Medical Quality Assurance (MQA) Services

License Verification

Data As Of **5/8/2014**

License Verification

Practitioner Profile

EMIL F FELSKI

LICENSE NUMBER: **OS3318**

Printer Friendly Version

General Information | Secondary Locations | Practitioner Profile

Profession
OSTEOPATHIC PHYSICIAN

License/Activity Status
CLEAR/ACTIVE

Controlled Substance Prescriber
YES

Qualifications
Dispensing Practitioner

License Expiration Date
3/31/2016

License Original Issue Date
02/09/1973

Discipline on File
NO

Public Complaint
NO

Address of Record
1120 STATE ROAD 436
SUITE 1000
CASSELBERRY, FL 32707-6102
UNITED STATES

The information on this page is a secure, primary source for license verification provided by The Florida Department of Health, Division of Medical Quality Assurance. This website is maintained by Division staff and is updated immediately upon a change to our licensing and enforcement database.

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Accessibility Information * Email Advisory
Download Data

PART B OS 3318 **RENEWAL NOTICE** 20 20 19

STATE OF FLORIDA DEPARTMENT OF HEALTH

BOARD OF OSTEOPATHIC MEDICINE

IMPORTANT: BY SUBMITTING THE APPROPRIATE RENEWAL FEES TO THE DEPARTMENT, A LICENSEE AFFIRMS COMPLIANCE WITH ALL REQUIREMENTS FOR RENEWAL, INCLUDING CONTINUING EDUCATION CREDITS.

Signature: Emil F. Felski, DO

Please Indicate Mailing Address Change Below

Licensee's Last Name	First	Middle Initial
	Street Address	
	Street Address	
City	State	Zip

YOUR **OSTEOPATHIC PHYSICIAN LICENSE**

WILL EXPIRE **JANUARY 31, 2000**

REMIT FEE OF **$505.00**

$705.00 **AFTER EXPIRATION**

EMIL F FELSKI
1120 SEMORAN BLVD
LAKE HOWELL SQUARE
CASSELBERRY, FL 32707-6102

*****OPTIONAL***** DISPENSING PRACTITIONER REGISTRATION *****OPTIONAL*****

DISPENSING - **IS DEFINED AS *SELLING* MEDICINAL DRUGS TO PATIENTS IN THE OFFICE.** A PRACTITIONER WHO WRITES PRESCRIPTIONS OR PROVIDES COMPLIMENTARY PROFESSIONAL SAMPLES IS NOT A "DISPENSING PRACTITIONER," AND THEREFORE DOES NOT NEED TO REGISTER WITH THE DEPARTMENT.

I DISPENSE MEDICINAL DRUGS FOR A FEE FROM MY PRACTICE LOCATION AND I UNDERSTAND AN ANNUAL INSPECTION OF MY DISPENSING RECORDS WILL BE CONDUCTED.

THE FEE FOR REGISTRATION AS A DISPENSING PRACTITIONER IS INCLUDED IN YOUR LICENSE RENEWAL FEE.

TYPE OR PRINT

LICENSE NUMBER: OS0003318 DATE: 11/9/99

NAME: **EMIL F.M. FELSKI, D.O.** SIGNATURE: Emil F.M. Felski, DO

DO NOT COMPLETE THIS FORM UNLESS YOU WISH TO *SELL* MEDICINAL DRUGS FROM YOUR OFFICE AND COMPLY WITH ALL INSPECTION REQUIREMENTS.

Florida Department of Health - Board of Osteopathic Medicine

License Renewal Notice

Active Dispensing Osteopathic Physician License # OS 3318 expires January 31, 2002.

To avoid a delinquent charge, the fee of **$554.00** and the renewal form must be postmarked or electronically submitted on or before January 31, 2002. Renewal notices/forms postmarked on or after February 1, 2002 require renewal and delinquency fees of **$754.00**.

1. CHANGE OF MAILING ADDRESS:

DEPARTMENT USE ONLY

Current Mailing Address:

EMIL F FELSKI
1120 SEMORAN BLVD
LAKE HOWELL SQUARE
CASSELBERRY, FL 32707-6102

New Mailing Address:

Licensee's Last Name First Middle Initial
Attn:
Street Address:

City: State: Zip:
Phone: ( )

2. CHANGE OF PRACTICE LOCATION:

Current Practice Location:

1120 SEMORAN BLVD
LAKE HOWELL SQUARE
CASSELBERRY, FL 32707-6102

New Practice Location:

Attn:
Street Address:

City: State: Zip:
Phone: ( )

3. Chapter 456, F.S., requires a background check to renew a license, please review the following data to verify that the information is correct, please make any necessary corrections. This information is critical in ensuring that background checks are attributed to the correct licensee.

Description	Department Information	Information is Accurate		Correct Information
Social Security #		◯ Yes	◯ No	
Date of Birth	05/06/44	◯ Yes	◯ No	
Sex	Data Missing	◯ Yes	◯ No	
Race	Not Given	◯ Yes	◯ No	

Race Options: White, Black, Native, Asian, Other, Hispanic & not given

4. COMPLETE THE FINANCIAL RESPONSIBILITY FORM ON THE REVERSE SIDE OF THIS FORM.

5. MILITARY STATUS:

◯ I am requesting Military Restricted Status. (Military Restricted must submit proof of active military duty. Attach a copy of your current active duty orders or a letter from your Commanding Officer.)

◯ Please remove the Military Restricted Status from my license. (Provide copy of DD214 or letter from Commanding Officer.)

6. Will you be available to provide health care services in special needs shelters or to help staff disaster medical assistance teams during times of emergency or major disaster?

◯ Yes

7. THERE ARE TWO RENEWAL METHODS AVAILABLE:

A. Internet E-Renewal: Web address http://www.doh.state.fl.us/erenewal

E-Renewal allows you to make address changes. E-Renewal does not allow you to renew online by adding or removing a status, such as paying a delinquency fee or changing a license status. Due to high volume, allow sufficient time to renew since **e-Renewal will not be available after midnight Eastern Time (ET) January 31, 2002**. E-Renewal will require the following information:

License Number: OS 3318

B. U.S. Mail:

Mail this completed renewal form and fee payable to the Department of Health to:

P.O. Box 6320
Tallahassee, Florida 32314-6320

8. Other Information:

File Number: 2210 20 20 Sequence Number: 30

FINANCIAL RESPONSIBILITY

The Financial Responsibility options are divided into two categories, coverage and exemptions. Choose only ONE option of the ten provided pursuant to s.459.0085, Florida Statutes.

CATEGORY I - CATEGORIES OF FINANCIAL RESPONSIBILITY COVERAGE:

◯ 1. I do not have hospital staff privileges and I have established an irrevocable letter of credit or an escrow account in an amount of $100,000/$300,000, in accordance with Chapter 675, F. S., for a letter of credit and s. 625.52, F. S., for an escrow account.

◯ 2. I have hospital staff privileges and I have established an irrevocable letter of credit or escrow account in an amount of $250,000/$750,000, in accordance with Chapter 675, F. S., for a letter of credit and s. 625.52, F. S., for an escrow account.

◯ 3. I do not have hospital staff privileges and I have obtained and maintain professional liability coverage in an amount not less than $100,000 per claim, with a minimum annual aggregate of not less than $300,000 from an authorized insurer as defined under s. 624.09, F. S., from a surplus lines insurer as defined under s. 626.914(2), F.S., from a risk retention group as defined under s. 627.942, F.S., from the Joint Underwriting Association established under s. 627.351(4), F. S., or through a plan of self-insurance as provided in s. 627.367, F.S. I further certify that I have been continuously insured with an entity as outlined above for the past two years (retroactive coverage) or if I seek insurance from a different entity providing insurance; I will purchase retroactive coverage for the two years proceeding my inception date of coverage. I further certify that in the event my coverage is terminated or that I desire to become uninsured and meet the financial responsibility requirements through other provisions in s. 458.320 or 459.0085, F.S., I will maintain coverage for incidents which may have occurred during the two years preceding my becoming uninsured.

◯ 4. I have hospital staff privileges and I have professional liability coverage in an amount not less than $250,000 per claim, with a minimum annual aggregate of not less than $750,000 from an authorized insurer as defined under s. 624.09, F. S., from a surplus lines insurer as defined under s. 626.914(2), F. S., from a risk retention group as defined under s. 627.942, F.S., from the Joint Underwriting Association established under s. 627.351(4), F. S., or through a plan of self insurance as provided in s. 627.367, F .S. I further certify that I have been continuously insured with an entity as outlined above for the past two years (retroactive coverage) or if I seek insurance from a different entity providing insurance I will purchase retroactive coverage for the two years preceding my inception date of coverage. I further certify that in the event my coverage is cancelled or that I desire to become uninsured and meet the financial responsibility requirements through other provisions in s. 458.320 or 459.0085, F.S., I will maintain coverage for incidents which may have occurred during the two years preceding my becoming uninsured.

◯ 5. I have elected not to carry medical malpractice insurance, however, I agree to satisfy any adverse judgements up to the minimum amounts pursuant to s. 458.320(5)(g)1 or 459.008S(5)(g)1, F. S. I understand that I must either post notice in the form of a "sign" prominently displayed in the reception area or provide a written statement to any person to whom medical services are being provided that I have decided not to carry medical malpractice insurance. I understand that such a sign or notice must contain the wording specified in s. 458.320(5)(g) or 459.008S(5)(g), F. S.

CATEGORY II - EXEMPTION CATEGORIES OF FINANCIAL RESPONSIBILITY COVERAGE:

◯ 6. I practice medicine exclusively as an officer, employee, or agent of the federal government, or of the state or its agencies or subdivisions;

◯ 7. I hold a limited license issued pursuant to s. 458.317 or 459.0075, F. S., and practice only under the scope of the limited license;

◯ 8. I do not practice medicine in the State of Florida;

◯ 9. I meet all of the following criteria:

(a) I have held an active license to practice in this state or another state or some combination thereof for more than 15 years;

(b) I am retired or maintain part time practice of no more than 1000 patient contact hours per year;

(c) I have had no more than two claims resulting in an indemnity exceeding $10,000 within the previous five year period;

(d) I have not been convicted of or pled guilty or nolo contendere to any criminal violation specified in Chapter 458 or 459, F. S.; and

(e) I have not been subject, within the past ten years of practice, to license revocation or suspension, probation for a period of three years or longer, or a fine of $500 or more for a violation of Chapter 458 or 459, F.S., or the medical practice act of another jurisdiction. A regulatory agency's acceptance of a relinquishment of license stipulation, consent order or other settlement offered in response to or in anticipation of filing of administrative charges against a license shall be construed as action against a license. I understand if I am claiming an exception under this section that I must either post notice in the form of a sign, prominently displayed in the reception area or provide a written statement to any person to whom medical services are being provided, that I have decided not to carry medical malpractice insurance. I understand such a sign or notice must contain the wording specified in s. 458.320(5)(t) or 459.0085(5)(t), F. S.; or

◯ 10. I practice only in conjunction with my teaching duties at an accredited medical school or its teaching hospitals. (Interns and residents do not qualify for this exemption).

Florida Department of Health - Board of Osteopathic Medicine

License Renewal Notice

Active Dispensing Osteopathic Physician License # OS 3318 expires January 31, 2002.

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1. CHANGE OF MAILING ADDRESS:

DEPARTMENT USE ONLY

Current Mailing Address:

EMIL F FELSKI
1120 SEMORAN BLVD
LAKE HOWELL SQUARE
CASSELBERRY, FL 32707-6102

New Mailing Address:

Licensee's Last Name / First / Middle Initial

-200

Attn:

Street Address:

City: State: Zip:

Phone: ( )

Received Date : 12/26/01
Deposit Date : 1/8/02
Deposit # : 167523
Batch Number : 011087
Validation # : 901093970
Check Amount : $554.00
PRO CDE : 1901

2. CHANGE OF PRACTICE LOCATION:

Current Practice Location:

1120 SEMORAN BLVD
LAKE HOWELL SQUARE
CASSELBERRY, FL 32707-6102

New Practice Location:

Attn:

Street Address:

City: State: Zip:

Phone: ( )

3. Chapter 456, F.S., requires a background check to renew a license, please review the following data to verify that the information is correct, please make any necessary corrections. This information is critical in ensuring that background checks are attributed to the correct licensee.

Description	Department Information	Information is Accurate		Correct Information
Social Security #	[redacted]	● Yes	○ No	
Date of Birth	05/06/44	● Yes	○ No	
Sex	Data Missing	○ Yes	○ No	Male
Race	Not Given	○ Yes	○ No	White
Race Options: White, Black, Native, Asian, Other, Hispanic & not given				

4. COMPLETE THE FINANCIAL RESPONSIBILITY FORM ON THE REVERSE SIDE OF THIS FORM.

5. MILITARY STATUS:

○ I am requesting Military Restricted Status. (Military Restricted must submit proof of active military duty. Attach a copy of your current active duty orders or a letter from your Commanding Officer.)

○ Please remove the Military Restricted Status from my license. (Provide copy of DD214 or letter from Commanding Officer.)

6. Will you be available to provide health care services in special needs shelters or to help staff disaster medical assistance teams during times of emergency or major disaster?

● Yes

7. THERE ARE TWO RENEWAL METHODS AVAILABLE:

A. Internet E-Renewal: Web address http://www.doh.state.fl.us/erenewal

E-Renewal allows you to make address changes. E-Renewal does not allow you to renew online by adding or removing a status, such as paying a delinquency fee or changing a license status. Due to high volume, allow sufficient time to renew since **e-Renewal will not be available after midnight Eastern Time (ET) January 31, 2002.** E-Renewal will require the following information:

[redacted]

License Number: OS 3318

B. U.S. Mail:

Mail this completed renewal form and fee payable to the Department of Health to:

P.O. Box 6320
Tallahassee, Florida 32314-6320

8. Other Information:

File Number: 2210 20 20 Sequence Number: 30

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Choose only ONE option of the ten provided pursuant to s.459.0085, Florida Statutes.

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2. I have hospital staff privileges and I have established an irrevocable letter of credit or escrow account in an amount of $250,000/$750,000, in accordance with Chapter 675, F. S., for a letter of credit and s. 625.52, F. S., for an escrow account.
3. I do not have hospital staff privileges and I have obtained and maintain professional liability coverage in an amount not less than $100,000 per claim, with a minimum annual aggregate of not less than $300,000 from an authorized insurer as defined under s. 624.09, F. S., from a surplus lines insurer as defined under s. 626.914(2), F.S., from a risk retention group as defined under s. 627.942, F.S., from the Joint Underwriting Association established under s. 627.351(4), F. S., or through a plan of self-insurance as provided in s. 627.367, F.S. I further certify that I have been continuously insured with an entity as outlined above for the past two years (retroactive coverage) or if I seek insurance from a different entity providing insurance; I will purchase retroactive coverage for the two years proceeding my inception date of coverage. I further certify that in the event my coverage is terminated or that I desire to become uninsured and meet the financial responsibility requirements through other provisions in s. 458.320 or 459.0085, F.S., I will maintain coverage for incidents which may have occurred during the two years preceding my becoming uninsured.
4. I have hospital staff privileges and I have professional liability coverage in an amount not less than $250,000 per claim, with a minimum annual aggregate of not less than $750,000 from an authorized insurer as defined under s. 624.09, F. S., from a surplus lines insurer as defined under s. 626.914(2), F. S., from a risk retention group as defined under s. 627.942, F.S., from the Joint Underwriting Association established under s. 627.351(4), F. S., or through a plan of self insurance as provided in s. 627.367, F .S. I further certify that I have been continuously insured with an entity as outlined above for the past two years (retroactive coverage) or if I seek insurance from a different entity providing insurance I will purchase retroactive coverage for the two years preceding my inception date of coverage. I further certify that in the event my coverage is cancelled or that I desire to become uninsured and meet the financial responsibility requirements through other provisions in s. 458.320 or 459.0085, F.S., I will maintain coverage for incidents which may have occurred during the two years preceding my becoming uninsured.
5. I have elected not to carry medical malpractice insurance, however, I agree to satisfy any adverse judgements up to the minimum amounts pursuant to s. 458.320(5)(g)1 or 459.008S(5)(g)1, F. S. I understand that I must either post notice in the form of a "sign" prominently displayed in the reception area or provide a written statement to any person to whom medical services are being provided that I have decided not to carry medical malpractice insurance. I understand that such a sign or notice must contain the wording specified in s. 458.320(5)(g) or 459.008S(5)(g), F. S.

CATEGORY II - EXEMPTION CATEGORIES OF FINANCIAL RESPONSIBILITY COVERAGE:

6. I practice medicine exclusively as an officer, employee, or agent of the federal government, or of the state or its agencies or subdivisions;
7. I hold a limited license issued pursuant to s. 458.317 or 459.0075, F. S., and practice only under the scope of the limited license;
8. I do not practice medicine in the State of Florida;
9. I meet all of the following criteria:
   (a) I have held an active license to practice in this state or another state or some combination thereof for more than 15 years;
   (b) I am retired or maintain part time practice of no more than 1000 patient contact hours per year;
   (c) I have had no more than two claims resulting in an indemnity exceeding $10,000 within the previous five year period;
   (d) I have not been convicted of or pled guilty or nolo contendere to any criminal violation specified in Chapter 458 or 459, F. S.; and
   (e) I have not been subject, within the past ten years of practice, to license revocation or suspension, probation for a period of three years or longer, or a fine of $500 or more for a violation of Chapter 458 or 459, F.S., or the medical practice act of another jurisdiction. A regulatory agency's acceptance of a relinquishment of license stipulation, consent order or other settlement offered in response to or in anticipation of filing of administrative charges against a license shall be construed as action against a license. I understand if I am claiming an exception under this section that I must either post notice in the form of a sign, prominently displayed in the reception area or provide a written statement to any person to whom medical services are being provided, that I have decided not to carry medical malpractice insurance. I understand such a sign or notice must contain the wording specified in s. 458.320(5)(t) or 459.0085(5)(t), F. S.; or
10. I practice only in conjunction with my teaching duties at an accredited medical school or its teaching hospitals. (Interns and residents do not qualify for this exemption).

Florida Department of Health - Board of Osteopathic Medicine
LICENSE RENEWAL NOTICE

DEPARTMENT USE ONLY

Active Dispensing Osteopathic Physician License # OS 3318 expires March 31, 2006.
The fee of **$530.00** and the renewal notice must be postmarked on or before March 31, 2006. Renewal notices postmarked on or after April 01, 2006 require renewal and delinquent fees of **$930.00**.

1. CURRENT MAILING ADDRESS:
This address will be used for all correspondence from the Department of Health.

EMIL F FELSKI
1120 STATE ROAD 436
SUITE 1000
CASSELBERRY, FL 32707-6102
(407) 677-1234

2. CURRENT PRACTICE LOCATION:
This address will be printed on your license and posted on the Internet.

1120 STATE ROAD 436
SUITE 1000
CASSELBERRY, FL 32707-6102
(407) 677-1234

3. RENEW ON LINE TODAY!

Go to www.doh-mqaservices.com to renew your license, change your address, and confirm information maintained by the Department. Listed below is your Account ID and password for online services. If you renew online, you will receive a temporary license upon successful completion of your renewal. Online renewals are processed immediately and your license status is updated online within seven business days.

Avoiding complaints can protect your clients and your ability to practice. Go to www.doh.state.fl.us/mqa/avoid.html to find out more.

4. CHANGES TO CURRENT LICENSE INFORMATION:

If you have any changes to the name, mailing address, practice location address, license status or military status information associated with your license, please provide the updated information in the appropriate fields of section 7 on the back of this form.

5. THERE ARE TWO RENEWAL METHODS AVAILABLE:

A. Online Renewal: Visit **www.doh-mqaservices.com** go to the Practitioner Logon box, select your profession and enter your Account ID and password. If you are requesting a status change, you will be ineligible to renew your license online. The system will be available for renewals until midnight, Eastern Standard Time (EST), March 31, 2006. To use the online system, you will need the following information:

(Note: Account ID and Password must be entered exactly as they appear.)

The online system will allow practitioners to update their address, profile, and to confirm licensee information maintained by the Department. Practitioners will receive confirmation of their successful renewal before logging out of the system.

B. **U.S. Mail:** Mail completed form and fee payable to the Department of Health to the following address:
Department of Health, Division of Medical Quality Assurance, PO Box 6320, Tallahassee, FL 32314-6320

6. OTHER INFORMATION:

By submitting the appropriate renewal fees to the Department, a licensee certifies compliance with all requirements for renewal, including continuing education credits.

File Number: 2210　　Sequence Number: 51
Profession Code: 1901　　20　　20

Please make changes to your license information in section 7 on the BACK of this form.

7. CHANGES TO CURRENT LICENSE INFORMATION:

CHANGE OF NAME:

Name changes require legal documentation showing the name change. Please make sure that a photocopy of one of the following accompanies this form: a marriage license (marriage license must indicate the original signature and seal from the cle of the court), a divorce decree indicating restoration of your maiden name, or a court order (e.g., adoption, name change, or federal identity change). Any one of these will be accepted unless the department has a question about the authenticity of the document. A driver's license or social security card is not considered legal documentation.

If the name change cannot be completed, your license will be renewed using the current name.

Last Name:

First Name:

Middle Name: Title: Suffix: *(Jr,Sr,I,II,etc.)* Qualifier: *(PhD,DDS,etc.)*

CHANGE OF MAILING ADDRESS:

Attention:

Addr1:

Addr2:

City:

State: Zip: - Phone: ( ) -

CHANGE OF PRACTICE LOCATION: (This address can not be a Post Office Box)

Attention:

Addr1:

Addr2:

City:

State: Zip: - Phone: ( ) -

CHECKLIST FOR MAILING RENEWAL FORM

If mailing your renewal form, use the checklist below as a guide for enclosing all the required items to ensure a smooth renewal. If renewing by mail, allow 2-4 weeks processing time.

REQUIRED:
- Renewal notice
- Check or Money order written to Department of Health
- Financial Responsibility form (check only one item on the FR form)
- Mail to: PO Box 6320, Tallahassee, Florida 32314-6320

If you are renewing to active status, would you be available to provide health care services in special needs shelters or to help staff disaster medical assistance teams during times of emergency or major disaster?

- Yes

CHANGE OF LICENSE STATUS:

- I wish to change my status from Active to Inactive. The fee for an inactive receipt is **$230.00**. The fee for inactive after March 31, 2006 is **$730.00**.

CHANGE OF MILITARY STATUS:

- I am requesting Military Restricted Status. (You must submit proof of active military duty. Attach a copy of your current active duty orders or a letter from your Commanding Officer.) The fee for military restricted is **$00.00**.

CHANGE OF RETIRED STATUS:

- I am requesting retired status. The fee for retired status is **$55.00** postmarked on or before March 31, 2006. The fee for retired status on or after April 01, 2006 is **$555.00**.

DISPENSING:

- I wish to discontinue my dispensing registration. I understand that I will no longer be able to dispense medicinal drugs for a fee from my practice location. Your renewal notice and fee of **$430.00** is due on or before March 31, 2006. Renewal notices postmarked on or after April 01, 2006 require a renewal fee of **$830.00**.

\ CAMERA III   ROLL # [illegible]

TEXAS STATE BOARD OF MEDICAL EXAMINERS
Southwest Tower - Suite 900
211 East 7th St.
Austin, Texas 78701

October 19, 1976

_______ American Medical Association

_______ Police Department

__XXX__ State Board of Medical Examiners of Florida

_______ Commissioner of Narcotics & Dangerous Drugs

_______ Federation of State Medical Boards

Gentlemen:

We would appreciate knowing if you have any unfavorable information concerning the following physician who is applying for a license to practice medicine in Texas:

Emil Fordyce Mourier Felski, D. O.
3617 Fenton
Fort Worth, Texas 76133

Date & Place of Birth Waynesburg, Pennsylvania - 8/6/44

School of Graduation Philadelphia College of Osteopathic Medicine-1971

Licensed: State (s) Missouri, Florida

~~Derogatory information or~~ other remarks: Dr. Felski's license #3318 issued 2-9-73, is current and up-to-date at this time. We have no derogatory information on him in our files. Thank you.

Sincerely,

A. Bryan Spires, Jr., M.D.
Secretary

BY Diane Baldwin
Acting Executive Secretary
Board of Osteopathic Medical Examiners

RECEIVED
OCT 26 1976
BOARD OF OSTEOPATHIC
MEDICAL EXAMINERS

CAMERA III   Release

New Smyrna Beach, Fla. 32069
July 9, 1973

(Place and Date)

Regional Director, #5
Bureau of Narcotics and Dangerous Drugs
201 NE 12th Street
Miami, Florida 33132

Dear Sir:

In reply to your inquiry, you are advised that

EMIL F. M. FELSKI, D. O.

(is) (xxxxxx) authorized by the laws of this state to engage in the business or practice of OSTEOPATHY and thereby entitled to handle controlled substances, and is assigned state license, certificate, or registration number 3310 issued 2-9-73 or is otherwise authorized by reason of

STATE BOARD OF OSTEOPATHIC MEDICAL EXAMINERS

MERVIN E. MECK, D. O., Executive Director

LICENSE CONFIRMATION FORM

Name: Emil F Felske Specialty: ——

State: Florida License #: OS 3318

Is license current? ✓ YES ___ NO If NO, why not? ____________

Has disciplinary action ever been taken? ___ YES ✓ NO

	YES	NO
Probation		✓
Censure		✓
Suspension		✓
Revocation		✓

If YES, why? ____________

Have complaints about the physician's practice or conduct ever been received? ___ YES ✓ NO

If YES, please indicate disposition:

	YES	NO
Closed - No Action		
Closed - Unconfirmed		
Under Review		
Open Investigation		

Anticipated final action: ____________

Has physician ever been requested to appear before the Board? no

If Yes, Why? ____________

Derogatory information, if any: ____________

Comments: ____________

12/19/88
Date

Janet Fasian
Signature

(904) 488-7546
Telephone Number

Senior Clerk
Title

Administered by
Gulf Group Services Corporation
Health Care Cost Containment Department
1301 Gulf Life Drive / Jacksonville, Florida 32207
904-390-7971

RECEIVED MAR PHCY / OSTEO

March 10, 1988

Ms. Dot Faircloth
Department of Professional Regulation
130 North Munroe
Tallahassee, Florida 32399

Dear Ms. Faircloth:

Please advise if there has beenany action taken against the following physicians:

no	James Blumenthal, D.O. 4347 2911 Red Bug Lake Road Casselberry, FL 32707	no	A. R. Traynor, D.O. 3779 7727 Lake Underhill Drive Orlando, FL 32822
no	Emil Felski, D.O. 3318 1120 Semoran Boulevard Casselberry, FL 32707	no	Robert A. Schamberger, D.O. 4697 71 South Central Avenue Oviedo, FL 32765
no	William M. Silverman, D.O. 3966 1120 S. Semoran Boulevard Casselberry, FL 32707	no	Dennis Horvath, D.O. 4264 7200 Curry Ford Road Orlando, FL 32822

Thank you for your assistance in this matter.

Sincerely,

Sharon Feldkamp
Sharon Feldkamp
Managed Care Coordinator

SF/pls

There has been no disciplinary action against the above named osteopathic physicians.

Barbara Kemp
Barbara Kemp
Administrative Assistant
Board of Osteopathic Medical Examiners
(904) 488-7546

Department of Professional Regulation

Governor
Bob Graham
Secretary
Fred Roche

Board of Osteopathic Medical Examiners
130 N. Monroe Street, Tallahassee, Florida 32301
(904) 488-7546

RECEIVED
OCT 29 1985

LICENSE RENEWAL NOTICE 1985-87 $100 BIENNIAL RENEWAL FEE

PLEASE TYPE ALL INFORMATION
NAME Emil F.M. Felski, D.O. OS License No. 0003318
MAILING ADDRESS

1120 Semoran Blvd.
Street, P.O. Box., etc.

City Casselberry County Seminole State Fla. Zip 32707
IS THIS A CHANGE OF ADDRESS FROM THAT SHOWN ON THE ENCLOSED CARD
Yes ( ) No (X) Home Telephone Number 305-788-0980

NOTE: Under Florida Statutes, 459.008(5), it states: "The licensee must have on file with the department the address of his primary place of practice within this state prior to engaging in that practice. Prior to changing the address of his primary place of practice, whether in or out of state, the licensee shall notify the department of the address of his primary place of practice.

A. Place of Current Employment Emil F.M. Felski, D.O. P.A.
Address of Employment 1120 Semoran Blvd., Casselberry, Fla. 32707
Business Telephone Number 305-677-1234

B. List states where you hold osteopathic licensure:
Missouri, Texas, Florida

CONTINUING EDUCATION: 40 hours of CME per biennium, 85-87. Hours must be in thee field of continuing education and must be AOA, AMA or Board approved.

Signature of Licensee Emil F.M. Felski Date 10/28/85

NOTICE; Chapter 459.013, F.S., provides that attempting to obtain a license to practice osteopathic medicine by fraudulent misrepresentation, constitutes a misdemeanor of the first degree, punishable as provided in Chapter 775.082, 775.083, or 775.084, F.S.

Board Members

Luis Barroso, D.O. James H. Taylor, D.O. Noble L. Sissle, Jr.
Virginia Ann Robine, D.O. Rose Deeb Kitchen Morton T. Smith, D.O. Louis J. Larmoyeux, Sr. D.O.

OS 3318

PART B 0000 OS 0003318 **RENEWAL NOTICE** I A 904

STATE OF FLORIDA DEPARTMENT OF BUSINESS AND PROFESSIONAL REGULATION

BD OF OSTEOPATHIC MEDICINE

YOUR OSTEOPATHIC PHYSICIAN LICENSE

IMPORTANT: BY SUBMITTING THE APPROPRIATE RENEWAL FEES TO THE DEPARTMENT OR THE AGENCY, A LICENSEE ACKNOWLEDGE COMPLIANCE WITH ALL REQUIREMENTS FOR RENEWAL.

Please Indicate Address Change Below

Licensee's Last Name	First
	Street Address
	Local Address
City	State

WILL EXPIRE JANUARY 31, 1996

REMIT FEE OF $405.00 $505.00

$805.00 AFTER EXPIRATION

SEND CHECK OR MONEY ORDER ONLY

*** DO NOT SEND CASH ***

FELSKI, EMIL F
1120 SEMORAN BLVD
LAKE HOWELL SQUARE
CASSELBERRY FL 32707-6

RECEIVED NOV REVENUE DPR

11/08/95

$505.00

$400.00
$100.00
$5.00

No F.R. Form

$400 2160
$5 2151
$100 2114

040500 02160 26324000003 00030301086

AGENCY FOR HEALTH CARE ADMINISTRATION
BOARD OF OSTEOPATHIC MEDICINE/RENEWAL NOTICE

PART A - Please read and follow the enclosed instruction sheet carefully. All sections below must be complete.

NAME: EMIL F FELSKI, D.O.
ADDRESS: 1120 SEMORAN BLVD
CASSELBERRY FL 32707-6102

LICENSE NUMBER: OS 00[illegible]3318

Section I. Active Practice Requirement - DISREGARD THIS SECTION

Section II. Financial Responsibility -

Write the correct number in the box from instruction sheet. [2]

Section III. Dispensing Practitioner Registration Requirement [X] YES [ ] NO

ADDITIONAL $100 FEE REQUIRED

Section IV. CME - Risk Mgt, HIV/AIDS & Domestic Violence [X] YES [ ] NO

The process of renewing a license may take four (4) to six (6) weeks. Please allow sufficient time before initiating telephone calls to confirm the receipt of fees or the status of your license.

A licensee who remains on inactive status for more than two (2) consecutive biennial licensure cycles and who wishes to reactivate the license may be required to demonstrate competency to resume active practice by sitting for a special purpose examination or by completing other reactivation requirements, as defined by rule of the board or the department when there is no board.

PART B STATE OF FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

IMPORTANT: BY SUBMITTING THE APPROPRIATE RENEWAL FEES TO THE DEPARTMENT OR THE AGENCY, A LICENSEE ACKNOWLEDGES COMPLIANCE WITH ALL REQUIREMENTS FOR RENEWAL.

Money Sent
Rct #9501524[illegible]
$505

Please Indicate Address Change Below

LICENSEE'S LAST NAME:		
FIRST NAME:		
MIDDLE INITIAL:		
STREET ADDRESS:		
CITY:	STATE:	ZIP:

SEND CHECK OR MONEY ORDER ONLY
** DO NOT SEND CASH **

RETURN TO:
AGENCY FOR HEALTH CARE ADMINISTRATION
BOARD OF OSTEOPATHIC MEDICINE
1940 NORTH MONROE STREET
TALLAHASSEE, FL 32399-0757

[illegible]R FEES - SEE INSERTS

Practitioner's Name EMIL F FELSKI

License # OS0003318

MANDATORY PRACTITIONER PROFILE QUESTIONNAIRE

FLORIDA DEPARTMENT OF HEALTH
Division of Medical Quality Assurance
P. O. Box 6330
Tallahassee, Florida 32314-6330

I. PRACTITIONER DATA

A. PROFESSIONAL LICENSE NUMBER: OS0003318 (check one) ☐ ME/MD ☒ OS/DO ☐ CH/DC ☐ PO/DPM

B. NAME (INCLUDE MAIDEN AND ON 2ND/3RD LINES ANY ALIASES, IF APPLICABLE):

CURRENT NAME:

FELSKI (LAST) EMIL (FIRST) F (MIDDLE AND MAIDEN NAME, IF APPLICABLE)

FORMER NAME(S):

(LAST) (FIRST) (MIDDLE)

(LAST) (FIRST) (MIDDLE)

D. MAILING ADDRESS: 1120 SEMORAN BLVD LAKE HOWELL SQUARE CASSELBERRY FL 32707-6102
(STREET AND NUMBER) (CITY) (STATE) (ZIP CODE)

PRIMARY PRACTICE ADDRESS: (Authority: s.455.565(1)(a)3.,F.S.)

1120 SEMORAN BLVD LAKE HOWELL SQUARE CASSELBERRY FL 32707-6102
(PRACTICE NAME) (STREET AND NUMBER) (CITY) (STATE) (ZIP CODE)

OTHER PRACTICE LOCATION(S): (OPTIONAL)

OFFICE 2: (OPTIONAL)

(PRACTICE NAME) (STREET AND NUMBER) (CITY) (STATE) (ZIP CODE)

OFFICE 3: (OPTIONAL)

(PRACTICE NAME) (STREET AND NUMBER) (CITY) (STATE) (ZIP CODE)

E. TELEPHONE: (407) 677-1234 (This will not be published as a part of the profile.)

F. YEAR BEGAN PRACTICING MEDICINE: 1972 (Authority: s. 455.565(1)(a)5., F.S.)

II. ALL MEDICAL EDUCATION

A. Name of all medical schools attended. (Authority: s. 455.565(1)(a)1., F.S.)

NAME OF SCHOOL/UNIVERSITY	DATES OF ATTENDANCE	DATE OF GRADUATION	TYPE OF DEGREE
PHILADELPHIA COLL OF OSTEO MED	9/67 - 6/71	1971	D.O.

B. Have you completed any graduate medical education? Yes ☒ No ☐
If "YES", list in chronological order from date of graduation to the present, all completed graduate medical education. Do not include coursework taken to meet the continuing education requirement for licensure renewal. (Authority: s. 455.565(1)(a)1., F.S.)

MEDICAL TRAINING PROGRAM NAME	INTERNSHIP / RESIDENCY / FELLOWSHIP / OTHER	SPECIALTY AREA	CITY / STATE / COUNTRY	FROM MM/DD/YYYY	TO MM/DD/YYYY
UNIV MED CTR-UFHSC/	RES	OBSTETRICS AND GYNECOLOGY	FL	7/1/72	6/30/75
Flint Osteo. Hosp. Rotating Internship	Intern	Rotating	MI	7/1/71	6/30/72

Practitioner's Name EMIL F FELSKI License # OS0003318

III. OTHER HEALTH RELATED DEGREES

Do you currently hold a degree in a health related profession other than the professional degree listed in II. A. above? Yes ☐ No ☒

If "YES", list all medical/professional schools from which a degree in a health related profession other than the professional degree was obtained. (Authority: s. 455.565.(1)(a)1., F.S.)

NAME OF SCHOOL / UNIVERSITY	CITY / STATE / COUNTRY	FROM MM/DD/YYYY	TO MM/DD/YYYY	DEGREE TITLE

IV. FACULTY APPOINTMENTS:

A. Have you had the responsibility for graduate medical education within the last 10 years? (Authority: s. 455.565.(1)(a)6., F.S.) Yes ☐ No ☒

B. Do you currently hold a faculty appointment at a medical/health related institution of higher learning? (Authority: s. 455.565(1)(a)6., F.S.) Yes ☐ No ☒

If "YES", to question "B" list the title of the current appointment, name(s) and city/state of institution(s).

	TITLE	INSTITUTION	CITY/STATE
1.			
2.			
3.			

V. STAFF PRIVILEGES:

Do you currently hold staff privileges in a hospital/medical/health institution? Yes ☒ No ☐

If "YES", list each hospital/medical/health institution at which you currently have staff privileges. (Authority: s. 455.565(1)(a)2., F.S.)

	NAME OF HOSPITAL/MEDICAL/HEALTH INSTITUTION	CITY/STATE
1.	Fla. Hosp.	Altamonte Springs, FL.
2.	South Seminole Hosp.	Longwood, FL.
3.	Winter Park Hosp.	Winter Park, FL
4.	Columbia Florida Surgery Center	Altamonte Springs, FL

VI. SPECIALTY BOARD CERTIFICATIONS:

Do you hold a certification from any specialty board recognized by the Florida board regulating the profession for which you are licensed? Yes ☒ No ☐ (Authority: s. 455.565(1)(a)4. , F.S.)

If "YES", complete section below.

	SPECIALTY BOARD NAME	CERTIFICATION / SPECIALITY / SUBSPECIALITY
1.	Board of Certification in Obstetrics & Gynecology	Ob-Gyn
2.		
3.		

VII. FINAL DISCIPLINARY ACTION:

A1. Within the previous ten (10) years, have you ever had any final disciplinary action taken against you by a specialty board recognized by the American Board of Medical Specialties, the American Osteopathic Association, the American Chiropractic Association, or other similar national organization? (Authority: s. 455.565(1)(a)8., F.S.) Yes ☐ No ☒

If "YES", list name(s) of specialty board(s), date, description of violation(s), description of the final disciplinary action(s), and indicate whether the final disciplinary action is under appeal. (attach copy of notice of appeal)

	SPECIALTY BOARD NAME	DATE	DESCRIPTION OF VIOLATION	DESCRIPTION OF FINAL DISCIPLINARY ACTION	UNDER APPEAL?
1.					Y / N
2.					Y / N
3.					Y / N

A2. Within the previous ten (10) years, have you ever had any final disciplinary action taken against you by the agency regulating your license, in this state or any other jurisdiction? (Authority: s. 455.565(1)(a)8., F.S.) Yes ☐ No ☒

If "YES", list name(s) of agency(s), date, description of violation(s), description of the final disciplinary action(s), and indicate whether the final disciplinary action is under appeal. (attach copy of notice of appeal)

	AGENCY NAME	DATE	DESCRIPTION OF VIOLATION	DESCRIPTION OF ACTION	UNDER APPEAL?
1.					Y / N
2.					Y / N
3.					Y / N

Practitioner's Name EMIL F FELSKI License # OS0003318

A3. Within the previous ten (10) years, have you ever had any final disciplinary action taken against you by a licensed hospital, health maintenance organization, prepaid health clinic, ambulatory surgical center, or nursing home? (Authority: s. 455.565(1)(a)8., F.S.) Yes ☐ No ☒

If "YES", list name(s) of medical institution(s), date, description of violation(s), description of the final disciplinary action(s), and indicate whether the final disciplinary action is under appeal. (attach copy of notice of appeal)

	ENTITY NAME	DATE	DESCRIPTION OF VIOLATION	DESCRIPTION OF ACTION	UNDER APPEAL?
1.					Y / N
2.					Y / N
3.					Y / N

B. Within the previous ten (10) years, have you ever been asked to or allowed to resign from or had any medical staff privileges restricted or not renewed by any medical/health-related institution in lieu of or in settlement of a pending disciplinary action related to competence or character? (Authority: s. 455.565(1)(a)8., F.S.) Yes ☐ No ☒

If "YES", list name(s) of the facility(s), date, description of violations, description of the final disciplinary action(s), and indicate whether the final disciplinary action is under appeal. (attach copy of notice of appeal)

	INSTITUTION NAME	DATE	DESCRIPTION OF VIOLATION	DESCRIPTION OF ACTION	UNDER APPEAL?
1.					Y / N
2.					Y / N
3.					Y / N

VIII. CRIMINAL OFFENSES

Have you ever been convicted or found guilty, regardless of whether adjudication of guilt was withheld, or pled guilty or nolo contendere to a criminal misdemeanor or felony in any jurisdiction? (Authority: s. 455.565 (1)(a)7., F.S.) Yes ☐ No ☒

If "YES", briefly describe the offense(s), indicate whether the conviction is under appeal, and attach copy of notice of appeal.

	DESCRIPTION OF OFFENSE	DATE	JURISDICTION	UNDER APPEAL?
1.				Y / N
2.				Y / N
3.				Y / N

IX. STATEMENT OF FINANCIAL RESPONSIBILITY (Allopathic and Osteopathic Physicians Only)

A. Hospital Privileges - (Check only one) (Authority s. 455.5651(4), F.S.)

☐ 1. I do not have hospital staff privileges and I have obtained and maintain professional liability coverage in an amount not less than $100,000 per claim, with a minimum annual aggregate of not less than $300,000 from an authorized insurer as defined under s. 624.09, F. S., from a surplus lines insurer as defined under s. 626.914(2), F.S., from a risk retention group as defined under s. 627.942, F.S., from the Joint Underwriting Association established under s. 627.351(4), F. S., or through a plan of self-insurance as provided in s. 627.367, F.S. I further certify that I have been continuously insured with an entity as outlined above for the past two years (retroactive coverage) or if I seek insurance from a different entity providing insurance, I will purchase retroactive coverage for the two years preceding my inception date of coverage. I further certify that in the event my coverage is terminated or that I desire to become uninsured and meet the financial responsibility requirements through other provisions in s. 458.320 or 459.0085, F.S., I will maintain coverage for incidents which may have occurred during the two years preceding my becoming uninsured.

☒ 2. I have hospital staff privileges and I have professional liability coverage in an amount not less than $250,000 per claim, with a minimum annual aggregate of not less than $750,000 from an authorized insurer as defined under s. 624.09, F. S., from a surplus lines insurer as defined under s. 626.914(2), F. S., from a risk retention group as defined under s. 627.942, F.S., from the Joint Underwriting Association established under s. 627.351(4), F. S., or through a plan of self insurance as provided in s.627.367, F.S. I further certify that I have been continuously insured with an entity as outlined above for the past two years (retroactive coverage) or if I seek insurance from a different entity providing insurance I will purchase retroactive coverage for the two years preceding my inception date of coverage. I further certify that in the event my coverage is canceled or that I desire to become uninsured and meet the financial responsibility requirements through other provisions in s. 458.320 or 459.0085, F.S., I will maintain coverage for incidents which may have occurred during the two years preceding my becoming uninsured.

☐ 3. I do not have hospital staff privileges and I have established an irrevocable letter of credit or an escrow account in an amount of $100,000/$300,000, in accordance with Chapter 675, F. S., for a letter of credit and s. 625.52, F. S., for an escrow account.

☐ 4. I have hospital staff privileges and I have established an irrevocable letter of credit or escrow account in an amount of $250,000/$750,000, in accordance with Chapter 675, F. S., for a letter of credit and s. 625.52, F. S., for an escrow account.

☐ 5. I have elected not to carry medical malpractice; however, I agree to satisfy any adverse judgments up to the minimum amounts pursuant to s. 458.320(5)(g)1 or 459.0085(5)(g)1, F. S. I understand that I must either post notice in the form of a "sign" prominently displayed in the reception area or provide a written statement to any person to whom medical services are being provided that I have decided not to carry medical malpractice insurance. I understand that such a sign or notice must contain the wording specified in s. 458.320(5)(g) or 459.0085(5)(g), F. S.

B. Exemption

I am exempt from demonstrating financial responsibility because I fall into one of the categories listed below: (Check one box only)

☐ 1. I practice medicine exclusively as an officer, employee, or agent of the federal government, or of the state or its agencies or subdivisions;

☐ 2. I hold a limited license issued pursuant to s. 458.317 or 459.0075, F. S., and practice only under the scope of the limited license;

☐ 3. I practice only in conjunction with my teaching duties at an accredited medical school or its teaching hospitals. (Interns and residents do not qualify for this exemption);

☐ 4. I do not practice medicine in the State of Florida; or

Practitioner's Name EMIL F FELSKI License # OS0003318

☐ 5. I meet all the following criteria:
(a) I have held an active license to practice in this state or another state or some combination thereof for more than 15 years;
(b) I am retired or maintain part time practice of no more than 1000 patient contact hours per year;
(c) I have had no more than two claims resulting in an indemnity exceeding $10,000 within the previous five year period;
(d) I have not been convicted of or pled guilty or nolo contendere to any criminal violation specified in Chapter 458 or 459, F. S.; and
(e) I have not been subject, within the past ten years of practice, to license revocation or suspension, probation for a period of three years or longer, or a fine of $500 or more for a violation of Chapter 458 or 459, F.S., or the medical practice act of another jurisdiction. A regulatory agency's acceptance of a relinquishment of license stipulation, consent order or other settlement offered in response to or in anticipation of filing of administrative charges against a license shall be construed as action against a license. I understand if I am claiming an exemption under this section that I must either post notice in the form of a sign, prominently displayed in the reception area or provide a written statement to any person to show medical services are being provided, that I have decided not to carry medical malpractice insurance. I understand such a sign or notice must contain the wording specified in s. 458.320(5)(f) or 459.0085(5)(f), F.S.

X. LIABILITY CLAIMS (Allopathic, Osteopathic and Podiatric Physicians Only)

A. Are you covered by an insurer required to report pursuant to s. 627.912 F.S. Yes ☒ No ☐
(Authority: s. 455.5651(4), F.S.; s. 455.565(1)(b),F.S.)

B. Have you been insured continuously during the last ten years? Yes ☒ No ☐
(Authority: s. 455.5651(4), F.S.; s. 455.565(1)(b),F.S.)

If you answered "NO" to either A or B above, you must complete the following: (Authority: s. 455.5651(4), F.S.; s. 455.5651(1)(b),F.S.)

Within the previous ten years have you had a liability claim or action for damages for personal injury settled or finally adjudicated in an amount that exceeds $5,000? Yes ☐ No ☐

If "YES", complete and attach a copy of EXHIBIT 1 for each occurrence. NOTE: Copies of reports previously submitted may be re-submitted with this questionnaire to satisfy this reporting requirement. (Authority: s. 455.5651(4), F.S.; s. 455.565(1)(b),F.S.)

XI. LIABILITY CLAIMS (Chiropractic Physicians Only)

Within the previous ten years have you had a liability claim or action for damages for personal injury settled or finally adjudicated in an amount that exceeds $5,000? Yes ☐ No ☐

If "YES", complete and attach a copy of EXHIBIT 1 for each occurrence. (Authority: s. 455.5651(4), F.S.; s. 455.565(1)(b),F.S.)

XII. OPTIONAL INFORMATION:

A. PUBLICATIONS: List any publications you have authored in peer-reviewed medical literature within the previous ten years:
(Authority s. 455.565(5)(a), F.S.)

	TITLE	PUBLICATION	DATE
1.			
2.			
3.			

B. DO YOU PARTICIPATE IN THE MEDICAID PROGRAM? (Authority s. 455.565(5)(d), F.S.) Yes ☒ No ☐

C. PROFESSIONAL OR COMMUNITY SERVICE ACTIVITIES, HONORS, OR AWARDS: (Authority s.455.565(5)(b), F.S.)

	COMMUNITY SERVICE/AWARD/HONOR	ORGANIZATION		COMMUNITY SERVICE/AWARD/HONOR	ORGANIZATION
1.	Physician's Recognition Award		2.		
3.	Fellow – American Academy of Osteo. Ob-Gyn		4.		

D. NATIONAL, STATE, LOCAL, COUNTY, PROFESSIONAL AFFILIATIONS: (Authority s.455.565(5)(b), F.S.)
ORGANIZATION

1. ACA
2.
3. A.A.P.S.
4.

E. LANGUAGES, OTHER THAN ENGLISH: Indicate languages other than English used by you to communicate with patients and any translation service available for patients at your primary place of practice. (Authority: s. 455.565(5)(c), F.S.)

1.
2.
3.
4.

F. E-MAIL ADDRESS:

G. COMMITTEES/MEMBERSHIPS: Indicate any committees on which you serve for any health entity with which you are affiliated.
ORGANIZATION

1.
2.
3.
4.

H. OTHER STATE LICENSURE:

	STATE	PROFESSION
1.	Missouri	Physician
2.	Texas	Physician
3.		

I affirm these statements are true and correct and recognize that providing false information may result in disciplinary action against my license or criminal penalties pursuant to Sections 455.624, 458.327, 458.331, 459.013, 459.015, 460.413, 461.013, 775.082, 775.083 and 775.084, Florida Statutes.

Emil F. M. Felski, DO (Signature of Physician) 4/12/99 (Date)

Practitioner's Name EMIL F FELSKI License # OS0003318

EXHIBIT 1 – REPORT ON PROFESSIONAL LIABILITY CLAIMS AND ACTIONS

Include information relating to liability actions occurring within the previous 10 years. The actions are required to be reported under section 455.697 F.S. You must submit a completed form for each occurrence. For Allopathic, Osteopathic and Podiatric physicians, copies of reports previously submitted under the requirements of s. 455.697, F.S., (formerly s. 355.247, F.S.) may be submitted in lieu of this exhibit to satisfy this reporting requirement.

Date of occurrence: ____/____/____ Date reported to licensee: ____/____/____

Injured person's name: (last, first, middle initial) ____________

Street Address: ____________

City: ____________ State: ________ Zip Code: ________

Age: ________ Sex: ________

Date of suit: ____/____/____

List other defendants involved in this claim:

1. ____________ 2. ____________

3. ____________ 4. ____________

Date of final claim disposition: ____/____/____

Was there an itemized verdict? ☐ Yes ☐ No (If "YES", attach copy of settlement verdict)

Indemnity paid on behalf of this defendant: $________

Loss adjustment expense paid to defense counsel: $________

All other loss adjustment expense paid: $________

Name of institution at which the injury occurred: ____________

Location of injury occurrence:

___ Patient's Room ___ Physical Therapy Dept. ___ Radiology ___ Labor & Delivery Room

___ Operating Suite ___ Nursery ___ Emergency Room ___ Special Procedure Room

___ Recovery Room ___ Critical Care Unit ___ Other ________

Final diagnosis for which treatment was sought or rendered. ____________

Describe misdiagnosis made, if any, of the patient's actual condition. ____________

Describe the operation, diagnostic or treatment procedure causing the injury. Use nomenclature and/or descriptions of the procedures used. Include method of anesthesia, or name of drug used for treatment, with detail of administration. ____________

Describe the principal injury giving rise to the claim. Use nomenclature and/or descriptions of the injury. Include type of adverse effect from drugs where applicable. ____________

Safety management steps taken by the licensee to make similar occurrences less likely. ____________

I affirm that these statements are true and correct and recognize that providing false information may result in disciplinary action against my license or criminal penalties pursuant to Sections 455.624, 458.327, 458.331, 459.013, 459.015, 460.413, 461.013, 775.082, 775.083, and 775.084, Florida Statutes.

Signature of Physician: ____________

Our records indicate the following reported claims:

Incident Date	Settlement Date	Incident Date	Settlement Date	Incident Date	Settlement Date	Incident Date	Settlement Date	Incident Date	Settlement Date
01/12/1997									

Jeb Bush
Governor

Robert G. Brooks, M.D.
Secretary

October 15, 1999

EMIL F FELSKI, D.O.
1120 SEMORAN BLVD
LAKE HOWELL SQUARE
CASSELBERRY, FL-32707-6102

Dear Dr. FELSKI

We have not received a response as of September 17, 1999, to a letter we sent to you asking you to verify the correctness of your profiling data which is to be published on the World Wide Web. Please review the profile information contained in this letter for any changes, corrections, and/or omissions to insure the information that will be published is correct. Even if you have no changes, check the correct box below and return it to the Department at Post Office Box 6330, Tallahassee, Florida 32314-6330. If you do have changes, please indicate them directly on this letter. If you do not respond to this request within two weeks of the date of this correspondence your profile will be published as it appears in this letter.

☐ My profiling information is correct.

☑ My profiling information is incorrect; changes are noted below.

I. **Practitioner Information**

License Number : 3318
Profession : Osteopathic Physician
License Status : ACTIVE CLEAR
Year Began Practicing : 01/01/1972

Primary Business:

1120 SEMORAN BLVD
LAKE HOWELL SQUARE
CASSELBERRY FL 32707-6102

Secondary Locations:

Staff Privileges:

Institution Name	City	State
FLORIDA HOSPITAL	ALTAMONTE SPRINGS	FLORIDA
SOUTH SEMINOLE HOSPITAL	LONGWOOD	FLORIDA
WINTER PARK MEMORIAL HOSPITAL	WINTER PARK	FLORIDA

Faculty Appointments:

This practitioner has not had the responsibility for graduate medical education within the last 10 years.

This practitioner does not currently hold faculty appointments at any medical/health related institutions of higher learning.

Participates in Medicaid Program:

Yes

II. Education and Training

Medical School : Dates of Attendance : Graduation Date : Degree Title
Philadelphia College of Osteopathic Medicine · Philadelphia, P.A. 1967-1971
The parctitioner failed to provide this mandatory information D.O. Degree

Other Health Related Degrees:

This practitioner does not hold any additional health related degrees.

III. Professional and Postgraduate Training

This practitioner has completed the following graduate medical education:
Program Name : Program Type : Specialty Area : City : State/Country : Dates Attended

1. UNIVERSITY MEDICAL CENTER AT THE UNIV OF FL HLTH SCI CNTR : RESIDENCY : OBG - OBSTETRICS AND GYNECOLOGY : .... : FLORIDA : 7/1/72 - 6/30/75

2. FLINT OSTEOPATHIC HOSPITAL : INTERNSHIP : TY - TRANSITIONAL YEAR : .... : MICHIGAN : 7/1/71 - 6/30/72

IV. Specialty

This practitioner holds the following certifications from specialty boards recognized by the Florida board which regulates the profession for which he/she is licensed:
Specialty Board : Certification
1. AMERICAN BOARD OF OBSTETRICS & GYNECOLOGY : OBG - OBSTETRICS AND GYNECOLOGY

V. Optional Information

Committees:/Memberships

This practitioner has not indicated any committees on which they serve for any health entity with which they are affiliated. American Osteopathic Association
American College of Osteopathic Obstetrics + Gynecology.

Professional or Community Service Awards

This practitioner has provided the following professional or community service activities, honors, or awards:
Community Service/Award/Honor : Organization
1. PHYSICIANS RECOGNITION AWARD : AOA
2. FELLOW AMERICAN ACAD OF OSTEO OBGYN : AAPS

Publications

This practitioner has not provided any publications that he/she authored in peer-reviewed medical literature within the last ten years.

Languages Other Than English

This practitioner has not indicated that any languages other than English are used to communicate with patients, or that any translation service is available for patients, at his/her primary place of practice.

Other Affiliations

This practitioner has not provided any national, state, local, county, or professional affiliations.

E-Mail Address
Not Provided

Other State Licensure

This practitioner has indicated the following additional state licensure:

Jurisdiction	Profession
MO	MD
TX	MD

VI. Financial Responsibility

I have hospital staff privileges and I have professional liability coverage in an amount not less than $250,000 per claim, with a minimum annual aggregate of not less than $300,000 from an authorized insurer as defined under s. 624.09, F. S., from a surplus lines insurer as defined under s. 626.914(2), F. S., from a risk retention group as defined under s. 627.942, F. S.,from the Joint Underwriting Association established under s. 627.351(4), F. S., or through a plan of self-insurance as provided in s. 627.367, F. S. I further certify that I have been continuously insured with an entity as outlined above for the past two years (retroactive coverage) or if I seek insurance from a different entity providing insurance, I will purchase retroactive coverage for the two years preceding my inception date of coverage. I further certify that in the event my coverage is terminated or that I desire to become uninsured and meet the financial responsibility requirement through other provisions in s. 458.320 or 459.0085, F. S., I will maintain coverage for incidents which may have occurred during the two years preceding my becoming uninsured.

VII. Criminal Offenses

The criminal history information, if any exists, will be incomplete; federal criminal history is not available to the public. The criminal history information provided by the practitioner has not been completely verified at this time. All criminal history checks should be completed by March 2000.

This practitioner has indicated that he/she has NO criminal offenses.

VIII. Final Disciplinary Action (Within last 10 years)

Pursuant to section 455.5651(5), F.S. the profile will not include disciplinary action taken by a hospital or ambulatory surgical centers licensed under chapter 395, F.S.

This practitioner has indicated that he/she has NOT had any final disciplinary action taken against him/her within the previous 10 years by a specialty board.

This practitioner has indicated that he/she has NOT had any final disciplinary action taken against him/her within the previous 10 years by a licensing agency.

This practitioner has indicated that he/she has NOT had any final disciplinary action taken against him/her within the previous 10 years by a health maintenance organization, pre-paid health clinic, nursing home, out-of-state hospital or out-of-state ambulatory surgical center.

This practitioner has indicated that he/she has NEVER been asked to or allowed to resign from or had any medical staff privileges restricted or revoked within the previous 10 years by a health maintenance organization, pre-paid health clinic, nursing home, out-of-state hospital or out-of-state ambulatory surgical center.

IX. Liability Claims Exceeding $5,000.00 (Within last 10 years)

Settlement of a claim may occur for a variety of reasons that do not necessarily reflect negatively on the professional competence or conduct of the physician. A payment settlement of a medical malpractice action or claim should not be construed as creating a presumption that medical malpractice has occurred.

There have not been any reported liability actions, which are required to be reported under section 455.697, F.S., within the previous 10 years.

If you wish to make changes to the profile after it has been published, please submit them to 2020 Capital Circle SE, Bin # C10, Tallahassee, Florida 32399-6230.

If you have any questions or comments, call (850) 410-3359 Extension 2009.

Sincerely,

Bureau of Operations

Florida Department of Health - Board of Osteopathic Medicine
LICENSE RENEWAL NOTICE

DEPARTMENT USE ONLY

Active Dispensing Osteopathic Physician License # OS 3318 expires March 31, 2004.

The fee of **$530.00** and the renewal notice must be postmarked on or before March 31, 2004. Renewal notices postmarked on or after April 01, 2004 require renewal and delinquent fees of **$930.00**.

1. CURRENT MAILING ADDRESS:

This address will be used for all correspondence from the Department of Health.

EMIL F FELSKI
1120 SEMORAN BLVD
LAKE HOWELL SQUARE
CASSELBERRY, FL 32707-6102

(407) 677-1234

2. CURRENT PRACTICE LOCATION:

This address will be printed on your license and posted on the Internet.

1120 SEMORAN BLVD
LAKE HOWELL SQUARE
CASSELBERRY, FL 32707-6102

3. RENEW ON LINE TODAY!

Go to **www.doh-mqaservices.com** and renew your license, change your address, update your profile, and confirm information maintained by the Department. Listed below is your user id and password for online services. If you renew online, you will receive a temporary license upon successful completion of your renewal. Online renewals are processed immediately and your license status is updated online within seven business days.

4. CHANGES TO CURRENT LICENSE INFORMATION:

If you have any changes to the name, mailing address, practice location address, license status or military status information associated with your license. Please provide the updated information in the appropriate fields of section 7 on the back of this form.

5. THERE ARE TWO RENEWAL METHODS AVAILABLE:

A. **Online Renewal:** Visit **www.doh-mqaservices.com** and click on Renew My License to renew your license online. If you are requesting a status change you will be ineligible to renew your license online. The system will be available for renewals until midnight, Eastern Standard Time (EST), March 31, 2004. To use the online system, you will need the following information:

(Note: Account Id and Password must be entered exactly as they appear.)

The online renewal system will allow practitioners to update their mailing and practice location addresses, profile, and to confirm licensee information maintained by the Department. Practitioners will receive a temporary license upon successful renewal before logging out of the system.

B. **U.S. Mail:** Mail completed form and fee payable to the Department of Health to the following address:

Department of Health
Division of Medical Quality Assurance
PO Box 6320
Tallahassee, FL 32314-6320

6. Other Information:

By submitting the appropriate renewal fees to the Department, a licensee certifies compliance with all requirements for renewal, including continuing education credits.

File Number: 2210　　Sequence Number: 40

Profession Code: 1901　　20　　20

Please make changes to your license information in section 7 on the BACK of this form.

7. CHANGES TO CURRENT LICENSE INFORMATION:

PLEASE READ THIS SECTION CAREFULLY BEFORE MAKING ANY CHANGES:

To indicate changes in any section, complete the change indicator oval like this
When providing updated information, print each character inside the box like this A B C 1 2 3
Use black/blue pen or No.2 pencil only for all changes.

CHANGE OF NAME:

Name changes require legal documentation showing the name change. Please make sure that a photocopy of one of the following accompanies this form: a marriage license (marriage license must indicate the original signature and seal from the clerk of the court), a divorce decree indicating restoration of your maiden name, or a court order (e.g., adoption, name change, or federal identity change). Any one of these will be accepted unless the department has a question about the authenticity of the document. A driver's license or social security card is not considered legal documentation.

If the name change cannot be completed, your license will be renewed using the current name.

Last Name:

First Name:

Middle Name: Title: Suffix: *(Jr,Sr,I,II,etc.)* Qualifier: *(PhD,DDS,etc.)*

CHANGE OF MAILING ADDRESS:

Attention:

Street Addr1:

Street Addr2:

City:

State: Zip: + Phone: ( ) -

CHANGE OF PRACTICE LOCATION: (This address can not be a Post Office Box)

Attention:

Street Addr1:

Street Addr2:

City:

State: Zip: + Phone: ( ) -

CHECKLIST FOR MAILING RENEWAL FORM

If mailing your renewal form, use the checklist below as a guide for enclosing all the required items to ensure a smooth renewal. If renewing by mail, allow 4-6 weeks processing time.

REQUIRED:
- Renewal notice
- Check or Money order written to Department of Health
- Financial responsibility form (check only one item on the FR form)
- Mail to: PO Box 6320, Tallahassee, Florida 32314-6320

If you are renewing to active status, would you be available to provide health care services in special needs shelters or to help staff disaster medical assistance teams during times of emergency or major disaster?

Yes

CHANGE OF LICENSE STATUS:

I wish to change my status from Active to Inactive. The fee for an inactive receipt is **$230.00**. The fee for inactive after March 31, 2004 is **$730.00**.

CHANGE OF MILITARY STATUS:

I am requesting Military Restricted Status. (You must submit proof of active military duty. Attach a copy of your current active duty orders or a letter from your Commanding Officer.) The fee for military restricted is **$00.00**.

DISPENSING:

I wish to discontinue my dispensing registration. I understand that I will no longer be able to dispense medicinal drugs for a fee from my practice location. Your renewal notice and fee of **$430.00** is due on or before March 31, 2004. Renewal notices postmarked on or after April 01, 2004 require a renewal fee of **$830.00**.

Florida Department of Health - Board of Osteopathic Medicine
License Renewal Notice

DEPARTMENT USE ONLY

Active Dispensing Osteopathic Physician License # OS 3318 expires March 31, 2008.

The fee of **$530.00** and the renewal notice must be postmarked on or before March 31, 2008. Renewal notices postmarked on or after April 01, 2008 require renewal and delinquent fees of **$930.00**.

1. CURRENT MAILING ADDRESS:

This address will be used for all correspondence from the Department of Health.

EMIL F FELSKI
1120 STATE ROAD 436
SUITE 1000
CASSELBERRY, FL 32707-6102

2. CURRENT PRACTICE LOCATION:

This address will be printed on your license and posted on the Internet.

EMIL F FELSKI
1120 STATE ROAD 436
SUITE 1000
CASSELBERRY, FL 32707-6102

3. RENEW YOUR LICENSE ONLINE:

Visit **www.flhealthsource.com**, from our main page, select **Licensee/Provider**, go to the **Practitioner Logon** box on the left side of the page, select your profession and enter your Account ID and password. If you are requesting a status change, you will be ineligible to renew your license online. Renew online and receive a temporary license immediately. The system will be available for renewals until midnight, Eastern Standard Time (EST), **March 31, 2008**.

The online system will also allow you to update your address and confirm licensure information maintained by the Department.

4. CHANGE OF LICENSE STATUS:

◯ I wish to change my status from active to inactive. The fee for inactive on or before March 31, 2008 is **$230.00**.

5. CHANGE TO MILITARY STATUS:

◯ I am requesting Military Restricted Status. (You must submit proof of active military duty. Attach a copy of your current active duty orders or a letter from your Commanding Officer.) The fee for military restricted on or before March 31, 2008 is **$00.00**. The fee on or after April 01, 2008 is **$00.00**.

6. CHANGE TO RETIRED STATUS:

◯ I am requesting retired status. The fee for retired status on or before March 31, 2008 is **$55.00**. The fee for retired status on or after April 01, 2008 is **$555.00**.

7. DISPENSING:

◯ I wish to discontinue my dispensing registration. I understand that I will no longer be able to dispense medicinal drugs for a fee from my practice location. Your renewal notice and fee of **$430.00** is due on or before March 31, 2008. Renewal notices postmarked on or after April 01, 2008 require a renewal fee of **$830.00**.

8. FINANCIAL RESPONSIBILITY:

Please complete the enclosed Financial Responsibility form. Please select ONLY ONE option from any category on the form.

9. OTHER INFORMATION:

By submitting the appropriate renewal fees to the Department, a licensee certifies compliance with all requirements for renewal, including continuing education credits.

A licensee who remains on inactive status for more than two consecutive biennial licensure cycles and who wishes to reactivate the license may be required to demonstrate the competency to resume active practice by sitting for a special purpose examination or by completing other reactivation requirements.

Avoiding complaints can protect your clients and your ability to practice. Go to **www.doh.state.fl.us/mqa/avoid.html** to find out more.

Verify your Continuing Education credits. Visit **www.cebroker.com** to find out more.

File No.: 2210
Profession Code: 1901

Seq. No.: 70
20 20

10. CHANGES TO CURRENT LICENSE INFORMATION:

◯ **CHANGE OF NAME:**

Name changes require legal documentation showing the name change. Please make sure that a photocopy of one of the following accompanies this form: a marriage license (marriage license must indicate the original signature and seal from the clerk of the court), a divorce decree indicating restoration of your maiden name, or a court order (e.g., adoption, name change, or federal identity change). Any one of these will be accepted unless the department has a question about the authenticity of the document. A driver's license or social security card is not considered legal documentation.

If the name change cannot be completed, your license will be renewed using the current name.

Last | First | Middle | Title | Suffix | Qualifier

◯ **CHANGE OF MAILING ADDRESS:**

Attention

Street Address | Apt./Suite No.

City | State | Zip Code | Country (if outside U.S.)

◯ **CHANGE OF PRACTICE LOCATION:**

Attention

Street Address | Apt./Suite No.

City | State | Zip Code | Country (if outside U.S.)

If you are renewing to active status, would you be available to provide health care services in special needs shelters or to help staff disaster medical assistance teams during times of emergency or major disaster?

◯ Yes

CHECKLIST FOR MAILING RENEWAL FORM:

If mailing your renewal form, use the checklist below as a guide for enclosing all the required items to ensure a smooth renewal. If renewing by mail, allow 2 - 4 weeks processing time.

REQUIRED:
- Renewal notice
- Cashier's Check or Money Order written to the Department of Health
- Financial Responsibility form (check only one item on the FR form)
- Updated paper copy of Profile
- Mail to: PO Box 6320, Tallahassee, Florida 32314-6320

PHYSICIAN WORKFORCE SURVEY

Governor Charlie Crist, State Surgeon General Ana Viamonte Ros and the Florida Legislature recognize the importance of assessing Florida's current and future physician workforce. Critical legislation was passed last year that requires the Department of Health to evaluate the geographic distribution and specialty mix of active Florida physicians. Please refer to F.S. 381.4018 Physician workforce assessment and development. The questions in this physician workforce survey will be instrumental in shaping Florida's health care and physician workforce policies. Your time and effort in responding to the questions below is appreciated.

<u>Instructions for completing the survey:</u>

- Questions 1 - 12 apply to all physicians
- If you are an on-call specialist taking emergency call in an emergency department, please also answer questions 13 - 16
- If you provide only radiological services, please also answer questions 17 - 25
- If you provide obstetric services, please also answer questions 26 - 32

1. Do you practice medicine at any time during the year in Florida?

- ○ Yes.
- ○ No. Please stop here and review the Affirmation Statement on page 4.

2. How many months per year do you practice in Florida?

- ○ 1-4 Months
- ○ 5-8 Months
- ○ 9-12 Months

3. In what Florida County(ies) is your medical practice located? (May select up to 5 counties - See p. 5 for county codes) For each county selected: How many hours per week do you practice in each setting?

County Name	Numeric Code	1-20 Hrs/Wk	21-40 Hrs/Wk	> 40 Hrs/Wk
		○	○	○
		○	○	○
		○	○	○
		○	○	○
		○	○	○

4. Are you in a solo practice?

- ○ Yes
- ○ No

5. Which practice setting best describes where the <u>majority</u> of your time is spent? (Choose Only One)

- ○ Private Office Setting
- ○ Federally Qualified Health Center
- ○ Governmental Clinical Setting (for example: County Health Department)
- ○ Federal Healthcare Facility (for example: military or VA)
- ○ Hospital-Outpatient Department/Service
- ○ Hospital-Inpatient
- ○ Hospital Emergency Department
- ○ Hospital Other (for example: hospital-based radiologist, pathologist, anesthesiologist or medical director)
- ○ Nursing Home/Extended Care Facility
- ○ Ambulatory Surgery Center/Free-Standing Imaging Diagnostic Center
- ○ Other Setting

6. Are you currently enrolled in an internship, residency program or fellowship program?

- ○ Yes
- ○ No

7. Does more than 20 percent of your practice include non clinical work (research, teaching, administration)?
   - ○ Yes
   - ○ No

8. List your primary specialty area, and any additional specialties, of your current clinical practice and the percentage of time you spend working in that area: (Select up to 5 Areas - See p. 6 for specialty codes)

Specialty Area	Numeric Code	1-20%	21-40%	41-60%	61-80%	81-100%
		○	○	○	○	○
		○	○	○	○	○
		○	○	○	○	○
		○	○	○	○	○
		○	○	○	○	○

9. Do you plan to retire, relocate outside of the State of Florida, or significantly reduce the scope of your practice within the next five years?
   - ○ Yes
   - ○ No

10. If you have changed the scope of your practice in the last two years, what are the reasons for the change (Choose All That Apply)?
   - ○ Liability
   - ○ Reimbursement
   - ○ Regulatory and Administrative Burden
   - ○ Retirement
   - ○ Lifestyle Considerations, Other than Retirement
   - ○ Other

11. Do you currently take emergency call or otherwise work clinically in a hospital emergency department or provide for the immediate, acute care of trauma patients?
   - ○ Yes
   - ○ No
   - ○ Exempt Due to Medical Staff Bylaws

12. If you take emergency call or otherwise work clinically in a hospital emergency department, are you
   - ○ Full Time
   - ○ On-Call Specialty

For on-call specialists taking emergency call in an emergency department please answer questions 13 - 16

13. At how many hospitals do you currently take emergency call?
   - ○ One
   - ○ Two
   - ○ Three or greater

14. How many days per month do you take call?
   - ○ 1-4
   - ○ 5-9
   - ○ 10 or greater

15. If you have taken hospital emergency department call during the past 2 years, has the number of emergency on-call hours that you work:
   - ○ Increased
   - ○ Decreased
   - ○ Stayed the Same

16. If you have decreased or plan to decrease or stop taking emergency department call, please check any reason that applies
    - ○ Liability
    - ○ Reimbursement
    - ○ Lifestyle Considerations
    - ○ Impact to Private Practice
    - ○ Changing Practice Patterns
    - ○ Exemption
    - ○ Other

<u>For physicians that provide only radiological services, please answer questions 17 - 25</u>

17. Do you read mammograms or other breast imaging exams?
    - ○ Yes
    - ○ No

18. If you do not read mammograms or other breast imaging exams, please choose the most important reason why:
    - ○ Liability
    - ○ Reimbursement
    - ○ Uninteresting Field
    - ○ Too Stressful
    - ○ Too Much Regulation
    - ○ Other

If you read mammograms, please continue.
If you do not read mammograms, please skip to question 26.

19. Do you read screening mammograms?
    - ○ Yes
    - ○ No

20. Do you read diagnostic mammograms and sonograms?
    - ○ Yes
    - ○ No

21. Do you perform BOTH ultrasound and stereotactic guided core biopsies?
    - ○ Yes
    - ○ No

22. Do you read breast MRIs?
    - ○ Yes
    - ○ No

23. Do you read breast MRIs AND perform MRI guided core biopsies?
    - ○ Yes
    - ○ No

24. In the next two years, will the number of mammograms you read change for any reason, including retirement:
    - ○ Increase
    - ○ Decrease
    - ○ Stay the Same
    - ○ Discontinue

25. Have you done a 6-month or greater breast imaging fellowship?
- ○ Yes
- ○ No

For physicians that provide obstetric services only, please answer questions 26 - 32

26. Do you deliver babies?
- ○ Yes
- ○ No. Thank you for taking this survey. Please review the Affirmation Statement on page 4.

27. How many routine deliveries per month?
- ○ None
- ○ Low, < 10 per month
- ○ Medium, 10-30 per month
- ○ High, >30 per month

28. How many high risk deliveries per month?
- ○ None
- ○ Low, < 10 per month
- ○ Medium, 10-30 per month
- ○ High, >30 per month

29. How many c-sections per month?
- ○ None
- ○ Low, < 10 per month
- ○ Medium, 10-30 per month
- ○ High, >30 per month

30. How many emergency room deliveries per month for patients having minimal or no "known" prenatal care?
- ○ None
- ○ Low, < 10 per month
- ○ Medium, 10-30 per month
- ○ High, >30 per month

31. How many assists or consultative services per month?
- ○ None
- ○ Low, < 10 per month
- ○ Medium, 10-30 per month
- ○ High, >30 per month

32. Are you planning to discontinue doing obstetric care for any reason, including retirement, in the next two years?
- ○ Yes
- ○ No

AFFIRMATION STATEMENT:

I affirm that I have completed the survey to the extent that it is applicable to me. This information provided is true and accurate to the best of my knowledge and the submission does not contain any knowingly false information.

County Names and Numeric Codes (Reference for question # 3)

11 ALACHUA	25 DIXIE	39 HILLSBOROUGH	53 MARTIN	67 SANTA ROSA
12 BAKER	26 DUVAL	40 HOLMES	54 MONROE	68 SARASOTA
13 BAY	27 ESCAMBIA	41 INDIAN RIVER	55 NASSAU	69 SEMINOLE
14 BRADFORD	28 FLAGLER	42 JACKSON	56 OKALOOSA	70 SUMTER
15 BREVARD	29 FRANKLIN	43 JEFFERSON	57 OKEECHOBEE	71 SUWANNEE
16 BROWARD	30 GADSDEN	44 LAFAYETTE	58 ORANGE	72 TAYLOR
17 CALHOUN	31 GILCHRIST	45 LAKE	59 OSCEOLA	73 UNION
18 CHARLOTTE	32 GLADES	46 LEE	60 PALM BEACH	74 VOLUSIA
19 CITRUS	33 GULF	47 LEON	61 PASCO	75 WAKULLA
20 CLAY	34 HAMILTON	48 LEVY	62 PINELLAS	76 WALTON
21 COLLIER	35 HARDEE	49 LIBERTY	63 POLK	77 WASHINGTON
22 COLUMBIA	36 HENDRY	50 MADISON	64 PUTNAM	78 UNKNOWN
23 DADE	37 HERNANDO	51 MANATEE	65 ST.JOHNS	79 OUT OF STATE
24 DESOTO	38 HIGHLANDS	52 MARION	66 ST.LUCIE	80 FOREIGN

See reverse side for specialty codes.

Specialty Areas and Numeric Codes (Reference for question # 8)

000 NO CLINICAL PRACTICE
020 ALLERGY AND IMMUNOLOGY
040 ANESTHESIOLOGY
045 CRITICAL CARE MEDICINE
048 PAIN MEDICINE
042 PEDIATRIC ANESTHESIOLOGY
060 COLON AND RECTAL SURGERY
080 DERMATOLOGY
100 DERMATOPATHOLOGY
081 PROCEDURAL DERMATOLOGY
110 EMERGENCY MEDICINE
118 MEDICAL TOXICOLOGY
114 PEDIATRIC EMERGENCY MEDICINE
116 SPORTS MEDICINE
119 UNDERSEA AND HYPERBARIC MEDICINE
120 FAMILY MEDICINE
125 GERIATRIC MEDICINE
127 SPORTS MEDICINE
140 INTERNAL MEDICINE
141 CARDIOVASCULAR DISEASE
154 CLINICAL CARDIAC ELECTROPHYSIOLOGY
142 CRITICAL CARE MEDICINE
143 ENDOCRINOLOGY, DIABETES, AND METABOLISM
144 GASTROENTEROLOGY
151 GERIATRIC MEDICINE
145 HEMATOLOGY
155 HEMATOLOGY AND ONCOLOGY
146 INFECTIOUS DISEASE
152 INTERVENTIONAL CARDIOLOGY
148 NEPHROLOGY
147 ONCOLOGY
149 PULMONARY DISEASE
156 PULMONARY DISEASE AND CRITICAL CARE MEDICINE
150 RHEUMATOLOGY
157 SPORTS MEDICINE
130 MEDICAL GENETICS
190 MOLECULAR GENETIC PATHOLOGY
160 NEUROLOGICAL SURGERY
180 NEUROLOGY
185 CHILD NEUROLOGY
187 CLINICAL NEUROPHYSIOLOGY
183 NEUROMUSCULAR MEDICINE
186 NEURODEVELOPMENTAL DISABILITIES
181 PAIN MEDICINE
188 VASCULAR NEUROLOGY
200 NUCLEAR MEDICINE
220 OBSTETRICS AND GYNECOLOGY
240 OPHTHALMOLOGY
260 ORTHOPAEDIC SURGERY
261 ADULT RECONSTRUCTIVE ORTHOPAEDICS
262 FOOT AND ANKLE ORTHOPAEDICS
263 HAND SURGERY
270 MUSCULOSKELETAL ONCOLOGY
268 ORTHOPAEDIC SPORTS MEDICINE
267 ORTHOPAEDIC SURGERY OF THE SPINE
269 ORTHOPAEDIC TRAUMA
265 PEDIATRIC ORTHOPAEDICS
280 OTOLARYNGOLOGY
286 NEUROTOLOGY
288 PEDIATRIC OTOLARYNGOLOGY
300 PATHOLOGY-ANATOMIC AND CLINICAL
305 BLOOD BANKING/TRANSFUSION MEDICINE
306 CHEMICAL PATHOLOGY
307 CYTOPATHOLOGY
310 FORENSIC PATHOLOGY
311 HEMATOLOGY
314 MEDICAL MICROBIOLOGY
315 NEUROPATHOLOGY
316 PEDIATRIC PATHOLOGY
301 SELECTIVE PATHOLOGY
320 PEDIATRICS
321 ADOLESCENT MEDICINE
329 NEONATAL-PERINATAL MEDICINE
325 PEDIATRIC CARDIOLOGY
323 PEDIATRIC CRITICAL CARE MEDICINE
324 PEDIATRIC EMERGENCY MEDICINE
326 PEDIATRIC ENDOCRINOLOGY
332 PEDIATRIC GASTROENTEROLOGY
327 PEDIATRIC HEMATOLOGY/ONCOLOGY
335 PEDIATRIC INFECTIOUS DISEASES
328 PEDIATRIC NEPHROLOGY
330 PEDIATRIC PULMONOLOGY
331 PEDIATRIC RHEUMATOLOGY
333 PEDIATRIC SPORTS MEDICINE
336 DEVELOPMENTAL-BEHAVIORAL PEDIATRICS
340 PHYSICAL MEDICINE AND REHABILITATION
341 PAIN MEDICINE
346 PEDIATRIC REHABILITATION
345 SPINAL CORD INJURY MEDICINE
360 PLASTIC SURGERY
361 CRANIOFACIAL CURGERY
363 HAND SURGERY
380 PREVENTIVE MEDICINE
399 MEDICAL TOXICOLOGY
398 UNDERSEA AND HYPERBARIC MEDICINE
400 PSYCHIATRY
401 ADDICTION PSYCHIATRY
405 CHILD AND ADOLESCENT PSYCHIATRY
406 FORENSIC PSYCHIATRY
407 GERIATRIC PSYCHIATRY
402 PAIN MEDICINE
409 PSYCHOSOMATIC MEDICINE
420 RADIOLOGY DIAGNOSTIC
421 ABDOMINAL RADIOLOGY
429 CARDIOTHORACIC RADIOLOGY
422 ENDOVASCULAR SURGICAL NEURORADIOLOGY
426 MUSCULOSKELETAL RADIOLOGY
423 NEURORADIOLOGY
425 NUCLEAR RADIOLOGY
424 PEDIATRIC RADIOLOGY
427 VASCULAR AND INTERVENTIONAL RADIOLOGY
430 RADIATION ONCOLOGY
520 SLEEP MEDICINE
440 SURGERY-GENERAL
443 HAND SURGERY
445 PEDIATRIC SURGERY
442 SURGICAL CRITICAL CARE
450 VASCULAR SURGERY
460 THORACIC SURGERY
480 UROLOGY
485 PEDIATRIC UROLOGY
999 OTHER

EMIL F FELSKI
1120 STATE ROAD 436
SUITE 1000
CASSELBERRY, FL 32707-6102

3318-4430

Your Osteopathic Physician License # **OS 3318** will expire at midnight, Eastern Standard Time (EST) on **Wednesday, March 31, 2010**.

Please log onto **www.FLHealthsource.com** and follow these steps:

1. Click **Renew My License** and log in.
2. Click **Renew License** and select your renewal option:
    a. Renew on-line
    b. Print your renewal notice to submit with your payment via mail

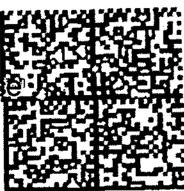
Renewals by mail **MUST** include the renewal form, not this postcard.

Visit **www.cebroker.com/subscribe** to purchase your **optional** subscription and track your continuing education credits. **NOTE:** This subscription is **not** required as a condition of license renewal.

Remember, all renewals MUST be submitted **no later than March 31, 2010** in order to avoid a delinquent fee. Questions? Contact the MQA Call Center at (850) 488-0595.

Division of Medical Quality Assurance
P.O.Box 6340
Tallahassee, Florida 32314-6340

FIRST CLASS



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US POSTAGE

AUTO

3318

06:06:01207 *** **Important License Information** ***

EMIL F FELSKI
1120 STATE ROAD 436
SUITE 1000
CASSELBERRY, FL 32707-6102

Your license is scheduled for renewal within the next 5 months. You are required to review and, if appropriate, update your profile before renewing your license. In addition, Section 456.042, Florida Statutes, requires you to submit profile updates within 15 days of any changes.

You may review, update and confirm the accuracy of your practitioner profile information online by visiting **www.FLHealthsource.com**. Select LICENSEE/PROVIDER, click on VIEW PROFILE, and Login with your Account ID and Password. If you make changes to your profile, BE SURE to click on "confirm changes" to update the Department's information system.

If you have any questions, please contact the MQA Call Center at (850) 488-0595, option 3.

Division of Medical Quality Assurance
P.O. Box 4839
Tampa, Florida 33677-4839

***** License Renewal Notification *****

EMIL F FELSKI
1120 STATE ROAD 436
SUITE 1000
CASSELBERRY, FL 32707-6102

License Renewal Notification

Your Osteopathic Physician License # **OS 3318** will expire at midnight, Eastern Standard Time (EST) on **Saturday, March 31, 2012**.

Please log onto **www.FLHealthsource.com** and follow these steps:

1. Click **Renew My License** and log in.
2. Click **Renew License** and select your renewal option:
   a. Renew on-line
   b. Print your renewal notice to submit with your payment via mail

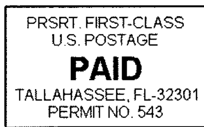
Renewals by mail **MUST** include the renewal form, not this postcard.

Visit **www.cebroker.com/subscribe** to purchase your **optional** subscription and track your continuing education credits.

Section 456.0635, F.S., may affect your ability to renew your license. Please visit **http://www.doh.state.fl.us/mqa/laws.html** for more information.

Remember, all renewals MUST be submitted **no later than March 31, 2012** in order to avoid a delinquent fee. Questions? Contact the MQA Call Center at (850) 488-0595.

Florida Department of Health
Division of Medical Quality Assurance
P.O.Box 6340
Tallahassee, Florida 32314-6340



AUTO 3318

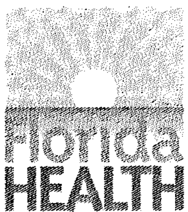
12:15:04379 *** **Important License Information** ***

EMIL F FELSKI
1120 STATE ROAD 436
SUITE 1000
CASSELBERRY, FL 32707-6102

Your license is scheduled for renewal within the next 5 months. You are required to review and, if appropriate, update your profile before renewing your license. In addition, Section 456.042, Florida Statutes, requires you to submit profile updates within 15 days of any changes.

You may review, update and confirm the accuracy of your practitioner profile information online by visiting **www.FLHealthsource.com**. Select LICENSEE/PROVIDER, click on VIEW PROFILE, and Login with your Account ID and Password. If you make changes to your profile, BE SURE to click on "confirm changes" to update the Department's information system.

If you have any questions, please contact the MQA Call Center at (850) 488-0595.



Division of Medical Quality Assurance
P.O. Box 4839
Tampa, Florida 33677-4839

***** License Renewal Notification *****

EMIL F FELSKI
1120 STATE ROAD 436
SUITE 1000
CASSELBERRY, FL 32707-6102

License Renewal Notification

Your Osteopathic Physician License # **OS 3318** will expire at midnight, Eastern Standard Time (EST) on **Monday, March 31, 2014**.

Please log onto **www.FLHealthsource.com** and follow these steps:

1. Click **Renew My License** and log in.
2. Click **Renew License** and select your renewal option:
   a. Renew on-line
   b. Print your renewal notice to submit with your payment via mail

Renewals by mail **MUST** include the renewal form, not this postcard.

***IMPORTANT: There have been changes to the license renewal and continuing education process. Visit CEAtRenewal.com to learn more.

Section 456.0635, F.S., may affect your ability to renew your license. Please visit **http://www.doh.state.fl.us/mqa/laws.html** for more information.

Remember, all renewals MUST be submitted **no later than March 31, 2014** in order to avoid a delinquent fee. Questions? Contact the MQA Call Center at (850) 488-0595.

iHEADER PRAES Production (MQ-P) 10/18/99
dwooden 11:59:02

tnrbal12/2.13 MAINTAIN ANY LICENSE DATA 1901/OSTEO-OS

File: 2210

Osteopathic Physician

Lic: 3318 CLEAR,ACTIVE

Name: EMIL F FELSKI (DBA:0 Old:0)

Addr: 1120 SEMORAN BLVD State: FL

LAKE HOWELL SQUARE Zip: 32707-6102

City: CASSELBERRY County: SEMINOLE

Certificate No: First License: 02/09/1973

" Date: 12/08/1997 In Rank Since: 02/09/1973

Last Renewal: License Method: GFTH

Current Expiry: 01/31/2000 Renewal Notice:

In Directory? Include

Status Date: 01/01/1801 Fee Exempt? N

Note:

Action: Query Transfer A-Address B-Basic_Data C-PSD D-Contact_Hst ...

Go to view only options

2 Sess-1 167.78.1.20 1 22/9

10/21/1999

$43.00

AC# **COPY** **STATE OF FLORIDA**

DEPARTMENT OF HEALTH

DIVISION OF MEDICAL QUALITY ASSURANCE

DATE	LICENSE NO.	CONTROL NO.
01/09/2002	**OS 3318**	**7350**

THE **OSTEOPATHIC PHYSICIAN**
NAMED BELOW HAS MET ALL REQUIREMENTS OF
THE LAWS AND RULES OF THE STATE OF FLORIDA.
EXPIRATION DATE: **MARCH 31, 2004**

QUALIFICATION(S):
DISPENSING PRACTITIONER

EMIL F FELSKI
1120 SEMORAN BLVD
LAKE HOWELL SQUARE
CASSELBERRY, FL 32707-6102

COPY COPY COPY

AC#
STATE OF FLORIDA
DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE
CONTROL NO. 7350
LICENSE NO. OS 3318
DATE 01/09/2002
THE OSTEOPATHIC PHYSICIAN
NAMED BELOW HAS MET ALL REQUIREMENTS OF
THE LAWS AND RULES OF THE STATE OF FLORIDA.
EXPIRATION DATE: MARCH 31, 2004
EMIL F FELSKI
COPY - NOT A VALID LICENSE - COPY

AT LEAST 90 DAYS PRIOR TO THE EXPIRATION DATE SHOWN ON THIS LICENSE, A NOTICE OF RENEWAL WILL BE SENT TO YOUR LAST KNOWN ADDRESS. IF YOU HAVE NOT RECEIVED YOUR NOTICE 60 DAYS PRIOR TO THE EXPIRATION DATE, PLEASE CALL (850) 410-3359.

COPY - NOT A VALID LICENSE - COPY

EXPIRATION DATE: **MARCH 31, 2004**

YOUR LICENSE NUMBER IS **OS 3318** ,PLEASE USE IT IN ALL CORRESPONDENCE WITH YOUR BOARD/COUNCIL. EACH LICENSEE IS SOLELY RESPONSIBLE FOR NOTIFYING THE DEPARTMENT IN WRITING OF THE LICENSEE'S CURRENT MAILING ADDRESS. USE THIS SECTION TO REPORT NAME AND/OR MAILING ADDRESS CHANGES.

NAME CHANGES REQUIRE LEGAL DOCUMENTATION SHOWING THE NAME CHANGE. PLEASE MAKE SURE THAT A PHOTOCOPY OF ONE OF THE FOLLOWING ACCOMPANIES THIS FORM: A MARRIAGE LICENSE (MARRIAGE LICENSE MUST INDICATE THE ORIGINAL SIGNATURE AND SEAL FROM THE CLERK OF THE COURT), A DIVORCE DECREE INDICATING RESTORATION OF YOUR MAIDEN NAME, OR A COURT ORDER (E.G., ADOPTION, NAME CHANGE, OR FEDERAL IDENTITY CHANGE). ANY ONE OF THESE WILL BE ACCEPTED UNLESS THE DEPARTMENT HAS A QUESTION ABOUT THE AUTHENTICITY OF THE DOCUMENT. **A DRIVER'S LICENSE OR SOCIAL SECURITY CARD IS NOT CONSIDERED LEGAL DOCUMENTATION.**

TO REQUEST A DUPLICATE LICENSE SUBMIT THIS FORM AND A CHECK, PAYABLE TO THE DEPARTMENT OF HEALTH, IN THE AMOUNT OF $25.00.

☐ REQUEST DUPLICATE LICENSE

____
SIGNATURE REQUIRED

DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE
LICENSURE SERVICES
4052 BALD CYPRESS WAY, BIN #C-10
TALLAHASSEE, FLORIDA 32399-3260

☐ NAME CHANGE (ATTACH LEGAL DOCUMENTATION)

FROM: ______________________________
LAST FIRST MIDDLE

TO: ______________________________
LAST FIRST MIDDLE

☐ MAILING ADDRESS CHANGE

____
____
____
CITY STATE ZIP

DH 2103, 5/98

DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE
LICENSURE SERVICES
4052 BALD CYPRESS WAY, BIN #C-10
TALLAHASSEE, FLORIDA 32399-3260

EMIL F FELSKI
1120 SEMORAN BLVD
LAKE HOWELL SQUARE
CASSELBERRY, FL 32707-6102

NAME: CAMERA III   DATE: ROLL

Secretary/Treasurer
State Board of Osteopathic
Medical Examiners
225 North Causeway
New Smyrna Beach, Florida 32069

DEPARTMENT OF JUSTICE
BUREAU OF NARCOTICS AND
DANGEROUS DRUGS
201 NE 12th STREET
MIAMI, FLORIDA 33132

Date: 2/5/73

Dear Sir:

FELSKI, Emil Fordyce Maurice D.O.
6100 Arlington Expressway Apt 8204
Jacksonville, Fla. 32211

has applied for BNDD registration under the Controlled Substances Act of 1970 in Schedule(s) 2-5 as a D.O. . It is necessary to verify the statement in the application that the applicant is authorized by the laws of your state to engage in the business or practice described above and thereby entitled to handle controlled substances. Therefore, please complete this form and return it to this office in the addressed envelope, postage paid, which is enclosed for your convenience.

2-7-73
#3318

Anthony R. Acre
Group Supervisor Compliance

Name:
CAMERA III

Date:
Roll:

May 9, 1972

Emil F. M. Pelski, D. O.
3901-B Beecher Road
Flint, Michigan 48504

Dear Dr. Pelski:

As of July 1, 1972, by legislative action, physicians who all parts of the examination conducted by the National Board of Examiners for Osteopathic Physicians and Surgeons" may be licensed by endorsement.

Statutory requirements for licensure by endorsement with the National Board, Sec. 459.11, F. S.:

(1) Submit application on forms supplied by board
(2) U. S. citizenship or evidence of intention to become a citizen of the United States
(3) 21 years of age or older
(4) Good moral character
(5) Diploma from approved osteopathic college
(6) Internship in approved hospital (unless graduated prior to 1946)
(7) Certificate from National Board
(8) License in another state with unlimited licensure
(9) Fee of $200, which is non-refundable

Insofar as a residency is concerned, Florida Statutes provide for a temporary license as long as the residency is in effect, but not more than four (4) years. Hospitals must register the names of residents every six months with the state board.

We enclose application with addenda. If you wish to apply, your file could be reviewed by the board when it meets in July.

Sincerely yours,

MERVIN E. KECK, D. O.

vmc

Enc.

\ CAMERA III

State of Florida

Department of Professional & Occupational Regulation

Board of Osteopathic Medical Examiners

EXECUTIVE OFFICE

828 NORTH CAUSEWAY — NEW SMYRNA BEACH, FLORIDA 32069 — TELEPHONE (904) 428-6741

M. E. MECK, D.O., EXECUTIVE DIRECTOR

February 16, 1973

George B. Palmer, M.D.
Executive Director
Florida State Board of Medical Examiners
100 West Pensacola Street
Tallahassee, Florida 32304

Dear Dr. Palmer:

There is a matter of mutual interest to our boards which I would like to discuss with you at your earliest convenience. It occurs to me that you will be attending the Legislative meeting called on February 22 and 23 by Mr. Ritter, so we might get together for a discussion of the matter at that time.

Our Practice Act (459.221 F.S.) prohibits practice by hospital residents and interns unless he has registered with the State Board of Osteopathic Medical Examiners and has received from the board a temporary certificate evidencing his right to take the residency or internship. This statute further sets forth the provision that every osteopathic hospital having a resident or intern training program shall furnish a list of all residents....... We enclose copy of this section of the statutes for your information.

Currently an osteopathic physician, Emil F. H. Pelski, is taking a residency in the University Hospital in Jacksonville. We anticipate there will be others. We feel that there will be a simple way to resolve the problem if we can work together on it.

Sincerely yours,

MERVYN E. MECK, D.O.

lhm
cc: Wm. E. White, D.O., Chm.

1972-1973 MEMBERS OF THE BOARD 1972-1973

Chairman:
Wm. E. WHITE, Jr., D.O.
401 Manatee Ave., East
Bradenton, Florida 33506

PETER J. GIGLIO, D.O.
109 N. Westshore Blvd.
Tampa, Florida 33609

Vice-Chairman:
LOUIS J. LARMOYEUX, Sr., D.O.
124 East Ashley Street
Jacksonville, Florida 32202

JAMES G. HULL, D.O.
73 West Granada Avenue
Ormond Beach, Florida 32074

Secretary-Treasurer:
JOSEPH G. STELLA, D.O.
421 San Marco Drive
Ft. Lauderdale, Florida 33301

MORTON TERRY, D.O.
16666 N. E. 19th Avenue
North Miami Beach, Florida 33162

CAMERA III ROLL [illegible]

STATE BOARD OF REGISTRATION FOR THE HEALING ARTS OF MISSOURI

Certifies That

FELOKI, EMIL F. M.
5811 ATLANTIC BLVD., APT. 159
JACKSONVILLE, FLA. 32207

D. O.
License No. 34332
Issued 4 29 72

Is duly registered to practice as a Physician & Surgeon
from July 1, 19[illegible] to June 30, 19[illegible]

[illegible]

John C. Hailey
Executive Secretary

ATHENS CLINIC, P. C.
OSTEOPATHIC PHYSICIANS AND SURGEONS
23265 EUREKA ROAD
TAYLOR, MICHIGAN 48180
287-3700

WILLIAM A. ATHENS, D.O.
ELLEN ATHENS, D.O.
ANDREW A. ATHENS, D.O.

SUTHERLAND, D.O.
ATHENS, D.P.M.

RECEIVED NOV 23 1988 PHCY./OSTEO.

Filing 3318

November 15, 1988

State of Florida Department of Professional Regulation
Board of Osteopathic Medical Examiners
Old Courthouse Square Building
130 N. Monroe
Tallahassee, Florida 32399-0750

License # OS 0003318

I am terminating my license to practice in the State of Florida as of this date. Enclosed you will find my license.

Since I do not have an active practice in the State of Florida, I do not feel that I should pay the $250.00 assessment imposed by NICA.

Your utmost attention to this matter will be greatly appreciated.

Very truly yours,

William A. Athens, D.O.

William A. Athens, D.O.

WAA/ka

cc: NICA

STATE OF FLORIDA Department of Professional Regulation
BOARD OF OSTEOPATHIC MEDICAL EXAMINERS

DATE: 01/09/88 LICENSE NO. OS 0003319 BATCH NO. 06203

THE OSTEOPATHIC PHYSICIAN
NAMED BELOW HAS REGISTERED
UNDER THE PROVISIONS OF CHAPTER 459 FOR
THE YEAR EXPIRING DEC 31, 1989

ATHENS, WILLIAM A
23265 EUREKA ROAD
TAYLOR MI 48180

TOM GALLAGHER

DISPLAY IN A CONSPICUOUS PLACE

American Association Of Osteopathic Specialists

PETER P. TYLER, Ph.D.
Executive Director

804 MAIN STREET
FOREST PARK, GEORGIA 30050
(404) 363-8263

November 6, 1986

Stephen R. Winn
Board of Osteopathic and Medical Examiners
The Hull Building
2007 Apalachee Parkway
Tallahassee, Florida 32301

RECEIVED
NOV 12 1986
DEPARTMENT OF PROFESSIONAL REGULATION

3318

Dear Mr. Winn:

Emil F. M. Felski, D.O., has applied for membership in A.A.O.S. Please verify for us that his medical license is current and valid.

Thanking you, I am

Sincerely,

Peter P. Tyler, Ph.D.
Executive Director

RECEIVED
NOV 13 1986
PHCY, I OSTEO

PPT:rjt

DR. FELSKI'S LICENSE (is, is not) CURRENT AND VALID.

Barbara Kemp
Signature

Nov. 14, 1986
Date

1986 - 1987 BOARD OF GOVERNORS

Dale L. Reinkel, D.O., F.A.A.O.S., PRESIDENT
G.A. Fuller III, D.O., F.A.A.O.S., PRESIDENT-ELECT
John C. Pellosie, D.O., F.A.A.O.S., IMMEDIATE PAST PRESIDENT
D.S. "Steve" Strickland, D.O., F.A.A.O.S., VICE-PRESIDENT
Ernest A. Teegarden, D.O., F.A.A.O.S., SECRETARY-TREASURER
Ralph H. Kelley, D.O., F.A.A.O.S., PUBLIC RELATIONS
Bert E. Maggio, D.O., F.A.A.O.S., 85-87 BOARD MEMBER
N.K. Pandeya, D.O., F.A.A.O.S., 85-87 BOARD MEMBER
C. William Mercer, D.O., F.A.A.O.S., 86-88 BOARD MEMBER
Dennis L. Streeter, D.O., F.A.A.O.S., 86-88 BOARD MEMBER

RECEIVED

EMIL FELSKI, D.O., P.A.

OBSTETRICS, GYNECOLOGY, INFERTILITY AND FAMILY PLANNING

JAN 9
PHCY / OSTEO

January 6, 1987

Department of Professional Regulations
Osteopathic Medical Examiners
130 N. Monroe Street
Tallahassee, Florida 32399-0750

To Whom It May Concern:

This letter is to inform the department of professional regulations that at present I am without coverage for professional liability insurance.

I will comply with Florida statute # 459.0085, in notifying my patients that I am not carrying malpractice insurance.

I hope to have liability coverage in the near future, but at present am unable to obtain coverage.

DEPT. OF PROFESSIONAL REGULATION
JAN 9 9 02 PM '87

Sincerely,

[signature]

Emil F.M. Felski D.O.
Obstetrics & Gynecology

LAKE HOWELL SQUARE • 1120 SEMORAN BOULEVARD • CASSELBERRY, FLORIDA 32707

CIGNA Healthplan of Florida, Inc.

1101 N. Lake Destiny Road
Suite 300
Maitland, FL 32751
(305) 660-1344

CIGNA

RECEIVED
DEC 16 1988
MEDICAL/NATUROPATH

December 14, 1988

Florida Board of Osteopathic Medical Examiners
Attn: Barbara Kempt
130 N. Monroe St., Suite 170
Tallahassee, FL 32399-0750

Re: Emil Felski, D.O. (OS00[illegible]3318)

Specialty: OB/Gyn

Dear Ms. Kempt:

The above-named physician has applied for membership with CIGNA Healthplan of Florida, Inc. According to the application, this doctor is licensed in the state of Florida. We would appreciate your confirmation of this on the enclosed form. Attached is an authorization to release information form signed by the applicant.

In addition, any further information you might furnish us regarding the doctor's professional competence or moral and ethical standing in the medical profession would be very helpful. Please be assured that this information will be kept strictly confidential.

We would appreciate your response within the next two weeks. A self-addressed envelope is enclosed for your convenience. Thank you very much for your assistance.

Sincerely,

Alice C. Voigt

Alice C. Voigt
Telecommunications Rep

ACV/jrm

Enclosures

RECEIVED
DEC 19 1988
PHCY/OSTEO

CREDENTIALS VERIFICATION RELEASE FORM
(Physician's Participation)

I acknowledge and agree that CIGNA Healthplan has a valid interest in obtaining and verifying information concerning my professional competence, in determining whether to enter into an agreement with me for the provision of medical services to members of its prepaid health care plan. Accordingly,

(i) I represent and warrant to CIGNA Healthplan that the information contained in the foregoing application is true and complete to the best of my knowledge and belief, and I agree to inform CIGNA Healthplan promptly if any material change in such information occurs, whether before or after my entering into an agreement with CIGNA Healthplan for the provision of medical services;

(ii) I authorize CIGNA Healthplan to consult with hospital administrators, members of medical staffs of hospitals, malpractice carriers and other persons to obtain and verify information concerning my professional competence, character and moral and ethical qualifications, and I release CIGNA Healthplan and its employees and agents from any and all liability for their acts performed in good faith and without malice in obtaining and verifying such information and in evaluating my application; and

(iii) I consent to the release by any person to CIGNA Healthplan of all information that may reasonably be relevant to an evaluation of my professional competency, character and moral and ethical qualifications, including any information relating to any disciplinary action; suspension or curtailment of surgical-medical privileges; malpractice allegations; and hereby release any such person providing such information from any and all liability for doing so.

Signed: [signature] Date: 4-24-88

RECEIVED
DEC 12 1988
PROVIDER RELATIONS DEPT.
CIGNA HEALTHPLAN · ORLANDO

CAMERA III Roll

Flint Osteopathic Hospital

This is to certify that

Emil F. M. Felski, D.O.

has satisfactorily completed an Internship in this Hospital from July 1, 1971 to June 30, 1972

In Witness Whereof the said Hospital has caused this Certificate to be signed by its duly authorized officers and its Corporate Seal here unto affixed.

PRESIDENT, BOARD OF TRUSTEES — W Dale Ferguson, ADMINISTRATOR — Roger D. Morrison DO, CHIEF OF STAFF

6-30-72
DATE ISSUED

\ CAMERA III ROLL ...

PHILADELPHIA · COLLEGE OF OSTEOPATHIC · MEDICINE

BE · IT · KNOWN · THAT

EMIL · FORDYCE · MOURIER · FELSKI

HAVING · SATISFIED · THE · REQUIREMENTS · FOR · THE · DEGREE · OF

DOCTOR · OF · OSTEOPATHY

HAS · ACCORDINGLY · BEEN · ADMITTED · TO · THAT · DEGREE · WITH · ALL · THE RIGHTS · PRIVILEGES · AND · RESPONSIBILITIES · THEREUNTO · APPERTAINING

IN · TESTIMONY · WHEREOF · THE · SEAL · OF · THE · COLLEGE · AND · THE · SIGNATURES AUTHORIZED · BY · THE · BOARD · OF · DIRECTORS · ARE · HEREUNTO · AFFIXED

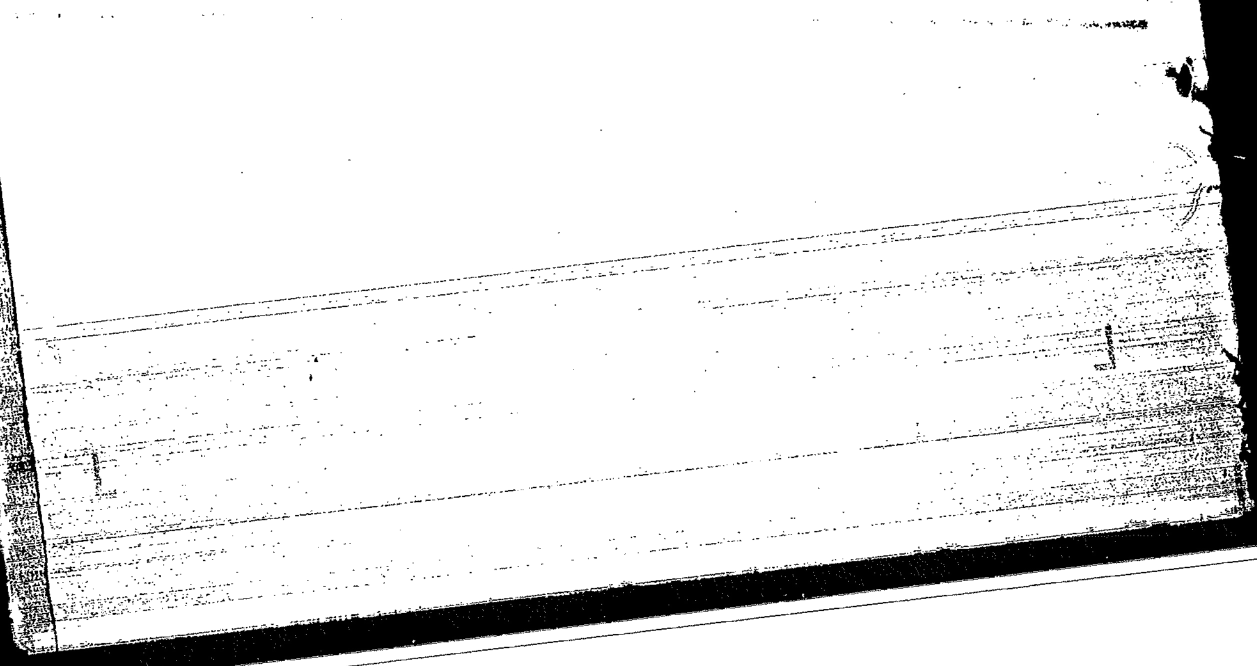
SIGNED · THIS · SIXTH · DAY · OF · JUNE · ANNO · DOMINI ONE · THOUSAND · NINE · HUNDRED · AND · SEVENTY · ONE

Frederic H. Barth
PRESIDENT

Paul H. Thomas, D.O., M.D.
DEAN

CHAIRMAN · BOARD · OF · DIRECTORS

Thomas M. Rowland
SECRETARY



Comment I

Felski, E.M

8

Low-Dose Demulen®

To whom it may concern:

I was on active duty in the Air Force until 3 Sept. 77. I was stationed at Carswell Air Force Base USAF Regional Hospital, in Ft. Worth, Tex. The last two years my license was issued, I was on active duty in the Air Force.

Emil F. M. Felski

Convention I   Date 4/3/80

Feleki, E. F. D.

AMERICAN COLLEGE OF OSTEOPATHIC OBSTETRICIANS AND GYNECOLOGISTS

AFFILIATED WITH
AMERICAN OSTEOPATHIC ASSOCIATION

SECRETARY-TREASURER
EXECUTIVE DIRECTOR
ARTHUR A. SPEIR, D.O.
BOX 66
MERRILL, MICHIGAN 48637

March 1, 1977

RECORD OF ATTENDANCE
C.M.E. CREDITS

NAME: Emil F. H. Feleki, D.O.

ADDRESS: 3617 Fenton

CITY: Fort Worth STATE Texas ZIP: 76133

A.O.A.# 00-

CREDIT HOURS: 27

The above attended the 44th Annual Convention of the American College of Osteopathic Obstetricians and Gynecologists, held February 15 to 18, 1977, at Omni International Hotel in Atlanta, Georgia

Professionally,

Arthur A. Speir, D.O.

Arthur A. Speir, D.O.
Executive Director

NOTE: For extra copies, please verifax this copy and forward to your respective Organizations.

NAME:
CAMERA 11
ROLL:
DATE:

FELSKI, EMIL

OS#3318

OS# 3318

RECEIVED SEP 2 8 1981

Emil F.M. Felski, D.O.

announces the relocation of his office to

Lake Howell Square

1120 Semoran Boulevard

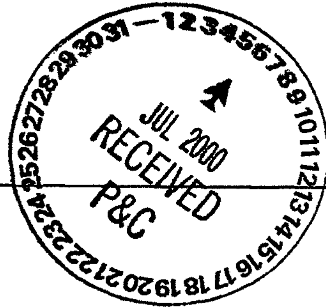
Casselberry, Florida 32707

By Appointment 677-1234

address changed on terminal

KT 9/30/81

Prot 11901
File 12210



Jeb Bush
Governor

Robert G. Brooks, M.D.
Secretary

PRACTITIONER PARTICIPATION AGREEMENT
(Comprehensive Release Form)

PARTICIPATION IN THIS PROGRAM IS VOLUNTARY

I acknowledge that I have received, read and understand the CoreSTAT User's Guide which explains the standardized credentialing program and I wish to participate in the standardized credentialing program of the Department of Health.

EMIL F.M. FELSKI, D.O.
Name (First, Middle, Last)

OS 0003318
Florida License Numbers(s):
(If you have more than one, list all)

Emil F.M. Felski DO
Signature

6/30/00
Date

IF you choose **not** to participate you understand that you must still comply with all reporting requirements of s. 455.557, Florida Statutes, *Standardized Credentialing for Health Care Practitioners.*

Division of Medical Quality Assurance
Bureau of Operations

2020 Capital Circle S.E., Bin #C10, Tallahassee, Florida 32399-3260

Name:
\ CAMERA III

Date:
Roll:

Form No. 1
Revised 8-10-71

3318 ... 73
2 ...

FLORIDA STATE BOARD OF
OSTEOPATHIC MEDICAL EXAMINERS
728 NORTH CAUSEWAY, NEW SMYRNA BEACH, FLORIDA 32069

APPLICATION

of

Earl Rodger Maurice Feles, D.O.
(Please print name as you wish it to appear on license)

FOR ADMISSION TO THE ______ (Month) ______ (Year) EXAMINATIONS

or ✓ check if applicable:

✓ LICENSURE BY ENDORSEMENT, Sec. 459.11 Fla. Statutes.

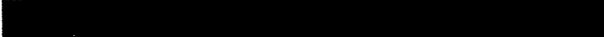
CURRENT MAILING ADDRESS:

5811 Atlantic Blvd., Apt. #157
Jacksonville, Fla.
Zip Code 32207

Race: Cauc.
Color of Hair: Blonde
Color of Eyes: Hazel

APPLICANT'S QUESTIONNAIRE AND AFFIDAVIT

1. State FULL Name Earl Rodger Maurice Feles



Have you ever used, or been known by any other name? No If so, please state in full each name used, or by which you have been known, and the reasons for use of each such name:

If your name has ever been changed by legal action (other than marriage) please state former name, and when, how and why the change was made. If change was made in a proceedings, please annex a certified copy of the order or other appropriate evidence. None

2. Date of Birth May 6, 1944 Present Age 28

Place of Birth Waynesboro (City or Town) Pa. (State) Greene (County)

Are you a citizen of the United States? Yes
If born in a foreign country, please state age at which you came to United States N.A.
If claiming citizenship other than by birth in the United States, please state the basis of such claim, and attach proof. N.A.

Marital Status: ___ Single ✓ Married ___ Widowed ___ Divorced

Lic. # 1945
12-21-72

PRESENT LEGAL RESIDENCE: 5811 Atlantic Blvd., Apt. #157
Jacksonville, Fla. 32207

Name: [illegible]
Camera III

Date: [illegible]
Roll: [illegible]

3. EDUCATIONAL BACKGROUND:

High School: West High School, [illegible], W. Va. (Name and Location) Graduation Date: [illegible]

College or University (Other than Osteopathic):

West Virginia University, [illegible] W. Va. (Name and Location) from Sept. 1962 to June 1966

from 19__ to 19__

Did you receive a degree? Yes If so, what degree? A.B. Date June, 1966

PROFESSIONAL EDUCATION:

Phila. College of Osteopathic Medicine (Osteopathic College) from Sept. 1966 to June 1971

Date of Graduation: June, 1971 Degree: D.O.

Internship: [illegible] Osteopathic Hosp., [illegible] Rd., [illegible], Mich. (Name of Hospital and Location)

Dates of Internship: July 1, 1971 to June 30, 1972

Residency: Jacksonville Hospitals [illegible] University Hosp., Jacksonville, Fla. (Name of Hospital and Location)

My residency was in Obstetrics - Gynecology (Specialty)

List all other specialty training received:

National Board Certificate #[illegible]
Issued: July 1, 1972

Are you board certified in specialty? No If so, give name of certifying board, and date of certification:

N.A.

Have you ever been dropped, suspended, placed on probation, expelled, or requested to resign from any school, college or university? Yes ___ No ✓
If so, please state cause, circumstances, date of such occurrence. (Use separate page to be attached)

Do you have a Florida Basic Science Certificate? No If so, give Number: N.A.

Are you licensed to practice osteopathy in any other state? Yes ✓ No ___

List every state in which you are now licensed to practice, date of issue of license, and method by which you were licensed, e.g., examination, if reciprocity, with whom?

State	Date of Issue	Method
Missouri	4/29/72	Examination

List every state in which you have previously been licensed but no longer hold a valid license, and reason for lapse, suspension or revocation of license:

State	Date of Issue	Date Voided	Reason
None			

Name: [illegible]
Camera III

Date: [illegible]
[illegible]

4. **PRACTICE EXPERIENCE:** Please make a complete statement of all practice of the healing arts since date of issue of first license to practice. Record all towns or cities, as well as states, your inclusive dates of practice, and your reason for leaving. If your practice was conducted under any degree other than D.O., please note. (If additional space is needed, attach separate page using same format.)

Town or City	State	Dates of Practice	Reason for Leaving
None			

If you were not engaged in the practice of osteopathy for any period longer than six months after the first date listed above, please give dates and reasons:

N. A.

5. Have you ever had your license revoked? Yes ____ No ✓

6. Have you ever been suspended from practice? Yes ____ No ✓

7. Have any charges or complaints ever been filed, or proceedings instituted against you? Yes ____ No ✓

8. Have you ever appeared formally or informally before any licensing board for reprimand or discipline? Yes ____ No ✓

If any of (5), (6), (7), (8) are affirmative, please state the date, the nature of the charge, jurisdictional authority, the facts, and the disposition of the matter. (Use a separate sheet of paper to be attached)

9. Have you ever been convicted of a felony? Yes ____ No ✓

If so, state the date, nature of the charge, court of conviction, the facts, and disposition of the matter. (Use separate sheet of paper to be attached.)

10. Have you ever been adjudged incompetent? [redacted]

If so state date, judicial authority, the facts, and disposition of the matter. (Use a separate sheet of paper to be attached)

11. Have you ever been admitted to, or confined within, a hospital or institution for the purpose of obtaining treatment or therapy for any mental or nervous disability? [redacted]

If so, state the date, nature of the disability, admitting authority, the facts, and the disposition of the matter. (Use a separate sheet of paper to be attached)

12. Have you ever been admitted to, or confined within, a hospital or institution for the purpose of obtaining treatment or therapy for habitual addiction to narcotics or any habit-forming drugs, or intoxicants? [redacted]

If so, state the date, nature of disability, admitting authority, the facts, and the disposition of the matter. (Use a separate sheet of paper to be attached)

13. Are you now, or have you ever been, addicted to the use of narcotics, drugs, hallucinogenic, depressant, or stimulatory substances, or intoxicants? [redacted]

If so, state aproximate dates, details, circumstances, and names and addresses of doctors consulted. (Use a separate sheet of paper to be attached)

I hereby authorize the release to the Board any information requested in respect to such admissions and/or treatment for conditions covered in questions 10 through 13, by all clinics, hospitals, institutions, and physicians involved.

Name: [illegible]
\ Camera III

Date: [illegible]
Roll: [illegible]

14. LITIGATION:

The following is a complete list of all litigation or other proceedings in any court of law or equity, or any criminal court, or before any governmental board or agency, or any arbitration board, to which I have been a party, either as plaintiff, defendant, co-defendant, or otherwise, since reaching the age of 21:

None — Name of Court or Agency
N.A. — Plaintiff or Prosecutor
N.A. — Defendant

N.A. — Complaint
N.A. — Type of Proceeding
N.A. — Disposition

N.A. — Date of Disposition
COMMENTS: None

(If additional space is needed, please attach separate pages using same format.)

15. MILITARY:

Have you ever served in the armed forces of the U.S.? Yes ____ No ✓

If so, complete the following:

Branch of Service: N.A. Your Rank: N.A. Dates: ____ to ____

Were you assigned to the Medical Corps? N.A.

As a member of armed forces, have any charges been made, or proceedings instituted against you? Yes ____ No N.A.

If affirmative, attach separate page outlining charges, facts, and disposition.

Have you ever been a defendant in any courts martial? Yes ____ No N.A.

If affirmative, attach a separate page stating dates, nature of the charge, the facts, disposition of the matter, and the location and designation of the military establishment where such proceeding took place.

What is your present reserve status, or Selective Service Classification? I-A

Have you ever been rejected for service in any of the armed services of the United States? Yes ____ No ✓

If so, please state the reason:

Have you ever served, or been accepted to serve, in the U.S. Public Health Service? Yes ____ No ✓

If so, please state dates of service, and assignment location, etc.

Time: [illegible] Date: [illegible]
Camera III Roll: [illegible]

16. **BEFORE COMPLETING THIS APPLICATION IT WILL BE NECESSARY FOR YOU TO READ THE ATTACHED CODE OF ETHICS, AND EXCERPTS FROM THE FLORIDA OSTEOPATHIC MEDICAL PRACTICE ACT AND RULES AND REGULATIONS.**

(a) I hereby certify that I have carefully and thoughtfully read the Code of Ethics, and the excerpts from the Florida Osteopathic Medical Practice Act, and Rules and Regulations, and

I hereby agree that if I am licensed by your Board I shall adhere at all times to those principles, statutes, rules and regulations, and the principles governing the reputable practice of osteopathic medicine and surgery.

[signature], D.O.
Signature of Applicant

(b) I clearly understand that the correctness and truth of my statements as recorded in this application are material, not only to the issuance of the certificate of license, as applied for, but also to the retention of said certificate, if issued;

I have read the foregoing questions and have answered the same fully and frankly. The answers are complete and true of my own knowledge. I have written/printed/typewritten the answers, or they have been typewritten under my supervision.

[signature], D.O.
Signature of Applicant

STATE OF Florida

COUNTY OF [illegible]

Sworn to and subscribed before me this 28th day of November A.D. 1972

(SEAL) [signature]
Notary Public

My commission expires: NOTARY PUBLIC, STATE of FLORIDA at LARGE MY COMMISSION EXPIRES [illegible] 28, 1974 BONDED THROUGH FRED W. [illegible]

17. **CERTIFICATES OF RECOMMENDATION:**

IF YOU ARE CURRENTLY PRACTICING, SECURE RECOMMENDATION (1) FROM THE STATE BOARD IN THE STATE WHERE YOU ARE NOW PRACTICING; SECURE RECOMMENDATION (2) FROM A MEMBER IN GOOD STANDING OF THE STATE OSTEOPATHIC ASSOCIATION IN THE STATE WHERE YOU ARE NOW PRACTICING.

N. A.

(1) This is to certify that I am the duly authorized Secretary of the ______ State Licensing Board; that the official records of said board show that the applicant, ______ is currently licensed and in good standing. A review of the records of the applicant reveals no information which would preclude our board from recommending the applicant as a person of good moral character and professional standing.

Date: ______ Signed: ______ (Secretary) ______ (State Licensing Board)

Address: ______

N. A.

(2) This is to certify that I am a member of the ______ (State) Osteopathic Medical Association, and that the applicant ______ is personally known to me through an acquaintance extending over a period of ______ years, and that I know the applicant to be of good moral character and professional standing.

Date: ______ Signed: ______

Address: ______

Name:
Camera III

Date:
Roll:

IF YOU HAVE RECENTLY GRADUATED, secure the recommendations of the Dean of the College from which you graduated, and one of your professors (Or if you are now interning, secure a recommendation from one of the supervisors of interns in the hospital where you are training). (3) & (4) below:

(3) This is to certify that I am Dean of the [illegible] College of Osteopathy, and that the applicant [illegible] is known to me, and I know the applicant to be of good moral character; further, that his student record reveals nothing which would preclude recommendation for licensure.

Date: [illegible] Signed: [illegible]
Dean
[illegible]
College

(4) This is to certify that the applicant [illegible] is personally known to me in my capacity as [illegible] and I can vouch for his good moral character and reputation.

Date: Nov. 28, 1972 Signed: Robert Jones [illegible], MD
Chairman Dept. of OB-GYN [illegible] Hospital Jacksonville
Position - Title
Jacksonville Hospitals [illegible]
Address: Jacksonville, Florida

IF YOU ARE CURRENTLY IN THE U. S. ARMED SERVICES, OR PUBLIC HEALTH SERVICE: secure the recommendations of two of your superior officers or supervisors; (5) & (6) below:

N.A.
(5) This is to certify that the applicant ________ is personally known to me in my capacity as ________ and that I know the applicant to be of good moral character and professional standing.

Date: ________ Signed: ________

Position - Title ________ Service ________

Address: ________

N.A.
(6) This is to certify that the applicant ________ is personally known to me in my capacity as ________ and that I know the applicant to be of good moral character and professional standing.

Date: ________ Signed: ________

Position - Title ________ Service ________

Address: ________

* N.A. = not applicable

Name: [illegible]
CAMERA III
Date: [illegible]
Roll: [illegible]

IF YOU HAVE RECENTLY GRADUATED, secure the recommendations of the Dean of the College from which you graduated, and one of your professors (Or if you are now interning, secure a recommendation from one of the supervisors of interns in the hospital where you are training). (3) & (4) below:

(3) This is to certify that I am Dean of the ______________ College of Osteopathy, and

that the applicant ______________ is known to me, and I know the applicant to be of good moral character; further, that his student record reveals nothing which would preclude recommendation for licensure.

Date: __________ Signed: ______________
Dean

____
College

(4) This is to certify that the applicant ______________ is personally known to me in

my capacity as ______________
and I can vouch for his good moral character and reputation.

Date: Nov. 28, 1972 Signed: Robert [illegible] [illegible]

Chairman, Dept. [illegible] — University Hospital [illegible] Jacksonville
Position - Title

Address: Jacksonville, Florida

IF YOU ARE CURRENTLY IN THE U. S. ARMED SERVICES, OR PUBLIC HEALTH SERVICE: secure the recommendations of two of your superior officers or supervisors: (5) & (6) below:

N.A.
(5) This is to certify that the applicant ______________ is personally known to me in

my capacity as ______________
and that I know the applicant to be of good moral character and professional standing.

Date: __________ Signed: ______________

______________ Position - Title ______________ Service

Address: ______________

N.A.
(6) This is to certify that the applicant ______________ is personally known to me in

my capacity as ______________
and that I know the applicant to be of good moral character and professional standing.

Date: __________ Signed: ______________

______________ Position - Title ______________ Service

Address: ______________

* N.A. = Not applicable

CAMERA III   [illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible] D.O.

having satisfied the requirements and having successfully [redacted] examinations is hereby declared a Diplomate of the National Board of Examiners for Osteopathic Physicians and Surgeons

[illegible]
President of the Board

Certificate No. [illegible]   Date [illegible]

[illegible]
Secretary of the Board.

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION
INVESTIGATIVE SERVICES
2727 Mahan Drive • Tallahassee, FL 32308

www.fdhc.state.fl.us

ROUTINE ☑ CHANGE LOC ☐ NEW ☐ DOB ☐ CHANGE OWNER ☐

File# 2210
Insp # 907
Next Insp # 1157

INVESTIGATIVE SERVICES INSPECTION FORM
DISPENSING PRACTITIONERS
INSPECTION AUTHORITY – CHAPTER 465.0276(3) F. S

NAME OF DISPENSING PRACTITIONER: Emil F. Felski	PERMIT NUMBER: 3318	DATE OF INSPECTION: 6/27/01
DOING BUSINESS AS	DEA NUMBER: AF 7849776	CHECK ONE: o Podiatrist; o Dentist
STREET ADDRESS (DISPENSING LOCATION): 1120 Semoran Blvd	TELEPHONE #: 407-677-1234	o Medical Physician; ☑ Osteopathic Physician; o Nurse Practitioner
CITY: Casselberry / COUNTY: Seminole	STATE/ZIP: Fl 32707	o Naturopath; o Optometrist

	SATISFACTORY	YES	NO
1	Practitioner properly registered with the board. {465.0276(2)(a), F.S.}	✓	
2	Dispensing area clean and safe.{64B16-28.105}	✓	
3	Generic drug sign displayed. {465.025(7),FS} {64B8-8.011(3)(b)10}	✓	
4	Stock medications appropriately labeled for dispensing from a licensed manufacturer. {499.007(2), FS}	✓	
5	Medications purchased from a Florida licensed wholesaler/distributor. {499.005(14), FS}	✓	
6	Outdated medications removed from stock. {499.007(2), FS.} {64B16-28.110}	✓	
7	Medications requiring refrigeration appropriately stored. {64B16-28.104}	N/A	
8	Medications dispensed being placed in childproof container. {16CFR 1700.14} {64B8-8.011(3)(b)16}	✓	
9	Medication labels properly completed for dispensing. {893.04(1)(e), FS.} {64B16-28.108}	✓	
10	Practitioner providing a written prescription for medication to be dispensed. {465.0276(2)(c), FS}	✓	
11	Practitioner advising prescription may be filled on premise or at any pharmacy. {465.0276(2)(c), FS}	✓	
12	Expiration/discard date on prescription label or provided in other written form. {64B16-28.402(1)(h)}	✓	
13	Practitioner is present when dispensing occurs. {64B16-27.400(4)}	✓	
14	Practitioner is personally certifying (checking) filled prescription for accuracy prior to patient receiving{64B16-27.400(1)(g), (3)}	✓	
15	Offer made to counsel patients regarding prescription made verbally and in writing. {64B16-27.820(1)}	✓	
16	Patient record contains medical history required for counseling. {64B16-27.800}	✓	
17	Controlled substances securely maintained and stored in a locked cabinet. {21CFR 1301.75}	N/A	
18	Controlled substance prescriptions initialed and dated by practitioner. {893.04(1)(b), FS}	↓	
19	Controlled substance prescriptions provide patient's name and address. {893.04(1)(c) 1, FS}	↓	
20	Controlled substance prescriptions provide practitioner's name/address and DEA number. {893.04(1)(c) 2, FS}	↓	
21	Controlled substance prescription refills initialed and dated by practitioner. {893.04(1)(b), FS}	↓	
22	Controlled substance prescriptions properly maintained. {893.04, FS} {893.07, FS}	↓	
23	Controlled substance purchase records properly maintained {893.07(1)(a) & (b),FS}	↓	
24	Controlled substance records readily retrievable. {893.07(4), FS} {21CFR 1304.04}	↓	
25	Controlled substance biennial inventory conducted. {893.07(1)(a), FS}	↓	
26	DEA 222 forms properly completed. {893.07(2), FS.} {21CFR 1305.09}	↓	
27*	Daily hard copy printout or log of all prescriptions is dated/signed by each practitioner if computer system utilized.	↓	
28*	Practitioner's computer information readily retrievable. {21CFR 1306.22} {64B16-28.140(3)(c)}	↓	

Questions with (*) may be answered n/a (not applicable).

Remarks:

I have read and have had this inspection report and the laws and regulations concerned herein explained, and do affirm that the information given herein is true and correct to the best of my knowledge.

[signature] — Signature of Licensee / Representative

6/27/01 — Date

[signature] 05-64 — Investigator/Sr. Pharmacist Signature/ID Number

INV 387 Revised 8/00 White Copy: Field Yellow Copy: Headquarters Gold Copy: Board Office Pink Copy: Licensee

AC# **COPY** STATE OF FLORIDA
DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE

DATE	LICENSE NO.	CONTROL NO.
01/09/2004	OS 3318	10169

The **OSTEOPATHIC PHYSICIAN** named below has met all requirements of the laws and rules of the state of Florida.

Expiration Date: **MARCH 31, 2006**

QUALIFICATION(S):
DISPENSING PRACTITIONER

EMIL F FELSKI
1120 STATE ROAD 436
SUITE 1000
CASSELBERRY, FL 32707-6102

COPY COPY COPY

AC#
STATE OF FLORIDA
DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE
DATE 01/09/2004
LICENSE NO. OS 3318
CONTROL NO. 10169
The OSTEOPATHIC PHYSICIAN named below has met all requirements of the laws and rules of the state of Florida
Expiration Date: MARCH 31, 2006
QUALIFICATION(S): Dispensing Practitioner

COPY - NOT A VALID LICENSE - COPY

COPY - NOT A VALID LICENSE - COPY

EXPIRATION DATE: **MARCH 31, 2006**

Your license number is **OS 3318**, please use it in all correspondence with your board/council. Each licensee is solely responsible for notifying the department in writing of the licensee's current mailing address and practice location address. Use this section to report name and/or practice location address and/or mailing address changes. If you have not received your renewal notice 90 days prior to the expiration date shown on this license, please call (850) 488-0595.

Name changes require legal documentation showing the name change. Please make sure that a photocopy of one of the following accompanies this form: a marriage license, a divorce decree or a court order. **A driver's license or social security card is not considered legal documentation.**

Medical Quality Assurance offers you the convenience of several online services. These services give you the ability to renew your license, update your mailing and practice location addresses and update your profile information.

1. Go to **www.DOH-MQAServices.com**
2. Choose one of the licensee services
3. Select your profession
4. Enter the account ID and password here **(Account ID and Password are case sensitive)** Account ID:__________ Password:__________

Your opinion is important to us. To help us continue to improve our customer service, please take a moment to complete our online survey about the kind of service we provided you in obtaining your license. **http://www.doh.state.fl.us/mqa/Surveys/new-lic.htm** Thank you for helping us better serve you and our other customers.

To request a duplicate license, submit this form and a check or money order, payable to the **DEPARTMENT OF HEALTH**, in the amount of **$25.00**.

MAIL TO: **DEPARTMENT OF HEALTH**
DIVISION OF MEDICAL QUALITY ASSURANCE
LICENSURE SERVICES
P.O. BOX 6320
TALLAHASSEE, FLORIDA 32314-6320

☐ **NAME CHANGE (ATTACH LEGAL DOCUMENTATION)**

FROM: __________
LAST FIRST MIDDLE

TO: __________
LAST FIRST MIDDLE

DH 2103, 5/98

☐ **PRACTICE LOCATION ADDRESS CHANGE**
(This address will be printed on your license and posted on the Internet.)

____
____
CITY STATE ZIP

☐ **MAILING ADDRESS CHANGE**
(This address will be used when mailing your license and for all other correspondance from the Department.)

____
____
CITY STATE ZIP

DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE
LICENSURE SERVICES
4052 BALD CYPRESS WAY, BIN #C-10
TALLAHASSEE, FLORIDA 32399-3260

EMIL F FELSKI
1120 STATE ROAD 436
SUITE 1000
CASSELBERRY, FL 32707-6102

AC# **COPY**

STATE OF FLORIDA
DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE

DATE	LICENSE NO.	CONTROL NO.
02/15/2006	**OS 3318**	**17567**

The **OSTEOPATHIC PHYSICIAN**
named below has met all requirements of
the laws and rules of the state of Florida.
Expiration Date: **MARCH 31, 2008**

QUALIFICATION(S):
DISPENSING PRACTITIONER

COPY COPY COPY

EMIL F FELSKI
1120 STATE ROAD 436
SUITE 1000
CASSELBERRY, FL 32707-6102
UNITED STATES

STATE OF FLORIDA
DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE
AC#
CONTROL NO. 17567
LICENSE NO. OS 3318
DATE 02/15/2006
The OSTEOPATHIC PHYSICIAN
named below has met all requirements of
COPY - NOT A VALID LICENSE - COPY

LICENSEE SIGNATURE

COPY - NOT A VALID LICENSE - COPY

QUALIFICATION(S):
Dispensing Practitioner

GOVERNOR SECRETARY

DISPLAY IF REQUIRED BY LAW

EXPIRATION DATE: **MARCH 31, 2008**

Your license number is **OS 3318**, please use it in all correspondence with your board/council. Each licensee is solely responsible for notifying the department in writing of the licensee's current mailing address and practice location address. Use this section to report name and/or practice location address and/or mailing address changes. If you have not received your renewal notice 90 days prior to the expiration date shown on this license, please call (850) 488-0595.

Name changes require legal documentation showing the name change. Please make sure that a photocopy of one of the following accompanies this form: a marriage license, a divorce decree or a court order. **A driver's license or social security card is not considered legal documentation.**

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1. Go to **www.DOH-MQAServices.com**
2. Choose one of the licensee services
3. Select your profession
4. Enter the account ID and password here **(Account ID and Password are case sensit**

To request a duplicate license, submit this form and a check or money order, payable to the **DEPARTMENT OF HEALTH**, in the amount of **$25.00**.
Now that you have your license, make sure you keep it. Go to **www.doh.state.fl.us/mqa/avoid.html** to find out more.

MAIL TO: **DEPARTMENT OF HEALTH**
DIVISION OF MEDICAL QUALITY ASSURANCE
LICENSURE SERVICES
P.O. BOX 6320
TALLAHASSEE, FLORIDA 32314-6320

☐ **NAME CHANGE (ATTACH LEGAL DOCUMENTATION)**

FROM: ______________________
LAST FIRST MIDDLE

TO: ______________________
LAST FIRST MIDDLE

DH 2103, 5/98

☐ **PRACTICE LOCATION ADDRESS CHANGE**
(This address will be printed on your license and posted on the Internet.)

____
____
CITY STATE ZIP

☐ **MAILING ADDRESS CHANGE**
(This address will be used when mailing your license and for all other correspondence from the Department.)

____
____
CITY STATE ZIP

DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE
LICENSURE SERVICES
4052 BALD CYPRESS WAY, BIN #C-10
TALLAHASSEE, FLORIDA 32399-3260

EMIL F FELSKI
1120 STATE ROAD 436
SUITE 1000
CASSELBERRY, FL 32707-6102
UNITED STATES

EMIL FELSKI, D.O., P.A.

OBSTETRICS, GYNECOLOGY, INFERTILITY AND FAMILY PLANNING

FLORIDA BOARDS OF
DENTISTRY AND ACUPUNCTURE

02 AUG 20 PM 3:22

Changed F.R. in PRAGS

August 16, 2002

The Florida Department of Health
Board of Osteopathic Medicine
4052 Bald Cypress Way Bin #C06
Tallahassee, Florida 32399-3253

To Whom It May Concern:

Enclosed please find completed Financial Responsibility Filing Form. Also, enclosed is copy of the notice that is posted in my office. Confirmation form is dated and signed by patient and placed in chart.

Thank you,

Emil Felski DO

Emil Felski, D.O.

OS 3318

LAKE HOWELL SQUARE • 1120 SEMORAN BOULEVARD • CASSELBERRY, FLORIDA 32707

FINANCIAL RESPONSIBILITY FILING FORM - PAGE 2

6. I am exempt from demonstrating financial responsibility because:

6A [ ] I practice medicine exclusively as an officer, employee, or agent of the federal government, or of the state or its agencies or its subdivisions.
6B [ ] I hold a limited license issued pursuant to s. 459.0075, F.S., and practice only under the scope of such limited license.
6C [ ] I practice only in conjunction with my teaching duties at an college of osteopathic medicine. (Residents do not qualify for this exemption.)
6D [ ] I do not practice osteopathic medicine in the State of Florida. I will notify the department immediately before commencing practice in the state.
6E [ ] I am exempt from demonstrating financial responsibility due to meeting all of the following criteria:

1) I have held an active license to practice in this state or another state or some combination thereof for more than 15 years.
2) I am retired or maintain part-time practice of no more than 1,000 patient contact hours per year.
3) I have had no more than 2 claims resulting in an indemnity exceeding $25,000 within the previous 5 year period.
4) I have not been convicted of, or pled nolo contendere to any criminal violation specified in s. 459. F.S., or the practice act of any other state.
5) I have not been subject, within the last 10 years of practice, to license revocation or suspension for any period of time, probation for a period of 3 years or longer, or a fine of $500 or more for a violation of s. 459, F.S., or the medical practice act of another jurisdiction. The regulatory agency's acceptance of an osteopathic physician's relinquishment of a license, stipulation, consent order, or other settlement, offered in response to or in anticipation of the filing of administrative charges against the osteopathic physician's license, shall be construed as action against the physician's license for the purposes of this section. I understand that I shall be required either to post notice in the form of a sign prominently displayed in the reception area and clearly noticeable by all patients or to provide a written statement to any person to whom medical services are being provided. Such sign or statement shall state that: Under Florida law, osteopathic physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. However, certain part-time osteopathic physicians who meet state requirements are exempt from the financial responsibility law. YOUR OSTEOPATHIC PHYSICIAN MEETS THESE REQUIREMENTS AND HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This notice is provided pursuant to Florida law.

AFFIRMATION:
I affirm that all statements given above are true and correct and recognize that providing false information may result in disciplinary action against my license or criminal penalties pursuant to Sections 456.072, 459.013, 459.015, 775.082, 775.083, and 775.084, Florida Statutes.

EMIL F.M. FELSKI, D.O.

Signature   Printed Name

****

DISPENSING PRACTITIONER - This is optional and should be completed only if the $100.00 fee is enclosed.

Section 465.0276, F.S., requires that licensees of the Board of Osteopathic Medicine who dispense medicinal drugs for a fee or remuneration of any kind, whether direct or indirect, shall be required to register with the Board and pay a fee of $100.00 at the time of such registration and upon each renewal of the practitioner's license. Practitioners who confine their activities to the dispensing of complimentary packages of medicinal drugs to their own patients in the regular course of their practice <u>shall not be required to register</u>. Please note that upon registration, your practice will be inspected annually by the Department's Investigative Services for compliance with Florida law relative to the dispensing of medicinal drugs.

YES, I plan to dispense medicinal drugs for a fee or other remuneration and hereby register pursuant to ss. 465.0276, F.S.. I understand that the fee for registration is $100.00 over and above the amount required for licensure.

YES [ ] ______________________ NO [ ] No signature required

Signature

FINANCIAL RESPONSIBILITY FILING FORM

THIS FORM MUST BE COMPLETED AND SUBMITTED WITH YOUR APPLICATION FOR LICENSURE. COMPLETE THE FORM BASED ON WHAT YOUR STATUS **WILL BE** UPON BEGINNING PRACTICE IN FLORIDA. IF THIS INFORMATION IS UNAVAILABLE, SEE SECTION 6D OF THIS FORM. PLEASE RETAIN A BLANK COPY OF THIS FORM SO THAT YOU MAY UPDATE YOUR STATUS IF NECESSARY AFTER YOU ARE APPROVED BY THE BOARD.

Check only the subsection box which applies to you - only one section should be checked.

1. [ ] I do not have hospital staff privileges and I have obtained and maintain professional liability coverage in an amount not less than $100,000 per claim, with a minimum annual aggregate of not less than $300,000, from an authorized insurer as defined under s. 624.09 FS, from a surplus lines insurer as defined under s. 626.914(2) FS, from a risk retention group as defined under s. 627.942 FS, from the Joint Underwriting Association established under s. 627.351(4) FS, or through a plan of self-insurance as provided in s. 627.357 FS.

2. [ ] I have hospital staff privileges and I have obtained and maintain professional liability coverage in an amount not less than $250,000 per claim, with a minimum annual aggregate of not less than $750,000, from an authorized insurer as defined under s. 624.09 FS, from a surplus lines insurer as defined under s. 626.914(2) FS, from a risk retention group as defined under s. 627.942 FS, from the Joint Underwriting Association established under s. 627.351(4) FS, or through a plan of self-insurance as provided in s. 627.357 FS, or through a plan of self-insurance which meets the conditions specified for satisfying financial responsibility in s. 766.110 FS.

3. [ ] I do not have hospital staff privileges and I have obtained and maintain an unexpired, irrevocable letter of credit, established pursuant to chapter 675 FS, in an amount of not less than $100,000 per claim with a minimum aggregate availability of credit of not less than $300,000. The letter of credit shall be payable to the osteopathic physician as beneficiary upon presentment of a final judgment indicating liability and awarding damages to be paid by the osteopathic physician or upon presentment of a settlement agreement signed by all parties to such agreement when such final judgment or settlement is a result of a claim arising out of the rendering of, or the failure to render, medical care and services. Such letter of credit shall be nonassignable and nontransferable. Such letter of credit shall be issued by any bank or savings association organized and existing under the laws of this state or any bank or savings association organized under the laws of the United States that has its principal place of business in this state or has a branch office which is authorized under the laws of this state or of the United States to receive deposits in this state. **OR** I do not have hospital staff privileges and I have established and maintain an escrow account consisting of cash or assets eligible for deposit in accordance with s. 625.52 FS in the per-claim amounts specified above.

4. [ ] I have hospital staff privileges and I have obtained and maintain an unexpired, irrevocable letter of credit, established pursuant to chapter 675 FS, in an amount not less than $250,000 per claim, with a minimum aggregate availability of credit of not less than $750,000. The letter of credit shall be payable to the osteopathic physician as beneficiary upon presentment of a final judgment indicating liability and awarding damages to be paid by the osteopathic physician or upon presentment of a settlement agreement signed by all parties to such agreement when such final judgment or settlement is a result of a claim arising out of the rendering of, or the failure to render, medical care and services. Such letter of credit shall be nonassignable and nontransferable. Such letter of credit shall be issued by any bank or savings association organized and existing under the laws of this state or any bank or savings association organized under the laws of the United States that has its principal place of business in this state or has a branch office which is authorized under the laws of this state or of the United States to receive deposits in this state **OR** I have hospital staff privileges and I have established and maintain an escrow account consisting of cash or assets eligible for deposit in accordance with s. 625.52 FS in the per-claim amounts specified above.

5. [X] I have decided not to carry malpractice insurance or otherwise demonstrate financial responsibility; however, I agree to satisfy any adverse judgments pursuant to the terms and conditions contained in s. 459.0085(5)(g), FS. I understand that I shall be required to either post notice in the form of a sign prominently displayed in the reception area and clearly noticeable by all patients and provide a written statement to any person to whom medical services are being provided. Such sign and statement shall state that: Under Florida law, osteopathic physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. YOUR OSTEOPATHIC PHYSICIAN HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This is permitted under Florida law subject to certain conditions. Florida law imposes strict penalties against noninsured osteopathic physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida law.

The purpose of this correspondence is to inform you that effective as of August 5, 2002, any osteopathic physicians employed by Emil F.M. Felski, D.O., P.A., including myself, will no longer maintain professional liability insurance. Under Florida law, osteopathic physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. YOUR OSTEOPATHIC PHYSICIAN HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This is permitted under Florida law subject to certain conditions. Florida law imposes strict penalties against noninsured osteopathic physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided to you pursuant to Florida law. Should you have any questions concerning this matter, please do not hesitate to contact me.

Sincerely,

Emil F.M. Felski, D.O.

Please confirm that you have received and read this letter, and that you acknowledge the foregoing, by signing this notice in the space indicated below.

____
Signature

Printed Name:_______________________
Date:____________________________

Enclosure

PLEASE READ

NOTICE TO PATIENTS OF EMIL F.M. FELSKI, D.O., P.A.

Under Florida law, osteopathic physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. THE OSTEOPATHIC PHYSICIANS EMPLOYED BY EMIL F.M. FELSKI, D.O., P.A., INCLUDING YOUR OSTEOPATHIC PHYSICIAN, HAVE DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE.

This is permitted under Florida law subject to certain conditions. Florida law imposes strict penalties against noninsured osteopathic physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida law. Should you have any questions regarding this matter, please contact Dr. Felski.

EMIL FELSKI, D.O., P.A.

OBSTETRICS, GYNECOLOGY, INFERTILITY AND FAMILY PLANNING

Changed F.R. born on PRAES EK 8/20/02

Fax Cover Sheet

Date 8/16/2002

Receiver's Name Board of Osteopathic Medicine

Number of Pages ______

Fax Number 850 487-9874

Sender's Name Emil Felski, DO.

Sending Physician ______

Office 407-677-1234 **Fax 407-677-1001**

This info is also being sent via certified mail.

Thanks

*****CONFIDENTIALITY NOTE: The information contained in this facsimile message is legally privileged and confidential. Information intended only for the use of the individual or entity named above. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this fax is strictly prohibited. If you have received this fax in error, PLEASE IMMEDIATELY NOTIFY US BY TELEPHONE AND RETURN THE ORIGINAL MESSAGE TO US AT THE ABOVE ADDRESS VIA THE UNITED STATES POSTAL SERVICE *****

LAKE HOWELL SQUARE • 1120 SEMORAN BOULEVARD • CASSELBERRY, FLORIDA 32707

EMIL FELSKI, D.O., P.A.

OBSTETRICS, GYNECOLOGY, INFERTILITY AND FAMILY PLANNING

August 16, 2002

The Florida Department of Health
Board of Osteopathic Medicine
4052 Bald Cypress Way Bin #C06
Tallahassee, Florida 32399-3253

To Whom It May Concern:

Enclosed please find completed Financial Responsibility Filing Form. Also, enclosed is copy of the notice that is posted in my office. Confirmation form is dated and signed by patient and placed in chart.

Thank you,

Emil Felski, D.O.

LAKE HOWELL SQUARE • 1120 SEMORAN BOULEVARD • CASSELBERRY, FLORIDA 32707

FINANCIAL RESPONSIBILITY FILING FORM

THIS FORM MUST BE COMPLETED AND SUBMITTED WITH YOUR APPLICATION FOR LICENSURE. COMPLETE THE FORM BASED ON WHAT YOUR STATUS **WILL BE** UPON BEGINNING PRACTICE IN FLORIDA. IF THIS INFORMATION IS UNAVAILABLE, SEE SECTION 6D OF THIS FORM. PLEASE RETAIN A BLANK COPY OF THIS FORM SO THAT YOU MAY UPDATE YOUR STATUS IF NECESSARY AFTER YOU ARE APPROVED BY THE BOARD.

Check only the subsection box which applies to you - only one section should be checked.

1. [ ] I do not have hospital staff privileges and I have obtained and maintain professional liability coverage in an amount not less than $100,000 per claim, with a minimum annual aggregate of not less than $300,000, from an authorized insurer as defined under s. 624.09 FS, from a surplus lines insurer as defined under s. 626.914(2) FS, from a risk retention group as defined under s. 627.942 FS, from the Joint Underwriting Association established under s. 627.351(4) FS, or through a plan of self-insurance as provided in s. 627.357 FS.

2. [ ] I have hospital staff privileges and I have obtained and maintain professional liability coverage in an amount not less than $250,000 per claim, with a minimum annual aggregate of not less than $750,000, from an authorized insurer as defined under s. 624.09 FS, from a surplus lines insurer as defined under s. 626.914(2) FS, from a risk retention group as defined under s. 627.942 FS, from the Joint Underwriting Association established under s. 627.351(4) FS, or through a plan of self-insurance as provided in s. 627.357 FS, or through a plan of self-insurance which meets the conditions specified for satisfying financial responsibility in s. 766.110 FS.

3. [ ] I do not have hospital staff privileges and I have obtained and maintain an unexpired, irrevocable letter of credit, established pursuant to chapter 675 FS, in an amount of not less than $100,000 per claim with a minimum aggregate availability of credit of not less than $300,000. The letter of credit shall be payable to the osteopathic physician as beneficiary upon presentment of a final judgment indicating liability and awarding damages to be paid by the osteopathic physician or upon presentment of a settlement agreement signed by all parties to such agreement when such final judgment or settlement is a result of a claim arising out of the rendering of, or the failure to render, medical care and services. Such letter of credit shall be nonassignable and nontransferable. Such letter of credit shall be issued by any bank or savings association organized and existing under the laws of this state or any bank or savings association organized under the laws of the United States that has its principal place of business in this state or has a branch office which is authorized under the laws of this state or of the United States to receive deposits in this state. OR I do not have hospital staff privileges and I have established and maintain an escrow account consisting of cash or assets eligible for deposit in accordance with s. 625.52 FS in the per-claim amounts specified above.

4. [ ] I have hospital staff privileges and I have obtained and maintain an unexpired, irrevocable letter of credit, established pursuant to chapter 675 FS, in an amount not less than $250,000 per claim, with a minimum aggregate availability of credit of not less than $750,000. The letter of credit shall be payable to the osteopathic physician as beneficiary upon presentment of a final judgment indicating liability and awarding damages to be paid by the osteopathic physician or upon presentment of a settlement agreement signed by all parties to such agreement when such final judgment or settlement is a result of a claim arising out of the rendering of, or the failure to render, medical care and services. Such letter of credit shall be nonassignable and nontransferable. Such letter of credit shall be issued by any bank or savings association organized and existing under the laws of this state or any bank or savings association organized under the laws of the United States that has its principal place of business in this state or has a branch office which is authorized under the laws of this state or of the United States to receive deposits in this state. OR I have hospital staff privileges and I have established and maintain an escrow account consisting of cash or assets eligible for deposit in accordance with s. 625.52 FS in the per-claim amounts specified above.

5. [X] I have decided not to carry malpractice insurance or otherwise demonstrate financial responsibility; however, I agree to satisfy any adverse judgments pursuant to the terms and conditions contained in s. 459.0085(5)(g), FS. I understand that I shall be required to either post notice in the form of a sign prominently displayed in the reception area and clearly noticeable by all patients and provide a written statement to any person to whom medical services are being provided. Such sign and statement shall state that: Under Florida law, osteopathic physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. YOUR OSTEOPATHIC PHYSICIAN HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This is permitted under Florida law subject to certain conditions. Florida law imposes strict penalties against noninsured osteopathic physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida law.

FINANCIAL RESPONSIBILITY FILING FORM - PAGE 2

6. I am exempt from demonstrating financial responsibility because:

6A [ ] I practice medicine exclusively as an officer, employee, or agent of the federal government, or of the state or its agencies or its subdivisions.

6B [ ] I hold a limited license issued pursuant to s. 459.0075., F.S., and practice only under the scope of such limited license.

6C [ ] I practice only in conjunction with my teaching duties at an college of osteopathic medicine. (Residents do not qualify for this exemption.)

6D [ ] I do not practice osteopathic medicine in the State of Florida. I will notify the department immediately before commencing practice in the state.

6E [ ] I am exempt from demonstrating financial responsibility due to meeting all of the following criteria:

1) I have held an active license to practice in this state or another state or some combination thereof for more than 15 years.
2) I am retired or maintain part-time practice of no more than 1,000 patient contact hours per year.
3) I have had no more than 2 claims resulting in an indemnity exceeding $25,000 within the previous 5 year period.
4) I have not been convicted of, or pled nolo contendere to any criminal violation specified in s. 459, F.S., or the practice act of any other state.
5) I have not been subject, within the last 10 years of practice, to license revocation or suspension for any period of time, probation for a period of 3 years or longer, or a fine of $500 or more for a violation of s. 459, F.S., or the medical practice act of another jurisdiction. The regulatory agency's acceptance of an osteopathic physician's relinquishment of a license, stipulation, consent order, or other settlement, offered in response to or in anticipation of the filing of administrative charges against the osteopathic physician's license, shall be construed as action against the physician's license for the purposes of this section. I understand that I shall be required either to post notice in the form of a sign prominently displayed in the reception area and clearly noticeable by all patients or to provide a written statement to any person to whom medical services are being provided. Such sign or statement shall state that: Under Florida law, osteopathic physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. However, certain part-time osteopathic physicians who meet state requirements are exempt from the financial responsibility law. YOUR OSTEOPATHIC PHYSICIAN MEETS THESE REQUIREMENTS AND HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This notice is provided pursuant to Florida law.

AFFIRMATION.
I affirm that all statements given above are true and correct and recognize that providing false information may result in disciplinary action against my license or criminal penalties pursuant to Sections 456.072, 459.013, 459.015, 775.082, 775.083, and 775.084, Florida Statutes.

Signature Printed Name

DISPENSING PRACTITIONER - This is optional and should be completed only if the $100.00 fee is enclosed.

Section 465.0276, F.S., requires that licensees of the Board of Osteopathic Medicine who dispense medicinal drugs for a fee or remuneration of any kind, whether direct or indirect, shall be required to register with the Board and pay a fee of $100.00 at the time of such registration and upon each renewal of the practitioner's license. Practitioners who confine their activities to the dispensing of complimentary packages of medicinal drugs to their own patients in the regular course of their practice shall not be required to register. Please note that upon registration, your practice will be inspected annually by the Department's Investigative Services for compliance with Florida law relative to the dispensing of medicinal drugs.

YES, I plan to dispense medicinal drugs for a fee or other remuneration and hereby register pursuant to ss. 465.0276, F.S. I understand that the fee for registration is $100.00 over and above the amount required for licensure.

YES [ ] ______________________ NO [ ] No signature required

Signature

PLEASE READ

NOTICE TO PATIENTS OF EMIL F.M. FELSKI, D.O., P.A.

Under Florida law, osteopathic physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. THE OSTEOPATHIC PHYSICIANS EMPLOYED BY EMIL F.M. FELSKI, D.O., P.A., INCLUDING YOUR OSTEOPATHIC PHYSICIAN, HAVE DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE.

This is permitted under Florida law subject to certain conditions. Florida law imposes strict penalties against noninsured osteopathic physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida law. Should you have any questions regarding this matter, please contact Dr. Felski.

The purpose of this correspondence is to inform you that effective as of August 5, 2002, any osteopathic physicians employed by Emil F.M. Felski, D.O., P.A., including myself, will no longer maintain professional liability insurance. Under Florida law, osteopathic physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. YOUR OSTEOPATHIC PHYSICIAN HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This is permitted under Florida law subject to certain conditions. Florida law imposes strict penalties against noninsured osteopathic physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided to you pursuant to Florida law. Should you have any questions concerning this matter, please do not hesitate to contact me.

Sincerely,

Felski, D.O.

Emil F.M. Felski, D.O.

Please confirm that you have received and read this letter, and that you acknowledge the foregoing, by signing this notice in the space indicated below.

____

Signature

Printed Name:______________________

Date:_____________________________

Enclosure

"No Check Attached"

5-4-00 '00 SEP 15 PM 12 54

Board of Medicine
Department of Professional Regulation
130 North Monroe St.
Tallahassee, FL 32399-9750

To whom it may concern,

I, Emil F. Felski, D.O., License #00003318, 1120 Semoran Blvd., Casselberry, FL 32707, have hereby entered into a formal supervisory relationship, standing orders and an established protocol with the following ARNP's:

Sandra C. Williamson, CNM, MSN
Elizabeth C. Carson, CNM, MSN
Suzanne M. Paszkowski, CNM,MN
Nora Hernando, CNM, MSN

Emil F. Felski, D.O.

2000 SEP 19 AM 10: 03

RECEIVED
SEP 18 2000
LICENSURE DOH

FLORIDA BOARDS OF
DENTISTRY AND ACUPUNCTURE
00 OCT -4 PM 3: 56

"No Check Attached"

'00 SEP 15 PM 12 58

University of South Florida
USF

July 10, 2000

Department of Health
Board of Medicine
1940 North Monroe Street, Suite 6
Tallahassee, Florida 32399-0770

RECEIVED
AUG 07 2000
BOARD OF NURSING

Florida Department of Health
Division of Medical Quality Assurance
Board of Nursing - Protocol Department
4080 Woodcock Drive, Suite 202
Jacksonville, Florida 32207

SUBJECT: F.S.S. Chapter 458.348(1)
"Mutual Agreement of Physician and CRNA"

Please be advised that the following physician has entered into a supervisory relationship using established protocols with the following Certified Registered Nurse Anesthetist.

Physician

Daniel B. Smith ,M.D.
License # ME 50890
DEA# [redacted]

Certified Registered Nurse Anesthetist

Eric C. Frendak ,CRNA
License # RN 3045062

Location of Practice

Tampa General Healthcare
Davis Islands
P.O. Box 1289
Tampa, Florida 33601

Copies of the collaborative agreement will be kept on file at the above location as well as by participants involved.

Respectfully submitted,

Department of Anesthesiology, College of Medicine
University of South Florida • 12901 Bruce B. Downs Boulevard, MDC 59 • Tampa, Florida 33612-4799
(813) 974-3099

The University of South Florida is an Affirmative Action/Equal Access/Equal Opportunity Institution

AC# COPY

STATE OF FLORIDA
DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE

DATE	LICENSE NO.	CONTROL NO.
02/29/2008	**OS 3318**	**24484**

The **OSTEOPATHIC PHYSICIAN**
named below has met all requirements of
the laws and rules of the state of Florida.
Expiration Date: **MARCH 31, 2010**

QUALIFICATION(S):
DISPENSING PRACTITIONER

EMIL F FELSKI
1120 STATE ROAD 436
SUITE 1000
CASSELBERRY, FL 32707-6102
UNITED STATES

COPY COPY COPY

STATE OF FLORIDA
DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE
AC#
DATE 02/29/2008
LICENSE NO. OS 3318
CONTROL NO. 24484
The OSTEOPATHIC PHYSICIAN
named below has met all requirements of

COPY - NOT A VALID LICENSE - COPY

LICENSEE SIGNATURE

COPY - NOT A VALID LICENSE - COPY

GOVERNOR STATE SURGEON GENERAL

QUALIFICATION(S):
Dispensing Practitioner

DISPLAY IF REQUIRED BY LAW

EXPIRATION DATE: **MARCH 31, 2010**

Your license number is **OS 3318**, please use it in all correspondence with your board/council. Each licensee is solely responsible for notifying the department in writing of the licensee's current mailing address and practice location address. Use this section to report name and/or practice location address and/or mailing address changes. If you have not received your renewal notice 90 days prior to the expiration date shown on this license, please call (850) 488-0595.

Name changes require legal documentation showing the name change. Please make sure that a photocopy of one of the following accompanies this form: a marriage license, a divorce decree or a court order. **A driver's license or social security card is not considered legal documentation.**

Medical Quality Assurance offers you the convenience of several online services. These services give you the ability to renew your license, update your mailing and practice location addresses and update your profile information.

1. Go to www.flhealthsource.com
2. Click on Licensee/Provider
3. Click on Practitioner Login
4. Select your profession
5. Enter the account ID and password here **(Account ID and Password are case sensit**
   Where 'l' is lowercase letter 'L' and 'o' is lowercase letter 'O'.
6. Click on Login

To request a duplicate license, submit this form and a check or money order, payable to the **DEPARTMENT OF HEALTH**, in the amount of **$25.00**.
Now that you have your license, make sure you keep it. Go to www.doh.state.fl.us/mqa/avoid.html to find out more.

MAIL TO: **DEPARTMENT OF HEALTH**
DIVISION OF MEDICAL QUALITY ASSURANCE
LICENSING AND AUDITING SERVICES UNIT
P.O. BOX 6320
TALLAHASSEE, FLORIDA 32314-6320

☐ **NAME CHANGE (ATTACH LEGAL DOCUMENTATION)**

FROM: ______________________
LAST FIRST MIDDLE

TO: ______________________
LAST FIRST MIDDLE

DH 2103, 5/98

☐ **PRACTICE LOCATION ADDRESS CHANGE**
(This address will be printed on your license and posted on the Internet.)

____
____
CITY STATE ZIP

☐ **MAILING ADDRESS CHANGE**
(This address will be used when mailing your license and for all other correspondence from the Department.)

____
____
CITY STATE ZIP

DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE
LICENSING AND AUDITING SERVICES UNIT
4052 BALD CYPRESS WAY, BIN #C-10
TALLAHASSEE, FLORIDA 32399-3260

EMIL F FELSKI
1120 STATE ROAD 436
SUITE 1000
CASSELBERRY, FL 32707-6102
UNITED STATES

AC# COPY

STATE OF FLORIDA
DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE

DATE	LICENSE NO.	CONTROL NO.
02/12/2010	**OS 3318**	**30402**

The **OSTEOPATHIC PHYSICIAN** named below has met all requirements of the laws and rules of the state of Florida.

Expiration Date: **MARCH 31, 2012**

QUALIFICATION(S):

DISPENSING PRACTITIONER

EMIL F FELSKI
1120 STATE ROAD 436
SUITE 1000
CASSELBERRY, FL 32707-6102
UNITED STATES

COPY COPY COPY

AC#
STATE OF FLORIDA
DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE
DATE 02/12/2010 LICENSE NO. OS 3318 CONTROL NO. 30402
The OSTEOPATHIC PHYSICIAN named below has met all requirements of

COPY - NOT A VALID LICENSE - COPY

LICENSEE SIGNATURE

QUALIFICATION(S):
Dispensing Practitioner

COPY - NOT A VALID LICENSE - COPY

GOVERNOR STATE SURGEON GENERAL

DISPLAY IF REQUIRED BY LAW

EXPIRATION DATE: **MARCH 31, 2012**

Your license number is **OS 3318**, please use it in all correspondence with your board/council. Each licensee is solely responsible for notifying the department in writing of the licensee's current mailing address and practice location address. If you have not received your renewal notice 90 days prior to the expiration date shown on this license, please call (850) 488-0595.

Use this section to report name change. Name changes require legal documentation showing the name change. Please make sure that a photocopy of one of the following accompanies this form: a marriage license, a divorce decree or a court order. **A driver's license or social security card is not considered legal documentation.**

Medical Quality Assurance offers you the convenience of several online services. These services give you the ability to renew your license, update your mailing and practice location addresses and update your profile information.

1. Go to **www.flhealthsource.com**
2. Click on Licensee/Provider
3. Click on Practitioner Login
4. Select your profession
5. Enter the account ID and password that was provided to you on your initial license
6. If you do not know your account ID and password, click on "**Get Login Help**" or call for assistance.

MAIL TO: **DEPARTMENT OF HEALTH**
DIVISION OF MEDICAL QUALITY ASSURANCE
LICENSING AND AUDITING SERVICES UNIT
P.O. BOX 6320
TALLAHASSEE, FLORIDA 32314-6320

☐ **NAME CHANGE (ATTACH LEGAL DOCUMENTATION)**

FROM: ______________________________
LAST FIRST MIDDLE

TO: ______________________________
LAST FIRST MIDDLE

DH 2103, 5/98

DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE
LICENSING AND AUDITING SERVICES UNIT
4052 BALD CYPRESS WAY, BIN #C-10
TALLAHASSEE, FLORIDA 32399-3260

EMIL F FELSKI
1120 STATE ROAD 436
SUITE 1000
CASSELBERRY, FL 32707-6102
UNITED STATES

Division of Medical Quality Assurance
P.O.Box 6340
Tallahassee, Florida 32314-6340

***** Important License Information *****

EMIL F FELSKI
1120 STATE ROAD 436
SUITE 1000
CASSELBERRY, FL 32707-6102

3318-1329

Your license is scheduled for renewal within the next 5 months. You are required to review and, if appropriate, update your profile before renewing your license. In addition, Section 456.042, Florida Statutes, requires you to submit profile updates within 15 days of any changes.

You may review, update and confirm the accuracy of your practitioner profile information online by visiting www.FLHealthsource.com. Select LICENSEE/PROVIDER, click on VIEW PROFILE, and Login with your Account ID and Password. If you make changes to your profile, BE SURE to click on "confirm changes" to update the Department's information system.

If you have any questions, please contact the MQA Call Center at (850) 488-0595, option 3.

Division of Medical Quality Assurance
P.O.Box 6340
Tallahassee, Florida 32314-6340

AUTO 3318

06:06:01207 *** **Important License Information** ***

EMIL F FELSKI
1120 STATE ROAD 436
SUITE 1000
CASSELBERRY, FL 32707-6102

:327076183508:

Your license is scheduled for renewal within the next 5 months. You are required to review and, if appropriate, update your profile before renewing your license. In addition, Section 456.042, Florida Statutes, requires you to submit profile updates within 15 days of any changes.

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If you have any questions, please contact the MQA Call Center at (850) 488-0595, option 3.

AC# **COPY**

STATE OF FLORIDA
DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE

DATE	LICENSE NO.	CONTROL NO.
03/08/2012	**OS 3318**	**38614**

The **OSTEOPATHIC PHYSICIAN**
named below has met all requirements of
the laws and rules of the state of Florida.
Expiration Date: **MARCH 31, 2014**

EMIL F FELSKI
1120 STATE ROAD 436
SUITE 1000
CASSELBERRY, FL 32707-6102

QUALIFICATION(S):
DISPENSING PRACTITIONER

COPY COPY COPY COPY COPY

STATE OF FLORIDA
DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE
AC#

DATE	LICENSE NO.	CONTROL NO.
03/08/2012	OS 3318	38614

The OSTEOPATHIC PHYSICIAN
named below has met all requirements of
the laws and rules of the state of Florida.
Expiration Date: MARCH 31, 2014

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LICENSEE SIGNATURE

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GOVERNOR   STATE SURGEON GENERAL

DISPLAY IF REQUIRED BY LAW

QUALIFICATION(S):
Dispensing Practitioner

EXPIRATION DATE: **MARCH 31, 2014**

Your license number is **OS 3318**. please use it in all correspondence with your board/council. Each licensee is solely responsible for notifying the department in writing of the licensee's current mailing address and practice location address. If you have not received your renewal notice 90 days prior to the expiration date shown on this license, please call (850) 488-0595.

Use this section to report name change. Name changes require legal documentation showing the name change. Please make sure that a photocopy of one of the following accompanies this form: a marriage license, a divorce decree or a court order. **A driver's license or social security card is not considered legal documentation.**

Medical Quality Assurance offers you the convenience of several online services. These services give you the ability to renew your license, update your mailing and practice location addresses and update your profile information.

1. Go to **www.flhealthsource.com**
2. Click on Licensee/Provider
3. Click on Practitioner Login
4. Select your profession
5. Enter the account ID and password that was provided to you on your initial license and cli
6. If you do not know your account ID and password, click on "**Get Login Help**" or call our C   sistance.

MAIL TO: **DEPARTMENT OF HEALTH**
DIVISION OF MEDICAL QUALITY ASSURANCE
LICENSING AND AUDITING SERVICES UNIT
P.O. BOX 6320
TALLAHASSEE, FLORIDA 32314-6320

☐ **NAME CHANGE (ATTACH LEGAL DOCUMENTATION)**

FROM: ______________________________
LAST   FIRST   MIDDLE

TO: ______________________________
LAST   FIRST   MIDDLE

DH 2103, 5/98

DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE
LICENSING AND AUDITING SERVICES UNIT
4052 BALD CYPRESS WAY, BIN #C-10
TALLAHASSEE, FLORIDA 32399-3260

********** **AUTO** **********

EMIL F FELSKI
1120 STATE ROAD 436
SUITE 1000
CASSELBERRY, FL 32707-6102

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STATE OF FLORIDA
DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE

DATE	LICENSE NO.	CONTROL NO.
02/19/2014	**OS 3318**	**44971**

The **OSTEOPATHIC PHYSICIAN**
named below has met all requirements of
the laws and rules of the state of Florida.
Expiration Date: **MARCH 31, 2016**

QUALIFICATION(S):
DISPENSING PRACTITIONER

EMIL F FELSKI
1120 STATE ROAD 436
SUITE 1000
CASSELBERRY, FL 32707-6102

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AC#
STATE OF FLORIDA
DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE

DATE	LICENSE NO.	CONTROL NO.
02/19/2014	OS 3318	44971

The **OSTEOPATHIC PHYSICIAN**
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Expiration Date: **MARCH 31, 2016**

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GOVERNOR STATE SURGEON GENERAL

DISPLAY IF REQUIRED BY LAW

QUALIFICATION(S):
Dispensing Practitioner

EXPIRATION DATE: **MARCH 31, 2016**

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4. Select your profession
5. Enter the account ID and password that was provided to you on your initial license and cli
6. If you do not know your account ID and password, click on "**Get Login Help**" or call our Customer Contact Center at (850) 488-0595 for assistance.

MAIL TO: **DEPARTMENT OF HEALTH**
DIVISION OF MEDICAL QUALITY ASSURANCE
LICENSURE SUPPORT SERVICES UNIT
P.O. BOX 6320
TALLAHASSEE, FLORIDA 32314-6320

☐ **NAME CHANGE (ATTACH LEGAL DOCUMENTATION)**

FROM: ______________________________
LAST FIRST MIDDLE
TO: ______________________________
LAST FIRST MIDDLE

DH 2103, 5/98

IMPORTANT ANNOUNCEMENT

THE DEPARTMENT OF HEALTH WILL NOW REVIEW YOUR CONTINUING EDUCATION RECORDS AT THE TIME OF LICENSE RENEWAL.

TO LEARN MORE, PLEASE VISIT WWW.CEatRENEWAL.COM

DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE
LICENSURE SUPPORT SERVICES UNIT
4052 BALD CYPRESS WAY, BIN #C-10
TALLAHASSEE, FLORIDA 32399-3260

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