License Verification

Data As Of 4/30/2014

KIMBERLY PAULINE VAN SCRIVER

LICENSE NUMBER: ME73993

Profession

MEDICAL DOCTOR

License/Activity Status Controlled Substance Prescriber

TEAD/ACTIVE

NO

CLEAR/ACTIVE

Qualifications

Dispensing Practitioner

License Expiration Date

1/31/2015

License Original Issue Date

08/20/1997

Discipline on File

Public Complaint

NO

NO

Address of Record

A PLACE FOR WOMEN, OBGYN 6817 SOUTHPOINT PKWY STE 2204 JACKSONVILLE, FL 32216 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.

AC#COPY

STATE OF FLORIDA DEPARTMENT OF HEALTH DIVISION OF MEDICAL QUALITY ASSURANCE

DATE	LICENSE NO.	CONTROL NO.
02/05/2000	ME 73993	40582

THE MEDICAL DOCTOR

NAMED BELOW HAS MET ALL REQUIREMENTS OF THE LAWS AND RULES OF THE STATE OF FLORIDA.

CMBERLY PAUL E VENSCRIVE AT N. 2004 WOMEN'S MEDICAL GROUP, P.A.

JOE ADAMS BLDG. JACKSONVILLE, FL 32216 STATE OF ELIDERAL ACATION OF ALTH OF A CONTROL NO.

DATE LICENSE NO. CONTROL NO.

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EXPIRATION DATE: JANUARY 31, 2002

KIMBERLY PAULINE VAN SCRIVER

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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: JANUARY 31, 2002

YOUR LICENSE NUMBER IS ME 73993 , 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.

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FROM: -	MIDDLE					
TO:	LAST	FIRST	MIDDLE	CITY	STATE	ZIP

DH 2103, 5/98

DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE
LICENSURE SERVICES
2020 CAPITAL CIRCLE, S.E., BIN #C-10
TALLAHASSEE, FLORIDA 32399-3260

KIMBERLY PAULINE VAN SCRIVER 4205 BELFORT RD STE 2004 JACKSONVILLE, FL 32216

02/01/2000 \$16.00 ID: 1501-64867 Type: F BT: H06295 DP: 168396

VL: 990059995

iHEADER 02/01/00 PRAES Production (MQ-P) dmixon 09:04:26 MAINTAIN ANY LICENSE DATA øtnrbal12/2.13 - 1501/MED-MEØ øFile: 64867 Ø øSSN: Medical Doctor Ø øLić: 73993 CLEAR, ACTIVE Ø øName: KIMBERLY PAULINE VAN SCRIVER (DBA:0 Old:0) Ø øAddr: 4205 BELFORT RD STE 2004 State: FL32216 Zip: øCity: JACKSONVILLE County: DUVAL First License: 08/20/1997 øCertificate No: . 17 Date: 02/10/1998 In Rank Since: 08/20/1997 øLast Renewal: License Method: ENDR Renewal Notice: 10/29/1999 øCurrent Expiry: 01/31/2000 In Directory? Include øStatus Date: 01/01/1801 Fee Exempt? øNote: Ø ØAction: Query Transfer A-Address B-Basic_Data C-PSD M-Modifiers ... Go to view only options 167.78.1.20 1 Sess-1 1 22/9



REVENUE DOH

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\$355.00 Type: F 168396



Extremely Urgent:
Recipient Please Hand Deliver to Addressee

Fedex | Finance | Finance | Federal 32399 -FL-US PRIORITY OVERNIGHT

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COPY STATE OF FLORIDA **DEPARTMENT OF HEALTH**

DIVISION OF MEDICAL QUALITY ASSURANCE

02/05/2002	ME 73993	94310
DATE	LICENSE NO.	CONTROL NO.

THE MEDICAL DOCTOR NAMED BELOW HAS MET ALL REQUIREMENTS OF THE LAWS AND RULES OF THE STATE OF FLORIDA EXPIRATION DATE: JANUARY 31, 2005 KIMBERLY PAULINE VAN SCRIVER ATTN: 4201 BELFORT ROAD, SUITE 2004 WOMEN'S MEDICAL GROUP, P.A. JOE ADAMS BLDG.

JACKSONVILLE, FL 32216

ASSURANCE KIMBERLY PAULINE VAN SCRIVER Š NOT A VALID LICENSE Ł COPY THE MED (THE LAV

> 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: JANUARY 31, 2005

YOUR LICENSE NUMBER IS ME 73993 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.

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FROM: LAST	FIRST	MIDDLE			
TO: LAST	FIRST	MIDDLE	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



DISPENSING PRACTITIONER REGISTRATION

Jeb Bush Governor John O. Agwunobi, M.D., M.B.A. Secretary

Department of Health Board of Medicine P.O. Box 6320

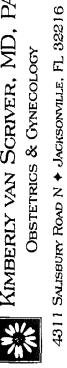
Tallahassee, FL. 32314-6320

OFFICE USE ONLY

Important – C	mportant – Complete one form per licensee.						Date : 2 /15/200 Date : 2/17/2006
practitioner who samples is no	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. Dispensing fee – The fee for registration as a dispensing practitioner is					Deposit # Batch Nu Balidation Check Ar	t 167434 mber : 00101924 n # : 805219121 nount : \$100.00 E : 6601
\$100.00 over	and a	The fee for registration as a combove the required license re lispensing records will be combount to the combount of the comb	newal fee.				
		PLEASE PRINT OR TY	PE THE FO	DLLOWING INFOR	MATION		
Name:		KIMBERLY Pauline 1					
License ME72		ME73993	93			301D	
Mailing Addr	ess:	4311 Sausbury ROAD	NOISTH,	JACKSONVILLE,	FL 32	-16	
Only practice lo	cation	s are published on the internet.					
	aispe	ensing medication at the fo	llowing to	cations: (attach ad	ditional	sheets	if needed)
Phone Number:	9	04 855 4211					
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	2000						
Phone Number:	90	4 448 - 8877					
2 nd Practice Location:	4	31 Umpersity Bloo	1 S BWI	ains2, Jackso	nville	h	3746
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To cancel dispensing practitioner status from your medical license, the licensee must submit a signed, written request to the Board office at the address listed below.

Please submit this request form and the dispensing fee to the:



KIMBERLY VAN SCRIVER, MD, PA
OBSTETRICS & GYNECOLOGY OBSTETRICS & GYNECOLOGY

JACKSONVILLE FL 322

LALED FROM 217 CODE 09 FEB 2006 PM 4:T

FLORIDA DEPAREMENT OF HEALTH
DISPENSING PRACHONDER PERISTRATION DEPT.
4052 BALD CYPRESS NAY, BIN# 203 TALLAHASCEE, FL 32399-3253 32359+7017 hillindiallabladadamannahillablabla

ACCOPY PUOPY" IN OF MANATID LICENSE - COPY STATE OF FLORIDA **DEPARTMENT OF HEALTH DIVISION OF MEDICAL QUALITY ASSURANCE** DATE LICENSE NO. CONTROL NO. 02/21/2006 LICENSE NO. ME 73993 187161 LICENSEE SIGNATURE * The MEDICAL DOCTOR named below has met all requirements of QUALIFICATION(S): the laws and rules of the state of Florida. #EAT DISPENSING PRACTITIONER Expiration Date: JANUARY 31, 2007 KIMBERLY PAULINE VAN SCRIVER 4311 SALISBURY RD N JACKSONVILLE, FL 32216

COPY - NOT A VALID LICENSE - COPY

GUVERNUR

DISPLAY IF REQUIRED BY LAW

QUALIFICATION(S):

EXPIRATION DATE: JANUARY 31, 2007
Your license number is MR 73993, 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.

- Go to www.DOH-MQAServices.com
 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.stateff.us/mqa/avoid.html to find out more.

MAIL	LICENSURE S P.O. BOX 632	MEDICAL QUALITY ASSURAN BERVICES	CE		printed on your license and pos	-
FRO	NAME CHANGE (A	TTACH LEGAL DOCUMENTA	TION)	CITY MAILING ADDF (This address will be correspondence from	used when mailing your license	ZIP and for all other
TO:	LAST	FIRST	MIDDLE			
DH 2	LAST 103, 5/98	FIRST	MIDDLE	CITY	STATE	ZIP

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

INITIAL LICENSURE FORM, 3 PAGES

Return the three pages of this form on or before January 15 to:

Department of Business and Professional Regulation (DBPR) Bureau of Revenue 1940 North Monroe Street Tallahassee, FL 32399-0783

08/19/97 \$355.60 ID: TYPE: S BT: 97006339 RC: 970099283 01-015-40 \$350.60 01-015-51 \$55.60

COMPLETE THIS FORM:

Market Ma	. 350 :	# 2.X	September 1
LANGEN SCRIVER	FIRST NAME: Kimberly	Pauline	· = 100
4319 Landour Dr			-
Jacksonville	FL STATE	32207.	. ; .

Section I Initial Licensure:

Attach the appropriate fees

Section 2a Financial Responsibility Form: Check the appropriate box, the one that nearest applies to you.

- I. 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, P. 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 2 years (retroactive coverage) or if I seek insurance from a different entity providing insurance, I will purchuse 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 Section 458.320, F.S., I will maintain coverage for incidents which may have occurr.d during the two years preceding my becoming uninsured.
- I have hospital staff privileges; and I have obtained and maintrin 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 nuthorized 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 2 years (retrocative coverage) or if I seek insurance from a different entity providing insurance I will purchase retroactive coverage for the 2 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 limincial responsibility requirements through other provisions in Section 458.320, F.S., I will maintain coverage for incidents which may have occurred during the two years preceding my becoming uninsured.
- I do not have hospital staff privileges and I have established an irrevocable letter of credit or an excrow 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.

- i. 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 majoractice insurance or otherwise demonstrate financial responsibility; however, I agree to satisfy any adverse judgments up to the minimum amounts pursuant to a 458.320(5)(g)1. F. S. I understand that I must post notice in the form of a "sign" prominently displayed in the reception area or provide a written statement to any person to whom .nedical services are being provided that I have decided not to carry medical majoractice insurance or otherwise demonstrate financial responsibility. I understand that such a sign or notice must contain the wording specified in s. 458.330(5)(g), F. S.
- 6. I am exempt from demonstrating financial responsibility because I fall into one of the categories listed below:

 A. I practice medicine exclusively as an officer, employee, or agent of the federal government, or of the state or lits agencies or subdivisions.
 - B. I hold a lim. d license issued pursuant to s. 458.317, F. S., and practice only under the scope of the limited license.1
 - C. I practice only in conjunction with my teaching duties at an accredited medical school or its main teaching thospitals. (interns and residents do not qualify for this exemption).
- D. I do not practice medicine in the State of Florida.

O

- E. I am exempt from demonstrating financial responsibility based on my meeting all the following criteria:
 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 1000 patient contact hours per year.
 - 3. I have had no more than 2 claims resulting in an indomnity exceeding \$10,000 within the previous 5 year period.
 - 4. I have not been convicted of or pled guilty or noto contendere to any criminal violation specified in Chapter 458, F. S.
 - 5. I have not been subject, within the past 16 years of practice, to license revocation or suspension, probation for a period of 3 years or longer, or a fine of \$500 or more for a violation of Chapter 458, F.S., or the med., a 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 chapter the charges against a license shall be construed as action against a license. I understand that I must 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 or otherwise demonstrate financial responsibility. I understand that such a sign or notice must contain the wording specified in s. 458,320(5)(f), F. S.
- Section 2b. Complete the HIV/AIDS Affidavit and Domestic Violence Course or Request for Extensions.
 - I hereby certify that subsequent to January 1, 1988, I have completed a minimum of three hours, AMA Category I, American Medical Association, Continuing Medical Education, which include the topics of Human Immunodeficiency Virus and Acquired Immuno Deficiency Syndrome: the disease and its spectrum of clinical manifestations; epidemiology of the disease, and related infection of TB; treatment, counseling, and prevention; transmission from healthcare worker to patient and patient to healthcare worker; universal precautions and isolation techniques; and legal issues related to the disease which meet the requirements of Chapter 455.2226, Florida Statutes, and Rule 59R-13.006(1), F.A.C. I understand that I must maintain such receipts, vouchers, certificates, or other papers to document completion of this requirement for a period of not less than four (4) years from the date the course was taken.
- I hereby certify that subsequent to January 1, 1988, I have not completed a minimum of three hours, AMA Category I, American Medical Association, Continuing Medical Education, which include the topics of Human Immunodeficiency Virus and Acquired immune Deficiency Syndrome: the disease and its spectrum of clinical manifestations; epidemiology of the disease and misted infection of TB; treatment,

counseling, and prevention; transmission from healthcare worker to patient and patient to healthcare worker; universal precontions and isolation techniques; and legal issues related to the discuse which meet the requirements of Chapter 485.2226, Florida Statutes, and Rule 59R-13.006(1), F.A.C. As I have not completed the required course for initial licensure, I understand that the six months extension is based on the date the Board of Medicine certified my application for licensure and I request an extension of up to 6 months to complete this requirement for the reason stated:

- 3 1 hereby certify that subsequent to July 1, 1995, I have completed a minimum of one hour, Continuing Medical Education, in domestic violence, as defined in a. 741.30.
- I hereby certify that subsequent to July 1, 1995, I have not completed a minimum of one hour, Continuing Medical Education, in domestic violence. As I have not completed the required course for initial licensure, I understand that the six months extension is based on the date the Board of Medicine certified my application for licensure and I request an extension of up to 6 months to complete this requirement for the reason stated:

Section 2c. Dispensing Practitioner Registration Requirement (This section is optional and is for in-State physicians only)

Section 465.0276, F.S., requires that licensies of the Board of 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. It is unlawful for any rerson to sell samples or complimentary packages of drug products. A practitioner who confines his/her activities to dispensing of complimentary packages of medicinal drugs to his/her own patients in the regular course of his/her practice shall not be required to register.

- 1 plan to dispense medicinal drugs for a fee or other remuneration and hereby register pursuant to Section 465.0276, F.S. I understand that the fee for the Dispensing Practitioner is \$100.00 OYER AND ABOVE the required renewal fee.
- 2d. Enclose with Initial Licensure Form the appropriate NICA assessment, exemption and form.

Signer(s) Other than N

775.084, Florida Statutes.		•
The foregoing instrument was ack	viedged before me this 1 day of <u>august</u> , 1997, by	
Kimberly P. v	n Soliver , who is personally known to me or who has	
produced / N/Q	as identification and did/did not take an outh.	
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Signature of Notary		
My Commission Expires:	Georgiatio Mandacteus Let consistencia o controls expenses	
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6 TELEPHONE: (904) 731-8732		**	
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PRACTICE/EMPLOYMENT - List in chronological order from date of graduation to present date, all practice employment, non-employment and/or any unaccounted period of time from date of matriculation into madical school							
(Type of Practice and Employment or Non- Employment)	Name and Address or Domicile (Street member, Lity, State, Territory, Country) of Non-employment, Justines Andlor Practice Liting	MONTH/YEA					
please so attached s	est d paper						
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9/99 - 6/90 1st year medicul school Wen York Medicul college(MA) 6/90 - 18/90 world - Sonte Am Sperm Brak , Sonte Am Children

3/9, - 6/91 2nd year of Medicul School NYMC.

"6/91 - 8/91 worked South Ann Spar Book, South Ana, Calforne

8/91 - 5/92 didn't biochemistry and was forced to split

Curriculum from my 2nd year in half.

by 5/92 I had competitly finished years

1:2 of matine shot.

6/92 It took part 1 of usmes, applied to trousle to university of Now Musico. It had to wait for my usuale test woulk prior to beginning my 3rd year in Medical school at university of Now Musico.

6/92-9/92 in distrimin & my mom. I did not water.
9/92-6/93- completed my 3 rd year of redict school and unsimily of Non Newsia.
6/93-5/94- completed my 4th year of redict school.

Graduated on 5/4/94.

for
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Vacation and would to Oklahom City to begin my intersty
in family Medicine
6/17/44- 6/30/45 - Internation Foly Medicin OKC, Oklahom
7/1/44- 6/30/45 - Internation Foly Medicin OKC, Oklahom
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<b>17</b> 77	es", give name(s) and	ADDRESSES OF	MEDICAL SO	CIETY.			
LIST MEDI	CAL AFFILIATIONS	: State, county,	national, in	cluding date(s)	and complete ad	idress (ctreel	, city, stat
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• •	u a citizen of the Uni	Λ.				Yes 🚅	<b>人 No _</b>
Have y	ou ever been in the L	Inited States Mil	ilary and/or	Public Health	Service?	Yes	No _
GF "VE	'LIST BRANCE OF SEE	VICE BANK DAY	TE OF CERVI	W S S S ENVIRON	T AND THE PARTY	ADOR DOM	
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p   II Jee.	, state date of certific		· <del>····································</del>				
Have y	ou ever failed State B	ioard/FLEX/Nat	ional Board	USMLE Exami	ination?		
Aze yo	u cestified by an Ame	rican Specialty	Board?			Yes	No _X
h II "yes"	List mane of Boars (ENC	A(s)_ HOSE COPY OF B	OARD CERTIF	CATE OR LETT	er verifying el	(GRULTY)	- Andreadon - Constitution - Constit
c Have y board o	ou ever applied for, t settilication for any r	aken an examin: tesos?	ution for, or	failed to receiv	e specialty	Yes	_ No _2
d . If "yee"	etdis,						
Have y	ou ever studied to bec in any state, e.g. JD,	ome, or do you	hold arry ot	er professional	ı. ·		_ No _2

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235"	Have you had any application for professional Recess or pay application to practice medicine/surgery dissind by any state board or other governmental agency of any state or country?	You .	N	)
•	off "yes" explains		-	
# &	Have you ever been notified to appear before any licensing agency for a hearing on a complaint of any nature, including, but not limited to, a charge or violation of the middless practice act, troprofessional or unothical conduct?  If "yes" explain:	· Yes _		) <b>X</b>
<b>. b</b>	Have you ever been required by any liceasing jurisdiction to enter into an impaired practitioner program?	d T		,
	If "yes" explain:	7		
<b>28</b>	Have you ever bad any professional license or license to practice medicine/surgery revoked, suspended, or other disciplinary action taken in any state, territory or country?	Yes _	No	ند
, i	If "yes" explain:		· .	5 · · · · · · · · · · · ·
<b>25</b>	Regardless of adjudication have you ever been convicted of a violation of, or pled Noto Conten ere, to, any Federal, State, Local statute, regulation or ordinance, or entered into any plea, negotiated plea, bargain, or settlement relating to a misdemeanor or fellosy?	Yes _	No	<b>X</b>
	If "yes" explain:			
<b>30</b>	Have any actions in bunkruptcy court or any civil judgments over been entered against you?		٠,	
7,	If "yes" explain:			
31	Have you ever been sued for malpractice?	Yes _	No	X
	If "yes" explain:		•	
22.6	Have you ever discontinued practice for any reason for a period of one month or longer?	Yes	No	<u>x</u>
	If "yes" explain:	·		
b	Have you ever had employment terminated for cause?	Yes _	No	<u> </u>
	If "yes" explain:			
<b>*</b>	Do you have a chronic medical filness or any medical condition that might affect your ability to practice your profession?			
	If "yes" explain:			
34	During the course of your medical education and training or practice experience, have you undergone counselling, therapy, or treatment for any mental or physical illusts or condition that impacted your ability to function in any educational or practice setting?			••
	If "yes" explain:		<del></del>	
35	Have you ever declined to follow the recommendation or request of a physician, counse	lan.		

A Carry Change	yer, supervisir, or ly or treatment for	•	Mayanan Managas es (	condition?			<b>.</b> .
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36 Do yo to safe	u háve any mental dy parform any pr	or physical Elina rocedure or task	es or condition wh within the scope o	ich effects your u f the practice of a	bility addicion?	e e e e e e e e e e e e e e e e e e e	,
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37 Have action	you ever been cris related to use or	nicely or civily misuse of drugs,	charged with any alcohol, or Hegal	intentional or neg chamical substant	ligent	Yes	No X
If "ye	i" explain:	*	And the second		· · · · · · · · · · · · · · · · · · ·	<u> </u>	- 10 m
	o the last 5 years, i ion or injury?	have you ever be	en hospitalized for	any physical or	mental Mness,	n of the	
l "ye	s" explain:	الخو	i i i i i i i i i i i i i i i i i i i		· · · · · · · · · · · · · · · · · · ·	74. V2. V	•
35 Have	you ever been wan	ned or called bef	fore the Drug Enfo	rement Agency	DEA)?	Yes	No.X
II "ye	esplain:					54-1	<b>-</b> ;
arvan	you ever been mad pement for other p	de an offer to con den or agreement plated by the DE	in lieu of a Feder	ed into any other al prosecution		Yes	Na X
for a	and antenna take		<b>M</b> .		**		
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. G APPIDAVIT OF APPLICANT: "Kim van Scriver being first duly or ora, depice and say that I men the purson enforced to in the funguing application and supporting documents, and that the attached photograph is a true Ulamo

asystif.

I kereby authorize all hospital(a), institution(s) or organization(s), my references/ personal physicians, employers, (past and present), and all governmental agencies and instrumentalities (local, state, federal or foreign) to reinese to the Florida Reard of Medicine any information which is material to my application for liceraure.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjusy that any answers and all statements made by me barein are true and correct. Should I furnish any false information in this application, I kereby agree that such act shall constitute cause for denial, suspenden or revocation of my license to practice medicine/majory in the State of Florida.

I understand that my records are protected under the Federal and State Regulations governing Confidentiality of Mental Health Patient Records and cannot be disclosed without my written consent unless otherwise provided in the regulations. I understand that my records are protected under the Federal and State Regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time except. consent unless otherwise provided in the regulations. Talso understand that I may revoke this consent at any time except. to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows

<i>#</i> 1 1 1	on of date, event or condition	on upon which (	his consent exp	yires)	
(Significant of Applicant) The faregoing fastrument was acknowledge		22 ment	May	10 97	a laber
	in Serius:	•	. 0	known to me or	13
produced	Norderson		identification	and diddid no	
Signature of Rotary My Commission Empires:	Strongette Hendungs ary consumeration of convoces day 17, 800	<b>a</b>			
Name of Notary Typed, Printed or SEAL	Stamped				
Attention Notary: Although the of this certificate to an unauthor		w is OPTIONAL	, it could preve	mi fraudulent	attachmedt
THIS CERTIFICATE MUST HE ATTACHED TO THE DOCUMENT	Title or Type of Docu Number of Pages			, , , , , ,	rida
DESCRIBED AT REGIT:				4	

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# AGENCY FOR HEALTH CARE ADMINISTRATION FLORIDA BOARD OF MEDICINE DIVISION OF HEALTH QUALITY ASSURANCE NORTHWOOD CENTER 1940 NORTH MONROE STREET TALLAR ASSEB, FLORIDA 32399-0750 904488-0595

DATE: June 17, 1997

To: Kimberly Pauline Van Scriver, M.D. 5501 Auburn Road, Apt. A Jacksonville, Florida 32207

FROM: JoAnne Davis, Regulation Specialist

NO APPLICATION WILL BE CONSIDERED COMPLETE UNTIL ALL OF THE REQUESTED INFORMATION BAS BEEN RECEIVED IN THE BOARD OFFICE. ALL COPIED DOCUMENTS TO BE SUBMITTED MUST BEAR THE STATEMENT FROM THE APPLICANT THAT THE DOCUMENTATION IS A "TRUE COPY OF THE ORIGINAL DOCUMENT", IN ORDER TO ENSURE THAT THE DOCUMENT HAS NOT BEEN ALTERED FROM THE ORIGINAL DOCUMENT. THE SIGNATURE OF THE APPLICANT THEN MUST BE NOTARIZED, PLEASE BE ADVISED THE FLORIDA BOARD OF MEDICINE WILL ACCEPT 5 HONE CALLS REGARDING THE APPLICATION STATUS ONLY FROM 2500M BST UNTIL 4:30pm EST. PURSUANT TO FLORIDA ADMINISTRATIVE CODE 64R, ALL LICENSER APPLICATION STATUS ONLY.

- 1. Please explain why you transferred from New York Medica! College to the University of New Mexico.
- 2. Please have New York Medical College confirm in a letter to the Florida Board that you left in good standing.
- 3. The USMLE score has not been received.
- A. Please explain why you left the OB/GYN program at the Univ. of N. Mexico after 23 months. Did you leave in good standing? Were you offered a contract to continue training?
- 5. The Data Bank report has not been received.
- 6. The AMA Physician Profile received lists your training at the Univ. of N. Mexico from 7/95-6/98 and does not list your training at the Univ. of Florida. Please have an updated Profile sent to the Fl. Board.
- 7. On 6/12/97 the Florida Board mailed an inquiry/evaluation form to the University of Oklahoma, the University of New Mexico and the University of Florida regarding your postgraduate training. These forms must be completed and signed by the current Program Director and returned to the Florida Board.

Agency for Health Care Administration Florida Board of Medicine Division of Health Quality Assurance Northwood Center 1940 North Monroe Street Tallahassee, FL 32399-0750

June 29, 1997

Re: Kimberly van Scriver M.D., application for licensure

To Whom it May Concern,

This letter is in reference to the request for additional information prior to licensing.

- 1. Transfer from New York Medical College to University of New Mexico. 1 transferred to New Mexico, in good standing, as my husband took a job related transfer to Albuquerque.
- 2. Letter of confirmation of standing has been requested from New York Medical College.
- 3. USMLE score requested June 12, 1997.
- 4. I left the Ob/Gyn program in New Mexico May 1, 1997 because my significant other was resident in General Surgery at the University of Florida at Jacksonville. I left in good standing, and would have been offered a contract to continue. I completed the last two months of my third year at the Jacksonville program.
- 5. Data Bank Report request form has been completed.
- 6. AMA Physician Profile no mention of University of Florida training. Updated profile has been requested.

Thank you for your attention to this matter.

Sincerely.

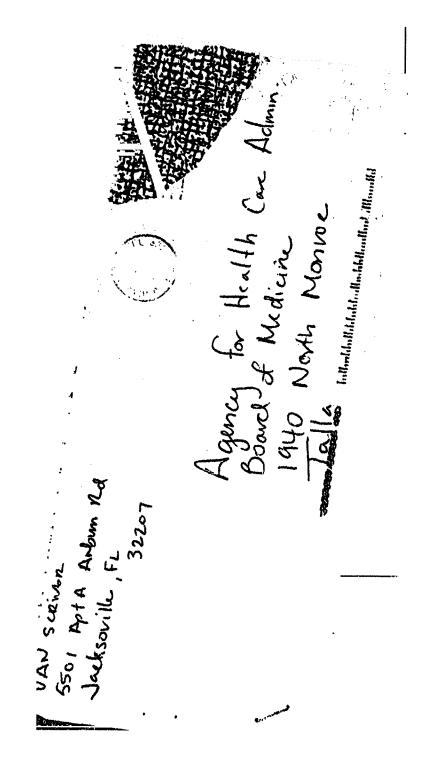
Kimberly van Scriver, M.D.

Kinkery P. Ve. Som MO

5501 A Auburn st.

Jacksonville, FL 32207

(904) 876-7326



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Fastpath:

P12-MAIN MENU

# DEPARTMENT OF HEALTH FLORIDA BOARD OF MEDICINE IVISION OF HEALTH OUALITY ASSURANCE

DIVISION OF HEALTH QUALITY ASSURANCE NORTHWOOD CENTER 1940 NORTH MONROE STREET TALLAHASSEE, FLORIDA 32399-0750 850/488-0595

**DATE: July 8, 1997** 

To: Kimberly Pauline Van Scriver, M.D. 5501 Auburn Road, Apt. A Jacksonville, Florida 32207

FROM: JoAnne Davis, Regulation Specialist

NO APPLICATION WILL BE CONSIDERED COMPLETE UNTIL ALL OF THE REQUESTED INFORMATION HAS BEEN RECEIVED IN THE BOARD OFFICE. ALL COPIED DOCUMENTS TO AE SUBMITTED MUST BEAR THE STATEMENT FROM THE APPLICANT THAT THE DOCUMENTATION IS A "FRUE COPY OF THE ORIGINAL DOCUMENT", IN ORDER TO ENSURE THAT THE DOCUMENT HAS NOT BEEN ALTERED FROM THE ORIGINAL DOCUMENT. THE SIGNATURE OF THE APPLICANT THEM MUST BE NOTARIZED. PLEASE BE ADVISED THE FLOMIDA BOARD OF MEDICINE WILL ACCEPT PHONE CALLS REGARDING THE APPLICATION STATUS ONLY FROM 2000MEST UNTIL 4400MEST. PURSUANT TO FLORIDA ADMINISTRATIVE CODE 66R, ALL LICENSER APPLICATIONS AND FEES ARE GOOD FOR ONE YEAR ONLY.

1. Please have New York Medical College confirm in a letter to the Florida Board that you left in good standing.

2. The USMLE score has not been received.

- 3 The Data Bank report has not been received.
- 4. The AMA Physician Profile received lists your training at the Univ. of N. Mexico from 7/35-6/98 and does not list your training at the Univ. of Florida. Please have an updated Profile sent to the Fl. Board.
- V6. On 6/12/97 the Florida Board mailed an inquiry/evaluation form to the University of New Mexico regarding your postgraduate training. This form has to been returned to the Florida Board.
- 6. Enclosed is the "Self Query" form from the Data Bank. Please send this form to the Data Bank so they can make a report to send to you. When you receive this report, please submit a copy to the Florida Board.

copy of a letter 1992

has conferred upon

# **Aimberly Pauline uan Scrive**

the degree of

# Ductur of Medicine

with all the rights and privileges appertaining to that degree.

at the Vaculty have granted this diploma bearing the seal of the Aniversity in testimony shereof the Regents of the Aniversity upon recommendation this fourteenth day of May, nincteen hundred and ninety-ione.

The Gelahoma State Aegents for Aigher Aducation

acting through

The University of Oklahoma Nealth Sciences Center

mukes known by these presents that

Kimberly van Scriver, M.D

has served ns

First Bear Aesident in Family Medicine

from July 1, 1994 through June 30, 1995

Civen under the Seal of the Aniversity of Oklahonna at the Acalth Sciences Center,

Nor the State Begrade

Har the Aniversity

TREF E D NUL

# THE AGENCY FOR HEALTH CAR'S ADMINISTRATION The physician listed in #1 submitted an FLORIDA BOARD OF N'EDICINE application for licensure and is under

Northwood Centre 1940 North Monroe Street Tallshassee, Floride 32399-0770 (904)488-0595 The physician listed in #1 submitted an application for licensure and is under investigation by this authority. Please complete items 3 through 8 of this form and return. Thank You!

DATE: June 12, 1997

TO: John P Zubialde, MD
Dept of Family Practice
University of Oklahoma HSC
900 NE 10th Street/PO BOX 26901
Oklahoma City, OK 73190

I. Name: <u>Kimberly Pauline Va</u>	<u>nScrive</u>	1			S	S#	
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Office of the Associate Dean for Graduate Medical Education

RECEIVED JUN 0 9 1997

June 2, 1997

Florida Board of medicine Agency for Healthcare Administration Board of Medicine 1940 North Monroe Tallahassee, FL 32399-0770

RE: Kimberly Van Scriver, M.D.

Dear Sirs:

Kimberly Van Scriver served at the University of New Mexico Health Sciences Center in the following capacity:

Reside acy: OB/GYN From 07/03/95 to 05/09/97

There is nothing of a derogatory nature in Dr. Van Scriver's file. All indications are that she performed in a professional and ethical manner.

Sincerely.

Program Director

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# THE LINVERSITY OF NEW MICHOD . HEALTH SOUNCES CONTER SCHOOL OF MEDICINE

Department of Obstetrics and Gyoscology 1211 Lonas Bodevard NE Albuqueque, New Monico 87131-5286 RAX (505) 2724385

Department Chair Master H. Dorin, M.D. (203) 272-4372

(SO3) 272-4372 Obmitties Division Late & Cores, M.D. Mchael C. Chedner, M.D., M.BH. (SO3) 272-600, M.E. (SO3) 272-600, M.E. Maria A. Reprierde, M.D. (SO3) 272-601

(203) 2774611

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Marine K. British M.D.
(203) 279-077

Denotely M. Barba M.D.
Garrado M. Brishand, M.D.
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Especialistico Enduccina Francio W. Byrn. M.D. Colle E. Domingues, M.D. (203) 272-1249

Breau Citate Dermin M. Berke, M.D. (202) 272-6368

(909) 272 d Bid Morro-Bidden dery Division Morro-Bidden dery Division May D. Saller, CNM, McR. Josepha Rockler, CNM, Virgulas, CNM, McR. May D. Saller, CNM, McR. May D. Saller, CNM, McR. May C. Code, CNM, McR. May D. Saller, CNM, McR. May D. Saller, CNM, McR. McR. May D. Saller, CNM, McR. McR. May D. Saller, CNM, McR. M

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the L. Repeteure, M.D., Ph.D.
the E. Serco, M.D., Ph.D.
the M. Cottleman M.S.
having S. Hatt, M.S.
third D. Levin, M.D.
D. 272 4611

July 16, 1997

The Agency for Health Care Administration FLORIDA BOARD OF MEDICINE Northwood Centre 1940 North Monroe Street Taliahassee, FL 32399-0770 atm: JoAnne Davis, Regulation Specialist fax: (904) 922-3040

RE: Kimberly van Seriver, MD

To whom it may concern:

This is a letter verifying Kimberly van Scriver. MD, entered the Residency Program in Obstetrics and Gynecology at the University of New Mexico June, 1995, and lest residency April 26, 1997. Dr. van Scriver did not complete our program in our instinution; she transferred to Complete and Gynecology. There were no complete her training in personal or professional demanance.

If you have any questions, please contact me at (505) 272-6381 Sincepoly years,

1 Am

Luis A. Izquierdo, MD Associate Professor Director, OB/GYN Residency Program

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THE AGENCY FOR MEALTH CARE ADMINISTRATION
FLORIDA BOARD OF MEDICINE
Northwood Centre
1940 North Montree Street
Tellahassee, Florida 32399-0770
18041428-0395
The physician listed in #1 submitted an application for Recessore and is under investigation by this authority. Please complete items 3 through \$ of this form and return. Thank You!

Maxine Drin, MD TO: Gloris & Barto, MD Phis University of New Mexico SOM Dept of Ob/Gyn ACC-4 2211 Lomes Sivd NE Albuquerque, NM 87131-5288

DATE: June 12, 1997

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Title or Type of Document, Application for Medical Licensus-Florida

Number of Pages _____ Date of Document _

THE CRATIFICATE
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TO THE DOCUMENT
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Menor(s) Other thus Names Above

Northwood Centre 1940 North Monroe Street Tallahassee, Florida 32399-0770 (904)488-0595

THE AGENCY FOR HEALTH CARE ADMINISTRATION. The physician listed in #1 submitted an FLORIDA BOARD OF MEDICINE application for licensure and is under investigation by this authority. Please complete items 3 through 8 of this form and return. Thank You!

RECEIVED

DATE: June 12, 1997 JUN 2 3 1997

TO: Robert J Thompson, MD University of Florida HSC Jacksonville Dept of Ob/Gyn 653-1 W Eighth Street Jacksonville, FL 32209

1. Name: Kimberly Pauline VanScriver			\$\$#			
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(PLEASE PRINT/STAMP NAME & AD. JESS BELOW) as a sove.

# © IOVELACE HEALTH SYSTEMS

May 22, 1997

13 27 1997

Florida State Board of Medical Examiners Northwest Centre 1940 North Monroy Tallahassee, FLA 32399-0770

RE: Kim vanScriver

Dear Board:

I have been asked by Dr. Kim vanScriver for a letter of recommendation addressing her medical competency and moral character. I have known Dr. vanScriver for the past year and have had the opportunity to work with her during a clinical rotation at our institution. Her technical skills are excellent in routing obstetrics and gynecology. She has an excellent rapport with staff and patients.

Dr. vanScriver's moral character and judgment are impeccable. She is honest in all situations and respected by her colleagues as well as her patients.

I feel Dr. vanScriver is an excellent physician and person and is very technically capable. If I may be of any further assistance please feel free to contact me at mu office address.

Sincerely.

Stephanie A. Hedstrom, MD

Perinatology

Obstetrics and Gynecology

5400 Gibson Bivd., S.E. Albuquerque, New Mexico 87108 (505) 262-7000

Group Practice • Medical Center • Statewide Network • Health Plan • Managed Care



# HEALTH SCIENCE CENTER / JACKSONVILLE Department of Obstetrics and Gynecology

May 22, 1997

653-1 West 8th Street
Jacksonville Florida 32209-6511

Tel.: (904) 549-3125 Fax: (904) 549-3124

Florida Board of Medicine 1940 North Monroe Street Tallahassee, FL 32399-1006

RE: Kimberly van Scriver, M.D.

Dear Florida Eoard of Medicine:

It is my pleasure to write this letter of recommendation for Dr. Kim van Seriver for licensure in the state of Florida. Dr. van Seriver is currently in her 3rd year as an OB/GYN resident at the University of Florida Health Science Center/Jacksonville. She has an anticipated graduation date of June 30, 1998.

Dr. van Scriver is an excellent clinician and surgeon. She is well liked by her patients, peers, attendings, and support personnel. Dr. van Scriver demonstrates excellent medical and personal ethics. She is responsible and conscientious in providing patient care.

I recommend Dr. van Scriver without reservation. If you require any further information, please do not hesitate to contact me.

Gdy I. Benrubi, M.D.

Professor and Associate Chairman

Department of Obstetrics and Gynecology

Director, Division of Gynecologic Oncology

GIB/glh

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HEALTH SCIENCE CENTER / JACKSONVILLE Department of Obstetrics and Gynecology

653-1 West 8th Street Jacksonville, Florida, 32209-6511 Tel.: (904) 545-3125 Fax: (904) 549-3124

August 4, 1997

Florida Board of Medicine 1940 North Mouroe Street Tallahassee, FL 32399

RE: Kimberly P. van Scriver, M.D. SS#

Florida Board:

This letter confirms that Dr. Kimberly van Scriver is currently a PGY-4 resident at the University of Florida Health Science Center-Jacksonville. She joined the residency program on May 5, 1997, and her anticipated date of graduation is June 30, 1998. Therefore, Dr. van Scriver is exempt from NICA dues.

Should additional information be required, please do not hesitate to contact this office.

Sincerely,

Guy I. Benrubi, M.D.

Professor and Associate Chairman
Department of Obstetrics and Gynecology
Division of Gynecologic Oncology

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YOU MUST CHOOSE ONE OF THE TWO OPTIONS OR CLAIM EXEMPTION UNDER THE TERMS DESCRIBED. YOU MUST COMPLETE THE FORM, AND MAIL THE TOP SIGNED COPY TO THE AGENCY FOR HEALTH CARE ADMINISTRATION (AHCA) WITH YOUR PAYMENT. THIS IS THE ASSESSMENT FOR THE CALENDAR YEAR 1997.

PLEASE BE SURE TO READ THE ENCLOSED INFORMATION, MARK YOUR OPTION OR EXEMPTION, ENCLOSE THE SIGNED AND DATED ASSESSMENT FORM AND ENCLOSE YOUR CHECK. IF YOU HAVE ANY QUESTIONS, CONTACT NICA, PO BOX 14567, TALLAHASSEE, FL 32317-4567, THANK YOU.

(Retain this portion for your records)



# NA VAN SCRIVER OF

## NEW YORK MEDICAL COLLEGE

Valhalia, New York 10595 (914) 993-1498 (914) 993-1613 (Pax)

OFFICE OF STUDENT AFFAIRS

RECEIVED

101 - 103

April 28, 1992

Ladies and Gentlemen:

This letter of recommendation is written at the request of Rimberly van Scriver, a member of the Class of 1994 in good standing, who wishes to transfer to your medical school for personal reasons. These relate to the job opportunities of her future husband. Ms. van Scriver was graduated from the University of California, Irvine, in 1988 with a B.A. degree and a major in Psychology. She also received a B.S. degree with a major in Biology from the University of Arisona. In college she was a volunteer at the Children's Rospital of Orange County and she was involved in several research projects. After graduation, she was a laboratory technician at the Fertility Center of Santa Ana.

Ms. van Soriver matriculated at New York Medical College in the fall of 1989. She all of the first year cor, see

a m in Behavioral Science in her first year, and she has

Biochemistry in her first year, and earned grades of in microbiology and Pharmacology with her original class. She has Pathology-Pathophysiology I with her new class. Currently she is taking Pathology-Pathophysiology II. Her academic problems related to the theft of her car and resultant transportation difficulties, which interfered with her class work. During her extended second year and the summer after the first year, she has worked as a technician at the Westchester Artificial Pidney Center performing nerve conduction tests on dialysis ""

87985 2 06

Tity in the Catholic Tradition

As Ms. van Scriver is performing well in her current courses, we would be delighted for her to remain at New York Medical College.

However, assuming she the remaining courses of the second year, she can be recommended for transfer with advanced standing to your third year class.

Sincerely yours,

William N. Christenson, N.D. Associate Dean Chairman, Graduate Medical Advisory Committee ADVANCENS TOTE: FEALTH THROUGH MEDICINE. BUTENCE & EDUCATION

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NEW YORK MEDICAL COLLEGE

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OFFICE OF THE RISCISTRAR

# Department of Health, Board of Medicine

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NAME: K	im Van Suriver	LICENSE NUMBER: M	:0073993
MAILING A	ADDRESS: 4134	Weatherwood estates Br	<del>.</del> 5
CITY:	Jacksonville	STATE: 7L	ZIP: 32223
Mailing add	ress will not be published o	n the internet.	
1st PRACTIO	CE LOCATION:		
836	Prudential de	ve suite 1506	
	Jacksonille,	STATE: 7L	ZIP: 37207
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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

DH-MQA 1014

	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.
	3a. 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.
	4a. 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.
	5a. 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.
	EXEMPTIONS
	select any numbers 1a-5a in the Financial Responsibility Section, you are not eligible for an ption.
catego	exempt from demonstrating the above financial responsibility because I fall into one of the ories listed below:  k one box only
	1b. I practice medicine exclusively as an officer, employee, or agent of the federal government, or of the state or its agencies or subdivisions;
	2b. 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;
	3b. 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);
	4b. I do not practice medicine in the State of Florida; or
	(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)(f) or 459.0085(5)(f), F. S.

5/00- jp

April 16, 2002

KIMBERELY P. VAN SCRIVER, MD 836 PRUDENTIAL DR., STE 1506 JACKSONVILLE, FL 32207

Re: Florida Malpractice Insurance

Dear Dr. Scriver:

The Florida Board of Medicine has received official notification from your previous insurance carrier, Florida Physicians Insurance Company, Inc. (FPIC) stating you have discontinued their services. Pursuant to section 458.320 Florida Statutes, licensees must notify the Board of Medicine in writing within thirty (30) days of any changes.

For your convenience, please find an enclosed copy of the amended Financial Responsibility form. Please review the following and select the answer that best matches your malpractice coverage. Indicate your answer by placing a check in the box by the paragraph you select. Even though you might qualify for more than one of the situations, please indicate only ONE answer. Please retain a copy for your records.

To avoid additional action, please return a copy of this letter with your amended form to the Board of Medicine, Licensure Maintenance Unit, 4052 Bald Cypress Way, BIN # C03, Tallahassee, FL 32399-3253 prior to May 17, 2002.

Should you have any additional questions, please call (850) 245-4131 ext. 3534.

Sincerely,

Joann Garland

Joann Garland

Regulatory Specialist I



## Insurance Solutions for Healthcare Providers

April 4, 2002

Ms. Tanya Williams, Exec. Dir. Department of Professional Regulation, **Board of Medical Examiners** 1940 N. Monroe St. Tallahassee, FL 32301

Re:

Cancellation of Professional Liability Policy First Professionals Insurance Company, Inc.

Physicians:

KIMBERLY P VAN SCRIVER, M.D.

Location:

DPR:1/20/87

JACKSONVILLE, FL

Florida License Number:

73993

Cancellation Effective:

November 17, 2001

Reason For Cancellation:

Non Payment

If any additional information is required, please contact Sharon Allen, Policyholder Services.

ø Lic: ø SSN:

ø File No: 64867 73993 Medical Doctor CLEAR, ACTIVE

ø Name:

KIMBERLY PAULINE VAN SCRIVER 836 PRUDENTIAL DR. STE 1506

@ Addr:

JACKSONVILLE, FL, 32207

, Phone:

(904) 296-3200 Ext:

#### STATE OF FLORIDA **DEPARTMENT OF HEALTH** CONTROL **DIVISION OF MEDICAL QUALITY ASSURANCE** LICENSE NO. CONTROL NO. DATE 01/23/2005 153206 ME 73993 IT OF HEALTH MEDICAL QUALITY ASSURANCE ş LICENSE The MEDICAL DOCTOR named below has met all requirements of the laws and rules of the state of Florida Expiration Date: **JANUARY 31, 2007**

COPY - NOT A VALID LICENSE - COPY

**COPY - NOT A VALID LICENSE - COPY** 

EXPIRATION DATE: JANUARY 31, 2007

Your licensee number is ME 73993. 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.

- Go to www.DOH-MOAServices.com
   Choose one of the licensee services
- 3. Select your profession

KIMBERLY PAULINE VAN SCRIVER . 4311 SALISBURY RD N JACKSONV(LLE, FL )32216

4. Enter the account ID and password here (Account ID and Password are case sonsitive

To request a duplicate license, submit this form and a check or money order, payable to the DEPARTMENT OF HEALTH, in the smooth of \$25,00.

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DEPARTMENT OF HEALTH DIVISION OF MEDICAL QUALITY ASSURANCE LICENSURE SERVICES 4652 BALD CYPRESS WAY, BIN #C-10 TALLAHASSEE, FLORIDA 32399-3269



John O. Agwunobi, M.D., M.B.A. Secretary

January 6, 2005

Kimberly P VanScriver 4311 Salisbury Road N Jacksonville, FL 32216

RE: ME 73993

Dear Ms. VanScriver:

We have received your check and renewal request; however, in order to process your request the Financial Responsibility part of the renewal needs to be filled out correctly. **Only one category can be checked on the entire form**. If you have two or more areas checked on the form the renewal is being returned to you.

Your request will not be processed until the Financial Responsibility Coverage part of your form is filled out properly and submitted to the department. To eliminate any further delays, please return the Financial Responsibility form and a copy of this letter in the enclosed self-addressed envelope.

If you have any questions, please contact our Licensure Help Desk at (850) 245-4260. Thank you for your cooperation.

Sincerely,

Licensure Services

Division of Medical Quality Assurance Bureau of Operations

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

Active Medical Doctor License # ME 73993 expires January 31, 2005.

The fee of \$454.00 and the renewal notice must be postmarked on or before January 31, 2005. Bate Number: 009442 Renewal notices postmarked on or after February 1, 2005 require a renewal fee of \$839.00.

Received Date: 1/4/05 Depthit Date: 1/4/05 Dep@it#: 167301

Validation # : 904067838 Check Amount: \$454.00

1. CURRENT MAILING ADDRESS:

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

KIMBERLY PAULINE VAN SCRIVER 4311 SALISBURY RD N JACKSONVILLE, FL 32216

2. CURRENT PRACTICE LOCATION: 1501

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

A WOMAN S PLACE OB/GYN 836 PRUDENTIAL DR STE 1506 JACKSONVILLE, FL 32207

(904) 855-4211

### 3. RENEW ON LINE TODAY!

Go to www.doh-maservices.com and renew your license, change your address, update profile information, 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:

Online Renewal: Visit www.doh-mqaservices.com go to the Practitioner Logon box, select your profession and enter your 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), January 31, 2005. To use the online system, you will need the following information:

Account ID:

Password:

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

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

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

> **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: 64867

Sequence Number: 14

Profession Code: 1501

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



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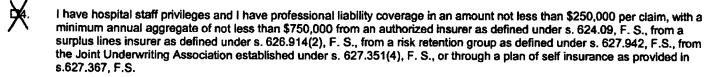
## FINANCIAL RESPONSIBILITY

NAME: Kimbuty P. Van Sonvir LICENSE NUMBER: MG 73993

Financial Responsibility options are divided into two categories, coverage and exemptions. <u>Choose only one option</u> of the ten provided pursuant to s. 458.320, Florida Statutes.

## **OPTION !: FINANCIAL RESPONSIBILITY COVERAGE**

- 1 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 an 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.
- 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.



□5. I have elected not to carry medical malpractice insurance, 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.

## **OPTION II: Financial Responsibility Exemptions**

- ☐1. I practice medicine exclusively as an officer, employee, or agent of the federal government, or of the state or its agencies or subdivisions;
- 1 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 do not practice medicine in the State of Florida;

4. 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 \$25,000 within the previous five-year period;
- (d) I have not been convicted of or pled guilty or noto 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 filling 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)(g) or 459.0085(5)(g), F. S.; or
- 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).

2127	454.00	
12/30/2004		
f Health		
Kimberty van Scriver, VLD., P.A. Department of Health	Compass	



KIMBERIY VAN SCRIVER, MD, PA
OBSTETRICS & GANEGOLOGY OBSTETRICS & GYNECOLOGY

4311 Salisbury Road N ◆ Jacksonville, FL 32216





Department of Health Division of Medical Quality Assurance PO 150% Leize Tallahassee, Fr. 32314-16320

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#### ACOPY STATE OF FLORIDA COPY - NOT A VALID LICENSE - COPY CONTROL NO. **DEPARTMENT OF HEALTH DIVISION OF MEDICAL QUALITY ASSURANCE** DATE LICENSE NO. CONTROL NO. 01/13/2007 ME 73993 211223 LICENSEE SIGNATURE ¥Ċŧ The MEDICAL DOCTOR named below has met all requirements of QUALIFICATION(S): the laws and rules of the state of Florida. #EXT# Expiration Date: JANUARY 31, 2008 KIMBERLY PAULINE VAN SCRIVER DISPENSING PRACTITIONER DEPARTMENT OF HEADIVISION OF MEDICAL STATE OF FLORIDA 4311 SALISBURY RD N JACKSONVILLE, FL 32216

## **COPY - NOT A VALID LICENSE - COPY**

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INTERNIVI OLUMETARI

DISPLAY IF REQUIRED BY LAW

☐ PRACTICE LOCATION ADDRESS CHANGE

**COALIFICATION(S):** 

EXPIRATION DATE: JANUARY 31, 2009
Your license number is MR 73993, 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.

- Go to www.fl heal theouroe.com
   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
- 6. Click on Login

MAIL TO: DEDARTMENT OF HEALTH

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.statefl.us/mqa/avoid.html to find out more

1417-112	DIVISION OF MEDICAL Q		ANCE	(This address will	be printed on your license and post	ed on the internet.)
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TO:	LAST	FIRST	MIDDLE			
DH 2	LAST 103, 5/98	FIRST	MIDDLE	CITY	STATE	ZIP

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



## First Professionals Insurance Company

2007 FEB - 1 Pil 3: 17

January 26, 2007

Mr. Larry McPherson, Exec. Dir. Department of Health, Board of Medicine 3052 Bald Cypress Way, BIN #C-03 Tallahassee, FL 32399-3252

F-61847

Re:

Cancellation of Professional Liability Policy First Professionals Insurance Company, Inc.

Physicians:

KIMBERLY P. VAN SCRIVER, M.D.

Location:

JACKSONVILLE, FL

Florida License Number:

73993

Cancellation Effective:

January 1, 2007

Reason For Cancellation:

**Lower Rates** 

If any additional information is required, please contact Sharon Allen, Policyholder Services.

DPR:1/20/87

# ACOPY STATE OF FLORIDA **DEPARTMENT OF HEALTH DIVISION OF MEDICAL QUALITY ASSURANCE**

01/27/2009	ME 73993	277928
DATE	LICENSE NO.	CONTROL NO.

The MEDICAL DOCTOR

named below has met all requirements of the laws and rules of the state of Florida.

Expiration Date: JANUARY 31, 2011
KIMBERLY PAULINE VAN SCRIVER

A PLACE FOR WOMEN, OBGYN 6817 SOUTHPOINT PKWY STE 2204 JACKSONVILLE, FL 32216

UNITED STATES

QUALIFICATION(S):

DISPENSING PRACTITIONER

CONTROL N DEPARTMENT OF HEALTH DIVISION OF MEDICAL QUALITY ASSURANCE LICENSE NO. DATE

COPY - NOT A VALID LICENSE - COPY

ICENSEE SIGNATURE

## **COPY - NOT A VALID LICENSE - COPY**

GUVERNUR

STATE SUNGEON GENERAL

DISPLAY IF REQUIRED BY LAW

QUALIFICATION(S):

EXPIRATION DATE: JANUARY 31, 2011
Your license number is ME 73993, 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.

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- Go to www.flheal theouroe.com
   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 '1' is number ONE. 6. Click on Login

MAIL TO: DEPARTMENT OF HEALTH DIVISION OF MEDICAL QUALITY ASSURANCE LICENSING AND AUDITING SERVICES UNIT P.O. BOX 6320

TALLAHASSEE, FLORIDA 32314-6320

LJ.	NAME	CHANGE	(ATTACH	LEGAL	DOCUMENTATION)

FROM: LAST MIDDLE FIRST 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

MG 73993UF-Jackson Ville

1. HOSPITAL: University Medical Cfr EMPLOYMENT DATE: 5/1/97	
2. NAME OF HOSPITAL ADMINISTRATOR: W.A. MCGRIFF TIL	
3. NAME OF DIRECTOR OF MEDICAL EDUCATION: ANN HARWOOD- NUSS, MD	
# PHOTO HERS  PHOTO MUST BEEN TAIEN HIN 60 DAYS DENCY DED  11	
REGISTRATION METHOD (CHECK ONLY ONE): REGISTRATION FEES ARE NON-REFUNDABL	E
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REGISTRATION FEE - \$100.00 HOUSE PHYSICIAN RENEWAL REGISTRATION FEE - \$200	
	<b></b> 전화
5. SOCIAL SECURITY NUMBER: APPLICATION SHOULD BE TYPE	
6. NAME: TOWN VALUE VAN SONVEY  (FIRST) (MIDDLE) CL	ASTO
7. MAILING ADDRESS: 6812 Mayhill ct NW Albuqueque NME 8 (No. & Stroot) (Clay)	<u>7</u> 120 ( <b>(24)</b>
8. PLACE OF BIRTH DATE OF BIRTH (Month/Day/	Year)
9. TELEPHONE NUMBER: 505 836 - 2863  Residence-area code/sumber  Office-area code/sumber	aber .
10. MEDICAL DEGREE WAS OBTAINED FROM: Un westly of New Musics 5/94	Dete
11. Are you at least twenty one years of age?  Yes X No	·
12. Have you ever had a license to practice medicine/surgery revoked, suspended or otherwise acted against by the licensing authority of any jurisdiction?  Yes No	
13. Have you ever been denied licensure by the licensing authority in any jurisdiction?  Yes No	<u>×</u> .
14. Have you ever been convicted of a felony or any other crime that relates to the practice of medicine or the ability to practice medicine.  Yes No	<u>X</u>
15. Did you graduate from a medical school or college as specified in s. 458.311(1)(f), F.S.? (check category):  a. an allopathic medical school or allopathic college recognized and approved by an accrediting agency recognized by the United States Office of Education.  b. a foreign medical school which has not been certified by DBPR pursuant to section 458.314, F.S. Yes No c. a foreign medical school which is recognized by the World Health Organization.  Yes No	
16. Are you under investigation in any state or jurisdiction for an act which would constitute the basis for imposing a disciplinary penalty specified in s. 458.331(2)(b), F.S.?  YesNo	<u>×</u> .
OVER N187985 THIS FORM MAY BE DUPLICA	TED

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# ACCOPY

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

DATE	LICENSE NO.	CONTROL NO.
01/08/2011	ME 73993	340946

The MEDICAL DOCTOR

JACKSONVILLE, FL 32216

named below has met all requirements of the laws and rules of the state of Florida.

Expiration Date: JANUARY 31, 2013 KIMBERLY PAULINE VAN SCRIVER A PLACE FOR WOMEN, OBGYN 6817 SOUTHPOINT PKWY STE 2204

QUALIFICATION(S):

DISPENSING PRACTITIONER

LICENSE NO.

CONTROL NO.

**CUALITY ASSURANCE** 

DEPARTMENT OF HE STATE OF FLORIDA

DATE

**\$** 

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ICENSEE SIGNATURE

COPY - NOT A VALID LICENSE - COPY

GUVERNUR

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DISPLAY IF REQUIRED BY LAW

QUALIFICATION(S):

EXPIRATION DATE: JANUARY 31, 2013
Your license number is ME 73993, 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.

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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.flhealthcource.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 a
- 6. If you do not know your account ID and password, click on "Get Login Heip" 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)

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 *******

KIMBERLY PAULINE VAN SCRIVER A PLACE FOR WOMEN, OBGYN 6817 SOUTHPOINT PKWY STE 2204 JACKSONVILLE, FL 32216

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# **COPY - NOT A VALID LICENSE - COPY**

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24900 500 500

## MEDICINE BOARL

# A Jacksonville Womens Health Center Inc.

2010 yay 17 Pil 3: 23

**Protocol for Advanced Registered Nurse Practitioner** 

A Jacksonville Womens Health Center Inc.

4131 University Blvd. S Bldg.2

Jacksonville, FL. 32216

The Advanced Registered Nurse Practitioner may manage health care for clients that have been educated in conjunction with A Jacksonville Womens Health Center Inc. Standards and Guildlines.

**Practice Guidelines:** 

Female Examinations including but not limited to:

Well Woman care, periodic health screenings

Abnormal pap smear:

Treat obvious infections or inflammation with treatment of choice.

Perform colposcopy and cryotherapy services if certified to do so.

Follow-up on repap, colpo, cryo and any further treatment

Follow-up on surgical and non surgical termination of pregnancy:

Pregnancy test, pelvic exam and/ or ultrasound if necessary.

Practitioner may not prescribe or initiate controlled substances. However, ARNP may initiate other measures depending on the client's condition and the judgment of the ARNP and medical director.

The following types of medications may be prescribed as per specific protocol:

Antibiotics

**Antibacterials** 

**Antiseptics** 

**Antifungals** 

Analgesics[®]

**Anticirals** 

Contraceptives

**Biologicals** 

merce of the second

MEDICINE BOARL

2710 may 17 PH 3: 23

**Emergency drugs** 

Hormone Therapy

Vaccinations

Supervison:

All of the above functions may be performed under general supervision.

The Medical Director provides on-site supervision amd is available by telephone during all clinic and off duty hours.

Kim van Scriver, MD 4131 University Blvd. Jacksonville, Fl 32216 herby enters a collaborative practice agreement/management protocol with the Advanced Registered Nurse Practitioner.

Kim van Scriver, MD Medical Director

Dare of signature

Desta Messer, ARNP

License # ARNP1677382

Date of signature

MEDICINE BOARD

## ADVANCED REGISTERED NURSE PRACTITIONER PROTOCOL

2019 voy 17 PH 3: 23

Name: Desta MESSER

Address: 1126 Baisdan Rand Jacksonville, FL 32218

License # ARNP 1677382 Employed by: A Jacksonville Warmens

Halle Oute

Business Address: 4131 University Blvd, Jany FL 32216

IRNP signature: W. JODEL KRAP

ADVANCED REGISTERED NURSE PRACTITIONER PROTOCOL

MEDICINE BOARD

2010 may 17 Pil 3: 23

Name: Dista MESSER

Address: 1126 Baisdaw Rand Acksonville, FL 32218

License #: ARNP 1677382 Employed by: A Jacksonville Womens

Thank Oute

Business Address: 431 University Blud, Jay 32 320 6

ARNP signature: W JODGLARD

# AC# COPY

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

DATE	LICENSE NO.	CONTROL NO.
01/17/2013	ME 73993	414788

The MEDICAL DOCTOR

JACKSONVILLE, FL 32216

named below has met all requirements of the laws and rules of the state of Florida.

Expiration Date JANUARY 31, 2015 KIMBERLY PAULINE VAN SCRIVER A PLACE FOR WOMEN, OBGYN 6817 SOUTHPOINT PKWY STE 2204

QUALIFICATION(\$): DISPENSING PRACTITIONER QUALITY ASSURANCE LICENSE NO.

CONTROL NO.

COPY - NOT A VALID LICENSE - COPY

**COPY - NOT A VALID LICENSE - COPY** 

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STATE GUINGLUIN GENENAL

DISPLAY IF REQUIRED BY LAW

QUALIFICATION(B): Dispensing Practitioner

Your license number is ME 73993, 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.

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- 1. Go to www.fihealthsource.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 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		

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

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

KIMBERLY PAULINE VAN SCRIVER A PLACE FOR WOMEN, OBGYN 6817 SOUTHPOINT PKWY STE 2204 JACKSONVILLE, FL 32216

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## American Medical Association

Physicians dedicated to the health of America



RECEIVED

JUN 1 2 1997

## Physician Profile Service

515 North State Street Chicago, Illinois 60610

Division of Survey and Data Resources Department of Data Services

Name and Address:

KIMBERLY P VAN SCRIVER MD

1416 SW 90TH ST

OKLAHOMA CITY OK 73159 USA

Phone: UNKNOWN Birthdate: 07/18/1965

Birthplace: LONG BEACH CA USA

Address shown has been reported undeliverable

Physician's Major Professional Activity: RESIDENT

Self Designated Practice Specialties (SDPS):

Frimary:

OBSTETRICS AND GYNECOLOGY

Secondary:

UNSPECIFIED

AMA membership: NOT A MEMBER

Following Data Provided by the Primary Sources -

UNIV OF NM SCH OF MED, ALBUQUERQUE NM 87131 (VERIFIED)

Year of Graduation: 1994 (VERIFIED)

Current and/or Prior Medicat Training or Fellowship:

Institution: UNIVERSITY HOSP

State: NEW MEXICO

RESIDENT

(VERIFIED)

Specialty: OBSTETRICS AND GYNECOLOGY

07/1995 - 06/1998

Institution: UNIV OF OK COLL OF MED

State: OKLAHOMA

RESIDENT

(VERIFIED)

Specialty: FAMILY PRACTICE

07/1994 - 06/1995 V

Additional information, used for appointment sts and privileges, is not solicited, nor is it received from the residency program directors. If additional information is required, please contact the program directoris).

National Board Certification Year:

NONE REPORTED TO DATE

AMA Files Checked 6/8/97 09:41:15

Profile for: Kimberly P Van Scriver MD © 1997 by the American Medical Association

Page 1 of 2

## American Medical Association

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### Physician Profile Service

515 North State Street Chicago, Illinois 60610 Division of Survey and Data Resources Department of Data Services

License(s):

MD/

Date Expiration Granted Date

Status

License

Type

As of

State

When the specific month and day are naknown, the date will display the default value of "01," Not all licensing beards maintain or provide full date values. A blank expiration date indicates that the data is not provided to AMA by the licensing board. Please contact the appropriate licensing board. directly for this information.

NONE REPORTED TO DATE

#### Federal Drug Enforcement Administration:

TO DATE, FEGGRAL DEA REGISTRATION STATUS IS UNKNOWN.

Note: Many states require then—we controlled substances registration/license.

Please chuck with your state licensing authority as the AMA does not maintain this information.

## Specialty Board Certification(s):

Specialty Board Certification(s) by one or more of the 24 boards recognized by the American Board of Medical Specialties (ABMS) and the American Medical Association (AMA) through the Liaison Committee on Specialty Boards, as reported by the ABMS:

## Primary Board: NONE REPORTED TO DATE

Effective:

Subcertification or Certificate of Special Competence: NONE REPORTED TO DATE

Effective:

Expires:

For certification dates, a default value of "01" appears in the month field if data was not provided to AMA. Please contact the appropriate specialty board directly for this information.

## Medicare/Medicaid Sanction(s):

TO DATE, THERE HAVE BEEN NO SUCH SANCTIONS REPORTED TO THE AMA BY HCFA.

## Other Federal Sanction(s):

TO DATE, THERE HAVE BEEN NO FEDERAL SANCTIONS REPORTED TO THE AMA BY ANY BRANCH OF THE US MILITARY, THE VETERAN'S ADMINSTRATION OR THE US PUF! IC HEALTH SERVICE.

The content of the Physician Profile is intended as an instrument to social with credentiality. Appropriate use of the Physician Masterfile data cretained on this profile by an organization would meet the primary source verification requirements of the Joint Connection on Accreditation of Residence Organizations and the Utilization Review Accreditation Commission. The Physician Masterfile meets the National Committee for Quality Assurance Standards for verification of medical education, residency training and board certification.

If you note any discrepancies, please mark them on a copy of the profile and return to: American Mealch." Association Department of Data Services, 518 N. State Street, Chicago, II 40610.

AMA Files Checked 6/8/97 09:41:15

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Page 2 of 2

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UNIV OF NM SCH OF M



# MANDATORY PRACTITIONER PROFILE QUESTIONNAIRE

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

١.	PRACTITIONER DA	<b>NTA</b>					
۹.	PROFESSIONAL LICENSE N	UMBER: ME00739	993	(check one)	ME/MD OS	/DO 🗅 CH/DO	PO/DPM
3.	NAME (INCLUDE MAIDEN A	AND ON 2ND/3RD LI	PPLICABLE):				
	VAN SCRIVER		KIMBERLY	PAULIN	F		
	(LAST)		(FIRST)		ND MAIDEN NAME, IF	APPLICABLE)	
	FORMER NAME(S):						
	None						
	(LAST)		(FIRST)		(MIDDL	.E)	
	NONE						
	(LAST)		(FIRST)		(MIDDI	LE)	
C.	SOCIAL SECURITY NUMBE	R:	(Thi	is will not be published as a part o	of the profile; also	o, see instructio	ns on page iii)
D.	MAILING		ONVILLE EL COCCE	UDAS Rolford	RX SI	. am	í
	ADDRESS:	(STREET AND	NUMBER)	4205 Belfort	ELACINATE	200	ZIP CODE)
	PRIMARY PRACTICE ADDR	RESS: (Authority: s.455.	565(1)(a)3.,F.S.)	oscionio ilic,		Y Cara	6
ιί	Domens Medic	ral Groun	JOA YOUR	Rolfort Rd S	30 20	M	
~	(PRACTICE NAME)	(STREET AND	NUMBER)	Belfort Rd. S CSONUIMP, Flo	SIAC (STATE	2216	(ZIP CODE)
	OTHER PRACTICE LOCATION OFFICE 2: (OPTIONAL)	ON(S): (OPTIONAL)	340			2 mm. ( 10	
	4040-15-THEOVERTOR	THORNON MALLS		)OP			
	(PRACTICE NAME)	(STREET AND		(CITY)	(STATE	•)	(ZIP CODE)
	OFFICE 3: (OPTIONAL)						
		None				·····	
	(PRACTICE NAME)	(STREET AND	•	(CITY)	(STATE	<b>E</b> )	(ZIP CODE)
	,—————————————————————————————————————	<u> 396-320</u>		will not be published as a part of	the profile.)		
F.	YEAR BEGAN PRACTICING	MEDICINE: 199	(Authority: s. 4	455.565(1)(a)5., F.S.)			
	I. ALL MEDICAL EI	DUCATION					
A	. Name of all medical school	ls attended. (Authority:	s. 455.565(1)(a)1., F.S.)				
	AME OF SCHOOL/UNIVERSIT			DATES OF	DATE OF		TYPE OF
				ATTENDANCE	GRADUATION		DEGREE
	UNIV OF NM SCH OF	MED, ALBUQU	<u>JE</u>	1992-1994	1994		M.D.
	New York 1	nedial ?	school	1989-1992	1992		none
В	Have you completed any g if "YES", list in chronologi to meet the continuing edu	cal order from date o	of graduation to the prese	ent, <u>all</u> completed graduate medica	al education. Do	not include cou	ırsework taken
Γ	MEDICAL TRAINING PROGRAM NAME	INTERNSHIP / RESIDENCY / FELLOWSHIP / OTHER	SI	PECIALTY AREA	CITY / STATE / COUNTRY	FROM MM/OD/YYYY	TO MM/DD/YYYY
T	UNIV OF FL COLL OF	RES	OBSTETRICS AND GYN	ECOLOGY	FL.	5/1/97	6/30/98
}_						<b></b>	· ·

FAMILY PRACTICE

**OBSTETRICS AND GYNECOLOGY** 

RES

RES

06/30/1995

04/30/1997

OK

NM

07/01/1994

07/01/1995

Have you had the—spor by for graduate medical education within the last 10 years? (Authority: a. 455.565.(1)(496, ES.)  Do you currently Id a H_L_by appointment at a medical/health related institution of higher learning? (Authority: a. 455.565.(1)(496, ES.)  Yes   No   Yes   No   Yes   No   Yes   No   Yes   No   No   Yes   Yes   No   No   Yes   Yes   No   No   Yes   Yes   Yes   No   No   Yes	actitioner's Name	(IMEEFLY	PAULINE VAN	SCRIVER		License # _	ME0073993	
If "YES", Ist all I — Idea   sestional schools from which a degree in a health related profession other than the professional degree was obtained.  MANE OF SCHOOL	I. OTHER H	ALT SE	LATED DEGI	REES				
No							7.5	
### AMORPHY ### AM			sional schools from	i which a degree in a	health related profession (	other than the profession	al degree was obtained	•
FACULTY   PP	NAME OF SCHOO	U <b>NIV</b> EETY	1	CITY / STATE / COUNTRY			DEGREE TITLE	
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SPECIALT   BU   CERTIFICATIONS:			- 1	mer	<u> </u>	ionville, F	which a!	
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Within the previou en ( rears, have you ever had any final disciplinary action taken against you by a specialty board recognized by the neric alloard of Medical Specialties, the American Osteopathic Association, the American Chiropractic recognized by the neric association, or other interest of the final disciplinary action (Authority: s. 455.565(1)(a)8. F.S.)  If "YES", list name of disciplinary action and peal. (attach copy of notice of appeal)  DATE DESCRIPTION OF VIOLATION DESCRIPTION OF FINAL DISCIPLINARY ACTION PARALLY NOTICE (Authority: s. 455.565(1)(a)8. F.S.)  Within the previou your license, in thi tate in yother jurisdiction? (Authority: s. 455.565(1)(a)8. F.S.)  If "YES", list name of a ry(s), date, description of violation(s), description of the final disciplinary action(s), and indicate whether the final disciplinary action to the final disciplinary action(s), and indicate whether the final disciplinary action of the final disciplinary action(s), and indicate whether the final disciplinary action(s), and indicate whether the final disciplinary action(s), and indicate whether the final disciplinary action(s) and indicate whether the final disciplinary action of the final disciplinary action(s) and indicate whether the final disciplinary action of a rearrange of a rearr								
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	ctitioner's Name KIMBERLY PAULINE VA				License # ME007	3993	
3.	Within the previous ten (10) years, have you ever health maintenance organization, prepaid health cl	had any final d	isciplinary action taken a	against you by a lic	ensed hospital,	Yes 🖵	N. No.
	If "YES", list name(s) of medical institution(s), dat	te, description (	of violation(s), description	-			
	final disciplinary action is under appeal. (attach co	py of notice of	appeal)	or are mar areas	piniary ababil(o), and mor	oato wholhor	THO
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							Y/N
				*****			
	Within the previous ten (10) years, have you ever restricted or not renewed by <u>any</u> medical/health-re to competence or character? (Authority: s. 455.565(1)(	elated institutio	or allowed to resign from n in lieu of or in settleme	n or had any medic ent of a pending di	cal staff privileges sciplinary action related	Yes 🗖	No
	If "YES", list name(s) of the facility(s), date, descridisciplinary action is under appeal. (attach copy of	ription of violati f notice of appe	ions, description of the f eal)	inal disciplinary ac	tion(s), and indicate whet	her the final	
	INSTITUTION NAME	DATE	DESCRIPTION OF VIOLATION	N	DESCRIPTION OF ACTION		UNDER Appeal?
			****		A	×	V/N
							Y/N
1	II. CRIMINAL OFFENSES  We you ever been convicted or found guilty, regardly contendere to a criminal misdemeanor or felony.  If "YES", briefly describe the offense(s), indicate was presented to the offense of the offense.	whether the cor	nviction is under appeal, DATE	and attach copy of JURISDICTION	f notice of appeal.	Yes 🗖	UNDER APPEAL?
i\	re you ever been convicted or found guilty, regardle contendere to a criminal misdemeanor or felony If "YES", briefly describe the offense(s), indicate was DESCRIPTION OF OFFENSE	whether the cor	DATE	and attach copy of JURISDICTION	f notice of appeal.		UNDER APPEAL? Y / N Y / N
3\ ) :	re you ever been convicted or found guilty, regardle contendere to a criminal misdemeanor or felony of "YES", briefly describe the offense(s), indicate we description of offense	whether the cor	nviction is under appeal,  DATE	and attach copy of JURISDICTION	f notice of appeal.		UNDER APPEAL? Y / N Y / N Y / N
3\	re you ever been convicted or found guilty, regardle contendere to a criminal misdemeanor or felony of "YES", briefly describe the offense(s), indicate we description of offense	whether the cor	nviction is under appeal,  DATE	and attach copy of JURISDICTION	f notice of appeal.		UNDER APPEAL? Y / N Y / N Y / N
avol.	re you ever been convicted or found guilty, regardly contendere to a criminal misdemeanor or felony of "YES", briefly describe the offense(s), indicate we description of offense  STATEMENT OF FINANCIAL RESEMBLY Privileges - (Check only one) (Authority solution of the privileges and I have the privileges	SPONSIBII s. 455.5651(4), ve obtained and	DATE  DATE  DATE  LITY (Allopathic, F.S.)	and attach copy of JURISDICTION  3 and Ustro iability coverage in	notice of appeal.  pathic Physician  an Mount not less than	ns <b>Only)</b> \$100.000 pe	UNDER APPEAL? Y / N Y / N Y / N
	If "YES", briefly describe the offense(s), indicate was DESCRIPTION OF OFFENSE  STATEMENT OF FINANCIAL REST Hospital Privileges - (Check only one) (Authority so the aminimum annual aggregate of not less than defined under s. 626.914(2), F.S., from a risk reter s. 627.351(4), F. S., or through a plan of self-insur as outlined above for the past two years (retroactic coverage for the two years preceding my inception uninsured and meet the financial responsibility requirements which may have occurred during the two years preceding my inception uninsured and meet the financial responsibility requirements of the past two years preceding my inception uninsured and meet the financial responsibility requirements of the two years preceding my inception date of control of the past two years (retroactive coverage for the two years preceding my inception date of control of the past two years (retroactive coverage) for the two years preceding my inception date of control of the past two years (retroactive coverage) for the two years preceding my inception date of control of the past two years (retroactive coverage) for the two years preceding my inception date of control of the past two years (retroactive coverage) for the two years preceding my inception date of control of the past two years (retroactive coverage) for the two years preceding my inception date of control of the past two years (retroactive coverage) for the two years preceding my inception date of control of the past two years (retroactive coverage) for the two years preceding my inception date of control of the past two years (retroactive coverage) for the two years preceding my inception date of control of the past two years (retroactive coverage) for the two years preceding my inception date of control of the past two years (retroactive coverage) for the two years preceding my inception date of control of the past two years (retroactive coverage) for the two years preceding my inception date of control of the past two years (retroactive two years precedin	sponsible of the core of the c	DATE  LITY (Allopathit, F.S.)  d maintain professional law an authorized insurer defined under s. 627.942 ed in s. 627.967, F.S. I for if I seek insurance from age. I further certify that ugh other provisions in second under s. 627.942, F.S., from the 67, F.S. I further certify that in the every provisions in s. 458.32 g uninsured.  an irrevocable letter of ce. 625.52, F. S., for an escriptive that in the every provisions in s. 458.32 g uninsured.  an irrevocable letter of ce. 625.52, F. S., for an escriptive that in the every provisions in s. 458.32 g uninsured.  an irrevocable letter of ce. 625.52, F. S., for an escriptive that in the every provisions in s. 458.32 g uninsured.	iability coverage in as defined under s 2, F.S., from the Join the event my coverage in the event my coverage in the event my coverage in the event my coverage is 10 or 459.00	pathic Physicial an amount not less than 824.09, F. S., from a sur nt Underwriting Association have been continuously in providing insurance, I will verage is terminated or that 085, F.S., I will maintain construction of the part of t	\$100,000 perplus lines insone establishers to be a minimum as defined at least to become under s. 627 an entity as retroactive of the second o	under APPEAL? Y / N Y / N Y / N Y / N Y / N Y / N Y / N An entity roactiv becom ncident annua under s .351(4) outline overag ninsure ts whic 800,000 0,000, i
	The you ever been convicted or found guilty, regardly contendere to a criminal misdemeanor or felony of the past two years preceding my inception date of the with a minimum annual aggregate of not less that defined under s. 626.914(2), F.S., from a risk reter s. 627.351(4), F.S., or through a plan of self-insur as outlined above for the past two years (retroactic coverage for the two years preceding my inception uninsured and meet the financial responsibility required under shape the financial responsibility required uninsured and meet the financial responsibility required uninsured and meet the financial responsibility required uninsured and meet the financial responsibility required to the two years preceding my inception date of can be self-insurance as proving the two years preceding my inception date of the two yea	s. 455.5651(4), we obtained and \$300,000 from tion group as rance as providing my be ofessional liabilithorized insurferined under seeding my be ofessional liabilithorized insurferined under seeding my becoming the seeding my becoming the setablished of credit and setablished and credit and setablished and credit and setablished and that I medical setablished and the setablished a	DATE  LITY (Allopathic, F.S.)  d maintain professional land and authorized insurer defined under s. 627.942 ed in s. 627.367, F.S. I for if I seek insurance from age. I further certify that ugh other provisions in seconing uninsured. illity coverage in an amarer as defined under s. 627.942, F.S., from the 67, F.S. I further certify that in the every provisions in s. 458.32 g uninsured. an irrevocable letter of c. 625.52, F. S., for an escire-vocable letter of cre irrevocable letter	iability coverage in as defined under s. F.S., from the Join the event my coverage in the event my coverage in the event my coverage is that I have been coverage is coverage is coverage is coverage is coverage is coverage is coverage in the coverage is coverage is coverage in the c	an amount not less than a 24.09, F. S., from a sur not Underwriting Association been continuously in providing insurance, I will verage is terminated or the 085, F.S., I will maintain co \$250,000 per claim, with a surplus lines insurer a Association established ontinuously insured with insurance I will purchase canceled or that I desire to i., I will maintain coverage account in an amount of punt in an amount of \$2 up to the minimum amon" prominently displayed led not to carry medical medi	\$100,000 per plus lines in purchase retat I desire to overage for in a minimum as defined at entity as retroactive con become under s. 627 an entity as retroactive con become une for incident \$100,000/\$250,000/\$750 punts pursua in the recept	under APPEAL? Y / N Y / N Y / N Y / N Y / N Y / N Y / N An entity become neident annua under s .351(4) ootline overag ninsure ts whic 800,000 0,000, i ant to se
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Practitioner's Name	KINTERLY PAULINE VAN SCRIVER	License #	ME0073993
(b) I am retired c= (c) I have had nc (d) I have not be= (e) I have not be= fine of \$500 c= of a relinquist- against a licer- notice in the being provide	tive se to practice in this state or another state paint and time practice of no more than 1000 papers wo claims resulting in an indemnity exception of or pled guilty or nolo contendere to an within the past ten years of practice, to lice that of the past ten years of practice, to lice that of the past ten years of practice, to lice that of the past ten years of practice, to lice that of the past ten years of practice, to lice that of the past ten years of practice, to lice that of the past ten years of practice, to lice that of the past ten years of practice, to lice that of the past ten years of practice, to lice that of the past ten years of practice, to lice that of the past ten years of practice, to lice that of the past ten years of practice, to lice that of the past ten years of practice, to lice that of the past ten years of practice, to lice that of the past ten years of practice, to lice that of the past ten years of practice, to lice that of the past ten years of practice, to lice that of the past ten years of practice, to lice that of the past ten years of practice, to lice that of the past ten years of practice, to lice that of the past ten years of practice, to lice that of the past ten years of practice, to lice that of the past ten years of practice, to lice that of the past ten years of practice, to lice that of the past ten years of practice, the past ten years of p	te or some combination thereof for more than 15 ye atient contact flours per year; eding \$16,000 within the previous five year period; ny criminal violation specified in Chapter 458 or 459 are revocation or suspension, probation for a perio the medical practice act of another jurisdiction. A natiement offered in response to or in anticipation of the medical practice act of another jurisdiction of the medical practice act of another jurisdiction. A natiement offered in response to or in anticipation of the medical practice act of another jurisdiction. A naticipation of the medical practice act of another jurisdiction.	e, F. S.; and d of three years or longer, or a egulatory agency's acceptance iling of administrative charges section that I must either post to show medical services are
X. LIABILITY	All (Allopathic, Osteopathic	and Pediatric Physicians Only)	NIA
A. Are you covered (Authority: s. 455.5651	n in required to report pursuant to s. 627.912 F.S.; 63565(1)(b),F.S.)	2 F.S.	Yes 🗆 No 🗅
B. Have you been ins	ed cill bously during the last ten years?		Yes 🗀 No 🖸
(Authority: s. 455,5651 If you answered "	F.S.; = 585(1)(b),F.S.) to = 1 if A or B above, you <u>must</u> complete the fol	llowing: (Authority: s. 455.5651(4), F.S.; s. 455.5651(1)(b),F.S.)	
Within the previou- finally adjudicated	en y shave you had a liability claim or action for an a nt that exceeds \$5,000?		Yes 🔲 No 🗀
If "YES", complete questionnaire to s		. NOTE: Copies of reports previously submitted ma	y be re-submitted with this
XI. LIABILITY	Al Chiropractic Physicians		
Within the previou	en ve sehave vou had a liability claim or action to	damages for personal injury settled or finally adjud	licated in Yes 🗆 No 🖸
an amount that ex If "YES", complet∈	ds ឤ 10? Id at ::::ra copy of EXHIBIT 1 for each occurrence.	. (Authority: s. 455.5651(4), F.S.; s. 455.565(1)(b),F.S.)	
XII. OPTIONAL	VF ATION:		
A. PUBLICATIONS: 1 (Authority s. 455.565(5		ved medical literature within the previous ten years:	
TITLE	PUBLI	ICATION DATE	
1None= 2			
3			
	EIN EMEDICAID PROGRAM? (Authority s. 455.5656	(5)(d), F.S.)	Yes No 🗖
C. PROFESSIONAL O COMMUNITY SERVICE/	COM JATY SERVICE ACTIVITIES, HONORS, OR A	AWARDS: (Authority s.455.565(5)(b), F.S.) COMMUNITY SERVICE/AWARD/HONOR	ORGANIZATION
1. None	- On a state of the state of th	2	Undanization
3.		4	,
ORGANIZATION	DCAL PUNTY, PROFESSIONAL AFFILIATIONS: (AI	•	1
1. Dewal Con	ty redical society		R 08/64N
•		4	al any funcional attack and a second
available for patien	at ycmarry place of practice. (Authority: s. 455.56	nglish used by you to communicate with patients ar 65(5)(c), F.S.)	
3	)	24	
F. E-MAIL ADDRESS:			
G. COMMITTEES/MEI			
	ERS	serve for any health entity with which you are affiliat	ed.
1	>	2	
1. NOT	2	2	
1. STATE LICE STATE LICE	SURE	2	
1. DOC  3. H. OTHER STATE LICE STATE  1. DOC	SURE	2	
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1. OTHER STATE LICE STATE  1. OOC 2. 3.	SURE	2	

License #	ME0073993
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# EXHIBIT 1 - REPORT ON PROFESSIONAL LIABILITY CLAIMS AND ACTIONS

must submit	nation relating to I a completed form of s. 455.697, F.S	for each occu	rrence. For Allopa	athic, Osteopat	hic and Podiatric	physicians, con	ies of reports pre	eviously submit	i.697 F.S. You ted under the
	rence: / _								
Injured perso	n's name: (last, fir	rst, middle initi	al)						
Street Addres	s:								
Cny: Age:	Sex:				**************************************	State:	Zip Cod	e:	
-	//								
	endants involved i	in this claim:							
_					2,				
	claim disposition:				4,	/	***************************************		
	itemized verdict?			tach copy of se	ttlement vergict)				
Indemnity pa Loss adjustm	id on behalf of this ent expense paid adjustment exper	s defendant: to defense cou	\$						
Name of insti	tution at which the njury occurrence: Room g Suite	e injury occurr f r	ed: Physical Therapy Jursery Critical Care Unit			y cy Room	\$	abor & Delivery pecial Procedur	
Final diagnos	is for which treatr		,						
Describe the	diagnosis made, i operation, diagno , or name of drug	stic or treatme	procedure caus	sing the injury.	Use nomenclatu	re and/or descri	ptions of the proc	edures used. Ir	nclude method
	principal injury g		e claim. Use non	nenclature and	or descriptions	of the injury. Inc	clude type of adv	erse effect fron	drugs where
Safety mana	gement steps take	n by the licens	ee to make simila	r occurrences	less likely				
penalties pur	these statements a								
Signature of	Physician:		<del>/</del>			7~(" ( )			
Our records	indicate the follow	ving reported c	aims:						
Incident Date	Settlement Date	Incident Date	Settlement Date	Incident Date	Settlement Date	Incident Date	Settlement Date	Incident Date	Settlement Date
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PINISION OF MEDICAL DUANTY ASSURANCE Tallahassee, Florida 32314-6330

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PRESORTED
FIRST-CLASS MAIL
U.S. POSTAGE PAID
FLORIDA DEPARTMENT OF HEALTH
84321

***SNGLP***

TO: KIMBERLY PAULINE VAN SCRIVER 4319 LANDOVER DR JACKSONVILLE FL 32207 THE RESIDENCE OF THE PARTY OF T

The mission of the Department of Health is to promote and protect the health and safety of all Floridians.

FLORIDA DEPARTMENT

Jeb Bush Governor

October 15, 1999

Robert G. Brooks, M.D. Secretary

KIMBERLY P VAN SCRIVER, M.D. 4205 BELFORT RD STE 2004 JACKSONVILLE, FL-32216

# Dear Dr. VAN SCRIVER

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: 73993

License Status

: ACTIVE CLEAR

Profession

: Medical Doctor

Year Began Practicing : 01/01/1997

# **Primary Business:**

**WOMENS MEDICAL GROUP PA** 4205 BELFORT RD STE 2004 JACKSONVILLE FL 32216

Secondary Locations:

# Staff Privileges:

Institution Name MEMORIAL HOSPITAL JACKSONVILLE ST. LUKE'S HOSPITAL **BAPTIST MEDICAL CENTER** 

City

State

**JACKSONVILLE JACKSONVILLE**  **FLORIDA** 

**JACKSONVILLE** 

**FLORIDA 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:

2020 Capital Circle SE, BIN # C-10 . Tallahassee, FL 32399-3260



# II. Education and Training

Medical School: Dates of Attendance: Graduation Date: Degree Title

# The parctitioner failed to provide this mandatory information

# 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 OF FLORIDA COLLEGE OF MEDICINE : RESIDENCY : OBG OBSTETRICS AND GYNECOLOGY : ...... : FLORIDA : 5/1/97 6/30/98
- 2. UNIVERSITY OF OKLAHOMA COLL OF MED: RESIDENCY: FP FAMILY PRACTICE: .....: OKLAHOMA: 7/1/94 6/30/95
- 3. UNIVERSITY OF NEW MEXICO SCH OF MED: RESIDENCY: OBG OBSTETRICS AND GYNECOLOGY: ...........: NEW MEXICO: 7/1/95 4/30/97

# IV. Specialty

This practitioner does not hold any certifications from specialty boards recognized by the Florida board which regulates the profession for which he/she is licensed.

# 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.

# Professional or Community Service Awards

This practitioner has not provided any professional or community service activities, honors, or awards.

### **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 provided the following national, state, local, county, or professional affiliations: 1. DUVAL CO. MED. SOC., AMER. COLL. OF OB/GYN, AMA

# E-Mail Address

Not Provided

# Other State Licensure

This practitioner has not indicated any additional state licensure.

# VI. Financial Responsibility

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

# 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.

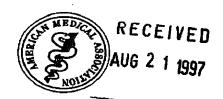
Sincerely.

**Bureau of Operations** 



# **American Medical Association**

Physicians dedicated to the health of America



# Physician Profile Service

515 North State Street Chicago, Illinois 60610 Division of Survey and Data Resources Department of Data Services

Name and Address:

KIMBERLY P VAN SCRIVER MD 5501 AUBURN RD APT A

JACKSONVILLE FL 32207 USA

Phone: UNKNOWN Birthdate: 07/18/1965

Birthplace: LONG BEACH CA USA

Physician's Major Professional Activity: RESIDENT

Self Designated Practice Specialties (SDPS):

Primary:

**OBSTETRICS AND GYNECOLOGY** 

Secondary:

UNSPECIFIED

AMA membership: NOT A MEMBER

Following Data Provided by the Primary Sources -

Medical School:

UNIV OF NM SCH OF MED, ALBUQUERQUE NM 87131 (VERIFIED)

Year of Graduation: 1994 (VERIFIED)

Current and/or Prior Medical Training or Fellowship:

Institution: UNIVERSITY HOSP

State: NEW MEXICO

RESIDENT

(VERIFIED)

Specialty: OBSTETRICS AND GYNECOLOGY

07/1995 - 05/1997

Institution:

UNIV OF OK COLL OF MED

State: OKLAHOMA

RESIDENT

(VERIFIED)

Specialty: FAMILY PRACTICE

07/1994 - 06/1995

Note:

Additional information, used for appointments and privileges, is not solicited, nor is it received from the residency program directors. If additional information is required, please contact the

program director(s).

National Board Certification Year:

NONE REPORTED TO DATE

AMA Files Checked 8/9/97 17:32:33

Profile for: Kimberly P Van Scriver MD © 1997 by the American Medical Association

Page 1 of 3

# 73993

# **American Medical Association**

Physicians dedicated to the health of America



# Physician Profile Service

515 North State Street Chicago, Illinois 60610 Division of Survey and Data Resources Department of Data Services

License(s):

MD/ DO

Date Granted Expiration Date

Status

License Type

As of

Note:

State

When the specific month and day are unknown, the date will display the default value of "OL." Not all licensing boards maintain or provide full date values. A blank expiration date indicates that the data is not provided to AMA by the licensing hoard. Please contact the appropriate licensing board directly for this information.

NONE REPORTED TO DATE

Federal Drug Enforcement Administration:

TO DATE, FEDERAL DEA REGISTRATION STATUS IS UNKNOWN.

Many states require their own controlled substances registration/license. Note:

Please check with your state licensing authority as the AMA does not maintain this information.

Specialty Board Certification(s):

Specialty Board Certification(s) by one or more of the 24 boards recognized by the American Board of Medical Specialties (ABMS) and the American Medical Association (AMA) through the Liaison Committee on Specialty Boards, as reported by the ABMS:

Primary Board: NONE REPORTED TO DATE

Effective:

Expires:

Subcertification or Certificate of Special Competence: NONE REPORTED TO DATE

Effective:

Expires:

Note:

For certification dates, a default value of "01" appears in the month field if data was not provided to AMA. Please contact the appropriate specialty board directly for this information.

Medicare/Medicaid Sanction(s):

TO DATE, THERE HAVE BEEN NO SUCH SANCTIONS REPORTED TO THE AMA BY HCFA.

Other Federal Sanction(s):

TO DATE, THERE HAVE BEEN NO FEDERAL SANCTIONS REPORTED TO THE AMA BY ANY BRANCH OF THE US MILITARY, THE VETERAN'S ADMINSTRATION OR THE US PUBLIC HEALTH SERVICE.

# 73993

# **American Medical Association**

Physicians dedicated to the health of America



# Physician Profile Service

515 North State Street Chicago, Illinois 60610 Division of Survey and Data Resources Department of Data Services

# Additional Information:

TO DATE, THERE IS NO ADDITIONAL INFORMATION FOR THIS PHYSICIAN ON FILE.

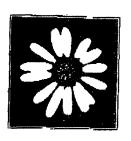
The content of the Physician Profile is intended as an instrument to assist with credentialing. Appropriate use of the Physician Masterfile data contained on this profile by an organization would meet the primary source verification requirements of the Joint Commission on Accreditation of Heulthcare Organizations and the Utilization Review Accreditation Commission. The Physician Masterfile meets the National Committee for Quality Assurance Standards for verification of medical education, residency training and board certification.

If you note any discrepancies, please mark them on a copy of the profile and return to: American Medical Association Department of Data Services, 515 N. State Street, Chicago, II 60610.

# KIMBERLY VAN SCRIVER, M.D., P.A.

FACSIMIL	E TRANSMITTAL SHEET
Tanya @ DOH	FROM: Kimberly van Scriver, M.D.
FAX NUMBER: 850 - 487 - 3284	DATE: 10 16 10 1-
COMPANY:	TOTAL NO. OF PAGES INCLUDING COVER:
PHONE NUMBER: 850 - 488 -0595	SENDER'S REFERENCE NUMBER:
RE:	YOUR REFERENCE NUMBER:
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This document is intended only for the use of the person to whom it is addressed. It may contain information that is privileged, confidential, and exempt from disclosure under applicable law. If you are not the intended recipient, any dissemination, distribution, coping, or use of this document is strictly prohibited. If you have received this communication in error, please notify us by telephone to arrange for the destruction or return of the original document to us.



# KIMBERLY VAN SCRIVER, MD, PA

**OBSTETRICS & GYNECOLOGY** 

Department of Health 4052 Bald Cypress Way, Bin C10 Tallahassee, FI. 32399-3260

October 6, 2005

Re: Update of Staff Privileges

Dear Sir or Madam:

I would like to update my Health Care Provider Information. Under the section entitled Staff Privileges, I am currently listed as having current privileges with Baptist Medical Center, Jacksonville, Florida. As of June 2002, I voluntarily resigned my privileges for one year as a result of disciplinary action. I am currently reapplying to Baptist Medical Center, Jacksonville, Florida, however in order to complete my application process I was instructed to update my Health Care Provider Information. I do currently hold privileges at St. Luke's Hospital, Jacksonville, Florida and Memorial Hospital, Jacksonville, Florida.

If further information is needed, I may be contacted at 904-855-4211 or 904-891-2802. Thank you for your attention to this matter.

Sincerely yours,

Kimberly P. van Scriver, MD

vca

# Florida Department of Health - Board of Medicine

# LICENSE RENEWAL NOTICE

Active Medical Doctor License # ME 73993 expires January 31, 2005.

The fee of \$454.00 and the renewal notice must be postmarked on or before January 31, 2005. Bato Number: 009442 Renewal notices postmarked on or after February 1, 2005 require a renewal fee of \$839.00.

Received Date: 1/4/05 Deposit Date: 1/4/05 Deposit #: 167301

Validation # : 904067838

Check Amount: \$454.00

1. CURRENT MAILING ADDRESS:

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

KIMBERLY PAULINE VAN SCRIVER 4311 SALISBURY RD N JACKSONVILLE, FL 32216

2. CURRENT PRACTICE LOCATION: 1501

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

A WOMAN S PLACE OB/GYN 836 PRUDENTIAL DR STE 1506 JACKSONVILLE, FL 32207

(904) 855-4211

3. RENEW ON LINE TODAY!

Go to www.doh-mqaservices.com and renew your license, change your address, update profile information, 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:

Online Renewal: Visit www.doh-mqaservices.com go to the Practitioner Logon box, select your profession and enter your 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), January 31, 2005. To use the online system, you will need the following information:

Account ID:

Password:

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

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

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

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

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

File Number: 64867

Sequence Number: 14

Profession Code: 1501

20

20

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



# **FINANCIAL RESPONSIBILITY**

NAM	E: LICENSE NUMBER:
	icial Responsibility options are divided into two categories, coverage and exemptions. <u>Choose one option</u> of the ten provided pursuant to s. 458.320, Florida Statutes.
OPTI	ON I: FINANCIAL RESPONSIBILITY COVERAGE
<b>□1.</b> (	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 an 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 selfinsurance as provided in s. 627.367, F.S
<b>□</b> 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.
<b>□</b> 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 459.0085(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.
OPTIC	ON II: Financial Responsibility Exemptions
<b>D</b> 1.	I practice medicine exclusively as an officer, employee, or agent of the federal government, or of the state or its agencies or subdivisions;
<b>□</b> 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;
<b>□</b> 3. ′	I do not practice medicine in the State of Florida;
<b>□</b> 4.	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 \$25,000 within the previous five-year period;  (d) I have not been convicted of or pled guilty or note 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)(g) or 459.0085(5)(g), F. S.; or

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).

□5.1

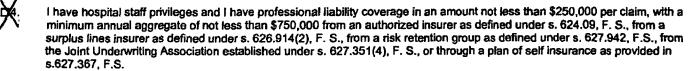
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1/ , ,	FINANCIAL RES	SPONSIBILITY	
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NAME: 1 1110019	11. Var) Jarva	LICENSE NUMBER:	120

Financial Responsibility options are divided into two categories, coverage and exemptions. <u>Choose only one option</u> of the ten provided pursuant to s. 458.320, Florida Statutes.

# **OPTION I: FINANCIAL RESPONSIBILITY COVERAGE**

- 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 an 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.
- 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.



15. I have elected not to carry medical malpractice insurance, 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.

# **OPTION II: Financial Responsibility Exemptions**

- I practice medicine exclusively as an officer, employee, or agent of the federal government, or of the state or its agencies or subdivisions;
- 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 do not practice medicine in the State of Florida;
  - 4. 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 \$25,000 within the previous five-year period;
    - (d) I have not been convicted of or pled guilty or noto 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)(g) or 459.0085(5)(g), F. S.; or
- 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).



KIMBERLY VAN SCRIVER, MD,

OBSTETRICS & GYNECOLOGY





Department of Health Division of Medical Quality Assurance Porox leoro Tallahassee, Fr. 32314-6320

2127

454.00





Compass



Jeb Bush Governor John O. Agwunobi, M.D., M.B.A. Secretary

January 6, 2005

Kimberly P VanScriver 4311 Salisbury Road N Jacksonville, FL 32216

RE: ME 73993

Dear Ms. VanScriver:

We have received your check and renewal request; however, in order to process your request the Financial Responsibility part of the renewal needs to be filled out correctly. **Only one category can be checked on the entire form**. If you have two or more areas checked on the form the renewal is being returned to you.

Your request will not be processed until the Financial Responsibility Coverage part of your form is filled out properly and submitted to the department. To eliminate any further delays, please return the Financial Responsibility form and a copy of this letter in the enclosed self-addressed envelope.

If you have any questions, please contact our Licensure Help Desk at (850) 245-4260. Thank you for your cooperation.

Sincerely,

Licensure Services

Division of Medical Quality Assurance Bureau of Operations

Kanberty van Scriver, M.D., P.A. 4311 Salisbury Rd N Jacksorwille FL 32216





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

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

Active (group 2) Medical Doctor License # ME 73993 expires January 31, 2002.

To avoid a delinquent charge, the fee of \$598.50 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 \$791.00.

1. CHANGE OF MAIL Current Mailing A	consistent in the State of Contract of the State of March and State of Stat	New Maili	ng Address:		DEPARTMENT USE ONLY
	RLY PAULINE VAN SCRIV	ER Licensee's Last 1	Name First	Middle Initial	
	ELFORT RD STE 2004	Attn:	######################################		
JACKS	ONVILLE, FL 32216	Street Address:			
		***************************************	***************************************		
		City:	State:	Zip:	
		Phone: (	1		
2. CHANGE OF PRA	CTICE LOCATION:	L. T.			
Current Practice I	TO THE RESERVE OF THE PROPERTY	Now Proc	tice Location:		
	ORT ROAD, SUITE 2004	Attn:	lice Location.		
WOMEN'S MEDIC	•				
JOE ADAMS BLD	· ·	Street Address:	**************************************	district (19)	
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Description	Department Informatio	n Information i	s Accurate	Corr	ect Information
Social Security #	- September 1990	◯ Yes	○ No		
Date of Birth	07/18/65	Yes	No		
Sex	Female	Yes	No		
Race	White	Yes	○ No	17/47k1 018k1 W Philosophi The Males of the 17/47k1	
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5. MILITARY STATU I am requestir your current a	n en man en en man en en antare en en man en en man en en man en	s. (Military Restricted from your Command	must submit proc ing Officer.)	of of active mil	itary duty. Attach a copy o
6. Will you be availal	ble to provide health care during times of emergend	services in special cy or major disaster	needs shelters ( ?	or to help stat	ff disaster medical
7. THERE ARE TWO	<b>RENEWAL METHODS AV</b>	AILABLE:			
A. Internet E-Ren E-Renewal allo status, such a	ewal:  ows you to make address class paying a delinquency fee wal will not be available	Web address <u>http://w</u> nanges. E-Renewal do or changing a license s	oes not allow you status. Due to hig	to renew online th volume, allow	w sufficient time to renew
	1	PIN Number:			
		License Number: ME	73993		
B. U.S. Mail:					
Mail this comp	pleted renewal form and fee l	e payable to the Depa P.O. Box 6320	rtment of Health	to:	
	•	Tallahassee, Florida	32314-6320		
8. Other Information					
File Number: 64867	7 20 20	Sequence Nun	nber: 1386		

# **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.458.320, Florida Statutes.

CATE	GORY I - CATEGORIES OF FINANCIAL RESPONSIBILITY COVERAGE:
<u> </u>	I do <u>not</u> 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.
<b>2</b> .	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 <u>not</u> 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.
<u> </u>	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.
CATE	GORY 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;
<b>◯</b> 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
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# Florida Department of Health - Board of Medicine LICENSE RENEWAL NOTICE

Active Dispensing Medical Doctor License # ME 73993 expires January 31, 2007.

The fee of **\$554.00** and the renewal notice must be postmarked on or before <u>January 31, 2007</u>. Renewal notices postmarked on or after <u>February 01, 2007</u> require renewal and delinquent fees of **\$939.00**.

### 1. CURRENT MAILING ADDRESS:

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

KIMBERLY PAULINE VAN SCRIVER 4311 SALISBURY RD N JACKSONVILLE, FL 32216

# 2. CURRENT PRACTICE LOCATION:

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

EPARTMENT USE ONLY

4311 SALISBURY RD N JACKSONVILLE, FL 32216

### 3. PROFILE CONFIRMATION:

Florida Statutes 456.039(1) and 456.0391(1) require that you update your profile at renewal. Please review and confirm the information in your profile before completing your renewal. Each practitioner who applies for license renewal must, in conjunction with procedures adopted by the Department of Health, and in addition to any other information that may be required, furnish the mandatory reporting requirements.

Note: A practitioner must submit updates to their profile within 15 days of any changes, 456.042, F.S.

You may review/update your profiling information by visiting the following link, <a href="www.flhealthsource.com">www.flhealthsource.com</a>. Use the login information provided on this notice. If you still choose to manually submit your information after visiting our website, please print out your profile using the print friendly version and make any changes directly on the profile. Please include your updates, if any, along with your other renewal information.

I have reviewed and confirmed the information in my profile.

# 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.flhealthsource.com, from our main page, select Licensee/Provider, go to the Practitioner Logon box located 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. The system will be available for renewals until midnight, Eastern Standard Time (EST), January 31, 2007. To use the online system, you will need the following information:

### Account ID:

### Password:

(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.

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

B. <u>U.S. Mail:</u> 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.

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.

File Number: 64867 Profession Code: 1501 Sequence Number: 28

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

Active Medical Doctor License # ME 73993 expires January 31, 2005.

The fee of **\$454.00** and the renewal notice must be postmarked on or before <u>January 31, 2005</u>. Renewal notices postmarked on or after <u>February 1, 2005</u> require a renewal fee of **\$839.00**.

### 1. CURRENT MAILING ADDRESS:

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

KIMBERLY PAULINE VAN SCRIVER 4311 SALISBURY RD N JACKSONVILLE, FL 32216

### 2. CURRENT PRACTICE LOCATION:

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

DEPARTMENT USE ONLY

A WOMAN S PLACE OB/GYN 836 PRUDENTIAL DR STE 1506 JACKSONVILLE, FL 32207

(904) 855-4211

# 3. RENEW ON LINE TODAY!

Go to <a href="https://www.doh-mqaservices.com">www.doh-mqaservices.com</a> and renew your license, change your address, update profile information, 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 <a href="https://www.doh-mqaservices.com">www.doh-mqaservices.com</a> go to the Practitioner Logon box, select your profession and enter your 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), January 31, 2005. To use the online system, you will need the following information:

### Account ID:

### Password:

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

The online renewal system will allow practitioners to update their addresses, update profile information 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>U.S. Mail:</u> 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: 64867 Sequence Number: 14
Profession Code: 1501 20 20

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

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KIMBERLY PAULINE VAN SCRIVER A PLACE FOR WOMEN, OBGYN 6817 SOUTHPOINT PKWY STE 2204 JACKSONVILLE, FL 32216

73993

Your Medical Doctor License # ME 73993 will expire at midnight, Eastern Standard Time (EST) on Saturday, January 31, 2009. The total fee due for this renewal is \$491.00.

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1. Click Renew My License and log in.
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You will be prompted to complete the Physician Workforce Survey online.

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Remember all renewals <u>MUST</u> be submitted **no later than January 31, 2009**. Questions? Contact the MQA Call Center at (850) 488-0595.



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

# *** Important License Information ***

VAN SCRIVER, KIMBERLY PAULINE A PLACE FOR WOMEN, OBGYN 6817 SOUTHPOINT PKWY STE 2204 JACKSONVILLE, FL 32216 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 <a href="www.FLHealthsource.com">www.FLHealthsource.com</a>. 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.

*** **AUTO** *** 006_010_04150

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:322168200547:

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*** License Renewal Notification ***
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