Form No. LII-OPA-1
81—P6172

APPLICATION FOR D.C. LICENSE

(please print in ink or type)

FOR OFFICE USE ONLY			APPLICATION NO. 84-GN-351
	AMOUNT OF FEE	DATE PAID	BASIS OF LICENSURE — date
APPLICATION	$.....	.....	☐ EXAMINATION ..... test score .....
EXAMINATION	$.....	.....	☐ RECIPROCITY ..... state .....
LICENSE	$.....	.....	☐ ENDORSEMENT ..... state .....
BOARD APPROVED			☐ OTHER ....
LICENSE PERIOD from 8-1-84 to 12-31-84			CATEGORY CODE 753 / AUDIT/LICENSE NO. 14675 / COMPLAINTS FILED ☐ Yes No ☐ / MIS ONLY / STREET CODE ..... / QUADRANT CODE .....

TO BE COMPLETED BY APPLICANT (PLEASE READ INSTRUCTIONS FIRST)

1. TYPE OF LICENSE: Licensure to Practice The Healing Art

2. NAME OF APPLICANT (Last, First, MI): Alexander, Kevin W.

3. RESIDENCE ADDRESS (Street, City, State, Zip Code)

4. BILLING ADDRESS (Street, City, State, Zip Code)

5. ☒ Individual ☐ Partnership ☐ Corporation

6. BASIS OF APPLICATION: ☐ Examination ☐ Re-examination ☐ Reciprocity ☒ Endorsement ☐ Other ..... (specify)

7. SEX ☒ Male ☐ Female

8. ☐ TRADE NAME ..... OR ☒ EMPLOYER NAME Howard Univ. Hosp.

9. BUSINESS ADDRESS (Street, City, State, Zip Code): 2041 Georgia Avenue, N.W. Washington, D.C. 20060

10. D.C. WARD

11. DATE OF APPLICATION: February 20, 1984

12. SOCIAL SECURITY NUMBER

13. DATE OF BIRTH

14. PLACE OF BIRTH

15. TELEPHONE NUMBER: Residence ..... Business (202) 745-6100

16. CERTIFICATE OF OCCUPANCY (if applicable) NUMBER .....

17. SCHOOL ATTENDED (name, city, state or foreign country)	18. Total No. of Hours	19. Date of Graduation	20. Type of Degree/Certificate	21. Year Degree Received
Johns Hopkins University Baltimore, Maryland		May 1976	BS	1976
Howard University Medical School Washington, D.C. 20060		May 1980	MD	1980

22. Have you ever been arrested or convicted of a crime? (omit traffic violations) ☐ Yes ☒ No If yes, attach explanation.

23. Are you currently bonded? ☐ Yes ☒ No If yes, give expiration date .....

24. Are you now or have you ever been licensed in D.C. or any other jurisdiction? ☐ Yes ☒ No
If yes, give the following information on original licensure: Jurisdiction .....
License Date ..... License No. ..... Issue Basis .....

25. Have you ever surrendered license or has license been denied, revoked or suspended by any jurisdiction? ☐ Yes ☒ No
If yes, attach explanation.

26. AFFIDAVIT OF APPLICANT

Kevin W. Alexander, M.D., being duly sworn, deposes and says: That the information given in this application, including all writings and exhibits attached hereto, is true and complete.

State of Maryland
~~District of Columbia~~ ss.

Kevin W. Alexander
Signature of Applicant

Subscribed and sworn to before me this 30th day of April, 1984 by the affiant, who personally appeared before me.

Deborah L. Thomas
Notary Public

My Commission expires

(SEAL)
DEBORAH L. THOMAS
NOTARY PUBLIC STATE OF MARYLAND
My Commission Expires July 1, 1986

1. All applicants must complete applicable portions of supplemental page and submit all supporting documents required.
2. Fee must accompany application. All fees are earned when paid and cannot be transferred or refunded.
3. Make checks payable to D.C. TREASURER. A charge of $15.00 will be imposed for dishonored checks. (Public Law 89-208)
4. False or misleading statements will be cause for rejection of application or revocation of license.
5. If more space is needed to fully answer questions, attach additional page(s).

GOVERNMENT OF THE DISTRICT OF COLUMBIA
COMMISSION ON LICENSURE TO PRACTICE THE HEALING AR
605 G Street, N. W., Room 202 Lower Level
Washington, D. C. 20001
SUPPLEMENTAL INFORMATION

NAME
Kevin W. Alexander, M.D.

ADDRESS

DATE OF APPLICATION
February 20, 1984

METHOD OF HEALING:
- ☐ Osteopathy & Surgery
- ☒ Medicine & Surgery
- ☐ Chiropractic
- ☐ Other (specify) _____

TH
BE
HEALI

1. If applying for licensure by endorsement, indicate whether FLEX ☐ or National Board ☒ and give date and place of examination.

2. Training and practice since date of graduation to the present. Include periods of unemployment and other employment.

	Name of Employer	Address	Zip Code	From Mo./Yr.	To Mo./Yr.
(1)	Howard University Hospital	2041 Georgia Ave, N.W Washington, D.C.	20060	7/80	present
(2)					
(3)					
(4)					
(5)					

3. References. List the names and full mailing addresses, including zip codes, of three personal acquaintances, not relatives, who have knowledge of your character and professional practice, or give the name and address of the chartered State or County Medical Society or other Society nearest your residence.

	Name	Address	Zip Code
(1)	John F. J. Clark, M.D.	Howard University Hospital	
(2)	Lennox S. Westney, M.D.	2041 Georgia Ave., N. W.	20060
(3)	~~Ernest L. Hopkins, M.D.~~	Washington, D. C.	

4. Declaration of Intent:

As part of my application for licensure to practice the healing art in the District of Columbia, I hereby declare that it is my intention, if issued a license, to engage in the practice of the healing art in the District of Columbia.

I understand that should I be granted a license by examination to practice the healing art in the District of Columbia, the Commission on Licensure to Practice the Healing Art in the District of Columbia will not certify my examination scores to another jurisdiction unless and until I have engaged in the practice of the healing art in the District of Columbia for at least six months subsequent to the issuance of my District of Columbia license.

Kevin W. Alexander — 4/30/84

Signature of Applicant — Date

5. Have you ever taken an examination in the basic sciences or any examination in the healing art under the authority of the Commission on Licensure to Practice the Healing Art in the District of Columbia? ☐ Yes ☒ No
If answer is yes, give date and type of examination.

GOVERNMENT OF THE DISTRICT OF COLUMBIA

COMMISSION ON LICENSURE TO PRACTICE THE HEALING ART
605 G Street, N.W., Room 202 Lower Level
Washington, D.C. 20001

ADDRESS ALL COMMUNICATIONS
TO THE COMMISSION

RECEIVED
1984 MAY 23 AM 9:02
ASSISTANT MEDICAL DIRECTOR'S OFFICE

May 21, 1984

Director of Medical Education
Howard University Hospital
2041 Georgia Avenue, N.W.
Washington, DC 20060

Dear Sir:

The physician whose name appears below has applied to the Commission on Licensure to Practice the Healing Art, for a license to practice the healing art in the District of Columbia.

In order to aid us in evaluating this application, we would greatly appreciate your providing the following information.

Sincerely,

P. Joseph Sarnella

P. Joseph Sarnella
Staff Director

Name Kevin W. Alexander, M.D. Date of Birth 10/5/54

Period of Employment: From July 1980 To Present

Title of Position Postgraduate Physician

Method of Healing Practiced Medicine/Surgery

Rating of Applicant's Performance Satisfactory

Remarks:

Martin G. Dillard

Signature of Official (Facsimile not accepted)
Martin G. Dillard, M.D.
Assistant Medical Director for Clinical Affairs

Title of Position
Howard University Hospital
2041 Georgia Ave., N.W., Washington, D.C. 20060

Agency, Institution, or Address of Private Practice

GOVERNMENT OF THE DISTRICT OF COLUMBIA

COMMISSION ON LICENSURE TO PRACTICE THE HEALING ART
605 G Street, N.W., Room 202 Lower Level
Washington, D.C. 20001

ADDRESS ALL COMMUNICATIONS
TO THE COMMISSION

May 21, 1984

Lennox S. Westney, M.D.
Howard University Hospital
2041 Georgia Avenue, N.W.
Washington, DC 20060

Applicant Kevin W. Alexander, M.D.

Address _____

_____

TO WHOM IT MAY CONCERN:

The applicant whose name and address are given above has applied for a license to practice the healing art in the District of Columbia. This voucher is being forwarded to you regarding his moral character and professional experience.

Your prompt return of this voucher, properly executed and signed by you, will greatly assist the Commission when considering his/her application for license. Your reply will be considered as confidential information by the Commission.

The Commission on Licensure to Practice the Healing Art will expect any person signing this voucher to understand that the Commission is required by law, to obtain evidence of the good character of applicants for license as a medical doctor. Statements by responsible persons with actual knowledge of the applicant's character and experience will be considered by the Commission as evidence in this regard.

Practice in the medical profession involves relations with the public that necessitate a high degree of honor, integrity and professional ability. Therefore, the Commission desires the person subscribing to this voucher to understand fully that the purpose of the law requiring a license is to protect the public from the practice of medicine by persons whose character is questionable or who are not competent to engage in such practice.

PLEASE RETURN THIS VOUCHER TO:

Government of the District of Columbia
Commission on Licensure to Practice the Healing Art
605 G Street, N.W., Room 202 Lower Level
Washington, DC 20001

Sincerely,

P. Joseph Sarnella

P. Joseph Sarnella
Staff Director

CHARACTER REFERENCE'S VOUCHER

May 24, 19 84

TO THE COMMISSION ON LICENSURE TO PRACTICE THE HEALING ART:

I hereby certify that since July 1, 1979 (insert date), I have been so closely associated with Dr. Kevin W. Alexander (applicant's name), residing in [illegible], as to be able to intelligently express an opinion as to his character, mental condition, and habits, and that to the best of my knowledge and belief, he/she is of good moral character and free from mental defects and drug habits liable to interfere with the proper practice of the healing art.

I certify further that to my personal knowledge he/she has been actually engaged in the practice of Medicine & Surgery for not less than one continuous year immediately preceding 5/24/84 (date of application).

Remarks: I recommend Dr. Kevin Alexander without reservation

Obstetrician - Gynecologist
Profession or Business

LEVINUS S. WESTNEY
(Name - print or type)

[signature]
Signature (Facsimile not acceptable)

2041 Georgia Avenue, NW
Washington D.C. - 20060
Address

GOVERNMENT OF THE DISTRICT OF COLUMBIA

COMMISSION ON LICENSURE TO PRACTICE THE HEALING ART
605 G Street, N.W., Room 202 Lower Level
Washington, D.C. 20001

ADDRESS ALL COMMUNICATIONS
TO THE COMMISSION

May 21, 1984

Ernest L. Hopkins, M.D.
Howard University Hospital
2041 Georgia Avenue, N.W.
Washington, DC 20060

Applicant Kevin W. ALexander, M.D.

Address _____

TO WHOM IT MAY CONCERN:

The applicant whose name and address are given above has applied for a license to practice the healing art in the District of Columbia. This voucher is being forwarded to you regarding his moral character and professional experience.

Your prompt return of this voucher, properly executed and signed by you, will greatly assist the Commission when considering his/her application for license. Your reply will be considered as confidential information by the Commission.

The Commission on Licensure to Practice the Healing Art will expect any person signing this voucher to understand that the Commission is required by law, to obtain evidence of the good character of applicants for license as a medical doctor. Statements by responsible persons with actual knowledge of the applicant's character and experience will be considered by the Commission as evidence in this regard.

Practice in the medical profession involves relations with the public that necessitate a high degree of honor, integrity and professional ability. Therefore, the Commission desires the person subscribing to this voucher to understand fully that the purpose of the law requiring a license is to protect the public from the practice of medicine by persons whose character is questionable or who are not competent to engage in such practice.

PLEASE RETURN THIS VOUCHER TO:

Government of the District of Columbia
Commission on Licensure to Practice the Healing Art
605 G Street, N.W., Room 202 Lower Level
Washington, DC 20001

Sincerely,

P. Joseph Sarnella

P Joseph Sarnella
Staff Director

CHARACTER REFERENCE'S VOUCHER

05/25, 1984

TO THE COMMISSION ON LICENSURE TO PRACTICE THE HEALING ART:

I hereby certify that since 9/1977 (insert date), I have been so closely associated with Dr. Kevin Alexander (applicant's name), residing in [illegible], as to be able to intelligently express an opinion as to his character, mental condition, and habits, and that to the best of my knowledge and belief, he/she is of good moral character and free from mental defects and drug habits liable to interfere with the proper practice of the healing art.

I certify further that to my personal knowledge he/she has been actually engaged in the practice of Medicine/OB Gyn for not less than one continuous year immediately preceding 3/01/84 (date of application).

Remarks: I have known Applicant as a Medical Student and a Post Doctoral Trainee. He is entering his 4th year of Post Doctoral Training. I personally have had examples of the highest integrity Exhibited by him. I have heard nothing which reflects adversely on his character or morality. I recommend him

Ernest Loyd Hayburn MD
(Name - print or type)

Practice of Medicine
Professor OBstetrics
Gynecology
Profession or Business

Ernest Loyd Hayburn MD
Signature (Facsimile not acceptable)

[illegible]

Washington DC
Address

GOVERNMENT OF THE DISTRICT OF COLUMBIA
COMMISSION ON LICENSURE TO PRACTICE THE HEALING ART
605 G Street, N.W., Room 202 Lower Level
Washington, D.C. 20001

ADDRESS ALL COMMUNICATIONS
TO THE COMMISSION

May 21, 1984

John F. J. Clark, M.D.
Howard University Hospital
2041 Georgia Avenue, N.W.
Washington, DC 20060

Applicant Kevin Alexander, M.D.

Address _____

TO WHOM IT MAY CONCERN:

The applicant whose name and address are given above has applied for a license to practice the healing art in the District of Columbia. This voucher is being forwarded to you regarding his moral character and professional experience.

Your prompt return of this voucher, properly executed and signed by you, will greatly assist the Commission when considering his/her application for license. Your reply will be considered as confidential information by the Commission.

The Commission on Licensure to Practice the Healing Art will expect any person signing this voucher to understand that the Commission is required by law, to obtain evidence of the good character of applicants for license as a medical doctor. Statements by responsible persons with actual knowledge of the applicant's character and experience will be considered by the Commission as evidence in this regard.

Practice in the medical profession involves relations with the public that necessitate a high degree of honor, integrity and professional ability. Therefore, the Commission desires the person subscribing to this voucher to understand fully that the purpose of the law requiring a license is to protect the public from the practice of medicine by persons whose character is questionable or who are not competent to engage in such practice.

PLEASE RETURN THIS VOUCHER TO:

Government of the District of Columbia
Commission on Licensure to Practice the Healing Art
605 G Street, N.W., Room 202 Lower Level
Washington, DC 20001

Sincerely,

P. Joseph Sarnella

P. Joseph Sarnella
Staff Director

CHARACTER REFERENCE'S VOUCHER

May 25, , 19 84

TO THE COMMISSION ON LICENSURE TO PRACTICE THE HEALING ART:

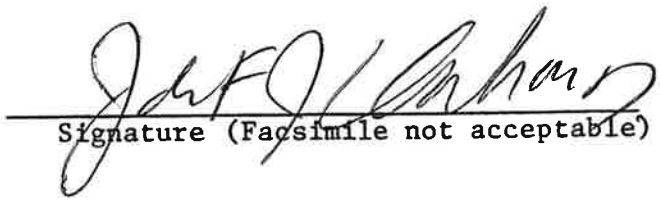
I hereby certify that since August 1974 (insert date), I have been so closely associated with Dr. Kevin Alexander (applicant's name), residing in ____, as to be able to intelligently express an opinion as to his character, mental condition, and habits, and that to the best of my knowledge and belief, he/she is of good moral character and free from mental defects and drug habits liable to interfere with the proper practice of the healing art.

I certify further that to my personal knowledge he/she has been actually engaged in the practice of medicine and surgery for not less than one continuous year immediately preceding May 25, 1984 (date of application).

Remarks: I recommend Dr. Alexander without hesitation or reservation.

Obstetrician-Gynecologist
Profession or Business

John F. J. Clark, M.D.
(Name - print or type)


Signature (Facsimile not acceptable)

Washington, D. C.
Address

AMA PHYSICIAN PROFILE

AMERICAN MEDICAL ASSOCIATION
535 NORTH DEARBORN STREET
CHICAGO, ILLINOIS 60610

DIVISION OF SURVEY AND DATA RESOURCES
DEPARTMENT OF DATA RELEASE SERVICES

DATE: 05-25-84
TIME: 11:54 AM

NAME: ALEXANDER,KEVIN WM, M.D.
ADDRESS:
BIRTHPLACE: BIRTHDATE: ..
MEDICAL EDUCATION (SCHOOL YEAR):
HOWARD UNIV COLL MED,WASHINGTON DC 20001 1980
NATIONAL BOARD CERTIFICATION: 1981
LICENSES:
NONE REPORTED TO DATE
PHYSICIAN'S PROFESSIONAL ACTIVITIES:
RESIDENT
PRIMARY SPECIALTY: OBSTETRICS AND GYNECOLOGY
SECONDARY SPECIALTY: UNSPECIFIED
TERTIARY SPECIALTY: UNSPECIFIED
SPECIALTY BOARD CERTIFICATION: NONE REPORTED TO DATE
MEMBER OF AMA: 1984 ACTIVE MEMBER THRU
NATIONAL SCIENTIFIC MEDICAL SOCIETIES: NONE REPORTED TO DATE
PROFESSORIAL APPOINTMENT: NONE REPORTED TO DATE
CURRENT MEDICAL TRAINING: RESIDENT
HOSPITAL: HOWARD UNIV AFFIL HOSP WASHINGTON DC 20060
DATES OF TRAINING: 07/81-06/85
SPECIALTY: OBSTETRICS AND GYNECOLOGY
SPECIALTY: UNSPECIFIED
INTERNSHIP:
HOSPITAL: HOWARD UNIV AFFIL HOSP WASHINGTON DC 20060
DATES OF TRAINING: 07/80-06/81
SPECIALTY: OBSTETRICS AND GYNECOLOGY
SPECIALTY: UNSPECIFIED
RESIDENCY:
NONE REPORTED TO DATE
FELLOWSHIP:
NONE REPORTED TO DATE

NATIONAL BOARD OF MEDICAL EXAMINERS® • 3930 CHESTNUT STREET, PHILADELPHIA, PENNA. 19104

ENDORSEMENT OF CERTIFICATION

NATIONAL BOARD OF MEDICAL EXAMINERS
OF THE
UNITED STATES OF AMERICA

Kevin W. Alexander, M.D.

having satisfied all the requirements and having successfully passed the examinations is hereby declared a Diplomate of the National Board of Medical Examiners.

Attest WILLIAM B. HOLDEN, M.D.
Chairman of the Board

SEAL EDITHE J. LEVIT, M.D.
President of the Board

Philadelphia, Pa.
07/01/81

Certificate # 237270

RECEIVED

It is certified that the above is a facsimile of the Diplomate Certificate which has been or will be* awarded to the physician named above, who graduated from HOWARD U COLLEGE MEDICINE in MAY ,1980 and whose birth date is [redacted] is physician has successfully completed all examinations required for certification by the National Board of Medical Examiners. The scores obtained by this physician upon which his/her certification is based are as follows:

	Standard Score	Scale Score
PART I passed 06/78		
Anatomy, incl. histology and embryology	[redacted]	[redacted]
Physiology		
Biochemistry		
Pathology		
Microbiology, incl. immunology		
Pharmacology and Materia Medica		
Behavioral Sciences		
TOTAL TEST (Minimum Passing Score 380/75)		
Part II passed 09/79		
Internal medicine and the medical specialties		
Surgery and the surgical specialties		
Obstetrics and Gynecology		
Public Health and Preventive Medicine		
Pediatrics		
Psychiatry		
TOTAL TEST (Minimum Passing Score 290/75)		
PART III passed 03/81		
A General Test of Clinical Competence		
TOTAL TEST (Minimum Passing Score 290/75)		
GENERAL AVERAGE (Parts, I, II, and III Scale Score)		

*For those individuals who have not yet satisfactorily completed one full year of post-M.D. training the date shown on the facsimile is the date which has been certified by the physician's residency program director as the date on which this requirement for certification by the National Board will be fulfilled and such certification will be awarded.

Ann K. Heverling
Secretary for Certification
05/15/84

SEAL

Date

HOWARD UNIVERSITY

HOWARD UNIVERSITY HOSPITAL AND AFFILIATED HOSPITALS
WASHINGTON, DISTRICT OF COLUMBIA

THIS IS TO CERTIFY THAT

KEVIN WILLIAM ALEXANDER, M.D.

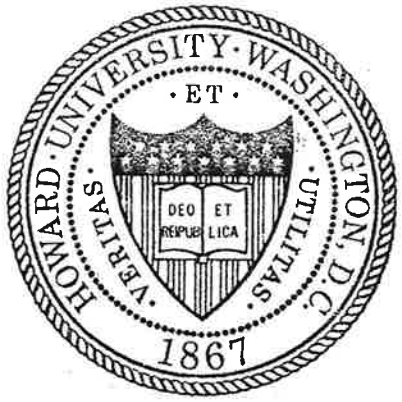
HAS SATISFACTORILY COMPLETED THE FIRST YEAR
OF POSTGRADUATE MEDICAL EDUCATION IN

OBSTETRICS AND GYNECOLOGY

THROUGH OUR TRAINING PROGRAMS AT HOWARD UNIVERSITY.
JUNE 28, 1980 TO JUNE 27, 1981

V. J. Roux M.D.
MEDICAL DIRECTOR

PROGRAM DIRECTOR



PRESIDENT OF THE UNIVERSITY

Owen D. Nichols
SECRETARY OF THE UNIVERSITY

CERTIFIED TO BE
A TRUE COPY

This is a true and correct copy of the original as seen by me this 30th day of April, 1984.

Deborah L. Thomas
DEBORAH L. THOMAS
NOTARY PUBLIC STATE OF MARYLAND
My Commission Expires July 1, 1986

April 30th 1984

Universitas Howardiana Washingtonii
in Regione Columbiana sita

omnibus ad quos hae litterae pervenerint salutem.

Praeses Curatoresque Universitatis Howardianae praeceptoribus academicis nominantibus ac probantibus **Kevin Willian Alexander** ad gradum Medicinae Doctoris admiserunt eique dederunt et concesserunt omnia insignia et iura quae ad hunc gradum pertinent. In cuius rei testimonium Praeses et Ordinis Curatorum Scriba et Decanus auctoritate rite commissa die X mensis Maii anno Salutis Humanae M C M L X X X Universitatisque Howardianae C X I X litteris hisce Universitatis sigillo munitis nomina subscripserunt.

This is certified to be a true and correct copy of the original as seen by me this 17th day of June, 1983.

DEBORAH L. THOMAS
NOTARY PUBLIC STATE OF MARYLAND
My Commission Expires July 1, 1986

This is certified to be a true & correct copy of the original as seen by me this 17th day of June, 1983.

DEBORAH L. THOMAS
NOTARY PUBLIC STATE OF MARYLAND
My Commission Expires July 1, 1986

Russell L. Miller
Decanus

Owen D. Nichols
Scriba

HOWARD UNIVERSITY · WASHINGTON, D.C. · VERITAS · 187

Praeses