	To: mo/day/yr	degree
S.U.N.Y. Buffalo	3435 Main St. Buffalo N.Y. 14214	Sept. 1972	Feb. 1, 1977	M.D.

Grossman, Gerald Evan

3. You must submit a copy of your original language diploma whether you are an American or foreign graduate.

If it is not in English, you must supply an original certified official translation of your medical diploma which will be returned to you. The translation must be on letterhead stationery, notarized and bear both the official seal and signature of the notary. The translation should be made by one of the following individuals or institutions:

a) a professor of languages in that language
b) a priest or cleric only in the case of Latin documents
c) a recognized translation service, in the United States, e.g., Berlitz
d) a foreign embassy or consulate authorized to certify translations
e) your medical school of graduation only in the case of your medical diploma

The translator must attest to the translation, sign, and date the translation in the presence of a notary or officer authorized to administer oaths. This translation must be submitted in addition to the notarized photocopy of your diploma in its original language.

4. Standard E.C.F.M.G. Certificate

Graduates of foreign medical schools who were not American citizens prior to entering medical school should possess a valid standard E.C.F.M.G. Certificate if they graduated after 1957. Give the number and date of your certificate if applicable.

Number_____ Date_____

5. Submit a copy of E.C.F.M.G. Certificate, if applicable.

SECTION 3: Postgraduate Training

All applicants are required to complete the chart below indicating the dates and hospitals of all postgraduate training in the U.S. Give the complete address of the hospital where you were employed. Give your position and department in which you served. Account for the percentage of your time spent in clinical and administrative duties. These two numbers should add up to 100 percent.

Date mo/yr-mo/yr	Hospital	Complete Address	Position & Department	% Clin.	% Adm
July 1977- June 1981	University Hospitals	University Circle Cleveland, Ohio 44106	Resident, Pathology	100	
July,1981-June,1982	University Hospitals	University Circle Cleveland, Ohio 44106	Intern, Psychiatry	100	
July,1982- Present	University Hospitals	University Circle Cleveland, Ohio 44106	Resident, Neurology	100	
(Note: Had leave of absence 7/79-12/79 because of illness)					

Total Number of Months in Approved* Training: 60
*Approved by LCME, AOA, or in Canada.

SECTION 4: Licensure Information- Answer All Questions

1. a) Are you a diplomate of the National Board of Medical Examiners?
Yes (X) No ( ) If so, specify year 1982
Are you a diplomate of the National Board of Examiners for Osteopathic Physicians and Surgeons?
Yes ( ) No ( ) If so, specify year _____
Are you a licentiate of the Medical Council of Canada?
Yes ( ) No ( ) If so, specify year _____

b) List all FLEX exams which you have taken. Indicate whether you took all three days (place an "X" next to Full) or whether you took only part of the exam (place an "X" next to Partial).

STATE	DATE (Mo/Yr.)				
_____		FULL ( )	PARTIAL ( )	PASS ( )	FAIL ( )
_____		FULL ( )	PARTIAL ( )	PASS ( )	FAIL ( )
_____		FULL ( )	PARTIAL ( )	PASS ( )	FAIL ( )
_____		FULL ( )	PARTIAL ( )	PASS ( )	FAIL ( )
_____		FULL ( )	PARTIAL ( )	PASS ( )	FAIL ( )

22 JUN 1983

c) List all other State Board exams taken. Indicate whether you took a full (place an "X" next to Full) or whether you took only part of the exam (place an "X" next to Partial). Also give the month and year you took the exam.

STATE	DATE (Mo/Yr.)				
_____		FULL ( )	PARTIAL ( )	PASS ( )	FAIL ( )
_____		FULL ( )	PARTIAL ( )	PASS ( )	FAIL ( )
_____		FULL ( )	PARTIAL ( )	PASS ( )	FAIL ( )

2. List ALL states in which you are or have been fully licensed to practice medicine and surgery or osteopathic medicine and surgery. Indicate the license number and the date it was issued. If the license is properly renewed, check YES under current. If the license was not renewed, check NO.

State	Date of Issuance	License Number	Current
None			YES ( ) NO ( )
			YES ( ) NO ( )
			YES ( ) NO ( )
			YES ( ) NO ( )
			YES ( ) NO ( )

3. List all foreign countries in which you hold a full right to practice medicine and surgery.

Country	Date Conferred	Is Right Currently Held? (Yes or No)
None		Yes ( ) No ( )
		Yes ( ) No ( )

4. Field of Specialization

List the field in which you have specialized (Family Medicine, Internal Medicine, Surgery, etc.). Indicate if you are Board Certified and the countries in which you are so certified.

Field	Board Certified	Year Certified	Country
Currently resident in	YES ( ) NO (x)		
Neurology	YES ( ) NO ( )		

SECTION 5: General Information- Answer All Questions

Each of the following questions must be answered with a yes or a no answer. Be sure to read each question carefully. All affirmative answers must be thoroughly explained. Attach a separate sheet of paper if necessary.

1. Has any license entitling you to practice in any foreign country or in any state or territory of the United States been suspended, surrendered, or revoked? YES ( ) NO (x) If so, give:

STATE_____ DATE_____ CHARGE_____

2. Have you ever been denied licensure or application for licensure in any other state or territory for any reason? YES ( ) NO (x)

If so, specify:_____
State or country Reason Date

3. Have you ever been or are you now addicted to the use of drugs or alcohol? YES ( ) NO (x)

4. Have you ever been convicted of a violation of a federal law, state law, or municipal ordinance other than a minor traffic violation? YES ( ) NO (x)

If so, specify:_____
State or country Court Offense

_____
Date Disposition

5. Has your narcotic license ever been suspended, surrendered, or revoked? YES ( ) NO (x)

If so, specify: _____
Reason Date

6. Have you ever withdrawn from, or been suspended, dismissed or expelled from a medical school or postgraduate training program? YES ( ) NO (x)

If so, specify: _____
School, Hospital or Institution

_____
City/State Country

7. Have you ever been denied or dismissed from hospital staff privileges? YES ( ) NO (x)

If so, specify _____
Hospital or Institution

_____
City/State Country

SECTION 6: Resume

List ALL activities from medical school graduation to the present time. ACCOUNT FOR ALL TIME, WORKING AND NON-WORKING, BY MONTH AND YEAR IN ALL COUNTRIES. Explain what you were doing FOR all nonworking time. PLACE ALL ACTIVITIES IN CHRONOLOGICAL ORDER. DO NOT SUBSTITUTE ANY OTHER RESUME FOR THIS FORM. Be sure to indicate the percentage of working time spent in clinical and administrative duties. If you require more space attach separate sheets.

GROSSMAN

DATES mo/yr-mo/yr	HOSPITAL OR UNIVERSITY	COMPLETE ADDRESS (INCLUDING STREET, APARTMENT, (IF, APPLICABLE), CITY, STATE ZIP CODE, AND COUNTRY (IF NOT IN THE U.S.)	POSITION & DEPARTMENT	% CLIN.	% ADM
7/77-6/81	University Hospitals	University Circle Cleveland, Ohio 44106	Resident, Pathology	100	
7/81-6/82	University Hospitals	University Circle Cleveland, Ohio 44106	Intern, Psychiatry *	100	
7/82---Present	University Hospitals	University Circle Cleveland, Ohio 44106	Resident, Neurology	100	

(Note: Had leave of absence 7/79-12/79 during pathology residency because of illness)

22 JUN 1983

SECTION 7: Examination Scheduling Request (To be completed by applicants for examination only)

1. I wish to apply for the June ( ) December ( ) _____ FLEX examination.
Fill in year

Indicate which FLEX examination you are applying to take by placing an "X" next to the appropriate month and filling in the appropriate year.

SECTION 8: Photograph, Photoslip, and Certificates of Recommendation (Form 3)

1. Certificates of Recommendation (Form 3) must be completed by two fully licensed physicians. The physicians must be licensed in the state in which the form is notarized. A Form 3 is enclosed for each recommending physician. Each recommending physician must also sign your photoslip as indicated below. The Certificates of Recommendation must be notarized. THE PHYSICIANS MUST HAVE KNOWN THE APPLICANT FOR AT LEAST A SIX MONTH PERIOD. NO RELATIVES CAN SERVE AS RECOMMENDING PHYSICIANS FOR FORM 3.

2. You must submit a recent color photograph. Attach the photoslip enclosed in the application to this photo. Sign and date the back of the photo and print your name. Have each of the physicians who signed your recommendation forms also sign the photoslip.

SECTION 9: Release of Applicant

STATE OF Ohio

COUNTY OF Cuyahoga ss:

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the State Medical Board of Ohio any information, files, or records requested by the Board in connection with this application. I further authorize the State Medical Board of Ohio to release to the organizations, individuals, or groups listed above any information which is material to my application.

Gerald Grossman
(Signature of Affiant)

Subscribed and sworn to this 16th day of June, 1983

Carol K. Scism
(Signature of Official Administering Oath)

April 14, 1986
(Date Commission Expires)

(SEAL)

Must be sworn to before a notary public or other person authorized to administer oaths.

SECTION 10: Affidavit of Applicant

STATE OF Ohio

SS:

COUNTY OF Cuyahoga

Before me, personally appeared GERALD GROSSMAN
(Affiant)

who being duly sworn says that he is the person referred to in the foregoing application for license to practice medicine and surgery or osteopathic medicine and surgery in the State of Ohio; that the statements therein and the documents or copies of documents attached thereto are strictly true in every respec and that he has read and understands this Affidavit.

Gerald Grossman
(Signature of Affiant)

Subscribed and sworn to this 16th day of June, 1983.

(SEAL)

Carol K. Scism
(Signature of Official Administering Oath)

April 14, 1986
(Date Commission Expires)

*Must be sworn to before a notary public or other person authorized to administer oaths.

2b 428

FOR BOARD USE ONLY

CERTIFICATE OF
PRELIMINARY EDUCATION

No. 63910

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

Ray D. Bungarner
Entrance Examiner

HENRY G. CRAMBLETT, M. D.
Secretary

7/13/83
Date Issued

FOR BOARD USE ONLY

NAME: Gerald Grossman

CERTIFICATE NO. 49351 DATE ISSUED 8-1-83

FILED Dec. 10, 19 82

FEE $175.00

DETERMINATION:

BOARD ACTION: Brd. appr. 7/20/83 p.v.

BASIS OF LICENSURE:

Revised:

22 JUN 1983

FORM 3

CERTIFICATE OF RECOMMENDATION

MUST BE COMPLETED FOR ALL APPLICANTS

This form is to be completed by a fully licensed physician in the state in which the form is notarized. The recommending physician should be sufficiently acquainted with the applicant for at least a six month period as to be able to evaluate and recommend the applicant. No relatives can serve as recommending physician. This form must be notarized. All questions must be answered. In addition, the recommending physician is strongly urged to include additional comments. This form is not intended to standardize the recommendation or restrict it in any way. However, its form is designed to insure that certain information is included.

I, Robert DAROFF, a licensed and practicing physician in the state of
Recommending Physician

OHIO, affirm that GERALD GROSSMAN has been known to me personally and professionally for 4 years and that he/she is of good moral and ethical character. I offer the following in support of his/her application for full licensure:

I rate his/her medical knowledge and technique as Excellent

His/her command of the English language is Excellent

I rate his/her ability to work well with peers and medical staff as Excellent

His/her relationship with patients is Excellent

In the space below, please add personal comments, evaluation, and recommendation. If more space is required, please attach additional sheets.

I hereby recommend GERALD GROSSMAN for full licensure to practice MEDICINE
Applicant

in Ohio.

U of Penn
Medical School of Graduation of Recommending Physician

Robert B. DAROFF
Signature of Recommending Physician

OHIO
State of Licensure of Recommending Physician

Robert B. DAROFF, MD
Name of Recommending Physician (Please print)

44873
License No. of Recommending Physician

Univ. Hosp, Cleveland
Address of Recommending Physician

216- ~~351~~ 844-3393
Telephone Number (Include area code)

Subscribed and sworn to this 16th day of June, 1983.

(SEAL)

Carol K. Scism
Notary Public

April 14, 1986
Date Commission Expires

UPON COMPLETION, RETURN TO:

STATE MEDICAL BOARD OF OHIO
65 SOUTH FRONT STREET
ROOM 510
COLUMBUS, OHIO 43215

22 JUN 1993

FORM 3

CERTIFICATE OF RECOMMENDATION

MUST BE COMPLETED FOR ALL APPLICANTS

This form is to be completed by a fully licensed physician in the state in which the form is notarized. The recommending physician should be sufficiently acquainted with the applicant for at least a six month period as to be able to evaluate and recommend the applicant. No relatives can serve as recommending physician. This form must be notarized. All questions must be answered. In addition, the recommending physician is strongly urged to include additional comments. This form is not intended to standardize the recommendation or restrict it in any way. However, its form is designed to insure that certain information is included.

I, B TODD TROOST, a licensed and practicing physician in the state of
Recommending Physician

OHIO, affirm that GERALD GROSSMAN has been known to me personally and professionally for 4 years and that he/she is of good moral and ethical character. I offer the following in support of his/her application for full licensure:

I rate his/her medical knowledge and technique as EXCELLENT

His/her command of the English language is EXCELLENT

I rate his/her ability to work well with peers and medical staff as EXCELLENT

His/her relationship with patients is EXCELLENT

In the space below, please add personal comments, evaluation, and recommendation. If more space is required, please attach additional sheets.

I hereby recommend GERALD GROSSMAN for full licensure to practice MEDICINE
Applicant

in Ohio.

HARVARD
Medical School of Graduation of Recommending Physician

B Todd Troost
Signature of Recommending Physician

OHIO
State of Licensure of Recommending Physician

B TODD TROOST
Name of Recommending Physician (Please print)

45134
License No. of Recommending Physician

DEPT NEUROLOGY CASE WESTERN RESERVE
Adelbert Rd Cleveland OH 44106
Address of Recommending Physician

216 321-7202
Telephone Number (Include area code)

Subscribed and sworn to this 16th day of June, 1993.

(SEAL)

Carol K. Sisson
Notary Public

April 14, 1986
Date Commission Expires

UPON COMPLETION, RETURN TO:

STATE MEDICAL BOARD OF OHIO
65 SOUTH FRONT STREET
ROOM 510
COLUMBUS, OHIO 43215

1 Gerald Grossman

Signature of Applicant

2 Gerald Grossman

Signature of Applicant

DATE PHOTOGRAPH TAKEN 6/9/83

I hereby certify that the photograph on the reverse side to which this slip is pasted is a genuine likeness of

Gerald Grossman

Applicant's Name (Please print)

who was recommended by me to the State Medical Board for a license to practice in Ohio.

1 [signature]

Signature of First Endorser

6/14/83

Date

2 [signature]

Signature of Second Endorser

6/14/83

Date

NATIONAL BOARD OF MEDICAL EXAMINERS® • 3930 CHESTNUT STREET, PHILADELPHIA, PENNA. 19104

ENDORSEMENT OF CERTIFICATION

NATIONAL BOARD OF MEDICAL EXAMINERS
OF THE
UNITED STATES OF AMERICA

20 JUN 1983

Gerald E. Grossman, M.D.

having satisfied all the requirements and having successfully passed the examinations is hereby declared a Diplomate of the National Board of Medical Examiners.

Attest WILLIAM B. HOLDEN
Chairman of the Board

SEAL

EDITHE J. LEVIT
President of the Board

Philadelphia, Pa.

04/19/82

Certificate # 168124

It is certified that the above is a facsimile of the Diplomate Certificate which has been or will be* awarded to the physician named above, who graduated from SUNY AT BUFFALO SCH MED in FEBRUARY ,1977 and whose birth date is 11/23/1948. This physician has successfully completed all examinations required for certification by the National Board of Medical Examiners. The scores obtained by this physician upon which his/her certification is based are as follows:

	Standard Score	Scale Score
PART I passed 06/74		
Anatomy, incl. histology and embryology	420	75
Physiology	560	84
Biochemistry	490	80
Pathology	425	76
Microbiology, incl. immunology	580	86
Pharmacology and Materia Medica	515	81
Behavioral Sciences	660	91
TOTAL TEST (Minimum Passing Score 380/75)	520	81
Part II passed 09/76		
Internal medicine and the medical specialties	405	77
Surgery and the surgical specialties	375	76
Obstetrics and Gynecology	535	84
Public Health and Preventive Medicine	565	85
Pediatrics	400	77
Psychiatry	565	85
TOTAL TEST (Minimum Passing Score 290/75)	460	80
PART III passed 03/82		
A General Test of Clinical Competence		
TOTAL TEST (Minimum Passing Score 290/75)	445	80.1
GENERAL AVERAGE (Parts, I, II, and III Scale Score)		80.4

*For those individuals who have not yet satisfactorily completed one full year of post-M.D. training the date shown on the facsimile is the date which has been certified by the physician's residency program director as the date on which this requirement for certification by the National Board will be fulfilled and such certification will be awarded.

Ann K. Steverling

Secretary for Certification

SEAL

06/16/83

Date

STATE OF OHIO
THE STATE MEDICAL BOARD
Suite 510
65 South Front Street
Columbus, Ohio 43215

RECEIVED
OHIO STATE
MEDICAL BOARD

'83 JUL 14 A10:04

Federation of State Medical Boards
of the United States

JUL 07 1983
PREV. CORRES
ANS: FILE
CHECK
BY

Mrs. Fisher
Federation of State Medical Boards
of the United States, Inc.
2630 West Freeway
Suite 138
Fort Worth, Texas 76102

Dear Mrs. Fisher:

The following physician has applied for endorsement licensure in Ohio based upon state examination.

Grossman, Gerald Evan, M.D.

Do your records indicate that this person has previously taken the FLEX? Yes ____ No ____ If yes, please forward all FLEX grades.

Please also indicate whether you have any derogatory information in your files. Thank you for your cooperation.

Sincerely,

Angela Albert

Angela Albert
Chief, Licensure

Derogatory Information:

JUL 12 1983

NO RECORD OF FLEX
NO DEROGATORY INFORMATION

Harold E. Jarvey, Jr., M.D.

EH

RECEIVED
OHIO STATE
MEDICAL BOARD
JUL 11 '83 P12:34

STATE OF OHIO
THE STATE MEDICAL BOARD
Suite 510
65 South Front Street
Columbus, Ohio 43215

DATE July 5, 1983

Dear Doctor,

Dr. Gerald E. Grossman, M.D. who is/was Intern/Resident 7/77-PRESENT Pathology/Psychiatry/Neurology 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 papers for licensure. Your immediate attention to this matter will be greatly appreciated by the doctor as well as by us. Information provided is considered confidential under Section 149.43(A)(2)(a), Ohio Revised Code. Thank you for your time and assistance.

(1) How long have you known the doctor? Since July 1980

(2) What was/is your supervisory capacity? Director of Department of Neurology

(3) At what hospital? University Hospitals of Cleveland

(4) How would you rate this doctor's medical knowledge and techniques? Excellent

(5) In your opinion, is this doctor a person of good moral and ethical character? Yes

(6) Does this doctor 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) NA

(9) Would you recommend this doctor for licensure? Yes

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

Please return this form to the Ohio State Medical Board at the above address,
Sincerely,

Angela Albert
Angela Albert
Chief, Licensure

Signature of Doctor, please type or print name legibly beneath

Robert B. Daroff, M.D.

Director, Department of Neurology, University Hospitals; Professor and Chairman, Department of Neurology, Case Western Reserve University
Position

DATE July 8, 1983

Telephone No. 216-444-3193 (Include Area Code)

STATE UNIVERSITY OF NEW YORK

STATE UNIVERSITY OF NEW YORK AT BUFFALO

ON THE RECOMMENDATION OF THE FACULTY
AND BY VIRTUE OF THE AUTHORITY VESTED IN THEM
THE TRUSTEES OF THE STATE UNIVERSITY OF NEW YORK
HAVE CONFERRED ON

GERALD GROSSMAN

THE DEGREE OF

DOCTOR OF MEDICINE

AND HAVE GRANTED THIS DIPLOMA AS EVIDENCE THEREOF
GIVEN IN THE CITY OF BUFFALO IN THE STATE OF NEW YORK
IN THE UNITED STATES OF AMERICA ON THE FIRST DAY OF
FEBRUARY ONE THOUSAND NINE HUNDRED AND SEVENTY-SEVEN

Chairman of the Board of Trustees

Chancellor of the State University of New York

Chairman of the Council State University at Buffalo

President of State University of New York at Buffalo

GRADUATES OF AMERICAN MEDICAL SCHOOLS REQUESTING ENDORSEMENT OF NATIONAL BOARD SCORES

NAME: GROSSMAN, Gerald Evan

SCHOOL OF GRADUATION: State University of New York SCHOOL LOCATION: Buffalo, NY

DATE DEGREE CONFERRED: 2/1/77 DEGREE CONFERRED: M.D.

INTERNSHIP: University Hospital Cleveland, OH 7/81-6/82

RESIDENCY: University Hospital '' 7/77-6/81

University Hospital '' 7/82-PRESENT

DIPLOMATE OF NATIONAL BOARD OF MEDICAL EXAMINERS: 4/19/82 GENERAL AVERAGE: 80.4

LETTERS OF RECOMMENDATION: Robert Daroff, M.D. Cleveland, OH

B. Todd Troost, M.D. ''

SPECIALTY: Neurology

SPECIALTY BOARDS: no

AMA INFORMATION: Ok

FEDERATION INFORMATION: Ok

RECOMMENDATION FORMS: Ok

(SEE ATTACHED RESUME)

REMARKS:

27 JUL 1983

PLEASE CHECK ONE

APPROVED	DISAPPROVED	ABSTAIN
✓		

PETER LANCIONE, M. D.

...been denied or dismissed from hospital staff privileges? YES ( ) NO (x)

If so, specify _____
Hospital or Institution

_____
City/State Country

SECTION 6: Resume

List ALL activities from medical school graduation to the present time. ACCOUNT FOR ALL TIME, WORKING AND NON-WORKING, BY MONTH AND YEAR IN ALL COUNTRIES. Explain what you were doing FOR all nonworking time. PLACE ALL ACTIVITIES IN CHRONOLOGICAL ORDER. DO NOT SUBSTITUTE ANY OTHER RESUME FOR THIS FORM. Be sure to indicate the percentage of working time spent in clinical and administrative duties. If you require more space attach separate sheets.

GROSSMAN

DATES mo/yr-mo/yr	HOSPITAL OR UNIVERSITY	COMPLETE ADDRESS (INCLUDING STREET, APARTMENT, (IF, APPLICABLE), CITY, STATE ZIP CODE, AND COUNTRY (IF NOT IN THE U.S.)	POSITION & DEPARTMENT	% CLIN.	% AI
7/77-6/81	University Hospitals	University Circle Cleveland, Ohio 44106	Resident, Pathology	100	
7/81-6/82	University Hospitals	University Circle Cleveland, Ohio 44106	Intern, Psychiatry *	100	
7/82---Present	University Hospitals	University Circle Cleveland, Ohio 44106	Resident, Neurology	100	

(Note: Had leave of absence 7/79-12/79 during pathology residency because of illness)

GRADUATES OF AMERICAN MEDICAL SCHOOLS REQUESTING ENDORSEMENT OF NATIONAL BOARD SCORES

NAME: GROSSMAN, Gerald Evan

SCHOOL OF GRADUATION: State University of New York SCHOOL LOCATION: Buffalo, NY

DATE DEGREE CONFERRED: 2/1/77 DEGREE CONFERRED: M.D.

INTERNSHIP: University Hospital Cleveland, OH 7/81-6/82

RESIDENCY: University Hospital '' 7/77-6/81

University Hospital '' 7/82-PRESENT

DIPLOMATE OF NATIONAL BOARD OF MEDICAL EXAMINERS: 4/19/82 GENERAL AVERAGE: 80.4

LETTERS OF RECOMMENDATION: Robert Daroff, M.D. Cleveland, OH

B. Todd Troost, M.D. ''

SPECIALTY: Neurology

SPECIALTY BOARDS: no

AMA INFORMATION: Ok

FEDERATION INFORMATION: Ok

RECOMMENDATION FORMS: Ok

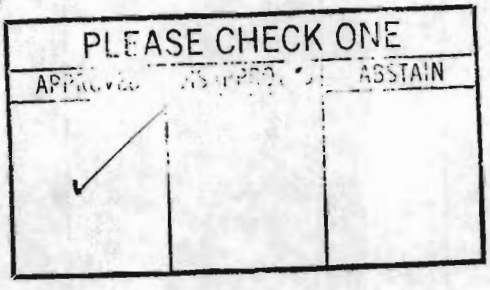
(SEE ATTACHED RESUME)

REMARKS:

26 JUL 1983

PLEASE CHECK ONE

APPROVED ABSTAIN



JOHN E. RAUCH, D.O.

7. Have you ever been denied or dismissed from hospital staff privileges? YES ( ) NO (x)

If so, specify _____
Hospital or Institution

_____
City/State Country

SECTION 6: Resume

List ALL activities from medical school graduation to the present time. ACCOUNT FOR ALL TIME, WORKING AND NON-WORKING, BY MONTH AND YEAR IN ALL COUNTRIES. Explain what you were doing FOR all nonworking time. PLACE ALL ACTIVITIES IN CHRONOLOGICAL ORDER. DO NOT SUBSTITUTE ANY OTHER RESUME FOR THIS FORM. Be sure to indicate the percentage of working time spent in clinical and administrative duties. If you require more space attach separate sheets.

GROSSMAN

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7/82---Present	University Hospitals	University Circle Cleveland, Ohio 44106	Resident, Neurology	100	

(Note: Had leave of absence 7/79-12/79 during pathology residency because of illness)

GRADUATES OF AMERICAN MEDICAL SCHOOLS REQUESTING ENDORSEMENT OF NATIONAL BOARD SCORES

NAME: GROSSMAN, Gerald Evan

SCHOOL OF GRADUATION: State University of New York SCHOOL LOCATION: Buffalo, NY

DATE DEGREE CONFERRED: 2/1/77 DEGREE CONFERRED: M.D.

INTERNSHIP: University Hospital Cleveland, OH 7/81-6/82

RESIDENCY: University Hospital '' 7/77-6/81

University Hospital '' 7/82-PRESENT

DIPLOMATE OF NATIONAL BOARD OF MEDICAL EXAMINERS: 4/19/82 GENERAL AVERAGE: 80.4

LETTERS OF RECOMMENDATION: Robert Daroff, M.D. Cleveland, OH

B. Todd Troost, M.D. ''

SPECIALTY: Neurology

SPECIALTY BOARDS: no

AMA INFORMATION: Ok

FEDERATION INFORMATION: Ok

RECOMMENDATION FORMS: Ok

(SEE ATTACHED RESUME)

REMARKS:

26 JUL 1983

PLEASE CHECK ONE		
APPROVED	ASSTPRO	ABSTAIN
✓		

OSCAR W. CLARKE, M.D.

Have you ever been denied or dismissed from hospital staff privileges? YES ( ) NO (x)

If so, specify _____
Hospital or Institution

_____
City/State Country

SECTION 6: Resume

List ALL activities from medical school graduation to the present time. ACCOUNT FOR ALL TIME, WORKING AND NON-WORKING, BY MONTH AND YEAR IN ALL COUNTRIES. Explain what you were doing FOR all nonworking time. PLACE ALL ACTIVITIES IN CHRONOLOGICAL ORDER. DO NOT SUBSTITUTE ANY OTHER RESUME FOR THIS FORM. Be sure to indicate the percentage of working time spent in clinical and administrative duties. If you require more space attach separate sheets.

GROSSMAN

DATES mo/yr-mo/yr	HOSPITAL OR UNIVERSITY	COMPLETE ADDRESS (INCLUDING STREET, APARTMENT, (IF, APPLICABLE), CITY, STATE ZIP CODE, AND COUNTRY (IF NOT IN THE U.S.)	POSITION & DEPARTMENT	% CLIN.	% AI
7/77-6/81	University Hospitals	University Circle Cleveland, Ohio 44106	Resident, Pathology	100	
7/81-6/82	University Hospitals	University Circle Cleveland, Ohio 44106	Intern, Psychiatry *	100	
7/82---Present	University Hospitals	University Circle Cleveland, Ohio 44106	Resident, Neurology	100	

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RESIDENCY: University Hospital '' 7/77-6/81

University Hospital '' 7/82-PRESENT

DIPLOMATE OF NATIONAL BOARD OF MEDICAL EXAMINERS: 4/19/82 GENERAL AVERAGE: 80.4

LETTERS OF RECOMMENDATION: Robert Daroff, M.D. Cleveland, OH

B. Todd Troost, M.D. ''

SPECIALTY: Neurology

SPECIALTY BOARDS: no

AMA INFORMATION: Ok

FEDERATION INFORMATION: Ok

RECOMMENDATION FORMS: Ok

(SEE ATTACHED RESUME)

REMARKS:

26 JUL 1983

PLEASE CHECK ONE		
APPROVED	DISAPPROVED	ABSTAIN
✓		

LUCY OXLEY M.D.

7. Have you ever been denied or dismissed from hospital staff privileges? YES ( ) NO (x)

If so, specify _____
Hospital or Institution

_____
City/State Country

SECTION 6: Resume

List ALL activities from medical school graduation to the present time. ACCOUNT FOR ALL TIME, WORKING AND NON-WORKING, BY MONTH AND YEAR IN ALL COUNTRIES. Explain what you were doing FOR all nonworking time. PLACE ALL ACTIVITIES IN CHRONOLOGICAL ORDER. DO NOT SUBSTITUTE ANY OTHER RESUME FOR THIS FORM. Be sure to indicate the percentage of working time spent in clinical and administrative duties. If you require more space attach separate sheets.

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NAME: GROSSMAN, Gerald Evan

SCHOOL OF GRADUATION: State University of New York SCHOOL LOCATION: Buffalo, NY

DATE DEGREE CONFERRED: 2/1/77 DEGREE CONFERRED: M.D.

INTERNSHIP: University Hospital Cleveland, OH 7/81-6/82

RESIDENCY: University Hospital '' 7/77-6/81

University Hospital '' 7/82-PRESENT

DIPLOMATE OF NATIONAL BOARD OF MEDICAL EXAMINERS: 4/19/82 GENERAL AVERAGE: 80.4

LETTERS OF RECOMMENDATION: Robert Daroff, M.D. Cleveland, OH

B. Todd Troost, M.D. ''

SPECIALTY: Neurology

SPECIALTY BOARDS: no

AMA INFORMATION: Ok

FEDERATION INFORMATION: Ok

RECOMMENDATION FORMS: Ok

(SEE ATTACHED RESUME)

REMARKS:

26 JUL 1983

PLEASE CHECK ONE		
APPROVED		ABSTAIN
✓		

WALTER H. PAULO

7. Have you ever been denied or dismissed from hospital staff privileges? YES ( ) NO (x)

If so, specify _____
Hospital or Institution

_____
City/State Country

SECTION 6: Resume

List ALL activities from medical school graduation to the present time. ACCOUNT FOR ALL TIME, WORKING AND NON-WORKING, BY MONTH AND YEAR IN ALL COUNTRIES. Explain what you were doing FOR all nonworking time. PLACE ALL ACTIVITIES IN CHRONOLOGICAL ORDER. DO NOT SUBSTITUTE ANY OTHER RESUME FOR THIS FORM. Be sure to indicate the percentage of working time spent in clinical and administrative duties. If you require more space attach separate sheets.

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LETTERS OF RECOMMENDATION: Robert Daroff, M.D. Cleveland, OH

B. Todd Troost, M.D. ''

SPECIALTY: Neurology

SPECIALTY BOARDS: no

AMA INFORMATION: Ok

FEDERATION INFORMATION: Ok

RECOMMENDATION FORMS: Ok

(SEE ATTACHED RESUME)

25 JUL 1983

REMARKS:

PLEASE CHECK ONE		
APPROVED		ABSTAIN
✓		

HENRY G. CRAMBLETT, M.D.

7. Have you ever been denied or dismissed from hospital staff privileges? YES ( ) NO (x)

If so, specify _____
Hospital or Institution

_____
City/State Country

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B. Todd Troost, M.D. ''

SPECIALTY: Neurology

SPECIALTY BOARDS: no

AMA INFORMATION: Ok

FEDERATION INFORMATION: Ok

RECOMMENDATION FORMS: Ok

(SEE ATTACHED RESUME)

25 JUL 1983

REMARKS:

PLEASE CHECK ONE

APPROVED	DISAPPROVED	ABSTAIN
✓		

JOSEPH P. YUT, M. D.

7. Have you ever been denied or dismissed from hospital staff privileges? YES ( ) NO (x)

If so, specify _____
Hospital or Institution

_____
City/State Country

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LETTERS OF RECOMMENDATION: Robert Daroff, M.D. Cleveland, OH

B. Todd Troost, M.D. ''

SPECIALTY: Neurology

SPECIALTY BOARDS: no

AMA INFORMATION: Ok

FEDERATION INFORMATION: Ok

RECOMMENDATION FORMS: Ok

(SEE ATTACHED RESUME)

25 JUL 1983

REMARKS:

PLEASE CHECK ONE		
APPROVED	DISAPPROVED	ABSTAIN
X		

LEONARD L. LOVSHIN, M.D.

7. Have you ever been denied or dismissed from hospital staff privileges? YES ( ) NO (x)

If so, specify _____
Hospital or Institution

_____
City/State Country

SECTION 6: Resume

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LETTERS OF RECOMMENDATION: Robert Daroff, M.D. Cleveland, OH

B. Todd Troost, M.D. ''

SPECIALTY: Neurology

SPECIALTY BOARDS: no

AMA INFORMATION: Ok

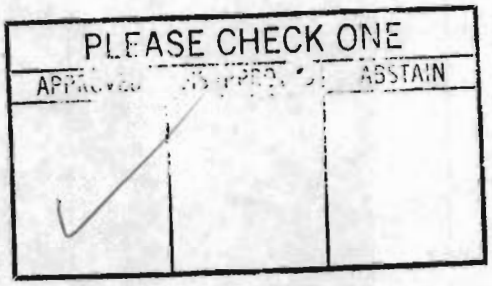
FEDERATION INFORMATION: Ok

RECOMMENDATION FORMS: Ok

25 JUL 1983

(SEE ATTACHED RESUME)

REMARKS:



JOHN M. BUCHAN, D.P.M.

Have you ever been denied or dismissed from hospital staff privileges? YES ( ) NO (x)

If so, specify _____
Hospital or Institution

_____
City/State Country

SECTION 6: Resume

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LETTERS OF RECOMMENDATION: Robert Daroff, M.D. Cleveland, OH

B. Todd Troost, M.D. ''

SPECIALTY: Neurology

SPECIALTY BOARDS: no

AMA INFORMATION: Ok

FEDERATION INFORMATION: Ok

RECOMMENDATION FORMS: Ok

(SEE ATTACHED RESUME)

29 JUL 1983

REMARKS:

PLEASE CHECK ONE		
APPROVED		ABSTAIN
✓		

WILLIAM W. JOHNSTON

7. Have you ever been denied or dismissed from hospital staff privileges? YES ( ) NO (x)

If so, specify _____
Hospital or Institution

_____
City/State Country

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7/82---Present	University Hospitals	University Circle Cleveland, Ohio 44106	Resident, Neurology	100	

(Note: Had leave of absence 7/79-12/79 during pathology residency because of illness)

DETACH HERE AND REMIT THIS PORTION WITH FEE

STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 43215 - 6127

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED DURING THE 2002 - 2004 CME PERIOD THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION IN COMPLIANCE WITH O.R.C. 4731.281 AND O.A.C. 4731-10, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.

X _____ 10/24/04
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE	$50 Late Fee Due After
35 . 049351	305.00	10/1/2004	1/1/2005

Dr. GERALD EVAN GROSSMAN
2860 FALMOUTH ROAD
SHAKER HTS OH 44122

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

N

☑ SPECIALTY CODE(S) CORRECT AS LISTED

IF CORRECTIONS ARE NECESSARY, PLEASE ENTER ALL SPECIALTY CODES. CODE1 CODE2 CODE3

RESIDENCE ADDRESS-THIS MUST BE ENTERED AT EACH RENEWAL.

2860 FALMOUTH ROAD
STREET
STREET
SHAKER HEIGHTS OH 44122
CITY STATE ZIP CODE
CUYAHOGA
COUNTY

SELECT ONE ADDRESS FOR MAILINGS FROM THE BOARD.
☑ RESIDENCE ☐ PRINICIPAL PRACTICE ADDRESS

0003667872 30500 35ZZ 049351

APPLICATION FOR LICENSURE / RENEWAL IN OHIO :

YES NO
☐ ☑ 1.) Have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a felony or misdemeanor?

YES NO
☐ ☑ 2.) Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse? **You may answer "NO" to this question** if you have successfully completed treatment at, or are currently enrolled in, a program approved by this Board and have adhered to all statutory requirements during and subsequent to treatment. You must answer "YES" if you have ever relapsed. Any questions concerning program approval or concerning this question can be directed to the board offices.

YES NO
☐ ☑ 3.) Have any malpractice awards or settlements been paid by you or on your behalf for acts occurring in any state other than Ohio?

YES NO
☐ ☑ 4.) Has any board, bureau, department, agency, or other body, including those in Ohio, **other than this board**, filed any charges, allegations or complaints against you?

YES NO
☐ ☑ 5.) Have you surrendered, or consented to limitation of, or to suspension, reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction? You may answer "NO" to this question if the only such surrender or consent was given to this board.

YES NO
☐ ☑ 6.) Have you had any clinical privileges or other similar institutional authority suspended, restricted or revoked for reasons **other than failure to maintain records on a timely basis or to attend staff meetings?**

10292004 711700
1 0009 005
1 SE 0000030500

PRINCIPAL PRACTICE ADDRESS - THIS ADDRESS MUST BE ENTERED AT EACH RENEWAL
☐ Check this Box if you have NO principal Practice address.

11109 EUCLID AVE
Street
Street
CLEVELAND OH 44106
City State Zip Code
CUYAHOGA
County

REQUIRED:
[redacted]
SOCIAL SECURITY NUMBER

DETACH HERE AND REMIT THIS PORTION WITH FEE

13718

STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 43215 - 6127

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 2000 - 2002 REGISTRATION PERIOD THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE **OHIO STATE MEDICAL ASSOCIATION** *AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.*

X _____ 10/4/02
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE	$50 Late Fee Due After
35-04-9351-G	$305.00	10/01/02	01/01/03

GERALD EVAN GROSSMAN,M.D.
2860 FALMOUTH ROAD
SHAKER HTS OH 44122

OHIO STATE MEDICAL BOARD
OCT 10 2002

0935049351 30500

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

N NEUROLOGY

☑ SPECIALTY CODE(S) CORRECT AS LISTED

IF CORRECTIONS ARE NECESSARY, PLEASE ENTER ALL SPECIALTY CODES. CODE1 CODE2 CODE3

RESIDENCE ADDRESS-THIS MUST BE ENTERED AT EACH RENEWAL.

2860 FALMOUTH RD
STREET
STREET
SHAKER HEIGHTS OH 44122
CITY STATE ZIP CODE
CUYAHOGA
COUNTY

AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION FOR RENEWAL OF YOUR CERTIFICATE:

1.) Have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony? YES ☐ NO ☐

2.) Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse? **You may answer "NO" to this question** if you have successfully completed treatment at, or are currently enrolled in, a program approved by this Board and have adhered to all statutory requirements during and subsequent to treatment. You must answer "YES" if you have ever relapsed. Any questions concerning program approval or concerning this question can be directed to the board offices. YES ☐ NO ☐

3.) Have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio? YES ☐ NO ☐

4.) Has any board, bureau, department, agency, or other body, including those in Ohio, **other than this board**, filed any charges, allegations or complaints against you? YES ☐ NO ☐

5.) Have you surrendered, or consented to limitation of, or to reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction? You may answer "NO" to this question if the only such surrender or consent was given to this board. YES ☐ NO ☐

6.) Have you had any clinical privileges or other similar institutional authority suspended, restricted or revoked for reasons **other than failure to maintain records on a timely basis or to attend staff meetings?** YES ☐ NO ☐

PRINCIPAL PRACTICE ADDRESS - THIS ADDRESS MUST BE ENTERED AT EACH RENEWAL

☐ Check this Box if you have NO principal Practice address.

11100 EUCLID AVE
Street
UNIVERSITY HOSPITALS
Street
CLEVELAND OH 44106
City State Zip Code
CUYAHOGA
County

[redacted]
SOCIAL SECURITY NUMBER

10222002 711700
0055 029
049351
1 SE 000030500

DETACH HERE AND REMIT THIS PORTION WITH FEE

STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 43266 - 0315

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 1998-2000 REGISTRATION PERIOD THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE **OHIO STATE MEDICAL ASSOCIATION** *AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.*

X [signature] 9/22/00
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-04-9351-G	$305.00	10/01/2000

GERALD EVAN GROSSMAN,M.D.
2860 FALMOUTH ROAD
SHAKER HTS OH 44122

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

N NEUROLOGY

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2860 FALMOUTH RD.
STREET
STREET
SHAKER HEIGHTS OH 44122
CITY STATE ZIP CODE
CUYAHOGA
COUNTY

:96969696 2: 0935049351 :0000030500:

MUST BE ENTERED AT EACH RENEWAL

2860 FALMOUTH RD.
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City State Zip Code
CUYAHOGA
County

AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION FOR RENEWAL OF YOUR CERTIFICATE:

YES ☐ NO ☐ 1.) Have you been found guilty of, or pled guilty or no contest to, or received treatment in lieu of conviction of, a misdemeanor or felony?

YES ☐ NO ☐ 2.) Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse? **You may answer "NO" to this question if** you have successfully completed treatment at a program approved by this board and have subsequently adhered to all statutory requirements as contained in sections 4731.224 and 4731.25 O.R.C., and related provisions, or you are currently enrolled in a board approved program. Any questions concerning approval can be directed to the board offices.

YES ☐ NO ☐ 3.) Have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?

YES ☐ NO ☐ 4.) Has any board, bureau, department, agency, or other body, including those in Ohio, **other than this board**, filed any charges, allegations or complaints against you?

YES ☐ NO ☐ 5.) Have you surrendered, or consented to limitation of a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction? You may answer "NO" to this question if the only such surrender or consent was given to this board.

YES ☐ NO ☐ 6.) Have you had any clinical privileges or other similar institutional authority suspended, restricted or revoked for reasons **other than failure to maintain records on a timely basis or to attend staff meetings?**

REQUIRED: [redacted] SOCIAL SECURITY NUMBER

DETACH HERE AND REMIT THIS PORTION WITH FEE

STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 43266 - 0315

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 1994-1996 BIENNIUM THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE OHIO STATE MEDICAL ASSOCIATION AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.

X _____ 7/17/96
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-04-9351	$250.00	05/01/96

GERALD EVAN GROSSMAN, M.D.
2860 FALMOUTH ROAD
SHAKER HTS OH 44122

61-40
2458
$ 275.00
8-13-96

:96969696 2: 0935049351 :00000 25000:

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

N NEUROLOGY

☑ SPECIALTY CODE(S) CORRECT AS LISTED

IF CORRECTIONS ARE NECESSARY, PLEASE ENTER ALL SPECIALTY CODES. CODE1 CODE2 CODE3

REPORT ANY CHANGE OF ADDRESS

STREET
STREET
CITY STATE ZIP CODE
COUNTY

FROM THE ADDRESS SHOWN ON FRONT:

Street
Street
City State Zip Code
County

AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION FOR RENEWAL OF YOUR CERTIFICATE HAVE YOU:

YES NO ☑ 1.) Been found guilty of, or pled guilty or no contest to a felony or misdemeanor.

YES NO ☑ 2.) Been found guilty of, or pled guilty or no contest to a federal or state law regulating the possession, distribution or use of any drug?

YES NO ☑ 3.) Been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse? You may answer "no" to this question if you have successfully completed treatment at a program approved by this board and have subsequently adhered to all statutory requirements as contained in sections 4731.224 and 4731.25 O.R.C., and related provisions, or you are currently enrolled in a board approved program. Any questions concerning approval can be directed to the board offices.

YES NO ☑ 4.) Had malpractice insurance cancelled or limited for other than failure to pay premiums?

YES NO ☑ 5.) Had any disciplinary action taken or initiated against you by any state licensing board other than the State Medical Board of Ohio?

YES NO ☑ 6.) Surrendered, or consented to limitation upon: a) A license to practice medicine; OR b) State or federal privileges to prescribe controlled substances?

YES NO ☑ 7.) Had any clinical privileges suspended, restricted or revoked for reasons other than failure to maintain records or attend staff meetings?

YES NO ☑ 8.) Referred a patient, or participated in an arrangement or scheme for referral of a patient, for clinical laboratory services to a person or facility in which either you or a member of your immediate family has an ownership or investment interest, or any compensation arrangement?

SOCIAL SECURITY NUMBER
(Optional for purposes of identification) [redacted]

DETACH HERE AND REMIT THIS PORTION WITH FEE

STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 43266 - 0315

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 1992-1994 BIENNIUM THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE OHIO STATE MEDICAL ASSOCIATION AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.

X [signature] 6/25/94
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-04-9351	$250.00	05/01/94

GERALD EVAN GROSSMAN, M.D.
2860 FALMOUTH ROAD
SHAKER HTS OH 44122

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

N NEUROLOGY

[X] SPECIALTY CODE(S) CORRECT AS LISTED

IF CORRECTIONS ARE NECESSARY, PLEASE ENTER ALL SPECIALTY CODES. CODE1 CODE2 CODE3

REPORT ANY CHANGE OF ADDRESS

STREET
STREET
CITY STATE ZIP CODE
COUNTY

⑆969696962⑆ 093504935 1⑈ ⑈0000025000⑈

FROM THE ADDRESS SHOWN ON FRONT:
ONE MT SINAI DRIVE
Street
Street
CLEVELAND OH 44106
City State Zip Code
CUYAHOGA
County

933 00332 063094 09363 250.00 063094 935049351
BATCH DATE SEQ MC# AMOUNT BATCHDATE ACCOUNT #

AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION FOR RENEWAL OF YOUR CERTIFICATE HAVE YOU :

YES [ ] NO [✓] 1.) Been found guilty of, or pled guilty or no contest to a felony or misdemeanor.

YES [ ] NO [✓] 2.) Been found guilty of, or pled guilty or no contest to a federal or state law regulating the possession, distribution or use of any drug?

YES [ ] NO [✓] 3.) Been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse? You may answer "no" to this question if you have successfully completed treatment at a program approved by this board and have subsequently adhered to all statutory requirements as contained in sections 4731.224 and 4731.25 O.R.C., and related provisions, or you are currently enrolled in a board approved program. Any questions concerning approval can be directed to the board offices.

YES [ ] NO [✓] 4.) Had malpractice insurance cancelled or limited for other than failure to pay premiums?

YES [ ] NO [✓] 5.) Had any disciplinary action taken or initiated against you by any state licensing board other than the State Medical Board of Ohio?

YES [ ] NO [✓] 6.) Surrendered, or consented to limitation upon: a) A license to practice medicine; OR b) State or federal privileges to prescribe controlled substances?

YES [ ] NO [✓] 7.) Had any clinical privileges suspended, restricted or revoked for reasons other than failure to maintain records or attend staff meetings?

YES [ ] NO [✓] 8.) After January 14, 1993, referred a patient, or participated in an arrangement or scheme for referral of a patient, for clinical laboratory services to a person or facility in which either you or a member of your immediate family has an ownership or investment interest, or any compensation arrangement?

[redacted]
SOCIAL SECURITY NUMBER
(Optional for purposes of identification)

DETACH HERE AND REMIT THIS PORTION WITH FEE

STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 43266 - 0315

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED DURING THE LAST BIENNIUM THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE OHIO STATE MEDICAL ASSOCIATION AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.

X _____ 6/7/92
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-04-9351	$160.00	07/01/92

GERALD EVAN GROSSMAN,M.D.
2860 FALMOUTH ROAD
SHAKER HTS OH 44122

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

32 NEUROLOGY

PROCESSED SPECIALTY CODE(S) CORRECT AS LISTED

IF THE SPECIALTY CODE(S) ARE IN ERROR, ENTER ALL SPECIALTY CODE NUMBERS. CODE1 CODE2 CODE3

CHANGE OF ADDRESS

STREET
STREET
CITY STATE ZIP CODE
COUNTY

:96969696 21: 093504935 1" "00000 16000"

FROM THE ADDRESS SHOWN ON FRONT:

MT SINAI MEDICAL CENTER
Street
Street
CLEVELAND OH 44106
City State Zip Code
CUYAHOGA
County

HAVE YOU BEEN FOUND GUILTY OF, OR PLED GUILTY OR NOT CONTEST TO :

YES NO
☐ ☑ A.) A felony or misdemeanor.
☐ ☑ B.) A federal or state law regulating the possession, distribution or use of any drug?

AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION FOR RENEWAL OF YOUR CERTIFICATE HAVE YOU :

YES NO
☐ ☑ 1.) Been addicted to or dependent upon alcohol or another chemical substance; or been treated for, or been diagnosed as suffering from drug or alcohol dependency or abuse? You may answer "no" to this question if you have successfully completed treatment at a program approved by this board and have subsequently adhered to all statutory requirements as contained in section 4731.224, O.R.C., and related provisions, or you are currently enrolled in a board approved program. Any questions concerning approval can be directed to the board offices.
☐ ☑ 2.) Had a license denied by or had any disciplinary action taken or initiated against you by any state licensing board other than the State Medical Board of Ohio?
☐ ☑ 3.) Surrendered, or consented to limitation upon: a) A license to practice medicine; OR b) State or federal privileges to prescribe controlled substances?
☐ ☑ 4.) Had any clinical privileges suspended, limited or revoked for reasons other than failure to maintain records or attend staff meetings?

[redacted]
(Optional for purposes of identification.)

0833 00129 081892 0177 2
TAX BATCH P DATE SEQ# MC#
160.00 031792
AMOUNT BATCHDATE
935049351
ACCOUNT #

DETACH HERE AND REMIT THIS PORTION WITH FEE

STATE MEDICAL BOARD OF OHIO

77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 43266 - 0315

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED DURING THE LAST BIENNIUM THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE OHIO STATE MEDICAL ASSOCIATION AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.

X Gerald Evan Grossman 9/30/90

(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER:	AMOUNT DUE	DATE DUE
35-04-9351	$160.00	11/01/90

GERALD EVAN GROSSMAN, M.D.
2860 FALMOUTH ROAD
SHAKER HTS OH 44122

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

32 NEUROLOGY

RECORDED SPECIALTY CODE(S) CORRECT AS LISTED

IF THE SPECIALTY CODE(S) ARE IN ERROR, ENTER ALL SPECIALTY CODE NUMBERS. CODE1 CODE2 CODE3

CHANGE OF ADDRESS

STREET

STREET

CITY STATE ZIP CODE

COUNTY

:96969696 2: 0935049351 "00000 16000"

FROM THE ADDRESS SHOWN ON FRONT:

Mt. Sinai Med Center
Street
Cleveland OH 44106
City State Zip Code
Cuyahoga
County

HAVE YOU BEEN FOUND GUILTY OF, OR PLEAD GUILTY OR NO CONTEST TO :

YES NO (X)
- A.) A felony
- B.) A federal or state law regulating the possession, distribution or use of any drug?

AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION FOR RENEWAL OF YOUR CERTIFICATE HAVE YOU :

YES NO
- 1.) Been addicted to or dependent upon alcohol or any chemical substance? You may answer "no" to this question if you have successfully completed treatment at a program approved by this board and have subsequently adhered to all statutory requirements as contained in section 4731.224, O.R.C., and related provisions, or you are currently enrolled in a board approved program. Any questions concerning approval can be directed to the board offices.
- 2.) Had any disciplinary action taken or initiated against you by any state licensing board?
- 3.) Surrendered, or consented to limitation upon: a) A license to practice medicine; OR b) State or federal privileges to prescribe controlled substances?
- 4.) Had any clinical privileges suspended or revoked for reasons other than failure to maintain records or attend staff meetings?

[redacted]
(Optional for purposes of identification)

STATE MEDICAL BOARD OF OHIO

I CERTIFY, UNDER PENALTY OF THE LOSS OF MY RIGHT TO PRACTICE MEDICINE AND SURGERY IN THE STATE OF OHIO, THAT I HAVE COMPLETED DURING THE LAST BIENNIUM THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE OHIO STATE MEDICAL ASSN AND APPROVED BY THE STATE MEDICAL BOARD AND HEREBY MAKE APPLICATION FOR RENEWAL

Gerald Evan Grossman 10/2/88
(SIGNAURE OF APPLICANT) (DATE)

APPLICATION FOR BIENNIAL LICENSE RENEWAL TO PRACTICE AS A; DOCTOR OF MEDICINE

IDENTIFICATION NUMBER 35-04-9351

QT-00223-OF

1 GERALD EVAN GROSSMAN
2860 FALMOUTH ROAD
SHAKER HTS OH 44122

MD & DO SPECIALTY CODES

SPECIALTY CODES CURRENTLY ON RECORD 32
IF NECESSARY TO CORRECT, ENTER ALL SPECIALTY CODE NUMBERS (SEE LIFE ON ENCLOSED CARD) (LIMIT OF 3)

AMOUNT DUE $100.00 DATE DUE 11/01/88

TO RECEIVE YOUR RENEWAL CARD BY DECEMBER 31ST, RETURN THIS APPLICATION AND FEE BY NOVEMBER 1.

INSTRUCTIONS

1. DO NOT FOLD OR STAPLE THIS CARD.
2. REVERSE SIDE MUST BE COMPLETED.
3. MAKE CHECK OR MONEY ORDER PAYABLE TO: TREASURER, STATE OF OHIO
4. PUT IDENTIFICATION NUMBER ON CHECK.
5. UPDATE SPECIALTY IF NEEDED.
6. SEND PAYMENT (DO NOT SEND CASH) AND THIS APPLICATION IN ENCLOSED ENVELOPE TO: TREASURER, STATE OF OHIO BOX 2438, COLUMBUS, OHIO 43216

REPORT ANY CHANGE OF ADDRESS OF RECORD
(PLEASE PRINT)

LAST NAME | FIRST NAME | INITIAL

STREET ADDRESS

CITY | STATE | ZIP CODE

COUNTY

THE ADDRESS SHOWN ON THE FRONT OF THIS CARD WILL BE MAINTAINED AS YOUR ADDRESS OF RECORD WITH THE BOARD.

PRINCIPAL PRACTICE ADDRESS—IF DIFFERENT FROM THAT SHOWN ON FRONT
(PLEASE PRINT)

GROSSMAN | GERALD | E.
LAST NAME | FIRST NAME | INITIAL

Mt. Sinai Medical Center
STREET ADDRESS

CLEVELAND | OHIO | 44106
CITY | STATE | ZIP CODE

CUYAHOGA

SOCIAL SECURITY NUMBER [redacted]

SECTION 4731.281, OHIO REVISED CODE REQUIRES THAT A RESPONSE BE GIVEN TO THE FOLLOWING QUESTION. PLEASE MARK THE CORRECT BOX.

SINCE YOU LAST RENEWED YOUR OHIO MEDICAL LICENSE, HAVE YOU BEEN FOUND GUILTY OR PLEAD GUILTY OR NO CONTEST TO:

YES	NO	
☐	☑	a.) a felony
☐	☑	b.) a federal or state law regulating the possession, distribution or use of any drug?

AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION FOR RENEWAL OF YOUR CERTIFICATION HAVE YOU:

YES	NO	
☐	☑	1.) Been addicted to or dependent upon alcohol or any chemical substance? You may answer no to this question if you have successfully completed treatment at a program approved by this Board and have subsequently adhered to all statutory requirements as contained in Section 4731.224, O.R.C., and related provisions; or are currently enrolled in a Board approved program.
☐	☑	2.) Had any disciplinary action taken or initiated against you by a state licensing agency?
☐	☑	3.) Surrendered or consented to limitation upon a license to practice medicine by any state or federal privileges to prescribe controlled substances.
☐	☑	4.) Had any clinical privileges suspended or revoked for other than failure to maintain records or attend staff meetings.

QT-00224-OB

STATE MEDICAL BOARD OF OHIO

65 SOUTH FRONT ST., SUITE 510 COLUMBUS, OHIO 43215

I CERTIFY, UNDER PENALTY OF THE LOSS OF MY RIGHT TO PRACTICE MEDICINE AND SURGERY IN THE STATE OF OHIO, THAT I HAVE COMPLETED DURING THE LAST BIENNIUM THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE OHIO STATE MEDICAL ASSN AND APPROVED BY THE STATE MEDICAL BOARD AND HEREBY MAKE APPLICATION FOR RENEWAL.

Gerald Grossman 10/25/86

(SIGNATURE OF APPLICANT) (DATE)

APPLICATION FOR BIENNIAL LICENSE RENEWAL TO PRACTICE AS A DOCTOR OF MEDICINE

IDENTIFICATION NUMBER 35-04-9351

1 GERALD EVAN GROSSMAN
2860 FALMOUTH ROAD
SHAKER HTS OH 44122

EDM-14946

MD & DO SPECIALTY CODES

ENTER ALL SPECIALTY CODES → 60 (SEE LIST ON ENCLOSED CARD) (LIMIT OF 3)

AMOUNT DUE $100.00

DATE DUE 11/15/86

INSTRUCTIONS

1. DO NOT FOLD OR STAPLE THIS CARD.
2. REVERSE SIDE MUST BE COMPLETED.
3. MAKE CHECK OR MONEY ORDER PAYABLE TO: TREASURER, STATE OF OHIO
4. PUT IDENTIFICATION NUMBER ON CHECK.
5. MARK CORRECT SPECIALTY CODE(S) BELOW.
6. SEND PAYMENT (DO NOT SEND CASH) AND THIS APPLICATION IN ENCLOSED ENVELOPE TO:

TREASURER, STATE OF OHIO
BOX 2438 COLUMBUS, OHIO 43216

REPORT ANY CHANGE OF ADDRESS OF RECORD

(PLEASE PRINT)

LAST NAME FIRST NAME INITIAL

STREET ADDRESS

CITY STATE ZIP CODE

COUNTY

TO RECEIVE YOUR RENEWAL CARD BY DECEMBER 31ST, RETURN THIS APPLICATION AND FEE BY NOVEMBER 15

THE ADDRESS SHOWN ON THE FRONT OF THIS CARD WILL BE MAINTAINED AS YOUR ADDRESS OF RECORD WITH THE BOARD.

PRINCIPAL PRACTICE ADDRESS – IF DIFFERENT FROM THAT SHOWN ON FRONT

(PLEASE PRINT) Dept. Neurology, University Hospitals

GROSSMAN GERALD E.

LAST NAME FIRST NAME INITIAL

2074 Abington Rd.

STREET ADDRESS

CLEVELAND OHIO 44106

CITY STATE ZIP CODE

CUYAHOGA

SOCIAL SECURITY NUMBER [redacted]

EDM-14946-B

SECTION 4731.281, OHIO REVISED CODE REQUIRES THAT A RESPONSE BE GIVEN TO THE FOLLOWING QUESTION. PLEASE MARK THE CORRECT BOX.

SINCE YOU LAST RENEWED YOUR OHIO MEDICAL LICENSE, HAVE YOU BEEN FOUND GUILTY OR PLEAD GUILTY OR NO CONTEST TO:

YES NO

☐ ☒ a.) a felony.

☐ ☒ b.) a misdemeanor committed in the course of your practice, or

☐ ☒ c.) a federal or state law regulating the possession, distribution or use of any drug?

AT ANY TIME SINCE THE LAST RENEWAL OF YOUR CERTIFICATE HAVE YOU:

YES NO

☐ ☒ 1.) Been addicted to or dependent upon alcohol or any chemical substance?

☐ ☒ 2.) Had any disciplinary action taken or initiated against you by a state licensing agency?

☐ ☒ 3.) Surrendered or consented to limitation [illegible] license to practice medicine, or state or federal privileges to prescribe controlled substances?

☐ ☒ 4.) Had any hospital privileges suspended or revoked?

STATE OF OHIO STATE MEDICAL BOARD

65 SOUTH FRONT ST., SUITE 510 COLUMBUS, OHIO 43215

I CERTIFY, UNDER PENALTY OF THE LOSS OF MY RIGHT TO PRACTICE MEDICINE AND SURGERY IN THE STATE OF OHIO, THAT I HAVE COMPLETED DURING THE LAST BIENNIUM THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE OHIO STATE MEDICAL ASSN AND APPROVED BY THE STATE MEDICAL BOARD AND HEREBY MAKE APPLICATION FOR RENEWAL.

Gerald Grossman 11/4/84

(SIGNATURE OF APPLICANT) (DATE)

APPLICATION FOR BIENNIAL LICENSE RENEWAL TO PRACTICE AS A DOCTOR OF MEDICINE

IDENTIFICATION NUMBER 35-04-9351

OP-0345-F

1 GERALD EVAN [redacted] GROSSMAN M.D.
3400 HOLLISTER RD
CLEVELAND OH 44118

MD & DO SPECIALTY CODES

SPECIALTY CODES CURRENTLY ON RECORD →

IF NECESSARY TO CORRECT, ENTER ALL SPECIALTY CODE NUMBERS → 34

(SEE LIST ON ENCLOSED CARD) (LIMIT OF 3)

AMOUNT DUE $100.00

DATE DUE 11/15/84

INSTRUCTIONS

1. DO NOT FOLD OR STAPLE THIS CARD.
2. REVERSE SIDE MUST BE COMPLETED.
3. MAKE CHECK OR MONEY ORDER PAYABLE TO: TREASURER, STATE OF OHIO
4. PUT IDENTIFICATION NUMBER ON CHECK.
5. MARK CORRECT SPECIALTY CODE(S) BELOW.
6. SEND PAYMENT (DO NOT SEND CASH) AND THIS APPLICATION IN ENCLOSED ENVELOPE TO: TREASURER, STATE OF OHIO BOX 2438 COLUMBUS, OHIO 43216

REPORT ANY CHANGE OF ADDRESS OF RECORD

(PLEASE PRINT)

LAST NAME FIRST NAME INITIAL

STREET ADDRESS

CITY STATE ZIP CODE

COUNTY

TO RECEIVE YOUR RENEWAL CARD BY DECEMBER 31ST, RETURN THIS APPLICATION AND FEE BY DUE DATE.

THE ADDRESS SHOWN ON THE FRONT OF THIS CARD WILL BE MAINTAINED AS YOUR ADDRESS OF RECORD WITH THE BOARD.

PRINCIPAL PRACTICE ADDRESS — IF DIFFERENT FROM THAT SHOWN ON FRONT
(PLEASE PRINT)

GROSSMAN GERALD I E.
LAST NAME FIRST NAME INITIAL

Dept. Neurology, University Hospitals, 2074 Abington Rd.
STREET ADDRESS

CLEVELAND OHIO 44106
CITY STATE ZIP CODE

CUYAHOGA

SOCIAL SECURITY NUMBER [redacted]

SECTION 4731.281, OHIO REVISED CODE REQUIRES THAT A RESPONSE BE GIVEN TO THE FOLLOWING QUESTION. PLEASE MARK THE CORRECT BOX.

SINCE YOU LAST RENEWED YOUR OHIO MEDICAL LICENSE, HAVE YOU BEEN CONVICTED OF OR PLEAD NOLO CONTENDERE TO:

YES	NO	
☐	☒	a.) a felony,
☐	☒	b.) a misdemeanor committed in the course of your practice, or
☐	☒	c.) a federal or state law regulating the possession, distribution or use of any drug?

AT ANY TIME SINCE THE LAST RENEWAL OF YOUR CERTIFICATE HAVE YOU:

YES	NO	
☐	☒	1). Been addicted to or dependent upon alcohol or any chemical substance?
☐	☒	2). Had any disciplinary action taken or initiated against you by a state licensing agency?
☐	☒	3). Surrendered or consented to limitation [redacted] license to practice medicine, or state or federal privileges to prescribe controlled substances?
☐	☒	4). Had any hospital privileges suspended or revoked?

0345-B

Date Posted: 10/4/2006 6:05:29 PM

Please review all information you have provided. Click on the "Review" button to change any information given or click on the "I Agree" button to verify that all information posted below is correct and to proceed to payment options.

Please note that knowingly providing false information may result in denial of registration.

License Information

License Number	35.049351
License Name	GERALD GROSSMAN
Email Address	

Fees

Relicensure Fee	$305.00
	========
Total Fees	**$305.00**

Specialty Codes

1. Please select one specialty from the field below

. . . . . NEUROLOGY

2. Please select one specialty from the field below, if applicable.

. . . . . *{not Answered}*

3. Please select one specialty from the field below, if applicable.

. . . . . *{not Answered}*

CME-Physicians

1. Have you met the above CME requirements for your license?

. . . . . YES

Discipline

1. Have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?

. . . . . NO

2. Have you surrendered, consented to limitation of, or to suspension, reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction other than Ohio?

. . . . . NO

3. Have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?

. . . . . NO

4. Has any board, bureau, department, agency, or any other body, including those in Ohio **other than this board,** filed any charges, allegations or complaints

against you?

. . . . . NO

5. Have you had any clinical privileges or other similar institutional authority suspended, restricted or revoked for reasons **other than failure to maintain records on a timely basis or to attend staff meetings?**

. . . . . NO

6. Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse?

. . . . . NO

Social Security Number

1.

. . . . . [redacted]

Nurse Collaboration Info

1. Are you currently in a collaboration agreement with any Clinical Nurse Specialists, Certified Nurse-Midwives or Certified Nurse Practitioners?

. . . . . NO

2. List the name/names and type of licensure for each nurse with whom you are collaborating. **For example: Jane Doe, CNP; Mary Smith, CNS.**

. . . . . *{not Answered}*

I understand that submitting a false, fraudulent, or forged statement or document or omitting a material fact in obtaining licensure may be grounds for disciplinary action against my license.

Under penalty of law, I hereby swear or affirm that the information I have provided in the application is complete and correct, and that I have complied with all criteria for applying on line.

Date Posted: 9/28/2008 8:26:01 PM

Please review all information you have provided. Click on the "Review" button to change any information given or click on the "I Agree" button to verify that all information posted below is correct and to proceed to payment options.

Please note that knowingly providing false information may result in denial of registration.

License Information

License Number	35.049351
License Name	GERALD GROSSMAN
Email Address	gegrossman@aol.com

Fees

Relicensure Fee	$305.00
	========
Total Fees	**$305.00**

Specialty Codes

1. Please select one specialty from the field below

. . . . . NEUROLOGY

2. Please select one specialty from the field below, if applicable.

. . . . . *{not Answered}*

3. Please select one specialty from the field below, if applicable.

. . . . . *{not Answered}*

CME-Physicians

1. Have you met the above CME requirements for your license?

. . . . . YES

Discipline

1. Have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?

. . . . . NO

2. Have you surrendered, consented to limitation of, or to suspension, reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction other than Ohio?

. . . . . NO

3. Have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?

. . . . . NO

4. Has any board, bureau, department, agency, or any other body, including those in Ohio **other than this board,** filed any charges, allegations or complaints

against you?

. . . . . NO

5. Have you had any clinical privileges or other similar institutional authority suspended, restricted, revoked or placed on probation for reasons **other than failure to maintain records on a timely basis or to attend staff meetings?**

. . . . . NO

6. Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse?

. . . . . NO

Social Security Number

1.

. . . . . [redacted]

Nurse Collaboration Info

1. Are you currently in a collaboration agreement with any Clinical Nurse Specialists, Certified Nurse-Midwives or Certified Nurse Practitioners?

. . . . . NO

2. List the name/names and type of licensure for each nurse with whom you are collaborating. **For example: Jane Doe, CNP; Mary Smith, CNS.**

. . . . . *{not Answered}*

I understand that submitting a false, fraudulent, or forged statement or document or omitting a material fact in obtaining licensure may be grounds for disciplinary action against my license.

Under penalty of law, I hereby swear or affirm that the information I have provided in the application is complete and correct, and that I have complied with all criteria for applying on line.

Date Posted: 8/24/2010 1:16:33 PM

Please review all information you have provided. Click on the "Review" button to change any information given or click on the "I Agree" button to verify that all information posted below is correct and to proceed to payment options.

Please note that knowingly providing false information may result in denial of registration.

Address Information

BUSINESS ADDRESS

University Hospitals Case Medical Center
Department of Neurology
11100 Euclid Ave
CLEVELAND, OH 44106
Cuyahoga County
216-844-8925

License Information

License Number 35.049351
License Name GERALD GROSSMAN

Fees

Relicensure Fee $305.00

========

Total Fees **$305.00**

Specialty Codes

1. Please select one specialty from the field below

. . . . . NEUROLOGY

2. Please select one specialty from the field below, if applicable.

. . . . . *{not Answered}*

3. Please select one specialty from the field below, if applicable.

. . . . . *{not Answered}*

CME-Physicians

1. Have you met the above CME requirements for your license?

. . . . . YES

Discipline

1. Have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?

. . . . . NO

2. Have you surrendered, consented to limitation of, or to suspension, reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction other than Ohio?

. . . . . NO

3. Have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?

. . . . . NO

4. Has any board, bureau, department, agency, or any other body, including those in Ohio **other than this board,** filed any charges, allegations or complaints against you?

. . . . . NO

5. Have you had any clinical privileges or other similar institutional authority suspended, restricted, revoked or placed on probation for reasons **other than failure to maintain records on a timely basis or to attend staff meetings?**

. . . . . NO

6. Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse?

. . . . . NO

Social Security Number

1.

. . . . . [redacted]

Nurse Collaboration Info

1. Are you currently in a collaboration agreement with any Clinical Nurse Specialists, Certified Nurse-Midwives or Certified Nurse Practitioners?

. . . . . NO

2. List the name/names and type of licensure for each nurse with whom you are collaborating. **For example: Jane Doe, CNP; Mary Smith, CNS.**

. . . . . *{not Answered}*

I understand that submitting a false, fraudulent, or forged statement or document or omitting a material fact in obtaining licensure may be grounds for disciplinary action against my license.

Under penalty of law, I hereby swear or affirm that the information I have provided in the application is complete and correct, and that I have complied with all criteria for applying on line.

Date Posted: 9/23/2012 10:40:45 PM

Please review all information you have provided. Click on the "Review" button to change any information given or click on the "I Agree" button to verify that all information posted below is correct and to proceed to payment options.

Please note that knowingly providing false information may result in denial of registration.

Address Information

CREDENTIAL MAIL ADDRESS

2860 FALMOUTH ROAD
SHAKER HTS, OH 44122
Cuyahoga County
gegrossman@aol.com

License Information

License Number 35.049351
License Name GERALD GROSSMAN

Fees

Relicensure Fee $305.00

========

Total Fees **$305.00**

Medical Board Correspondence Email

1. **Did you provide a Credential email address? Please note this information is a public record.**

. . . . . YES

Specialty Codes

1. Please select one specialty from the field below

. . . . . NEUROLOGY

2. Please select one specialty from the field below, if applicable.

. . . . . *{not Answered}*

3. Please select one specialty from the field below, if applicable.

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2. List the name/names and type of licensure for each nurse with whom you are collaborating. **For example: Jane Doe, CNP; Mary Smith, CNS.**

. . . . . *{not Answered}*

Ohio Employment

1. Do you practice in Ohio?

. . . . . YES

Ohio Workforce Questions

1. "Clinical" - direct patient care

. 35-39

2. "Research" - study of a treatment, procedure or medication done in a medical setting or for a medical purpose

. 0

3. "Administration" - activities related generally to patient care other than direct contact with a patient (e.g. recordkeeping, clerical tasks, chart review, prior authorizations with insurers, claims, billing issues, etc.)

. 10-14

4. "Education" - preceptor, mentor, etc.

. 1-4

5. "Volunteering" - providing medical and medical-related services at no cost

. 0

6. "Other" - medical professional activities not included in above categories

. 0

Clinical - Practice setting

1. Enter the number of hours per week spent in "Office/Clinic/Ambulatory care" (out-patient care).

. 35-39

2. Enter the number of hours per week spent in "Hospital (in-patient care)".

. 0

3. Enter the number of hours per week spent in "Emergency Room".

. 0

4. Enter the number of hours per week spent in "Urgent Care".

. 0

5. Enter the number of hours per week spent in "Other".

. 0

Workforce Counties

1. Enter the first zip code:

. 44106

2. Enter the first county:

. . . . . Cuyahoga

3. Enter the second zip code:

. 44122

4. Enter the second county:

. . . . . Cuyahoga

5. Enter the third zip code:

. . . . . *{not Answered}*

6. Enter the third county:

. . . . . *{not Answered}*

7. Do you have more than one practice location?

. . . . . YES

Workforce Practice Address

1. Please list all practice locations. Include street address, city, state and zip. Example "123 E Main St, Suite 2, Anywhere, OH 55555;" Separate multiply addresses with a semicolon.

. . . . . 11100 Euclid Ave., Cleveland, Ohio, 44106; 1000 Auburn Drive, Beachwood, Ohio, 44122

Practice Arrangement (size)

1. Solo practitioner

. . . . . NO

2. Single-specialty Group

. . . . . 10+

3. Multi-specialty Group

. . . . . N/A

4. Employee of a clinical facility or hospital? (Clinical facility is an urgent care, industrial clinic or similar entity)

. . . . . NO

Workforce Language Question

1. Do practitioners or staff in your practice communicate in sign language or in a language other than spoken English?

. . . . . NO

ABMS Certified

1. Are you certified by an ABMS Board?

. . . . . YES

ABMS Specialty

1. Choose specialty from the dropdown list.

. . . . . Neurology

2. Choose specialty from the dropdown list.

. . . . . *{not Answered}*

3. Choose specialty from the dropdown list.

. . . . . *{not Answered}*

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Under penalty of law, I hereby swear or affirm that the information I have provided in the application is complete and correct, and that I have complied with all criteria for applying on line.

Date Posted: 12/7/2014 9:44:21 PM

Please review all information you have provided. Click on the "Review" button to change any information given or click on the "I Agree" button to verify that all information posted below is correct and to proceed to payment options.

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License Information

License Number	35.049351
License Name	GERALD GROSSMAN

Fees

Relicensure Fee	$305.00
	========
Total Fees	**$305.00**

Medical Board Correspondence Email

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. . . . . YES

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1. Have you met the above CME requirements for your license?

. . . . . YES

Discipline

1. **At any time since signing your last application for renewal of your certificate** have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?

. . . . . NO

2. **At any time since signing your last application for renewal of your certificate** have you surrendered, consented to limitation of, or to suspension, reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction other than Ohio?

. . . . . NO

3. **At any time since signing your last application for renewal of your certificate** have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?

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2. "Research" - study of a treatment, procedure or medication done in a medical

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. 0

3. "Administration" - activities related generally to patient care other than direct contact with a patient (e.g. recordkeeping, clerical tasks, chart review, prior authorizations with insurers, claims, billing issues, etc.)

. 20-24

4. "Education" - preceptor, mentor, etc.

. 5-9

5. "Volunteering" - providing medical and medical-related services at no cost

. 1-4

6. "Other" - medical professional activities not included in above categories

. 0

Clinical - Practice setting

1. Enter the number of hours per week spent in "Office/Clinic/Ambulatory care" (out-patient care).

. 30-34

2. Enter the number of hours per week spent in "Hospital (in-patient care)".

. 0

3. Enter the number of hours per week spent in "Emergency Room".

. 0

4. Enter the number of hours per week spent in "Urgent Care".

. 0

5. Enter the number of hours per week spent in "Other".

. 0

Workforce Counties

1. Enter the first zip code:

. 44106

2. Enter the first county:

. . . . . Cuyahoga

3. Enter the second zip code:

. 44122

4. Enter the second county:

. . . . . *{not Answered}*

5. Enter the third zip code:

. . . . . *{not Answered}*

6. Enter the third county:

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1. Please list all practice locations. Include street address, city, state and zip. Example "123 E Main St, Suite 2, Anywhere, OH 55555;" Separate multiply addresses with a semicolon.

. . . . . 11100 Euclid Ave. Cleveland Ohio 44106; Ahuja Medical Center, Richmond Road, Beachwood, 44122

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. . . . . NO

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4. Employee of a clinical facility or hospital? (Clinical facility is an urgent care, industrial clinic or similar entity)

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. . . . . Neurology

2. Choose specialty from the dropdown list.

. . . . . *{not Answered}*

3. Choose specialty from the dropdown list.

. . . . . *{not Answered}*

NPI number

1. Please enter your current NPI number

. 1346268828

DEA number

1. Please enter your DEA number. Only enter one, or the primary DEA number.

. . . . . AG2296982

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Under penalty of law, I hereby swear or affirm that the information I have provided in the application is complete and correct, and that I have complied with all criteria for applying on line.