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nitial Medical Licensure	 STATE OF MARYLAND
ERSONAL INFORMATION	 BOARD OF PHYSICIANS
7/2003	P.O. Box 37217 • Baltimore, MD 21:

PHYSICIANS Baltimore, MD 21297

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Date:1/17/03

Page 2

9. Chronology of Activities (DO NOT ATTACH RESUME OR CURRICULUM VITAE.):

Beginning with the date you completed medical school and continuing through the present, list chronologically all of your activities. Account for all periods of time including each post-graduate training program you attended (regardless of whether or not you completed the program), each job you held (regardless of whether or not it was medically related or whether or not you were compensated), and any periods of unemployment.

Date Medical School was Completed: US 87
Activities after completing medical school: Please type or print.
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Address: 2802 Hichcrest Dr. Grapevine, TX
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Address: 6550 Famin St. St. 8014 Houston TX
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Address: 6550 Fanals St., St. 801A Hourson, TX

CONTINUED ON PAGE 3: If you will need more space than page 3 allows, please photocopy page 3 for your use or attach a separate sheet. Please sign and date each sheet you attach.

And the second s	Initial Medical Licensure MEDICAL EDUCATION 07/2003 Print Your Name: Date 7/17/03	Page 4
. l	MEDICAL EDUCATION: List all medical schools you have attended From: MM/YY To MM/	11
.W.	Texas Tech University School of Medicine 08/83 To 05/8	37
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	Medical School From Which You Received Your Medical Degree: Texas Tech University	
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	Language(s) of Instruction: English	
	Type of Degree: M.D. D.O. M.D./Ph.D M.B.B.S. M.B.B.Ch Other:)
	GRADUATES OF FOREIGN MEDICAL SCHOOLS (Graduates of schools not in the U.S. or its territories, Puerto Rico, or Canada Attach the following documents to this application: 1) A copy of your valid ECFMG certificate or Fifth Pathway Cer 2) A copy of your medical school diploma and a certified trans 3) If you listed an affiliation above (see * in 10 above), attach a the Certificate of Medical Education and Examinations Taken, Good Conduct Certificate or Intern Certificate (the ce must show your name, name of the medical school, and name of the university), and a certified translation. (Please that your name is written the same way on all documents. If it is not, you must submit documentation to show how and why your name difference.	tificate; lation; copy of rtificate be certain
11.	(See English Language Competency Requirements for Medical Licensure in Maryland in the introductory material included with your application.)	
	a. I graduated from a medical school or, after at least three years of attendance, a high school (includes GED), undergraduate co university where English was the only language of instruction throughout (you must provide documentation); or	llege, or
	b. I passed either [] the TOEFL or [] the ECFMG English test after December 31, 1973 AND I passed the [] TSE or [] OPI (If you have taken the Test of English as a Foreign Language (TOEFL) and either the Test of Spoken English (TSE) or the Oral Proficiency In (OPI), please request that Education Testing Service and/or Language Testing International send verification of your scores directly to the Bo	terview ard.)
	Are you claiming speech impairment? YES (If "YES," please write or call the Board for additional information.	
	ND41000000000000000000000000000000000000	

Stop! Following this page you will find Form MBP IML2, Verification of Education and English Language
Instruction. Complete Part 1 of form IML2 and send it to the institution from which you received your
medical degree and to the institution at which you satisfied Maryland's English language competency
requirements if it was somewhere other than your medical school. Please instruct the institution(s) to mail
the completed IML2 directly to the Board in an envelope that clearly bears the institution's name and address.
Forms not received directly from the institution(s) will not be accepted.

-	Initial Medical Licensu: POSTGRADUATE TRAINING	Print Your	Dallas	W	Johnson		Date: 7/17/03	Page
-	07/2003	Name:	<u> </u>		ZOMBUN	and with the first of the second state of the first of the second state of the second		
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12. POSTGRADUATE TRAINING (DO NOT ATTACH RESUME OR CURRICULUM VITAE.) List in chronological order ALL postgraduate training undertaken in the United States, its territories or possessions, Puerto Rico, or Canada regardless of whether it was completed or not and regardless of whether it was compensated or not. (Copies of training certificates are helpful, but not required.)

NOTE: On a case by case basis, the Board may consider full time teaching in an LCME -accredited medical school in the United States as an alternative to the accredited postgraduate clinical medical education required in the Code of Maryland Regulations 10.32.01.03D. Applicants who intend to request consideration of teaching experience as an alternative to accredited postgraduate clinical medical education should contact the Board's licensure division for further information.

- Effective October 1, 2000, graduates of all medical schools NOT in the U.S., its territories or possessions, Puerto Rico, or Canada are required to submit evidence acceptable to the Board of successful completion of 2 years of training in a postgraduate clinical medical education program accredited by an accrediting organization recognized by the Board (ACGME, AOA, or equivalent). If you have not met this requirement, DO NOT submit this application.
- A Fifth Pathway Program graduate must have been a U.S. citizen during the time of medical education and must have successfully completed two years of ACGME-accredited postgraduate clinical medical education after successfully completing a Board-approved Fifth Pathway program. If you have not met these two criteria, DO NOT submit this application.
- If after 10/1/92 you passed any medical licensing exam (or part, step, or component thereof) that you failed three or more times, either before or after 10/1/92, then you must successfully complete another year of ACGME/AOA-accredited clinical postgraduate training in addition to the year(s) usually required by Maryland. All of the additional year must have begun after the date of the last fail. Teaching will not be accepted as an alternative to a year required following three or more fails. If you have not met this requirement, DO NOT submit this application.

NOTE: Postgraduate training program cycles usually run from July 1 to June 30. If the dates of your postgraduate training are not within the usual cycle,

NOTE: Post	graduate training program cycles usually run from July 1 to June 30 the complete cycle, or extend beyond the usual cycle, please attach a	complete explanation of the reas	ion(s) that your training was "oll-cycle.") month year TO month year
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(ATTACH A SEPARATE SIGNED AND DATED PAGE IF ADDITIONAL SPACE IS NEEDED)

Following page 6 you will find Form MBP IML3, Verification of Postgraduate Medical Education. For each of the programs you have listed above, complete Part I of the IML3 and send a *copy of the IML3 to the STOP Program Director. Be certain to contact all programs before you send the IML3. Many programs now charge a fee for verification of training. All fees are the responsibility of the applicant.

^{*} Please remember to copy both sides of Form IML3 before mailing it to the Program Director.

Initial Medical Licensure HOSPITAL PRIVILEGES 07/2003 Print Your Name: Dallas W. Johnson		historia
Hospital Privileges After Postgraduate Training: Please list all hospitals at which you after the completion of your postgraduate training for the five year period preceding to space will be needed and enclose each signed and dated addition between pages 6 and	17.	
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Initial Medical Licensure

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Remember, following this page you will find MBP Form IML3, Verification of Postgraduate Medical Education. STOPI For each of the postgraduate medical education programs you listed on page 5, complete Part I of the IML3 and send an IML3 to each Program Director. Please remember to copy both sides of Form IML3 if you are sending the form to more than one Program Director. Be certain to contact ail programs before you send the IML 3. Many programs now charge a fee for verification training. All fees are the responsibility of the applicant.

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Initial Medical Licensure MEDICAL EXAMS 07/2003	Print Your Name: Dallas W.	Johnson	Date: 7 (17/03	Page 7
by individual states prior steps, or components or	to January 1, 1985) DO NOT SUBM of your medical licensing examinat	IIT THIS APPLICATION until you have tions or if you have more than 3 fail	verage, Medical Council of Canada, and licensing ve received written verification of having passe s any step, part or component of an examinatio	n.
complete medical licensi	edical licensing examinations ing examination history and sontact the administering author	scores directly to this board.	the administering authority of each exam In each examination category below, y	to send the ou will find
Have you ever failed any me	edical licensing examination (or part	t, step, or component thereof)? NO	YES Since October 1, 1992, I	nave you
passed any medical licensing	examination (or part, step, or compo	onent thereof) which at any time you h	au lancu unec or more unes:	Immonat
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f. National Boar	rd of Osteopathic Medical Exan	niners } Certifications issued befor	e January 1, 1971 are not accepted for licensur	e in Maryland.
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Stop! Following this page you will find form MBP IML7. Complete Part 1 of form IML7 and send a copy to each medical board in the U.S., its possessions and territories, Puerto Rico, and Canada that ever issued you a license/registration or administered to you a state/provincial licensing examination. Please check with each board first to determine if a fee is charged for the verification. The addresses and telephone numbers of all U.S. state medical boards can be found on the Federation of State Medical Board internet site at **www.fsmb.org**.

1	Initial Medical Licensu SPEX, Character/Fitne 07/2003		
5.	Check YES or N		
***************************************	X	Did you successfully complete a medical licensing exam (USMLE, NBME, etc.) within the 15-year period prior to filing this application?	
	図[During the past 10 years, have you maintained uninterrupted licensure since you were first issued a license in the United States, its territories, Puerto Rico, or Canada?	
		Do you have lifetime certification from, or within the past 10 years have you been certified or recertified by, a specialty board recognized by the American Board of Medical Specialties, the American Osteopathic Association, or the Royal College of Physicians and Surgeons of Canada?	
		If "YES," in which specialty were you certified? OB/GVNDate certified	
	itenilan sunu	swered "NO" to <u>all three</u> of the above questions, you MUST take the Special Purpose Examination. After you send on, contact the Federation of State Medical Boards at 817-571-2949 and tell them you are required to take the SI'EX in ase make arrangements for your scores to be sent to the Maryland Board.	
7.	Character and Fitn	ess Questions (Check either YES or NO)	
	YES NO	Has a state licensing or disciplinary board (including Maryland), or a comparable body in the armed services, denied your application for licensure, reinstatement, or renewal?	1
	a. b.	Has a state licensing or disciplinary board (including Maryland), or a comparable body in the armed services, taken action against you. Inc. nse? (Such actions include, but are not limited to, limitations of practice, required education admonishment, reprimand suspension, or revocation.) [Refer to the document <i>Grounds for Board Action in Maryland</i> included in your application packet.]	į.
		you, inches? (Such actions include, but are not infinited to, infinited	1
	C.	Has any licensing or disciplinary board in any jurisdiction (including Maryland), or a comparable body in the armed services, filed any complaints or charges against you or investigated you for any reason?	
	d.	Have you ever withdrawn your application for a medical license or other health professional license?	
	e.	Has a hospital, related health care institution, or alternative health care system investigated you or brought charges against you?	r
	4	Has a hospital, related health care facility, or alternative health care system denied your application for or failed to renew you privileges, or limited, restricted, suspended, or revoked your privileges in any way?	
	g.	Have you committed a criminal act to which you plead guilty or nolo contendere or for which you were convicted or received probation before judgement?	
	<u> </u>	Have you committed an offense involving alcohol or controlled dangerous substances to which you plead guilty or noio contender or for which you were convicted or received probation before judgement? (Such offenses include, but are not limited to, driving while under the influence of alcohol and/or controlled dangerous substances.)	•
	- com	Excluding minor traffic violations, are you currently under arrest or released on bond, or are there any current or pending charge against you in any court of law?	\$
	A Showing.	Do you illegally use drugs?	
	×.	Oo you have any physical or mental condition that currently impairs your ability to practice medicine or that would caus reasonable questions to be raised about your physical, mental, or professional competency?	8
	1.	Within the past five years, has anyone filed or settled a medical malpractice action in which you were named as a defendant?	
	m.	Are you in default of a service obligation that you incurred by receiving State or federal funds for your medical education?	
	C	Have you failed to make arrangements to satisfy State or federal loans that financed your medical education?	u
	O	Has your employment by any hospital, HMO, other health care facility or institution, or military entity been terminated for disciplinary reasons?	
	р.	Have you voluntarily resigned from any hospital, HMO, other health care facility or institution, or military entity while under investigation by that institution for disciplinary reasons?	AL .
	q.	Has the use of drugs and/or alcohol resulted in an impairment of your ability to practice your profession?	
	7.	Have you surrendered your license or allowed it to lapse while you were under investigation by any licensing or disciplinary boar of any jurisdiction or any entity of the armed services?	d

*** If you answered "YES" to any of the questions in item 17, on the following page please list all adverse actions taken against you and provide a complete explanation. Attach any supporting documentation that applies (copies of all complaints, malpractice claims, adverse or disciplinary actions, arrests, pleadings, judgements, or final orders). Sign and date all pages submitted.

Initial Medical Licensure Character/Fitness Details 07/2003 Print Your Name:	Dallas 1	Ν.,	Johnson	annippeable basing single of the season process of the season of the sea	Date:	1/03	Page 10
18. If you answered "YES" complaints, pleadings a	to any of the o	question Attach a	s in item 17, additional sign	please provide ar ed and dated page	n explanation belo es as needed.	w and at	tach all
Number of malpractice claims ever fi	iled against you	<u>6</u> Nur	mber of malpractic	e claims filed or settled	against you within the I	ast 5 years_	<u>ø</u> _
Number of claims paid within the las five years, explain below and include co	t 5 vaore 11 pe a re	scult of had	nment ø	2) prior to judame	nt Ø (If thre	e or more in t	1
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I have attached the following number of pages to this application:_

Initial Medical Licensure Release and Certification 07/2003

RELEASE AND CERTIFICATION

Page 12

Release: agree that the Maryland Board of Physicians (the Board) may request any is agree that the Maryland Board of Physicians (the Board) may request any is laryland from any person or agency, including but not limited to postgraduate practitioner Data Bank, the Ference of Practition and Protection Data Bank, the Ference of Practition and Protection Data Bank, the Ference of Practition Protection Data Bank, the Ference of Practition Protection Data Bank, the Ference of Practicion Data Bank, the Practicion Data Bank, the Ference of Practicion Data Bank, the Ference of Practicion Data Bank, the Practicion Data Bank, the Ference of Practicion Data Bank, the	information necessary to process my appliprogram directors, individual physicians, government of State Medical Boards, hospitals uested. I also agree to sign any subsequent	ication for medical licensure in vernment agencies, the National and other licensing bodies, and release for information that
	ukkokokusephopoistakatokokokkepiakaustaalekarepakukutuobaeustakokokokakatokokokokokokokokokokokokoko	
21. (OPTIONAL) Third Party Release: (Although the Board enco		
I agree that the Maryland Board of Physicians may release any information p	pertaining to the status of my application to	ure ronowing person:
Name:	administrative .	
	мерания инфармациональной принципациональной принципацион принципацио	та по подражения по по подражения по подражения по
Phone:	Applicant's signature	MPNG AREADH MINISTER AREADH AN CHOISE AN
22. I agree that I will cooperate fully with any request for information or with the State of Maryland, including the subpoena of documents or records or the During the period in which my application is being processed, I shall inform this application, any arrest or conviction, any change of address or any action under Md. Code Ann Health Occ. § 14-404. Signature 23. Affidavit: (To be completed by the applicant in the presence of a notal	n the Board within 30 days of any change to the state of	to any answer I originally gave in would be grounds for disciplinary
I certify that I have personally reviewed all the responses to items 1- accurate to the best of my knowledge. I understand and agree that I Maryland unless licensed by the Board. Applicant's signature STATE OF Texas CITY/COUNTY OF Houston / Harris	as the mation and that the infatt	mation I have given is true and
THEREBY CERTIFY that on this day of	W Johnson, MD., whose tapplicant's name) ade oath in due form of law to be the narrow	e, a Notary Public of the State and likeness is identifiable as that of preferred to in the above

PRINT RETURN



BOARD OF PHYSICIANS P.O. Box 17314 Baltimore, Maryland 21297-0475 Application for Renewal of Medical License (410) 764-4705



Your address(es) on the online (es) that are not reflected on database.	Dr. Dallas Wayne Johnson 9/27/2004 com and Non-Public address. If either address has changed, please correct here, in a renewal application is current as of July 1, 2004. If you requested any changes to your address, this application, please make the change at this time. These changes will be updated in the main independent of the public. dress: This address is for Board use only and is where your license will be mailed. However, if no address will also be made available to the public.
Email: dallasj72@yahoo.co ADDRESS CHANGES You must submit a Public ar Your address(es) on the onli (es) that are not reflected on database. 3a. Non-Public Mailing Ad public address is listed, this Street Street (2) City	nd Non-Public address. If either address has changed, please correct here. This ine renewal application is current as of July 1, 2004 . If you requested any changes to your address this application, please make the change at this time. These changes will be updated in the main the dress: This address is for Board use only and is where your license will be mailed. However, if no
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State/Province	DC
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PERSONAL AND PROFES 4. Do you give the Marylan date of birth to the Federati Center? See instruction	d Board of Physicians permission to report my 🎉 Yes C No on of State Medical Boards' Physician Data
the period since July 1, 200	e direct care of patients in the State of Maryland? Answer yes if you saw one or more patients within 02 or initial licensure or reinstatement in Maryland whichever is more recent. * the previous question, did your practice include making decisions that had direct impact on patient

CHARACTER AND FITNESS QUESTIONS

6. The following questions pertain to the period since July 1, 2002. If this is your first renewal, these questions apply to the period commencing with the date of your initial licensure or reinstatement.

Check the box YES or NO next to each question. If you answer Yes, provide an explanation at the prompt.

* All questions must be answered Yes or No.

QUESTION

- Has any licensing or disciplinary board of any jurisdiction (except this licensing board), or any entity of the armed services denied your application for licensure, reinstatement or renewal, or taken any action against your license, including but not limited to reprimand, suspension, revocation, a fine, or nonjudicial punishment, for an act that would be grounds for disciplinary action under Md. Code Ann. Health Occ. §14-404?
- Have any complaints, investigations or charges been brought against you, or are any currently pending in any jurisdiction by any licensing or disciplinary board (except this licensing board) or an entity of the armed services?
- Has your application for a medical or health professional license been withdrawn for reasons that would be grounds for disciplinary action under Md. Code Ann. Health Occ. §14-404?
- Has an investigation or charge been brought against you by a hospital, related institution, or alternative health care system that would be grounds for disciplinary action under Md. Code Ann. Health Occ. §14-404?
- Have you had any denial of application for privileges, failure to renew your privileges, or limitation, restriction, suspension, revocation or loss in privileges in a hospital, related health care facility, or alternative health care system that would be grounds for disciplinary action under Md. Code Ann. Health Occ. §14-404?
- Have you had a plea of guilty, noto contendere, conviction, or receipt of probation before judgment or other diversionary disposition of any criminal act, excluding traffic violations?
- Have you had a plea of guilty, nolo contendere, conviction, or receipt of probation before judgment or other diversionary disposition for an alcohol or controlled dangerous substance offense, including but not limited to driving while under the influence of alcohol or controlled dangerous substances?
- Are there any pending criminal charges against you in any court of law, excluding minor traffic violations?
- Do you have a physical or mental condition that currently impairs your ability to practice medicine?
- Has the use of drugs and/or alcohol resulted in an impairment of your ability to practice your profession?
- Do you illegally use drug(s)?
- Have you surrendered or allowed your license to lapse while under investigation by any licensing or disciplinary board of any jurisdiction or an entity of the armed services?



- Have you been named as a defendant in a filing or settlement of a medical malpractice action?
- Has your employment by any hospital, HMO, related health care or other institution, or military entity been terminated for any disciplinary reasons?
- Have you voluntarily resigned from any hospital, HMO, other health care facility or institution, or military entity while under investigation by that institution for disciplinary reasons?
 - Are you in default of a service obligation resulting from your receipt of state or federal funding for your medical education?
 - Have you failed to make arrangements to satisfy any state or federal loans that financed your medical education?

CONTINUING MEDICAL EDUCATION

Primary Concentration *

Secondary Concentration

- You must complete this form for your license to be renewed. Choose one statement that applies to you.
- 7. Choose one statement that applies to you.
- © CME met. I have earned 50 credit hours of Category 1 continuing medical education during the two (2) years prior to this renewal.
- First Renewal & NPO. I am exempt from CME during the renewal period because this is my first renewal after initial medical licensure in Maryland and I have completed the Board's New Physician Orientation Program. The New Physician Orientation is for NEWLY licensed physicians only. If you were licensed prior to 1999 or reinstated, you are not required to take the NPO. See New Physician Orientation Program web site
- First Renewal after reinstatement. I am exempt from CME during the renewal period because this is my first renewal after reinstatement of my medical licensure in Maryland.

PERSONAL AND PROFESSIONAL INFORMATION (Part 2)	
8. Ethnicity and Race: (Select all that apply) Hispanic or Latino American Indian or Alaska native Asian Black or African American Native Hawaiian or other Pacific Islander White Other	
9. Are you employed by the Federal Government?10. Do you plan on ending your medical practice in the next 2 years?	○ Yes ● No ○ Yes ● No
11. Do you plan to leave Maryland in the next 2 years? * ○ Yes ○ No ○ Military ○ Unknown ● Not Applicable	
12. Which best describes your current area(s) of concentration:	

Obstetrics & Gynecology (General)

Gynecology

OF TYAAC1700

13. List up to two (2) specialty areas only if certified by a recognized board of the American Board of Medical Specialties or the
13. List up to two (2) specialty areas only in certified by a recognized distribution of recertification. (If you select a Primary or Secondary American Osteopathic Association and provide the year of your certification or recertification is required.)
Primary Specialty Obstetrics & Gynecology (General) Year 2004 (yyyy)
Secondary Specialty None Year (уууу)
HEALTH CLAIMS ARBITRATION OFFICE QUESTIONS
14. The following questions pertain to the period since July 1, 2002. If this is your first renewal, these questions apply to the period commencing with the date of your initial licensure or reinstatement. Check the box YES or NO next to each question. If you answer Yes, provide an explanation at the prompt. * All questions must be answered Yes or No.
QUESTION Output Outp
Yes No
b Have you, your partners or associates, or anyone in your immediate family or household, been sued or had claim filed against you or any of them for medical malpractice?
C House you tootified as a medical witness in a judicial or administrative proceeding?
Have you testified as a medical witness in a judicial or administrative proceeding? Yes No No. **The proceeding**
⊖ d Have you been an arbitrator?
Yes No
e Are you currently an arbitrator?
Yes No
Yes No Case?
g Is there any reason why you could not hear and decide impartially a health care malpractice claim solely o the basis of the law and the evidence presented?
PRACTICE INFORMATION 15. Do you currently practice medicine? • Yes • No
16. If you are not in practice, are you:
①, 1. Retired, permanently not in practice
2. Semi-Retired, working outside of the practice of medicine
3. Temporarily not in practice
4. Inactive for other reasons
5. Working full-time outside the practice of medicine
17. What percent of your average work day is spent in personally providing PRIMARY/PREVENTIVE CARE SERVICES in Maryland? 0 %
18. If all offices are located outside Maryland, do you treat Maryland residents? 🌘 Yes 🔘 No 💚 Not Applicable
10. What is the total number of practice/office locations at which you personally work within Maryland?

20. Primary Practice / Off	ice Location	and the second of the second o
Organization Name	Medical Faculty As	sociates of GWU
Street Address	Dept of OBG	
Street2	2150 Pennsylvania	Ave, NW
City	Washington	
State	DC	· · · · · · · · · · · · · · · · · · ·
Zip Code	20037	
Office Phone	202 741 2554	
Office Fax	202 741 2550	
Jurisdiction	Non-Maryland	
Employer Tax ID		
At this site, what is the ave	rage number of hours per v	week you are available for ALL PATIENT CARE? 40 (if None,
enter 0)	in the second se	· · · · · · · · · · · · · · · · · · ·
Setting	University or College	Application of the first of the second of the first of th
Practice	Multi-Specialty Gro Clinical/Direct Pati	Application of the process of the contraction of th
Primary Role	The first of the second of the	ent Care
Secondary Role	Teaching Not for profit	
Private/Public 21 Is your primary practice	e currently submitting claim	s electronically to:
Medicare?	Medicaid?	HMOs and Private Insurers?
Most of the time	Most of the time	Most of the time
Occasionally	Occasionally	Occasionally
Seldom	○ Seldom	○ Seldom
○ Not at all	Not at all	○ Not at all
Not applicable	Not applicable	○ Not applicable
22. Secondary Practice /	Office Location	
Organization Name	 International Control of the Control o	
Street Address		
Street2	provide service of the service of the efficiency period.	
City	i de la companya de l	anger en la reconstruction de Proposition de la reconstruction de la reconstruction de la reconstruction de la
State	ing a gradient of the contract	V .
Zip Code	in the second of	
Office Phone	Control of the contro	
Office Fax	graph and the second se	
Jurisdiction	and the second of the second o	V
Employer Tax ID	ng in any any and a second street for a second second	
	erage number of hours per	week you are available for ALL PATIENT CARE?
enter 0)		and the second s
Setting	in a many management	and the control of th
Practice	englijes groeerieg het voor in die voor in die	<u> </u>
Primary Role	konnegge vongenmele som had som i 1900 och 1900 och	and the second s
Secondary Role	di di gi se a companda septemberata sentra trada international francia international se	and the second s
Private/Public	e No composition of the property of the composition	

Dept of OBG

2150 Pennsylvania Ave, NW

Street

Street (2)

24. If YES, enter the Mary	he Maryland Medical Assistance Program (Medicaid)? Yes No Not Applicable /land Medical Assistance Rendering Provider Number:
25. If YES, are you accep	iting new Maryland Medical Assistance patients? 🔘 Yes 🔘 No
26. Do you participate in l 27. If YES, enter the Indix	Medicare? Yes No Not Applicable
28. If YES, are you accep	oting new Medicare patients? C Yes C No
29. Do you offer a sliding (Utilize a standardized fe	fee scale based on ability to pay? e reduction schedule for low-income) C Yes No Not Applicable
31. If YES, report the nur uncompensated care in a	
32. Is a Physician Assist	ant, Nurse Practitioner, or Nurse Midwife included as part of your practice (employee or on staff)?
33. Worker's Compensatio Workers' Compensatio that you verify that you	tion n coverage: If you <u>employ one or more persons,</u> the Md. Code Ann. Health Occ. §1-202 requires I are complying with the Workers' Compensation Law for your renewal to be issued.
I do not practice in N	ing: Not Applicable (Do not complete below) Maryland. one in my practice in Maryland. re persons in my Maryland practice and have the following Workers' Compensation coverage.
Name of Insurance Carr	
Policy Number	
Expiration Date	
DUVSTAN FMFF	RGENCY CONTACT INFORMATION
As part of Maryland's er the need for certain con	nergency preparedness efforts, the Department of Health and Mental Hygiene has identified tact information for licensed physicians in Maryland who may be needed to respond to a ergency. (Catastrophic Health Emergencies Act Md. Code. Ann., Article 41 Sec. 2-201-204 cle Section 18-901 et seq. sets forth the powers of the Governor and Secretary of the
	ate) the following information that should be used in the event of an actual emergency.
Pager Cell Phone	Prologopation and Comments and
Home Contact:	
Telephone	
Fax	
Email	The second secon
Work Contact: Telephone	Constant of the Constant of th
Fax	
Email	
Name of Practice	Medical Faculty Associates of GWU

•	
County	Non-Maryland Y
City	Washington
State	DC Y
Zip	20037
Please provide	(or update) the one best number that should be used in the event of an actual emergency.
Daytime Contact	
Nighttime Cont	act and a second
Preference Are Indicate which	a: counties you would prefer to work in the case of an actual emergency.
Anne Arunde	
Indicate by che following speci-	cking any box that applies whether you have any particular training and experience regarding the fic agents:
Chemical	Biological Radiological
✓ Check her Physicians.	e if you are interested in being contacted about training opportunities provided by the Board of
	Thank you for your assistance!
	TION OF RENEWAL APPLICATION AND PAYMENT
 You mi You wi You als you m Once y I affirm through I author pertain I shall 	ust affirm your answers on the application before you can pay your license renewal fee. Ill not be allowed to change any answers once you affirm your answers. By wish to recheck your answers by returning to the Menu before you affirm. By have the option of viewing your renewal application online anytime after completion. To exercise this option ust select the option box below. By affirmation and Authorization (Please check each box to affirm the following questions) That the information I have given in this application, including that given to Character and Fitness questions (a) in (q), is true and correct to the best of my knowledge and belief. Fixe any person(s) to release to the Maryland Board of Physicians any information or documents needed ing to my application for licensure. Inform the Board, by certified mail, return receipt requested, within 30 days of:
(a) acti time di	ion that would be grounds for disciplinary action under <u>Md. Code Ann. Health Occ. §14-404,</u> that occurred at an uring the application period;
(b) cha	ange in any answer that was originally given in this application.
Check Otherv	: Here if you wish to have the option of viewing your completed application online after you renew your license. vise, your application will not be available online for your later viewing.
	Maryland Board of Physicians P.O. Box 2571 Baltimore, Maryland 21215-0095 Help Line (410)764-4705 Main (800) 492-6836 Fax (410)358-2252

1-800-735-2258 TTD for Disabled Email <u>bpga@erols.com</u>

<u>RETURN</u>



GENERAL APPLICATION INFORMATION ONLINE LICENSE RENEWAL

DO NOT MAIL THIS COPY TO THE BOARD. IF YOU WOULD LIKE TO SUBMIT A PAPER APPLICATION AND NOT COMPLETE YOUR RENEWAL ONLINE, PLEASE LOG OUT, RETURN TO www.mbp.state.md.us, AND CLICK ON "DOWNLOAD FORMS" TO DOWNLOAD THE PAPER APPLICATION.

Application for renewal of: Physicians

Renewal Fee: \$	618.00 ·
License No. D(10061788
Dr. Dallas Wa	ayne Johnson
please indicate by Email Address	SS: This is your email address on file. If it has changed, please edit below. If you have no email address checking the checkbox below. an email address
You must submit a	ges (Non-Public and Public): Public and Non-Public address. If either address has changed, please correct here. On the online renewal application is current as of July 1, 2008. If you requested any changes to your address(es) that are not opplication, please make the change at this time. These changes will be updated in the main database.
3a. Non-Public public address is Street	: Address: This address is for Board use only and is where your license will be mailed. However, if no listed, this address will also be made available to the public.
Street (2) Street (3) City State	If selecting a country other than USA or Canada, please
ZipCode Country	Simple A original depot of the control of the contr
3b. Public Add	iress: This address, usually your office, is available to the public and will be posted on the Internet. If you do public address, your non-public address will be posted on the Internet.
	lic Address is the same as your Non Public address (the address above will be automatically entered below.)
Street	UTHSCSA
Street (2)	Dept of OBG
Street (3)	7703 Floyd Curl Drive
City	San Antonio
State	Texas If selecting a country other than USA or Canada, please choose "Foreign" as your state
ZipCode	78229
•	promote and the second

4. Do you give the Maryland Board of Physicians permission to report your date of birth to the Federation of State Medical Boards' Physician Data Center? See instruction	● Yes	○ No
· · · · · · · · · · · · · · · · · · ·	CYes	No No
5b. If you answered NO to the previous question, did your practice include making decisions that had direct impact on patient care in Maryland (such as radiology, pathology, or medical	Oyes	● No
director)?		·····································

CHARACTER AND FITNESS

6. The following questions pertain to the period since July 1, 2006. If this is your first renewal, these questions apply to the period commencing with the date of your initial licensure or reinstatement. Check the box YES or NO next to each question. If you answer Yes, provide an explanation at the prompt.

* All questions must be answered Yes or No.



- a. Has any licensing or disciplinary board of any jurisdiction (except this licensing board), or any entity of the armed service denied your application for licensure, reinstatement or renewal, or taken any action against your license, including but not limited to reprimand, suspension, revocation, a fine, or nonjudicial punishment, for an act that would be grounds for disciplinary action under Md. Code Ann. Health Occ. §14-404?.
- b. Have any complaints, investigations or charges been brought against you or are any currently pending in any jurisdiction by any licensing or disciplinary board (except this licensing board) or an entity of the armed services?
- c. Has your application for a medical or health professional license been withdrawn for reasons that would be grounds for disciplinary action under Md. Code Ann. Health Occ. §14-404?
- d. Has an investigation or charge been brought against you by a hospital, related institution, or alternative health care system that would be grounds for action under Md. Code Ann. Health Occ. §14-404?
- e. Have you had any denial of application for privileges, failure to renew your privileges, or limitation, restriction, suspension, revocation or loss in privileges in a hospital, related health care facility, or alternative health care system that would be grounds for disciplinary action under Md. Code Ann. Health Occ. §14-404?
- f. Have you had a plea of guilty, noto contendere, conviction, or receipt of probation before judgment or other diversionary disposition of any criminal act, excluding traffic violations?
- g. Have you had a plea of guilty, noto contendere, conviction, or receipt of probation before judgment or other diversionary disposition for an alcohol or controlled dangerous substance offense, including but not limited to driving while under the influence of alcohol or controlled dangerous substances?
- h. Are there any pending criminal charges against you in any court of law, excluding minor traffic violations?
- i. Do you have a physical or mental condition that currently impairs your ability to practice medicine?



Has the use of drugs and/or alcohol resulted in an impairment of your ability to practice your profession?

- k. Do you illegally use drugs?
- Have you surrendered or allowed your license to lapse while under investigation by any licensing or disciplinary board of any jurisdiction or an entity of the armed services?
- m. Have you been named as a defendant in a filing or settlement of a medical malpractice action?
- n. Has your employment by any hospital, HMO, related health care or other institution, or military entity been terminated for any diciplinary reasons?
- o. Have you voluntarily resigned from any hospital, HMO, or other health care facility or institution, or military entity while under investigation by that institution for disciplinary reasons?
- p. Are you in default of a service obligation resulting from your receipt of state or federal funding for your medical education?
- q. Have you failed to make arrangements to satisfy any state or federal loans that financed your medical education?

CONTINUING MEDICAL EDUCATION

- a. <u>CME met</u>. I have earned 50 credit hours of Category 1 continuing medical education during the two years prior to this renewal.
- b. First Renewal & NPO. I am exempt from CME during the renewal period because this is my first renewal after initial medical licensure in Maryland and I have completed the Board's New Physician Orientation Program. The New Physician Orientation is for NEWLY licensed physicians only. If you were licensed prior to September 30, 2006 or reinstated, this does not apply to you. See New Physician Orientation Program web site. Your license will not be renewed unless you have completed the orientation.
- c. <u>First Renewal after reinstatement.</u> I am exempt from CME during the renewal period because this is my first renewal after reinstatement of my medical licensure in Maryland.

PERSONAL AND PROFESSIONAL - PART 2

8. Ethnicity and Race: (Select all that apply)

Hispanic or Latino

American Indian or Alaska native

Asian

Black or African American

Native Hawaiian or other Pacific Islander

White

Other

9. Are you employed by the Federal Government?

O Yes . No

Market were		
•	r medical practice in the next 2 years?	
○ Yes ● No ○ Not Applica		
11. Which best describes you	r current area(s) of concentration:	
Primary Concentration Secondary Concentration	Gynecology None	
12. SPECIALTY BOARD CERcertified by a recognized boar the American Osteopathic As	RTIFICATION: List up to two (2) specialty areas only if d of the American Board of Medical Specialties (ABMS) or sociation (AOA).	
Primary Certification Secondary Certification	Obstetrics & Gynecology [General]	
13. The following question:	ATIVE DISPUTE RESOLUTION QUESTIONS is pertain to the period since July 1, 2006. If this is your nicing with the date of your initial licensure or reinstater ou answer Yes, provide an explanation at the prompose	HOHE OTHER
⊖Yes ® No a. Ha	ive you been the subject of professional discipline?	
⊖Yes ® No b. Ha	ave you, your partners or associates or anyone in your immed had a claim filed against you or any of them for medical malp	liate family or household, been sued practice?
⊖yes ® Ño c. Ha	ave you testified as a medical witness in a judicial or administ	trative proceeding?
⊜Yes ® No d. H	ave you been an arbitrator?	
⊖ _{Yes} ® _{No} e. A	re you currently an arbitrator?	
Cyes ● No f. A	re you, or any member of your immediate family or household inalpractice case?	d, currently a party in a medical
⊖Yes ● No g. Is s	there any reason why you could not hear and decide impart olely on the basis of the law and the evidence presented?	ially a health care malpractice claim
PRACTICE	the same of the sa	\$ ^
answer NO you will be required	stion 14, you will be required to answer Questions 16-31. If you did not answer Question 15.	Yes No
PRIMARY/PREVENTIVE C	verage work day is spent in personally providing ARE SERVICES in Maryland?	0%
77. If ALL OFFICES are loc	cated outside Maryland, do you treat Maryland residents?	○ Yes No ○ Not Applicable
18. What is the total number within Maryland? If non	er of practice/office locations at which you personally work e, enter 0.	0

•	UTHSCSA
Street Address	Dept of OBG
Street2	7703 Floyd Curl Drive
City	San Antonio
State	Texas
Zip Code	78229
Jurisdiction	Non-Maryland V
Employer Tax ID	
At this site, what is the available for ALL PAT	average number of hours per week you are ENT CARE? If none, enter 0. 40 Hours
Setting	University or College
Practice	Multi-Specialty Group
Primary Role	Clinical/Direct Patient Care
Secondary Role	Teaching
Private/Public	Public-State V
diagnosing or treati all information technolo	
diagnosing or treating	ng your patients. In your practice, are computers or other forms of information technology assured
diagnosing or treatilial information technolo	ng your patients. In your practice, are computers or other forms of information technology asca. To obtain information about treatment alternatives or recommended guidelines?
diagnosing or treati all information technolo	agy your patients. In your practice, are computers or other forms of information technology asset. A. To obtain information about treatment alternatives or recommended guidelines? B. To send prescriptions electronically to a pharmacy?
diagnosing or treatilial information technolo	ng your patients. In your practice, are computers or other forms of information technology asca. To obtain information about treatment alternatives or recommended guidelines?
diagnosing or treatilial information technolo	A. To obtain information about treatment alternatives or recommended guidelines? B. To send prescriptions electronically to a pharmacy? If you answered yes to 20B, what percentage of prescriptions are
diagnosing or treatilial information technolo Yes No Yes No	A. To obtain information about treatment alternatives or recommended guidelines? B. To send prescriptions electronically to a pharmacy? If you answered yes to 20B, what percentage of prescriptions are submitted electronically? Use whole numbers.
diagnosing or treating all information technological information technological information technological information technological information technological information technological information information technological infor	A. To obtain information about treatment alternatives or recommended guidelines? B. To send prescriptions electronically to a pharmacy? If you answered yes to 20B, what percentage of prescriptions are submitted electronically? Use whole numbers. C. To generate reminders for you about preventive services needed for your patients?
diagnosing or treating all information technology. Yes No Yes No Yes No Yes No Yes No	A. To obtain information about treatment alternatives or recommended guidelines? B. To send prescriptions electronically to a pharmacy? If you answered yes to 20B, what percentage of prescriptions are submitted electronically? Use whole numbers. C. To generate reminders for you about preventive services needed for your patients? D. To access patient notes, medication lists, or problem lists?
diagnosing or treating all information technological information technological information technological information technological information technological information infor	A. To obtain information about treatment alternatives or recommended guidelines? B. To send prescriptions electronically to a pharmacy? If you answered yes to 20B, what percentage of prescriptions are submitted electronically? Use whole numbers. C. To generate reminders for you about preventive services needed for your patients? D. To access patient notes, medication lists, or problem lists? E. For clinical data and image exchanges WITH OTHER PHYSICIANS? F. For clinical data and image exchanges WITH HOSPITALS AND LABORATORIES? G. To communicate about clinical issues with patients by email?
diagnosing or treating all information technological information technological information technological information technological information technological information technological information inf	A. To obtain information about treatment alternatives or recommended guidelines? B. To send prescriptions electronically to a pharmacy? If you answered yes to 20B, what percentage of prescriptions are submitted electronically? Use whole numbers. C. To generate reminders for you about preventive services needed for your patients? D. To access patient notes, medication lists, or problem lists? E. For clinical data and image exchanges WITH OTHER PHYSICIANS? F. For clinical data and image exchanges WITH HOSPITALS AND LABORATORIES?

22. Do you participate in the Maryland Medical Assistance Program (Medicaid)?	○ Yes No ○ Not Applicable
23. If YES, are you accepting new Maryland Medical Assistance patients?	⊖Yes ⊖No
24. Do you participate in Medicare?	
25. If YES, are you accepting new Medicare patients?	● Yes ○ No
26. National Provider Identifier (NPI): If you have your NPI number, please enter. Otherwise, enter the word "None".	1942390430
27. Do you offer a sliding fee scale based on ability to pay? (Utilize a standardized fee reduction schedule for low-income)	○ Yes ● No ○ Not Applicable
28. Do you offer uncompensated (charity) care?	C Yes ● No C Not Applicable
29. If YES, report the number of hours you personally provide in uncompensated care in a month. • Use whole numbers.	Hours
30. Is a Physician Assistant, Nurse Practitioner, or Nurse Midwife included as part of your practice (employee or on staff)?	● Yes ○ No
31. Workers Compensation	
Workers Compensation coverage: If you employ one or more persons, the Md. Code Ann.	Health Occ. §1-202 requires that you
Workers Compensation coverage: If you employ one or more persons, the Mid. Code Parket verify that you are complying with the Workers' Compensation Law for your renewal to be	issued.
I hereby certify:	
Not Applicable (Do not complete below)	
🖲 I do not practice in Maryland.	
○ I do not employ anyone in my practice in Maryland.	
1 employ one or more persons in my Maryland practice and have the following Workers Compen-	sation coverage.
if you are a Maryland employer you must provide the information requested below.	
Insurance Company	
Policy Number Expiration Date Enter as MM/DD/YYYY	
Expiration page	
PHYSICIANS EMERGENCY CONTACT INFORMATION 32. As part of Maryland's emergency preparedness efforts, the Department of Health and	Mental Hygiene has
identified the need for certain contact information for licensed physicians in Maryland Will	may be needed to
connent to a catactrophic health emergency (Public Safety Article, Sec. 14-3A-U1 et seq.	and Health General Article
Section 18-901 et seq. sets forth the powers of the Governor and Secretary of the Departr	ment of Health and Mental
Hygiene.	
* Required Field	M.
Please provide the phone number that should be used in the event of an actual emergence	y.
Daytime *	
Nighttime*	
	u unio u par consentin se 45-se
Indicate by checking any box that applies whether you have any particular training and exfollowing specific agents:	penence regarding the
Chemical Biological Radiological	
If you are interested in being contacted about training opportunities provided by the Board	of Physicians, please visit
If you are interested in being contacted about training opportunities provided by the Board the Maryland Professional Volunteer Corps website at http://bioterrorism.dhmh.state.md.u	s/volunteer.htm.

Thank you for your assistance!

AFFIRM AND SELECT PAYMENT

Affirmation and Authorization

(Please check each box to affirm the following questions)

- I certify that I have personally reviewed all responses to the items in this application and that the information I have given is true and correct to the best of my knowledge and that any false information provided as part of my application may be cause for the denial of my application.
- I agree that the Maryland Board of Physicians (the Board) may request any information necessary to process my application for renewal from any person or agency, including but not limited to former and current employers, government agencies, the National Practitioners Data Bank, the Healthcare Integrity and Protection Data Bank, hospitals and other licensing bodies, and I agree that any person or agency may release to the Board the information requested. I also agree to sign any subsequent releases for information that may be requested by the Board.
- I shall inform the Board, by certified mail, return receipt requested, within 30 days of:
 - (a) action that would be grounds for disciplinary action under Md. Code Ann. Health Occ. §14-404, that occurred at any time during the application period;
 - (b) change in any answer that was originally given in this application.
- Check Here if you wish to have the option of viewing your completed application online after you renew your license. Otherwise, your application will not be available online for later viewing. If selected, viewing is available until 12/1/08.

Select a Payment Option: License Fee \$

- If you select the credit card option, you will be taken to a secure Bank of America credit card processing site to pay your
 application fee. You will then return to the license site to receive your receipt.
- If you select the Send Check option, you will receive an invoice. However, your application will not be complete until the payment is received by the Board.



○ Mail Check

0

Send your check and invoice (which you will receive next) to:
MBP
Renewal
Unit
P.O. Box
17314
Baltimore,
MD
212970475

	d. Please allow up to 7 business days for receipt of your payment.
Third Party Payer	€ Enter Payer's name
Please note: This is NOT for credit cards. This is only to ger	derate an invoice to give to another organization that is paying bur employer or hospital you work for is paying your renewal fee

Remember to notify your payer that you have completed the application. Give a copy of your electronic invoice (which you will receive next) to your third party payer. Your license will not be renewed until payment is received. Please allow up to 7 business days for receipt of your payment.

n_1_:__1 0.1:___T\nn21700

Please provide your e	lectronic signature below:		
Name	Dallas W Johnson	Ú	Enter your name

Today's Date Date of Birth 9/30/2008 Enter as mm/dd/yyyy
7/30/1946 Enter as mm/dd/yyyy

PAYMENT RECEIPT

Date Application was Submitted 9/30/2008

----- END OF APPLICATION -----

DO NOT MAIL THIS TO THE BOARD. RETAIN THIS APPLICATION FOR YOUR RECORDS.

Application for n	enewal of:	Phys	icians
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I do not have an NPI Intered in the field for Rendering NPI on a claim (10 digit number) Intered in the field for Rendering NPI on a claim (10 digit number) It is your email address on file. If it has changed, please edit below. If you do not have an email of checking the checkbox below. Tagmac.com It is address In Public and Public: Ind Non-Public address. If either address has changed, please correct here. Interenewal application is current as of July 1, 2010. If you requested any changes to your address(es) that are not reflected that the change at this time. These changes will be updated in the main database. Ses: This address is for Board use only and is where your license will be mailed. However, if no is address will also be made available to the public.
A checking the checkbox below. 72@mac.com il address on-Public and Public): nd Non-Public address. If either address has changed, please correct here. ine renewal application is current as of July 1, 2010. If you requested any changes to your address(es) that are not reflected that the change at this time. These changes will be updated in the main database. SS: This address is for Board use only and is where your license will be mailed. However, if no
on-Public and Public): Ind Non-Public address. If either address has changed, please correct here. Ind Non-Public address. If either address has changed, please correct here. Index one of the change is current as of July 1, 2010. If you requested any changes to your address(es) that are not reflected to the change at this time. These changes will be updated in the main database. SS: This address is for Board use only and is where your license will be mailed. However, if no
nd Non-Public address. If either address has changed, please correct nere. Ine renewal application is current as of July 1, 2010 . If you requested any changes to your address(es) that are not reflected nake the change at this time. These changes will be updated in the main database. SS: This address is for Board use only and is where your license will be mailed. However, if no
ss: This address is for Board use only and is <u>where your license will be mailed</u> . However, if no is address will also be made available to the public.
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September 1998 September 1994 Septem
V La Company of the C
a country other than USA or Canada, please choose "Foreign" as your state
his address, usually your office, is available to the public and will be posted on the Internet. If you do
dress, your non-public address will be posted on the Internet.
ess is the same as your Non-Public address (the address above will be automatically entered below.)
ot of OBG
3 Floyd Curl Drive
n Antonio
(AS
ecting a country other than USA or Canada, please choose "Foreign" as your state
229
ited States

CHARACTER AND FITNESS (Question 6)

6. The following questions pertain to the period since July 1, 2008. If this is your first renewal, these questions apply to the period commencing with the date of your initial licensure or reinstatement. Check the box YES or NO next to each question. If you answer Yes, provide an explanation at the prompt.

* All questions must be answered Yes or No.



- a. Has any licensing or disciplinary board of any jurisdiction (except this licensing board), or any entity of the armed services denied your application for licensure, reinstatement or renewal, or taken any action against your license, including but not limited to reprimand, suspension, revocation, a fine, or nonjudicial punishment, for an act that would be grounds for disciplinary action under Md. Code Ann. Health Occ. §14-404?
- Have any complaints, investigations or charges been brought against you or are any currently pending in any jurisdiction by any licensing or disciplinary board (except this licensing board)



or an entity of the armed services?

- c. Has your application for a medical or health professional license been withdrawn for reasons that would be grounds for disciplinary action under Md. Code Ann. Health Occ. §14-404?
- d. Has an investigation or charge been brought against you by a hospital, related institution, or alternative health care system that would be grounds for action under Md. Code Ann. Health Occ. §14-404?
- e. Have you had any denial of application for privileges, failure to renew your privileges, or limitation, restriction, suspension, revocation or loss in privileges in a hospital, related health care facility, or alternative health care system that would be grounds for disciplinary action under Md. Code Ann. Health Occ. §14-404?
- f. Have you had a plea of guilty, nolo contendere, conviction, or receipt of probation before judgment or other diversionary disposition of any criminal act, excluding traffic violations?
- g. Have you had a plea of guilty, noto contendere, conviction, or receipt of probation before judgment or other diversionary disposition for an alcohol or controlled dangerous substance offense, including but not limited to driving while under the influence of alcohol or controlled dangerous substances?
- h. Are there any pending criminal charges against you in any court of law, excluding minor traffic violations?
- i. Do you have a physical or mental condition that currently impairs your ability to practice medicine?
- j. Has the use of drugs and/or alcohol resulted in an impairment of your ability to practice your profession?
- k. Do you illegally use drugs?
- I. Have you surrendered or allowed your license to lapse while under investigation by any licensing or disciplinary board of any jurisdiction or an entity of the armed services?
- m. Have you been named as a defendant in a filing or settlement of a medical malpractice action?
- n. Has your employment by any hospital, HMO, related health care or other institution, or military entity been terminated for any diciplinary reasons?
- o. Have you voluntarily resigned from any hospital, HMO, or other health care facility or institution, or military entity while under investigation by that institution for disciplinary reasons?



- p. Are you in default of a service obligation resulting from your receipt of state or federal funding for your medical education?
- q. Have you failed to make arrangements to satisfy any state or federal loans that financed your medical education?

CONTINUING MEDICAL EDUCATION (Question 7)

- a. CME met. I have earned 50 credit hours of Category 1 continuing medical education during the two (2)
 years prior to this renewal.
- b. First Renewal & NPO. I am exempt from CME during the renewal period because this is my first renewal after initial medical licensure in Maryland and I have completed the Board's New Physician Orientation Program. The New Physician Orientation is for NEWLY licensed physicians only. If you were licensed prior to September 30, 2008 or reinstated, this does not apply to you. See New Physician Orientation Program web site. Your license will not be renewed unless you have completed the orientation.
- c. First Renewal after reinstatement. I am exempt from CME during the renewal period because this is my first renewal after reinstatement of my medical licensure in Maryland.

PERSONAL AND PROFESSIONAL INFORMATION (Questions 8-17)

8. Ethnicity and Race: (Select all that apply)

lispanic or Latino
American Indian or Alaska native
Asian
Black or African American
Jative Hawaiian or other Pacific Islander

White
Other

9. Are you employed by the Federal Government?

○ Yes
10. Please indicate if you are currently in: a) a residency program accredited by the Accreditation Council for Graduate Medication or an internship or residency program approved by the American Osteopathic Association; or b) a fellowship

(subspecialty) training program accredited by the ACGME.

If you answer Yes to either a, or b, you will not be required to complete the Practice Information section (Questions 15-26) of this application.

a. In an accredited/approved internship or residency program?

Oyes ● No

Oyes No

b.	in	an	accredited	fellowship	(subspecialty)	training	program?
----	----	----	------------	------------	----------------	----------	----------

11. Which best describes your current area(s) of concentration:

Primary Concentration
Secondary Concentration

can energy of or cone	110 0000	

Gynecology	*	~
Chippondl		

None

imary Certification	Obstetrics & Gynecology
econdary Certification	None
3. Please indicate below humber of hours in your typ	now the hours in your typical work week are allocated. The sum of these hours should reflect the initial work week. Definitions of these categories are listed below.
III If you allocate 0 hours	per week to a. Patient Care Related Activities you will not be required to complete the Practice ons 15-26) of this application.
ad radiologic assessment	vities include seeing patients, writing prescriptions, patient-related clinical activities (such as pathologic s), maintaining patient records, obtaining and reviewing test results, arranging referrals, consulting with nts, talking with a patient's family members.
lesearch includes clinical,	laboratory, and analytical research
eaching includes teachin	g of medical undergraduate & graduate students and other graduate students.
and the second s	Administration includes practice management (billing, contract negotiations, personnel, regulatory of institutions or programs (health departments, health insurance, hospitals, other health-related
Use whole numbers. No	fractional hours. If none enter 0.
. Patient Care Related	Scientinecodesassium
. Research	0 hours per week
Teaching	0 hours per week
. Administration & Other	er 10 hours per week
dtal Hours	50 hours per week
elated activities in the nex	istion 13 that you are not engaged in patient care related activities, do you intend to resume patient care to 2 years? ATION (Questions 15-26) Itinue patient care related activities in the next two years?
15. Do you plan to discon ○ Yes	
○ Yes No No	the number of practice/office locations at which you routinely deliver patient care for reimbursement.
O Yes No	ons in Maryland (if none, enter 0)
16. Please indicate below a. Number of location b. Number of location If you have location answer (b).	ons in Maryland (if none, enter 0) ons outside of Maryland (if none, enter 0) tions outside Maryland, please answer (c) below after you 3
16. Please indicate below a. Number of location b. Number of location If you have location answer (b).	ons in Maryland (if none, enter 0) ons outside of Maryland (if none, enter 0) tions outside Maryland, please answer (c) below after you treat Maryland patients at your practice/office location(s) outside of Maryland?

18.	Primary Practice / Office Loc	ation Primary Practice / Office Location	
Ú F	lease answer all Primary Practice qu	estions	
a.	Organization Name	Continence Care Group	
b.	Street Address	510 Dusty Leather Court	•
C.	Street2	(F. S. to 101 or Poom 101)	
		Enter suite or room number here. (Ex. Suite 101 or Room 101) Pflugerville	
	City		
e.	State	78660 V	
t.	Zip Code	Non-Maryland	
g.	Jurisdiction	INOR-IWaryianu	paintain ny faritain dia kaominina paosina ny faritr'i Austria ny faritr'i Austria ny faritr'i Austria ny fari
i.	Employer Toy ID	None What is Employer tax ID?	
n.	Employer Tax ID	Enter "None" if you do not have an Employer tax ID	*
		Enter None a you do not have an employer carrie	
i.	Please select one of the follow	ring related to the NPI used for billing insurers:	•
		NPI for billing. Please Enter >	y udagonic aportion de proposition de proposition de la company de la co
	I use my Individual NPI !		Organizational NPI
	O I do not bill public or pri		
	have a part of the state of the		ANN NEW STORY OF THE STORY OF T
j.		, 40 hours of Patient Care Related Activities during a typical w	ork
	week. How many of those Patient Ca	are Related Activity hours in your typical work week are deliver	ed at Iso
	this practice/office location?		40 Hours
	If none, enter 0.		
k.	Setting	Other Clinic	
I.	Private/Public	Private-For profit	
m	. Practice	Solo	
	Please answer the following	regarding staffing at this practice/office location on a typical providers is listed below.	sical day.
	U If none, enter 0; if you don	t know the number, enter 999	
	Number of physicians (MDs	, DOs, residents, fellows) including yourself at this location	on. [1]
			-
	Number of mid-level medica	al providers at this location. : nurse practitioners, nurse midwives, nurse anesthetists and ph	vsician assistants.
	A Mid-level medical broalders	. muise practitioners, turise interactor, notice and a	halanning mendelegieri daharkan pangapan kalandah kalandah kalandah kalandah kalandah kalandah kalandah kalanda
19). Secondary Practice / Offic	e Location	
-		fice location and you've checked the box above, you will see a series of qu	estions that must be completed.
Û	·	Institute of Pelvic Medicine	,
a.	2		
b.	Street Address	510 Dusty Leather Court	
C.	Street2	Enter suite or room number (Ex. Suite 101 or Room 101)	
d	. City	Pflugerville	
e	. State	Texas	
f.	Zip Code	78660	
g	E o de alla alla alla alla	Non-Maryland >	
\$			oddsuppophinininininingopiassa-epppophininiste

CIII	ployer	Tax ID	None Enter None if you	bu do not have an Employ			
Ple	ase se	elect one of the follow	owing related to the N	NPI used for billing inst	ırers:		
С) I use	an Organizationa	al NPI for billing. Pl	lease Enter >		ļ.,	
		my Individual NF				Organ	nizational NPI
		not bill public or					a province and a stable policy policy proper proper design behavior by the proper prop
we Ho thi:	iek. iw mar s pract	rated in Question 1 ny of those Patient cice/office location? a, enter 0.	Care Related Activity	ent Care Related Activi	ties during a t	ypical work e delivered at	40 Hours
Se	etting	adalanta da la santan kada kada kada kada kada da la santan kada kada kada kada kada da da da da kada kada kad	Other Clinic		V		
	ivate/P	Public	Private-For profi		V		
a Dr	actica		Solo			$\overline{\mathbf{Y}}$	
D:	efinitic If no	on of mid-level mone, enter 0; if you d	edical providers is it lon't know the number	ng at this practice/off isted below. , enter 999 fellows) including yo		•	1
N	umber Mid-le	r of mid-level med evel medical provid	dical providers at thi ers: nurse practitioner	is locauori. rs. nurse midwives, nur	se anesthetist	s and physiciar	assistants.
na n	anga pagangangangangangangangangangangangangan				and the second s		and the state of t
Či		of Minney Denetic	/ (Primary Practice	/ Office Location)			-
J Plea	ase ans	wer all Primary Practic	(Primary Practice	/ Office Location) y questions	in technology	such as hand	-held computers, in
Plea his d liagn	ase ans	wer all Primary Praction on is about the use or treating your pa	(Primary Practice of Computers and other of Computers and other of Computers and other of Computers and Other of Computers at your primary	/ Office Location)	in technology n, which you l	such as hand isted in questi	-held computers, in
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Plea This diagn liagn Yes	ase ansoquestic	wer all Primary Praction is about the use or treating your part. A. To obtain information. B. To send prescured to the process of the proce	(Primary Practice) ce Information Technolog e of computers and other tients at your primary mation about treatme	/ Office Location) y questions her forms of informatic office/practice locatio int alternatives or recor to a pharmacy?	in technology n, which you l mmended gui	such as hand isted in question	-held computers, in
Fried Piece Chicagon (1998) Yes	ase ansiquestion osing No	wer all Primary Praction is about the use or treating your part. A. To obtain inform B. To send prescuring your answered in the submitted electrons.	(Primary Practice of computers and officients at your primary mation about treatme riptions electronically Yes to 20B, what perconically? Use who	/ Office Location) y questions her forms of informatic office/practice locatio int alternatives or recor to a pharmacy?	in technology n, which you l mmended gui	such as hand isted in question delines?	-held computers, in
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l Doi	es your primary office/practice location use e	lectronic MEDICAL RECORDS (not including billing records)?	?	
Оуе	s, all electronic OYes, part paper and part	electronic No O Don't know		
	21a. If No. please indicate your most signific	ant reason for not using electronic medical records.		
		sk of privacy breaches Retiring soon		
		ck of technology standards O Not my decision		
	O Physician resistance to adoption O Int	angible benefits		
2. Plea	se indicate if you participate in the following privat e program patients.	e and public insurance programs, and whether you are currently acce	epting :	new public
	Participate in any PRIVATE insurance plan netwo	rorks including PPO, EPO, HMO, etc.	•	0
а.	Participate in any PRIVATE insurance pair norm	ama amazang / tal an al t	Yes	No
b.	Participate in the MARYLAND MEDICAL ASSIS Care Organization)	TANCE PROGRAM (in either the traditional program or a Managed	O Yés	● No
		the state of the s		0
	b1. If Yes, are you accepting new Maryland Med	dical Assistance patients?	Yes	No
				\sim
C.	Participate in the MEDICARE (in either the tradi	tional program or a Medicare Advantage Plan)?	● Yes	O No
	·		•	0
	c1. If Yes, are you accepting new Medicare pati	ents?	Yes	No
	you offer a sliding fee scale based on ability to pages O No O NA	y? (Utilize a standardized fee reduction schedule for low-income)	. Co	
	ase report the typical number of hours per week y			I debt).
● Ye	es O No O NA	y? (Utilize a standardized fee reduction schedule for low-income)		debt).
24. Ple 5 If you a	ase report the typical number of hours per week y hours per week. If none, enter 0 are practicing as an adult primary care specialist (i	y? (Utilize a standardized fee reduction schedule for low-income)	de bac	se skip to (
24. Ple 5 If you a	ase report the typical number of hours per week y hours per week. If none, enter 0 are practicing as an adult primary care specialist (i	y? (Utilize a standardized fee reduction schedule for low-income) ou personally provide care to patients on a charity basis (do not inclu-	de bac	se skip to (
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24. Ple 5 If you 2 25. Do O Y 26. V Worke verify I heret O N	ase report the typical number of hours per week y hours per week. If none, enter 0 for practicing as an adult primary care specialist (if you charge patients an annual fee for participating es No No Norkers Compensation for Compensation coverage: If you employ of that you are complying with the Workers' Composition of Applicable (Do not complete below) do not practice in Maryland.	y? (Utilize a standardized fee reduction schedule for low-income) ou personally provide care to patients on a charity basis (do not inclu- internal medicine, family practice, general medicine), answer Q.25. Of g on your patient panel (sometime called direct, concierge, or retained internal medicine, family practice, general medicine), answer Q.25. Of g on your patient panel (sometime called direct, concierge, or retained internal medicine, family practice, general medicine), answer Q.25. Of g on your patient panel (sometime called direct, concierge, or retained internal medicine, family practice, general medicine), answer Q.25. Of g on your patient panel (sometime called direct, concierge, or retained internal medicine, family practice, general medicine), answer Q.25. Of g on your patient panel (sometime called direct, concierge, or retained internal medicine, family practice, general medicine), answer Q.25. Of g on your patient panel (sometime called direct, concierge, or retained internal medicine, family practice, general medicine), answer Q.25. Of g on your patient panel (sometime called direct, concierge, or retained internal medicine, family practice, general medicine), answer Q.25. Of g on your patient panel (sometime called direct, concierge, or retained internal medicine, family practice, general medicine), answer Q.25. Of g on your patient panel (sometime called direct, concierge, or retained internal medicine, family practice, general medicine), answer Q.25. Of g on your patient panel (sometime called direct, concierge, or retained internal medicine, family practice, general medicine), answer Q.25. Of g on your patient panel (sometime called direct, concierge, or retained internal medicine, family practice, general medicine), and g on your patient panel (sometime called direct, concierge, grant panel (sometime c	de bac	e skip to (dipractice)
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Andrew Cold Cold Cold Cold Cold Cold Cold Cold	Enter as MM/DD/YYYY Enter as MM/DD/YYYY
PHYSICIAN	IS EMERGENCY CONTACT INFORMATION
ntified the n	Maryland's emergency preparedness efforts, the Department of Health and Mental Hygiene has eed for certain contact information for licensed physicians in Maryland who may be needed to atastrophic health emergency. (Public Safety Article, Sec. 14-3A-01 et seq. and Health General Article I et seq. sets forth the powers of the Governor and Secretary of the Department of Health and Mental
equired Field	
ase provide	the phone number that should be used in the event of an actual emergency.
lowing spec	ecking any box that applies whether you have any particular training and experience regarding the ific agents: Biological Radiological
Chemical ou are inter Maryland F	rested in being contacted about training opportunities provided by the Board of Physicians, please visit Professional Volunteer Corps website at http://bioterrorism.dhmh.state.md.us/volunteer.htm .
·	Thank you for your assistance!
	ION PACKET FOR EXEMPTION FROM LICENSE FEE
28. CERTI	FICATION AND AUTHORIZATION OF LICENSE APPLICATION Sk the first 3 boxes to certify and affirm your renewal application.
28. CERTI	FICATION AND AUTHORIZATION OF LICENSE APPLICATION
28. CERTI	FICATION AND AUTHORIZATION OF LICENSE APPLICATION the first 3 boxes to certify and affirm your renewal application. a. I certify that I have personally reviewed all responses to the items in this application and that the information I have given is true and correct to the best of my knowledge and that any false information provided as part of my application.
28. CERTI	Ek the first 3 boxes to certify and affirm your renewal application. a. I certify that I have personally reviewed all responses to the items in this application and that the information I have given is true and correct to the best of my knowledge and that any false information provided as part of my application may be cause for the denial of my application. b. I agree that the Maryland Board of Physicians (the Board) may request any information necessary to process my application for renewal from any person or agency, including but not limited to former and current employers, govern agencies, the National Practitioners Data Bank, the Healthcare Integrity and Protection Data Bank, hospitals and oth licensing bodies, and I agree that any person or agency may release to the Board the information requested. I also a
28. CERTI	Ex the first 3 boxes to certify and affirm your renewal application. a. I certify that I have personally reviewed all responses to the items in this application and that the information I have given is true and correct to the best of my knowledge and that any false information provided as part of my application may be cause for the denial of my application. b. I agree that the Maryland Board of Physicians (the Board) may request any information necessary to process my application for renewal from any person or agency, including but not limited to former and current employers, govern agencies, the National Practitioners Data Bank, the Healthcare Integrity and Protection Data Bank, hospitals and oth licensing bodies, and I agree that any person or agency may release to the Board the information requested. I also a to sign any subsequent releases for information that may be requested by the Board. c. I shall inform the Board, by certified mail, return receipt requested, within 30 days of: (a) action that would be grouf for disciplinary action under Md. Code Ann. Health Occ. §14-404, that occurred at any time during the application per
28. CERTI	Ex the first 3 boxes to certify and affirm your renewal application. a. I certify that I have personally reviewed all responses to the items in this application and that the information I have given is true and correct to the best of my knowledge and that any false information provided as part of my application may be cause for the denial of my application. b. I agree that the Maryland Board of Physicians (the Board) may request any information necessary to process my application for renewal from any person or agency, including but not limited to former and current employers, govern agencies, the National Practitioners Data Bank, the Healthcare Integrity and Protection Data Bank, hospitals and oth licensing bodies, and I agree that any person or agency may release to the Board the information requested. I also a to sign any subsequent releases for information that may be requested by the Board. c. I shall inform the Board, by certified mail, return receipt requested, within 30 days of: (a) action that would be grout for disciplinary action under Md. Code Ann. Health Occ. §14-404, that occurred at any time during the application per (b) change in any answer that was originally given in this application. d. Check Here if you wish to have the option of viewing your completed application online after you renew your licens Otherwise, your application will not be available online for your later viewing. If selected, viewing is available until 12/1/2010.

*	Please note: Credit cards may be used for online payment only. If you or a 3rd party is sending in payment, it must be by check.				
-	Your renewal fee is:				
***************************************	Credit Card	3rd Party Payer:			

PAYMENT
APPLICATION COMPLETION INFORMATION:
Date Application Started 9/30/2010
Date Application Submitted 10/1/2010

APrint

DO NOT MAIL THIS TO THE BOARD. RETAIN THIS APPLICATION FOR YOUR RECORDS.

Application for renewal of: Physicians 1. License Number D0061788 Dr. Dallas Wayne Johnson I do not have an NPI Individual National Provider Identifier NPI This is the NPI entered in the field for Rendering INPI on a claim (10 digit number) 2. **NPI** Information 3. EMAIL ADDRESS: This is your email address on file, if it has changed, please edit below. If you do not have an email address please indicate by checking the checkbox below. I do not have an email address Address Changes (Non-Public and Public): You must submit a Public and Non-Public address. If either address has changed, please correct here.
Your address(es) on the online renewal application is current as of July 1, 2012. If you requested any changes to your address(es) that are not reflected on this application, please make the change at this time. These changes will be updated in the main database. 4a. Non-Public Address: This address is for Board use only and is where your license will be mailed. However, if no public address is listed, this address will also be made available to the public. Street (2) Street (3) City State country other than USA or Canada, please choose "Foreign" as your state ZipCode Country 4b. Public Address: This address, usually your office, is available to the public and will be posted on the Internet. If you do not designate a public address, your non-public address will be posted on the Internet. Check if Public Address is the same as your Non-Public address (the address above will be automatically entered below.) UTHSCSA Street Dept of OBG Street (2) 7703 Floyd Curl Drive Street (3) City San Antonio Texas State f selecting a country other than USA or Canada, please choose "Foreign" as your state 78229 ZipCode United States Country

CHARACTER AND FITNESS (Question 6)

6. The following questions pertain to the period since July 1, 2010. If this is your first renewal, these questions apply to the period commencing with the date of your initial licensure or reinstatement. Check the box YES or NO next to each question. If you answer Yes, provide an explanation at the prompt.

* All questions must be answered Yes or No.

5. Do you give the Maryland Board of Physicians permission to report your date of birth to

the Federation of State Medical Boards' Physician Data Center? See instruction



a. Has any licensing or disciplinary board of any jurisdiction (except this licensing board), or any entity of the armed services denied your application for licensure, reinstatement or renewal, or taken any action against your license, including but not limited to reprimand, suspension, revocation, a fine, or nonjudicial punishment, for an act that would be grounds for disciplinary action under Md. Code Ann. Health Occ. §14-404?

● Yes ○ No

 Have any complaints, investigations or charges been brought against you or are any currently pending in any jurisdiction by any licensing or disciplinary board (except this licensing board)

or an entity of the armed services?

- c. Has your application for a medical or health professional license been withdrawn for reasons that would be grounds for disciplinary action under Md. Code Ann. Health Occ. §14-404?
- d. Has an investigation or charge been brought against you by a hospital, related institution, or alternative health care system that would be grounds for action under Md. Code Ann. Health Occ. §14-404?
- e. Have you had any denial of application for privileges, failure to renew your privileges, or limitation, restriction, suspension, revocation or loss in privileges in a hospital, related health care facility, or alternative health care system that would be grounds for disciplinary action under Md. Code, Ann. Health Occ. §14-404?
- f. Have you had a plea of guilty, nolo contendere, conviction, or receipt of probation before judgment or other diversionary disposition of any criminal act, excluding traffic violations?
- g. Have you had a plea of guilty, nolo contendere, conviction, or receipt of probation before judgment or other diversionary disposition for an alcohol or controlled dangerous substance offense, including but not limited to driving while under the influence of alcohol or controlled dangerous substances?
- h. Are there any pending criminal charges against you in any court of law, excluding minor traffic violations?
- i. Do you have a physical or mental condition that currently impairs your ability to practice medicine?
- j. Has the use of drugs and/or alcohol resulted in an impairment of your ability to practice your profession?
- k. Do you illegally use drugs?
- Have you surrendered or allowed your license to lapse while under investigation by any licensing or disciplinary board of any jurisdiction or an entity of the armed services?
- m. Have you been named as a defendant in a filing or settlement of a medical malpractice action?
- n. Has your employment by any hospital, HMO, related health care or other institution, or military entity been terminated for any diciplinary reasons?
- o. Have you voluntarily resigned from any hospital, HMO, or other health care facility or institution, or military entity while under investigation by that institution for disciplinary reasons?
- p. Are you in default of a service obligation resulting from your receipt of state or federal funding for your medical education?



q. Have you failed to make arrangements to satisfy any state or federal loans that financed your medical education?

CONTINUING MEDICAL EDUCATION (Question 7)

- a. CME met. I have completed and have been granted credit for at least 50 credit hours of Category 1 continuing medical education activities within the two year period immediately preceding submission of this application for license renewal. Physician is obliged to obtain requisite documentation of CME activity and maintain documentation for a period of six years for possible inspection by the Board. For additional information on CME, see Maryland Regulations, 10.32.01.09.
- b. First Renewal & NPO. I am exempt from CME during the renewal period because this is my first renewal after initial medical licensure in Maryland and I have completed the Board's New Physician Orientation Program. The New Physician Orientation is for NEWLY licensed physicians only. If you were licensed prior to September 30, 2010 or reinstated, this does not apply to you. See New Physician Orientation Program web site. Your license will not be renewed unless you have completed the orientation.
- c. First Renewal after reinstatement. I am exempt from CME during the renewal period because this is my first renewal after reinstatement of my medical licensure in Maryland.

PERSONAL AND PROFESSIONAL INFORMATION (Questions 8-17)

8a.

8b. RACE/ETHNIC IDENTIFICATION - PLEASE CHECK ALL THAT APPLY

Are you of Hispanic or Latino origin? (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.)

O Yes ● No

Select one or more of the following racial categories:

nerican Indian or Alaska Native (A person having origins in any of the original peoples of North or South America, including Central America, and who maintains tribal affiliations or community attachment.)

sian (A person having origin in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, ambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.)

lack or African American (A person having origins in any of the black racial groups of Africa.)

lative Hawaiian or other Pacific Islander (A person having origins in the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.)

White (A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.)

othe

9. Are you employed by the Federal Government?

()	Yes	(1)	No

- 10. Please indicate if you are currently in: a) a residency program accredited by the Accreditation Council for Graduate Medical Education or an internship or residency program approved by the American Osteopathic Association; or b) a fellowship (subspecialty) training program accredited by the ACGME.
- If you answer Yes to either a. or b. you will not be required to complete the Practice Information section (Questions 15-26) of this application.
- a. In an accredited/approved internship or residency program?

Oyes ® No

b. In an accredited fellowship (subspecialty) training program?

Oyes
No

			ntration:		
Primary Concentration Secondary Concentration	200000000000000000000000000000000000000	ics & Gynecology Jiogy			
15 SPECIALTY BOAR	D CERTIFIC	ATION: List up to tv	vo (2) specialty areas	only if certified by	a recognized board of the
American Board of Medic	cal Specialtie	s (ABMS) or the An	nerican Osteopathic	Association (AOA).	
Primary Certification Secondary Certification	Obstetr None	ics & Gynecology	nen en		
2. Please select all state	es (excluding	Maryland) where y	ou hold a medical lic	ense.	
Alabama	☐ Florida	☐ Kentucky	□ Nebraska	Oklahoma	Utah
□Alaska	☐ Georgia	□Louisiana	□ Nevada	☐ Oregon	☐ Vermont
□Arizona	☐ Guam	☐ Maine	☐ New Hampshire	☐ Pennsylvania	□Virginia
☑ Arkansas	☐Hawaii	Massachusetts	☐ New Jersey	☐ Puerto Rico	☐ Virgin Islands
California	Idaho	Michigan	☐ New Mexico	Rhode Island	☐Washington
Colorado		Minnesota	New York	South Carolina	☐ West Virginia
☐ Connecticut	□ Indiana	☐ Mississippi	☐ North Carolina	South Dakota	☐ Wisconsin
and the	□ lowa	□ Missouri	☐ North Dakota	☐ Tennessee	☐ Wyoming
☐ Delaware		loosed	Ohio	☑ Texas	.,
☐ District of Columbia	∟ Kansas	∟ Montana	LJOnio	Z) I EXAS	
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	Please indicate below the nu	umber of practice/office locations at which you routinely deliver patient care for reimbursement
	a. Number of locations in N	varyiand (if tione, enter o)
	If you have locations ou	side of Maryland (if none, enter 0) tside Maryland, please answer (c) below after you 5
,	c. Do you routinely treat M	laryland patients at your practice/office location(s) outside of Maryland?
	O Yes ● No O Dor	
	· · · · · · · · · · · · · · · · · · ·	
		the state of the same surroutly have admitting privileges.
. [Please indicate below the n Number of hospitals in Ma	umber of hospitals at which you currently have admitting privileges.
		An annual and a second a second and a second a second and
).	Number of nospitals outsic	le of Maryland (if none, enter 0) 6
١.	Primary Practice / Office I	Location Primary Practice / Office Location
	Please answer all Primary Practic	
	Organization Name	Pelvic Medicine Institute
		3002 Iron Stone Court
	Street Address	WAS THE COURSE OF THE COURSE O
-	Street2	Enter suite or room number here. (Ex. Suite 101 or Room 101)
	City	San Antonio
	State	Texas
	Zip Code	78230
	Jurisdiction	Non-Maryland V
,	Parameter (Property)	
		If you do not have an EIN enter 00-0000000
	Employer Tax ID	If you do not have an EIN enter 00-0000000
١.	Employer Tax ID	Company of the Compan
7	Employer Tax ID	What is Employer tax ID?
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j. k.	Please select one of the form of the select one of the form of the select one of the form of the select one of the selec	What is Employer tax ID? collowing related to the NPI used for billing insurers: al NPI for billing. Please Enter > Organizational NPI PI for billing. corivate insurers. a 13a, 40 hours of Patient Care Related Activities during a typical work and Care Related Activity hours in your typical work week are delivered at no? Free Standing Medical Facility Private-Not for profit Single-Specialty Group ing regarding staffing at this practice/office location on a typical day. Definition of mid- is listed below. u don't know the number, enter 999

		ondary Practice / Office L			d
Ú ľ	f you l		location and you've checked the box above, you will see a series of questions that must be	Complet	eu.
a.	Orga	- I support	Pelvic Medicine Institute		
b.	Stree	t Address	3002 Iron Stone Court		
C,	Stree	l2	▶ Enter suite or room number (Ex. Suite 101 or Room 101)		
d	City	r	San Antonio		
	State	£ .	Texas		
	Zip (,	78230		
	·		Non-Maryland V		

ħ.	Emp	loyer Tax ID	₩ If you do not have an EIN enter 00-0000	000	
			What is Employer tax ID?		
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i.			ng related to the NPI used for billing insurers:		
		-	I for billing. Please Enter >) i	
,		I use my Individual NPI for		•	
	0	I do not bill public or private	e insurers.	**********	
:	Van	indicated in Question 13a	40 hours of Patient Care Related Activities during a typical work		
*		\$			
	Hov	v many of those Patient Car practice/office location?	e Related Activity hours in your typical work week are delivered at		
		f none, enter 0.	Hours		
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k.	Set	ting	Other Clinic Y		
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	leve	el medical providers is listed	garding staffing at this practice/office location on a typical day. Definition of r i below. 't know the number, enter 999	iliu-	
	Nui	mber of physicians (MDs, D	Os, residents, fellows) including yourself at this location.		
	Nu	mber of mid-level medical p	roviders at this location.		
		Mid-level medical providers istants.	nurse practitioners, nurse midwives, nurse anesthetists and physician	heringa periodo personal sente.	nesteration de la constitue de
20·	-21 He	ealth Information Technology q	uestions has been moved to a seperate section. You are required to complete the Hea	alth Info	rmation
22.	Plea	se indicate if you participate in e program patients.	the following private and public insurance programs, and whether you are currently ac	cepting	new public
	a.	Participate in any PRIVATE is	nsurance plan networks, including PPO, EPO, HMO, etc.	Yes	O No
	b.	Participate in the MARYLANI Care Organization)	D MEDICAL ASSISTANCE PROGRAM (in either the traditional program or a Managed) () Yes	● No
		b1. If Yes, are you accepting	new Maryland Medical Assistance patients?	Yes	○ No
	G.	Participate in the MEDICARE	E (in either the traditional program or a Medicare Advantage Plan)?		

		● Yes	O No
c1. If Yes , are you	accepting new Medicare patients?	(*) Yes	O No
23. Do you offer a sliding fee	scale based on ability to pay? (Utilize a standardized fee reduction so	chedule for low-income)	
24. Please report the typical 3 hours per we	number of hours per week you personally provide care to patients on ek. if none, enter 0	a charity basis (do not include bac	i debi).
If you are practicing as an a	lult primary care specialist (internal medicine, family practice, general	medicine), answer Q.25. Otherwis	se skip to Q.26.
25. Do you charge patients a	in annual fee for participating on your patient panel (sometime called	direct, concierge, or retainer-based	d practice)?
26. Workers Compens Workers Compensation overify that you are compl I hereby certify:	ation overage: If you <u>employ one or more persons,</u> the Md. Code A ring with the Workers' Compensation Law for your renewal to	nn. Health Occ. §1-202 requin be ìssued.	es that you
O Not Applicable (Do r	ot complete below)		
● I do not practice in N	aryland.		
•	ne in my practice in Maryland.	,	
, , ,	e persons in my Maryland practice and have the following Wo	rkers Compensation coverage	
	d employer you must provide the information requested below.	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
Insurance Company	1 Curbos of Age Heart by a say of the say of		
Policy Number			
Expiration Date	Enter as MM/DD/YYYY Enter as MM/D	D/YYYY	
HEALTH INFORMATION	TECHNOLOGY		
Please contact the Maryland H	ealth Care Commission at 410-764-3330 for questions relating to this	s section.	
1	Record Incentive		erapus mammamanahahahahahahahahahahahahahahahah
Medicare or Medic which program you \$63,750 over six y	physicians that adopt an electronic health record are eligible aid. To receive this incentive, a physician must meet certain or choose. The Medicare incentive is up to \$44,000 over five years. Physicians are encouraged to learn more about these in the and Medicaid Services website http://www.cms.gov/EHRI	criteria, which varies depending ears and the Medicaid incentive acentive opportunities by visiting	on e is up to
patients at your primary office/ Question 18 - Primary Practi	of computers and other forms of information technology, such as han practice location, which you listed in ce / Office Location Primary Practice / Office Location lie use of computers and other forms of information technology your office.		
Are you computerized in y a. To obtain informat • Yes O No	our office: ion about treatment alternatives or recommended guidelines?		

b. To send prescriptions electronically to a pharmacy?

○Yes No			
If you answered Yes to 20B, what (Enter Whole number)	percentage of prescriptions a	are submitted electronically? %	
c. To generate reminders for you a Yes No	bout preventive services nee	eded for your patients?	
d. To access patient notes, medica	ation lists, or problem lists?		
e. For clinical data and image excl ● Yes ○ No	nanges with other physicians	9?	
f. For clinical data and image exch Yes ONo	anges with hospitals and Lab	boratories?	
g. To communicate about clinical i	ssues with patients by email ^r	?	
h. To obtain information on potent	ial patient drug interactions w	with other drugs, allergies, and/or patient conditions?	
2. Does your primary office/practice local Oyes, all electronic Yes, part part	ation use electronic MEDICA per and part electronic O No	aL RECORDS (not including billing records)? o ○ Don't know	
2a. If Yes, what is the name and violetic GE Centricity Practice Solution			,
Other	, belgegeblig, as cost-costeles ethickels ethickels (in an activity district technical department)		
2b. If No, please indicate your mo	st significant reason for not u	using electronic medical records.	
	Lack of technology standards		
Overburdened staff	Intangible benefits	○ Not my decision	
Risk of privacy breaches			
3. Please answer the following Teleme	dicine question(s)		
telecommunications of electron	ic technology by a licensed h	Ith care services, the use of interactive audio, video, or other nealth care provider to deliver health care service(s) within the e site at which the patient is located.	scope
3a. Approximately how many times in t (Enter 0 if you did not use telemedi		used telemedicine for any purpose? 0	
3b. If you used telemedicine, what are Second opinion Diagnosis Follow-up Emergency Chronic disease management	your common uses of teleme	edicine technology (mark all that apply)?	
Other (specify)		Description and the second of	

PHYSICIANS EMERGENCY CONTACT INFORMATION

27. As part of Maryland's emergency preparedness efforts, the Department of Health and Mental Hygiene has identified the need for certain contact information for licensed physicians in Maryland who may be needed to respond to a catastrophic health emergency. (Public Safety Article, Sec. 14-3A-01 et seq. and Health General Article

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Section 18-901 et seq. sets forth the powers of the Governor and Secretary of the Department of Health and Mental Hygiene.
* Required Field
Please provide the phone number that should be used in the event of an actual emergency. Daytime * Nighttime*
Indicate by checking any box that applies whether you have any particular training and experience regarding the following specific agents: Chemical Biological Radiological If you are interested in being contacted about training opportunities provided by the Board of Physicians, please visit the Maryland Professional Volunteer Corps website at https://mdresponds.dhmh.maryland.gov/ .
Thank you for your assistance!
28. CERTIFICATION AND AUTHORIZATION OF LICENSE APPLICATION
a. I certify that I have personally reviewed all responses to the items in this application and that the information I have given is true and correct to the best of my knowledge and that any false information provided as part of my application may be cause for the denial of my application.
b. I agree that the Maryland Board of Physicians (the Board) may request any information necessary to process mapplication for renewal from any person or agency, including but not limited to former and current employers, government agencies, the National Practitioners Data Bank, the Healthcare Integrity and Protection Data Bank, hospitals and other licensing bodies, and I agree that any person or agency may release to the Board the information requested. I also agree to sign any subsequent releases for information that may be requested by the Board.
c. I shall inform the Board, by certified mail, return receipt requested, within 30 days of: (a) action that would be grounds for disciplinary action under Md. Code Ann. Health Occ. §14-404, that occurred at any time during the application period; (b) change in any answer that was originally given in this application.
d. Check Here if you wish to have the option of viewing your completed application online after you renew your license. Otherwise, your application will not be available online for your later viewing. If selected, viewing is available until 12/1/2012.
29. Please provide your electronic signature (type your name) below:
Name Dalias W Johnson 87/2012 E8
Today's Date 8/7/2012 FEE
30. Select a Payment Option here to complete your application. Please note: Credit cards may be used for online payment only. If you or a 3rd party is sending in payment, it must be by check.
Your renewal fee is:
Credit Card Send Check 3rd Party Check 3rd Party Payer:
PAYMENT APPLICATION COMPLETION INFORMATION: Date Application Started 8/7/2012 Date Application Started 8/7/2012

APrint

DO NOT MAIL THIS TO THE BOARD. RETAIN THIS APPLICATION FOR YOUR RECORDS.

plication for rer	newal of: Physicians
	mber D0061788 Dr. Dallas Wayne Johnson
2. This is th	I National Provider Identifier NPI: I do not have an NPI e NPI entered in the field for Rendering NPI on a claim (10 digit number)
<u>V NPL</u>	information
. EMAIL ADI	ORESS: Please enter your most current email address where we may contact you regarding your license.
ou must submit a our address(es) or ease make the ch	inges (Non-Public and Public): Public and Non-Public address, if either address has changed, please correct here. Public and Non-Public address, if either address has changed, please correct here. If the online renewal application is current as of July 1, 2014. If you requested any changes to your address(es) that are not reflected on this application the online renewal application is current as of July 1, 2014. If you requested any changes to your address(es) that are not reflected on this application and the online renewal application is current as of July 1, 2014. If you requested any changes to your address(es) that are not reflected on this application that are not reflected on this application.
a. Non-Publi ublic address is treet	c Address: This address is for Board use only and is where your license will be mailed. However, if no list at this address will also be made available to the public.
treet (2)	See the debag and special production of the second
treet (3)	- Same the state of the state o
ity	
tate	If see Ning a country other than USA or Canada, please choose "Foreign" as your state
(ipCode	Sept. Miles and a sept.
Country	Onited States
4b. Public Ad	idress: This address, usually your office, is available to the public and will be posted on the Internet. If you do public address, your non-public address will be posted on the Internet.
Check if Pu	blic Address is the same as your Non-Public address (the address above will be automatically entered below.)
Itreet	Whole Woman's Health Clinic
Street (2)	4025 E. Sauthcross Blvd
Street (3)	Superior and the superi
City	San Antonio
State	Texas If selecting a country other than USA or Canada, please choose "Foreign" as your state
ZipCode	78753
Country	United States

CHARACTER AND FITNESS (Question 6)

6. The following questions pertain to the period since July 1, 2012. If this is your first renewal, these questions apply to the period commencing with the date of your initial licensure or reinstatement. Check the box YES or NO next to each question. If you answer Yes, provide an explanation at the prompt.

* All questions must be answered Yes or No.

the Federation of State Medical Boards' Physician Data Center? See instruction



- Has any licensing or disciplinary board of any jurisdiction (except this licensing board), or any entity of the armed services denied your application for licensure, reinstatement or renewal, or taken any action against your license, including but not limited to reprimand, suspension, revocation, a fine, or nonjudicial punishment, for an act that would be grounds for disciplinary action under Md. Code Ann. Health Occ. §14-404?
- Have any complaints, investigations or charges been brought against you or are any currently pending in any jurisdiction by any licensing or disciplinary board (except this licensing board) or an entity of the armed services?



- Has your application for a medical or health professional license been withdrawn for reasons that would be grounds for disciplinary action under Md. Code Ann. Health Occ. §14-404?
- Has an investigation or charge been brought against you by a hospital, related institution, or alternative health care system that would be grounds for action under Md. Code Ann. Health Occ. §14-404?
- Have you had any denial of application for privileges, failure to renew your privileges, or limitation, restriction, suspension, revocation or loss in privileges in a hospital, related health care facility, or alternative health care system that would be grounds for disciplinary action under Md. Code Ann. Health Occ. §14-404?
- Have you had a plea of guilty, nolo contendere, conviction, or receipt of probation before judgment or other diversionary disposition of any criminal act, excluding traffic violations?
- Have you had a plea of guilty, noto contendere, conviction, or receipt of probation before judgment or other diversionary disposition for an alcohol or controlled dangerous substance offense, including but not limited to driving while under the influence of alcohol or controlled dangerous substances?
- Are there any pending criminal charges against you in any court of law, excluding minor traffic violations?
- Do you have a physical or mental condition that currently impairs your ability to practice
- Has the use of drugs and/or alcohol resulted in an impairment of your ability to practice your profession?
- Do you illegally use drugs?
- Have you surrendered or allowed your license to lapse while under investigation by any licensing or disciplinary board of any jurisdiction or an entity of the armed services?
- Have you been named as a defendant in a filing or settlement of a medical malpractice action?
- Has your employment by any hospital, HMO, related health care or other institution, or military entity been terminated for any diciplinary reasons?
- Have you voluntarily resigned from any hospital, HMO, or other health care facility or institution, or military entity while under investigation by that institution for disciplinary reasons?
- Are you in default of a service obligation resulting from your receipt of state or federal funding for your medical education?



q. Have you failed to make arrangements to satisfy any state or federal loans that financed your medical education?

CONTINUING MEDICAL EDUCATION (Question 7)

- a. CME met. I have completed and have been granted credit for at least 50 credit hours of Category 1 continuing medical education activities within the two-year period immediately preceding submission of this application for license renewal. Physician is obliged to obtain requisite documentation of CME activity and maintain documentation for a period of six years for possible inspection by the Board. For additional information on CME, see Maryland Regulations, 10.32.01.09.
- b. First Renewal & NPO. I am exempt from CME during the renewal period because this is my first renewal after initial medical licensure in Maryland and I have completed the Board's New Physician Orientation Program. The New Physician Orientation is for NEWLY licensed physicians only. If you were licensed prior to September 30, 2012 or reinstated, this does not apply to you. See New Physician Orientation Program web site. Your license will not be renewed unless you have completed the orientation.
- c. First Renewal after reinstatement. I am exempt from CME during the renewal period because this is my first renewal after reinstatement of my medical licensure in Maryland.

PERSONAL AND PROFESSIONAL INFORMATION (Questions 8-17)

Ah I	RACE/ETHNIC IDENTIFICATION - PLEASE CHECK ALL THAT APPLY	
Are	e you of Hispanic or Latino origin? (A person of Cuban, Mexican, Puerto Rican, South or Central nerican, or other Spanish culture or origin, regardless of race.)	○ Yes
Sele	lect one or more of the following racial categories: merican Indian or Alaska Native (A person having origins in any of the original peoples of North or South nd who maintains tribal affiliations or community attachment.)	America, including Central America
	sian (A person having origin in any of the original peoples of the Far East, Southeast Asia, or the Indian cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.	subcontinent including, for example,
	black or African American (A person having origins in any of the black racial groups of Africa.)	
	lative Hawaiian or other Pacific Islander (A person having origins In the original peoples of Hawaii, Guam	, Samoa, or other Pacific Islands.)
	White (A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.)	
	Dther	
	re you employed by the Federal Government?	daniahandarangandarandaran baratan dan dan dan dan dan dan dan dan dan d
Jobildh	Yes No	

- 10. Please indicate if you are currently in: a) a residency program accredited by the Accreditation Council for Graduate Medical Education or an internship or residency program approved by the American Osteopathic Association; or b) a fellowship (subspecialty) training program accredited by the ACGME.
- If you answer Yes to either a. or b. you will not be required to complete the Practice Information section (Questions 15-26) of this application.
- a. In an accredited/approved internship or residency program?
- O yes No
- b. In an accredited fellowship (subspecialty) training program?
- O Yes
 No
- 11a. Which best describes your current area(s) of concentration:

American Board of Medic	D CERTIFIC			**************************************	
Dalamana Mankillankina	cal Specialtic	ATION: List up to tves (ABMS) or the Ar	vo (2) specialty areas nerican Osteopathic	only if certified by a	a recognized board of the
Primary Certification Secondary Certification	Obsteti None	ics & Gynecology	, 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1		
secondary Certification	[IANIA				kirinda kanala kan
2. Please select all state	es (excludin	g Maryland) where y	ou hold a medical lic	ense.	
Alabama	□Florida	☐ Kentucky	□ Nebraska	Oklahoma	□Utah
□ Alaska	☐Georgia	□Louisiana	□Nevada	☐ Oregon	□Vermont
☐ Arizona	☐Guam	☐Maine	☐ New Hampshire	☐ Pennsylvania	Virginia
☑ Arkansas	□Hawaii	☐Massachusetts	☐ New Jersey	Puerto Rico	☐ Virgin Islands
☐ California	□ldaho	☐Michigan	☐ New Mexico	Rhode Island	☐Washington
☐ Colorado	□ Illinois	☐Minnesota	☐ New York	☐ South Carolina	☐ West Virginia
☐ Connecticut	□Indiana	☐ Mississippi	☐ North Carolina	☐ South Dakota	☐ Wisconsin
Delaware	lowa	☐ Missouri	☐ North Dakota	Tennessee	☐ Wyoming
☐ District of Columbia	Kansas	☐ Montana	Ohio	☑ Texas	
				, majangangangan pengangan digunas salah sal	
13a. How many weeks p	er year do y	ou work? 50			
	**			eek . The sum of th	nese hours should reflect the
13b. Please indicate belo number of hours in your	ow how the l typical work	hours are allocated week. Definitions o	in your typical work w f these categories are	e listed below.	ese hours should reflect the
number of hours in your file of house in your file of house in formation section (Que	ow how the l typical work ars per weel estions 15-26	nours are allocated week. Definitions of k to a. Patient Care 5) of this application	in your typical work w f these categories are Related Activities you	e listed below. u will not be required	d to complete the Practice
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13b. Please indicate belonumber of hours in your If you allocate 0 hour information section (Que Patient Care Related Artificial and includes about particular providers about particular includes clinic Teaching includes the teactivities) & management institutions or programs)	ow how the latypical work are per weel estions 15-26 ctivities incents), maintaitients, talking cal, laborator eaching of mar: Administration of institution; Other	nours are allocated week. Definitions of k to a. Patient Care 6) of this application lude seeing patients sining patient record g with a patient's fairly, and analytical retainedical undergraduation includes practions or programs (he	in your typical work we fithese categories are Related Activities you will be a categories are so that the second prescriptions of the second prescription and review the second prescription of the second prescr	e listed below. u will not be required s, patient-related cli ewing test results, a uts and other gradua	d to complete the Practice nical activities (such as pathologi rranging referrals, consulting with ate students. tions, personnel, regulatory
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	Number of locations of the locations of the locations of the locations	outside of Maryland (if none, enter 0) outside Maryland, please answer (c) below after you 2	
c.	answer (b). Do you routinely treat	t Maryland patients at your practice/office location(s) outside of Maryland?	?
***	Oyes ® No Ot		
		number of hospitals at which you currently have admitting privileges.	
		Maryland (if none, enter 0)	
o. 1	Number of hospitals out	side of Maryland (if none, enter 0)	
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C	organization Name2		
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. 5	Street2	Enter suite or room number here. (Ex. Suite 101 or Room 101)	
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k. I. m.	● I use my Individual ○ I do not bill public of You indicated in Quest week. How many of those Pa this practice/office loca If none, enter 0. Setting Private/Public Practice Please answer the folk level medical providers	I NPI for billing. Organizational NPI or private insurers. Cion 13a, 30 hours of Patient Care Related Activities during a typical work stient Care Related Activity hours in your typical work week are delivered at stion? Free Standing Medical Facility Private-For profit Single-Specialty Group-independent owing regarding staffing at this practice/office location on a typical day. Definition of mid-	
k. I. m.	I use my Individual O I do not bill public of You indicated in Quest week. How many of those Pa this practice/office loca If none, enter 0. Setting Private/Public Practice Please answer the folk level medical providers If none, enter 0; if	I NPI for billing. Organizational NPI or private insurers. Cion 13a, 30 hours of Patient Care Related Activities during a typical work stient Care Related Activity hours in your typical work week are delivered at tition? Free Standing Medical Facility Private-For profit Single-Specialty Group-independent owing regarding staffing at this practice/office location on a typical day. Definition of midsis listed below.	

			C C Yes No
c. Participate in the	MEDICARE (in either the	e traditional program or a Medicare Advantage Plan)?	○
c1. If Yes , are yo	⊖ ⊖ Yes No		
23. Do you offer a sliding Yes No NA		to pay? (Utilize a standardized fee reduction schedule for k	ow-income)
24. Please report the typic 5 hours per		reek you personally provide care to patients on a charity bas ter 0	sis (do not include bad debt).
Check this box and sk	rip to Q.26.	alist (internal medicine, family practice, general medicine), pripating on your patient panel, sometimes called direct, conc	
phonoconomics to the property and the second control of the second			
verify that you are com I hereby certify: Not Applicable (Do	n coverage: If you <u>emp</u> plying with the Workers o not complete below)	oloy one or more persons, the Md. Code Ann. Health s' Compensation Law for your renewal to be issued.	Occ. §1-202 requires that yo
Workers Compensation verify that you are compensation that you are compensations of the compensation of the compensation verify. Not Applicable (Down I do not practice in the compensation)	n coverage: If you <u>emp</u> aplying with the Workers o not complete below) a Maryland.	s' Compensation Law for your renewal to be issued.	Occ. §1-202 requires that yo
Workers Compensation verify that you are compensation verify that you are complete that	n coverage: If you emp applying with the Workers o not complete below) a Maryland. ayone in my practice in aore persons in my Man	s' Compensation Law for your renewal to be issued.	
Workers Compensation verify that you are commended in the commendation of the commenda	n coverage: If you employlying with the Workers o not complete below) n Maryland. nyone in my practice in lore persons in my Man land employer you must pre-	Maryland. yland practice and have the following Workers Comprovide the information requested below. Enter as MM/DD/YYYY Enter as MM/DD/YYYY	
Workers Compensation verify that you are commended in the proof of the	n coverage: If you employlying with the Workers o not complete below) n Maryland. nyone in my practice in lore persons in my Man land employer you must pre- controlly the complete below)	Maryland. yland practice and have the following Workers Comprovide the information requested below. Enter as MM/DD/YYYY Enter as MM/DD/YYYY	ensation coverage.
Workers Compensation verify that you are compensation verify that you are compensation verify that you are compensation. I do not practice in the compensation of the	n coverage: If you employlying with the Workers o not complete below) n Maryland. nyone in my practice in lore persons in my Man land employer you must pre- controlly the complete below)	Maryland. yland practice and have the following Workers Comprovide the information requested below. Enter as MM/DD/YYYY Enter as MM/DD/YYYY	ensation coverage.

This question is about the use of computers and other forms of information technology, such as hand-held computers, in diagnosing or treating your patients at your primary office/practice location, which you listed in Question 18 - Primary Practice / Office Location Primary Practice / Office Location

Please complete the following HIT questions for: Female Pelvic Medicine Institute

1. This question is about the use of computers and other forms of information technology, such as hand-held computers, in diagnosing or treating your patients in your office.

● Yes ○ No	n about treatment alternatives or re	podititionaca damenina	
and a server on 1 to the			
b. To send prescription	ns electronically to a pharmacy?	•	
Oyes ● No			
If you answered Yes to (Enter Whole number)	o 1b, what percentage of prescription	ons are submitted electronically?	%
c. To generate remind Yes ONo	ers for you about preventive servic	es needed for your patients?	.*
	otes, medication lists, or problem li	ists?	
● Yes ○ No			·
e. For clinical data and	d image exchanges with other phys	sicians?	
○Yes No			
f. For clinical data and	I image exchanges with hospitals a	nd laboratories?	·
● Yes ○ No			•
g. To communicate at	out clinical issues with patients by	email?	
● Yes ○ No			
h. To obtain informatio	on on potential patient drug interact	tions with other drugs, allergies, and/o	r patient conditions?
● Yes ○ No			
2 Does vour námary office	/practice location use electronic ME	EDICAL RECORDS (not including billing	ng records)?
	es, part paper and part electronic		
	name and version of the EHR sys		
athenaClinicals	Tilane and vesion of the LTTT 335	(6)313	
O de la	, 1985年,1985年,1985年,1985年,1985年,1985年,1985年,1985年,1985年,1985年,1985年,1985年,1985年,1985年,1985年,1985年,1985年,1985年,1	istratura principal principal principal de la companya de la companya de la companya de la companya de la comp	
Other			
2b. If No. please indic	cate your most significant reason fo	or not using electronic medical records	
2b. If No , please indic		or not using electronic medical records ndards C Retiring soon	
* *	ys Cack of technology sta		
Capital cost outla	Lack of technology sta O Intangible benefits	ndards C Retiring soon	
Capital cost outla Overburdened st Risk of privacy br	aff Clack of technology sta Clack of technology sta Intangible benefits reaches	ndards C Retiring soon C Not my decision	
Capital cost outla Overburdened st Risk of privacy br	Lack of technology sta O Intangible benefits	ndards C Retiring soon C Not my decision	
Capital cost outla Overburdened st Risk of privacy br 3. Have you used telemedir Yes No Telemedicine m	Lack of technology stars aff Intangible benefits reaches cine for any purpose in the last 12 interesting the last 12 intere	ndards C Retiring soon C Not my decision	active audio, video, or other alth care service(s) within the scope
Capital cost outla Overburdened sta Risk of privacy br 3. Have you used telemedia Yes No Telemedicine matelecommunications of practice of the he	Lack of technology sta aff Intangible benefits reaches cine for any purpose in the last 12 integrals, as it relates to the delivery of the care provider at a site other the contract of the last 12 months have	ndards C Retiring soon C Not my decision months? of health care services, the use of internsed health care provider to deliver he	active audio, video, or other alth care service(s) within the scope ted.
Capital cost outla Overburdened sta Risk of privacy br 3. Have you used telemedia Yes No Telemedicine in telecommunications of practice of the he 3a. Approximately how man (Enter 0 if you did not use	Tack of technology stars aff Intangible benefits reaches cine for any purpose in the last 12 means, as it relates to the delivery of sof electronic technology by a licer tealth care provider at a site other than times in the last 12 months have use telemedicine)	ndards C Retiring soon C Not my decision months? of health care services, the use of internsed health care provider to deliver he can the site at which the patient is local	active audio, video, or other alth care service(s) within the scope ted.
Capital cost outla Overburdened st Risk of privacy br 3. Have you used telemedic Yes No Telemedicine matelecommunications of practice of the her 3a. Approximately how man (Enter 0 if you did not used telemedicin Second opinion	Tack of technology stars aff Intangible benefits reaches cine for any purpose in the last 12 means, as it relates to the delivery of sof electronic technology by a licer tealth care provider at a site other than times in the last 12 months have use telemedicine)	ndards C Retiring soon C Not my decision months? of health care services, the use of internsed health care provider to deliver he can the site at which the patient is locate you used telemedicine for any purpose.	active audio, video, or other alth care service(s) within the scope ted.
Capital cost outla Overburdened st Risk of privacy br 3. Have you used telemedic Yes No Telemedicine matelecommunications of practice of the he 3a. Approximately how man (Enter 0 if you did not used telemedicin Second opinion Diagnosis	Tack of technology stars aff Intangible benefits reaches cine for any purpose in the last 12 means, as it relates to the delivery of sof electronic technology by a licer tealth care provider at a site other than times in the last 12 months have use telemedicine)	ndards C Retiring soon C Not my decision months? of health care services, the use of internsed health care provider to deliver he can the site at which the patient is locate you used telemedicine for any purpose.	active audio, video, or other alth care service(s) within the scope ted.
Capital cost outla Overburdened st Risk of privacy br 3. Have you used telemedic Yes No Telemedicine man telecommunications of practice of the her 3a. Approximately how man (Enter 0 if you did not used telemedicin Second opinion Diagnosis Follow up	Tack of technology stars aff Intangible benefits reaches cine for any purpose in the last 12 means, as it relates to the delivery of sof electronic technology by a licer tealth care provider at a site other than times in the last 12 months have use telemedicine)	ndards C Retiring soon C Not my decision months? of health care services, the use of internsed health care provider to deliver he can the site at which the patient is locate you used telemedicine for any purpose.	active audio, video, or other alth care service(s) within the scope ted.
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Capital cost outla Overburdened st Risk of privacy br 3. Have you used telemedic Yes No Telemedicine man telecommunications of practice of the her 3a. Approximately how man (Enter 0 if you did not used telemedicin Second opinion Diagnosis Follow up	Tack of technology stars aff Intangible benefits reaches cine for any purpose in the last 12 integrals, as it relates to the delivery of sof electronic technology by a licer ealth care provider at a site other the my times in the last 12 months have use telemedicine) e, what are your common uses of the safe in the last 12 months have use telemedicine)	ndards C Retiring soon C Not my decision months? of health care services, the use of internsed health care provider to deliver he can the site at which the patient is locate you used telemedicine for any purpose.	active audio, video, or other alth care service(s) within the scope ted.

The following que	estions are to be answered ONLY if your Practice Setting is one of the following: le-Specialty Group; (3) Multi-Specialty Group; or (4) HMO Group/Staff
4. Does your pract ● Yes ○ No	tice use high speed Internet?
4a. Verizon Wire	eless Y Please Specify:
	cess the Internet? le Modem O Fiber to the office Wireless O Other O Unknown Wi-Fi access to your patients in your waiting area?
Oyes ●No	O Unknown
PHYSICIANS EN	MERGENCY CONTACT INFORMATION
dentified the need to	land's emergency preparedness efforts, the Department of Health and Mental Hygiene has for certain contact information for licensed physicians in Maryland who may be needed to crophic health emergency. (Public Safety Article, Sec. 14-3A-01 et seq. and Health General Article seq. sets forth the powers of the Governor and Secretary of the Department of Health and Mental
' Required Field	
Please provide the	phone number that should be used in the event of an actual emergency.
following specific at Chemical	Biological Radiological
lf you are interested the Maryland Profe	d in being contacted about training opportunities provided by the Board of Physicians, please visit essional Volunteer Corps website at https://mdresponds.dhmh.maryland.gov/ .
	Thank you for your assistance!
28. CERTIFICA	TION AND AUTHORIZATION OF LICENSE APPLICATION
Ø	a. I certify that I have personally reviewed all responses to the items in this application and that the information I have given is true and correct to the best of my knowledge and that any false information provided as part of my application may be cause for the denial of my application.
2	b. I agree that the Maryland Board of Physicians (the Board) may request any information necessary to process my application for renewal from any person or agency, including but not limited to former and current employers, government agencies, the National Practitioners Data Bank, the Healthcare Integrity and Protection Data Bank, hospitals and other licensing bodies, and I agree that any person or agency may release to the Board the information requested. I also agree to sign any subsequent releases for information that may be requested by the Board.
Σ	c. I shall inform the Board, by certified mail, return receipt requested, within 30 days of: (a) action that would be grounds for disciplinary action under Md. Code Ann. Health Occ. §14-404, that occurred at any time during the application period; (b) change in any answer that was originally given in this application.
Ø	d. Check Here if you wish to have the option of viewing your completed application online after you renew your license. Otherwise, your application will not be available online for your later viewing. If selected, viewing is available until 12/1/2014.

29. Please provide your electronic signature (type your name) below:

	•		
Name	Dallas W. Johnson, MD		
Today's Date 30. Select a Payment Option Please note: Credit cards may be			ayment, it must be by check.
a factorion of the fact	, ,		
Your renewal fee is:			
Credit Card	eck 3rd Party Check	3rd Party Payer:	
PAYMENT APPLICATION COMPLET Date Application Started Date Application Submitter	9/13/2014		