License Verification

Data As Of **4/30/2014**

KIMBERLY PAULINE VAN SCRIVER

LICENSE NUMBER: **ME73993**

Profession

MEDICAL DOCTOR

License/Activity Status	Controlled Substance Prescriber
CLEAR/ACTIVE	NO

Qualifications

Dispensing Practitioner

License Expiration Date	License Original Issue Date
1/31/2015	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.
EXPIRATION DATE: **JANUARY 31, 2002**

KIMBERLY PAULINE VAN SCRIVER
ATTN: 4201 BELFORT ROAD, SUITE 2004
WOMEN'S MEDICAL GROUP, P.A.
JOE ADAMS BLDG.
JACKSONVILLE, FL 32216

AC#
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.
EXPIRATION DATE: JANUARY 31, 2002
KIMBERLY PAULINE VAN SCRIVER
COPY - NOT A VALID LICENSE - COPY

COPY - NOT A VALID LICENSE - COPY

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

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.**

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

☐ REQUEST DUPLICATE LICENSE

_____
SIGNATURE REQUIRED

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

☐ NAME CHANGE (ATTACH LEGAL DOCUMENTATION)

FROM: _____
MIDDLE

TO: _____
LAST FIRST MIDDLE

☐ MAILING ADDRESS CHANGE

_____

_____

_____
CITY STATE ZIP

DH 2103, 5/98

DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE
LICENSURE SERVICES
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

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øtnrbal12/2.13             MAINTAIN ANY LICENSE DATA                  1501/MED-MEø
øFile: 64867                                                                     ø
øSSN:              Medical Doctor                                                ø
øLic:  73993       CLEAR,ACTIVE                                                  ø
øName: KIMBERLY PAULINE VAN SCRIVER (DBA:0 Old:0)                                ø
øAddr: 4205 BELFORT RD STE 2004                    State:   FL                   ø
ø                                                  Zip:     32216                ø
øCity: JACKSONVILLE                                County:  DUVAL                ø
ø                                                                                ø
øCertificate No: [redacted]  First License:    08/20/1997                        ø
ø     "    Date: 02/10/1998  In Rank Since:    08/20/1997                        ø
øLast Renewal:               License Method:   ENDR                              ø
øCurrent Expiry: 01/31/2000  Renewal Notice:   10/29/1999                        ø
ø                            In Directory?     Include                           ø
øStatus Date:    01/01/1801  Fee Exempt?       N                                 ø
øNote:                                                                           ø
ø                                                                                ø
ø                                                                                ø
øAction:  Query  Transfer  A-Address  B-Basic_Data  C-PSD  M-Modifiers ...      ø
ø         Go to view only options                                                ø
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RECEIVED
FEB 01 2000
REVENUE DOH

AC# 4961016

STATE OF FLORIDA
DEPARTMENT OF HEALTH
BOARD OF MEDICINE

DATE	BATCH NUMBER	LICENSE NBR
02/10/1998	9702870	ME 0073993

The PHYSICIAN Named below IS LICENSED Under the provisions of Chapter 458 FS.
Expiration date: JAN 31, 2000

VAN SCRIVER, KIMBERLY PAULINE
4319 LANDOVER DRIVE
JACKSONVILLE FL 3220

RECEIVED
JAN 31 2000
DISPLAY AS REQUIRED BY LAW

LAWTON CHILES
GOVERNOR

JAMES T. HOWELL, M. D., M. P. H.
SECRETARY

REVENUE DOH

I affirm compliance w all requirement for renewal including CE cadits.

Kimberly P. Van Scriver
1/28/00

02/01/2000 $355.00
ID: 1501-64867 Type: F
BT: H06293 DP: 168396
VL: 990059968

CIA

FEDERAL EXPRESS

Extremely Urgent:
Recipient Please Hand Deliver to Addressee

FedEx. PRIORITY OVERNIGHT MON
eep# 91218 28JAN00
Deliver By: 31JAN00
TRK# 8097 2888 6318 FORM 0210
AA
TLH
32399 -FL-US XB TLHA

Place Completed ... This Space

Do Not Send Cash.

... deliver to P.O. Boxes or ...

FedEx. USA Airbill FedEx Tracking Number 809728886318 Form I.D. No. 0210 BOR11 Recipient's Copy

1 From
Date 01/28/00 [redacted]
Sender's Name Debbie Willis Phone (904) 296-3200
Company WOMENS MEDICAL GROUP
Address 4205 BELFORT RD STE 2004 Dept./Floor/Suite/Room
City JACKSONVILLE State FL ZIP 32216

2 Your Internal Billing Reference Information

3 To
Recipient's Name Dept of Health Phone ( )
Company Licensure Services
Address 2020 Capital Circle SE [redacted] Bin # C99 Dept./Floor/Suite/Room
(To "HOLD" at FedEx location, print FedEx address here)
☐ Check here if residence (Extra charge applies for FedEx Express Saver)
City Tallahassee State FL ZIP 32399-3299

For HOLD at FedEx Location check here
☐ Hold Weekday ☐ Hold Saturday
For WEEKEND Delivery check here
☐ Saturday Delivery ☐ NEW Sunday Delivery

8 0 9 7 2 8 8 8 6 3 1 8

4a Express Package Service Packages under 150 lbs.
☒ FedEx Priority Overnight ☐ FedEx Standard Overnight
☐ FedEx First Overnight
☐ FedEx 2Day ☐ FedEx Express Saver

4b Express Freight Service Packages over 150 lbs.
☐ FedEx Overnight Freight ☐ FedEx 2Day Freight ☐ FedEx Express Saver Freight
(Call for delivery schedule. See back for detailed descriptions of freight services.)

5 Packaging ☐ FedEx Letter ☒ FedEx Pak ☐ FedEx Box ☐ FedEx Tube ☐ Other Pkg.

6 Special Handling
Does this shipment contain dangerous goods? ☐ No ☐ Yes ☐ Yes
☐ Dry Ice ☐ Cargo Aircraft Only

7 Payment
Bill to: ☒ Sender ☐ Recipient ☐ Third Party ☐ Credit Card ☐ Cash/Check ☐ Obtain Recipient FedEx Account No.
[redacted]

Total Packages 1 Total Weight 1 Total Declared Value $ .00 Total Charges $
Credit Card Auth.

8 Release Signature

Questions?
Call 1·800·Go·FedEx (800)463-3339

321

0080400321

PRIORITY OVERNIGHT
Next business morning service not available to all locations

STANDARD OVERNIGHT
Next business day service not available to all locations

INTERNATIONAL
Scheduled delivery times vary by location

Check For Saturday Delivery:

See Reverse Side For Additional Information

FEDEX PAK

AC# **COPY**

STATE OF FLORIDA
DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE

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

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

AC#
STATE OF FLORIDA
DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE
DATE 02/05/2002 | LICENSE NO. ME 73993 | CONTROL NO. 94310
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
COPY - NOT A VALID LICENSE - COPY

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

COPY - NOT A VALID LICENSE - COPY

EXPIRATION DATE: **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.

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

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

☐ REQUEST DUPLICATE LICENSE

_____
SIGNATURE REQUIRED

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

☐ NAME CHANGE (ATTACH LEGAL DOCUMENTATION)

FROM: _____
LAST FIRST MIDDLE

TO: _____
LAST FIRST MIDDLE

☐ MAILING ADDRESS CHANGE

_____

_____

_____
CITY STATE ZIP

DH 2103, 5/98

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

KIMBERLY PAULINE VAN SCRIVER
836 PRUDENTIAL DR. STE 1506
JACKSONVILLE, FL 32207

FLORIDA DEPARTMENT OF HEALTH

Jeb Bush
Governor

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

DISPENSING PRACTITIONER REGISTRATION

Important – Complete one form per licensee.

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 **$100.00** over and above the required license renewal fee. An annual inspection of your dispensing records will be conducted.

OFFICE USE ONLY

Received Date : 2/15/2006
Deposit Date : 2/17/2006
Deposit # : 167434
Batch Number : 001019241
Validation # : 005219121
Check Amount : $100.00
PRO_CDE : 5601

PLEASE PRINT OR TYPE THE FOLLOWING INFORMATION

Name:	KIMBERLY PAULINE VANSCRIVER MD
License Number:	ME73993 3DID
Mailing Address:	4311 SALISBURY ROAD NORTH, JACKSONVILLE, FL 32216

Only practice locations are published on the Internet.

I will be dispensing medication at the following locations: (attach additional sheets if needed)

Phone Number:	904 855-4211			
1st Practice Location:	4311 SALISBURY ROAD NORTH	JACKSONVILLE	FL	32216
	Street name and number	City	State	Zip
Phone Number:	904 448-8877			
2nd Practice Location:	4131 University Blvd S Building 2	Jacksonville	FL	32216
	Street name and number	City	State	Zip

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

Department of Health
Board of Medicine
P.O. Box 6320
Tallahassee, FL. 32314-6320

Signature of Physician

2/7/06
Date of signature

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.

KIMBERLY VAN SCRIVER, MD, PA
OBSTETRICS & GYNECOLOGY
4311 SALISBURY ROAD N ✦ JACKSONVILLE, FL 32216

JACKSONVILLE FL 322
09 FEB 2006 PM 4 T

MAILED FROM ZIP CODE

FLORIDA DEPARTMENT OF HEALTH
DISPENSING PRACTIONER REGISTRATION DEPT.
4052 BALD CYPRESS WAY, BIN # C03
TALLAHASSEE, FL 32399-3253

32399+7017

AC# **COPY**

STATE OF FLORIDA
DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE

DATE	LICENSE NO.	CONTROL NO.
02/21/2006	**ME 73993**	**187161**

The **MEDICAL DOCTOR**
named below has met all requirements of
the laws and rules of the state of Florida.
Expiration Date: **JANUARY 31, 2007**

QUALIFICATION(S):
DISPENSING PRACTITIONER

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

AC#
STATE OF FLORIDA
DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE
LICENSE NO. ME 73993
CONTROL NO. 187161
DATE 02/21/2006

The MEDICAL DOCTOR
named below has met all requirements of
COPY - NOT A VALID LICENSE - COPY

LICENSEE SIGNATURE

COPY - NOT A VALID LICENSE - COPY

GOVERNOR

DISPLAY IF REQUIRED BY LAW

SECRETARY

QUALIFICATION(S):
Dispensing Practitioner

EXPIRATION DATE: **JANUARY 31, 2007**

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. Use this section to report name and/or practice location address and/or mailing address changes. If you have not received your renewal notice 90 days prior to the expiration date shown on this license, please call (850) 488-0595.

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

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

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

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

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

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

FROM: _____
LAST FIRST MIDDLE

TO: _____
LAST FIRST MIDDLE

DH 2103, 5/98

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

_____

_____

CITY STATE ZIP

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

_____

_____

CITY STATE ZIP

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

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

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

RECEIVED
AUG 15 1997
REVENUE DEPT

08/19/97 $355.00
ID : TYPE: S
BT: 97006339 RC: 97009928
01-015-40 $350.00
01-015-51 $5.00

COMPLETE THIS FORM:

SS#:

LAST NAME:	FIRST NAME:	MIDDLE NAME:
VAN SCRIVER	Kimberly	Pauline

CURRENT ADDRESS: 4319 Landover Dr

CITY:	STATE:	ZIP CODE:
Jacksonville	FL	32207-

Section 1 **Initial Licensure:** **Attach the appropriate fees**

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

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

☐ **2.** **I have hospital staff privileges; and I have obtained and maintain professional liability coverage in an amount not less than $250,000 per claim, with a minimum annual aggregate of not less than $750,000 from an authorized insurer as defined under s. 624.09, 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 (retroactive 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 financial 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.**

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

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

☐ 5. I have elected not to carry medical malpractice insurance or otherwise demonstrate financial responsibility; however, I agree to satisfy any adverse judgments up to the minimum amounts pursuant to s 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 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)(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 its agencies or subdivisions.

☐ B. I hold a limited license issued pursuant to s. 458.317, F. S., and practice only under the scope of the limited license.]

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

☐ D. I do not practice medicine in the State of Florida.

☐ E. I am exempt from demonstrating financial responsibility based on my meeting all the following criteria:
1. I have held an active license to practice in this state or another state or some combination thereof for more than 15 years.
2. I am retired or maintain part time practice of no more than 1000 patient contact hours per year.
3. I have had no more than 2 claims resulting in an indemnity exceeding $10,000 within the previous 5 year period.
4. I have not been convicted of or pled guilty or nolo contendere to any criminal violation specified in Chapter 458, F. S.
5. I have not been subject, within the past 10 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 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 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.

☒ 1 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 Immune 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.

☐ 2 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 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. 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 I 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 s. 741.30.

☐ 4 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 licensees 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 person 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.

☐ I 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 OVER AND ABOVE the required renewal fee.

2d. Enclose with Initial Licensure Form the appropriate NICA assessment, exemption and form.

I affirm that these statements are true and correct and recognize that providing false information may result in disciplinary action against my license or criminal penalties pursuant to Sections 455.2272, 458.327, 458.331, 775.082, 775.083 and 775.084, Florida Statutes.

Kimberly P. van Scriver MD
(Signature of Physician)

The foregoing instrument was acknowledged before me this 7 day of August, 1997, by Kimberly P. van Scriver, who is personally known to me or who has produced N/A as identification and did/did not take an oath.

Georgette Henderson Commission No. CC570055
Signature of Notary

My Commission Expires:

Georgette Henderson
MY COMMISSION # CC570055 EXPIRES
JULY 17, 2000
BONDED THRU TROY FAIN INSURANCE, INC.

Name of Notary Typed, Printed or Stamped

SEAL

Attention Notary: Although this information is OPTIONAL, it could prevent fraudulent attachment of this certificate to an unauthorized document.
THIS CERTIFICATE IS INCORPORATED IN THE DOCUMENT DESCRIBED AT RIGHT:
Title or Type of Document Florida Board of Medicine, Initial Licensure Form
Number of Pages 3 Date of Document
Signer(s) Other than Names Above

ATTACH PHOTO HERE

RECEIVED

MAY 29 1997

REVENUE 05/29/97 $460.00
ID ID TYPE: S
BT: 96039322 RC: 960719787
01-015-10 $460.00

APPLICATION FEES ARE NON-REFUNDABLE
APPLICATION SHOULD BE TYPED

2 SOCIAL SECURITY NUMBER: _____

3 NAME: Kimberly (FIRST) Pauline (MIDDLE) van Scriver (LAST)

4 MAILING ADDRESS: 5501 Auburn Rd St Apt A (STREET AND NUMBER) Jacksonville (CITY) FL (STATE) 32207 (ZIP)

PERMANENT ADDRESS: 6812 Mayhill ct NW (STREET AND NUMBER) Albuquerque (CITY) NM (STATE) 87120 (ZIP)

5 PLACE OF BIRTH Long Beach (CITY) CA (STATE) USA (COUNTRY) DATE OF BIRTH 07/18/65 (MO) (DAY) (YEAR)

6 TELEPHONE: (904)731-8732 RESIDENCE (904)317-3898 OFFICE NUMBER

7 Have you ever legally CHANGED YOUR NAME? Yes ___ No X

8 DOCTOR OF MEDICINE DEGREE WAS OBTAINED FROM: University of New Mexico (Medical School)

Albuquerque, New Mexico (Location) on 5/14/94 (Month) (Day) (Year)

9 Are you or have you ever held any professional/medical license in any State in the U.S., to include Canada, Guam, Puerto Rico or U.S. Virgin Islands? Yes ___ No X

(If yes, list profession(s), state(s), license number(s) and date(s) of issuance.)

(If yes, list profession(s), state(s), license number(s) and date(s) of issuance.)

We are required to ask that you furnish the following information as part of your voluntary compliance with Section 2, Uniformed Guidelines on Employee Selection Procedure (1978) 43 FR38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

RACE: Caucasian X Black ___ Hispanic ___ Oriental ___ Native American ___ Other ___
SEX: Male ___ Female X

CATEGORY:	EXAM SITE:	Rev. Code 1510 AHCA/ME/001 1-90;07/94
SCHOOL CODE:	EXAM DATE:	AHCA/ME/031/1-90, Rev 07/94; 1/95
EDUCATION:	EXAM CODE:	
CANDIDATE #:		

10

UNDERGRADUATE/GRADUATE EDUCATION

NAME COLLEGE/UNIVERSITY	CITY/STATE/COUNTRY	FROM	TO	MAJOR/MINOR COURSE OF STUDY	DID YOU GRADUATE	DEGREE RECEIVED
University of California, Irvine	Irvine, CA USA	9/85	9/89	Biology (Major) Psychology (Minor)	Yes	BA-Psychology
University of Arizona	Tucson, Arizona	6/87	5/93	Biology	yes	BS-Biology
New York Medical college	Valhalla, New York	8/89	5/92	Medicine	No	
University of New Mexico	Albuquerque, NM	9/92	5/94	Medicine	yes	M.D.

11

PROFESSIONAL/MEDICAL EDUCATION; e.g. JD, Ed.D., Ph.D., RN, PA, MD, DO, DDS, DC, etc.

Did you receive advanced standing into Medical School? Yes ____ No X

If "yes" explain: _____

Was attendance in Medical School for a period other than the normal curriculum? Yes X No ____

If "yes" explain: I split my second year of medical school into 2 years thereby taking an extra year to finish medical school.

NAME SCHOOL/UNIVERSITY	ADDRESS & CITY/STATE/COUNTRY	FROM	TO	DOMICILE ADDRESS & CITY/STATE/COUNTRY	DID YOU GRADUATE	DEGREE RECEIVED
New York Medical College	Valhalla, New York	8/89	5/92	140 W. Shady Dr. Putnam Valley, NY Medicine	NO n/a	
University of New Mexico	Albuquerque, NM	9/92	5/94	6712 Mayfield NW Albuquerque, NM Medicine	Yes	MD 5/94

All applicants must complete questions 15 through 44:

15

PROFESSIONAL/POST GRADUATE TRAINING -
List all professional/postgraduate training program(s) begun, whether completed or not.

During any postgraduate training were you ever on probation, restriction, suspension, revocation, modification, or otherwise acted against (explain "otherwise" actions)? Yes ____ No X

If "YES", list name(s) and address(es) of postgraduate training institution(s)

If "YES", list name(s) and address(es) of hospital(s)

Have you ever been requested to leave, temporarily or permanently, a medical training program prior to completion of training? Yes ____ No X

If "yes" explain _____

List in chronological order from date of graduation from medical school all professional/postgraduate training (Internship, Residency, Fellowship) to the present.

Program (Internship/Residency/Fellowship) Address and Specialty Area	Domicile/Where Lived	MONTH/YEAR FROM		TO		Credit Received Yes	No
University of Oklahoma - Family Practice, Oklahoma City	1818 SW 90th St Oklahoma City, OK 73159	7	94	6	95	X	
University of New Mexico - OB/Gyn	4812 Menaul St NE Albuquerque, NM	6	95	5	97	X	
University of Florida, Jacksonville, Fl OB/Gyn	5501 Auburn Rd Dept A Jacksonville, FL	5	97	current		X	

16

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 medical school.

(Type of Practice and Employment or Non-Employment)	Name and Address or Domicile (Street number, City, State, Territory, Country) of Non-employment, Employment and/or Practice Setting	MONTH/YEAR FROM		TO	
please see attached sheet of paper					

Kimberly van Sumeren
[redacted]

9/89 - 6/90 1st year Medical school New York Medical college(NYMC)
6/90 - 8/90 worked - Santa Ana sperm Bank, Santa Ana, California
for summer
8/90 - 6/91 2nd year of Medical school NYMC
6/91 - 8/91 worked Santa Ana sperm Bank, Santa Ana, California
8/91 - 5/92 didn't biochemistry and was forced to split curriculum from my 2nd year in half.
by 5/92 I had completely finished years 1 & 2 of medical school.

Then in:
6/92 I took part 1 of USMLE, applied to transfer to university of New Mexico. I had to wait for my USMLE test results prior to beginning my 3rd year in Medical school at University of New Mexico.

I spent from
6/92 - 9/92 in California & my room. I did not work.
9/92 - 6/93 - completed my 3rd year of medical school at university of New Mexico.
6/93 - 5/94 - completed my 4th year of medical school graduated on 5/14/94.

from
5/14/94 - 6/17/94 I travelled in the United states on vacation and moved to Oklahoma City to begin my internship in family Medicine
6/17/94 - 6/30/95 - Internship Fam Medicine OKC, Oklahoma
7/1/96 - 5/9/97 - 2nd & 3rd year in OB/Gyn Albuquerque, NM
5/5/97 - present - 3rd year in OB/Gyn Jacksonville, Fl

17

STAFF PRIVILEGES -

Have you ever been denied any staff privileges? Yes ____ No X

If "YES", list name(s) and address(es) of hospital(s)

If "YES", list name(s) and address(es) of hospital(s)

Have you ever been asked to or allowed to resign from any hospital, institution, clinic or medical facility in lieu of disciplinary action? Yes ____ No X

If "YES", please explain and list name(s) and address(es) of practice setting.

If "YES", please explain and list name(s) and address(es) of practice setting.

Have you ever had any staff privileges suspended, revoked, modified, restricted, placed on probation, asked to resign or asked to take a temporary leave of absence or otherwise acted against (explain "otherwise" actions)?. Yes ____ No X

If "YES", list name(s) and address(es) of hospital(s)

If "YES", list name(s) and address(es) of hospital(s)

Have you ever been asked, or allowed to resign from any hospital, institution, clinic or medical facility in lieu of disciplinary action or during any pending investigations into your practice? Yes ____ No X

If "YES", please explain and list name(s) and address(es) of practice setting from which you resigned.

If "YES", please explain and list name(s) and address(es) of practice setting from which you resigned.

List any hospital(s) where you have staff privileges (Do Not List Training Privileges).

(Name of Hospital)	Address (City/State/Zip)	MONTH/YEAR			
		FROM		TO	

18

MEDICAL AFFILIATIONS

Have you ever had an application for membership rejected for medical society membership? Yes ____ No X.

If "yes" explain: _____

Have you ever had a medical society membership suspended? Yes ____ No X.

If "yes" explain: _____

Have you ever been notified to appear before a medical society in regard to charges/complaints filed against you? Yes ____ No X.

_____
IF "YES", GIVE NAME(S) AND ADDRESS(ES) OF MEDICAL SOCIETY.

_____
IF "YES", GIVE NAME(S) AND ADDRESS(ES) OF MEDICAL SOCIETY.

LIST MEDICAL AFFILIATIONS: State, county, national, including date(s) and complete address (street, city, state)

19 IF FOREIGN BORN, give date and place of Naturalization: _____

20 Are you a citizen of the United States? Yes X No ____.

21 Have you ever been in the United States Military and/or Public Health Service? Yes ____ No X.

_____
(IF "YES" LIST BRANCH OF SERVICE, RANK, DATES OF SERVICE >>>ENCLOSE COPY OF DISCHARGE FORM)

22 a Are you a diplomate of the National Board of Medical Examiners? Yes ____ No X.

b If "yes", state date of certification _____

23 Have you ever failed State Board/FLEX/National Board/USMLE Examination?

24 a Are you certified by an American Specialty Board? Yes ____ No X.

b If "yes", List name of Board(s)_____
(ENCLOSE COPY OF BOARD CERTIFICATE OR LETTER VERIFYING ELIGIBILITY)

c Have you ever applied for, taken an examination for, or failed to receive specialty board certification for any reason? Yes ____ No X.

d If "yes" explain _____

25 Have you ever studied to become, or do you hold any other professional license in any state, e.g. JD, Ed.D., Ph.D., RN, PA, DO, DDS, DC, etc.? Yes ____ No X.

26 Have you had any application for professional license or any application to practice medicine/surgery denied by any state board or other governmental agency of any state or country? Yes ____ No X

If "yes" explain: _____

27 a 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 medical practice act, unprofessional or unethical conduct? Yes ____ No X

If "yes" explain: _____

b Have you ever been required by any licensing jurisdiction to enter into an impaired practitioner program? [redacted]

If "yes" explain: _____

28 Have you ever had any professional license or license to practice medicine/surgery revoked, suspended, or other disciplinary action taken in any state, territory or country? Yes ____ No X

If "yes" explain: _____

29 Regardless of adjudication have you ever been convicted of a violation of, or pled Nolo Contendere, to, any Federal, State, Local statute, regulation or ordinance, or entered into any plea, negotiated plea, bargain, or settlement relating to a misdemeanor or felony? Yes ____ No X

If "yes" explain: _____

30 Have any actions in bankruptcy court or any civil judgments ever been entered against you?

If "yes" explain: _____

31 Have you ever been sued for malpractice? Yes ____ No X

If "yes" explain: _____

32 a Have you ever discontinued practice for any reason for a period of one month or longer? Yes ____ No X

If "yes" explain: _____

b Have you ever had employment terminated for cause? Yes ____ No X

If "yes" explain: _____

33 Do you have a chronic medical illness 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 illness or condition that impacted your ability to function in any educational or practice setting?

If "yes" explain: _____

35 Have you ever declined to follow the recommendation or request of a physician, counselor,

employer, supervisor, or medical training program director or representative that you enter therapy or treatment for any mental or physical illness or condition?

If "yes" explain: _____

36. Do you have any mental or physical illness or condition which effects your ability to safely perform any procedure or task within the scope of the practice of medicine?

If "yes" explain: _____

37. Have you ever been criminally or civilly charged with any intentional or negligent action related to use or misuse of drugs, alcohol, or illegal chemical substances? Yes ____ No X

If "yes" explain: _____

38. Within the last 5 years, have you ever been hospitalized for any physical or mental illness, condition or injury?

If "yes" explain: _____

39. Have you ever been warned or called before the Drug Enforcement Agency (DEA)? Yes ____ No X

If "yes" explain: _____

40. Have you ever been made an offer to compromise or entered into any other arrangement for other plea or agreement in lieu of a Federal prosecution for a drug violation regulated by the DEA? Yes ____ No X

If "yes" explain: _____

41. Have you ever been denied, or surrendered, a DEA Registration? Yes ____ No X

If "yes" explain: _____

42. PERSONAL DATA:

DATE: 5/10/97 COLOR OF EYES: Blue

AGE: 31 COLOR OF HAIR: Brown

HEIGHT: 5'10" WEIGHT: 165

OTHER MEANS OF IDENTIFICATION: _____

3

43 AFFIDAVIT OF APPLICANT:

I, Kim van Scriver, being first duly sworn, depose and say that I am the person referred to in the foregoing application and supporting documents, and that the attached photograph is a true likeness of myself.

I hereby authorize all hospital(s), 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 release to the Florida Board of Medicine any information which is material to my application for licensure.

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 perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of my license to practice medicine/surgery 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 to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

_____
(specification of date, event or condition upon which this consent expires)

Kimberly P. van Scriver MD
(Signature of Applicant)

The foregoing instrument was acknowledged before me this 22 day of May, 19 97, by Dr Kim van Scriver, who is personally known to me or who has produced _____ as identification and did/did not take an oath.

Georgette Henderson
Signature of Notary
My Commission Expires:

Commission No. CC570055

Georgette Henderson
MY COMMISSION # CC570055 EXPIRES
July 17, 2000

Name of Notary Typed, Printed or Stamped

SEAL

Attention Notary: Although the information requested below is OPTIONAL, it could prevent fraudulent attachment of this certificate to an unauthorized document.

THIS CERTIFICATE MUST BE ATTACHED TO THE DOCUMENT DESCRIBED AT RIGHT:

Title or Type of Document Application for Medical Licensure-Florida

Number of Pages _____ Date of Document _____

Signer(s) Other than Names Above _____

AGENCY FOR HEALTH CARE ADMINISTRATION
FLORIDA BOARD OF MEDICINE
DIVISION OF HEALTH QUALITY ASSURANCE
NORTHWOOD CENTER 1940 NORTH MONROE STREET
TALLAHASSEE, FLORIDA 32399-0750
904/488-0595

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 HAS 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 PHONE CALLS REGARDING THE APPLICATION STATUS ONLY FROM 2:00pm EST UNTIL 4:30pm EST. PURSUANT TO FLORIDA ADMINISTRATIVE CODE 64R, ALL LICENSER APPLICATIONS AND FEES ARE GOOD FOR ONE YEAR ONLY.

1. Please explain why you transferred from New York Medical 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.

4. 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. I 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.

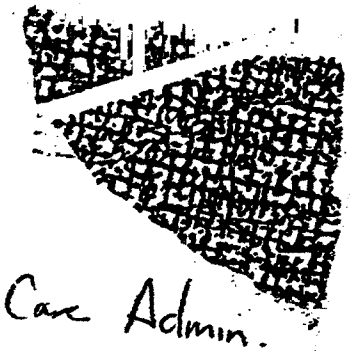
Thank you for your attention to this matter.

Sincerely,

Kimberly P. van Scriver MD

Kimberly van Scriver, M.D.
5501 A Auburn st.
Jacksonville, FL 32207
(904) 876-7326

VAN scriven
5501 Apt A Arbum Rd
Jacksoville, FL
32207



Agency for Health Care Admin.
Board of Medicine
1940 North Monroe
Talla

PR22 - Ver 01.05 Florida BPR Automated Systems 06/17/97
PROFILE 08:09:43

>>----------> PERSONAL PROFILE <----------<<

ID NBR: ID TYPE: S SSN BOARD: 15 DATE ADDED: 05/29/97
LAST: VAN SCRIVER DOB: 07/18/65
FIRST: KIMBERLY MIDDLE: PAULINE SUFFIX:

LICENSES		REFERENCE NUMBER	PROCESS DATE	RECEIPT AMOUNT	PROCESS STATUS DESCRIPTION	BOARD	OCC
	A		06/16/97		UNLICENSED PHYSICIA	15	ME
	A		06/13/97		JOANN/PEND/INITIAL	15	ME
	R	960747290	06/13/97	100.00	RECEIPT	15	
	R	960719787	08/29/97	460.00	RECEIPT	15	

NEXT KEY: FASTPATH:

F1-HELP F3-SUB MENU F4-EXIT F12-MAIN MENU

1 8088-1 199.250.21.49 22/75

DEPARTMENT OF HEALTH
FLORIDA BOARD OF MEDICINE
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 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 PHONE CALLS REGARDING THE APPLICATION STATUS ONLY FROM 2:00pm EST UNTIL 4:30pm EST. PURSUANT TO FLORIDA ADMINISTRATIVE CODE 65R, 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 7/95-6/98 and does not list your training at the Univ. of Florida. Please have an updated Profile sent to the Fl. Board.

✓ 5. 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 not 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

This is a true and correct copy of the original document

I certify that Dr. van Scriver appeared before me and that the above is her original signature.

The University of New Mexico

has conferred upon

Kimberly Pauline van Scriver

the degree of

Doctor of Medicine

with all the rights and privileges appertaining to that degree,
in testimony whereof the Regents of the University upon recommendation
of the Faculty have granted this diploma bearing the seal of the University
this fourteenth day of May, nineteen hundred and ninety-four.

Arthur D. Melendres
President of the Regents

Bruce Bailey
Secretary of the Regents

Richard Peck
President of the University

Mary Sue Coleman
Provost of the University

The Oklahoma State Regents for Higher Education

acting through

The University of Oklahoma Health Sciences Center

makes known by these presents that

Kimberly van Scriver, M.D.

has served as

First Year Resident in Family Medicine

from July 1, 1994 through June 30, 1995

Given under the Seal of the University of Oklahoma
at the Health Sciences Center,
Oklahoma City, Oklahoma.

For the State Regents

Chairman

Secretary

Chancellor

For the University

Chairman, Board of Regents

President of the University

Program Director

THE UNIVERSITY OF OKLAHOMA
CRESCIT EVNDO
1890

RECEIVED
JUN 03 1997

This is an exact copy of a true and original document

Notary Public

MY COMMISSION EXPIRES 5-13-98

THE AGENCY FOR HEALTH CARE ADMINISTRATION
FLORIDA BOARD OF MEDICINE
Northwood Centre
1940 North Monroe Street
Tallahassee, Florida 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 Zubiaide, MD
Dept of Family Practice
University of Oklahoma HSC
900 NE 10th Street/PO BOX 26901
Oklahoma City, OK 73190

1. Name: Kimberly Pauline VanScriver SS#
2. Internship . . . . . From: 7/94 To: 6/95
3. PLEASE VERIFY
   a. If this is a position allocated by the ACGME . . . . . Yes ✓ No ____
   b. If dates of training listed in #2 are correct: Yes ✓ No ____ FROM: ____ TO: ____
   c. Check levels completed under your purview: PGY I ✓ PGY II ____ PGY III ____ PGY IV ____ PGY V ____
   d. If for any reason the program was not completed at your institution on the reverse of this form explain why not; specify if he/she left in good standing and indicate if a contract to continue the program was offered.

(EVALUATE COMPARED TO PHYSICIAN OF SIMILAR EXPERIENCE)

4. PROFESSIONAL CHARACTER:	Poor	Fair	Good	Superior	Don't Know
a. Basic Medical Knowledge			✓		
b. Diagnostic/Clinical Ability			✓		
c. Teaching Ability				✓	
d. Research Potential			✓		
e. Fitness for Clinical Practice			✓		
5. PERSONAL CHARACTER					
a. Motivation				✓	
b. Initiative				✓	
c. Responsibility				✓	
d. Integrity				✓	
e. Appearance				✓	
f. Knowledge of English				✓	
6. PROFESSIONAL RELATIONSHIP WITH:					
a. Teaching Staff				✓	
b. Colleagues				✓	
c. Nursing Staff				✓	
d. Patients				✓	

RECEIVED
JUN 3 0 1997

7. CONDUCT ASSESSMENT (any mental or physical illness or condition which would affect any procedure or task within the scope of the practice of medicine)
Comments to #7: ____

8. OVERALL EVALUATION (If item a or d is checked, please provide a written explanation on the reverse side of this form.
   a. ✓ Recommended as an Outstanding Applicant.
   b. ____ Recommended as Qualified and Competent.
   c. ____ Recommended with some Reservation.
   d. ____ Cannot Recommend.

SIGNED: John P Zubiaide
POSITION: Program Director
(PLEASE PRINT/STAMP NAME & ADDRESS BELOW)

The University of New Mexico Health Sciences Center
SCHOOL OF MEDICINE
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:

Residency: 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,

Pat Brusuelas
Program Director

BioMedical Research Building, SOM, Box 535, Albuquerque, NM 87131-5136 • TELEPHONE (505) 272-6225 • FAX (505) 272-5184

7/16/97 12:03 ☎505 2726385 UNM DEPT OBGYN ••• BD OF MED FL 001

The University of New Mexico • Health Sciences Center
SCHOOL OF MEDICINE

Department of Obstetrics and Gynecology
2211 Lomas Boulevard NE
Albuquerque, New Mexico 87131-5286
FAX (505) 272-6385

July 16, 1997

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

RE: Kimberly van Scriver, 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 left residency April 26, 1997. Dr. van Scriver did not complete our program in our institution; she transferred to the University of Florida / Jacksonville to complete her training in Obstetrics and Gynecology. There were no complaints in regards to her personal or professional demeanor.

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

Sincerely yours,

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

m:\lou\rel\Privileges.ltr.doc

Post-it™ brand fax transmittal memo 7671 | # of pages ▸ (3)

To JoAnne Davis	From Beth Rae Coond
Co. FL Bd of Med.	Co. UNM OB/GYN
Dept. REGULATIONS	Phone # 505 272-6863
Fax # (904) 922-3040	Fax # 505 272-6385

THE AGENCY FOR HEALTH CARE ADMINISTRATION
FLORIDA BOARD OF MEDICINE
Northwood Centre
1940 North Monroe Street
Tallahassee, Florida 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!

Maxine Dorin, MD
TO: ~~Gloria E Soto, MD PhD~~
University of New Mexico SOM
Dept of Ob/Gyn ACC-4
2211 Lomas Blvd NE
Albuquerque, NM 87131-5286

DATE: June 12, 1997

1. Name: Kimberly Pauline VanScriver SS#
2. Residency ..... From: 8/95 To: 8/97
3. PLEASE VERIFY
   a. If this is a position allocated by the ACGME ..... Yes ✓ No ____
   b. If dates of training listed in #2 are correct: Yes ✓ No ____ FROM: ____ TO: ____
   c. Check levels completed under your purview: PGY I ____ PGY II ✓ PGY III ✓ PGY IV ____ PGY V ____
   d. If for any reason this program was not completed at your institution on the reverse of this form explain why not; specify if he/she left in good standing and indicate if a contract to continue the program was offered. (Left OBGYN)

(EVALUATE COMPARED TO PHYSICIAN OF SIMILAR EXPERIENCE)

	Poor	Fair	Good	Superior	Don't Know
4. PROFESSIONAL CHARACTER:					
a. Basic Medical Knowledge			✓		
b. Diagnostic/Clinical Ability			✓		
c. Teaching Ability			✓		
d. Research Potential			✓		
e. Fitness for Clinical Practice			✓		
5. PERSONAL CHARACTER					
a. Motivation			✓		
b. Initiative			✓		
c. Responsibility			✓		
d. Integrity			✓		
e. Appearance			✓		
f. Knowledge of English			✓		
6. PROFESSIONAL RELATIONSHIP WITH:					
a. Teaching Staff			✓		
b. Colleagues			✓		
c. Nursing Staff			✓		
d. Patients			✓		

7. CONDUCT ASSESSMENT (any mental or physical illness or condition which would affect any procedure or task within the scope of the practice of medicine)
Comments to #7: ____

8. OVERALL EVALUATION (If item c or d is checked, please provide a written explanation on the reverse side of this form.
   a. ✓ Recommended as an Outstanding Applicant.
   b. ____ Recommended as Qualified and Competent.
   c. ____ Recommended with some Reservation.
   d. ____ Cannot Recommend.

SIGNED: [signature]

POSITION: ____

(PLEASE PRINT/STAMP NAME & ADDRESS BELOW)

3

AFFIDAVIT OF APPLICANT:

I, Kim van Scriver, being first duly sworn, depose and say that I am the person referred to in the foregoing application and supporting documents, and that the attached photograph is a true likeness of myself.

I hereby authorize all hospital(s), 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 release to the Florida Board of Medicine any information which is material to my application for licensure.

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 perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of my license to practice medicine/surgery 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 to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

_____
(specification of date, event or condition upon which this consent expires)

Kim L. van Scriver MD
(Signature of Applicant)

The foregoing instrument was acknowledged before me this 22 day of May, 19 97, by Dr. Kim van Scriver, who is personally known to me or who has produced _____ as identification and did/did not take an oath.

Georgette Henderson Commission No. CC570055
Signature of Notary
My Commission Expires:

Georgette Henderson
MY COMMISSION # CC570055 EXPIRES
July 17, 2000
(407) 539-0104 Florida Notary Service, Inc.

Name of Notary Typed, Printed or Stamped

SEAL

Attention Notary: Although the information requested below is OPTIONAL, it could prevent fraudulent attachment of this certificate to an unauthorized document.

THIS CERTIFICATE MUST BE ATTACHED TO THE DOCUMENT DESCRIBED AT RIGHT:

Title or Type of Document Application for Medical Licensure-Florida

Number of Pages _____ Date of Document _____

Signer(s) Other than Names Above _____

THE AGENCY FOR HEALTH CARE ADMINISTRATION
FLORIDA BOARD OF MEDICINE
Northwood Centre
1940 North Monroe Street
Tallahassee, Florida 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!

RECEIVED
JUN 2 3 1997

DATE: June 12, 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 SS# _____
2. Residency ..... From: 5/97 To: present
3. PLEASE VERIFY
   a. If this is a position allocated by the ACGME ..... Yes ✓ No _____
   b. If dates of training listed in #2 are correct: Yes ✓ No ____ FROM: _____ TO: _____
   c. Check levels completed under your purview: PGY I ____ PGY II ____ PGY III ____ PGY IV ✓ PGY V ✓ just started
   d. If for any reason the program was not completed at your institution on the reverse of this form explain why. If resident is still in training specify if he/she left in good standing and indicate if a contract to continue the program was offered. Began about 2 mos ago.

(EVALUATE COMPARED TO PHYSICIAN OF SIMILAR EXPERIENCE)

	Poor	Fair	Good	Superior	Don't Know
4. PROFESSIONAL CHARACTER:					
a. Basic Medical Knowledge				✓	
b. Diagnostic/Clinical Ability				✓	
c. Teaching Ability				✓	
d. Research Potential				✓	
e. Fitness for Clinical Practice				✓	
5. PERSONAL CHARACTER					
a. Motivation				✓	
b. Initiative				✓	
c. Responsibility				✓	
d. Integrity				✓	
e. Appearance				✓	
f. Knowledge of English				✓	
6. PROFESSIONAL RELATIONSHIP WITH:					
a. Teaching Staff				✓	
b. Colleagues				✓	
c. Nursing Staff				✓	
d. Patients				✓	

I am impressed with her over this short period of time

7. CONDUCT ASSESSMENT (any mental or physical illness or condition which would affect any procedure or task within the scope of the practice of medicine)

Comments to #7: _____

8. OVERALL EVALUATION (If item c or d is checked, please provide a written explanation on the reverse side of this form.

a. ✓ Recommended as an Outstanding Applicant.
b. _____ Recommended as Qualified and Competent.
c. _____ Recommended with some Reservation.
d. _____ Cannot Recommend.

SIGNED: Robert J Thompson MD

POSITION: Prof.

(PLEASE PRINT/STAMP NAME & ADDRESS BELOW)

as above.

LOVELACE HEALTH SYSTEMS

May 22, 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 Blvd., S.E.
Albuquerque, New Mexico 87108
(505) 262-7000

UNIVERSITY OF FLORIDA

HEALTH SCIENCE CENTER / JACKSONVILLE
Department of Obstetrics and Gynecology

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

May 22, 1997

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

RE: Kimberly van Scriver, M.D.

Dear Florida Board of Medicine:

It is my pleasure to write this letter of recommendation for Dr. Kim van Scriver for licensure in the state of Florida. Dr. van Scriver 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.

Sincerely,

Guy I. Benrubi, M.D.
Professor and Associate Chairman
Department of Obstetrics and Gynecology
Director, Division of Gynecologic Oncology

GIB/glh

SIG. JDT DATE 7/7/97 1ST REVIEW
SIG. CP DATE 11/5/97 2ND REVIEW
FEE ✓ PHOTO ✓
OMITTED TIME OR DISCREPENCIES_____
_____
NAME CHANGE DOC. ___TRANS_____
NAME VARIANCE EXPLAINED_____
HONORABLE DISCHARGE_____
UNDERGRAD GRADES ✓
TRANSCRIPT(S) 2 ✓ TRAN(S)_____
MEDICAL DEGREE ✓ TRAN(S)_____
SCHOOL INQUIRY Univ of NM
SCORES
NAT'L BOARD SCORE____YEAR_____
FLEX SCORE_____YEAR_____
SPEX SCORE__ __YEAR_____
USMLE SCORE ✓ YEAR 1a/95
TRAINING
INTERNSHIP CERTIFICATE ✓ ✓
INQUIRY (FP) Univ of OK 7/94-6/95 ✓

RESIDENCY CERTIFICATE(S) ✓
INQUIRY(S) (OG) Univ of NM 6/95-5/97 ✓ UF 5/97-present ✓

FELLOWSHIP CERTIFICATE(S)_____
INQUIRY(S)

SPECIALTY BOARD CERTIFICATE(S)_____

2 ORIGINAL LETTERS OF RECOMMENDATION ✓ ✓
(1) Hedstrom ✓ (2) Bedrubi
CURRENT STAFF PRIVILEGES none
DENIED PRIVILEGES no
STATE LICENCE(S) none
DATA BANK REVIEWED ✓
AMA ✓
UPDATES REQUESTED OR CONFIRMED BY PHONE_____
_____
_____

INITIAL APPLICATION PROCESS BY Lellania Nichols
Kimberly P. VanScriver

UNIVERSITY OF FLORIDA

HEALTH SCIENCE CENTER / JACKSONVILLE
Department of Obstetrics and Gynecology

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

August 4, 1997

Florida Board of Medicine
1940 North Monroe 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

GIB/gh

FLORIDA BIRTH-RELATED NEUROLOGICAL INJURY COMPENSATION ASSOCIATION

$5,000 PARTICIPATING	$250.00 NON-PARTICIPATING	$0 EXEMPT	AMOUNT ENCLOSED $

IMPORTANT: If exemption is claimed, appropriate documentation must be provided to AHCA and to NICA. See attachment for explanation.

I HAVE READ THE EXPLANATORY INFORMATION PROVIDED BY NICA, AND I CHOOSE THE OPTION CIRCLED ABOVE.

4319 Landover Dr
STREET ADDRESS

Kimberly Pauline van Scriver
FULL NAME PRINTED

Jacksonville, Florida 32207
CITY, STATE, ZIP

Kimberly P van Scriver 8/11/97
SIGNATURE DATE

RETURN SIGNED COPY WITH PAYMENT TO: AHCA
This is the assessment for the calendar year 1997.
(Return this portion with your remittance)

FLORIDA BIRTH-RELATED NEUROLOGICAL INJURY COMPENSATION ASSOCIATION

$5,000 PARTICIPATING PHYSICIAN	$250.00 NON-PARTICIPATING PHYSICIAN	$0 EXEMPT	AMOUNT ENCLOSED $

I HAVE READ THE EXPLANATORY INFORMATION PROVIDED BY NICA, AND I CHOOSE THE OPTION CIRCLED ABOVE.

4319 Landover Dr.
STREET ADDRESS

Kimberly Pauline van Scriver
FULL NAME PRINTED

Jacksonville, Florida 32207
CITY, STATE, ZIP

Kimberly P van Scriver 8/11/97
SIGNATURE DATE

*** PHYSICIAN COPY ***
Retain for your records

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)

[illegible]AHCA1.frm

NM VAN SCRIVER BA

NEW YORK MEDICAL COLLEGE
Valhalla, New York 10595
(914) 993-4498
(914) 993-4613 (Fax)

OFFICE OF STUDENT AFFAIRS

RECEIVED
JUN 21 1997

April 28, 1992

Ladies and Gentlemen:

This letter of recommendation is written at the request of Kimberly 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 Arizona. In college she was a volunteer at the Children's Hospital 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.

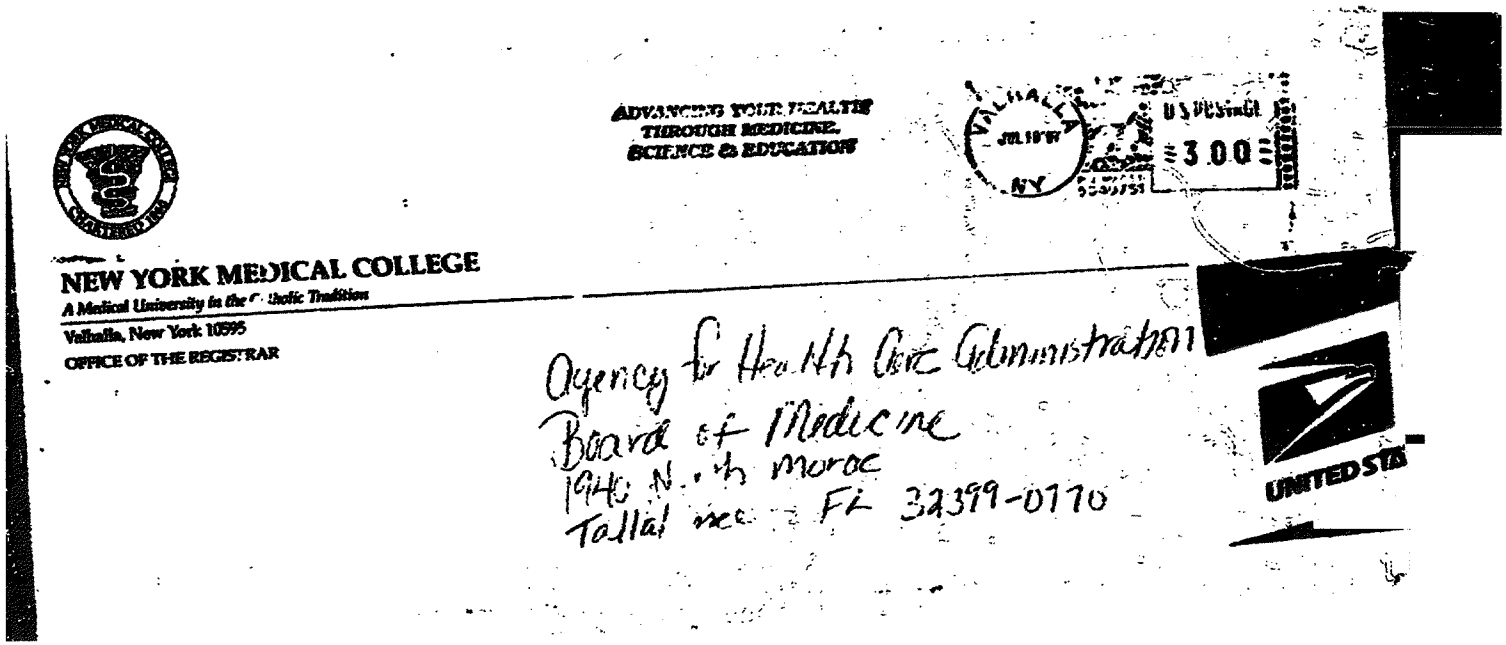
Ms. van Scriver matriculated at New York Medical College in the fall of 1989. She all of the first year courses [illegible], thus becoming a member of the Class of 1994. She earned a [illegible] in Behavioral Science in her first year, and she has Biochemistry in her first year, and earned grades of in Microbiology amd Pharmacology with her original class. She has [redacted] 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 Kidney Center performing nerve conduction tests on dialysis [illegible]

N187985

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 [illegible] 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, M.D.
Associate Dean
Chairman, Graduate Medical
Advisory Committee



ADVANCING YOUR HEALTH
THROUGH MEDICINE,
SCIENCE & EDUCATION

VALHALLA JUL 19 W NY

U.S. POSTAGE
3.00

NEW YORK MEDICAL COLLEGE
A Medical University in the Catholic Tradition
Valhalla, New York 10595
OFFICE OF THE REGISTRAR

Agency for Health Care Administration
Board of Medicine
1940 North Monroe
Tallahassee FL 32399-0770

UNITED STATES

Department of Health, Board of Medicine

ADDRESS CHANGE, PLEASE PRINT THE FOLLOWING INFORMATION

NAME: Kim Van Scriver LICENSE NUMBER: ME0073993

MAILING ADDRESS: 4134 Weatherwood estates Dr. S

CITY: Jacksonville STATE: FL ZIP: 32223

Mailing address will not be published on the internet.

1st PRACTICE LOCATION:

8316 Prudential drive suite 1506

CITY: Jacksonville, STATE: FL ZIP: 32207

Practice locations will be published on the internet.

2nd PRACTICE LOCATION:

CITY: STATE: ZIP:

Practice locations will be published on the internet.

2002 MAY -2 AM 8:21 MEDICINE BOARD

STATEMENT OF FINANCIAL RESPONSIBILITY and EXEMPTIONS

Amended Date: 4/02

FINANCIAL RESPONSIBILITY

If you are exempt from demonstrating financial responsibility, please disregard questions 1a. -5a.

Check one Box only

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

☒ **2a. I have hospital staff privileges and I have professional liability coverage in an amount not less than $250,000 per claim, with a minimum annual aggregate of not less than $750,000 from an authorized insurer as defined under s. 624.09, F. S., from a surplus lines insurer as defined under s. 626.914(2), F. S., from a risk retention group as defined under s. 627.942, F.S., from the Joint Underwriting Association established under s. 627.351(4), F. S., or through a plan of self insurance as provided in s.627.367, F.S. I further certify that I have been continuously insured with an entity as**

outlined above for the past two years (retroactive coverage) or if I seek insurance from a different entity providing insurance I will purchase retroactive coverage for the two years preceding my inception date of coverage. I further certify that in the event my coverage is canceled or that I desire to become uninsured and meet the financial responsibility requirements through other provisions in s. 458.320 or 459.0085, F.S., I will maintain coverage for incidents which may have occurred during the two years preceding my becoming uninsured.

☐ 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

If you select any numbers 1a-5a in the Financial Responsibility Section, you are **not eligible for an exemption.**

I am exempt from demonstrating the above financial responsibility because I fall into one of the categories listed below:
Check 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

☐ 5b. I meet all the following criteria:
(a) I have held an active license to practice in this state or another state or some combination thereof for more than 15 years;
(b) I am retired or maintain part time practice of no more than 1000 patient contact hours per year;
(c) I have had no more than two claims resulting in an indemnity exceeding $10,000 within the previous five year period;
(d) I have not been convicted of or pled guilty or nolo contendere to any criminal violation specified in Chapter 458 or 459, F. S.; and
(e) I have not been subject, within the past ten years of practice, to license revocation or suspension, probation for a period of three years or longer, or a fine of $500 or more for a violation of Chapter 458 or 459, F.S., or the medical practice act of another jurisdiction. A regulatory agency's acceptance of a relinquishment of license stipulation, consent order or other settlement offered in response to or in anticipation of filing of administrative charges against a license shall be construed as action against a license. I understand if I am claiming an 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.

eb Bush
Governor

FLORIDA DEPARTMENT OF HEALTH

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

5/02- 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

FPIC

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

MEDICINE BOARD
2002 APR -9 AM 11:55

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: November 17, 2001

Reason For Cancellation: Non Payment

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

DPR:1/20/87

ø File No: 64867 Medical Doctor
ø Lic: 73993 CLEAR, ACTIVE
ø SSN:
ø Name: KIMBERLY PAULINE VAN SCRIVER
ø Addr: 836 PRUDENTIAL DR. STE 1506
ø JACKSONVILLE, FL, 32207
ø
ø
ø
ø Phone: (904) 296-3200 Ext:
ø
ø Action: Exit

1000 Riverside Avenue, Suite 800 • Jacksonville, Florida 32204 • (904) 354-5910 • 1-800-741-3742 • Fax (904) 358-6728
P.O. Box 44033 • Jacksonville, Florida 32231-4033 • *Internet Address:* http://www.medmal.com

AC# **COPY**

STATE OF FLORIDA
DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE

DATE	LICENSE NO.	CONTROL NO.
01/23/2005	ME 73993	153206

The **MEDICAL DOCTOR**
named below has met all requirements of
the laws and rules of the state of Florida.
Expiration Date: **JANUARY 31, 2007**
KIMBERLY PAULINE VAN SCRIVER
4311 SALISBURY RD N
JACKSONVILLE, FL 32216

AC#
STATE OF FLORIDA
DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE
LICENSE NO. ME 73993
CONTROL NO. 153206
DATE 01/23/2005
The MEDICAL DOCTOR named below has met all requirements of the laws and rules of the state of Florida.
COPY - NOT A VALID LICENSE - COPY
LICENSEE SIGNATURE

COPY - NOT A VALID LICENSE - COPY

DISPLAY IF REQUIRED BY LAW

EXPIRATION DATE: JANUARY 31, 2007

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. Use this section to report name and/or practice location address and/or mailing address changes. If you have not received your renewal notice 90 days prior to the expiration date shown on this license, please call (850) 488-0595.

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

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

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

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

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

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

FROM: _____
LAST FIRST MIDDLE

TO: _____
LAST FIRST MIDDLE

DH 2103, 5/98

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

_____
_____
_____
CITY STATE ZIP

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

_____
_____
_____
CITY STATE ZIP

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

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

FLORIDA DEPARTMENT OF HEALTH

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

P.O. Box 6320 • Tallahassee, FL 32314-6320

Florida Department of Health - Board of Medicine
LICENSE RENEWAL NOTICE

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

Received Date : 1/4/05
Deposit Date : 1/4/05
Deposit # : 167301
Batch Number : 009442
Validation # : 904067838
Check Amount : $454.00
PRO CDE : 1501

The fee of **$454.00** and the renewal notice must be postmarked on or before January 31, 2005. Renewal notices postmarked on or after February 1, 2005 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.

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:

A. **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.

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

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

6. Other Information:

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

File Number: 64867 Sequence Number: 14
Profession Code: 1501 20 20

* M E 0 0 0 0 7 3 9 9 3 *

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

MQA
the road to quality health care begins here.

7. CHANGES TO CURRENT LICENSE INFORMATION:

PLEASE READ THIS SECTION CAREFULLY BEFORE MAKING ANY CHANGES:

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

( ) **CHANGE OF NAME:**

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

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

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

( ) **CHANGE OF MAILING ADDRESS:**

Attention:
Street Addr1:
Street Addr2:
City:
State: Zip: - Phone: ( ) -

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

Attention: KIMBERLY VANSCRIVER, MD. PA
Street Addr1: 4311 SALISBURY ROAD NORTH
Street Addr2:
City: JACKSONVILLE
State: FL Zip: 32216- Phone: (904) 855-4211

CHECKLIST FOR MAILING RENEWAL FORM

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

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

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

( ) Yes

CHANGE OF LICENSE STATUS:

( ) I wish to change my status from Active to Inactive. The fee for an inactive receipt is **$415.00**. The fee for inactive after January 31, 2005 is **$900.00**.

CHANGE OF MILITARY STATUS:

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

DISPENSING:

( ) I wish to dispense medicinal drugs for a fee from my practice location and I understand an annual inspection of my dispensing records will be conducted. The fee for registration as a dispensing practitioner is **$100.00** in addition to your renewal fee.

FINANCIAL RESPONSIBILITY

NAME: Kimberly P. VanSciver LICENSE NUMBER: ME 73993

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.

OPTION I: FINANCIAL RESPONSIBILITY COVERAGE

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

☐2. I have hospital staff privileges and I have established an irrevocable letter of credit or 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 self insurance as provided in s. 627.367, F.S

☒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.

☐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;

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

☐3. I 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 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)(g) or 459.0085(5)(g), F. S.; or

☐5. 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).

[redacted]

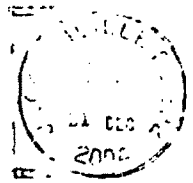
Kimberly van Scriver, M.D., P.A.

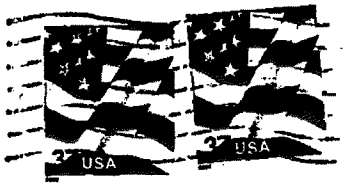
2127

Department of Health	12/30/2004	454.00
Compass		454.00

[redacted]

KIMBERLY VAN SCRIVER, MD, PA
OBSTETRICS & GYNECOLOGY
4311 SALISBURY ROAD N ✦ JACKSONVILLE, FL 32216





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

32314+6320

AC# **COPY**

STATE OF FLORIDA
DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE

DATE	LICENSE NO.	CONTROL NO.
01/13/2007	**ME 73993**	**211223**

The **MEDICAL DOCTOR**
named below has met all requirements of
the laws and rules of the state of Florida.
Expiration Date: **JANUARY 31, 2009**

QUALIFICATION(S):
DISPENSING PRACTITIONER

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

AC# CONTROL NO. 211223
STATE OF FLORIDA
DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE
LICENSE NO. ME 73993
DATE 01/13/2007
The **MEDICAL DOCTOR**
named below has met all requirements of

COPY - NOT A VALID LICENSE - COPY

LICENSEE SIGNATURE

COPY - NOT A VALID LICENSE - COPY

QUALIFICATION(S): Dispensing Practitioner

GOVERNOR INTERIM SECRETARY

DISPLAY IF REQUIRED BY LAW

EXPIRATION DATE: **JANUARY 31, 2009**

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. Use this section to report name and/or practice location address and/or mailing address changes. If you have not received your renewal notice 90 days prior to the expiration date shown on this license, please call (850) 488-0595.

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

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

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

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

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

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

FROM: _____
LAST FIRST MIDDLE

TO: _____
LAST FIRST MIDDLE

DH 2103, 5/98

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

_____

_____

CITY STATE ZIP

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

_____

_____

CITY STATE ZIP

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

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

First Professionals Insurance Company

2007 FEB -1 PM 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-061847

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

1000 Riverside Avenue, Suite 800 • Jacksonville, Florida 32204 • (904) 354-5910 • 1-800-741-3742 • Fax (904) 358-6728
P.O. Box 44033 • Jacksonville, Florida 32231-4033 • *Internet Address*: http://www.medmal.com

AC# **COPY**

STATE OF FLORIDA
DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE

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

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

Expiration Date: **JANUARY 31, 2011**

QUALIFICATION(S):
DISPENSING PRACTITIONER

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

AC# COPY
STATE OF FLORIDA
DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE
LICENSE NO. ME 73993
CONTROL NO. 277928
DATE 01/27/2009
The MEDICAL DOCTOR
named below has met all requirements of
COPY - NOT A VALID LICENSE - COPY
LICENSEE SIGNATURE

COPY - NOT A VALID LICENSE - COPY

QUALIFICATION(S):
Dispensing Practitioner

GOVERNOR STATE SURGEON GENERAL

DISPLAY IF REQUIRED BY LAW

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.

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

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

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

FROM: _____
LAST FIRST MIDDLE

TO: _____
LAST FIRST MIDDLE

DH 2103, 5/98

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

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

ME 73993UF - Jacksonville

1. HOSPITAL: University Medical Ctr EMPLOYMENT DATE: 5/1/97
2. NAME OF HOSPITAL ADMINISTRATOR: W.A. McGRIFF III
3. NAME OF DIRECTOR OF MEDICAL EDUCATION: ANN HARWOOD-NUSS, MD

H PHOTO HERE
PHOTO MUST BEEN TAKEN HIN 60 DAYS DING DATE OF PLICATION
RECEIVED
N 1 2 1997
REVENUE
DPR

06/13/97 $100.00
ID [redacted] D TYPE: S
BT: 960041494 RC: 960747290
01-015-10 $100.00

4.

REGISTRATION METHOD (CHECK ONLY ONE): REGISTRATION FEES ARE NON-REFUNDABLE

A1 [ ] I AM APPLYING FOR INTERN/RESIDENT/FELLOW REGISTRATION
B1 [ ] I AM APPLYING FOR HOUSE PHYSICIAN REGISTRATION
A2 [ ] RENEWAL
B2 [ ] RENEWAL

REGISTRATION FEE - $100.00 HOUSE PHYSICIAN RENEWAL REGISTRATION FEE - $200

5. SOCIAL SECURITY NUMBER: _____ APPLICATION SHOULD BE TYPED

6. NAME: Kimberly (FIRST) Pauline (MIDDLE) Van Scriver (LAST)

7. MAILING ADDRESS: 6812 Mayhill ct NW (No. & Street) Albuquerque (City) NM (State) 87120 (Zip)

8. PLACE OF BIRTH Long Beach, CA (City, State and Country) DATE OF BIRTH 7/18/65 (Month/Day/Year)

9. TELEPHONE NUMBER: (505) 836-2863 Residence-area code/number _____ Office-area code/number

10. MEDICAL DEGREE WAS OBTAINED FROM: University of New Mexico (Medical School) (Country) 5/94 Date

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 X.

13. Have you ever been denied licensure by the licensing authority in any jurisdiction? Yes ___ No X.

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 X.

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. Yes X No ___.
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.? Yes ___ No X.

OVER

N187985

THIS FORM MAY BE DUPLICATED

17. Check category: [X] U.S. Citizen [ ] Naturalized Citizen [ ] Immigrant [ ] Refugee
[ ] Filed declaration of intention

18. PHYSICAL DESCRIPTION: COLOR OF EYES: Blue WEIGHT: 165/160
COLOR OF HAIR: Brown HEIGHT: 5'10"
OTHER MEANS OF IDENTIFICATION: _____

19. List all places of previous medical employment in the United States, including Florida. If additional space is needed attach to application:

EMPLOYMENT/HOSPITAL	ADDRESS	EMPLOYMENT DATES		POSITION	APPROVED TRAINING	
		FROM	TO		YES	NO
University of Oklahoma	Oklahoma City	6/94	6/95	internship-FP	X	
University of New Mexico	Albuquerque, NM	7/95	5/97	Residency-OB/Gyn	X	

20. AFFIDAVIT OF APPLICANT

I, Kimberly P. van Servir, being first duly sworn, depose and say that I am the person referred to in the foregoing registration application and supporting documentation, and that the attached photograph is a true likeness of myself.

I hereby authorize all hospital(s), 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 release to the Florida Board of Medicine any information which is material to my registration application pursuant to 458.345, F.S.

I have carefully read the questions in the foregoing registration application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this registration application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of my registration as an unlicensed physician in the State of Florida.

Kimberly P. van Servir MD
(Signature of Applicant)

The foregoing instrument was acknowledged before me this 17 day of April, 19 97, by Kimberly P. van Servir, MD, who is personally known to me or who has produced as identification and did/did not take an oath.

Barbara E Dodson
Signature of Notary

BARBARA E. DODSON
Name of Notary Typed, Printed or Stamped

Commission No. 4/11/2001
Commission Number and Expiration Date

SEAL

Attention Notary: Although the information requested below is OPTIONAL, it could prevent fraudulent attachment of this certificate to an unauthorized document.

THIS CERTIFICATE MUST BE ATTACHED TO THE DOCUMENT DESCRIBED AT RIGHT:

Title or Type of Document Registration application pursuant to 458.345, F.S.

Number of Pages two Date of Document _____

Signer(s) Other than Names Above _____

AC# COPY

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**
named below has met all requirements of
the laws and rules of the state of Florida.
Expiration Date: **JANUARY 31, 2013**

QUALIFICATION(S):
DISPENSING PRACTITIONER

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

STATE OF FLORIDA
DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE

AC#

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

The **MEDICAL DOCTOR**
named below has met all requirements of

COPY - NOT A VALID LICENSE - COPY

LICENSEE SIGNATURE

COPY - NOT A VALID LICENSE - COPY

QUALIFICATION(S):
Dispensing Practitioner

GOVERNOR DEPUTY SECRETARY

DISPLAY IF REQUIRED BY LAW

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.

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

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

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

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

FROM: _____
LAST FIRST MIDDLE

TO: _____
LAST FIRST MIDDLE

DH 2103, 5/98

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

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

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

A Jacksonville Womens Health Center Inc.

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 measeures 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

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.

11/11/10

Kim van Scriver, MD Medical Director — Dare of signature

11/9/2010

Desta Messer, ARNP — Date of signature

License # ARNP1677382

MEDICINE BOARD

2017 NOV 17 PM 3:23

ADVANCED REGISTERED NURSE PRACTITIONER PROTOCOL

Name: Desta Messer

Address: 1126 Baisdew Road, Jacksonville, FL 32218

License #: ARNP 10777382 Employed by: Jacksonville Womens Health Center

Business Address: 4131 University Blvd. Jax FL 32216

ARNP signature: D Messer ARNP

ADVANCED REGISTERED NURSE PRACTITIONER PROTOCOL

MEDICINE BOARD
2017 NOV 17 PM 3:23

Name: Dista Messer

Address: 1126 Baisdew Road Jacksonville, FL 32218

License #: ARNP 10077382 Employed by: Jacksonville Womens Health Cente

Business Address: 4131 University Blvd. Jax, FL 32216

ARNP signature: D Messer ARNP

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**
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
JACKSONVILLE, FL 32216

QUALIFICATION(S):
DISPENSING PRACTITIONER

AC#
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**
named below has met all requirements of
the laws and rules of the state of Florida.
Expiration Date: **JANUARY 31, 2015**

COPY - NOT A VALID LICENSE - COPY
LICENSEE SIGNATURE

COPY - NOT A VALID LICENSE - COPY

GOVERNOR STATE SURGEON GENERAL

DISPLAY IF REQUIRED BY LAW

QUALIFICATION(S):
Dispensing Practitioner

EXPIRATION DATE: **JANUARY 31, 2015**

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.

Use this section to report name change. Name changes require legal documentation showing the name change. Please make sure that a photocopy of one of the following accompanies this form: a marriage license, a divorce decree or a court order.

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

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

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

RECEIVED
JUN 12 1997

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):
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 RESIDENT	State: NEW MEXICO (VERIFIED)
Specialty :	OBSTETRICS AND GYNECOLOGY	07/1995 - 06/1998
Institution:	UNIV OF OK COLL OF MED RESIDENT	State: OKLAHOMA (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

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) : State	MD/ DO	Date Granted	Expiration Date	Status	License Type	As of

Note: When the specific month and day are unknown, the date will display the default value of "01." 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 board. 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.

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

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 Healthcare 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, Il 60610.

Practitioner's Name KIMBERLY PAULINE VAN SCRIVER License # ME0073993

FLORIDA DEPARTMENT OF HEALTH

MANDATORY PRACTITIONER PROFILE QUESTIONNAIRE

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

I. PRACTITIONER DATA

A. PROFESSIONAL LICENSE NUMBER: ME0073993 (check one) ☒ ME/MD ☐ OS/DO ☐ CH/DC ☐ PO/DPM

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

CURRENT NAME:

VAN SCRIVER	KIMBERLY	PAULINE
(LAST)	(FIRST)	(MIDDLE AND MAIDEN NAME, IF APPLICABLE)

FORMER NAME(S):

NONE		
(LAST)	(FIRST)	(MIDDLE)
NONE		
(LAST)	(FIRST)	(MIDDLE)

C. SOCIAL SECURITY NUMBER: _____ (This will not be published as a part of the profile; also, see instructions on page iii)

D. MAILING ADDRESS: [redacted] 4205 Belfort Rd. Su. 2004 Jacksonville, Florida 32216
(STREET AND NUMBER) (CITY) (STATE) (ZIP CODE)

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

Womens Medical Group, P.A. 4205 Belfort Rd. Su. 2004 Jacksonville, Florida 32216
(PRACTICE NAME) (STREET AND NUMBER) (CITY) (STATE) (ZIP CODE)

OTHER PRACTICE LOCATION(S): (OPTIONAL)

OFFICE 2: (OPTIONAL)

[redacted] None
(PRACTICE NAME) (STREET AND NUMBER) (CITY) (STATE) (ZIP CODE)

OFFICE 3: (OPTIONAL)

None
(PRACTICE NAME) (STREET AND NUMBER) (CITY) (STATE) (ZIP CODE)

E. TELEPHONE: (904) 296-3200 (This will not be published as a part of the profile.)

F. YEAR BEGAN PRACTICING MEDICINE: 1997 (Authority: s. 455.565(1)(a)5., F.S.)

II. ALL MEDICAL EDUCATION

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

NAME OF SCHOOL/UNIVERSITY	DATES OF ATTENDANCE	DATE OF GRADUATION	TYPE OF DEGREE
UNIV OF NM SCH OF MED, ALBUQUE	1992-1994	1994	M.D.
New York Medical School	1989-1992	1992	none

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

MEDICAL TRAINING PROGRAM NAME	INTERNSHIP / RESIDENCY / FELLOWSHIP / OTHER	SPECIALTY AREA	CITY / STATE / COUNTRY	FROM MM/DD/YYYY	TO MM/DD/YYYY
UNIV OF FL COLL OF	RES	OBSTETRICS AND GYNECOLOGY	FL	5/1/97	6/30/98
UNIV OF OK COLL OF	RES	FAMILY PRACTICE	OK	07/01/1994	06/30/1995
UNIV OF NM SCH OF M	RES	OBSTETRICS AND GYNECOLOGY	NM	07/01/1995	04/30/1997

Practitioner's Name GIMEFLY PAULINE VAN SCRIVER License # ME0073993

III. OTHER H ALT ELATED DEGREES

Do you currently hol deg n a health related profession other than the professional degree listed In II. A. above? Yes ☐ No ☒

If "YES", list all ical essional schools from which a degree in a health related profession other than the professional degree was obtained. (Authority: s. 455.56)(a)1.

NAME OF SCHOO UNIVE Y	CITY / STATE / COUNTRY	FROM MM/DD/YYYY	TO MM/DD/YYYY	DEGREE TITLE

IV. FACULTY PP MENTS:

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

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

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

	T E	INSTITUTION	CITY/STATE
1.			
2.			
3.			

V. STAFF PR LE ES:

Do you currently hol aff p ges in a hospital/medical/health institution? Yes ☒ No ☐

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

	NAME OF HOS AL/ME L/HEALTH INSTITUTION	CITY/STATE
1.	Memoria Medical Center	Jacksonville, Florida
2.	St. Luk s Hospital	
3.	Baptis M dical Center	

VI. SPECIALT BO D CERTIFICATIONS:

Do you hold a certific on fr ny specialty board recognized by the Florida board regulating the profession for which you are licensed? Yes ☐ No ☒
(Authority: s. 455.565(1)(a F.S.)

If "YES", complete se on be

	SPECIALTY BC D NA	CERTIFICATION / SPECIALITY / SUBSPECIALITY
1.		
2.		
3.		

VII. FINAL DIS PL RY ACTION:

A1. Within the previou en (ears, have you ever had any final disciplinary action taken against you by a specialty board recognized by the neric Board of Medical Specialties, the American Osteopathic Association, the American Chiropractic Association, or oth sim national organization? (Authority: s. 455.565(1)(a)8., F.S.) Yes ☐ No ☒

If "YES", list name of e ialty board(s), date, description of violation(s), description of the final disciplinary action(s), and indicate whether the final disciplinary action und peal. (attach copy of notice of appeal)

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

A2. Within the previou en (1 ears, have you ever had any final disciplinary action taken against you by the agency regulating your license, in thi tate ny other jurisdiction? (Authority: s. 455.565(1)(a)8., F.S.) Yes ☐ No ☒

If "YES", list name of a y(s), date, description of violation(s), description of the final disciplinary action(s), and indicate whether the final disciplinary action und ppeal. (attach copy of notice of appeal)

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

Practitioner's Name KIMBERLY PAULINE VAN SCRIVER License # ME0073993

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

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

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

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

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

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

VIII. CRIMINAL OFFENSES

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

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

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

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

A. Hospital Privileges - (Check only one) (Authority s. 455.5651(4), F.S.) 2 | A

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

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

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

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

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

B. Exemption

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

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

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

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

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

Practitioner's Name KIMERLY PAULINE VAN SCRIVER License # ME0073993

☐ 5. I meet all the following criteria: N/A

(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 a license stipulation, consent order or other settlement offered in response to or in anticipation of filing of administrative charges against a license shall not be construed as action against a license. I understand if I am claiming an exemption under this section that I must either post notice in the form of a sign, prominently displayed in the reception area or provide a written statement to any person to show medical services are being provided that I have decided not to carry medical malpractice insurance. I understand such a sign or notice must contain the wording specified in s. 458.320(5)(f) or s. 459.0085(5)(f), F.S.

X. LIABILITY INFORMATION (Allopathic, Osteopathic and Podiatric Physicians Only) N/A

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

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

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

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

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

XI. LIABILITY INFORMATION (Chiropractic Physicians Only) N/A

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

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

XII. OPTIONAL INFORMATION:

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

	TITLE	PUBLICATION	DATE
1.	None		
2.			
3.			

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

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

	COMMUNITY SERVICE/AWARD/HONOR	ORGANIZATION		COMMUNITY SERVICE/AWARD/HONOR	ORGANIZATION
1.	None		2.		
3.			4.		

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

	ORGANIZATION		ORGANIZATION
1.	Duval County Medical Society	2.	American College of OB/GYN
3.	American Medical Association	4.	

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

1.	None	2.	
3.		4.	

F. E-MAIL ADDRESS:

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

	ORGANIZATION		
1.	None	2.	
3.		4.	

H. OTHER STATE LICENSURE

	STATE	PROFESSION
1.	None	
2.		
3.		

I affirm these statements are true and correct and recognize that providing false information may result in disciplinary action against my license or criminal penalties pursuant to Sections 456.624, 458.327, 458.331, 459.013, 459.015, 460.413, 461.013, 775.082, 775.083 and 775.084, Florida Statutes.

(Signature of Physician) 4-1-99 (Date)

Practitioner's Name KIMBERLY PAULINE VAN SCRIVER License # ME0073993

EXHIBIT 1 – REPORT ON PROFESSIONAL LIABILITY CLAIMS AND ACTIONS

Include information relating to liability actions occurring within the previous 10 years. The actions are required to be reported under section 455.697 F.S. You must submit a completed form for each occurrence. For Allopathic, Osteopathic and Podiatric physicians, copies of reports previously submitted under the requirements of s. 455.697, F.S., (formerly s. 355.247, F.S.) may be submitted in lieu of this exhibit to satisfy this reporting requirement. None

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

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

Street Address: _____

City: _____ State: _____ Zip Code: _____

Age: _____ Sex: _____

Date of suit: _____ / _____ / _____

List other defendants involved in this claim:

1. _____ 2. _____
3. _____ 4. _____

Date of final claim disposition: _____ / _____ / _____

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

Indemnity paid on behalf of this defendant: $_____

Loss adjustment expense paid to defense counsel: $_____

All other loss adjustment expense paid: $_____

Name of institution at which the injury occurred: _____

Location of injury occurrence:

___ Patient's Room	___ Physical Therapy Dept.	___ Radiology	___ Labor & Delivery Room
___ Operating Suite	___ Nursery	___ Emergency Room	___ Special Procedure Room
___ Recovery Room	___ Critical Care Unit	___ Other_____	

Final diagnosis for which treatment was sought or rendered _____

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

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

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

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

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

Signature of Physician: _____ 4-1-99

Our records indicate the following reported claims:

Incident Date	Settlement Date	Incident Date	Settlement Date	Incident Date	Settlement Date	Incident Date	Settlement Date	Incident Date	Settlement Date

DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE
Tallahassee, Florida 32314-6330

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

CONFIDENTIAL

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

Jeb Bush
Governor

FLORIDA DEPARTMENT OF
HEALTH

Robert G. Brooks, M.D.
Secretary

October 15, 1999

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
Profession : Medical Doctor
License Status : ACTIVE CLEAR
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	City	State
MEMORIAL HOSPITAL JACKSONVILLE	JACKSONVILLE	FLORIDA
ST. LUKE'S HOSPITAL	JACKSONVILLE	FLORIDA
BAPTIST MEDICAL CENTER	JACKSONVILLE	FLORIDA

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

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

Participates in Medicaid Program:

Yes

II. Education and Training

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

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

Aff. 73993

FL

American Medical Association

Physicians dedicated to the health of America

RECEIVED
AUG 2 1 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
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 RESIDENT	**State:** NEW MEXICO (VERIFIED)
Specialty :	OBSTETRICS AND GYNECOLOGY	07/1995 - 05/1997
Institution:	UNIV OF OK COLL OF MED RESIDENT	**State:** OKLAHOMA (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

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) : State	MD/ DO	Date Granted	Expiration Date	Status	License Type	As of

Note: When the specific month and day are unknown, the date will display the default value of "01." 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 board. 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.

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

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

FACSIMILE TRANSMITTAL SHEET

TO: Tanya @ DOH	FROM: Kimberly van Scriver, M.D.
FAX NUMBER: 850 - 487 - 3284	DATE: 10/6/05
COMPANY:	TOTAL NO. OF PAGES INCLUDING COVER: 2
PHONE NUMBER: 850 - 488 - 0595	SENDER'S REFERENCE NUMBER:
RE:	YOUR REFERENCE NUMBER:

☐ URGENT ☐ FOR REVIEW ☐ PLEASE COMMENT ☐ PLEASE REPLY ☐ PLEASE RECYCLE

NOTES/COMMENTS:

profiling Specialist

KIMBERLY VAN SCRIVER, M.D., P.A.
PHONE: 904-855-4211 • FAX: 904-425-0192

KIMBERLY VAN SCRIVER, MD, PA
OBSTETRICS & GYNECOLOGY

Department of Health
4052 Bald Cypress Way, Bin C10
Tallahassee, FL. 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

4311 SALISBURY ROAD N ♦ JACKSONVILLE, FL 32216 ♦ PHONE: 904.855.4211 ♦ FAX: 904.425.0192

Florida Department of Health - Board of Medicine

LICENSE RENEWAL NOTICE

FOR DEPARTMENT USE ONLY
Received Date : 1/4/05
Deposit Date : 1/4/05
Deposit # : 167301
Batch Number : 009442
Validation # : 904067838
Check Amount : $454.00
PRO. CDE. : 1501

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. Renewal notices postmarked on or after February 1, 2005 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

(904) 855-4211

2. CURRENT PRACTICE LOCATION:

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

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:

A. **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.

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

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

6. Other Information:

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

File Number: 64867 Sequence Number: 14
Profession Code: 1501 20 20

ME 0 0 0 0 0 7 3 9 9 3

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

MQA
the road to quality health care begins here.

FINANCIAL RESPONSIBILITY

NAME:_____ **LICENSE NUMBER:** _____

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.

OPTION I: FINANCIAL RESPONSIBILITY COVERAGE

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

☐2. I have hospital staff privileges and I have established an irrevocable letter of credit or 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

☐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.

☐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.

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;

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

☐3. I 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 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)(g) or 459.0085(5)(g), F. S.; or

☐5. 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).

7. CHANGES TO CURRENT LICENSE INFORMATION:

PLEASE READ THIS SECTION CAREFULLY BEFORE MAKING ANY CHANGES:

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

( ) **CHANGE OF NAME:**

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

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

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

( ) **CHANGE OF MAILING ADDRESS:**

Attention:
Street Addr1:
Street Addr2:
City:
State: Zip: - Phone: ( ) -

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

Attention: KIMBERLY VANSCRIVER, MD. PA
Street Addr1: 4311 SALISBURY ROAD NORTH
Street Addr2:
City: JACKSONVILLE
State: FL Zip: 32216- Phone: (904) 855-4211

CHECKLIST FOR MAILING RENEWAL FORM

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

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

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

( ) Yes

CHANGE OF LICENSE STATUS:

( ) I wish to change my status from Active to Inactive. The fee for an inactive receipt is **$415.00**. The fee for inactive after January 31, 2005 is **$900.00**.

CHANGE OF MILITARY STATUS:

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

DISPENSING:

( ) I wish to dispense medicinal drugs for a fee from my practice location and I understand an annual inspection of my dispensing records will be conducted. The fee for registration as a dispensing practitioner is **$100.00** in addition to your renewal fee.

FINANCIAL RESPONSIBILITY

NAME: Kimberly P. VanSant LICENSE NUMBER: ME 73993

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.

OPTION I: FINANCIAL RESPONSIBILITY COVERAGE

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

☐2. I have hospital staff privileges and I have established an irrevocable letter of credit or 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 self insurance as provided in s. 627.367, F.S

☒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.

☐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;

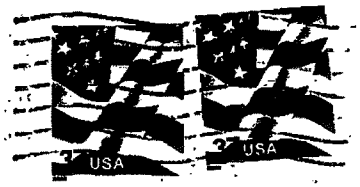
☐2. I hold a limited license issued pursuant to s. 458.317 or 459.0075, F. S., and practice only under the scope of the limited license;

☐3. I 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 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)(g) or 459.0085(5)(g), F. S.; or

☐5. 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, PA
OBSTETRICS & GYNECOLOGY
4311 SALISBURY ROAD N ✦ JACKSONVILLE, FL 32216



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

32314+6320

Kimberly van Scriver, M.D., P.A.

Department of Health

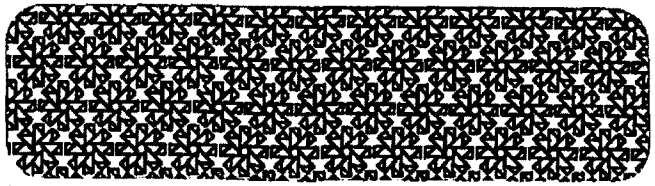
12/30/2004

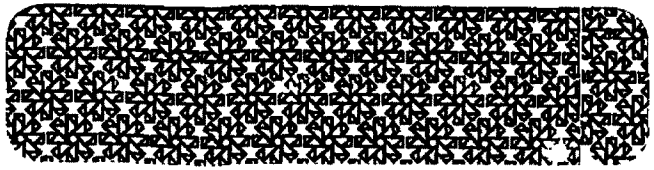
2127

454.00

Compass

454.00





FLORIDA DEPARTMENT OF HEALTH

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.

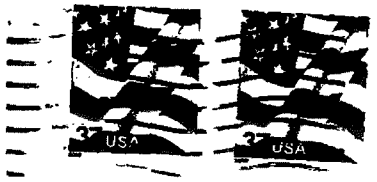
Sincerely,

Licensure Services

Division of Medical Quality Assurance
Bureau of Operations

P.O. Box 6320 • Tallahassee, FL 32314-6320

Kimberly van Scriver, M.D., P.A.
4311 Salisbury Rd N
Jacksonville FL 32216



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

32314+6320

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 MAILING ADDRESS:

Current Mailing Address:

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

New Mailing Address:

Licensee's Last Name First Middle Initial

Attn:

Street Address:

City: State: Zip:

Phone: ( )

DEPARTMENT USE ONLY

2. CHANGE OF PRACTICE LOCATION:

Current Practice Location:

ATTN: 4201 BELFORT ROAD, SUITE 2004
WOMEN'S MEDICAL GROUP, P.A.
JOE ADAMS BLDG.
JACKSONVILLE, FL 32216

New Practice Location:

Attn:

Street Address:

City: State: Zip:

Phone: ( )

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

Description	Department Information	Information is Accurate		Correct Information
Social Security #		◯ Yes	◯ No	
Date of Birth	07/18/65	◯ Yes	◯ No	
Sex	Female	◯ Yes	◯ No	
Race	White	◯ Yes	◯ No	
Race Options: White, Black, Native, Asian, Other, Hispanic & not given				

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

5. MILITARY STATUS:

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

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

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

◯ Yes

7. THERE ARE TWO RENEWAL METHODS AVAILABLE:

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

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

PIN Number:
License Number: ME 73993

B. U.S. Mail:

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

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

8. Other Information:

File Number: 64867 20 20 Sequence Number: 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.

CATEGORY I - CATEGORIES OF FINANCIAL RESPONSIBILITY COVERAGE:

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

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

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

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

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

CATEGORY II - EXEMPTION CATEGORIES OF FINANCIAL RESPONSIBILITY COVERAGE:

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

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

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

◯ 9. I meet all of the following criteria:

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

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

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

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

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

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

Florida Department of Health - Board of 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 January 31, 2007. Renewal notices postmarked on or after February 01, 2007 require renewal and delinquent fees of **$939.00**.

DEPARTMENT USE ONLY

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.

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, **www.flhealthsource.com**. 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 **www.doh.state.fl.us/mqa/avoid.html** to find out more.

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

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

6. OTHER INFORMATION:

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

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 Sequence Number: 28
Profession Code: 1501 20 20

ME0000073993

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

7. CHANGES TO CURRENT LICENSE INFORMATION:

◯ **CHANGE OF NAME:**

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

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

Last Name:

First Name:

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

◯ **CHANGE OF MAILING ADDRESS:**

Attention:

Addr1:

Addr2:

City:

State: Zip: - Phone: ( ) -

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

Attention:

Addr1:

Addr2:

City:

State: Zip: - Phone: ( ) -

CHECKLIST FOR MAILING RENEWAL FORM:

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

REQUIRED:
- ◯ Renewal notice
- ◯ Check or Money order written to Department of Health
- ◯ Financial Responsibility form (check only one item on the FR form)
- ◯ Updated paper copy of Profile, if you are mailing your renewal notice
- ◯ Mail to: PO Box 6320, Tallahassee, Florida 32314-6320

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

◯ Yes

CHANGE OF LICENSE STATUS:

◯ I wish to change my status from active to inactive. The fee for an inactive receipt is **$415.00**. The fee for inactive after January 31, 2007 is **$900.00**.

CHANGE TO MILITARY STATUS:

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

CHANGE TO RETIRED STATUS:

◯ I am requesting retired status. The fee for retired status is **$55.00** postmarked on or before January 31, 2007. The fee for retired status on or after February 01, 2007 is **$540.00**.

DISPENSING:

◯ I wish to discontinue my dispensing registration. I understand that I will no longer be able to dispense medicinal drugs for a fee from my practice location. Your renewal notice and fee of **$454.00** is due on or before January 31, 2007. Renewal notices postmarked on or after February 01, 2007 require a renewal fee of **$839.00**.

Florida Department of Health - Board of Medicine
LICENSE RENEWAL NOTICE

DEPARTMENT USE ONLY

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. Renewal notices postmarked on or after February 1, 2005 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

(904) 855-4211

2. CURRENT PRACTICE LOCATION:

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

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:

A. **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.

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

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

6. Other Information:

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

File Number: 64867 Sequence Number: 14

Profession Code: 1501 20 20

ME0000073993

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

7. CHANGES TO CURRENT LICENSE INFORMATION:

PLEASE READ THIS SECTION CAREFULLY BEFORE MAKING ANY CHANGES:

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

◯ CHANGE OF NAME:

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

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

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

◯ CHANGE OF MAILING ADDRESS:

Attention:
Street Addr1:
Street Addr2:
City:
State: Zip: - Phone: ( ) -

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

Attention:
Street Addr1:
Street Addr2:
City:
State: Zip: - Phone: ( ) -

CHECKLIST FOR MAILING RENEWAL FORM

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

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

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

◯ Yes

CHANGE OF LICENSE STATUS:

◯ I wish to change my status from Active to Inactive. The fee for an inactive receipt is **$415.00**. The fee for inactive after January 31, 2005 is **$900.00**.

CHANGE OF MILITARY STATUS:

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

DISPENSING:

◯ I wish to dispense medicinal drugs for a fee from my practice location and I understand an annual inspection of my dispensing records will be conducted. The fee for registration as a dispensing practitioner is **$100.00** in addition to your renewal fee.

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**.

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

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

You will be prompted to complete the Physician Workforce Survey online.

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

Remember all renewals MUST 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 www.FLHealthsource.com. Select LICENSEE/PROVIDER, click on VIEW PROFILE, and Login with your Account ID and Password. If you make changes to your profile, BE SURE to click on "confirm changes" to update the Department's information system.

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

*** **AUTO** *** 006_010_04150 73993-4150

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

:322168200547:

Your Medical Doctor License # **ME 73993** will expire at midnight, Eastern Standard Time (EST) on **Monday, January 31, 2011**.

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

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

You will be prompted to complete the Physician Workforce Survey online.

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

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

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

Remember, all renewals MUST be submitted **no later than January 31, 2011** in order to avoid a delinquent fee. Questions? Contact the MQA Call Center at (850) 488-0595.

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

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

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

License Renewal Notification

Your Medical Doctor License # **ME 73993** will expire at midnight, Eastern Standard Time (EST) on **Thursday, January 31, 2013**.

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

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

You will be prompted to complete the Physician Workforce Survey online.

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

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

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

Remember, all renewals MUST be submitted **no later than January 31, 2013** in order to avoid a delinquent fee. Questions? Contact the MQA Call Center at (850) 488-0595.