Application For Renewal Of Oklahoma License
MEDICAL DOCTOR From 07/02/2014 To 07/01/2015

This form must be completed and returned to this office with a renewal fee of $200.00 on or before July 01, 2014. After that date, the license becomes inactive. Renewals may be accepted for 60 days with a fee of $350.00. After 60 days, unrenewed Licensees are suspended. YOU CANNOT PRACTICE WITH AN INACTIVE OR SUSPENDED LICENSE.

Mail Renewal application to: **Oklahoma State Board Of Medical Licensure And Supervision**
PO Box 18256
Oklahoma City, OK 73154-0256

RECEIVED
JUN 06 2014
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

License Number: 13761

KATHLEEN ANN GLAZE

Mailing Address	Practice Address
1145 SOUTH UTICA AVENUE #514 TULSA, OK 74104-4018	1145 SOUTH UTICA AVENUE SUITE 514 TULSA, OK 74104-4018

	Yes	No
You are required pursuant to 59 O.S. 355 1(B) to indicate your preference. Please read and check in the appropriate response. Any Medical Doctor who desires to DISPENSE "dangerous drugs" as defined in the Pharmacy Law, must register annually with the Board. This is for dispensing only and does not include prescribing, administering, or the giving of samples.		
I wish to be registered to dispense dangerous drugs.		X

The following information is mandatory and information provided may be investigated further.
Since 05/23/2013 Do Any Of The Following Apply To You?

A. Has your application for a license been denied?		X
B. Have you surrendered a license or had any disciplinary action taken on any license?		X
C. Have you been investigated by or requested to appear before a licensing or disciplinary agency?		X
D. Have you been arrested for, charged with, or convicted of a felony or misdemeanor other than a traffic violation?		X
E. Have you been arrested for, charged with, or convicted of a traffic violation involving the use of any drug or chemical substance including alcohol?		X
F. Have you been addicted to or abused any drug or chemical substance including alcohol?		X
G. Have you obtained an assessment or been treated for use of any drug or chemical substance including alcohol?		X
H. Have you had any mental or physical disorder or condition which if untreated could affect your ability to practice competently?		X
I. Have you been denied provider participation, terminated, sanctioned or penalized by any third party payor to include TRICARE, MEDICARE, or MEDICAID?		X
J. Have you surrendered or had any adverse action taken against any narcotic permit (State or Federal)?		X
K. Have you been denied membership or had disciplinary action taken by a national, state, or county medical organization?		X
L. Have you been denied or had removed or suspended hospital staff privileges?		X
M. Have you surrendered hospital staff privileges while under investigation or to avoid investigation?		X
N. Have you entered into an Agreement with a Federal, State, or Local jurisdictional body to avoid formal action?		X
O. Have you been the subject of an investigation or disciplinary action, including probation, by a hospital, clinic, practice group, or residency program?		X
P. Have you had any adverse judgment, settlement, or award against you arising from a professional liability claim?		X
Q. Have you been reported to the National Practitioner Data Bank (NPDB) or to the Healthcare Integrity and Protection Data Bank (HIPDB)?		X
DO YOU WISH TO APPLY FOR PHYSICIAN EMERITUS (FULLY RETIRED) STATUS?		X

If "YES" then a $50 processing fee is to be included and there is no renewal fee.
The Following Restrictions apply to Physician Emeritus (FULLY RETIRED) Physicians:
A) You may continue to use the title "DOCTOR" and suffix "MD", but must indicate retired status.
B) You cannot practice medicine in any form. You cannot prescribe, dispense or administer drugs.

(Remember to sign and date form, before mailing)

Specialties:
Gynecology *

Board Certifications (Current):
AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

Post Graduate Training (Current):

Type of Training: _____
Hospital: _____
Location: _____
Date Entered: _____
Expected Completion Date: _____

Practice Information (Current):

Employer: PRIVATE PRACTICE
City, State, County: TULSA, OK USA

13761/20

Type of Practice or Specialty: GYNECOLOGY

Date Started: 7/1985

I, the undersigned, have to the best of my knowledge, complied with the laws and rules regulating my profession. I hereby state that the information contained in this application is true and correct. This form is public information.

Signature of Applicant: Kathleen A Glaze MD Date: 6/4/14

(Remember to sign and date form before mailing) Page 2 of 2 - KATHLEEN ANN GLAZE

Attention MAC users: Please select "File" on your browser and then "Print"

RECEIVED

JUN 06 2014

OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

Application For Renewal Of Oklahoma License

MEDICAL DOCTOR From 07/02/2013 To 07/01/2014

This form must be completed and returned to this office with a renewal fee of $200.00 on or before July 01, 2013. After that date, the license becomes *inactive. Renewals may be accepted for 60 days with a fee of $350.00. After 60 days, unrenewed Licensees are suspended. YOU CANNOT PRACTICE* WITH AN INACTIVE OR SUSPENDED LICENSE.

Mail Renewal application to: **Oklahoma State Board Of Medical Licensure And Supervision**
PO Box 18256
Oklahoma City, OK 73154-0256

License Number: 13761

KATHLEEN ANN GLAZE

Mailing Address	**Practice Address**
1145 SOUTH UTICA AVENUE #514 TULSA, OK 74104-4018	1145 SOUTH UTICA AVENUE SUITE 514 TULSA, OK 74104-4018

	Yes	No
You are required pursuant to 59 O.S. 355 1(B) to indicate your preference. Please read and check in the appropriate response. Any Medical Doctor who desires to DISPENSE "dangerous drugs" as defined in the Pharmacy Law, must register annually with the Board. This is for dispensing only and does not include prescribing, administering, or the giving of samples.		
I wish to be registered to dispense dangerous drugs.		X

The following information is mandatory and information provided may be investigated further.

Since 05/30/2012 Do Any Of The Following Apply To You?

A. Has your application for a license been denied?		X
B. Have you surrendered a license or had any disciplinary action taken on any license?		X
C. Have you been investigated by or requested to appear before a licensing or disciplinary agency?		X
D. Have you been arrested for, charged with, or convicted of a felony or misdemeanor other than a traffic violation?		X
E. Have you been arrested for, charged with, or convicted of a traffic violation involving the use of any drug or chemical substance including alcohol?		X
F. Have you been addicted to or abused any drug or chemical substance including alcohol?		
G. Have you obtained an assessment or been treated for use of any drug or chemical substance including alcohol?		X
H. Have you had any mental or physical disorder or condition which if untreated could affect your ability to practice competently?		X
I. Have you been denied provider participation, terminated, sanctioned or penalized by any third party payor to include TRICARE, MEDICARE, or MEDICAID?		X
J. Have you surrendered or had any adverse action taken against any narcotic permit (State or Federal)?		
K. Have you been denied membership or had disciplinary action taken by a national, state, or county medical organization?		X
L. Have you been denied or had removed or suspended hospital staff privileges?		X
M. Have you surrendered hospital staff privileges while under investigation or to avoid investigation?		X
N. Have you entered into an Agreement with a Federal, State, or Local jurisdictional body to avoid formal action?		X
O. Have you been the subject of an investigation or disciplinary action, including probation, by a hospital, clinic, practice group, or residency program?		X
P. Have you had any adverse judgment, settlement, or award against you arising from a professional liability claim?		
Q. Have you been reported to the National Practitioner Data Bank (NPDB) or to the Healthcare Integrity and Protection Data Bank (HIPDB)?		X
DO YOU WISH TO APPLY FOR PHYSICIAN EMERITUS (FULLY RETIRED) STATUS?		X

If "YES" then a $50 processing fee is to be included and there is no renewal fee.
The Following Restrictions apply to Physician Emeritus (FULLY RETIRED) Physicians:
A) You may continue to use the title "DOCTOR" and suffix "MD", but must indicate retired status.
B) You cannot practice medicine in any form. You cannot prescribe, dispense or administer drugs.

(Remember to sign and date form, before mailing) Page 1 of 2 - KATHLEEN ANN GLAZE

RECEIVED
MAY 28 2013
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

5/19/13 5:58 PM

Specialties:
Gynecology *

Board Certifications (Current):
AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

Post Graduate Training (Current):

Type of Training: _____
Hospital: _____
Location: _____
Date Entered: _____
Expected Completion Date: _____

Practice Information (Current):

Employer: PRIVATE PRACTICE
City, State, County: TULSA, OK USA
Type of Practice or Specialty: GYNECOLOGY
Date Started: 7/1985

I, the undersigned, have to the best of my knowledge, complied with the laws and rules regulating my profession. I hereby state that the information contained in this application is true and correct. This form is public information.

Signature of Applicant: Kathleen Ann Glaze MD Date: 5/20/13

(Remember to sign and date form before mailing) Page 2 of 2 - KATHLEEN ANN GLAZE

Attention MAC users: Please select "File" on your browser and then "Print"

Application For Renewal Of Oklahoma License

MEDICAL DOCTOR From 07/02/2012 To 07/01/2013

This form must be completed and returned to this office with a renewal fee of $200.00 on or before July 01, 2012. After that date, the license becomes *inactive. Renewals may be accepted for 60 days with a fee of $350.00. After 60 days, unrenewed Licensees are suspended. YOU CANNOT PRACTICE* WITH AN INACTIVE OR SUSPENDED LICENSE.

Mail Renewal application to: **Oklahoma State Board Of Medical Licensure And Supervision**
PO Box 18256
Oklahoma City, OK 73154-0256

License Number: 13761

KATHLEEN ANN GLAZE

Mailing Address	Practice Address
1145 SOUTH UTICA AVENUE #514 TULSA, OK 74104-4018	1145 SOUTH UTICA AVENUE SUITE 514 TULSA, OK 74104-4018

	Yes	No
Have you met the Oklahoma CME Requirement?	X	

You are required pursuant to 59 O.S. 355 1(B) to indicate your preference. Please read and check in the appropriate response. Any Medical Doctor who desires to DISPENSE "dangerous drugs" as defined in the Pharmacy Law, must register annually with the Board. This is for dispensing only and does not include prescribing, administering, or the giving of samples.

I wish to be registered to dispense dangerous drugs.		X

The following information is mandatory and information provided may be investigated further.

Since 05/22/2011 Do Any Of The Following Apply To You?

A. Has your application for a license been denied?		X
B. Have you surrendered a license or had any disciplinary action taken on any license?		X
C. Have you been investigated by or requested to appear before a licensing or disciplinary agency?		X
D. Have you been arrested for, charged with, or convicted of a felony or misdemeanor other than a traffic violation?		X
E. Have you been arrested for, charged with, or convicted of a traffic violation involving the use of any drug or chemical substance including alcohol?		X
F. Have you been addicted to or abused any drug or chemical substance including alcohol?		X
G. Have you obtained an assessment or been treated for use of any drug or chemical substance including alcohol?		X
H. Have you had any mental or physical disorder or condition which if untreated could affect your ability to practice competently?		X
I. Have you been denied provider participation, terminated, sanctioned or penalized by any third party payor to include TRICARE, MEDICARE, or MEDICAID?		X
J. Have you surrendered or had any adverse action taken against any narcotic permit (State or Federal)?		X
K. Have you been denied membership or had disciplinary action taken by a national, state, or county medical organization?		X
L. Have you been denied or had removed or suspended hospital staff privileges?		X
M. Have you surrendered hospital staff privileges while under investigation or to avoid investigation?		X
N. Have you entered into an Agreement with a Federal, State, or Local jurisdictional body to avoid formal action?		X
O. Have you been the subject of an investigation or disciplinary action, including probation, by a hospital, clinic, practice group, or residency program?		X
P. Have you had any adverse judgment, settlement, or award against you arising from a professional liability claim?		X
Q. Have you been reported to the National Practitioner Data Bank (NPDB) or to the Healthcare Integrity and Protection Data Bank (HIPDB)?		X
DO YOU WISH TO APPLY FOR PHYSICIAN EMERITUS (FULLY RETIRED) STATUS?		X

If "YES" then a $50 processing fee is to be included and there is no renewal fee.
The Following Restrictions apply to Physician Emeritus (FULLY RETIRED) Physicians:
A) You may continue to use the title "DOCTOR" and suffix "MD", but must indicate retired status.
B) You cannot practice medicine in any form. You cannot prescribe, dispense or administer drugs.

(Remember to sign and date form, before mailing) Page 1 of 2 - KATHLEEN ANN GLAZE

RECEIVED
MAY 30 2012
OKLAHOMA STATE BOARD OF
MEDICAL LICENSURE
AND SUPERVISION

5/27/12 3:00 PM

Specialties:
Gynecology *

Board Certifications (Current):
AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

Post Graduate Training (Current):

Type of Training: _____
Hospital: _____
Location: _____
Date Entered: _____
Expected Completion Date: _____

Practice Information (Current):

Employer: PRIVATE PRACTICE
City, State, County: TULSA, OK USA
Type of Practice or Specialty: GYNECOLOGY
Date Started: 7/1985

I, the undersigned, have to the best of my knowledge, complied with the laws and rules regulating my profession. I hereby state that the information contained in this application is true and correct. This form is public information.

Signature of Applicant: Kathleen Ann Glaze Date: 5/27/2012

(Remember to sign and date form before mailing) Page 2 of 2 - KATHLEEN ANN GLAZE

Attention MAC users: Please select "File" on your browser and then "Print"

Print

Application For Renewal Of Oklahoma License

MEDICAL DOCTOR From 07/02/2010 To 07/01/2011

This form must be completed and returned to this office with a renewal fee of $200.00 on or before July 01, 2010. After that date, the license becomes inactive. Renewals may be accepted for 60 days with a fee of $350.00. After 60 days, unrenewed Licensees are suspended. YOU CANNOT PRACTICE WITH AN INACTIVE OR SUSPENDED LICENSE.

Mail Renewal application to: **Oklahoma State Board Of Medical Licensure And Supervision**
PO Box 18256
Oklahoma City, OK 73154-0256

RECEIVED
JUN 04 2010
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

License Number: 13761

KATHLEEN ANN GLAZE

Mailing Address	Practice Address
1145 SOUTH UTICA AVENUE #514 TULSA, OK 74104-4018	1145 SOUTH UTICA AVENUE SUITE 514 TULSA, OK 74104-4018

	Yes	No
You are required pursuant to 59 O.S. 355 1(B) to indicate your preference. Please read and check in the appropriate response. Any Medical Doctor who desires to DISPENSE "dangerous drugs" as defined in the Pharmacy Law, must register annually with the Board. This is for dispensing only and does not include prescribing, administering, or the giving of samples.		
I wish to be registered to dispense dangerous drugs.		X

The following information is mandatory and information provided may be investigated further.

Since 06/04/2009 Do Any Of The Following Apply To You?

A. Has your application for a license been denied?		X
B. Have you surrendered a license or had any disciplinary action taken on any license?		X
C. Have you been investigated by or requested to appear before a licensing or disciplinary agency?		X
D. Have you been arrested for, charged with, or convicted of a felony or misdemeanor other than a traffic violation?		X
E. Have you been arrested for, charged with, or convicted of a traffic violation involving the use of any drug or chemical substance including alcohol?		X
F. Have you been addicted to or abused any drug or chemical substance including alcohol?		X
G. Have you obtained an assessment or been treated for use of any drug or chemical substance including alcohol?		X
H. Have you had any mental or physical disorder or condition which if untreated could affect your ability to practice competently?		X
I. Have you been denied provider participation, terminated, sanctioned or penalized by any third party payor to include TRICARE, MEDICARE, or MEDICAID?		X
J. Have you surrendered or had any adverse action taken against any narcotic permit (State or Federal)?		X
K. Have you been denied membership or had disciplinary action taken by a national, state, or county medical organization?		X
L. Have you been denied or had removed or suspended hospital staff privileges?		X
M. Have you surrendered hospital staff privileges while under investigation or to avoid investigation?		X
N. Have you entered into an Agreement with a Federal, State, or Local jurisdictional body to avoid formal action?		X
O. Have you been the subject of an investigation or disciplinary action, including probation, by a hospital, clinic, practice group, or residency program?		X
P. Have you had any adverse judgment, settlement, or award against you arising from a professional liability claim?		X
Q. Have you been reported to the National Practitioner Data Bank (NPDB) or to the Healthcare Integrity and Protection Data Bank (HIPDB)?		X
DO YOU WISH TO APPLY FOR PHYSICIAN EMERITUS (FULLY RETIRED) STATUS?		X

If "YES" then a $50 processing fee is to be included and there is no renewal fee.
The Following Restrictions apply to Physician Emeritus (FULLY RETIRED) Physicians:
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B) You cannot practice medicine in any form. You cannot prescribe, dispense or administer drugs.

(Remember to sign and date form, before mailing)

Specialties:
Gynecology *

Board Certifications (Current):
AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

Post Graduate Training (Current):

Type of Training: _____
Hospital: _____
Location: _____
Date Entered: _____
Expected Completion Date: _____

Practice Information (Current):

Employer: PRIVATE PRACTICE
City, State, County: TULSA, OK USA

Type of Practice or Specialty: GYNECOLOGY

Date Started: 7/1985

I, the undersigned, have to the best of my knowledge, complied with the laws and rules regulating my profession. I hereby state that the information contained in this application is true and correct. This form is public information.

Signature of Applicant: Kathleen A Glaze MD Date: 6/2/10

(Remember to sign and date form before mailing) Page 2 of 2 - KATHLEEN ANN GLAZE

Attention MAC users: Please select "File" on your browser and then "Print"

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Application For Renewal Of Oklahoma License

MEDICAL DOCTOR From 07/02/2009 To 07/01/2010

This form must be completed and returned to this office with a renewal fee of $150.00 on or before July 01, 2009. After that date, the license becomes inactive. Renewals may be accepted for 60 days with a fee of $275.00. After 60 days, unrenewed Licensees are suspended. YOU CANNOT PRACTICE WITH AN INACTIVE OR SUSPENDED LICENSE.

RECEIVED

JUN 04 2009

OKLAHOMA STATE BOARD O
MEDICAL LICENSURE
AND SUPERVISION

Mail Renewal application to: **Oklahoma State Board Of Medical Licensure And Supervision**
PO Box 18256
Oklahoma City, OK 73154-0256

License Number: 13761

KATHLEEN ANN GLAZE

Mailing Address	Practice Address
1145 SOUTH UTICA AVENUE #514 TULSA, OK 74104-4018	1145 SOUTH UTICA AVENUE SUITE 514 TULSA, OK 74104-4018

	Yes	No
Have you met the Oklahoma CME Requirement?	X	

You are required pursuant to 59 O.S. 355 1(B) to indicate your preference. Please read and check in the appropriate response. Any Medical Doctor who desires to DISPENSE "dangerous drugs" as defined in the Pharmacy Law, must register annually with the Board. This is for dispensing only and does not include prescribing, administering, or the giving of samples.

I wish to be registered to dispense dangerous drugs.		X

The following information is mandatory and information provided may be investigated further.

Since 05/07/2008 Do Any Of The Following Apply To You?

A. Has your application for a license been denied?		X
B. Have you surrendered a license or had any disciplinary action taken on any license?		X
C. Have you been investigated by or requested to appear before a licensing or disciplinary agency?		X
D. Have you been arrested for, charged with, or convicted of a felony or misdemeanor other than a traffic violation?		X
E. Have you been arrested for, charged with, or convicted of a traffic violation involving the use of any drug or chemical substance including alcohol?		X
F. Have you been addicted to or abused any drug or chemical substance including alcohol?		X
G. Have you obtained an assessment or been treated for use of any drug or chemical substance including alcohol?		X
H. Have you had any mental or physical disorder or condition which if untreated could affect your ability to practice competently?		X
I. Have you been denied provider participation, terminated, sanctioned or penalized by any third party payor to include TRICARE, MEDICARE, or MEDICAID?		X
J. Have you surrendered or had any adverse action taken against any narcotic permit (State or Federal)?		X
K. Have you been denied membership or had disciplinary action taken by a national, state, or county medical organization?		X
L. Have you been denied or had removed or suspended hospital staff privileges?		X
M. Have you surrendered hospital staff privileges while under investigation or to avoid investigation?		X
N. Have you entered into an Agreement with a Federal, State, or Local jurisdictional body to avoid formal action?		X
O. Have you been the subject of an investigation or disciplinary action, including probation, by a hospital, clinic, practice group, or residency program?		X
P. Have you had any adverse judgment, settlement, or award against you arising from a professional liability claim?		X
Q. Have you been reported to the National Practitioner Data Bank (NPDB) or to the Healthcare Integrity and Protection Data Bank (HIPDB)?		X
DO YOU WISH TO APPLY FOR PHYSICIAN EMERITUS (FULLY RETIRED) STATUS?		X

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(Remember to sign and date form, before mailing)

Specialties:

Gynecology *

Board Certifications (Current):

AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

Post Graduate Training (Current):

Type of Training: _____

Hospital: _____

Location: _____

Date Entered: _____

Expected Completion Date: _____

Practice Information (Current):

Employer: PRIVATE PRACTICE

City, State, County: TULSA, OK USA

Type of Practice or Specialty: GYNECOLOGY

Date Started: 7/1985

I, the undersigned, have to the best of my knowledge, complied with the laws and rules regulating my profession. I hereby state that the information contained in this application is true and correct. This form is public information.

Signature of Applicant: Kathleen A Glaze MD Date: 6/2/09

(Remember to sign and date form before mailing)

Attention MAC users: Please select "File" on your browser and then "Print"

Print

Application For Renewal Of Oklahoma License
MEDICAL DOCTOR From 07/02/2008 To 07/01/2009

RECEIVED
MAY 07 2008
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

This form must be completed and returned to this office with a renewal fee of $150.00 on or before July 01, 2008. After that date, the license becomes inactive. Renewals may be accepted for 60 days with a fee of $275.00. After 60 days, unrenewed Licensees are suspended. YOU CANNOT PRACTICE WITH AN INACTIVE OR SUSPENDED LICENSE.

Mail Renewal application to: **Oklahoma State Board Of Medical Licensure And Supervision**
PO Box 18256
Oklahoma City, OK 73154-0256

License Number: 13761

KATHLEEN ANN GLAZE

Mailing Address	Practice Address
1145 SOUTH UTICA AVENUE #514 TULSA, OK 74104-4018	1145 SOUTH UTICA AVENUE SUITE 514 TULSA, OK 74104-4018

	Yes	No
You are required pursuant to 59 O.S. 355 1(B) to indicate your preference. Please read and check in the appropriate response. Any Medical Doctor who desires to DISPENSE "dangerous drugs" as defined in the Pharmacy Law, must register annually with the Board. This is for dispensing only and does not include prescribing, administering, or the giving of samples.		
I wish to be registered to dispense dangerous drugs.		X

The following information is mandatory and information provided may be investigated further.
Since 05/26/2007 Do Any Of The Following Apply To You?

A. Has your application for a license been denied?		X
B. Have you surrendered a license or had any disciplinary action taken on any license?		X
C. Have you been investigated by or requested to appear before a licensing or disciplinary agency?		X
D. Have you been arrested for, charged with, or convicted of a felony or misdemeanor other than a traffic violation?		X
E. Have you been arrested for, charged with, or convicted of a traffic violation involving the use of any drug or chemical substance including alcohol?		X
F. Have you been addicted to or abused any drug or chemical substance including alcohol?		X
G. Have you obtained an assessment or been treated for use of any drug or chemical substance including alcohol?		X
H. Have you had any mental or physical disorder or condition which if untreated could affect your ability to practice competently?		X
I. Have you been denied provider participation, terminated, sanctioned or penalized by any third party payor to include TRICARE, MEDICARE, or MEDICAID?		X
J. Have you surrendered or had any adverse action taken against any narcotic permit (State or Federal)?		X
K. Have you been denied membership or had disciplinary action taken by a national, state, or county medical organization?		X
L. Have you been denied or had removed or suspended hospital staff privileges?		X
M. Have you surrendered hospital staff privileges while under investigation or to avoid investigation?		X
N. Have you entered into an Agreement with a Federal, State, or Local jurisdictional body to avoid formal action?		X
O. Have you been the subject of an investigation or disciplinary action, including probation, by a hospital, clinic, practice group, or residency program?		X
P. Have you had any adverse judgment, settlement, or award against you arising from a professional liability claim?		X
Q. Have you been reported to the National Practitioner Data Bank (NPDB) or to the Healthcare Integrity and Protection Data Bank (HIPDB)?		X
DO YOU WISH TO APPLY FOR PHYSICIAN EMERITUS (FULLY RETIRED) STATUS?		X

If "YES" then a $50 processing fee is to be included and there is no renewal fee.
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8147:MD (Remember to sign and date form, before mailing) Page 1 of 2

Specialties:
Gynecology *

Board Certifications (Current):
AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

Post Graduate Training (Current):

Type of Training: _____
Hospital: _____
Location: _____
Date Entered: _____

Printable Application For Renewal of Oklahoma Medical License

Expected Completion Date: _____

Practice Information (Current):

Employer: PRIVATE PRACTICE

City, State, County: TULSA, OK USA

Type of Practice or Specialty: GYNECOLOGY

Date Started: 7/1985

I, the undersigned, have to the best of my knowledge, complied with the laws and rules regulating my profession. I hereby state that the information contained in this application is true and correct. This form is public information.

Signature of Applicant: Kathleen A Glaze MD Date: 5/6/08

8147:MD (Remember to sign and date form before mailing) Page 2 of 2

Attention MAC users: Please select "File" on your browser and then "Print"

APPLICATION FOR RENEWAL OF OKLAHOMA MEDICAL LICENSE

JULY 1, 1985 TO JUNE 30, 1986

This form must be completed in full and returned with your fee of $50.00. A penalty of $10.00 is imposed if this application is postmarked after June 10th. Licenses not renewed by June 30, 1985 become inactive.

13761

KATHLEEN GLAZE, M.D.
~~4025 E. 43RD~~
~~TULSA, OK 74135~~
1145 S. Utica
Suite 1100
Tulsa, OK 74104

Please mark any changes to your mailing address in the box to the left.

FINAL NOTICE

COMPLETE THE FOLLOWING :

PRACTICE SETTING : List the percentage of practice time spent in the following :

Patient Care :

Hospital based ____ Resident ____ Staff ✓ Other ____
Office based ____ Solo ✓ Group ____ Partnership ____

Other Professional Activity :

Teaching ____ Administration ____ Research ____ Other ____

ORIGINAL OKLAHOMA LICENSE OBTAINED BY : Exam ____ Endorsement ____ National Boards ✓ State

MAKE APPROPRIATE CHANGES TO THE INFORMATION LISTED BELOW :

PRACTICE ADDRESS :

~~TULSA OB/GYN CENTER~~
~~2815 S. SHERIDAN~~
~~TULSA, OK 74129~~
1145 S. Utica
Suite 1100
Tulsa, Ok. 74104

STATUS : ACTIVE

SPECIALTIES :

1. Primary (greater than 50% time spent) OBSTETRICS AND GYNECOLOGY
2. ____ 3. ____

BOARD CERTIFICATIONS (CURRENT) :

American Board of ____
American Board of ____

DISCIPLINARY ACTION : Have you ever been the subject of disciplinary action by any Governmental or Licensing Authority, Federal, State or Local? No
If "Yes" explain briefly : ____

POST-GRADUATE TRAINING (CURRENT) :

Type of training : RESIDENCY Hospital UNIV. OKLA.-TULSA MED. CLG.
Location : TULSA, OK
Date Entered : 07/82 Date expected to complete : 6/30/85 ✓

MAIL APPLICATION TO : Oklahoma State Board of Medical Examiners
P. O. Box 18256 Oklahoma City, OK 73154

Kathleen A. Glaze MD
Signature of Physician

FORM BMEREC 05-85

APPLICATION FOR RENEWAL CERTIFICATE OF REGISTRATION
JULY 1, 1984 TO JUNE 30, 1985

This form must be completed in full and returned with your fee to the Board of Medical Examiners by June 10, 1984

Registration Fee $50.00 Penalty $10.00 Imposed after June 10, 1984

13761

KATHLEEN GLAZE , M.D.
4025 E. 43RD
TULSA OK 74135

Please mark any changes to your mailing address in the box to the left.

RECEIVED
JUN 5 1984
STATE BOARD
MEDICAL EXAMINERS

PRACTICE ADDRESS : Must be the location of your office and must be identical to your current address on file with the Drug Enforcement Agency (DEA). DO NOT use P.O. Box #.

Street & Suite # [2808 S. Sheridan (Adm. office) 2815 S. Sheridan Tulsa Obst. & Gynecology Center]
City [Tulsa] State [Okla.] Zip [74129]
(If not U.S.) Province [ ] Country [ ]

SOCIAL SECURITY # : [ ] **PRACTICE STATUS** : [✓] Active [ ] Retired

RACE : [✓] Caucasian [ ] Black [ ] Am. Indian [ ] Hispanic [ ] Other

SEX (M/F) : [F]

SPECIALTIES : Primary specialty should be the specialty you practice greater than 50% of the time.
PRIMARY SPECIALTY [Obstetrics / Gynecology]
SECONDARY [ ] SECONDARY [ ]

BOARD CERTIFICATIONS : List CURRENT American Specialty Board certifications.

American Board of [ ]
American Board of [ ]

DISCIPLINARY ACTION : Have you ever been the subject of disciplinary action by any Governmental or Licensing Authority, Federal, State or Local? [No]

(If "Yes") When [ ] State [ ]
Explain in brief. [ ]

PRACTICE SETTING : List your current employer or self-employed practice setting.

EMPLOYER [State of Oklahoma] DATE STARTED (MO/YR) [6/81]

POST GRADUATE TRAINING : Fill out if you are currently in a training program.

Type of Training : [✓] Resident [ ] Fellowship [ ] Continuing Ed. [ ] Clerkship
Hospital or School [University of Oklahoma Tulsa Medical College]
CITY [Tulsa] State [Oklahoma]
Date Entered [6/81] (If not U.S.) Country [ ]

Kathleen A. Glaze MD
(Physician's Signature)

FORM BMEREG 03-84

APPLICATION FOR RENEWAL OF OKLAHOMA MEDICAL LICENSE

JULY 1, 1988 TO JUNE 30, 1989

This form must be completed in full and returned with your fee. REGISTRATION FEE $100.00. PENALTY IMPOSED AFTER JUNE 30, 1988 $150.00 (PLUS RENEWAL FEE). As of July 1, 1988 ~~un-~~ renewed licenses become inactive. After August 29, 1988 unrenewed licenses are suspended due to failure to renew. Reinstatement of suspended licenses is $300.00.

13761

KATHLEEN ANN GLAZE, M.D.
1145 S. UTICA
SUITE ~~1100~~ 462
TULSA, OK 74104-4018

RECEIVED
MAR 25 1988
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

Please mark any changes to your mailing address in the box to the left.

COMPLETE THE FOLLOWING :

PRACTICE SETTING : List the percentage of practice time spent in the following :

Hospital based - Resident ____ % Staff 20 % Other ____ %
Office based - Solo 80 % Group ____ % Partnership ____ %
Teaching ____ % Administration ____ % Research ____ % Other ____ %

List your current employer or self-employed practice setting:

EMPLOYER Self DATE STARTED (MO/YR) 6/85

MAKE APPROPRIATE CHANGES TO THE INFORMATION LISTED BELOW :

PRACTICE ADDRESS :

1145 S. UTICA
SUITE ~~1100~~ 462
TULSA, OK 74104

STATUS : ACTIVE

SPECIALTIES :

1. Primary (greater than 50% time spent) OBSTETRICS AND GYNECOLOGY
2. ____ 3. ____

BOARD CERTIFICATIONS (CURRENT) :

American Board of Obstetricians & Gynecologists (30)
American Board of ____

DISCIPLINARY ACTION : Have you ever been the subject of disciplinary action by any Governmental or Licensing Authority, Federal, State or Local? No
If "Yes" explain briefly : ____

POST-GRADUATE TRAINING (CURRENT) :

Type of training : ____ Hospital ____
Location : ____
Date Entered : ____ Date expected to complete : ____

MAIL APPLICATION TO : Oklahoma State Board of Medical Licensure and Supervision
P. O. Box 18256 Oklahoma City, OK 73154-0256

Kathleen A Glaze MD
Signature of Physician

APPLICATION FOR RENEWAL OF OKLAHOMA MEDICAL LICENSE

JULY 1, 1987 TO JUNE 30, 1988

This form must be completed in full and returned with your fee of $100.00. A penalty of $10.00 is imposed if this application is postmarked after June 10th. Licenses not renewed by June 30, 1987 become inactive and reactivation including penalties and fee will be $260.00.

13761

KATHLEEN ANN GLAZE, M.D.
1145 S. UTICA
SUITE 1100
TULSA, OK 74104-4018

RECEIVED
MAY 21 1987
STATE BOARD
MEDICAL EXAMINERS

Please mark any changes to your mailing address in the box to the left.

COMPLETE THE FOLLOWING :

PRACTICE SETTING : List the percentage of practice time spent in the following :

Hospital based - Resident ____ % Staff ____ % Other ____ %
Office based - Solo 100 % Group ____ % Partnership ____ %
Teaching ____ % Administration ____ % Research ____ % Other ____ %

List your current employer or self-employed practice setting:

EMPLOYER self employed DATE STARTED (MO/YR) July '85

MAKE APPROPRIATE CHANGES TO THE INFORMATION LISTED BELOW :

PRACTICE ADDRESS :

1145 S. UTICA
SUITE 1100
TULSA, OK 74104

STATUS : ACTIVE

SPECIALTIES :

1. Primary (greater than 50% time spent) OBSTETRICS AND GYNECOLOGY
2. ____ 3. ____

BOARD CERTIFICATIONS (CURRENT) : None

American Board of ____
American Board of ____

DISCIPLINARY ACTION : Have you ever been the subject of disciplinary action by any Governmental or Licensing Authority, Federal, State or Local? No
If "Yes" explain briefly : ____

POST-GRADUATE TRAINING (CURRENT) :

Type of training : ____ Hospital ____
Location : ____
Date Entered : ____ Date expected to complete : ____

MAIL APPLICATION TO : Oklahoma State Board of Medical Examiners
P. O. Box 18256 Oklahoma City, OK 73154-0256

Kathleen A Glaze MD
Signature of Physician

Dr. Kathleen Glaze, M.D.

07/23/2013

Oklahoma State Board of Medical Licensure and Supervision:

As part of my licensure requirements, I am writing to inform you that I will be dispensing prescription medications to my patients within my practice setting. This will not be a registered pharmacy, nor open to the public. Furthermore, I am also registered/licensed by the DEA and OBNDD. My license number is: 13761. Please contact me anytime with questions or concerns regarding this status.

Kathleen A. Glaze MD 7/23/13

Physician Signature Date

13761

[redacted] phone: 918.665.6400 | fax: 918.627.3693 | 6136 E. 32nd Place, Tulsa, OK 74135 |

THE GLENDENING LAW FIRM, P.L.L.C.

JEFFREY A. GLENDENING

8816 S. SHERIDAN ROAD
TULSA, OKLAHOMA 74133

TELEPHONE: (918) 494-7037
FACSIMILE: (918) 494-0766

September 30, 2005

Oklahoma State Board of
Medical Licensure and Supervision
5104 N. Francis, Suite C
Oklahoma City, OK 73118

Re: *Woodruff v. Glaze*
Kathleen Ann Glaze, M.D. – 13761

Dear Sir/Madam:

Please allow this letter to serve as a request for a complete copy of Dr. Kathleen Ann Glaze's medical conduct file, including but not limited to any and all applications for licensing, statement of charges, complaints, correspondence, memorandums, electronic mail, records, reports, and investigative notes and reports regarding Dr. Glaze's medical license issued by the state of Oklahoma. Please forward your copies along with an invoice for costs and our office will promptly forward payment upon receipt.

If you have any questions or need additional information regarding Dr. Glaze, please do not hesitate to contact me by phone (918) 494-7037, facsimile (918) 494-0766, or e-mail: janderson@glenlawfirm.com.

Thank you for your anticipated cooperation in this matter.

Sincerely,

Jami L. Anderson

JAMI L. ANDERSON
Legal Assistant to JEFFREY A. GLENDENING

/jla
063/0528/ltr/OkMedBoard001

Mailed 10-3-05 a 52

FELDMAN, FRANDEN, WOODARD, FARRIS & BOUDREAUX
ATTORNEYS AT LAW
1000 PARK CENTRE
525 SOUTH MAIN
TULSA, OKLAHOMA 74103-4509
www.tulsalawyer.com

OF COUNSEL
RAYMOND G. FELDMAN

BELINDA AGUILAR
THAYLA PAINTER BOHN
PAUL T. BOUDREAUX
JASEN R. CORNS
JOSEPH R. FARRIS
ROBERT A. FRANDEN
JASON GOODNIGHT
JODY R. NATHAN
PAUL F. PRATHER
PAULA J. QUILLIN
CURTIS J. ROBERTS
VICTOR R. WANDRES
JOHN R. WOODARD, III

TELEPHONE (918) 583-7129
TELECOPY (918) 584-3814

September 14, 2005

Sent via Facsimile to (405) 848-8240

Connie Reed
Oklahoma State Board of Medical Licensure
P. O. Box 18256
Oklahoma City, OK 73154-0256

Re: Kathleen Glaze, M.D.; License No. 13761

Dear Ms. Reed:

This letter is to confirm our phone conversation of today's date regarding this firm's request for a copy of the entire file on the above referenced physician. We will have a representative of the firm at your office on Thursday, September 15, to pick up that portion of the file that cannot be transmitted electronically. It is my understanding that you will have the same ready for him, transmit the remainder via e-mail and then bill this firm for the copies. Thank you for your pleasant demeanor and helpfulness in securing the requested file.

Sincerely,

FELDMAN, FRANDEN, WOODARD,
FARRIS & BOUDREAUX

Terri Cooper

Terri Cooper, CLA
Paralegal to Paul T. Boudreaux
Reply to sender at:
Tel.: (918) 764-3104
Fax: (918) 764-3004
E-mail: tcooper@tulsalawyer.com

:tc

pick up file

50

Stuart K. Bensch
1007 W. Padon Avenue
Blackwell, Oklahoma 74631
(580) 363-2971
skbensch@ruralnetusa.net
15 January 2003

Board of Medical Licensure & Supervision
Suite C
5104 N. Francis
P.O. Box 18256
Oklahoma City, OK 73154-0256

Records:

Please send a copy of your file for Kathleen Ann Glaze (License 13761). If this costs $40 or less, please invoice with copy. If this costs more than $40, please call to get approval first.

Stuart Bensch

44

1-21-03 JN

LAW OFFICES
Best, Sharp, Sheridan & Stritzke
A PROFESSIONAL CORPORATION
SUITE 700 KENNEDY BUILDING
321 SOUTH BOSTON
TULSA, OKLAHOMA 74103

JOSEPH M. BEST
JOSEPH A. SHARP
JOHN H. T. SHERIDAN
JERRY D. STRITZKE
ANDREW B. MORSMAN
TIMOTHY G. BEST
DANIEL S. SULLIVAN

TELEPHONE
AREA CODE 918
582-1234
FAX: 585-9447

September 22, 1989

Ms. Carole A. Smith
Board of Medical Examiners
P. O. Box 18256
Oklahoma City, Oklahoma 73154

Re: Green v. Glaze
Our File 1-205

Anderson v. Carlson
Our File 1-207

Dear Ms. Smith:

We are defending the doctors in the above-captioned lawsuits filed here in Tulsa County and we would appreciate your sending us the entire file of Dr. Kathleen A. Glaze and Dr. Kathleen Carlson together with your charge for photostating.

We greatly appreciate your help in this matter.

Very truly yours,

Joseph M. Best

JMB:md

13761 Glaze
11624 Carlson.

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

Kathleen A. Glaze, 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.

RECEIVED
JUN 1 1982
STATE BOARD
MEDICAL EXAMINERS

Attest WILLIAM B. HOLDEN
Chairman of the Board

SEAL

EDITHE J. LEVIT
President of the Board

Philadelphia, Pa.
07/01/82

Certificate # 252969

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 UNIV OKLAHOMA COL OF MED in JUNE ,1981 and whose birth date is 05/02/1952 This 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 06/79		
Anatomy, incl. histology and embryology	715	94
Physiology	455	78
Biochemistry	505	81
Pathology	520	82
Microbiology, incl. immunology	590	86
Pharmacology and Materia Medica	545	83
Behavioral Sciences	585	86
TOTAL TEST (Minimum Passing Score 380/75)	565	84
Part II passed 04/80		
Internal medicine and the medical specialties	420	78
Surgery and the surgical specialties	500	82
Obstetrics and Gynecology	500	82
Public Health and Preventive Medicine	515	83
Pediatrics	555	85
Psychiatry	575	86
TOTAL TEST (Minimum Passing Score 290/75)	510	82
PART III passed 03/82		
A General Test of Clinical Competence		
TOTAL TEST (Minimum Passing Score 290/75)	540	83.6
GENERAL AVERAGE (Parts, I, II, and III Scale Score)		83.2

*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

SEAL

05/26/82
Date

The Oklahoma State Regents for Higher Education

acting through the

University of Oklahoma

have admitted

Kathleen Ann Glaze

to the degree of

Doctor of Medicine

and all the honors, privileges and obligations belonging thereto, and in witness thereof have authorized the issuance of this diploma duly signed and sealed.

Issued at the University of Oklahoma on the seventh day of June, A.D. nineteen hundred and eighty-one.

OKLAHOMA STATE REGENTS FOR HIGHER EDUCATION
VITA ABUNDANTIOR
1941

CIVI ET REIPUBLICAE

For the State Regents

Chairman

Secretary

Chancellor

For the University

President, Board of Regents

President of the University

Academic Dean

The
University of Oklahoma
Tulsa Medical College

Department of Gynecology-Obstetrics

March 12, 1982

TO WHOM IT MAY CONCERN:

This letter is to certify that Katy Glaze, is a resident enrolled in the University of Oklahoma Tulsa Medical College Residency Training Program required for certification as a specialist in Obstetrics and Gynecology. Dr. Glaze was enrolled in our program as a first year resident on July 1, 1981 and is expected to graduate on June 30, 1982.

If there are any further questions you might have, please contact me.

Thank you.

Cordially,

John B. Nettles, M.D.
Professor

JBN:veh

2808 South Sheridan Road Tulsa, Oklahoma 74129 AC 918 838-3464

The
University of Oklahoma
Tulsa Medical College

Department of Internal Medicine

March 12, 1982

TO WHOM IT MAY CONCERN:

This is to certify that Katy Glaze is a resident enrolled in the University of Oklahoma Tulsa Medical College Residency Training Program required for certification as a specialist in Obstetrics and Gynecology. Dr. Glaze is of the highest moral and ethical standing and will make an excellent physician in the State of Oklahoma. I highly recommend her for your consideration. If I may be of further assistance, please call.

Sincerely,

F. Daniel Duffy, M.D., Chairman
Department of Internal Medicine

FDD/co

2808 S. Sheridan Tulsa, Oklahoma 74129 AC 918 838-3464

THE FOLLOWING MUST BE COMPLETED AND RETURNED WITH APPLICATION BEFORE APPLICATION CAN BE ACCEPTED.

STATE OF Oklahoma)

COUNTY OF Tulsa)

The applicant Kathleen A. Glaze, M.D.

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), business and professional associates (past and present) and all government agencies (local, state, federal or foreign) to release to the OKLAHOMA STATE BOARD OF MEDICAL EXAMINERS or its successors any information, files or records requested by that Board in connection with this application. I further authorize the OKLAHOMA STATE BOARD OF MEDICAL EXAMINERS or its successors to release to the organizations, individuals or groups listed above any information which is material to this application or any subsequent licensure.

Kathleen A. Glaze, M.D.
APPLICANT'S SIGNATURE

Subscribed and sworn to before me this 1 day of March, 19 82.

Connie T. Davis
Notary Public

My commission expires on the 18 day of February 19 84

I. Kathleen A. Glaze, M.D., M.D., certify that I (HAVE ____) (HAVE NOT X) been involved in a malpractice claim.

IF YOU HAVE BEEN, EXPLAIN FULLY IN DETAIL ON A SEPARATE SHEET OF PAPER.

Kathleen A. Glaze, M.D.
APPLICANT'S SIGNATURE

Subscribed and sworn to before me this 1 day of March, 19 82.

Connie T. Davis
Notary Public

My commission expires on the 18 day of February, 19 84.

7-17-87
DC

LAW OFFICES

Best, Sharp, Thomas, Glass & Atkinson

* PROFESSIONAL CORPORATION

1500 PARKCENTRE
525 SOUTH MAIN, TULSA, OKLAHOMA 74103
(918) 582-8877

JOSEPH M. BEST *
JACK M. THOMAS *
JOSEPH F. GLASS *
MICHAEL P. ATKINSON *
WALTER D. HASKINS *
GREGORY D. NELLIS *
PAUL T. BOUDREAUX *
JOHN H. SHERIDAN
JERRY D. STRITZKE
JANINE A. FULTON

ANDREW B. MORSMAN
RENEÉ J. HARTER
JODY R. NATHAN
ROBERT A. CANINO
DANIEL E. HOLEMAN
K. CLARK PHIPPS
MARTHA J. PHILLIPS

OF COUNSEL
JOSEPH A. SHARP *

July 14, 1987

Ms. Carole A. Smith
Board of Medical Examiners
5104 North Francis, Suite C
Oklahoma City, Oklahoma 73118

Re: Tellefson v. Nassif, M.D.
Our File 8-374

Dear Ms. Smith:

I am defending Dr. Linda Nassif and Dr. Kathleen Glaze in litigation here in Tulsa. Please send me a copy of the entire file of each of these doctors.

Very truly yours,

Joseph M. Best

Joseph M. Best

JMB:md

Board of Medical Examiners
State of Oklahoma

RECEIVED
MAR 30 1982
STATE BOARD
MEDICAL EXAMINERS

OFFICE OF THE SECRETARY
TELEPHONE 848-6841
P.O. BOX 18256
5104 N. FRANCIS, SUITE C
OKLAHOMA CITY, OKLAHOMA 73115

Federation of State Medical Boards
of the United States

MAR 19 1982
PREV. CORRES
ANS. FILE
CHECK
BY

DRUG ENFORCEMENT ADMINISTRATION

FEDERATION OF STATE MEDICAL BOARDS

Gentlemen:

We would appreciate knowing if you have any derogatory information concerning the following physician who is applying for a license to practice medicine in the State of Oklahoma.

NAME:
Kathleen Ann Glaze, M.D.

ADDRESS:
4012 East 42nd Place
Tulsa, Oklahoma 74135

DATE OF BIRTH:
May 2, 1952

M. D. DEGREE:
University of Oklahoma College of Medicine

Sincerely,

Betty J. Rogers

(Miss) Betty J. Rogers
Executive Secretary

BJR/njp

REMARKS:

Date MAR 26 1982

We have no unfavorable information regarding the above named physician.

Harold Harvey, Jr., M.D.
Executive Director-Secretary

THE OKLAHOMA STATE BOARD OF MEDICAL EXAMINERS

GREAT SEAL OF THE STATE OF OKLAHOMA 1907.

Be it known that Kathleen Ann Glaze, M.D. having given satisfactory evidence of fitness as to age, character, preliminary education, medical instruction, and all other matters required by law, was fully examined by the Members of the State Board of Medical Examiners of the State of Oklahoma, whose signatures are hereto attached, and found duly qualified to receive this Certificate Authorizing Her to Practice Medicine and Surgery, in this State under and pursuant to the provisions of the Statutes of the State of Oklahoma.

SEAL

Medical License No. 13761

IN TESTIMONY WHEREOF, we have hereunto set our hands and caused the official seal of said board to be impressed thereon, this 1st day of July A.D. 1982.

Carroll Holsted M.D. PRESIDENT

J. William McDaniel M.D. VICE-PRESIDENT

Frank Glenn M.D. SECRETARY

Robert E. Hood M.D.

R L Winters M.D.

Frank L. Oelman M.D.

M.D.

Board of Medical Examiners
State of Oklahoma

OFFICE OF THE SECRETARY
TELEPHONE 848-6841
P.O. BOX 18256
5104 N. FRANCIS, SUITE C
OKLAHOMA CITY, OKLAHOMA 73154

DRUG ENFORCEMENT ADMINISTRATION

FEDERATION OF STATE MEDICAL BOARDS

Gentlemen:

We would appreciate knowing if you have any derogatory information concerning the following physician who is applying for a license to practice medicine in the State of Oklahoma.

NAME: Kathleen Ann Glaze, M.D. N/R

ADDRESS: 4012 East 42nd Place
Tulsa, Oklahoma 74135

DATE OF BIRTH: May 2, 1952

M. D. DEGREE: University of Oklahoma College of Medicine

Sincerely,

Betty J. Rogers

(Miss) Betty J. Rogers
Executive Secretary

BJR/njp

REMARKS:

MAR 19 1982 date

☐ with DEA in schedules is currently registered.

☐ is not registered with DEA.

☒ is not of record with DEA.

K. Glaze

L. Barker
Lw

APPLICATION FOR RENEWAL OF OKLAHOMA LICENSE

MEDICAL DOCTOR From 7/2/2011 To 7/1/2012

This form must be completed and returned to this office with a renewal fee of $200.00 on or before July 1, 2011. After that date, the license becomes inactive. Renewals may be accepted for 60 days with a fee of $350.00. After 60 days, unrenewed Licenses are suspended. YOU CANNOT PRACTICE WITH AN INACTIVE OR SUSPENDED LICENSE.

Mail Renewal application to: **OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION**
PO BOX 18256
OKLAHOMA CITY, OK 73154-0256

Mark any changes to the addresses below. Please inform this office of all address changes.

13761
KATHLEEN ANN GLAZE, M.D.

MAIL	PRACT
1145 SOUTH UTICA AVENUE #514 TULSA, OK 74104-4018	1145 SOUTH UTICA AVENUE SUITE 514 TULSA, OK 74104-4018 (918) 583-6868

You are required pursuant to 59 O.S. § 355.1(B) to indicate your preference. Please read and check appropriate response. Any Medical Doctor who desires to DISPENSE "dangerous drugs" as defined in the Pharmacy Law, must register annually with the Board. This is for dispensing only and does not include prescribing, administering, or the giving of samples.

I wish to be registered to dispense dangerous drugs. _____YES __X_NO

The following information is mandatory and information provided may be investigated further.

Since the last renewal or initial licensure (whichever is most recent):	YES	NO
A. Has your application for a license been denied?	____	X
B. Have you surrendered a license or had any disciplinary action taken on any license?	____	X
C. Have you been investigated by or requested to appear before a licensing or disciplinary agency other than the Oklahoma State Board of Medical Licensure and Supervision?	____	X
D. Have you been arrested for, charged with, or convicted of a felony or misdemeanor other than a traffic violation?	____	X
E. Have you been arrested for, charged with, or convicted of a traffic violation involving the use of any drug or chemical substance including alcohol?	____	X
F. Have you been addicted to or abused any drug or chemical substance including alcohol?	____	X
G. Have you obtained an assessment or been treated for use of any drug or chemical substance including alcohol?	____	X
H. Have you had any mental or physical disorder or condition which if untreated could affect your ability to practice competently?	____	X
I. Have you been denied provider participation, terminated, sanctioned or penalized by any third party payor to include TRICARE, MEDICARE, or MEDICAID?	____	X
J. Have you surrendered or had any adverse action taken against any narcotic permit (State or Federal)?	____	X
K. Have you been denied membership or had disciplinary action taken by a national, state, or county medical organization?	____	X
L. Have you been denied or had removed or suspended hospital staff privileges?	____	X
M. Have you surrendered hospital staff privileges while under investigation or to avoid investigation?	____	X
N. Have you entered into an Agreement with a Federal, State, or Local jurisdictional body to avoid formal action?	____	X

APPLICATION FOR RENEWAL OF OKLAHOMA LICENSE

MEDICAL DOCTOR From 7/2/2007 To 7/1/2008

This form must be completed and returned to this office with a renewal fee of $150.00 on or before July 1, 2007. After that date, the license becomes inactive. Renewals may be accepted for 60 days with a fee of $275.00. After 60 days, unrenewed Licenses are suspended. YOU CANNOT PRACTICE WITH AN INACTIVE OR SUSPENDED LICENSE.

Mail Renewal application to: **OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION**
PO BOX 18256
OKLAHOMA CITY, OK 73154-0256

Mark any changes to the addresses below. Please inform this office of all address changes.

13761
KATHLEEN ANN GLAZE, M.D.

1145 SOUTH UTICA AVENUE #514 TULSA, OK 74104-4018	MAIL

1145 SOUTH UTICA AVENUE SUITE 514 TULSA, OK 74104-4018 (918) 583-6868	PRACT

You are required pursuant to 59 O.S. § 355.1(B) to indicate your preference. Please read and check appropriate response. Any Medical Doctor who desires to DISPENSE "dangerous drugs" as defined in the Pharmacy Law, must register annually with the Board. This is for dispensing only and does not include prescribing, administering, or the giving of samples.

I wish to be registered to dispense dangerous drugs. _____YES __X_NO

The following information is mandatory and information provided may be investigated further.

Since the last renewal or initial licensure (whichever is most recent):

	YES	NO
A. Has your application for examination or a license been denied?		X
B. Have you surrendered a license or had a license revoked?		X
C. Has any disciplinary action been taken on any license?		X
D. Have you been requested to appear before a licensing or disciplinary agency?		X
E. Have you been arrested for, charged with, or convicted of a felony or misdemeanor other than a traffic violation?		X
F. Have you been arrested for, charged with, or convicted of a traffic violation involving the use of drugs and/or alcohol?		X
G. Have you been addicted to or abused any drug or chemical substance including alcohol?		X
H. Have you obtained an assessment or been treated for use of any drug or chemical substance including alcohol?		X
I. Have you had any mental, emotional or nervous disorder or condition which could affect, or if untreated could affect, your ability to practice competently?		X
J. Have you been denied provider participation, terminated, sanctioned or penalized by any third party payor to include CHAMPUS, MEDICARE, MEDICAID?		X
K. Have you surrendered any license or narcotic permit (State or Federal)?		X
L. Have you been denied membership or had disciplinary action taken by a national, state, or county medical association?		X
M. Have you been denied or had removed or suspended hospital staff privileges?		X
N. Have you surrendered hospital staff privileges while under investigation or to avoid investigation?		X
O. Have you withdrawn an application for hospital staff privileges?		X
P. Have you entered into an Agreement with a Federal, State, or Local jurisdictional body to avoid formal action?		X
Q. Have you been the subject of disciplinary action, including probation, by a hospital, clinic, residency program or professional school?		X

APPLICATION FOR RENEWAL OF OKLAHOMA LICENSE

MEDICAL DOCTOR From 7/2/2006 To 7/1/2007

This form must be completed and returned to this office with a renewal fee of $150.00 on or before July 1, 2006. After that date, the license becomes inactive. Renewals may be accepted for 60 days with a fee of $275.00. After 60 days, unrenewed Licenses are suspended. YOU CANNOT PRACTICE WITH AN INACTIVE OR SUSPENDED LICENSE.

Mail Renewal application to: **OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION**
PO BOX 18256
OKLAHOMA CITY, OK 73154-0256

Mark any changes to the addresses below. Please inform this office of all address changes.

13761
KATHLEEN ANN GLAZE, M.D.

1145 SOUTH UTICA AVENUE #514 TULSA, OK 74104-4018	MAIL

PRACT	1145 SOUTH UTICA AVENUE SUITE 514 TULSA, OK 74104-4018 (918) 583-6868

You are required pursuant to 59 O.S. § 355.1(B) to indicate your preference. Please read and check appropriate response. Any Medical Doctor who desires to DISPENSE "dangerous drugs" as defined in the Pharmacy Law, must register annually with the Board. This is for dispensing only and does not include prescribing, administering, or the giving of samples.

I wish to be registered to dispense dangerous drugs. _____YES __X_NO

The following information is mandatory and information provided may be investigated further.

Since the last renewal or initial licensure (whichever is most recent):	**YES**	**NO**
A. Has your application for examination or a license been denied?	____	X
B. Have you surrendered a license or had a license revoked?	____	X
C. Has any disciplinary action been taken on any license?	____	X
D. Have you been requested to appear before a licensing or disciplinary agency?	____	X
E. Have you been arrested for, charged with, or convicted of a felony or misdemeanor other than a traffic violation?	____	X
F. Have you been arrested for, charged with, or convicted of a traffic violation involving the use of drugs and/or alcohol?	____	X
G. Have you been addicted to or abused any drug or chemical substance including alcohol?	____	X
H. Have you obtained an assessment or been treated for use of any drug or chemical substance including alcohol?	____	X
I. Have you had any mental, emotional or nervous disorder or condition which could affect, or if untreated could affect, your ability to practice competently?	____	X
J. Have you been denied provider participation, terminated, sanctioned or penalized by any third party payor to include CHAMPUS, MEDICARE, MEDICAID?	____	X
K. Have you surrendered any license or narcotic permit (State or Federal)?	____	X
L. Have you been denied membership or had disciplinary action taken by a national, state, or county medical association?	____	X
M. Have you been denied or had removed or suspended hospital staff privileges?	____	X
N. Have you surrendered hospital staff privileges while under investigation or to avoid investigation?	____	X
O. Have you withdrawn an application for hospital staff privileges?	____	X
P. Have you entered into an Agreement with a Federal, State, or Local jurisdictional body to avoid formal action?	____	X
Q. Have you been the subject of disciplinary action, including probation, by a hospital, clinic, residency program or professional school?	____	X

APPLICATION FOR RENEWAL OF OKLAHOMA LICENSE

MEDICAL DOCTOR From 7/2/2005 To 7/1/2006

This form must be completed and returned to this office with a renewal fee of $150.00 on or before July 1, 2006. After that date, the license becomes inactive. Renewals may be accepted for 60 days with a fee of $275.00. After 60 days, unrenewed Licenses are suspended. YOU CANNOT PRACTICE WITH AN INACTIVE OR SUSPENDED LICENSE.

Mail Renewal application to: **OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION**
PO BOX 18256
OKLAHOMA CITY, OK 73154-0256

Mark any changes to the addresses below. Please inform this office of all address changes.

13761
KATHLEEN ANN GLAZE, M.D.

MAIL	PRACT
1145 SOUTH UTICA AVENUE #514 TULSA, OK 74104-4018	1145 SOUTH UTICA AVENUE SUITE 514 TULSA, OK 74104-4018 (918) 583-6868

You are required pursuant to 59 O.S. § 355.1(B) to indicate your preference. Please read and check appropriate response. Any Medical Doctor who desires to DISPENSE "dangerous drugs" as defined in the Pharmacy Law, must register annually with the Board. This is for dispensing only and does not include prescribing, administering, or the giving of samples.

I wish to be registered to dispense dangerous drugs. _____YES __X_NO

The following information is mandatory and information provided may be investigated further.

Since the last renewal or initial licensure (whichever is most recent):	**YES**	**NO**
A. Has your application for examination or a license been denied?		X
B. Have you surrendered a license or had a license revoked?		X
C. Has any disciplinary action been taken on any license?		X
D. Have you been requested to appear before a licensing or disciplinary agency?		X
E. Have you been arrested for, charged with, or convicted of a felony or misdemeanor other than a traffic violation?		X
F. Have you been arrested for, charged with, or convicted of a traffic violation involving the use of drugs and/or alcohol?		X
G. Have you been addicted to or abused any drug or chemical substance including alcohol?		X
H. Have you obtained an assessment or been treated for use of any drug or chemical substance including alcohol?		X
I. Have you had any mental, emotional or nervous disorder or condition which could affect, or if untreated could affect, your ability to practice competently?		X
J. Have you been denied provider participation, terminated, sanctioned or penalized by any third party payor to include CHAMPUS, MEDICARE, MEDICAID?		X
K. Have you surrendered any license or narcotic permit (State or Federal)?		X
L. Have you been denied membership or had disciplinary action taken by a national, state, or county medical association?		X
M. Have you been denied or had removed or suspended hospital staff privileges?		X
N. Have you surrendered hospital staff privileges while under investigation or to avoid investigation?		X
O. Have you withdrawn an application for hospital staff privileges?		X
P. Have you entered into an Agreement with a Federal, State, or Local jurisdictional body to avoid formal action?		X
Q. Have you been the subject of disciplinary action, including probation, by a hospital, clinic, residency program or professional school?		X

APPLICATION FOR RENEWAL OF OKLAHOMA LICENSE

MEDICAL DOCTOR From 7/2/2004 To 7/1/2005

This form must be completed and returned to this office with a renewal fee of $150.00 on or before July 1, 2005. After that date, the license becomes inactive. Renewals may be accepted for 60 days with a fee of $275.00. After 60 days, unrenewed Licenses are suspended. YOU CANNOT PRACTICE WITH AN INACTIVE OR SUSPENDED LICENSE.

Mail Renewal application to: **OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION**
PO BOX 18256
OKLAHOMA CITY, OK 73154-0256

Mark any changes to the addresses below. Please inform this office of all address changes.

13761
KATHLEEN ANN GLAZE, M.D.

MAIL	PRACT
1145 SOUTH UTICA AVENUE #514 TULSA, OK 74104-4018	1145 SOUTH UTICA AVENUE SUITE 514 TULSA, OK 74104-4018 (918) 583-6868

You are required pursuant to 59 O.S. § 355.1(B) to indicate your preference. Please read and check appropriate response. Any Medical Doctor who desires to DISPENSE "dangerous drugs" as defined in the Pharmacy Law, must register annually with the Board. This is for dispensing only and does not include prescribing, administering, or the giving of samples.

I wish to be registered to dispense dangerous drugs. _____YES __X_NO

The following information is mandatory and information provided may be investigated further.

Since the last renewal or initial licensure (whichever is most recent):

	YES	NO
A. Has your application for examination or a license been denied?	____	X
B. Have you surrendered a license or had a license revoked?	____	X
C. Has any disciplinary action been taken on any license?	____	X
D. Have you been requested to appear before a licensing or disciplinary agency?	____	X
E. Have you been arrested for, charged with, or convicted of a felony or misdemeanor other than a traffic violation?	____	X
F. Have you been arrested for, charged with, or convicted of a traffic violation involving the use of drugs and/or alcohol?	____	X
G. Have you been addicted to or abused any drug or chemical substance including alcohol?	____	X
H. Have you obtained an assessment or been treated for use of any drug or chemical substance including alcohol?	____	X
I. Have you had any mental, emotional or nervous disorder or condition which could affect, or if untreated could affect, your ability to practice competently?	____	X
J. Have you been denied provider participation, terminated, sanctioned or penalized by any third party payor to include CHAMPUS, MEDICARE, MEDICAID?	____	X
K. Have you surrendered any license or narcotic permit (State or Federal)?	____	X
L. Have you been denied membership or had disciplinary action taken by a national, state, or county medical association?	____	X
M. Have you been denied or had removed or suspended hospital staff privileges?	____	X
N. Have you surrendered hospital staff privileges while under investigation or to avoid investigation?	____	X
O. Have you withdrawn an application for hospital staff privileges?	____	X
P. Have you entered into an Agreement with a Federal, State, or Local jurisdictional body to avoid formal action?	____	X
Q. Have you been the subject of disciplinary action, including probation, by a hospital, clinic, residency program or professional school?	____	X

APPLICATION FOR RENEWAL OF OKLAHOMA LICENSE

MEDICAL DOCTOR From 7/2/03 To 7/1/04

This form must be completed and returned to this office with a renewal fee of $150.00 on or before July 1, 2003. After that date the license becomes inactive. Renewals may be accepted for 60 days with a fee of $275.00. After 60 days, unrenewed Licenses are suspended. YOU CANNOT PRACTICE WITH AN INACTIVE OR SUSPENDED LICENSE.

RECEIVED
2003 JUN 20 AM 8:13
OK STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

Mail Renewal application to: **OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION**
PO BOX 18256
OKLAHOMA CITY, OK 73154-0256

Mark any changes to the addresses below. Please inform this office of all address changes.

13761
KATHLEEN ANN GLAZE, M.D.

1145 SOUTH UTICA AVENUE #514 TULSA, OK 74104-4018	**MAIL**

1145 SOUTH UTICA AVENUE SUITE 514 TULSA, OK 74104-4018 (918) 583-6868 x	**PRACT**

Have you met the Oklahoma CME requirement? X YES ___ NO

You are required pursuant to 59 O.S. § 355.1(B) to indicate your preference. Please read and check appropriate response. Any Medical Doctor who desires to DISPENSE "dangerous drugs" as defined in the Pharmacy Law, must register annually with the Board. This is for dispensing only and does not include prescribing, administering, or the giving of samples.

I wish to be registered to dispense dangerous drugs. ___ YES X NO

The following information is mandatory and information provided may be investigated further.

Since the last renewal or initial licensure (whichever is most recent):

	YES	NO
A. Has your application for examination or a license been denied?	___	X
B. Have you surrendered a license or had a license revoked?	___	X
C. Has any disciplinary action been taken on any license?	___	X
D. Have you been requested to appear before a licensing or disciplinary agency?	___	X
E. Have you been arrested for, charged with or convicted of a felony or misdemeanor other than a traffic violation?	___	X
F. Have you been arrested for, charged with or convicted of a traffic violation involving the use of drugs and/or alcohol?	___	X
G. Have you been addicted to or abused any drug or chemical substance including alcohol?	___	X
H. Have you obtained an assessment or been treated for use of any drug or chemical substance including alcohol?	___	X
I. Have you had any mental, emotional or nervous disorder or condition which could affect, or if untreated could affect, your ability to practice competently?	___	X
J. Have you been denied provider participation, terminated, sanctioned or penalized by any third party payor to include CHAMPUS, MEDICARE, MEDICAID?	___	X
K. Have you surrendered any license or narcotic permit (State or Federal)?	___	X
L. Have you been denied membership or had disciplinary action taken by a national, state, or county medical association?	___	X
M. Have you been denied or had removed or suspended hospital staff privileges?	___	X
N. Have you surrendered hospital staff privileges while under investigation or to avoid investigation?	___	X
O. Have you withdrawn an application for hospital staff privileges?	___	X
P. Have you entered into an Agreement with a Federal, State, or Local jurisdictional body to avoid formal action?	___	X
Q. Have you been the subject of disciplinary action, including probation, by a hospital, clinic, residency program or professional school?	___	X

(Complete Back of Form)

APPLICATION FOR RENEWAL OF OKLAHOMA LICENSE

MEDICAL DOCTOR From 7/2/02 To 7/1/03

This form must be completed and returned to this office with a renewal fee of $150.00 on or before July 1, 2002. After that date, the license becomes inactive. Renewals may be accepted for 60 days with a fee of $275.00. After 60 days, unrenewed Licenses are suspended. YOU CANNOT PRACTICE WITH AN INACTIVE OR SUSPENDED LICENSE.

RECEIVED

02 MAY 15 AM 8:35

Mail Renewal application to: **OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION**
PO BOX 18256
OKLAHOMA CITY, OK 73154-0256

Mark any changes to the addresses below. Please inform this office of all address changes.

13761
KATHLEEN ANN GLAZE, M.D.

1145 SOUTH UTICA AVENUE #514 TULSA, OK 74104-4018	MAIL

1145 SOUTH UTICA AVENUE SUITE 514 TULSA, OK 74104-4018 918-583-6868 **You Must Provide a Practice Phone #**	PRACT

You are required pursuant to 59 O.S. § 355.1(B) to indicate your preference. Please read and check appropriate response. Any Medical Doctor who desires to DISPENSE "dangerous drugs" as defined in the Pharmacy Law, must register annually with the Board. This is for dispensing only and does not include prescribing, administering, or the giving of samples.

I wish to be registered to dispense dangerous drugs. ____YES X NO

The following information is mandatory and information provided may be investigated further.

Since the last renewal or initial licensure (whichever is most recent):

		YES	NO
A.	Has your application for examination or a license been denied?	____	X
B.	Have you surrendered a license or had a license revoked?	____	X
	Has any disciplinary action been taken on any license?	____	X
	Have you been requested to appear before a licensing or disciplinary agency?	____	X
C.	Have you been arrested or charged or convicted of a felony or misdemeanor?	____	X
D.	Have you been addicted to or abused any drug or chemical substance including alcohol?	____	X
E.	Have you obtained an assessment or been treated for use of any drug or chemical substance including alcohol?	____	X
F.	Have you had any mental, emotional or nervous disorder or condition which could affect, or if untreated could affect, your ability to practice competently?	____	X
G.	Have you been denied provider participation, terminated, sanctioned or penalized by any third party payor to include CHAMPUS, MEDICARE, MEDICAID?	____	X
H.	Have you surrendered any license or narcotic permit (State or Federal)?	____	X
I.	Have you been denied membership or had disciplinary action taken by a national, state, or county medical association?	____	X
J.	Have you been denied or had removed or suspended hospital staff privileges?	____	X
	Have you surrendered hospital staff privileges while under investigation or to avoid investigation?	____	X
	Have you withdrawn an application for hospital staff privileges?	____	X
K.	Have you entered into an Agreement with a Federal, State, or Local jurisdictional body to avoid formal action?	____	X
L.	Have you been the subject of disciplinary action, including probation, by a hospital, clinic, residency program or professional school?	____	X

(Complete Back of Form)

APPLICATION FOR RENEWAL OF OKLAHOMA LICENSE

This form must be completed and returned to this office with a renewal fee of $150.00 on or before July 1, 2001. Renewals may be accepted for 60 days after that date with a fee of $275.00. After 60 days, unrenewed Licenses are suspended. Mail Renewal application to:

RECEIVED
01 JUL -7 AM 8:22

OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION
PO BOX 18256
OKLAHOMA CITY, OK 73154-0256

Mark any changes to the addresses below. Please inform this office of all address changes.

13761
KATHLEEN ANN GLAZE, M.D.

1145 SOUTH UTICA AVENUE #514 TULSA, OK 74104-4018	MAIL

PRACT	1145 SOUTH UTICA AVENUE SUITE 514 TULSA, OK 74104-4018

DO YOU WISH TO APPLY FOR PHYSICIAN EMERITUS (FULLY RETIRED) STATUS? ___ YES _X_ NO
If "YES", Enclose a $50 processing fee. There will be no renewal fee.
The Following Restrictions apply to Physician Emeritus (FULLY RETIRED) Physicians:
A) You may continue to use the title "DOCTOR" and suffix "MD", but must indicate your retired status.
EX: John Doe, MD (RET)
B) You cannot practice medicine in any form. You cannot prescribe, dispense or administer drugs.

The following information is mandatory and information provided may be investigated further.
Since the last renewal or initial licensure (whichever is most recent):

	YES	NO
Have you been the subject of disciplinary action by any governmental or licensing authority, federal, state, or local?	___	X
Have you been charged with or convicted of a felony or misdemeanor?	___	X
Are you now using any drug or chemical substance including alcohol which has an adverse impact on your ability to practice your profession?	___	X
Do you have a mental disorder which has an adverse impact on your ability to practice your profession?	___	X
Have you been reported to the National Practitioner Data Bank (NPDB)? If "yes", enclose a copy of the report received from the NPDB.	___	X
Have you voluntarily surrendered any medical license or narcotic permit (State or Federal)?	___	X
Have you been denied privileges, lost privileges or received discipline by any hospital or other professional medical organization?	___	X
Has a malpractice claim been filed against you?	___	X
Have you had a major illness or been hospitalized within the past year?	___	X

You are required pursuant to 59O.S. S.S.355.1(B) to indicate your preference. Please read and check appropriate response. Any Medical Doctor who desires to DISPENSE "dangerous drugs" as defined in the Pharmacy Law, must register annually with the Board. This is for dispensing only and does not include prescribing, administering, or the giving of samples.

I wish to be registered to dispense dangerous drugs.	___	X

(Complete Back of Form)

APPLICATION FOR RENEWAL OF OKLAHOMA LICENSE

MEDICAL DOCTOR From July 2 2000 To July 1 2001

This form must be completed and returned to this office with a renewal fee of $150 on or before **July 1 2000**
Renewals may be accpeted for 60 days after that date with a fee of $275. After 60 days, unrenewed licenses are suspended. Mail renewal application to:

OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION
PO BOX 18256
OKLAHOMA CITY OK 73154-0256

Mark any changes to the addresses below. Please inform this office of all address changes.

13761
KATHLEEN ANN GLAZE, M.D.

1145 SOUTH UTICA AVENUE #514 TULSA OK 74104-4018	MAIL	PRACT	1145 SOUTH UTICA AVENUE SUITE 514 TULSA OK 74104-4018

Have you met the Oklahoma CME requirement? X YES ____ NO

DO YOU WISH TO APPLY FOR PHYSICIAN EMERITUS (FULLY RETIRED) STATUS? ____ YES X NO
If "YES", Enclose a $50 processing fee. There will be no renewal fee.
The Following Restrictions apply to Physician Emeritus (FULLY RETIRED) Physicians:
A) You may continue to use the title "DOCTOR" and suffix "MD", but must indicate your retired status.
EX: John Doe, MD (RET)
B) You cannot practice medicine in any form. You cannot prescribe, dispense or administer drugs.

The following information is mandatory and information provided may be investigated further.
Since the last renewal or initial licensure (whichever is most recent):

	YES	NO
Have you been the subject of disciplinary action by any governmental or licensing authority, federal, state, or local?	____	X
Have you been charged with or convicted of a felony or misdemeanor?	____	X
Are you now using any drug or chemical substance including alcohol which has an adverse impact on your ability to practice your profession?	____	X
Do you have a mental disorder which has an adverse impact on your ability to practice your profession?	____	X
Have you been reported to the National Practitioner Data Bank (NPDB)? If "yes", enclose a copy of the report received from the NPDB.	____	X
Have you voluntarily surrendered any medical license or narcotic permit (State or Federal)?	____	X
Have you been denied privileges, lost privileges or received discipline by any hospital or other professional medical organization?	____	X
Has a malpractice claim been filed against you?	____	X
Have you had a major illness or been hospitalized within the past year?	____	X

You are required pursuant to 59O.S. S.S.355.1(B) to indicate your preference. Please read and check appropriate response. Any Medical Doctor who desires to DISPENSE "dangerous drugs" as defined in the Pharmacy Law, must register annually with the Board. This is for dispensing only and does not include prescribing, administering, or the giving of samples.

I WISH TO BE REGISTERED TO DISPENSE DANGEROUS DRUGS. ____ X

(COMPLETE BACK OF FORM)

APPLICATION FOR RENEWAL OF OKLAHOMA MEDICAL LICENSE

JULY 1, 1994 TO JUNE 30, 1995

This form must be completed in full and returned with your fee. The annual renewal fee is $150.00 and must be paid on or before June 30, 1994. As of July 1, 1994 unrenewed licenses become inactive ~~and may~~ be reactivated upon payment of the reactivation fee of $275.00. After August 29, 1994 unrenewed licenses are suspended due to failure to renew. Reinstatement of a suspended license is $400.00, submittal of an application and evidence that certain requirements have been met.

MAILING ADDRESS

KATHLEEN ANN GLAZE, M.D.
1145 S UTICA AVE ~~#462~~ #514
TULSA, OK 74104-4018

COMPLETE BOTH SIDES OF THIS FORM. MAKE APPROPRIATE CORRECTIONS TO THE INFORMATION AND ADD ANY MISSING INFORMATION TO PROTECT THE ACCURACY OF YOUR PUBLIC FILE.

NOTE: The information on this page is mandatory and renewal will NOT be accepted if incomplete or blank.

LICENSE NUMBER: 13761 SOCIAL SECURITY NUMBER: _____

I DO ☒ DO NOT ☐ WISH TO BE REGISTERED TO DISPENSE DANGEROUS DRUGS.

DISCIPLINARY ACTION: Have you ever been the subject of disciplinary action by any Governmental or Licensing Authority, Federal, State, or Local? No

If yes, explain briefly: _____

PRACTICE ADDRESS

1145 S. UTICA
SUITE 462
TULSA, OK 74104

RECEIVED
JUL 7 1994
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

OTHER STATES IN WHICH YOU ARE OR HAVE BEEN LICENSED TO PRACTICE MEDICINE:

RECEIVED
JUN 30 1994
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

DO YOU WISH TO APPLY FOR PHYSICIAN EMERITUS (FULLY RETIRED) STATUS? YES ☐ NO ☒

IF "YES":

A) ENCLOSE A $50.00 PROCESSING FEE. THERE WILL BE NO RENEWAL FEE.
B) RETURN TO THIS BOARD YOUR WALLET CARD. (A NEW CARD WILL BE ISSUED IDENTIFYING YOU AS PHYSICIAN EMERITUS.)

THE FOLLOWING RESTRICTIONS APPLY TO PHYSICIAN EMERITUS (FULLY RETIRED PHYSICIANS).

A) YOU MAY CONTINUE TO USE THE TITLE "DOCTOR" AND THE SUFFIX "M.D.", BUT MUST INDICATE YOUR RETIRED STATUS. EXAMPLE: DOCTOR JOHN DOE, M.D. (RET.)
B) YOU CANNOT PRACTICE MEDICINE IN ANY FORM.
C) YOU CANNOT PRESCRIBE, DISPENSE OR ADMINISTER DRUGS.

APPLICATION FOR RENEWAL OF OKLAHOMA MEDICAL LICENSE

JULY 1, 1993 TO JUNE 30, 1994

This form must be completed in full and returned with your fee. The annual renewal fee is $150.00 and must be paid on or before June 30, 1993. As of July 1, 1993 unrenewed licenses become inactive and may be reactivated upon payment of the reactivation fee of $275.00. After August 29, 1993 unrenewed licenses are suspended due to failure to renew. Reinstatement of a suspended license is $400.00, submittal of an application and evidence that certain requirements have been met.

MAILING ADDRESS

KATHLEEN ANN GLAZE, M.D.
1145 S UTICA AVE #462
TULSA, OK 74104-4018

[redacted]

MAKE APPROPRIATE CORRECTIONS TO THE INFORMATION AND ADD ANY MISSING INFORMATION TO PROTECT THE ACCURACY OF YOUR PUBLIC FILE.

NOTE: The information on this page is mandatory and renewal will NOT be accepted if incomplete or blank.

LICENSE NUMBER: 13761 SOCIAL SECURITY NUMBER: _____

I DO ☒ DO NOT ☐ WISH TO BE REGISTERED TO DISPENSE DANGEROUS DRUGS.

DISCIPLINARY ACTION: Have you ever been the subject of disciplinary action by any Governmental or Licensing Authority, Federal, State, or Local? No

If yes, explain briefly: _____

PRACTICE ADDRESS

1145 S. UTICA

SUITE 462

TULSA, OK 74104

RECEIVED
JUN 24 1993
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

OTHER STATES IN WHICH YOU ARE OR HAVE BEEN LICENSED TO PRACTICE MEDICINE:

RECEIVED
JUN 9 1993
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

DO YOU WISH TO APPLY FOR PHYSICIAN EMERITUS (FULLY RETIRED) STATUS? YES ☐ NO ☒

IF "YES":

A) ENCLOSE A $50.00 PROCESSING FEE. THERE WILL BE NO RENEWAL FEE.
B) RETURN TO THIS BOARD YOUR WALLET CARD. (A NEW CARD WILL BE ISSUED IDENTIFYING YOU AS PHYSICIAN EMERITUS.)

THE FOLLOWING RESTRICTIONS APPLY TO PHYSICIAN EMERITUS (FULLY RETIRED PHYSICIANS).

A) YOU MAY CONTINUE TO USE THE TITLE "DOCTOR" AND THE SUFFIX "M.D.", BUT MUST INDICATE YOUR RETIRED STATUS. EXAMPLE: DOCTOR JOHN DOE, M.D. (RET.)
B) YOU CANNOT PRACTICE MEDICINE IN ANY FORM.
C) YOU CANNOT PRESCRIBE, DISPENSE OR ADMINISTER DRUGS.

APPLICATION FOR RENEWAL OF OKLAHOMA MEDICAL LICENSE

JULY 1, 1992 TO JUNE 30, 1993

This form must be completed in full and returned with your fee. The annual renewal fee is $150.00 and must be paid on or before June 30, 1992. As of July 1, 1992 unrenewed licenses become inactive and may be reactivated upon payment of the reactivation fee of $275.00. After August 29, 1992 unrenewed licenses are suspended due to failure to renew. Reinstatement of a suspended license is $400.00, submittal of an application and evidence that certain requirements have been met.

MAILING ADDRESS

KATHLEEN ANN GLAZE, M.D.
1145 S UTICA AVE #462
TULSA, OK 74104-4018

COMPLETE BOTH SIDES OF THIS FORM. MAKE APPROPIATE CORRECTIONS TO THE INFORMATION AND ADD ANY MISSING INFORMATION TO PROTECT THE ACCURACY OF YOUR PUBLIC FILE.

NOTE: The information on this page is mandatory and renewal will NOT be accepted if incomplete or blank.

LICENSE NUMBER: 13761 SOCIAL SECURITY NUMBER: _____

I DO ☒ DO NOT ☐ WISH TO BE REGISTERED TO DISPENSE DANGEROUS DRUGS.

DISCIPLINARY ACTION: Have you ever been the subject of disiciplinary action by any Governmental or Licensing Authority, Federal, State, or Local? No

If yes, explain briefly: _____

PRACTICE ADDRESS

1145 S. UTICA

SUITE 462

TULSA, OK 74104

OTHER STATES IN WHICH YOU ARE OR HAVE BEEN LICENSED TO PRACTICE MEDICINE:

_____

_____

_____

_____

_____

_____

_____

_____

DO YOU WISH TO APPLY FOR PHYSICIAN EMERITUS (FULLY RETIRED) STATUS? YES ☐ NO ☒

IF "YES" :

A) ENCLOSE A $50.00 PROCESSING FEE. THERE WILL BE NO RENEWAL FEE.
B) RETURN TO THIS BOARD YOUR WALLET CARD. (A NEW CARD WILL BE ISSUED IDENTIFYING YOU AS PHYSICIAN EMERITUS.)

THE FOLLOWING RESTRICTIONS APPLY TO PHYSICAN EMERITUS (FULLY RETIRED PHYSICIANS).

A) YOU MAY CONTINUE TO USE THE TITLE "DOCTOR" AND THE SUFFIX "M.D.", BUT MUST INDICATE YOUR RETIRED STATUS. EXAMPLE: DOCTOR JOHN DOE, M.D. (RET.)
B) YOU CANNOT PRACTICE MEDICINE IN ANY FORM.
C) YOU CANNOT PRESCRIBE, DISPENSE OR ADMINISTER DRUGS.

APPLICATION FOR RENEWAL OF OKLAHOMA MEDICAL LICENSE

JULY 1, 1990 TO JUNE 30, 1991

This form must be completed in full and returned with your fee. The annual renewal fee is $100.00 and must be paid on or before June 30, 1990. As of July 1, 1990, unrenewed licenses become inactive and may be reactivated upon payment of the reactivation fee of $200.00. After August 29, 1990, unrenewed licenses are suspended. Reinstatement of a suspended license is $300.00, submittal of an application and evidence that certain requirements have been met.

MAILING ADDRESS

KATHLEEN ANN GLAZE, M.D.
1145 S UTICA AVE #462
TULSA, OK 74104-4018

PRACTICE ACTIVITY STATUS (X)

✓ Currently practicing
__ Not currently practicing
__ Retired
__ Semi-Retired 30 hrs or less/wk
__ Other (specify)

COMPLETE BOTH SIDES OF THIS FORM. MAKE APPROPRIATE CORRECTIONS TO THE INFORMATION AND ADD ANY MISSING INFORMATION TO PROTECT THE ACCURACY OF YOUR PUBLIC FILE.

LICENSE NUMBER: 13761 SOCIAL SECURITY NUMBER: _____

I DO____ DO NOT_____ WISH TO BE REGISTERED TO DISPENSE CONTROLLED DANGEROUS DRUGS.

SPECIALITIES:

1. Primary (greater than 50% time spent) OBSTETRICS AND GYNECOLOGY
2. _____ 3. _____

BOARD CERTIFICATIONS (CURRENT): Add Boards by exact name-give mailing address of Board Office.

AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

DISCIPLINARY ACTION: Have you ever been the subject of disciplinary action by any Governmental or Licensing Authority, Federal, State, or Local? NO If yes, explain briefly: _____

POST-GRADUATE TRAINING (CURRENT):

Type of training: _____ Hospital: _____
Location: _____
Date entered: _____ Date expected to complete: _____

PRACTICE INFORMATION (CURRENT):

Employer: PRIVATE PRACTICE
City, State/Country: TULSA, OKLAHOMA
Type of practice or specialty: OB-GYN Date started: 07/85

PRACTICE ADDRESS

1145 S. UTICA
SUITE 462
TULSA, OK 74104

OTHER STATES IN WHICH YOU ARE OR HAVE BEEN LICENSED TO PRACTICE MEDICINE:

RECEIVED
MAY 14 1990
OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

FORM BMEREG 01-90

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: 03-22-82
TIME: 2:25 PM

AME: GLAZE,KATHLEEN ANN, M.D.
DDRESS: 4012 E 42ND PLACE TULSA OK 74135
IRTHPLACE: OKLAHOMA,OK BIRTHDATE: 05/02/52
EDICAL EDUCATION (SCHOOL YEAR):
UNIV OF OKLAHOMA COLL MED,OKLAHOMA CITY OK 73104 1981
ATIONAL BOARD CERTIFICATION: NONE REPORTED TO DATE
ICENSES:
NONE REPORTED TO DATE
HYSICIAN'S PROFESSIONAL ACTIVITIES:
INTERN
RIMARY SPECIALTY: OBSTETRICS AND GYNECOLOGY
ECONDARY SPECIALTY: UNSPECIFIED
ERTIARY SPECIALTY: UNSPECIFIED
PECIALTY BOARD CERTIFICATION: NONE REPORTED TO DATE
EMBER OF AMA: 1981 ACTIVE MEMBER THRU OK
ATIONAL SCIENTIFIC MEDICAL SOCIETIES: NONE REPORTED TO DATE
ROFESSORIAL APPOINTMENT: NONE REPORTED TO DATE
URRENT MEDICAL TRAINING: INTERN
HOSPITAL: U OK-TULSA MED AFFIL HOSP TULSA OK 74114
DATES OF TRAINING: 07/81-06/85
SPECIALTY: OBSTETRICS AND GYNECOLOGY
SPECIALTY: UNSPECIFIED
NTERNSHIP:
NONE REPORTED TO DATE
ESIDENCY:
NONE REPORTED TO DATE

APPLICATION FOR RENEWAL OF OKLAHOMA MEDICAL LICENSE

July 2, 1999 TO July 1, 2000

This form must be completed in full and returned with your fee on or before July 1, 1999. The amount to be remitted is posted below. As of July 2, 1999 unrenewed licenses become inactive and are subject to suspension if not activated by Sep. 2, 1999. Reactivation fee is $275.00. Reinstatement of suspended license is $400.00.

PLEASE PAY THIS AMOUNT: $150.00 **TO RENEW THROUGH:** 07/01/2000

MAILING ADDRESS

KATHLEEN ANN GLAZE MD
1145 SOUTH UTICA AVENUE #514
TULSA OK 74104-4018

COMPLETE BOTH SIDES OF THIS FORM. MAKE APPROPRIATE CORRECTIONS TO THE INFORMATION AND ADD ANY MISSING INFORMATION TO PROTECT THE ACCURACY OF YOUR PUBLIC FILE.

NOTE: The information on this page is mandatory and renewal will NOT be accepted if incomplete or blank.

LICENSE NUMBER: 13761 SOCIAL SECURITY NUMBER: ___ ___ ____

PRACTICE ADDRESS:

1145 SOUTH UTICA AVENUE
SUITE 514
TULSA, OK 74104-4018

OTHER STATES IN WHICH YOU ARE OR HAVE BEEN LICENSED TO PRACTICE MEDICINE:

DO YOU WISH TO APPLY FOR PHYSICIAN EMERITUS (FULLY RETIRED) STATUS? YES ☐ NO ☒
IF "YES":

A) ENCLOSE A $50.00 PROCESSING FEE. THERE WILL BE NO RENEWAL FEE.
B) RETURN TO THIS BOARD YOUR WALLET CARD. (A NEW CARD WILL BE ISSUED IDENTIFYING YOU AS PHYSICIAN EMERITUS.)

THE FOLLOWING RESTRICTIONS APPLY TO PHYSICIAN EMERITUS (FULLY RETIRED PHYSICIANS).

A) YOU MAY CONTINUE TO USE THE TITLE "DOCTOR" AND THE SUFFIX "M.D.", BUT MUST INDICATE YOUR RETIRED STATUS. EXAMPLE: DOCTOR JOHN DOE, M.D. (RET.)
B) YOU CANNOT PRACTICE MEDICINE IN ANY FORM.
C) YOU CANNOT PRESCRIBE, DISPENSE OR ADMINISTER DRUGS.

THE FOLLOWING INFORMATION IS MANDATORY AND INFORMATION PROVIDED MAY BE INVESTIGATED FURTHER.

SINCE THE LAST RENEWAL OR INITIAL LICENSURE (WHICHEVER IS MOST RECENT)	YES	NO
HAVE YOU BEEN THE SUBJECT OF DISCIPLINARY ACTION BY ANY GOVERNMENTAL OR LICENSING AUTHORITY, FEDERAL, STATE, OR LOCAL?		✓
HAVE YOU BEEN CHARGED WITH OR CONVICTED OF A FELONY OR MISDEMEANOR? (DO NOT INCLUDE EXPUNGED INFORMATION)		✓
ARE YOU NOW USING ANY DRUG OR CHEMICAL SUBSTANCE INCLUDING ALCOHOL WHICH HAS AN ADVERSE IMPACT ON YOUR ABILITY TO PRACTICE MEDICINE AND SURGERY?		✓
DO YOU HAVE A MENTAL DISORDER WHICH HAS AN ADVERSE IMPACT ON YOUR ABILITY TO PRACTICE MEDICINE AND SURGERY?		✓
HAVE YOU BEEN REPORTED TO THE NATIONAL PRACTITIONER DATA BANK(NPDB)? IF YES, ENCLOSE A COPY OF THE REPORT RECEIVED FROM THE NPDB.		✓
HAVE YOU VOLUNTARILY SURRENDERED ANY MEDICAL LICENSE OR NARCOTIC PERMIT (STATE OR FEDERAL)?		✓
HAVE YOU BEEN DENIED PRIVILEGES, LOST PRIVILEGES OR RECEIVED DISCIPLINE BY ANY HOSPITAL OR OTHER PROFESSIONAL MEDICAL ORGANIZATION?		✓
HAS A MALPRACTICE CLAIM BEEN FILED AGAINST YOU?		✓
HAVE YOU HAD A MAJOR ILLNESS OR BEEN HOSPITALIZED WITHIN THE PAST YEAR?		✓

APPLICATION FOR RENEWAL OF OKLAHOMA MEDICAL LICENSE

July 2, 1998 TO July 1, 1999

This form must be completed in full and returned with your fee on or before July 1, 1998. The amount to be remitted is posted below. As of July 2, 1998 unrenewed licenses become inactive and are subject to suspension if not activated by Aug. 30, 1998. Reactivation fee is $275.00. Reinstatement of suspended licence is $400.00.

PLEASE PAY THIS AMOUNT: $150.00 **TO RENEW THROUGH:** 07/01/99

MAILING ADDRESS

KATHLEEN ANN GLAZE MD
1145 SOUTH UTICA AVENUE
SUITE 514
TULSA OK 74104-4018

COMPLETE BOTH SIDES OF THIS FORM. MAKE APPROPRIATE CORRECTIONS TO THE INFORMATION AND ADD ANY MISSING INFORMATION TO PROTECT THE ACCURACY OF YOUR PUBLIC FILE.

NOTE: The information on this page is manditory and renewal will NOT be accepted if incomplete or blank.

LICENSE NUMBER: 13761 SOCIAL SECURITY NUMBER: _____

PRACTICE ADDRESS:

1145 SOUTH UTICA AVENUE
SUITE 514
TULSA, OK 74104-4018

OTHER STATES IN WHICH YOU ARE OR HAVE BEEN LICENSED TO PRACTICE MEDICINE:

None

DO YOU WISH TO APPLY FOR PHYSICIAN EMERITUS (FULLY RETIRED) STATUS? YES ☐ NO ☒

IF "YES":

A) ENCLOSE A $50.00 PROCESSING FEE. THERE WILL BE NO RENEWAL FEE.
B) RETURN TO THIS BOARD YOUR WALLET CARD. (A NEW CARD WILL BE ISSUED IDENTIFYING YOU AS PHYSICIAN EMERITUS.)

THE FOLLOWING RESTRICTIONS APPLY TO PHYSICIAN EMERITUS (FULLY RETIRED PHYSICIANS).

A) YOU MAY CONTINUE TO USE THE TITLE "DOCTOR" AND THE SUFFIX "M.D.", BUT MUST INDICATE YOUR RETIRED STATUS. EXAMPLE: DOCTOR JOHN DOE, M.D. (RET.)
B) YOU CANNOT PRACTICE MEDICINE IN ANY FORM.
C) YOU CANNOT PRESCRIBE, DISPENSE OR ADMINISTER DRUGS.

THE FOLLOWING INFORMATION IS MANDATORY AND INFORMATION PROVIDED MAY BE INVESTIGATED FURTHER.

SINCE THE LAST RENEWAL OR INITIAL LICENSURE (WHICHEVER IS MOST RECENT)	YES	NO
HAVE YOU BEEN THE SUBJECT OF DISCIPLINARY ACTION BY ANY GOVERNMENTAL OR LICENSING AUTHORITY, FEDERAL, STATE, OR LOCAL?		X
HAVE YOU BEEN CHARGED WITH OR CONVICTED OF A FELONY OR MISDEMEANOR? (DO NOT INCLUDE EXPUNGED INFORMATION)		X
ARE YOU NOW USING ANY DRUG OR CHEMICAL SUBSTANCE INCLUDING ALCOHOL WHICH HAS AN ADVERSE IMPACT ON YOUR ABILITY TO PRACTICE MEDICINE AND SURGERY?		X
DO YOU HAVE A MENTAL DISORDER WHICH HAS AN ADVERSE IMPACT ON YOUR ABILITY TO PRACTICE MEDICINE AND SURGERY?		X
HAVE YOU BEEN REPORTED TO THE NATIONAL PRACTITIONER DATA BANK(NPDB)? IF YES, ENCLOSE A COPY OF THE REPORT RECEIVED FROM THE NPDB.		X
HAVE YOU VOLUNTARILY SURRENDERED ANY MEDICAL LICENSE OR NARCOTIC PERMIT (STATE OR FEDERAL)?		X
HAVE YOU BEEN DENIED PRIVILEGES, LOST PRIVILEGES OR RECEIVED DISCIPLINE BY ANY HOSPITAL OR OTHER PROFESSIONAL MEDICAL ORGANIZATION?		X
HAS A MALPRACTICE CLAIM BEEN FILED AGAINST YOU?		X
HAVE YOU HAD A MAJOR ILLNESS OR BEEN HOSPITALIZED WITHIN THE PAST YEAR?		X

APPLICATION FOR RENEWAL OF OKLAHOMA MEDICAL LICENSE

July 2, 1997 TO July 1, 1998

This form must be completed in full and returned with your fee on or before July 1, 1997. The amount to be remitted is posted below. As of July 2, 1997 unrenewed licenses become inactive and are subject to suspension if not activated by Aug. 30, 1997. Reactivation fee is $275.00. Reinstatement of suspended licence is $400.00.

PLEASE PAY THIS AMOUNT: $150.00 **TO RENEW THROUGH:** 07/01/98

MAILING ADDRESS

KATHLEEN ANN GLAZE MD
1145 SOUTH UTICA AVENUE
SUITE 514
TULSA OK 74104-4018

COMPLETE BOTH SIDES OF THIS FORM. MAKE APPROPRIATE CORRECTIONS TO THE INFORMATION AND ADD ANY MISSING INFORMATION TO PROTECT THE ACCURACY OF YOUR PUBLIC FILE.

NOTE: The information on this page is manditory and renewal will NOT be accepted if incomplete or blank.

LICENSE NUMBER: 13761 SOCIAL SECURITY NUMBER: _____

DISCIPLINARY ACTION: Have you ever been the subject of disciplinary action by any governmental or Licensing Authority, Federal, State, or Local? No
If yes, explain briefly. _____

PRACTICE ADDRESS:

1145 SOUTH UTICA AVENUE
SUITE 514
TULSA, OK 74104-4018

OTHER STATES IN WHICH YOU ARE OR HAVE BEEN LICENSED TO PRACTICE MEDICINE:

DO YOU WISH TO APPLY FOR PHYSICIAN EMERITUS (FULLY RETIRED) STATUS? YES ☐ NO ☒
IF "YES":
A) ENCLOSE A $50.00 PROCESSING FEE. THERE WILL BE NO RENEWAL FEE.
B) RETURN TO THIS BOARD YOUR WALLET CARD. (A NEW CARD WILL BE ISSUED IDENTIFYING YOU AS PHYSICIAN EMERITUS.)

THE FOLLOWING RESTRICTIONS APPLY TO PHYSICIAN EMERITUS (FULLY RETIRED PHYSICIANS).
A) YOU MAY CONTINUE TO USE THE TITLE "DOCTOR" AND THE SUFFIX "M.D.", BUT MUST INDICATE YOUR RETIRED STATUS. EXAMPLE: DOCTOR JOHN DOE, M.D. (RET.)
B) YOU CANNOT PRACTICE MEDICINE IN ANY FORM.
C) YOU CANNOT PRESCRIBE, DISPENSE OR ADMINISTER DRUGS.

THE FOLLOWING INFORMATION IS MANDATORY AND INFORMATION PROVIDED MAY BE INVESTIGATED FURTHER. YES ANSWERS REQUIRE A NOTARIZED, DETAILED STATEMENT.

SINCE THE LAST RENEWAL OR INITIAL LICENSURE (WHICHEVER IS MOST RECENT)	YES	NO
HAVE YOU BEEN CONVICTED OF A FELONY OR MISDEMEANOR?		X
ARE YOU NOW USING ANY DRUG OR CHEMICAL SUBSTANCE INCLUDING ALCOHOL WHICH HAS AN ADVERSE IMPACT ON YOUR ABILITY TO PRACTICE MEDICINE AND SURGERY?		X
DO YOU HAVE A MENTAL DISORDER WHICH HAS AN ADVERSE IMPACT ON YOUR ABILITY TO PRACTICE MEDICINE AND SURGERY?		X
HAVE YOU BEEN REPORTED TO THE NATIONAL PRACTITIONER DATA BANK(NPDB)? IF YES, ENCLOSE A COPY OF THE REPORT RECEIVED FROM THE NPDB.		X
HAVE YOU VOLUNTARILY SURRENDERED ANY MEDICAL LICENSE OR NARCOTIC PERMIT (STATE OR FEDERAL)?		X
HAVE YOU BEEN DENIED PRIVILEGES, LOST PRIVILEGES OR RECEIVED DISCIPLINE BY ANY HOSPITAL OR OTHER PROFESSIONAL MEDICAL ORGANIZATION?		X
HAS A MALPRACTICE CLAIM BEEN FILED AGAINST YOU?		X
HAVE YOU HAD A MAJOR ILLNESS OR BEEN HOSPITALIZED WITHIN THE PAST YEAR?		X

MDAA01 12-16-96 ABR

APPLICATION FOR RENEWAL OF OKLAHOMA MEDICAL LICENSE

July 2, 1996 TO July 1, 1997

This form must be completed in full and returned with your fee on or before July 1, 1996. The amount to be remitted is posted below. As of July 2, 1996 unrenewed licenses become inactive and are subject to suspension if not reactivated by Aug. 30, 1996. Reactivation fee is $275.00. Reinstatement of suspended license is $400.00.

PLEASE PAY THIS AMOUNT: $150.00 **TO RENEW THROUGH:** 07/01/97

MAILING ADDRESS

KATHLEEN ANN GLAZE, M.D.
1145 SOUTH UTICA AVENUE
SUITE 514
TULSA, OK 74104-4018

COMPLETE BOTH SIDES OF THIS FORM. MAKE APPROPRIATE CORRECTIONS TO THE INFORMATION AND ADD ANY MISSING INFORMATION TO PROTECT THE ACCURACY OF YOUR PUBLIC FILE.

NOTE: The information on this page is mandatory and renewal will NOT be accepted if incomplete or blank.

LICENSE NUMBER: 13761 SOCIAL SECURITY NUMBER: _____

DISCIPLINARY ACTION: Have you ever been the subject of disciplinary action by any Governmental or Licensing Authority, Federal, State, or Local? No
If yes, explain briefly: _____

PRACTICE ADDRESS

1145 SOUTH UTICA AVENUE
SUITE 514
TULSA, OK 74104-4018

OTHER STATES IN WHICH YOU ARE OR HAVE BEEN LICENSED TO PRACTICE MEDICINE:

DO YOU WISH TO APPLY FOR PHYSICIAN EMERITUS (FULLY RETIRED) STATUS? YES ☐ NO ☒
IF "YES":

A) ENCLOSE A $50.00 PROCESSING FEE. THERE WILL BE NO RENEWAL FEE.
B) RETURN TO THIS BOARD YOUR WALLET CARD. (A NEW CARD WILL BE ISSUED IDENTIFYING YOU AS PHYSICIAN EMERITUS.)

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C) YOU CANNOT PRESCRIBE, DISPENSE OR ADMINISTER DRUGS.

THE FOLLOWING INFORMATION IS MANDATORY AND INFORMATION PROVIDED MAY BE INVESTIGATED FURTHER. YES ANSWERS REQUIRE A NOTARIZED, DETAILED STATEMENT.

SINCE THE LAST RENEWAL OR INITIAL LICENSURE (WHICHEVER IS MOST RECENT)	YES	NO
HAVE YOU BEEN CONVICTED OF A FELONY OR MISDEMEANOR?		X
ARE YOU NOW USING ANY DRUG OR CHEMICAL SUBSTANCE INCLUDING ALCOHOL WHICH HAS AN ADVERSE IMPACT ON YOUR ABILITY TO PRACTICE MEDICINE AND SURGERY?		X
DO YOU HAVE A MENTAL DISORDER WHICH HAS AN ADVERSE IMPACT ON YOUR ABILITY TO PRACTICE MEDICINE AND SURGERY?		X
HAVE YOU BEEN REPORTED TO THE NATIONAL PRACTITIONER DATA BANK(NPDB)? IF YES, ENCLOSE A COPY OF THE REPORT RECEIVED FROM THE NPDB.		X
HAVE YOU VOLUNTARILY SURRENDERED ANY MEDICAL LICENSE OR NARCOTIC PERMIT (STATE OR FEDERAL)?		X
HAVE YOU BEEN DENIED PRIVILEGES, LOST PRIVILEGES OR RECEIVED DISCIPLINE BY ANY HOSPITAL OR OTHER PROFESSIONAL MEDICAL ORGANIZATION?		X
HAS A MALPRACTICE CLAIM BEEN FILED AGAINST YOU?		X
HAVE YOU HAD A MAJOR ILLNESS OR BEEN HOSPITALIZED WITHIN THE PAST YEAR?		X

RENAPP 12-18-96 AM

APPLICATION FOR RENEWAL OF OKLAHOMA MEDICAL LICENSE

1995 TO 1996

This form must be completed in full and returned with your fee on or before June 30, 1995. The amount to be remitted is posted below. As of July 1, 1995 unrenewed licenses become inactive and are subject to suspension if not reactivated by August 29, 1995. Reactivation fee is $275.00.

PLEASE PAY THIS AMOUNT: $150.00 **TO RENEW THROUGH:** 07/01/96

MAILING ADDRESS

KATHLEEN ANN GLAZE, M.D.
1145 SOUTH UTICA AVENUE
SUITE 514
TULSA, OK 74104-4018

COMPLETE BOTH SIDES OF THIS FORM. MAKE APPROPRIATE CORRECTIONS TO THE INFORMATION AND ADD ANY MISSING INFORMATION TO PROTECT THE ACCURACY OF YOUR PUBLIC FILE.

NOTE: The information on this page is mandatory and renewal will NOT be accepted if incomplete or blank.

LICENSE NUMBER: 13761 SOCIAL SECURITY NUMBER: ___ -- ____

DISCIPLINARY ACTION: Have you ever been the subject of disciplinary action by any Governmental or Licensing Authority, Federal, State, or Local? No
If yes, explain briefly: _____

PRACTICE ADDRESS

1145 SOUTH UTICA AVENUE
SUITE 514
TULSA, OK 74104-4018

OTHER STATES IN WHICH YOU ARE OR HAVE BEEN LICENSED TO PRACTICE MEDICINE:

RECEIVED
95 JUL 26 AM 9:53
OK STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

DO YOU WISH TO APPLY FOR PHYSICIAN EMERITUS (FULLY RETIRED) STATUS? YES ☐ NO ☒
IF "YES":

A) ENCLOSE A $50.00 PROCESSING FEE. THERE WILL BE NO RENEWAL FEE.
B) RETURN TO THIS BOARD YOUR WALLET CARD. (A NEW CARD WILL BE ISSUED IDENTIFYING YOU AS PHYSICIAN EMERITUS.)

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B) YOU CANNOT PRACTICE MEDICINE IN any FORM.
C) YOU CANNOT PRESCRIBE, DISPENSE OR ADMINISTER DRUGS.

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SINCE THE LAST RENEWAL OR INITIAL LICENSURE (WHICHEVER IS MOST RECENT)	YES	NO
HAVE YOU BEEN CONVICTED OF A FELONY OR MISDEMEANOR?		✓
ARE YOU NOW USING ANY DRUG OR CHEMICAL SUBSTANCE INCLUDING ALCOHOL WHICH HAS AN ADVERSE IMPACT ON YOUR ABILITY TO PRACTICE MEDICINE AND SURGERY?		✓
DO YOU HAVE A MENTAL DISORDER WHICH HAS AN ADVERSE IMPACT ON YOUR ABILITY TO PRACTICE MEDICINE AND SURGERY?		✓
HAVE YOU BEEN REPORTED TO THE NATIONAL PRACTITIONER DATA BANK(NPDB)? IF YES, ENCLOSE A COPY OF THE REPORT RECEIVED FROM THE NPDB.		✓
HAVE YOU VOLUNTARILY SURRENDERED ANY MEDICAL LICENSE OR NARCOTIC PERMIT (STATE OR FEDERAL)?		✓
HAVE YOU BEEN DENIED PRIVILEGES, LOST PRIVILEGES OR RECEIVED DISCIPLINE BY ANY HOSPITAL OR OTHER PROFESSIONAL MEDICAL ORGANIZATION?		✓
HAS A MALPRACTICE CLAIM BEEN FILED AGAINST YOU?		✓
HAVE YOU HAD A MAJOR ILLNESS OR BEEN HOSPITALIZED WITHIN THE PAST YEAR?		✓

93

APPLICATION FOR ENDORSEMENT

Oklahoma State Board of Medical Examiners

(Read Entire Blank Carefully)

(FOR OFFICE USE ONLY)
Name
Application Requested
Application Sent

PRINT OR TYPE ANSWERS TO ALL QUESTIONS ON THIS FORM IN FULL

License Certificate No. 252969 having been issued to me by the National Board of Medical Examiners OR the Board of Medical Examiners for the State of on the 1st day of July, 1982,

I hereby apply for license to practice Medicine and Surgery in the State of Oklahoma, and submit the following statement of facts:

1. My name in full Kathleen Ann Glaze. (First, middle and last name must be given), Age 29
2. My nationality is U.S.A. and I speak and write the English language.
3. My present post office address is 4012 E. 42nd Place, Tulsa (Street and City), State of Oklahoma
4. I was born at Oklahoma City, on the 2nd day of May, 1952
5. I intend to locate at Tulsa Medical College, in Tulsa County.
6. Type of Practice Resident / Obstetrics & Gynecology - PG II

Specialty Certification Member Spec. Board

Basic Science Exam. Yes X No Where OU - College of Medicine

Military Commission (Active Service) (Rank and Branch) From To

Height 5'7" Weight 145 lbs Race C Complexion fair

Color Hair Blonde (Strawberry) Color Eyes Blue Marks or Scars none

PRE-MEDICAL EDUCATION

7. HIGHSCHOOL Muskogee Central
CITY Muskogee STATE Okla
FROM 1967 TO 1970

HIGHSCHOOL
CITY STATE
FROM TO
DATE OF GRAD
REMARKS

8. PRE-MED. COLLEGE Randolph-Macon Woman's College
CITY Lynchburg STATE Va.
FROM 1970 TO 72 1973-74
REMARKS (A.B. / Biology)

PRE-MED. COLLEGE Davidson College
CITY Davidson STATE N.C.
FROM 1972 TO 1973
DEGREE Exchange student
REMARKS

INTERNSHIP

11. HOSP TMC - affiliated hosp.
CITY Tulsa STATE Okla.
FROM 7/1/81 TO 6/31/82
SPECIAL WORK OB-Gyn PG-I

POST GRAD. COLLEGE Wake Forest Univ.
CITY Winston-Salem STATE N. Carolina
FROM 1974 TO 1976
REMARKS (Bowman Gray Sch. of Med) B.S. - Anatomy

12. RESIDENCY OR FELLOWSHIP

HOSP
CITY STATE
FROM TO
SPECIAL WORK

RESIDENCY OR FELLOWSHIP, CONT.

HOSP
CITY STATE
FROM TO
SUPERVISOR
SPECIAL WORK

HOSP
CITY STATE
FROM TO
SUPERVISOR
SPECIAL WORK

HOSP
CITY STATE
FROM TO
SUPERVISOR
SPECIAL WORK

9. **MEDICAL EDUCATION** (Give exact dates)

First Year From 8/29, 1977, to 6/2, 1978, in OU - Med College
Second Year From 8/28, 1978, to 6/1, 1979, in OU - Med College
Third Year From 7/12, 1979, to 7/9, 1980, in OU - TMC College
Fourth Year From 7/10, 1980, to 6/5, 1981, in OU - TMC College

10. **THE DEGREE**, Doctor of Medicine was conferred on me by the University of Oklahoma, College of Medicine the 7th day of June, 1981

13. **PRACTICE RECORD**

FROM	TO	CITY	STATE	CLINIC HOSP. GOVT. OR STATE AGENCIES OR NON-PROFIT ORG.	TYPE PRACTICE

17. RECOMMENDATION OF COUNTY MEDICAL SOCIETY.

We, the undersigned, President and Secretary of the _____ County Medical Society, Certify that _____ (Full Name of Applicant) is personally known to us, and that he/she is an ethical practitioner and is of good moral and professional character.

We further certify that the said Dr. _____ has been engaged in the reputable practice of medicine in the State of _____ for _____ years immediately preceding the date of this application and that he/she has never been an itinerant or advertising doctor during the period he/she has practiced in this State. We have carefully reviewed all the statements made by the applicant herein and believe them to be true in every respect.

We also certify that the attached photograph is a likeness of the said Dr. _____.

We hereby recommend said applicant for license to practice medicine in the State of Oklahoma.

_____ President.

_____ Secretary.

The applicant must answer the following questions:

18. 1. Has your application for examination or for license been rejected by any State Board? No
If yes, by what Board and for what reason? _____

2. Have you failed in examination before any State Board? No. If you have, name the Board and give date of the Examination _____

3. Has any State Board ever suspended or revoked a License it had granted to you? No. If yes, name the Board, and say why such action was taken _____

4. Do you intend to become a resident of Oklahoma? I am currently an Okla. State resident.

5. Are you now or have you ever been directly or indirectly associated with an advertising physician or an advertising medical office? NO. If you have, state when and where _____

6. If granted license, do you agree to avoid such associations and practice in Oklahoma? _____

7. Have you ever been convicted of a felony or of a violation of a State or Federal medical or narcotic law? No. If you have, give particulars _____

8. Do you understand that if issued the license asked for, it will be on the truth of the statement contained herein, which if false will subject you to criminal prosecution? Yes

9. Are you now or have you ever been addicted to the excessive use of alcohol, narcotics, barbiturates, or habit-forming drugs? No. If answer is yes, explain fully in sworn affidavit.

10. Are you now or have you ever been emotionally or mentally ill? NO

11. Have you ever been a patient (voluntarily or otherwise) in any institution for the treatment of mental or emotional illness, drug addiction, or inebriety? NO. If the answer is yes, give details, including dates, names and locations of the institutions and names and addresses of physicians who treated you, and written authorization for release of such information to this Board by such physicians and/or institutions.

12. Have you ever been treated, but not hospitalized for mental or emotional illness, drug addiction, or inebriety? No. If answer is yes, give details, dates, and names and addresses of physicians who treated you, together with written authorization for release of such information to this Board by such physicians.

13. Have you ever been indicted or charged with the commission of a crime? NO. If answer is yes, state where and whether you were convicted, fined, placed on probation, or exonerated. Have you ever been involved in court action, either as a plaintiff or defendant? No. If answer is yes, explain fully in sworn affidavit. Have you ever been charged with any crime or law violation in any way relative to your medical practice? NO. If answer is yes, explain fully in a sworn affidavit.

14. Have you ever been called before or warned by a Narcotic Enforcement Agency (Federal or State)? NO
If answer is yes, explain fully in sworn affidavit.

15. Have you ever surrendered your Narcotic Tax Stamp? No. If answer is yes, explain fully in sworn affidavit.

16. Have you ever been denied membership in any County Medical Society No. If answer is yes, explain fully in sworn affidavit.

17. Have you ever been denied Staff Membership in any hospital? NO. If answer is yes, explain fully in sworn affidavit.

18. Have you ever been warned, or censured by, or requested to withdraw from any hospital? No
If answer is yes, explain fully in sworn affidavit.

19. List of hospitals and addresses where you have staff privileges:
NONE

19. I hold, or have held, licenses in the following States: NONE

20. APPLICANT'S OATH.

STATE OF Oklahoma }
County of Tulsa } ss.

I, Kathleen A Glaze M.D., hereby certify under oath that I am the person named in this application for license to practice medicine and surgery in the State of Oklahoma, that all statements I have made herein are true; that I am the person named in the Medical Diploma or photographic reproduction thereof submitted herewith, as a credential, and that I am the original and the lawful possessor of said diploma; that the photograph attached to this application is a true resemblance of me and that it was made within the last sixty days; that, in consideration of the issuance to me of a license to practice medicine and surgery in the State of Oklahoma, I hereby pledge that I shall abstain from deceptive or fraudulent methods of practice and from immoral, unprofessional and unethical conduct; if granted license to practice in Oklahoma, to abstain from professional association with, or acting as a shield for, an unlicensed practitioner or other person; and I hereby agree that violation of this pledge shall constitute cause for the revocation of my medical license and the withdrawal of the rights and privileges that accrued to me thereunder.

Kathleen A. Glaze, Applicant.
(Full Name)

Subscribed and sworn to before me, this 1 day of March, 1982

(SEAL)

Connie T. Davis
Notary Public.

My commission expires on the 18 day of February, 1984

21. The applicant must paste an unmounted photograph of himself, or herself, in the space below. It must carry the signature of the Dean or Registrar of his or her Medical School or State Board Secretary, properly certified before a Notary Public, that the applicant is known to him and that it is a recent photograph of the applicant, or that it is a true likeness of applicant's photograph on file in that office. (If neither is possible, photograph may be taken before a Notary Public for certification).

Kathleen Glaze, M.D.

State of Oklahoma } ss.
County of Tulsa }

This is to certify that the above is a correct likeness of Dr. Kathleen A. Glaze M.D. whose name appears elsewhere on this application.

Dean/Registrar/Secretary.

Subscribed and sworn to before me, a Notary Public, in and for Tulsa County, State of Oklahoma, on this 1 day of March, 1982.

Connie J. Adams
Notary Public.

My Commission expires 2-18-84
(Seal)

NOTE: Seal of the school or Medical Board may be affixed on picture in lieu of Notarization.

Oklahoma State Board
MEDICAL EXAMINERS

For Use of Secretary Only

Kathleen Ann Glaze
(Full name of applicant)

Tulsa, Okla.
(Present Address of Applicant)

Application for Certificate Through Endorsement.

With National Board

State Certificate No. 252969

Granted 7-1-82

Application received 3-11 1982

Fee, $100.00 paid 3-11 1982

Approved 5-13 1982
Rejected
Withdrawn

Fee returned 19

Certificate Issued 7-1 1982

No. 13761

Sent

By

NOTE—If not a member of Medical Society or State Association explain why and furnish at least three (3) letters from reputable physicians duly licensed, as to character, professional standing, etc.

22. CERTIFICATE FROM THE SECRETARY OF THE STATE MEDICAL ASSOCIATION.

I hereby certify that the records of my office show that Dr. _____, of _____, has been a member in good standing of the _____ State Medical Association for the past _____ years, and that he/she is now in good standing.

Given under my hand and the seal of the _____ State Medical _____ this _____ day of _____, 19____.

(SEAL)

Secretary _____ State Medical Association,

Address _____

The reciprocity fee is $100.00 which must accompany application. In case of rejection, $85.00 will be refunded.

A 6x8-inch photographic or photostatic reproduction of your Medical Diploma must accompany application for the office file.

Applicant must supply a certified photograph of himself/herself as directed on this application.

Applicants may be required to appear before the Board in person at the discretion of the Board.

Applicant is required to submit letters from the Chief-of-Staff [illegible] Service of any hospital where he/she has trained or is in training; also, any hospital or clinic in which he/she has privileges or practices.

Applicants who graduated in 1933 and thereafter must show evidence of one-year of approved postgraduate training. A 6x8-inch photo of postgraduate certificate must accompany application.

A photostatic copy of discharge from military service must accompany this application.

Address all communications and make all remittances payable to: BOARD OF MEDICAL EXAMINERS, Oklahoma City, Oklahoma.

If license is issued, please mail it to me at 4012 E. 42nd Place
(Street or P.O. Box No.)

Tulsa (City), Oklahoma 74135 (State)

STATE BOARD OF MEDICAL EXAMINERS
P.O. Box 18256 — 5104 N. Francis
Oklahoma City, Oklahoma 73154

14. HEALTH CERTIFICATE.

I, Theresa Farden, M.D., a legally qualified physician in the state of Oklahoma, hereby certify that I have made a careful physical examination of Dr. Kathleen Slagle, whom I know to be the identical person making the above and foregoing application for license to practice medicine in the State of Oklahoma, and it is my opinion that he/she is in good, general health and is physically and mentally able to safely engage in the practice of medicine.

15. COPY OF LICENSE UPON WHICH ENDORSEMENT IS ASKED.

(A photostatic or typewritten copy of license upon which Endorsement is based must appear in space below.)

---

16. CERTIFICATE OF SECRETARY.

I, _____, Secretary of the _____ Board of
(State or National)

_____, hereby certify that the foregoing transcript is a true and correct copy of

Certificate or Medical License No. _____, issued to Dr. _____, of

_____ upon the following qualifications: _____ and a Diploma from
(Approved college or examination)

_____ dated the _____ day of _____, 19____
(Name of Medical College)

and that on the _____ days of _____ 19____, in his/her written examination before this Board made a general average of _____ per cent, as shown by the following items:

SUBJECT	GRADE	SUBJECT	GRADE

I further certify that this License has never been Suspended or Revoked and that there are no charges of Unprofessional or Unethical Conduct now pending against the holder of said Certificate and that, so far as the records of this office show, Dr. _____ is justly entitled to receive this Endorsement to the Board of Medical Examiners of the State of Oklahoma.

Given under my hand and seal this _____ day of _____, 19____.

(SEAL)

_____, M.D.

Secretary _____ Board of _____

Address _____

SPECIALTIES:

1. Primary (greater than 50% time spent) GYNECOLOGY
2. _____ 3. _____

BOARD CERTIFICATIONS (CURRENT): Add Boards by exact name.

AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

CURRENT POST-GRADUATE TRAINING:

Type of training: _____ Hospital: _____
Location: _____
Date entered: _____ Date expected to complete: _____

CURRENT PRACTICE INFORMATION:

Employer: PRIVATE PRACTICE
City, State/Country: TULSA, OKLAHOMA
Type of practice or specialty: GYNECOLOGY
Date started: 07/85

PLEASE INDICATE BELOW HOW THE MAJORITY OF YOUR TIME IS SPENT:

PRIMARY PRACTICE TYPE (Check only one)

- [x] Solo Practice
- [ ] Group or Partnership
- [ ] Medical School
- [ ] Hospital Based(Name) _____
- Federal Government:
  - [ ] Military Service
  - [ ] Civil Service
  - [ ] Veterans Administration
  - [ ] Indian Health Service
  - [ ] Public Health Service
- [ ] State Government
- [ ] County Government
- [ ] Local Government
- [ ] Other (Specify) _____

PRIMARY PRACTICE SETTING (Check only one)

- [x] Office/Clinic
- [ ] Hospital Staff(Name) _____
- [ ] Resident/Training
- [ ] Nursing Home Staff
- [ ] Medical Teaching
- [ ] Administration
- [ ] Research
- [ ] Other (Specify) _____

PRACTICE ACTIVITY STATUS (X)

- [x] Currently practicing
- [ ] Not currently practicing
- [ ] Retired
- [ ] Semi-Retired (30 hrs/week or less)
- [ ] Other (Specify) _____

HAVE YOU PRACTICED MEDICINE GREATER THAN 50% OF THE TIME SINCE JULY 1, 1994? YES
TOTAL AMOUNT OF TIME SPENT IN PRACTICE 60 (hours per week)
WHAT PERCENT OF YOUR TIME DO YOU SPEND IN DIRECT PATIENT CARE IN AN AVERAGE WEEK? 80%

If you are practicing in OKLAHOMA, please list the hospitals at which you are currently a member of the staff. When indicating status, please use one of the following: ACTIVE, INACTIVE, RESTRICTED, COURTESY, OTHER.

FACILITY/LOCATION: Hillcrest Medical Center Tulsa OK STATUS: Active
FACILITY/LOCATION: St. John Med. Center Tulsa OK STATUS: Courtesy
FACILITY/LOCATION: _____ STATUS: _____
FACILITY/LOCATION: _____ STATUS: _____

You are required pursuant to 59O.S. S.S.355.1(B) to indicate your preference. Please read and check the appropriate box.

Any medical doctor who desires to DISPENSE "dangerous drugs" as defined in the Pharmacy Law, must register annually with the Board. This is for dispensing only and does not include prescribing, administering, or the giving of samples.

I DO ☐ DO NOT ☒ WISH TO BE REGISTERED TO DISPENSE DANGEROUS DRUGS

I certify that all information on this form is accurate and descriptive of my professional activities.

NAME OF PHYSICIAN: Kathleen A. GLAZE MD
(Print or Type)

SIGNATURE: Kathleen A Glaze MD DATE: 6/21/95

MAIL APPLICATION TO: Oklahoma State Board of Medical Licensure and Supervision
P. O. Box 18256 Oklahoma City, Oklahoma 73154-0256
Telephone Number (405) 848-6841

SPECIALTIES:

1. Primary (greater than 50% time spent) GYNECOLOGY
2. _____ 3. _____

BOARD CERTIFICATIONS (CURRENT): Add Boards by exact name.

AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

CURRENT POST-GRADUATE TRAINING:

Type of training: _____ Hospital: _____

Location: _____

Date entered: _____ Date expected to complete: _____

CURRENT PRACTICE INFORMATION:

Employer: PRIVATE PRACTICE

City, State/Country: TULSA, OKLAHOMA

Type of practice or specialty: GYNECOLOGY

Date started: 07/85

PLEASE INDICATE BELOW HOW THE MAJORITY OF YOUR TIME IS SPENT:

PRIMARY PRACTICE TYPE (Check only one)

- [X] Solo Practice
- [ ] Group or Partnership
- [ ] Medical School
- [ ] Hospital Based(Name) _____
- Federal Government:
  - [ ] Military Service
  - [ ] Civil Service
  - [ ] Veterans Administration
  - [ ] Indian Health Service
  - [ ] Public Health Service
- [ ] State Government
- [ ] County Government
- [ ] Local Government
- [ ] Other
  (Specify) _____

PRIMARY PRACTICE SETTING (Check only one)

- [ ] Office/Clinic
- [ ] Hospital Staff(Name) _____
- [ ] Resident/Training
- [ ] Nursing Home Staff
- [ ] Medical Teaching
- [ ] Administration
- [ ] Research
- [ ] Other
  (Specify) _____

PRACTICE ACTIVITY STATUS (X)

- [X] Currently practicing
- [ ] Not currently practicing
- [ ] Retired
- [ ] Semi-Retired (30 hrs/week or less)
- [ ] Other
  (Specify) _____

HAVE YOU PRACTICED MEDICINE GREATER THAN 50% OF THE TIME SINCE JULY 1, 1994? yes

TOTAL AMOUNT OF TIME SPENT IN PRACTICE [50] (hours per week)

WHAT PERCENT OF YOUR TIME DO YOU SPEND IN DIRECT PATIENT CARE IN AN AVERAGE WEEK? [80%]

If you are practicing in OKLAHOMA, please list the hospitals at which you are currently a member of the staff. When indicating status, please use one of the following: ACTIVE, INACTIVE, RESTRICTED, COURTESY, OTHER.

FACILITY/LOCATION: Hillcrest Medical Center STATUS: Active

FACILITY/LOCATION: St. John Medical Center STATUS: Courtesy

FACILITY/LOCATION: _____ STATUS: _____

FACILITY/LOCATION: _____ STATUS: _____

You are required pursuant to 59O.S. S.S.355.1(B) to indicate your preference. Please read and check the appropriate box.

Any medical doctor who desires to DISPENSE "dangerous drugs" as defined in the Pharmacy Law, must register annually with the Board. This is for dispensing only and does not include prescribing, administering, or the giving of samples.

I DO [ ] DO NOT [X] WISH TO BE REGISTERED TO DISPENSE DANGEROUS DRUGS

I certify that all information on this form is accurate and descriptive of my professional activities.

NAME OF PHYSICIAN: Kathleen A. Glaze MD
(Print or Type)

SIGNATURE: Kathleen A. Glaze MD DATE: 4/26/96

MAIL APPLICATION TO: Oklahoma State Board of Medical Licensure and Supervision
P. O. Box 18256 Oklahoma City, Oklahoma 73154-0256
Telephone Number (405) 848-6841

SPECIALTIES:

1. Primary (greater than 50% time spent) GYNECOLOGY
2. _____ 3. _____

BOARD CERTIFICATIONS (CURRENT): Add Boards by exact name.

AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

CURRENT POST-GRADUATE TRAINING:

Type of training: _____ Hospital: _____
Location: _____
Date entered: _____ Date expected to complete: _____

CURRENT PRACTICE INFORMATION:

Employer: PRIVATE PRACTICE
City, State/Country: TULSA, OKLAHOMA
Type of practice or specialty: GYNECOLOGY
Date started: 07/85

PLEASE INDICATE BELOW HOW THE MAJORITY OF YOUR TIME IS SPENT:

PRIMARY PRACTICE TYPE (Check only one)

- [X] Solo Practice
- [ ] Group or Partnership
- [ ] Medical School
- [ ] Hospital Based(Name) _____
  - Federal Government:
    - [ ] Military Service
    - [ ] Civil Service
    - [ ] Veterans Administration
    - [ ] Indian Health Service
    - [ ] Public Health Service
- [ ] State Government
- [ ] County Government
- [ ] Local Government
- [ ] Other
  (Specify) _____

PRIMARY PRACTICE SETTING (Check only one)

- [X] Office/Clinic
- [ ] Hospital Staff(Name) _____
- [ ] Resident/Training
- [ ] Nursing Home Staff
- [ ] Medical Teaching
- [ ] Administration
- [ ] Research
- [ ] Other
  (Specify) _____

PRACTICE ACTIVITY STATUS (X)

- [X] Currently practicing
- [ ] Not currently practicing
- [ ] Retired
- [ ] Semi-Retired (30 hrs/week or less)
- [ ] Other
  (Specify) _____

HAVE YOU PRACTICED MEDICINE GREATER THAN 50% OF THE TIME SINCE LAST RENEWAL? Yes
TOTAL AMOUNT OF TIME SPENT IN PRACTICE [60] (hours per week)
WHAT PERCENT OF YOUR TIME DO YOU SPEND IN DIRECT PATIENT CARE IN AN AVERAGE WEEK? [80 %]

If you are practicing in OKLAHOMA, please list the hospitals at which you are currently a member of the staff. When indicating status, please use one of the following: ACTIVE, INACTIVE, RESTRICTED, COURTESY, OTHER.

FACILITY/LOCATION: Hillcrest Medical Center Tulsa OK STATUS: Active
FACILITY/LOCATION: St John Med. Center Tulsa OK STATUS: Courtesy
FACILITY/LOCATION: _____ STATUS: _____
FACILITY/LOCATION: _____ STATUS: _____

You are required pursuant to 59O.S. S.S.355.1(B) to indicate your preference. Please read and check the appropriate box.

Any medical doctor who desires to DISPENSE "dangerous drugs" as defined in the Pharmacy Law, must register annually with the Board. This is for dispensing only and does not include prescribing, administering, or the giving of samples.

I DO ☐ DO NOT ☒ WISH TO BE REGISTERED TO DISPENSE DANGEROUS DRUGS

I certify that all information on this form is accurate and descriptive of my professional activities.

NAME OF PHYSICIAN: Kathleen A. Glaze M.D.
(Print or Type)

SIGNATURE: Kathleen A Glaze MD DATE: 5/15/97

MAIL APPLICATION TO: Oklahoma State Board of Medical Licensure and Supervision
P. O. Box 18256 Oklahoma City, Oklahoma 73154-0256
Telephone Number (405) 848-6841

SPECIALTIES:

1. Primary (greater than 50% time spent) GYNECOLOGY
2. _____ 3. _____

BOARD CERTIFICATIONS (CURRENT): Add Boards by exact name and attach copy of certificate.

AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

CURRENT POST-GRADUATE TRAINING:

Type of training: _____ Hospital: _____

Location: _____

Date entered: _____ Date expected to complete: _____

CURRENT PRACTICE INFORMATION:

Employer: PRIVATE PRACTICE

City, State/Country: TULSA, OKLAHOMA

Type of practice or specialty: GYNECOLOGY

Date started: 07/85

You are required pursuant to 59O.S. S.S.355.1(B) to indicate your preference. Please read and check the appropriate box.

Any medical doctor who desires to DISPENSE "dangerous drugs" as defined in the Pharmacy Law, must register annually with the Board. This is for dispensing only and does not include prescribing, administering, or the giving of samples.

I DO ☒ DO NOT ☐ WISH TO BE REGISTERED TO DISPENSE DANGEROUS DRUGS

I certify that all information on this form is accurate and descriptive of my professional activities.

NAME OF PHYSICIAN: Kathleen A. Glaze (Print or Type)

SIGNATURE: Kathleen A. Glaze MD DATE: 5/27/98

MAIL APPLICATION TO: Oklahoma State Board of Medical Licensure and Supervision
P. O. Box 18256 Oklahoma City, Oklahoma 73154-0256
Telephone Number (405) 848-6841

SPECIALTIES:

1. Primary (greater than 50% time spent) GYNECOLOGY
2. _____ 3. _____

BOARD CERTIFICATIONS (CURRENT): Add Boards by exact name and attach copy of certificate.

AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

CURRENT POST-GRADUATE TRAINING:

Type of training: _____ Hospital: _____
Location: _____
Date entered: _____ Date expected to complete: _____

CURRENT PRACTICE INFORMATION:

Employer: PRIVATE PRACTICE
City, State/Country: TULSA, OKLAHOMA
Type of practice or specialty: GYNECOLOGY
Date started: 07/1985

You are required pursuant to 59O.S. S.S.355.1(B) to indicate your preference. Please read and check the appropriate box.

Any medical doctor who desires to DISPENSE "dangerous drugs" as defined in the Pharmacy Law, must register annually with the Board. This is for dispensing only and does not include prescribing, administering, or the giving of samples.

I DO ☐ DO NOT ☒ WISH TO BE REGISTERED TO DISPENSE DANGEROUS DRUGS

I certify that all information on this form is accurate and descriptive of my professional activities.

NAME OF PHYSICIAN: Kathleen A. Glaze
(Print or Type)

SIGNATURE: Kathleen A Glaze MD DATE: 5/7/99

MAIL APPLICATION TO: Oklahoma State Board of Medical Licensure and Supervision
P. O. Box 18256 Oklahoma City, Oklahoma 73154-0256
Telephone Number (405) 848-6841

AMA PHYSICIAN PROFILE (CONTINUED)

IT IS MUTUALLY AGREED BETWEEN THE AMERICAN MEDICAL ASSOCIATION (AMA) AND THE REQUESTING ORGANIZATION THAT THIS PHYSICIAN PROFILE (SEE REVERSE) IS PROVIDED TO THE REQUESTING ORGANIZATION WITH THE UNDERSTANDING THAT (1) THE INFORMATION ON THE PROFILE WILL BE TREATED WITH TOTAL CONFIDENTIALITY; (2) THAT SUCH INFORMATION IS GRANTED SOLELY TO THE REQUESTING ORGANIZATION AND IS GRANTED AS A NON-EXCLUSIVE LIMITED LICENSE, CONSISTENT WITH AND LIMITED TO THE SPECIFIC PURPOSES SET FORTH ON THE PHYSICIAN PROFILE REQUEST FORM; (3) THAT NO PROFILE INFORMATION WILL BE RELEASED, COPIED, EXTRACTED OR OTHERWISE USURPED FOR THE USE BY ANY OTHER PARTY, ENTITY, ORGANIZATION OR GOVERNMENT AGENCY; AND (4) THAT UPON A BREACH OF ANY OF THE FOREGOING COVENANTS OR UPON THE EFFECTIVE DATE OF ANY STATUTE, REGULATION OR COURT DECISION MANDATING ANY DISCLOSURE WHATSOEVER OF SUCH PROFILE INFORMATION BY THE REQUESTING ORGANIZATION, SUCH LICENSE TO USE AND POSSESS THE PROFILE SHALL BE AUTOMATICALLY AND IMMEDIATELY TERMINATED AND THE PROFILE AND ANY INFORMATION OR DATA CONTAINED THEREON OR, IN ANY WAY, DERIVED THEREFROM SHALL BE RETURNED TO THE AMA IMMEDIATELY, BUT, IN NO EVENT, LATER THAN 48 HOURS AFTER SUCH AUTOMATIC TERMINATION.

PLEASE INDICATE BELOW HOW THE MAJORITY OF YOUR TIME IS SPENT:

PRACTICE TYPE (check only one)

Solo Practice	✓
Group or Partnership	
Medical School	
Hospital Based	
Federal Government :	
Military Service	
Civil Service	
Veterans Admin.	
Indian Health Serv.	
Public Health Serv.	
State Government	
County Government	
Local Government	
Other	
(Specify)	

PRACTICE SETTING (check only one)

Office/Clinic	✓
Hospital Staff	
Resident/Training	
Nursing Home Staff	
Medical Teaching	
Administration	
Research	
Other	
(Specify)	

TOTAL AMOUNT OF TIME SPENT IN PRACTICE 65 (hrs. per week)
WHAT % OF YOUR TIME DO YOU SPEND IN DIRECT PATIENT CARE IN AN AVERAGE WEEK? 80%

PLEASE LIST THE HOSPITALS AT WHICH YOU ARE CURRENTLY A STAFF MEMBER. WHEN INDICATING STATUS, PLEASE USE ONE OF THE FOLLOWING : ACTIVE, INACTIVE, RESTRICTED, COURTESY, OTHER

NAME/LOCATION Hillcrest Medical Center/Tulsa STATUS Active
NAME/LOCATION St. John Med. Center / Tulsa STATUS Active
NAME/LOCATION _____ STATUS _____

DO YOU WISH TO APPLY FOR FULLY RETIRED STATUS?

YES _____
NO ✓

IF "YES" :

A) ENCLOSE A $50.00 PROCESSING FEE. THERE WILL BE NO RENEWAL FEE.
B) RETURN TO THIS BOARD YOUR WALLET CARD AND YOUR CERTIFICATE OF LICENSURE. (A NEW CARD AND CERTIFICATE WILL BE ISSUED IDENTIFYING YOU AS A FULLY RETIRED PHYSICIAN.)

THE FOLLOWING RESTRICTIONS APPLY TO FULLY RETIRED PHYSICIANS.

A) YOU MAY CONTINUE TO USE THE TITLE "PHYSICIAN", BUT MUST INDICATE YOUR RETIRED STATUS (EXAMPLE: JOHN DOE, M.D. (RET.))
B) YOU CANNOT PRACTICE MEDICINE IN ANY FORM.
C) YOU CANNOT WRITE PRESCRIPTIONS.
D) YOU CANNOT DISPENSE OR ADMINISTER DRUGS.
E) YOU CANNOT CONSULT IN ANY FORM.

Kathleen A Glaze MD
SIGNATURE

Kathleen A. GLAZE
NAME OF PHYSICIAN
(please type or print)

I certify that all information on this form is accurate and descriptive of my professional activities.

SIGNATURE Kathleen A Glaze MD DATE 1/29/90

MAIL APPLICATION TO : BOARD OF MEDICAL LICENSURE AND SUPERVISION, STATE OF OKLAHOMA
P.O. BOX 18256 OKLAHOMA CITY, OK 73154-0256

SPECIALTIES:

1. Primary (greater than 50% time spent) ~~OBSTETRICS AND~~ GYNECOLOGY, WOMEN'S HEALTH CARE
2. OBSTETRICS 3.

BOARD CERTIFICATIONS (CURRENT): Add Boards by exact name and give mailing address of Board Office.

AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY ADDRESS
ADDRESS
ADDRESS

CURRENT POST-GRADUATE TRAINING:

Type of training: Hospital:
Location:
Date entered: Date expected to complete:

CURRENT PRACTICE INFORMATION:

Employer: PRIVATE PRACTICE
City, State/Country: TULSA, OKLAHOMA
Type of practice or specialty: OB-GYN
Date started: 07/85

PLEASE INDICATE BELOW HOW THE MAJORITY OF YOUR TIME IS SPENT:

PRIMARY PRACTICE TYPE (Check only one)

- [X] Solo Practice
- [ ] Group or Partnership
- [ ] Medical School
- [ ] Hospital Based
  - Federal Government:
    - [ ] Military Service
    - [ ] Civil Service
    - [ ] Veterans Administration
    - [ ] Indian Health Service
    - [ ] Public Health Service
- [ ] State Government
- [ ] County Government
- [ ] Local Government
- [ ] Other
  (Specify)

PRIMARY PRACTICE SETTING (Check only one)

- [X] Office/Clinic
- [ ] Hospital Staff
- [ ] Resident/Training
- [ ] Nursing Home Staff
- [ ] Medical Teaching
- [ ] Administration
- [ ] Research
- [ ] Other
  (Specify)

PRACTICE ACTIVITY STATUS (X)

- [X] Currently practicing
- [ ] Not currently practicing
- [ ] Retired
- [ ] Semi-Retired (30 hrs/week or less)
- [ ] Other
  (Specify)

TOTAL AMOUNT OF TIME SPENT IN PRACTICE 60 (hours per week)
WHAT PERCENT OF YOUR TIME DO YOU SPEND IN DIRECT PATIENT CARE IN AN AVERAGE WEEK? 80%

If you are practicing in OKLAHOMA, please list the hospitals at which you are currently a member of the staff. When indicating status, please use one of the following: ACTIVE, INACTIVE, RESTRICTED, COURTESY, OTHER

NAME/LOCATION: Hillcrest Med. Center, Tulsa, OK STATUS: Active
NAME/LOCATION: St. John Med. Center, Tulsa, OK STATUS: Active
NAME/LOCATION:

SPECIALTIES:

1. Primary (greater than 50% time spent) GYNECOLOGY
2. ~~OBSTETRICS~~ discontinued 9/92 3. ✓

BOARD CERTIFICATIONS (CURRENT):

Add Boards by exact name and give mailing address of Board Office.

AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY ADDRESS _____

_____ ADDRESS _____

_____ ADDRESS _____

CURRENT POST-GRADUATE TRAINING:

Type of training: _____ Hospital: _____

Location: _____

Date entered: _____ Date expected to complete: _____

CURRENT PRACTICE INFORMATION:

Employer: PRIVATE PRACTICE

City, State/Country: TULSA, OKLAHOMA

Type of practice or specialty: OB-GYN

Date started: 07/85

PLEASE INDICATE BELOW HOW THE MAJORITY OF YOUR TIME IS SPENT:

PRIMARY PRACTICE TYPE (Check only one)

- [x] Solo Practice
- [ ] Group or Partnership
- [ ] Medical School
- [ ] Hospital Based
  - Federal Government:
    - [ ] Military Service
    - [ ] Civil Service
    - [ ] Veterans Administration
    - [ ] Indian Health Service
    - [ ] Public Health Service
- [ ] State Government
- [ ] County Government
- [ ] Local Government
- [ ] Other
  - (Specify) _____

PRIMARY PRACTICE SETTING (Check only one)

- [x] Office/Clinic
- [ ] Hospital Staff
- [ ] Resident/Training
- [ ] Nursing Home Staff
- [ ] Medical Teaching
- [ ] Administration
- [ ] Research
- [ ] Other
  - (Specify) _____

PRACTICE ACTIVITY STATUS (X)

- [x] Currently practicing
- [ ] Not currently practicing
- [ ] Retired
- [ ] Semi-Retired (30 hrs/week or less)
- [ ] Other
  - (Specify) _____

HAVE YOU PRACTICED MEDICINE GREATER THAN 50% OF THE TIME SINCE JULY 1, 1992? Yes

TOTAL AMOUNT OF TIME SPENT IN PRACTICE 50 (hours per week)

WHAT PERCENT OF YOUR TIME DO YOU SPEND IN DIRECT PATIENT CARE IN AN AVERAGE WEEK? 75%

[redacted] please list the hospitals at which you are currently [redacted] indicating status, please use one of the following: ACTIVE, INACTIVE, RESTRICTED, COURTESY, OTHER.

FACILITY/LOCATION: Hillcrest Med. Center - Tulsa STATUS: Active

FACILITY/LOCATION: St. John Med. Center - Tulsa STATUS: Active

FACILITY/LOCATION: _____ STATUS: _____

SPECIALTIES:

1. Primary (greater than 50% time spent) GYNECOLOGY
2. _____ 3. _____

BOARD CERTIFICATIONS (CURRENT): Add Boards by exact name and give mailing address of Board Office.

AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY ADDRESS _____

_____ ADDRESS _____

_____ ADDRESS _____

CURRENT POST-GRADUATE TRAINING:

Type of training: _____ Hospital: _____

Location: _____

Date entered: _____ Date expected to complete: _____

CURRENT PRACTICE INFORMATION:

Employer: PRIVATE PRACTICE

City, State/Country: TULSA, OKLAHOMA

Type of practice or specialty: GYNECOLOGY

Date started: 07/85

PLEASE INDICATE BELOW HOW THE MAJORITY OF YOUR TIME IS SPENT:

PRIMARY PRACTICE TYPE (Check only one)

- [x] Solo Practice
- [ ] Group or Partnership
- [ ] Medical School
- [ ] Hospital Based
  - Federal Government:
    - [ ] Military Service
    - [ ] Civil Service
    - [ ] Veterans Administration
    - [ ] Indian Health Service
    - [ ] Public Health Service
- [ ] State Government
- [ ] County Government
- [ ] Local Government
- [ ] Other
  (Specify) _____

PRIMARY PRACTICE SETTING (Check only one)

- [x] Office/Clinic
- [ ] Hospital Staff
- [ ] Resident/Training
- [ ] Nursing Home Staff
- [ ] Medical Teaching
- [ ] Administration
- [ ] Research
- [ ] Other
  (Specify) _____

PRACTICE ACTIVITY STATUS (X)

- [x] Currently practicing
- [ ] Not currently practicing
- [ ] Retired
- [ ] Semi-Retired (30 hrs/week or less)
- [ ] Other
  (Specify) _____

HAVE YOU PRACTICED MEDICINE GREATER THAN 50% OF THE TIME SINCE JULY 1, 1993? yes

TOTAL AMOUNT OF TIME SPENT IN PRACTICE 52 (hours per week)

[redacted] YOU SEE IN DIRECT [redacted] CARE IN AN AVERAGE WEEK? 70 %

If you are practicing in OKLAHOMA, please list the hospitals at which you are currently a member of the staff. When indicating status, please use one of the following: ACTIVE, INACTIVE, RESTRICTED, COURTESY, OTHER.

FACILITY/LOCATION: Hillcrest Medical Center - Tulsa STATUS: Active

FACILITY/LOCATION: St John Medical Center - Tulsa STATUS: Courtesy

FACILITY/LOCATION: _____ STATUS: _____

SPECIALTIES:

List specialty you spend greater than 50% of your time in #1.

1. Gynecology
2.
3.
4.
5.

BOARD CERTIFICATIONS (CURRENT):

Add Boards by exact name and attach a copy of certificate if new certification.

1. AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY
2.
3.

POST GRADUATE TRAINING (CURRENT):

Type of Training:

Hospital:

Location:

DateFrom

Expected Completion Date:

PRACTICE INFORMATION (CURRENT):

Employer: PRIVATE PRACTICE

City, State/Country: TULSA, OK

Type of practice or specialty: GYNECOLOGY

Date Started: 7 / 1985

Other States in which you are licensed to practice Medicine:

I, the undersigned, have to the best of my knowledge, complied with the laws and rules regulating my profession. I hereby state that the information contained in this application is true and correct.

Signature of Applicant: Kathleen A Glaze MD Date: 5/1/2000

991120: MDRENEW

Specialties:

List Specialty you spend greater than 50% of your time in #1.

1. Gynecology
2.
3.
4.
5.

Board Certifications (Current):

Add Boards by exact name and attach a copy of certificate if new certification.

1. AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY
2.
3.

Post Graduate Training (Current):

Type of Training:

Hospital:

Location:

Date Entered:

Expected Completion Date:

Practice Information (Current):

Employer: PRIVATE PRACTICE

City, State, Country: TULSA, OK

Type of Practice or Specialty: GYNECOLOGY

Date Started: 7/1985

Other States in which you are licensed to practice Medicine:

I, the undersigned, have to the best of my knowledge, complied with the laws and rules regulating my profession. I hereby state that the information contained in this application is true and correct.

Signature of Applicant: Kathleen A Glanz MD Date: 6/6/2001

	YES	NO
M. Have you been named as a defendant in a civil suit (including malpractice)?	___	X
N. Have you been reported to the National Practitioner Data Bank (NPDB) or to the Healthcare Integrity and Protection Data Bank (HIPDB)? (If yes, enclose a copy of the report.)	___	X
O. Have you had a major illness or been hospitalized within the past year?	___	X

DO YOU WISH TO APPLY FOR PHYSICIAN EMERITUS (FULLY RETIRED) STATUS? ___ YES X NO

If "YES", Enclose a $50 processing fee. There will be no renewal fee.
The Following Restrictions apply to Physician Emeritus (FULLY RETIRED) Physicians:
A) You may continue to use the title "DOCTOR" and suffix "MD", but must indicate your retired status.
B) You cannot practice medicine in any form. You cannot prescribe, dispense or administer drugs.

Specialties:

List Specialty you spend greater than 50% of your time in #1.

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2. _____
3. _____
4. _____

Board Certifications (Current):

Add Boards by exact name and attach a copy of certificate if new certification.

1. AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY
2. _____
3. _____

Post Graduate Training (Current):

Type of Training: _____
Hospital: _____
Location: _____
Date Entered: _____
Expected Completion Date: _____

Practice Information (Current):

Employer: PRIVATE PRACTICE
City, State, Country: TULSA, OK
Type of Practice or Specialty: GYNECOLOGY
Date Started: 7/1985

Other States in which you are licensed to practice Medicine:

_____
_____
_____

I, the undersigned, have to the best of my knowledge, complied with the laws and rules regulating my profession.
I hereby state that the information contained in this application is true and correct.

Signature of Applicant: Kathleen A Glaze MD Date: 5/15/2002

	YES	NO
R. Have you been named as a defendant in a civil suit (including malpractice)?	____	X
S. Have you been reported to the National Practitioner Data Bank (NPDB) or to the Healthcare Integrity and Protection Data Bank (HIPDB)?	____	X
T. Have you had a major illness or been hospitalized within the past year?	____	X

DO YOU WISH TO APPLY FOR PHYSICIAN EMERITUS (FULLY RETIRED) STATUS? ____ YES X NO

If "YES", Enclose a $50 processing fee. There will be no renewal fee.
The Following Restrictions apply to Physician Emeritus (FULLY RETIRED) Physicians:
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2. _____
3. _____

Post Graduate Training (Current):

Type of Training: _____
Hospital: _____
Location: _____
Date Entered: _____
Expected Completion Date: _____

Practice Information (Current):

Employer: PRIVATE PRACTICE
City, State, Country: TULSA, OK
Type of Practice or Specialty: GYNECOLOGY
Date Started: 7/1985

Other States in which you are licensed to practice Medicine:

_____
_____
_____

I, the undersigned, have to the best of my knowledge, complied with the laws and rules regulating my profession. I hereby state that the information contained in this application is true and correct.

Signature of Applicant: Kathleen A Glass MD Date: 6/17/03

	YES	NO
R. Have you been named as a defendant in a civil suit (including malpractice)?	____	X
S. Have you been reported to the National Practitioner Data Bank (NPDB) or to the Healthcare Integrity and Protection Data Bank (HIPDB)?	____	X
T. Have you had a major illness or been hospitalized within the past year?	____	X

DO YOU WISH TO APPLY FOR PHYSICIAN EMERITUS (FULLY RETIRED) STATUS? ____ YES __X__ NO

If "YES", Enclose a $50 processing fee. There will be no renewal fee.
The Following Restrictions apply to Physician Emeritus (FULLY RETIRED) Physicians:
A) You may continue to use the title "DOCTOR" and suffix "MD", but must indicate your retired status.
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2. _____
3. _____
4. _____

Board Certifications (Current):

Add Boards by exact name and attach a copy of certificate if new certification.

1. AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY
2. _____
3. _____

Post Graduate Training (Current):

Type of Training: _____
Hospital: _____
Location: _____
Date Entered: _____
Expected Completion Date: _____

Practice Information (Current):

Employer: PRIVATE PRACTICE
City, State, Country: TULSA, OK
Type of Practice or Specialty: GYNECOLOGY
Date Started: 7/1985

Other States in which you are licensed to practice Medicine:

_____
_____
_____

I, the undersigned, have to the best of my knowledge, complied with the laws and rules regulating my profession. I hereby state that the information contained in this application is true and correct.

Signature of Applicant: Renewed Online Date: 05/07/2004 Time: 5:11:15 pm

	YES	NO
R. Have you been named as a defendant in a civil suit (including malpractice)?	____	X
S. Have you been reported to the National Practitioner Data Bank (NPDB) or to the Healthcare Integrity and Protection Data Bank (HIPDB)?	____	X
T. Have you had a major illness or been hospitalized within the past year?	____	X

DO YOU WISH TO APPLY FOR PHYSICIAN EMERITUS (FULLY RETIRED) STATUS? ____ YES __X__ NO

If "YES", Enclose a $50 processing fee. There will be no renewal fee.
The Following Restrictions apply to Physician Emeritus (FULLY RETIRED) Physicians:
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3. _____
4. _____

Board Certifications (Current):

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1. AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY
2. _____
3. _____

Post Graduate Training (Current):

Type of Training: _____
Hospital: _____
Location: _____
Date Entered: _____
Expected Completion Date: _____

Practice Information (Current):

Employer: PRIVATE PRACTICE
City, State, Country: TULSA, OK USA
Type of Practice or Specialty: GYNECOLOGY
Date Started: 7/1985

Other States in which you are licensed to practice Medicine:

_____
_____
_____

I, the undersigned, have to the best of my knowledge, complied with the laws and rules regulating my profession. I hereby state that the information contained in this application is true and correct.

Signature of Applicant: Renewed Online Date: 05/05/2005 Time: 9:42:03 pm

	YES	NO
R. Have you been named as a defendant in a civil suit (including malpractice)?	X	
S. Have you been reported to the National Practitioner Data Bank (NPDB) or to the Healthcare Integrity and Protection Data Bank (HIPDB)?		X
T. Have you had a major illness or been hospitalized within the past year?		X

DO YOU WISH TO APPLY FOR PHYSICIAN EMERITUS (FULLY RETIRED) STATUS? ____ YES __X__ NO

If "YES", Enclose a $50 processing fee. There will be no renewal fee.
The Following Restrictions apply to Physician Emeritus (FULLY RETIRED) Physicians:
A) You may continue to use the title "DOCTOR" and suffix "MD", but must indicate your retired status.
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Board Certifications (Current):

Add Boards by exact name and attach a copy of certificate if new certification.

1. AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY
2.
3.

Post Graduate Training (Current):

Type of Training:
Hospital:
Location:
Date Entered:
Expected Completion Date:

Practice Information (Current):

Employer: PRIVATE PRACTICE
City, State, Country: TULSA, OK USA
Type of Practice or Specialty: GYNECOLOGY
Date Started: 7/1985

Other States in which you are licensed to practice Medicine:

I, the undersigned, have to the best of my knowledge, complied with the laws and rules regulating my profession. I hereby state that the information contained in this application is true and correct. This form is Public Information.

Signature of Applicant: Renewed Online Date: 06/14/2006 Time: 7:00:23 pm

	YES	NO
R. Have you been named as a defendant in a civil suit (including malpractice)?	X	
S. Have you been reported to the National Practitioner Data Bank (NPDB) or to the Healthcare Integrity and Protection Data Bank (HIPDB)?	X	
T. Have you had a major illness or been hospitalized within the past year?		X

DO YOU WISH TO APPLY FOR PHYSICIAN EMERITUS (FULLY RETIRED) STATUS? ____ YES __X__ NO

If "YES", Enclose a $50 processing fee. There will be no renewal fee.
The Following Restrictions apply to Physician Emeritus (FULLY RETIRED) Physicians:
A) You may continue to use the title "DOCTOR" and suffix "MD", but must indicate your retired status.
B) You cannot practice medicine in any form. You cannot prescribe, dispense or administer drugs.

Specialties:

List Specialty you spend greater than 50% of your time in #1.

1. Gynecology
2.
3.
4.

Board Certifications (Current):

Add Boards by exact name and attach a copy of certificate if new certification.

1. AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY
2.
3.

Post Graduate Training (Current):

Type of Training:
Hospital:
Location:
Date Entered:
Expected Completion Date:

Practice Information (Current):

Employer: PRIVATE PRACTICE
City, State, Country: TULSA, OK USA
Type of Practice or Specialty: GYNECOLOGY
Date Started: 7/1985

Other States in which you are licensed to practice Medicine:

I, the undersigned, have to the best of my knowledge, complied with the laws and rules regulating my profession. I hereby state that the information contained in this application is true and correct. This form is Public Information.

Signature of Applicant: Renewed Online Date: 05/26/2007 Time: 8:22:03 am

	YES	NO
O. Have you been the subject of an investigation or disciplinary action, including probation, by a hospital, clinic, practice group, or residency program?	____	X
P. Have you had any adverse judgment, settlement, or award against you arising from a professional liability claim?	____	X
Q. Have you been reported to the National Practitioner Data Bank (NPDB) or to the Healthcare Integrity and Protection Data Bank (HIPDB)?	____	X

DO YOU WISH TO APPLY FOR PHYSICIAN EMERITUS (FULLY RETIRED) STATUS? ____ YES __X__ NO

If "YES", there will be no renewal fee.

The Following Restrictions apply to Physician Emeritus (FULLY RETIRED) Physicians:

A) You may continue to use the title "DOCTOR" and suffix "MD", but must indicate your retired status.

B) You cannot practice medicine in any form. You cannot prescribe, dispense or administer drugs.

Specialties:

List Specialty you spend greater than 50% of your time in #1.

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Board Certifications (Current):

Add Boards by exact name and attach a copy of certificate if new certification.

1. AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY
2. _____
3. _____

Post Graduate Training (Current):

Type of Training: _____

Hospital: _____

Location: _____

Date Entered: _____

Expected Completion Date: _____

Practice Information (Current):

Employer: PRIVATE PRACTICE

City, State, Country: TULSA, OK USA

Type of Practice or Specialty: GYNECOLOGY

Date Started: 7/1985

Other States in which you are licensed to practice Medicine:

_____

_____

_____

I, the undersigned, have to the best of my knowledge, complied with the laws and rules regulating my profession. I hereby state that the information contained in this application is true and correct. This form is Public Information.

Signature of Applicant: Renewed Online Date: 05/22/2011 Time: 3:43:17 pm

21. The applicant must paste an unmounted photograph of himself, or herself, in the space below. It must carry the signature of the Dean or Registrar of his or her Medical School or State Board Secretary, properly certified before a Notary Public, that the applicant is known to him and that it is a recent photograph of the applicant, or that it is a true likeness of applicant's photograph on file in that office. (If neither is possible, photograph may be taken before a Notary Public for certification).

Kathleen Glaze, M.D.

State of Oklahoma } ss.
County of Tulsa }

This is to certify that the above is a correct likeness of Dr. Kathleen A. Glaze M.D. whose name appears elsewhere on this application.

Dean/Registrar/Secretary.

Subscribed and sworn to before me, a Notary Public, in and for Tulsa County, State of Oklahoma, on this 1 day of March, 1982.

Connie J. Sams
Notary Public.

My Commission expires 2-18-84
(Seal)

NOTE: Seal of the school or Medical Board may be affixed on picture in lieu of Notarization.

Oklahoma State Board
MEDICAL EXAMINERS

For Use of Secretary Only

Kathleen Ann Glaze
(Full name of applicant)
Tulsa, Okla.
(Present Address of Applicant)

Application for Certificate
Through Endorsement.

With National Boards

State Certificate No. 252165

Granted 7-1-82

Application received 3-11 1982

Fee, $100.00 paid 3-11 1982

Approved 5-13 1982
Rejected
Withdrawn

Fee returned 19

Certificate Issued 7-1 1982

No. 13761

Sent

By

NOTE—If not a member of Medical Society or State Association explain why and furnish at least three (3) letters from reputable physicians duly licensed, as to character, professional standing, etc.

22. **CERTIFICATE FROM THE SECRETARY OF THE STATE MEDICAL ASSOCIATION.**

I hereby certify that the records of my office show that Dr. _____, of _____, has been a member in good standing of the _____ State Medical Association for the past _____ years, and that he/she is now in good standing.

Given under my hand and the seal of the _____ State Medical _____ this _____ day of _____, 19____.

(SEAL)

Secretary _____ State Medical Association.

Address _____

The reciprocity fee is $100.00 which must accompany application. In case of rejection, $85.00 will be refunded.

A 6x8-inch photographic or photostatic reproduction of your Medical Diploma must accompany application for the office file.

Applicant must supply a certified photograph of himself/herself as directed on this application.

Applicants may be required to appear before the Board in person at the discretion of the Board.

Applicant is required to submit letters from the Chief-of-Staff, Hospital Administrator, Chief of Nursing Service of any hospital where he/she has trained or is in training; also, any hospital or clinic in which he/she has privileges or practices.

Applicants who graduated in 1933 and thereafter must show evidence of one-year of approved postgraduate training. A 6x8-inch photo of postgraduate certificate must accompany application.

A photostatic copy of discharge from military service must accompany this application.

Address all communications and make all remittances payable to: BOARD OF MEDICAL EXAMINERS, Oklahoma City, Oklahoma.

If license is issued, please mail it to me at 4012 E. 42nd Place
(Street or P.O. Box No.)

Tulsa, Oklahoma 74135
(City) (State)

STATE BOARD OF MEDICAL EXAMINERS
P.O. Box 18256 — 5104 N. Francis
Oklahoma City, Oklahoma 73154