1501 MEDICAL DOCTOR
APPLICATION FOR LICENSURE

Read instructions before and while you complete this application.
(Failure to do so may result in delays in processing your application)

2. Application category/applicable fees: Client 1501
[X] Endorsement (1021) [ ] Examination (1024)

3. Name: Jackson, MD (Last) Darwin (First) Clinton (Middle)

3a. Have you ever changed your name through marriage, naturalization or action of a court? [ ] YES [X] NO
If yes; list original name(s) and date(s) of changes in mm/dd/yy.

Last (Date of change) First (Date of change) Middle (Date of change)

3b. Have you ever been known by any other names (aliases)? [ ] YES [X] NO

If 'yes', list name(s) (Last, First, Middle, and Suffix).

4. Mailing address:

13400 Skyline Drive (Street and number or PO Box) Plainfield, (City) IL (State/Province) 60585-1914 (Zip/Postal Code) USA (Country)

5. Primary practice/physical address (current practice location address):

5086 North Elston Avenue (Street and number) Chicago, (City) IL (State/Province) 60630 (Zip/Postal Code) USA (Country)

6. Telephone (815) 609-1686 (Home: Area Code/Phone Number) (773) 725-0200 (Work: Area Code/Phone Number)

(630) 770-5211 (Cellular: Area Code/Phone Number)

7. E-mail address: darwin_jackson@msn.com

8. Are you a citizen of the United States? [X] YES [ ] NO

Birth Date: 04/13/1950 Birth Place: Louisville, KY Naturalization Date: _____

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

Race: [ ] Caucasian [X] Black [ ] Hispanic [ ] Asian [ ] Native American [ ] Other

Sex: [X] Male [ ] Female

10. Disaster Registry: As a Florida licensed physician, are you willing to provide health care services in special need shelters or to work with disaster medical teams during times of emergency or major disasters? [X] YES [ ] NO

1501 MEDICAL DOCTOR
APPLICATION FOR LICENSURE

Read instructions before and while you complete this application.
(Failure to do so may result in delays in processing your application)

1. U.S. Social Security Number:

CONFIDENTIAL AND EXEMPT FROM PUBLIC RECORDS DISCLOSURE*

Florida Department of Health
Board of Medicine

Name: Jackson, MD — Darwin — Clinton
Last — First — Middle

Social Security Number: [redacted]

*This page is exempt from public records disclosure. The Department of Health is required and authorized to collect social security numbers relating to applications for professional licensure pursuant to Title 42 USCS § 666 (a)(13). For all professions regulated under Chapter 456, Florida Statutes, the collection of social security numbers is required by Section 456.013 (1)(a), Florida Statutes.

11. Have you ever been in the United States Military and/or Public Health Service? [ ] YES [X] NO

If yes, list branch of service, rank, dates of service. (Enclose copy of discharge form.)

11a. Have charges ever been brought against you by any branch of the United States Military and/or Public Health Service? [ ] YES [X] NO
If yes, explain the circumstances on a separate sheet.

12. Education: Undergraduate, graduate, medical, and professional education – Starting with undergraduate education, list in chronological order all schools, colleges, and universities attended, whether completed or not. Submit on a separate sheet if needed.

College and University Name and Address	Major and Degree	From: mm/yy	To: mm/yy	Date Degree Received
Ohio State University, Office of the Registrar 281 West Lane Avenue Columbus, OH 43210	Zoology Bachelor of Science	09/1968	06/1972	06/1972
Washington University Medical School 660 South Euclid Avenue St Louis, MO 63110	Medicine Doctor of Medicine	09/1972	06/1976	06/1976

For items 12a-d, if yes explain on a separate sheet providing accurate details.

12a. Have you ever been dropped, suspended, placed on probation, asked to resign, or expelled from **any** school, college or university? [ ] YES [X] NO

12b. Did you attend medical school for a period other than the normal curriculum, or were you required to repeat **any** of your medical education including classes, test/exams, lectures or any other part of the curriculum? [ ] YES [X] NO

12c. Did you take **any** type of break or leave of absence for any reason during medical school? [ ] YES [X] NO
(Including maternity/paternity, medical leave or any other type of break or leave.)

12d. Have you ever defaulted on any health education loan or scholarship obligation? [ ] YES [X] NO

12e. If you are an international medical graduate, did you perform your core clerkships in the United States? n/a [ ] YES [ ] NO
If 'yes', list on a separate sheet core clerkship, institution, address, and date of each rotation completed in the U.S.

13. Postgraduate Training: In the table below list, in chronological order, all postgraduate training from date you graduated from medical school to present (Internship/Residency/Fellowship).

Program Name and Full Mailing Address	Specialty Area	From: mm/yy	To: mm/yy	Did you receive credit? Yes or No
Washington University Medical School 660 South Euclid Avenue Campus Box 10864 St Louis, MO 63110	Residency in Obstetrics and Gynecology	7/1976	6/1980	Yes

For items 13a-c, if yes, explain on a separate sheet providing accurate details.

13a. Have you ever been dropped, suspended, placed on probation, asked to resign or expelled from **any** postgraduate training program? [ ] YES [X] NO

13b. Was attendance in a postgraduate training program for a period other than the established timeframe or were you required to repeat **any** of your postgraduate training including classes, test/exams, lectures or any other part of the curriculum? [ ] YES [X] NO

13c. Did you take **any** type of break or leave of absence for any reason during your postgraduate training? (Including maternity/paternity, medical leave or any other type of break or leave.) [ ] YES [X] NO

14. Licensing Examination: State Board (prior to 1974), State Board (after 1974) & SPEX, LMCC & SPEX, NBME, FLEX, USMLE III, or Combination (prior to 2000)

Exam taken NBME Date passed 06/30/1976
mm/dd/yy

15. List the date you legally first began to practice medicine, mm/07 dd/01 yy/1976. This would be the date you began practicing medicine and could be the date you began your postgraduate training.

16. Licensure: In the table below, list **all state** licenses to practice medicine where you **hold** or ever **held** a license regardless of current status in **any** jurisdiction. Training licenses are not required.

State or Country	License number	State or Country	License number
Missouri	R8089	Illinois	036-091457

For items 16a-e, if yes, explain on a separate sheet providing accurate details.

16a. Have you had **any** application for a medical license or professional license denied by **any** state board or other governmental agency of **any** state, territory, or country? [ ] YES [X] NO

16b. Have you ever been allowed to withdraw an application for medical licensure for **any** reason or during a pending investigation in any jurisdiction in lieu of your license being denied? [ ] YES [X] NO

16c. Are you currently under investigation in any jurisdiction for an act or offense that would constitute a violation of Section 458.331, Florida Statutes? [ ] YES [X] NO

16d. Have you ever been notified, invited or required to appear before **any** licensing agency for a hearing on a complaint of **any** nature including, but not limited to, a charge or violation of the Medical Practice Act, involving unprofessional or unethical conduct? [ ] YES [X] NO

16e. Have you ever had **any** professional license or license to practice medicine revoked, suspended, placed on probation, received a citation, or other disciplinary action taken in **any** state, territory or country? [ ] YES [X] NO

17. Practice/Employment: In the table below, list in chronological order **all** employment, non-employment, and/or **any unaccounted period of time** from date you graduated medical school to present.
If needed, continue on a separate sheet of paper.

Name and full mailing address of employment or activity	Type of employment or activity	From: mm/yy	To: mm/yy
Darwin C. Jackson, MD			
Ob-Gyn Specialties, 837 Dunn Rd, Suite 107	Private Medical Practice	07/1980	08/2002
Hazelwood, MO 63042			
Family Planning Associates Medical Group			
5086 North Elston Avenue	Associate Medical Director	08/2002	Present
Chicago, IL 60630			

For items 17a-b, if yes, explain on a separate sheet providing accurate details.

17a. Have you ever had employment terminated for cause? [ ] YES [X] NO

17b. Have you ever been asked, or allowed to resign from any facility instead of disciplinary action or during any pending investigations into your practice? [ ] YES [X] NO

17c. In the table below, list **all** hospital(s), health institution(s), clinic(s), or medical facilities where you currently hold staff privileges. Do not list training privileges.

Name/mailing address of facility	Chief of staff	Type of privileges	From: mm/yy	To: mm/yy
Northwestern Memorial Hospital	Arvydas Vanagunas, MD	Active in Ob-Gyn	11/2002	Present
251 East Huron Street				
Chicago, IL 60611				

For items 17d-e, if yes, explain on a separate sheet providing accurate details.

17d. Have you ever had any staff privileges denied, suspended, revoked, modified, restricted, or placed on probation, or have you been asked to resign or take a temporary leave of absence or otherwise acted against by any facility? [ ] YES [X] NO

17e. Have you ever had any staff privileges restricted or not renewed by any facility instead of disciplinary action? [ ] YES [X] NO

18. Have you had responsibility for graduate medical education within the last 10 years? [X] YES [ ] NO
If yes, list in the table below.

19. Do you currently hold a faculty appointment at a medical or health-related institution of higher learning? [X] YES [ ] NO
If yes, list in the table below.

20. In the table below, list any hospital, health institution, clinic or medical facility where you have or had faculty appointment(s) of higher learning.

Name of institution	Full mailing address	Title of appointment
Norwestern University	251 East Huron Street, Chicago, IL 60611	Instructor, Clinical Gynecology
Feinberg School of Medicine		
Washington University	660 S. Euclid Ave, St Louis, MO 63110	Assistant Professor, Ob-Gyn
Medical School		

21. American Board of Medical Specialties: Are you certified by any specialty board recognized by the American Board of Medical Specialties, or specialty board approved by the Florida Board of Medicine? [X] YES [ ] NO
If yes, list in the table below.

Board Name	Certification/ Specialty/Sub-Specialty	Date of Certification mm/yy
American Board of Ob-Gyn	Obstetrics and Gynecology	11/1982

For items 21a-30, if yes, explain on a separate sheet providing accurate details.

21a. Have you ever failed to receive specialty board certification or re-certification for any reason? [ ] YES [X] NO

21b. Have you ever had any sanctions taken against you by a specialty board or other similar national organization? [ ] YES [X] NO

22. Have you ever been warned or called before the United States Drug Enforcement Administration (DEA)? [ ] YES [X] NO

23. Have you ever been made an offer to compromise or entered into any arrangement plea, or agreement instead of a federal prosecution for a drug violation regulated by DEA? [ ] YES [X] NO

24. Have you ever been denied or surrendered a DEA registration? [ ] YES [X] NO

25. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, Chapter 817, or Chapter 893, Florida Statutes; or 21 U.S.C. ss. 801-970 or 42 U.S.C. ss. 1395-1396? (If no, do not answer 25a.) [ ] YES [X] NO

25a. Has it been more than 15 years prior to the date of this application since the sentence and completion of any subsequent period of probation for each such conviction? n/a [ ] YES [ ] NO

26 Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes? (If no, do not answer 26a.) [ ] YES [X] NO

26a. If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years? n/a [ ] YES [ ] NO

27. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state or federal government, from any other state Medicaid program or the federal Medicare program? (If no, do not answer 27a and 27b.) [ ] YES [X] NO

27a. Have you been in good standing with a state Medicaid program or the federal Medicare program for the most recent five years? [X] YES [ ] NO

27b. Did the termination occur at least 20 years prior to the date of this application? n/a [ ] YES [ ] NO

28. Have you ever been denied or been excluded from Medicare and/or state health care programs? [ ] YES [X] NO

29.	Have you ever had an application for membership denied by a medical society or association or had a medical society or association membership revoked, suspended, placed on probation, or other disciplinary action taken?	[ ] YES	[X] NO
30.	Have you ever been notified to appear before a medical society or association about charges or complaints filed against you?	[ ] YES	[X] NO
31.	Have you ever had a judgment entered against you for medical malpractice where the incident(s) of malpractice occurred after November 2, 2004?	[ ] YES	[X] NO
32.	Within the last 10 years have you had any liability claim(s) or action(s) for damages for personal injury settled or finally adjudicated in an amount that exceeds $100,000.00? If yes, explain on a separate sheet providing accurate details and complete Exhibit 1 for each occurrence.	[X] YES	[ ] NO
33.	Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to any crime in any jurisdiction other than a minor traffic offense? You must include all misdemeanors and felonies even if adjudication was withheld by the court so that you would not have a record of conviction. Driving under the influence or driving while impaired is not a minor traffic offense for purposes of this question.	[ ] YES	[X] NO
34.	Have you ever been arrested or criminally or civilly charged with any intentional or negligent action related to the use or misuse of drugs, alcohol, or illegal chemical substances?	[ ] YES	[X] NO

For items 35-40 if yes, explain on a separate sheet providing accurate details.

35. In the last five years, have you been enrolled in, required to enter into, or participated in any drug or alcohol recovery program or impaired practitioner program for treatment of drug or alcohol abuse that occurred within the past five years?

36. In the last five years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental disorder or impairment?

37. During the last five years, have you been treated for or had a recurrence of a diagnosed mental disorder that has impaired your ability to practice medicine within the past five years?

38. In the last five years, have you been treated for or had a recurrence of a diagnosed physical disorder that has impaired your ability to practice medicine?

39. In the last five years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol/drug) disorder or, if you were previously in such a program, did you suffer a relapse within the last five years?

40. During the last five years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol/drug) disorder that has impaired your ability to practice medicine within the last five years?

The application instructions provide information about documents needed to support your explanation of the 'yes' responses.

41. Prevention of Medical Errors:

[X] I hereby certify that since June 1, 2002, I have completed a minimum of two (2) hours of Prevention of Medical Errors continuing medical education as defined by s. 456.013(7), Florida Statutes. The education must meet requirements defined in § 456.013(7), Florida Statutes and be completed prior to the issuance of your license number. Please contact the Florida Medical Association (FMA) at (850) 224-6496 or www.fmaonline.org for a list of providers of CME. Other resources for CME are the American Medical Association (AMA) at (312) 464-5000, or Medical Education Group Learning Systems (MEGLAS) at 800-547-0308 or www.informed.cme.edu.

42. Dispensing Practitioner Registration:

This is optional and for physicians whose primary practice is in the State of Florida. Dispensing relates to physicians who maintain a "mini-pharmacy" in their private office for profit. Section 465.0276, F. S., requires that licensees of the Board of Medicine who dispense medicinal drugs pay a fee of $100.00 at the time of such registration and upon each renewal of the practitioner's license. It is unlawful for any person to sell samples or complimentary packages of drug products. A practitioner who confines his/her activities to dispensing complimentary packages of medicinal drugs to patients in the regular course of his/her practice is **not** required to register.

Check if applicable to you.

[ ] I plan to dispense medicinal drugs in the State of Florida for a fee or other remuneration and hereby register as required by Section 465.0276, F. S. I understand that the fee for the Dispensing Practitioner is $100.00 **over and above** the required initial license fee and will submit it along with the license fee.

43. Financial Responsibility

The Financial Responsibility options are divided into two categories, coverage and exemptions. Check only **one** option of the ten provided as required by s. 458.320, Florida Statutes.

Category I: Financial Responsibility Coverage

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

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

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

☐**4.** I **have** hospital staff privileges and I have professional liability coverage in an amount not less than $250,000 per claim, with a minimum annual aggregate of not less than $750,000 from an authorized insurer as defined under s. 624.09, F. S., from a surplus lines insurer as defined under s. 626.914(2), F. S., from a risk retention group as defined under s. 627.942, F. S., from the Joint Underwriting Association established under s. 627.351(4), F. S., or through a plan of self insurance as provided in s. 627.357, F. S.

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

Category II: Financial Responsibility Exemptions

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

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

☒**8.** **I do not practice medicine in the State of Florida.**

☐**9.** I meet all of the following criteria:

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

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

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

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

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

Under penalties of perjury, I declare that I have read the foregoing response in sub-question 9 of question 43, and the facts stated in it are true. A person who knowingly makes a false declaration under Section 92.525(2), F.S. is guilty of the crime of perjury by false written declaration, a felony of the third degree, punishable as provided in s. 755.082, s. 775.083, or s. 775.084.

Signature of physician: Darwin C. Jackson MD **Date:** 8-30-2010

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

44. Optional Information:

a. List all medical or professional society or association memberships:

American College of Obstetricians and Gynecologists
American Medical Association

b. Publications: List any publications you have authored in peer-reviewed medical literature within the previous ten years.

None

(Title) (Publication) (Date)

(Title) (Publication) (Date)

(Title) (Publication) (Date)

(Title) (Publication) (Date)

c. Do you participate in the Medicaid program? [X] YES [ ] NO
If yes list:

(Type of Provider) (State)

(Type of Provider) (State)

d. Professional or community service activities, honors, or awards:

Three "Teacher of the Year" awards, Department of Ob-Gyn, Barnes-Jewish Hospital, St Louis, MO
(Activity/Honor/Award) (Organization)

(Activity/Honor/Award) (Organization)

e. Languages other than English: List languages other than English that you use to communicate with patients and any translation service available for patients at your primary place of practice.

f. Comments and additional information: List comments or information that you want the board to be aware of.

I will pursue a teaching position at the University of Central Florida in Orlando. This would be a good way to finish my medical career. I have a long and distinguished experience in Ob-Gyn to share with residents, fellows and students.

45. Florida Birth Related Neurological Compensation Association

You must choose one of the three options described below. Please be sure to view the information about each exemption at www.nica.com. Check only one.

[ ]	[X]	[ ]	
$5,000	$250	$0	$250
Participating	Non-participating	Exempt	Amount enclosed

If you choose "$0 Exempt" provide appropriate documentation to the Board of Medicine and to NICA.

I have read the explanatory information provided by NICA, and I choose the option above.

Darwin C. Jackson MD 8-30-2010
Signature Date

Darwin C. Jackson, MD
Name
13400 Skyline Drive
Street Address
Plainfield, IL 60585-1914
City, State, Zip

If you are a participating or non-participating physician, or a physician claiming exemption, you must complete, sign and date this form and return it with your payment to this address.

Department of Health
Board of Medicine
4052 Bald Cypress Way, #C-03
Tallahassee, FL 32399-3253

If you are a physician claiming exemption, you must also send a copy of your completed, signed, and dated form with proof of your exemption to:

NICA
2360 Christopher Place
Tallahassee, FL 32308

If you have any questions about NICA or this form, please contact NICA at www.nica.com or (850) 488-8191.

46. Statement of Applicant

I state that these statements are true and correct. I recognize that providing false information may result in denial of licensure, disciplinary action against my license, or criminal penalties pursuant to Sections 456.067, 775.083, and 775.084, Florida Statutes. I state that I have read Chapters 456, 458 and 766.301-.316, Florida Statutes and Chapter 64B8, Florida Administrative Code.

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Florida Board of Medicine information which is material to my application for licensure.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind. I state that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act constitutes cause for denial, suspension, or revocation of my license to practice Medicine in the State of Florida. If there are any changes to my status or any change that would affect any of my answers to this application I must notify the board within 30 days. I understand that my records are protected under federal and state regulations governing Confidentiality of Mental Health Patient Records and cannot be disclosed without my written consent unless otherwise provided in the regulations. I understand that my records are protected under federal and state regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it.

Darwin C. Jackson, MD
(Please print your name.)

Darwin C. Jackson MD — 8-30-2010
(Signature of applicant required.) (Date signed required.)

Personal Data:

Height: 6ft, 0in Weight: 220 lbs

Eye Color: Brown Hair Color: Black

1501 MEDICAL DOCTOR
APPLICATION FOR LICENSURE

Read instructions before and while you complete this application.
(Failure to do so may result in delays in processing your application)

1. U.S. Social Security Number:

CONFIDENTIAL AND EXEMPT FROM PUBLIC RECORDS DISCLOSURE*

Florida Department of Health
Board of Medicine

Name: Jackson, Darwin Clinton
Last First Middle

Social Security Number: [redacted]

*This page is exempt from public records disclosure. The Department of Health is required and authorized to collect social security numbers relating to applications for professional licensure pursuant to Title 42 USCS § 666 (a)(13). For all professions regulated under Chapter 456, Florida Statutes, the collection of social security numbers is required by Section 456.013 (1)(a), Florida Statutes.

1501 MEDICAL DOCTOR
APPLICATION FOR LICENSURE

F 106055

04/02/2010 1,227.00
ID: 106055 Type: F
BT: 3009784
VL: 909070890

Read instructions before and while you complete this application.
(Failure to do so may result in delays in processing your application)

NFP 4-6-10

2. Application category/applicable fees: Client 1501
[X] Endorsement (1021) [ ] Examination (1024)

3. Name: Jackson (Last) Darwin (First) Clinton (Middle)

3a. Have you ever changed your name through marriage, naturalization or action of a court? [ ] YES [X] NO
If yes; list original name(s) and date(s) of changes in mm/dd/yy.

Last (Date of change) First (Date of change) Middle (Date of change)

3b. Have you ever been known by any other names (aliases)? [ ] YES [X] NO

If 'yes', list name(s) (Last, First, Middle, and Suffix).

4. Mailing address:

13400 Skyline Drive (Street and number or PO Box) Plainfield, (City) IL (State/Province) 60585-1914 (Zip/Postal Code) USA (Country)

5. Primary practice/physical address (current practice location address):

5086 North Elston Avenue (Street and number) Chicago, (City) IL (State/Province) 60630 (Zip/Postal Code) USA (Country)

6. Telephone (815) 609-1686 (Home: Area Code/Phone Number) (773) 725-0200 (Work: Area Code/Phone Number)
(630) 770-5211 (Cellular: Area Code/Phone Number)

7. E-mail address: darwin_jackson@msn.com

8. Are you a citizen of the United States? [X] YES [ ] NO

Birth Date: 04/13/1950 Birth Place: Louisville, KY Naturalization Date: _____

2010 APR -7 AM 6:51 BOARD OF MEDICINE

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

Race: [ ] Caucasian [X] Black [ ] Hispanic [ ] Asian [ ] Native American [ ] Other

Sex: [X] Male [ ] Female

10. Disaster Registry: As a Florida licensed physician, are you willing to provide health care services in special need shelters or to work with disaster medical teams during times of emergency or major disasters? [X] YES [ ] NO

7

11. Have you ever been in the United States Military and/or Public Health Service? [ ] YES [X] NO

If yes, list branch of service, rank, dates of service. (Enclose copy of discharge form.)

11a. Have charges ever been brought against you by any branch of the United States Military and/or Public Health Service? [ ] YES [X] NO
If yes, explain the circumstances on a separate sheet.

12. Education: Undergraduate, graduate, medical, and professional education – Starting with undergraduate education, list in chronological order all schools, colleges, and universities attended, whether completed or not. Submit on a separate sheet if needed.

College and University Name and Address	Major and Degree	From: mm/yy	To: mm/yy	Date Degree Received
Ohio State University, Columbus, Ohio	Zoology, B. S.	09/68	06/72	06/72
Washington University School of Medicine 660 South Euclid Avenue St Louis, MO 63110	Medicine, M.D.	9/72	06/76	06/76

For items 12a-d, if yes explain on a separate sheet providing accurate details.

12a. Have you ever been dropped, suspended, placed on probation, asked to resign, or expelled from **any** school, college or university? [ ] YES [X] NO

12b. Did you attend medical school for a period other than the normal curriculum, or were you required to repeat **any** of your medical education including classes, test/exams, lectures or any other part of the curriculum? [ ] YES [X] NO

12c. Did you take **any** type of break or leave of absence for any reason during medical school? [ ] YES [X] NO
(Including maternity/paternity, medical leave or any other type of break or leave.)

12d. Have you ever defaulted on any health education loan or scholarship obligation? [ ] YES [X] NO

12e. If you are an international medical graduate, did you perform your core clerkships in the United States? N/A [ ] YES [ ] NO
If 'yes', list on a separate sheet core clerkship, institution, address, and date of each rotation completed in the U.S.

11. Have you ever been in the United States Military and/or Public Health Service? [ ] YES [X] NO

If yes, list branch of service, rank, dates of service. (Enclose copy of discharge form.)

11a. Have charges ever been brought against you by any branch of the United States Military and/or Public Health Service? [ ] YES [X] NO
If yes, explain the circumstances on a separate sheet.

12. Education: Undergraduate, graduate, medical, and professional education – Starting with undergraduate education, list in chronological order all schools, colleges, and universities attended, whether completed or not. Submit on a separate sheet if needed.

College and University Name and Address	Major and Degree	From: mm/yy	To: mm/yy	Date Degree Received

For items 12a-d, if yes explain on a separate sheet providing accurate details.

12a. Have you ever been dropped, suspended, placed on probation, asked to resign, or expelled from **any** school, college or university? [ ] YES [X] NO

12b. Did you attend medical school for a period other than the normal curriculum, or were you required to repeat **any** of your medical education including classes, test/exams, lectures or any other part of the curriculum? [ ] YES [X] NO

12c. Did you take **any** type of break or leave of absence for any reason during medical school? [ ] YES [X] NO
(Including maternity/paternity, medical leave or any other type of break or leave.)

12d. Have you ever defaulted on any health education loan or scholarship obligation? [ ] YES [X] NO

12e. If you are an international medical graduate, did you perform your core clerkships in the United States? n/a [ ] YES [ ] NO
If 'yes', list on a separate sheet core clerkship, institution, address, and date of each rotation completed in the U.S.

13. Postgraduate Training: In the table below list, in chronological order, all postgraduate training from date you graduated from medical school to present (Internship/Residency/Fellowship).

Program Name and Full Mailing Address	Specialty Area	From: mm/yy	To: mm/yy	Did you receive credit? Yes or No
Washington University School of Medicine 660 South Euclid Avenue Campus Box 10864 St Louis, MO 63110	Residency in Ob-Gyn	7/76	6/80	Yes

For items 13a-c, if yes, explain on a separate sheet providing accurate details.

13a. Have you ever been dropped, suspended, placed on probation, asked to resign or expelled from **any** postgraduate training program? [ ] YES [X] NO

13b. Was attendance in a postgraduate training program for a period other than the established timeframe or were you required to repeat **any** of your postgraduate training including classes, test/exams, lectures or any other part of the curriculum? [ ] YES [X] NO

13c. Did you take **any** type of break or leave of absence for any reason during your postgraduate training? (Including maternity/paternity, medical leave or any other type of break or leave.) [ ] YES [X] NO

14. Licensing Examination: State Board (prior to 1974), State Board (after 1974) & SPEX, LMCC & SPEX, NBME, FLEX, USMLE III, or Combination (prior to 2000)

Exam taken NBME Date passed 06/30/76
mm/dd/yy

15. List the date you legally first began to practice medicine, mm/ 07 dd/ 01 yy 76. This would be the date you began practicing medicine and could be the date you began your postgraduate training.

16. Licensure: In the table below, list **all state** licenses to practice medicine where you **hold** or ever **held** a license regardless of current status in **any** jurisdiction. Training licenses are not required.

State or Country	License number	State or Country	License number
Missouri	R8089	Illinois	036-091457

For items 16a-e, if yes, explain on a separate sheet providing accurate details.

16a. Have you had **any** application for a medical license or professional license denied by **any** state board or other governmental agency of **any** state, territory, or country? [ ] YES [X] NO

16b. Have you ever been allowed to withdraw an application for medical licensure for **any** reason or during a pending investigation in any jurisdiction in lieu of your license being denied? [ ] YES [X] NO

16c. Are you currently under investigation in any jurisdiction for an act or offense that would constitute a violation of Section 458.331, Florida Statutes? [ ] YES [X] NO

16d. Have you ever been notified, invited or required to appear before **any** licensing agency for a hearing on a complaint of **any** nature including, but not limited to, a charge or violation of the Medical Practice Act, involving unprofessional or unethical conduct? [ ] YES [X] NO

16e. Have you ever had **any** professional license or license to practice medicine revoked, suspended, placed on probation, received a citation, or other disciplinary action taken in **any** state, territory or country? [ ] YES [X] NO

17. Practice/Employment: In the table below, list in chronological order **all** employment, non-employment, and/or **any unaccounted period of time** from date you graduated medical school to present.
If needed, continue on a separate sheet of paper.

Name and full mailing address of employment or activity	Type of employment or activity	From: mm/yy	To: mm/yy
Darwin C. Jackson, MD Ob-Gyn Specialties 837 Dunn Road, Suite 107 Hazelwood, MO 63042	Private Medical Practice	7/1980	8/2002
Family Planning Associate 5086 North Elston Avenue Chicago, IL 60630	Associate Medical Director	8/2002	Present

For items 17a-b, if yes, explain on a separate sheet providing accurate details.

17a. Have you ever had employment terminated for cause? [ ] YES [X] NO

17b. Have you ever been asked, or allowed to resign from any facility instead of disciplinary action or during any pending investigations into your practice? [ ] YES [X] NO

17c. In the table below, list **all** hospital(s), health institution(s), clinic(s), or medical facilities where you currently hold staff privileges. Do not list training privileges.

Name/mailing address of facility	Chief of staff	Type of privileges	From: mm/yy	To: mm/yy
Northwestern Memorial Hospital	Arvydas Vanagunas, MD	Active in Ob-Gyn	11/2002	Present

For items 17d-e, if yes, explain on a separate sheet providing accurate details.

17d. Have you ever had any staff privileges denied, suspended, revoked, modified, restricted, or placed on probation, or have you been asked to resign or take a temporary leave of absence or otherwise acted against by any facility? [ ] YES [X] NO

17e. Have you ever had any staff privileges restricted or not renewed by any facility instead of disciplinary action? [ ] YES [X] NO

18. Have you had responsibility for graduate medical education within the last 10 years? [X] YES [ ] NO
If yes, list in the table below.

19. Do you currently hold a faculty appointment at a medical or health-related institution of higher learning? [X] YES [ ] NO
If yes, list in the table below.

20. In the table below, list any hospital, health institution, clinic or medical facility where you have or had faculty appointment(s) of higher learning.

Name of institution	Full mailing address	Title of appointment
Northwestern University Feinberg School of Medicine	251 East Huron Street Chicago, IL 60611	Instructor of Clinical Gynecology
Washington University School of Medicine	660 South Euclid Avenue St Louis, MO 63110	Assistant Professor of Clinical Obstetrics and Gynecology

21. American Board of Medical Specialties: Are you certified by any specialty board recognized by the American Board of Medical Specialties, or specialty board approved by the Florida Board of Medicine? [X] YES [ ] NO
If yes, list in the table below.

Board Name	Certification/ Specialty/Sub-Specialty	Date of Certification mm/yy
American Board of Obsterics and Gynecology	Obstetrics and Gynecology	11/82

For items 21a-30, if yes, explain on a separate sheet providing accurate details.

21a. Have you ever failed to receive specialty board certification or re-certification for any reason? [ ] YES [X] NO

21b. Have you ever had any sanctions taken against you by a specialty board or other similar national organization? [ ] YES [X] NO

22. Have you ever been warned or called before the United States Drug Enforcement Administration (DEA)? [ ] YES [X] NO

23. Have you ever been made an offer to compromise or entered into any arrangement plea, or agreement instead of a federal prosecution for a drug violation regulated by DEA? [ ] YES [X] NO

24. Have you ever been denied or surrendered a DEA registration? [ ] YES [X] NO

25. Have you ever been denied or been excluded from Medicare and/or state health care programs? [ ] YES [X] NO

26. Have you ever had an application for membership denied by a medical society or association or had a medical society or association membership revoked, suspended, placed on probation, or other disciplinary action taken? [ ] YES [X] NO

27. Have you ever been notified to appear before a medical society or association about charges or complaints filed against you? [ ] YES [X] NO

28. Have you ever had a judgment entered against you for medical malpractice where the incident(s) of malpractice occurred after November 2, 2004? [ ] YES [X] NO

29. Within the last 10 years have you had any liability claim(s) or action(s) for damages for personal injury settled or finally adjudicated in an amount that exceeds $100,000.00? [X] YES [ ] NO
If yes, explain on a separate sheet providing accurate details and complete Exhibit 1 for each occurrence.

30. Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to any crime in any jurisdiction other than a minor traffic offense? You must include all misdemeanors and felonies even if adjudication was withheld by the court so that you would not have a record of conviction. Driving under the influence or driving while impaired is not a minor traffic offense for purposes of this question. [ ] YES [X] NO

31. Have you ever been arrested or criminally or civilly charged with any intentional or negligent action related to the use or misuse of drugs, alcohol, or illegal chemical substances? [ ] YES [X] NO

For items 32-37, if yes, explain on a separate sheet providing accurate details.

32. In the last five years, have you been enrolled in, required to enter into, or participated in any drug or alcohol recovery program or impaired practitioner program for treatment of drug or alcohol abuse that occurred within the past five years?

33. In the last five years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental disorder or impairment?

34. During the last five years, have you been treated for or had a recurrence of a diagnosed mental disorder that has impaired your ability to practice medicine within the past five years?

35. In the last five years, have you been treated for or had a recurrence of a diagnosed physical disorder that has impaired your ability to practice medicine?

36. In the last five years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol/drug) disorder or, if you were previously in such a program, did you suffer a relapse within the last five years?

37. During the last five years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol/drug) disorder that has impaired your ability to practice medicine within the last five years?

The application instructions provide information about documents needed to support your explanation of the 'yes' responses.

38. Prevention of Medical Errors:

[ ] I hereby certify that since June 1, 2002, I have completed a minimum of two (2) hours of Prevention of Medical Errors continuing medical education as defined by s. 456.013(7), Florida Statutes. The education must meet requirements defined in § 456.013(7), Florida Statutes and be completed prior to the issuance of your license number. Please contact the Florida Medical Association (FMA) at (850) 224-6496 or www.fmaonline.org for a list of providers of CME. Other resources for CME are the American Medical Association (AMA) at (312) 464-5000, or Medical Education Group Learning Systems (MEGLAS) at 800-547-0308 or www.informed.cme.edu.

39. Dispensing Practitioner Registration:

This is optional and for physicians whose primary practice is in the State of Florida. Dispensing relates to physicians who maintain a "mini-pharmacy" in their private office for profit. Section 465.0276, F. S., requires that licensees of the Board of Medicine who dispense medicinal drugs pay a fee of $100.00 at the time of such registration and upon each renewal of the practitioner's license. It is unlawful for any person to sell samples or complimentary packages of drug products. A practitioner who confines his/her activities to dispensing complimentary packages of medicinal drugs to patients in the regular course of his/her practice is **not** required to register.

Check if applicable to you.

[ ] I plan to dispense medicinal drugs in the State of Florida for a fee or other remuneration and hereby register as required by Section 465.0276, F. S. I understand that the fee for the Dispensing Practitioner is $100.00 **over and above** the required initial license fee and will submit it along with the license fee.

31. Have you ever been arrested or criminally or civilly charged with any intentional or negligent action related to the use or misuse of drugs, alcohol, or illegal chemical substances? [ ] YES [✓] NO

For items 32-37, if yes, explain on a separate sheet providing accurate details.

32. In the last five years, have you been enrolled in, required to enter into, or participated in any drug or alcohol recovery program or impaired practitioner program for treatment of drug or alcohol abuse that occurred within the past five years?

33. In the last five years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental disorder or impairment?

34. During the last five years, have you been treated for or had a recurrence of a diagnosed mental disorder that has impaired your ability to practice medicine within the past five years?

35. In the last five years, have you been treated for or had a recurrence of a diagnosed physical disorder that has impaired your ability to practice medicine?

36. In the last five years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol/drug) disorder or, if you were previously in such a program, did you suffer a relapse within the last five years?

37. During the last five years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol/drug) disorder that has impaired your ability to practice medicine within the last five years?

The application instructions provide information about documents needed to support your explanation of the 'yes' responses.

38. Prevention of Medical Errors:

[X] I hereby certify that since June 1, 2002, I have completed a minimum of two (2) hours of Prevention of Medical Errors continuing medical education as defined by s. 456.013(7), Florida Statutes. The education must meet requirements defined in § 456.013(7), Florida Statutes and be completed prior to the issuance of your license number. Please contact the Florida Medical Association (FMA) at (850) 224-6496 or www.fmaonline.org for a list of providers of CME. Other resources for CME are the American Medical Association (AMA) at (312) 464-5000, or Medical Education Group Learning Systems (MEGLAS) at 800-547-0308 or www.informed.cme.edu.

39. Dispensing Practitioner Registration:

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Check if applicable to you.

[ ] I plan to dispense medicinal drugs in the State of Florida for a fee or other remuneration and hereby register as required by Section 465.0276, F. S. I understand that the fee for the Dispensing Practitioner is $100.00 **over and above** the required initial license fee and will submit it along with the license fee.

40. Financial Responsibility

The Financial Responsibility options are divided into two categories, coverage and exemptions. Check only **one** option of the ten provided as required by s. 458.320, Florida Statutes.

Category I: Financial Responsibility Coverage

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

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

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

☐**4.** I **have** hospital staff privileges and I have professional liability coverage in an amount not less than $250,000 per claim, with a minimum annual aggregate of not less than $750,000 from an authorized insurer as defined under s. 624.09, F. S., from a surplus lines insurer as defined under s. 626.914(2), F. S., from a risk retention group as defined under s. 627.942, F. S., from the Joint Underwriting Association established under s. 627.351(4), F. S., or through a plan of self insurance as provided in s. 627.357, F. S.

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

Category II: Financial Responsibility Exemptions

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

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

☒**8.** **I do not practice medicine in the State of Florida**.

☐**9.** I meet all of the following criteria:

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

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

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

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

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

Under penalties of perjury, I declare that I have read the foregoing response in sub-question 9 of question 40, and the facts stated in it are true. A person who knowingly makes a false declaration under Section 92.525(2), F.S. is guilty of the crime of perjury by false written declaration, a felony of the third degree, punishable as provided in s. 755.082, s. 775.083, or s. 775.084.

Signature of physician: Darwin C. Jackson MD **Date:** 3-12-2010

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

41. Optional Information:

a. List all medical or professional society or association memberships:

American College of Obstetricians and Gynecologists, American Medical Association, Association of Reproductive Health Professionals

b. Publications: List any publications you have authored in peer-reviewed medical literature within the previous ten years.

(Title) (Publication) (Date)

(Title) (Publication) (Date)

(Title) (Publication) (Date)

(Title) (Publication) (Date)

c. Do you participate in the Medicaid program? [X] YES [ ] NO
If yes list:

Active — Illinois
(Type of Provider) (State)

(Type of Provider) (State)

d. Professional or community service activities, honors, or awards:

Three "Teacher of the Year" Awards, Department of Ob-Gyn, Barnes-Jewish Hospital, St Louis, MO
(Activity/Honor/Award) (Organization)

(Activity/Honor/Award) (Organization)

e. Languages other than English: List languages other than English that you use to communicate with patients and any translation service available for patients at your primary place of practice.

f. Comments and additional information: List comments or information that you want the board to be aware of.

I am pursuing a faculty position in the medical school at the University of Central Florida in Orlando. Teaching there would be a great way to finish my career in medicine.

42. Florida Birth Related Neurological Compensation Association

You must choose one of the three options described below. Please be sure to view the information about each exemption at www.nica.com. Check only one.

[ ]	[X]	[ ]	
$5,000	$250	$0	$250
Participating	Non-participating	Exempt	Amount enclosed

If you choose "$0 Exempt" provide appropriate documentation to the Board of Medicine and to NICA. See attachment for explanation.

I have read the explanatory information provided by NICA, and I choose the option above.

Darwin Jackson MD 3-12-2010
Signature Date

Darwin C. Jackson
Name
13400 Skyline Drive
Street Address
Plainfield, IL 60585-1914
City, State, Zip

If you are a participating or non-participating physician, or a physician claiming exemption, you must complete, sign and date this form and return it with your payment to this address.

Department of Health
Board of Medicine
4052 Bald Cypress Way, #C-03
Tallahassee, FL 32399-3253

If you are a physician claiming exemption, you must also send a copy of your completed, signed, and dated form with proof of your exemption to:

NICA
2360 Christopher Place
Tallahassee, FL 32308

If you have any questions about NICA or this form, please contact NICA at www.nica.com or (850) 488-8191.

43. Statement of Applicant

I state that these statements are true and correct. I recognize that providing false information may result in denial of licensure, disciplinary action against my license, or criminal penalties pursuant to Sections 456.067, 775.083, and 775.084, Florida Statutes. I state that I have read Chapters 456, 458 and 766.301-.316, Florida Statutes and Chapter 64B8, Florida Administrative Code.

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Florida Board of Medicine information which is material to my application for licensure.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind. I state that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act constitutes cause for denial, suspension, or revocation of my license to practice Medicine in the State of Florida. If there are any changes to my status or any change that would affect any of my answers to this application I must notify the board within 30 days. I understand that my records are protected under federal and state regulations governing Confidentiality of Mental Health Patient Records and cannot be disclosed without my written consent unless otherwise provided in the regulations. I understand that my records are protected under federal and state regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it.

Darwin C. Jackson
(Please print your name.)

Darwin C. Jackson MD
(Signature of applicant required.)

3-12-2010
(Date signed required.)

Personal Data:

Height: 6ft, 0in

Weight: 220 lb

Eye Color: Brown

Hair Color: Black

Affix photo with tape here