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



KATHLEEN ANN GLAZE JUN 0 6 2014 License Number: 13761 Mailing Address Practice Address OKLAHOMA STATE BOARD OF 1145 SOUTH UTICA AVENUE #514 1145 SOUTH UTICA AVENUE MEDICAL LICENSURE TULSA, OK 74104-4018 SUITE 514 AND SUPERVISION 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 Phermacy 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? B. Have you surrendered a license or had any disciplinary action taken on any license? C. Have you been investigated by or requested to appear before a licensing or disciplinary agency? 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 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? 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?** J. Have you surrendered or had any adverse action taken against any narcotic permit (State or Federal)? Y Х K. Have you been denied membership or had disciplinary action taken by a national, state, or county medical organization? 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? O. Have you been the subject of an investigation or disciplinary action, including probation, by a hospital, clinic, practice group, or residency program? 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? 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 Specialties: Gynecology * Board Certifications (Current): AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY Post Graduate Training (Current): Type of Training: Hospital:

City, State, County: TULSA, OK USA

Employer: PRIVATE PRACTICE

Location: Date Entered:

Expected Completion Date:

Practice information (Current):

Type of Practice	or Specialty:	GYNECOLOGY				
	ate Started:	7/1985				
I, the underaigned, have to the best of application is true and correct. This for Signature of Applicant:	m la sublic l	-formation	ne laws and poles regula	. ()	ereby state that the information	contained in this
	(Rememb	er to sign and date	a form before mailing	Pana 2 of 2 - KA	THI FEN ANN GLAZE	•

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

RECEIVED

JUN 9 6 2014

OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

Application For Renewal Of Oklahoma License

MEDICAL DOCTOR From,87/02/2013 Td 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: Oktahoma State Board Of Medical Licensure And Supervision PO Box 18256 Oklahoma City, OK 73154-0256 License Numb : 13761 KATHLEEN ANN GLAZE **Mailing Address** Practice Address 1145 SOUTH UTICA AVENUE #514 1145 SOUTH UTICA AVENUE TULSA, OK 74104-4018 SUITE 514 TULSA, OK 74104-4018 Yes 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 4 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? 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? 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? 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? I. Have you been denied provider participation, terminated, sanctioned or penalized by any third party payor to include TRICARE, MEDICARE, or MEDICAID? 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? Х O. Have you been the subject of an investigation or disciplinary action, including probation, by a hospital, clinic, practice group, or residency Х P. Have you had any adverse judgment, settlement, or award against you arising from a professional liability claim?

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:

DO YOU WISH TO APPLY FOR PHYSICIAN EMERITUS (FULLY RETIRED) STATUS?

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)

Q. Have you been reported to the National Practitioner Data Bank (NPDB) or to the Healthcare Integrity and Protection Data Bank (HIPDB)?

Page 1 of 2 - KATHLEEN ANN GLAZE

MAY 2 8 2013

OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

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Specialties: Gynecology *	
Board Certifications (Current): AMERICAN BOARD OF OBSTETRICS AND G	SYNECOLOGY
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
Signature of Applicant (Rentember to sig	n and date form before mailing) Page 2 of 2 - KATHLEEN ANN GLAZE
Attention M/	AC users: Please select "File" on your browser and then "Print"



MAY 2 3 2013

OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

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 80 days with a fee of \$350.00. After 80 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 18266
Oklahoma City, OK 73154-0256

Cicarae Municipal 15/01	KATHLEEN ANN GLAZE		
Malling Address	Practice Address		
1145 SOUTH UTICA AVENUE #514	1145 SOUTH UTICA AVENUE		
TULSA, OK 74104-4018	SUITE 514		
	TULSA, OK 74104-4018		
)		
	<u> </u>		
Have you met the Oklahoma CME Requirement?		Yes X	No
You are required pursuant to 59 O.S. 355 1(B) to indicate your preference. Doctor who desires to DISPENSE "dangerous drugs" as defined in the Phadispensing only and does not include prescribing, administering, or the givin	MRCV Law, must register enqually with the Roant This is to	 -	
	I wish to be registered to dispense dangerous drugs.		х
The following information is mandatory and in	nation provided may be investigated further		
A. Has your application for a license been denied?			X
B. Have you surrendered a license or had any disciplinary action taken on a			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 mis			X
E. Have you been arrested for, charged with, or convicted of a traffic violatic alcohol?	n involving the use of any drug or chemical substance including		X
F. Have you been addicted to or abused any drug or chemical substance in	cluding alcohol?		×
G. Have you obtained an assessment or been treated for use of any drug or			
H. Have you had any mental or physical disorder or condition which if untree		-	X
 Have you been denied provider participation, terminated, sanctioned or p MEDICARE, or MEDICAID? 	enalized by any third party payor to include TRICARE.		x
J. Have you surrendered or had any adverse action taken against any narco	otic permit (State or Federal)?		X
K. Have you been denied membership or had disciplinary action taken by a		<u> </u>	
L. Have you been denied or had removed or suspended hospital staff privile			
M. Have you surrendered hospital staff privileges while under investigation of	r to avoid investigation?		÷
N. Have you entered into an Agreement with a Federal, State, or Local jurisc			$\hat{\mathbf{x}}$
O. Have you been the subject of an investigation or disciplinary action, incluprogram?	fing probation, by a hospital, clinic, practice group, or residency		x
P. Have you had any adverse judgment, settlement, or award against you ar	ising from a professional liability claim?		х
Q. Have you been reported to the National Practitioner Data Bank (NPDB) of	r to the Healthcare Integrity and Protection Data Bank (HIDDR)		÷
DO YOU WISH TO APPLY FOR PHYSICIAN EMERITUS (FULLY RETIRE!	D) STATUS?		$\hat{\mathbf{x}}$
If "YES" then a \$50 processing fee is to be included and there is no renewal f The Following Restrictions apply to Physician Emeritus (FULLY RETIRED) Pi	· •		<u> </u>

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

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

Page 1 of 2 - KATHLEE

MAY 3 0 2012

OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION



Specialties: Gynscology *		
Board Certifications (Current): AMERICAN BOARD OF OBSTETRICS AND (SYNECOLOGY	
Post Graduate Training (Current):		
Type of Training:	·	
Hospital:		•
Location:		•
Date Entered:		1
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	•
contained in this application is true and correct. T	eco Con Hay Dotte: 5/6	27/2012
,	gn and date form before mailing) Page 2 of 2 - KATHLEEN ANN GLAZE AC users: Please select "File" on your browser and then "Print"	•
	Dried)	

Application For Renewal Of Oklahoma License
MEDICAL DOCTOR From 87/02/2010 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.

Practice Information (Current):

Employer: PRIVATE PRACTICE

City, State, County: TULSA, OK USA

Mail Renewal application to: Oklahoma State Board Of Medical Licensure And Supervision

PO Box 18256

PO Box 18256		
Oklahoma City, OK	73154-0256	
License Number: 13761	73154-0256 KATHLEEN ANN GLAZE Practice Address	MISTO
Mailing Address	Practice Address	7 A TE
1145 SOUTH UTICA AVENUE #514	The second of th	
TULSA, OK 74104-4018	TILSA, OK 74104-4018 Practice Address JUN 0 4 OKLAHOMA STATE AND SUPER	201n
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You are required oursuant to 50 0 S 355 1/R) to indicate your professor	nce. Please read and check in the appropriate response. Any Medical Doctor	
who desires to DISPENSE "dangerous drugs" as defined in the Pharmac	cy Law, must register annually with the Board. This is for dispensing only and	
does not include prescribing, administering, or the giving of samples.	oy caw, must register annually with the board. This is for dispersing only and	
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The following information to manufacture and to the	I wish to be registered to dispense dangerous drugs.	<u>x</u>
The following information is mandatory and info Since 06/04/2009 Do Any Of The Following Apply To	ormation provided may be investigated further.	
	Tour	
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 licen	nsing or disciplinary agency?	X
D. Have you been arrested for, charged with, or convicted of a felony or	or misdemeanor other than a traffic violation?	×
E. Have you been arrested for, charged with, or convicted of a traffic vic	olation involving the use of any drug or chemical substance including alcohol?	
F. Have you been addicted to or abused any drug or chemical substance	- to to the time of the total	
		X
G. Have you obtained an assessment or been treated for use of any dru		<u>X</u>
H. Have you had any mental or physical disorder or condition which if u	_	X
I. Have you been denied provider participation, terminated, sanctioned of MEDICAID?	or penalized by any third party payor to include TRICARE, MEDICARE, or	X
J. Have you surrendered or had any adverse action taken against any r	narcotic permit (State or Federal)?	X
K. Have you been denied membership or had disciplinary action taken b	by a national, state, or county medical organization?	х
L. Have you been denied or had removed or suspended hospital staff p	privileges?	<u>x</u>
M. Have you surrendered hospital staff privileges while under investigation	on or to avoid investigation?	x
N. Have you entered into an Agreement with a Federal, State, or Local j	jurisdictional body to avoid formal action?	
O. Have you been the subject of an investigation or disciplinary action, in	including probation, by a hospital, clinic, practice group, or residency program?	X
P. Have you had any adverse judgment, settlement, or award against yo	ou arising from a professional liability claim?	
Q. Have you been reported to the National Practitioner Data Bank (NPDI	B) or to the Healthcare Integrity and Protection Data Bank (HIPDB)?	X
DO YOU WISH TO APPLY FOR PHYSICIAN EMERITUS (FULLY RETI	IRED) STATUS?	x
If "YES" then a \$50 processing fee is to be included and there is no rene		
The Following Restrictions apply to Physician Emeritus (FULLY RETIRED		
 A) You may continue to use the title "DOCTOR" and suffix "MD", but m B) You cannot practice medicine in any form. You cannot prescribe, dis 	nust indicate retired status.	
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(Remember to sign and date form, Specialties:	, before mailing) Page 1 of 2 - KATHLEEN ANN GLAZE	
Gynecology *		
Board Certifications (Current): AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY		
Post Graduate Training (Current):		
Type of Training:		
Hospital:		
Location:		
Date Entered:		
Expected Completion Date:		

Type of Practice or Specialty:	GYNECOLOGY	
Date Started:	7/1985	
Signature of Applicant: (Remember	to sign and date form before mailing) Page 2 of 2 - KATHLEEN ANN GLAZE ion MAC users: Please select "File" on your browser and then "Print"	Intained in this

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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 iconsective inactive. Renewals may be accepted for 60 days with a fee of \$275.00. After 60 days, unfernewed 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

Practice information (Current):

Employer: PRIVATE PRACTICE

Oklahoma City, OK 73154-0256

JUN 04 2009

License Number: 13761	KATHLEEN ANN GLAZE OKLAHOMA STA	^ =	-
Mailing Address	Practice Address MEDICAL LI	VIL E	30AR
1145 SOUTH UTICA AVENUE #514 TULSA, OK 74104-4018	Prectice Address MEDICAL LI 1145 SOUTH UTICA AVENUE SUITE 514 TULSA, OK 74104-4018	RVIS	SUR E ION
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ou 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 Law, must register annually with the Board. This is for dispensing only and	<u>x</u>	
	I wish to be registered to dispense dangerous drugs.		<u>X</u>
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A. Has your application for a license been denied?	ou :		¥
I. Have you surrendered a license or had any disciplinary action taken on	any license?		
. Have you been investigated by or requested to appear before a licensing	•		^
. Have you been arrested for, charged with, or convicted of a felony or m			X
	ion involving the use of any drug or chemical substance including alcohol?		<u>~</u>
. Have you been addicted to or abused any drug or chemical substance is			
. Have you obtained an assessment or been treated for use of any drug of			<u> </u>
. Have you had any mental or physical disorder or condition which if untre	sated could affect your ability to practice competently?		X
. Have you been denied provider participation, terminated, senctioned or p MEDICAID?	• • • • • • • • • • • • • • • • • • • •		X
. Have you surrendered or had any adverse action taken against any naro	cotic permit (State or Federal)?		<u>x</u>
L Have you been denied membership or had disciplinary action taken by a	a national, state, or county medical organization?		X
Have you been denied or had removed or suspended hospital staff privi	ileges?		<u>x</u>
I. Have you surrendered hospital staff privileges while under investigation of	or to avoid investigation?		<u> </u>
l. Have you entered into an Agreement with a Federal, State, or Local juris	adictional body to avoid formal action?		<u> </u>
L Have you been the subject of an investigation or disciplinary action, inclu	uding probation, by a hospital, clinic, practice group, or residency program?		<u> </u>
. Have you had any adverse judgment, settlement, or award against you a	arising from a professional liability claim?	-	_X_
I. Have you been reported to the National Practitioner Data Bank (NPDB) of	or to the Healthcare Integrity and Protection Data Bank (HIPDB)?		<u> </u>
DO YOU WISH TO APPLY FOR PHYSICIAN EMERITUS (FULLY RETIRE	ED) STATUS?		<u> </u>
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(Remember to sign and date form, be	efore mailing) Page 1 of 2 - KATHLEEN ANN GLAZE		
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cerd Certifications (Current): AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY			
ost Graduate Training (Current);			
Type of Training:			
Hospital:	**************************************		
Location:			
Date Entered:			
Expected Completion Date:			

City, State, County:		
Type of Practice or Specialty:	GYNECOLOGY	
Date Started:	7/1985	
depression is and and correct. This follows	edge, complied with the laws and rules regulating my profession. I hereby state that the information continuous of the laws and rules regulating my profession. I hereby state that the information continuous of the laws and rules regulating my profession. I hereby state that the information continuous of the laws and rules regulating my profession. I hereby state that the information continuous of the laws and rules regulating my profession. I hereby state that the information continuous of the laws and rules regulating my profession.	ntained in this
(Remember	to sign and date form before mailing) Page 2 of 2 - KATHLEEN ANN GLAZE	
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Application For Renewal Of Oklahoma License MEDICAL DOCTOR From 07/02/2008 To 07/01/2008

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Mail Renewal application to: Okiahoma State Board Of Medical Licensure And Supervision MAY 0.7 2008

KATHLEEN ANN GLAZE

PO Box 18256

Okiahoma City, OK 73154-0256

OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

License Number: 13761

Mailing Address

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

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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.

does not include prescribing, administering, or the giving of samples.

I wish to be registered to dispense dangerous drugs.

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?

- B. Have you surrendered a license or had any disciplinary action taken on any license?
- C. Have you been investigated by or requested to appear before a licensing or disciplinary agency?
- D. Have you been arrested for, charged with, or convicted of a felony or misdemeanor other than a traffic violation?
- 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?
- 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?
- H. Have you had any mental or physical disorder or condition which if untreated could affect your ability to practice competently?
- I. Have you been denied provider participation, terminated, sanctioned or penalized by any third party payor to include TRICARE, MEDICARE, or MEDICAID?
- 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?
- L. Have you been denied or had removed or suspended hospital staff privileges?
- M. Have you surrendered hospital staff privileges while under investigation or to avoid investigation?
- N. Have you entered into an Agreement with a Federal, State, or Local jurisdictional body to avoid formal action?
- O. Have you been the subject of an investigation or disciplinary action, including probation, by a hospital, clinic, practice group, or residency program?
- 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)?

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If "YES" then a \$50 processing fee is to be included and there is no renewal fee.
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- A) You may continue to use the title "DOCTOR" and suffix "MD", but must indicate refired status.
- B) You cannot practice medicine in any form. You cannot prescribe, dispense or administer drugs.

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:	

Th

Expected Completion Date:	
Practice Information (Current): Employer:	PRIVATE PRACTICE
City, State, County:	
Type of Practice or Specialty:	
Date Started:	7/1985
application is true and correct. This form is pulping. Signature of Applicant: 8147:MD	Affiles a specific mailing Page 2 of 2

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. 1145 S. Utica 4025 E. 43RD Please mark any changes TULSA, OK 74135 Suite 1100 to your mailing address Tulsa, OK 74104 in the box to the left. **FINAL NOTICE** COMPLETE THE FOLLOWING : PRACTICE SETTING: List the percentage of practice time spent in the following: 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: STATUS: ACTIVE TULSA OB/94N CENTER /145 S. Utica 2815 S. SHERIDAN TULSA, OK 74129

TULSA, OK 74129

TULSA, Ok. 74104 SPECIALTIES: 1. Primary (greater than 50% time spent) OBSTETRICS AND GYNECOLOGY 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. Date expected to complete :_ Date Entered: 07/82 MAIL APPLICATION TO: Oklahoma State Board of Medical Examiners P. O. Box 18256 Oklahoma City, QK 73154

ORM BMEREC 03-85

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. Please mark any changes
/ 4025 F 43RD
TULSA OK 74135 DEGETIMENT in the box to the left.
TULSA OK 74135 DECEIVED in the box to the left.
JUN 5 1984
STATE BOARD
PRACTICE ADDRESS: Must be the location of EDICAL FEGAMINED and be identical to
Jan Shoriday (DEA). DO NOT use P.O. Box #.
Street & Suite # [2815 S. Sheridan Tulsa Obst. & Gynecology Center City [Tulsa] State [Okla.] Zip [74/29
(If not U.S.) Province [] State [Okla.] Zip [74/29
SOCIAL SECURITY # : [] PRACTICE STATUS ! L'Active Retired
BACE: 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. FRIMARI SPECIALITY (COSTETTICS / COUNCED/100 V
BOARD CERTIFICATIONS: List CURRENT American Specialty Board certifications.
American Board of [
American Board of [
Governmental or Licensing Authority, Federal, State or Local? []
1//
(If "Yes") When [] State []
PRACTICE SETTING: List your current employer or self-employed practice setting.
PRACTICE SETTING: List your current employer or self-employed practice setting. EMPLOYER [State of Oklahoma] DATE STARTED (MO/YR) [6/1]
EMPLOYER [State of Oklahoma] DATE STARTED (MO/YR) [6/91]
EMPLOYER [State of Oklahoma] DATE STARTED (MO/YR) [6/41] POST GRADUATE TRAINING: Fill out if you are currently in a training program. Type of Training: Resident Fellowship Continue To Continue Training Program.
EMPLOYER [State of Oklahoma] DATE STARTED (MO/YR) [6/91] 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]
EMPLOYER [State of Oklahoma] DATE STARTED (MO/YR) [6/4]] 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]
EMPLOYER [State of Oklahoma] DATE STARTED (MO/YR) [6/91] 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]
EMPLOYER [State of Oklahoma] DATE STARTED (MO/YR) [6/4]] 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]
EMPLOYER [State of Oklahoma] DATE STARTED (MO/YR) [6/4]] 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]

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 unrenewed licenses become inactive. After August 29, 1988 unrenewed licenses are suspended due to failure to renew. Reinstatement of suspended licenses is \$300.00.

KATHLEEN ANN GLAZE, M.D. 1145 S. UTICA SUITE 1100 46.2 TULSA, OK 74104-4018

REGERVED.

MAR 25 1988

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

13761

OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

COMPLET	E THE	FOLL.	OWING	ì
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PRACTICE SETTING: List the percentage of	practice time spent in the following:
Office based - Solo X Teaching % Adminis	nt % Staff % Other % % Group % Partnership % tration % Research % Other %
List your current emplo	yer or self-employed practice setting:
employer Self	DATE STARTED (MO/YR) 6/85
MAKE APPROPRIATE CHANGES TO THE INFORM	ATION LISTED BELOW :
PRACTICE ADDRESS :	STATUS: ACTIVE
1145 S. UTICA SUITE 1100 ALQ TULSA, OK 74104	
SPECIALTIES :	
 Primary (greater than 50% time spent) 	OBSTETRICS AND GYNECOLOGY
BOARD CERTIFICATIONS (CURRENT): American Board of Obstetricians & Ly. American Board of	
DISCIPLINARY ACTION	
DISCIPLINARY ACTION: Have you ever been Governmental or Licensing Authority, Federa If "Yes" explain briefly:	i. State or local? Y Y
POST-GRADUATE TRAINING (CURRENT) :	
Type of training :	-Hospital
Location : Date Entered : Da	te expected to complete :
MAIL APPLICATION TO : Oklahoma State Board	· · · · · · · · · · · · · · · · · · ·



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.

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

RECEIVED

13761

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

STATE BOARD MEDICAL EXAMINERS

COMPLE	ETE THE	FOLL	DWING

1		
PRACTICE SETTING :	List the percentage of pr	actice time spent in the following:
	Office based - Solo /00	% Staff% Other% % Group% Partnership% ation% Research% Other%
	List your current employe	r or self-employed practice setting:
EMPLOYER	self employed	r or self-employed practice setting: V DATE STARTED (MO/YR) V DATE STARTED (MO/YR)
MAKE APPROPRIATE	CHANGES TO THE INFORMAT	TION LISTED BELOW :
PRACTICE ADDRESS	•	STATUS : ACTIVE
SUITE	S. UTICA 1100 , OK 74104	
SPECIALTIES :		
1. Primary (greate	er than 50% time spent)O	BSTETRICS AND GYNECOLOGY 3.
BOARD CERTIFICATIO American Board of American Board of	ONS (CURRENT): Nexe	
Governmental of FIC	ensing Authority, Federal.	subject of disciplinary action by any State or Local?
POST-GRADUATE TRA	Н	ospital
Location:	· · · · · · · · · · · · · · · · · · ·	
Date Entered :	Date	expected to complete:
MAIL APPLICATION T	O: Oklahoma State Board o P. O. Box 18256 Oklaho	oma City, OK, 73154-0256 Athleen & Laye May 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.

sician Signature

Date

RECEIVED

AUG 0 2 2013

ÖKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUBERVISION

1376

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

JEFFREY A. GLENDENING

OK STATE BOARD OB816 S. SHERIDAN ROAD MEDICOL EXERCIPIETULSA, 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 75118

Re:

Woodruff v. Glaze

Kathleen Ann Glaze, M.D. - 1376

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

Legal Assistant to JEFFREY A. GLENDENING

umi S. anderson

/jla 063/0528/ltr/OkMedBoard001

mailed 10-3-05 52

FELDMAN, FRANDEN, WOODARD, FARRIS & BOUDREAUX

ATTORNEYS AT LAW 1000 PARK CENTRE 525 SOUTH MAIN TULSA, OKLAHOMA 74103-4509 www.tulsalawyer.com

> OF COUNSPL RAYMOND G. HILDMAN

BELINDA AGUILAR THAYLA PAINTER BOHN PAUL T. BOUDREAUX JASEN R CORNS Joseph R. Parris Robert A. Franden Jason Goodnight JODY R. NATHAN FAUL F. PRATHER PAULA J. QUILLIN CURTIS J. ROBERTS VICTOR R. WANDRES JOHN R. WOODARD, III

September 14, 2005

TELEPHONE (918) 583-7129 TIL BCOPY (918) 584-3814

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 Seri 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

pickup file

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

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

September 22, 1989

TELEPHONE AREA CODE 918 582-1234

FAX: 585 - 9447

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,

oseph M. Best

JMB:md

13761 Hlaze 11624 carlson.

SEP 23 1989

OKLAHOMA DAA - BUARD OF MEDICAL LIGHTSURE AND SUPERVISION

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

RECEIVED

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.

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	Scale
07.70	Score	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)

SEAL

83.2

Secretary for Certification

05/26/82

^{*}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.

The Oklahoma State Regents for Higher Lducation acting through the



have admitted

Kuthleen Ann Gluze

to the degree of

Dortor 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.A. niveteen hundred and eighty-one.



For the Aniversity

For the State Regents

Secretary Of 1



Department of Gynecology-Obstetrics

March 12, 1982



STATE BOARD MEDICAL EXAMINERS

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



Department of Internal Medicine

March 12, 1982



STATE BOARD MEDICAL EXAMINERS

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

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

STATE OF <u>Oklahoma</u>)	
COUNTY OF Tulsa	
The applicant Kathleen A-Glaze M.D.	
I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past an present), business and professional associates (past and present) and all government agencies (local, state, federal foreign) to release to the OKLAHOMA STATE BOARD OF MEDICAL EXAMINERS or its successors as information, files or records requested by that Board in connection with this application. I further authorize to OKLAHOMA STATE BOARD OF MEDICAL EXAMINERS or its successors to release to the organization individuals or groups listed above any information which is material to this application or any subsequent licensury. APPLICANTS SIGNATURE	or ny he
Subscribed and sworn to before me this	• .
Notary Public	
My commission expires on the 18 day of Dalway 19 8	į
I. Kathleen A. Glaze, M.D., certify that I (HAVE) HAVE NOT X) been involved in a malpractice claim.	ł
IF YOU HAVE BEEN, EXPLAIN FULLY IN DETAIL ON A SEPARATE SHEET OF PAPER. APPLICANT'S SIGNATURE M.D.	
subscribed and sworn to before me this 1 day of Morch . 19 82	
Connie 7. Davis Notary Public	
ly commission expires on the 18 day of Jalouery	

7-17-87

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

LAW OFFICES

Best, Sharp, Thomas, Glass & Atkinson

PROFESSIONAL CORPORATION

1500 PARKCENTRE

525 SOUTH MAIN, TULSA, OKLAHOMA 74103

(918) 582-8877

July 14, 1987

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 *

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.

y truly yours,

Jøseph M/ Best

1

JMB:md

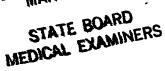
DEGETVED

JUL 15 1987

OKLAHUMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION

Board of Medical Examiners State of Oklahoma





DRUG ENFORCEMENT ADMINISTRATION

Gentlemen:

NAME:

the State of Oklahoma.

FEDERATION OF STATE MEDICAL BOARDS



OFFICE OF THE SECRETARY

TELEPHONE 848-6841 P.O. BOX 18256

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

Kathleen Ann Glaze, M.D.

OKLAHOMA CITY, OKLAHOMA 7315 ACCOPACION OF STATE MEDICAL BOSTIS of the United States

MAR 191982

PREV. CORRES_

ANS:__ CHECK

BY_

		informa the abo	ve no unfavorable tion regarding ove named physician dependent of the physician ve Director-Secretor), 1D.
		Date	MAR 2 5 1982	
REMARKS:				
BJR/njp				
Miss) Betty J. Rogers Executive Secretary	∠ 8			
Sincerely,				
M. D. DEGREE:	University of Oklah	oma College o	f Medicine	
DATE OF BIRTH:	May 2, 1952			
ADDRESS:	4012 East 42nd Plac Tulsa, Oklahoma 741			



UR MEDICAL, EXAMINERE

hursuant to the (Klahoma, satisfactory evidence of Be it known that Board



Medical License No. 1376

IN TESTIMONY WHERE OF, we have hereunto set our hands and I the official seal of said board to be inpressed thereon, this

THE CHAPT

Board of Medical Kxaminers State of Oklahoma



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



STATE BOARD MEDICAL EXAMINERS

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,

(Miss) Betty J. Rogers Executive Secretary

BJR/njp

REMARKS:

MAR 19 1982

MAR 19 1982

date
date

date

is currently registered with DEA.

is not of record with DEA.

is not of record with DEA.

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.

M
A
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i

P	1145 SOUTH UTICA AVENUE
R	SUITE 514
A	TULSA, OK 74104-4018
C T	(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.

pr	rescribing, administering, or the giving of samples. I wish to be registered to dispense dangerous drugsYES	X NO
T	he following information is mandatory and information provided may be investigated Since the last renewal or initial licensure (whichever is most recent).	further.
A.	Has your application for a license been denied?	X_
В.	Have you surrendered a license or had any disciplinary action taken on any license?	<u></u>
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?	
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.		
G.	Have you obtained an assessment or been treated for use of any drug or chemical substance including alcohol?	
Н.	Have you had any mental or physical disorder or condition which if untreated could affect your ability to practice competently?	, ———
l.	Have you been denied provider participation, terminated, sanctioned or penalized by any third party payor to include TRICARE, MEDICARE, or MEDICAID?	
J.		
K.	Have you been denied membership or had disciplinary action taken by a national, state, or county medical organization?	
L.	Have you been denied or had removed or suspended hospital staff privileges?	_ <u>x</u>
М.	Have you surrendered hospital staff privileges while under investigation or to avoid investigation?	
N.	Have you entered into an Agreement with a Federal, State, or Local jurisdictional body to avoid formal action?	

071213:MDRENEW Page 1 of 2

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.

TU	145 SOUTH UTICA AVENUE #514 ULSA, OK 74104-4018 M A I L C T (918) 583-6868	
Ph	ou are required pursuant to 59 O.S. § 355.1(B) to indicate your preference. Please read and check propriate response. Any Medical Doctor who desires to DISPENSE "dangerous drugs" as defined narmacy Law, must register annually with the Board. This is for dispensing only and does not incluse escribing, administering, or the giving of samples.	4 1 41
	i wish to be registered to dispense dangerous drugsYE	S X NO
~		
	he following information is mandatory and information provided may be investigat Since the last renewal or initial licensure (whichever is most recent): Has your application for examination or a license been denied?	VEO NO
A. B. C.	Have you surrendered a license or had a license revoked? Has any disciplinary action been taken on any license?	YES NO
A. B. C. D. E.	Have you surrendered a license or had a license revoked? Has any disciplinary action been taken on any license? Have you been requested to appear before a licensing or disciplinary agency? Have you been arrested for, charged with, or convicted of a felony or misdemeanor other than a traffic violation?	YES NO X X X X
A. B. C. D. E.	Have you been arrested for, charged with, or convicted of a traffic violation involving the use of	YES NO X X X X X X X X X X X X X X X X X X
A. B. C. D. E.	Have you been arrested for, charged with, or convicted of a traffic violation involving the use of	YES NO X X X X X X
A. B. C. D. E. F.	Have you been arrested for, charged with, or convicted of a traffic violation involving the use of drugs and/or alcohol?	YES NO X X X X X X

020116:MDRENEW Page 1 of 2

Have you been denied provider participation, terminated, sanctioned or penalized by any third party payor to include CHAMPUS, MEDICARE, MEDICAID?-----

K. Have you surrendered any license or narcotic permit (State or Federal)?

or county medical association?

M. Have you been denied or had removed or suspended hospital staff privileges?
 N. Have you surrendered hospital staff privileges while under investigation or to avoid investigation?

P. Have you entered into an Agreement with a Federal, State, or Local jurisdictional body to avoid formal action?

clinic, residency program or professional school?

Have you been denied membership or had disciplinary action taken by a national, state,

O. Have you withdrawn an application for hospital staff privileges?

Q. Have you been the subject of disciplinary action, including probation, by a hospital,

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.

13761

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.

	ATHLEEN ANN GLAZE, M.D.						
1	145 SOUTH UTICA AVENUE #514			. 14	145 SOUTH UTICA AVENUE		
TI	ULSA, OK 74104-4018	M	I P		SUITE 514		
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	- Andrews - Andr						
Y	ou are required pursuant to 59 O.S. § 355	.1(B) to indi	icate vour	pre	ference. Please read and chec	ŀ	
ah	propriate response. Any Megical Doctor	Who desire:	s to DISPE	-NS	SE "dangeroue dauge" ee desee.	al : Al	
	idimacy Law, must register annually with	the Board	This is for	dis	spensing only and does not inclu	ude	
pr	escribing, administering, or the giving of s	amples.			•		
	l wish to be i	registered	to dispens	se (dangerous drugsYE	ES _x	_NO
T	he following information is mandat	orv and in	nformatio	n i	provided may be investige	tod forti	her.
	Since the last renewal of	or initial lie	censure ((wi	hichever is most recent).	\/ = 0	
A.	Has your application for examination or	a license b	een denied	j?			X
B.	Have you surrendered a license or had	a license re	avokad2				v
Ç.	Has any disciplinary action been taken of Have you been requested to appear her	on any licer	rse?	• • • • • •		-	- -
							X
	a traffic violation?	ui, or convi	cted of a re	∍IO∏	ly or misdemeanor other than		
F.	Have you been arrested for charged with	th, or convid	cted of a tr	affi	c violation involving the use of	·	
G	drugs and/or alcohol?	•••••			······································	· <u> </u>	<u> </u>
G.	Have you been addicted to or abused ar	ny arug or c	chemical su	ubs	tance including alcohol?		_X_
H.	Have you obtained an assessment or be	en treated	for use of a	any	/ drug or chemical substance		
i.						·	<u>_x</u>
••	Have you had any mental, emotional or affect, or if untreated could affect, your a	nervous als ability to pra	soraer or co actice comm	ond	lition which could		Y
J.	Have you been denied provider participa by any third party payor to include CHAN	ation, termin	nated, san	ctic	oned or penalized		v
K.	Have you surrendered any license or na	rcotic perm	nit (State or	Fe	deral)?		_X
L.	Have you been denied membership or h	ad disciplin	any action :	tak	en by a national atota		
	or county medical association?				en by a national, state,		<u>X</u>
М	Have you been denied or had ramayed a						
١٦.	Have you been denied or had removed of Have you surrendered hospital staff privil Have you withdrawn an application for he	ileaes While	inder inva	acti	iastion of to ovaid investigations	•	-^
0.	Have you withdrawn an application for he	ospital staff	f privileges	ლა ?	gation of to avoid investigation?	<u> </u>	\\ \\ \\
٠.	Have you entered into an Agreement wit formal action?	n a recerai	ı, State, or	LO	cal jurisdictional body to avoid		Y
<u>.</u>							
u.	Have you been the subject of disciplinary clinic, residency program or professional	/ action, inc	cluding prob	bati	ion, by a hospital,		v
	program or professional	201001	••••••••	•••••			

020116:MDRENEW

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.

	45 SOUTH UTICA AVENUE #514 ILSA, OK 74104-4018 M A I L		P 1145 SOUTH UTICA AVENUE SUITE 514 TULSA, OK 74104-4018 C (918) 583-6868			
app Pha pre	ne following information is mandatory ar Since the last renewal or initi	esires to DISF ard. This is f s. ered to dispe nd informat al licensure	SPENSE "dangerous drugs" as defined in for dispensing only and does not include pense dangerous drugs. YES ation provided may be investigated re (whichever is most recent):	_X_NO		
A.	Has your application for examination or a licen	se been deni	nied?	X		
D. E.	Have you surrendered a license or had a license revoked? Has any disciplinary action been taken on any license? Have you been requested to appear before a licensing or disciplinary agency? Have you been arrested for, charged with, or convicted of a felony or misdemeanor other than a traffic violation?					
	Have you been arrested for, charged with, or c drugs and/or alcohol?	convicted of a	a traffic violation involving the use of	~		
H.	Have you obtained an assessment or been treincluding alcohol?	ated for use o	of any drug or chemical substance	_ <u>_x</u>		
J.	Have you been denied provider participation, to by any third party payor to include CHAMPUS,	erminated s:	sanctioned or penalized			
K.	Have you surrendered any license or narcotic	permit (State	e or Federal)?	<u> </u>		
	Have you been denied membership or had discor county medical association?		·			
N.	Have you been denied or had removed or susp Have you surrendered hospital staff privileges Have you withdrawn an application for hospital	while under i	investigation or to avoid investigation?	X		
P.	Have you entered into an Agreement with a Fe formal action?	deral, State,	, or Local jurisdictional body to avoid	<u></u> X_		
Q.	Have you been the subject of disciplinary action clinic, residency program or professional school	n, including p ນ່າ?·····	probation, by a hospital,	<u>_x</u> _		

020116:MDRENEW Page 1 of 2

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. 1145 SOUTH UTICA AVENUE #514 TULSA, OK 74104-4018 M A I L P R A C T (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 drugsYE	S	X N	10			
I ne following information is mandatory and information provided may be investigated further. Since the last renewal or initial licensure (whichever is most recently)							
A.	ries your application for examination or a license been denied?			O X			
B. C.	Have you surrendered a license or had a license revoked? Has any disciplinary action been taken on any license? Have you been requested to appear before a licensing or disciplinary agency? Have you been arrested for, charged with, or convicted of a felony or misdemeanor other than have you been arrested for, charged with, or convicted of a traffic violation?	·——		X Y			
	denies and the state of the sta						
	or chemical substance including alcohol?			<u>X</u> _			
H.	Have you obtained an assessment or been treated for use of any drug or chemical substance						
1.	Have you had any mental, emotional or nervous disorder or condition which could affect, or if untreated could affect, your ability to practice competently?						
J.	Have you been denied provider participation, terminated, sanctioned or penalized by any third party payor to include CHAMPUS, MEDICARE, MEDICAID?						
K.	Have you surrendered any license or narcotic permit (State or Federal)?		_)	<u> </u>			
	Have you been denied membership or had disciplinary action taken by a national, state, or county medical association?						
M. N.	Have you been denied or had removed or suspended hospital staff privileges? ————————————————————————————————————						
P.	Have you entered into an Agreement with a Federal, State, or Local jurisdictional body to avoid formal action?						
Q.	Have you been the subject of disciplinary action, including probation, by a hospital, clinic, residency program or professional school?	_	-				

020116:MDRENEW

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 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 OK STATE BOARD OF OKLAHOMA CITY, OK 73154-0256 Mark any changes to the addresses below. Please inform this office of all address changes. SUPERVISION MEDICAL LICENSURE 13761 KATHLEEN ANN GLAZE, M.D. 1145 SOUTH UTICA AVENUE #514 1145 SOUTH UTICA AVENUE TULSA, OK 74104-4018 M **SUITE 514** R Α TULSA, OK 74104-4018 A C (918) 583-6868 x T Have you met the Oklahoma CME requirement? X YES 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. The following information is mandatory and information provided may be investigated further. Since the last renewal or initial licensure (whichever is most recent): A. Has your application for examination or a license been denied?.... Have you surrendered a license or had a license revoked?

Has any disciplinary action been taken on any license?

Have you been requested to appear before a licensing or disciplinary agency?

Have you been arrested for, charged with or convicted of a felony or misdemeanor other than a traffic violation? Have you been arrested for, charged with or convicted of a traffic violation involving the use of drugs and/or alcohol?.... G. Have you been addicted to or abused any drug or chemical substance including alcohol?..... Have you obtained an assessment or been treated for use of any drug or chemical substance affect, or if untreated could affect, your ability to practice competently?..... Have you been denied provider participation, terminated, sanctioned or penalized by any third party payor to include CHAMPUS, MEDICARE, MEDICAID?-----K. Have you surrendered any license or narcotic permit (State or Federal)?----Have you been denied membership or had disciplinary action taken by a national, state, or county medical association? Have you been denied or had removed or suspended hospital staff privileges?----Have you surrendered hospital staff privileges while under investigation or to avoid investigation? Have you withdrawn an application for hospital staff privileges? Have you entered into an Agreement with a Federal, State, or Local jurisdictional body to avoid formal action?.... Q. Have you been the subject of disciplinary action, including probation, by a hospital, clinic, residency program or professional school?.....

(Complete Back of Form)

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

This form must be completed a	nd returned to this office with a renewal fee of \$150,00 on or before July 1, 2002. After that date,
the liceuse becomes mactive.	(enewals may be accepted for 60 days with a fee of \$275 on Affer so days when a
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 963. 434 20.15

OKLAHOMA CITY, OK 73154-0256

	Mark any changes to the addresses below. Please inform this office of all address changes.	
13	761	* ¹⁷
K/	ATHLEEN ANN GLAZE, M.D.	
1 T	145 SOUTH UTICA AVENUE #514 TULSA, OK 74104-4018 M A I L P R A C T You Must Provide a Practice Phone #	
a _i P	ou are required pursuant to 59 O.S. § 355.1(B) to indicate your preference. Please read and check ppropriate response. Any Medical Doctor who desires to DISPENSE "dangerous drugs" as defined in the harmacy Law, must register annually with the Board. This is for dispensing only and does not include rescribing, administering, or the giving of samples.	
	I wish to be registered to dispense dangerous drugsYES	10
• Т	he following information is mandatory and information provided may be investigated furth Since the last renewal or initial licensure (whichever is most recent): YES	
A.	Has your application for examination or a license been denied?	20
	Have you surrendered a license or had a license revoked? Has any disciplinary action been taken on any license? Have you been requested to appear before a licensing or disciplinary agency?	<u>×</u>
	Have you been arrested or charged or convicted of a felony or misdemeanor?	×
D.	Have you been addicted to or abused any drug or chemical substance including alcohol?	<u>×</u>
E.	Have you obtained an assessment or been treated for use of any drug or chemical substance including alcohol?	<u> </u>
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?	<u> </u>
Н.	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? Have you surrendered hospital staff privileges while under investigation or to avoid investigation? Have you withdrawn an application for hospital staff privileges?	<u>\</u>
K.	Have you entered into an Agreement with a Federal, State, or Local jurisdictional body to avoid	,

(Complete Back of Form)

L. Have you been the subject of disciplinary action, including probation, by a hospital, clinic, residency program or professional school?....

formal action?

This form must be completed and returned to this office with Renewals may be accepted for 60 days after that date with a suspended. Mail Renewal application to:	a renewal fee of \$15 fee of \$275.00. Aft	50.00 on or before Ju er 60 days, unrenew	ed Licenses are	CHIVED
OKLAHOMA STATE BOARD OF ME PO BOX 18256 OKLAHOMA CITY, OK 73154-028		RE AND SUPERV	ISION OK TO	-7 All 8: 22
Mark any changes to the addresses below.	Please inform th	is office of all add	iress changes	المحروف الأراث الأولاد الأولاد الأولاد الأولاد الأولا
13761 KATHLEEN ANN GLAZE, M.D.				
1145 SOUTH UTICA AVENUE #514	PRA	1145 SOUTH I SUITE 514	UTICA AVENUE	
TULSA, OK 74104-4018	C	TULSA, OK 7	4104-4018	
DO YOU WISH TO APPLY FOR PHYSICIAN EM If "YES", Enclose a \$50 processing fee. There will The Following Restrictions apply to Physician Eme A) You may continue to use the title "DOCTOR EX: John Doe, MD (RET) B) You cannot practice medicine in any form. Y	t be no renewal feritus (FULLY RI " and suffix "MD ou cannot preso	ee. ETIRED) Physici ", but must indica ribe, dispense o	ans: ate your retired st r administer drug:	atus.
The following information is mandatory and in Since the last renewal or initial licensure (which	hever is most r	ecent):		r. YES NO
Have you been the subject of disciplinary a		federal,	state, or local?	_\ <u>×</u>
Have you been charge				\X
Are you now using any drug or chemical substance	e including alcoh on your ab	ol which has an illity to practice ye	adverse impact our profession?	
Do you have a mental disorder which has a	ın adverse impad	ct on your ability	to practice your profession?	X
	se a copy of the	report received f	rom the NPDB.	<u>×</u>
Have you voluntarily surrendered any medic				×
Have you been denied privileges, lost privilege	es or received di pro	scipline by any h fessional medica	ospital or other Il organization?	
. 1	Has a malpractio	e claim been file	ed against you?	X
Have you had a major i	liness or been ho	spitalized within	the past year?	<u>X</u>
You are required pursuant to 59O.S. S.S.355.1(B) check appropriate response. Any Medical Doctor widefined in the Pharmacy Law, must register annual does not include prescribing, administering, or the	/ho desires to DI lly with the Board	SPENSE "dange L This is for disp	rous druge" es	
		dispense dang	erous drugs.	<u> </u>
(Complete E	Back of Form)			

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 accepted 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 th	is offi	ice o	f all address changes.			4.
13761 Kathleen ann glaze, m.d.						
1145 SOUTH UTICA AVENUE #514 TULSA OK 74104-4018	M A I L	P R A C T	1145 SOUTH UTICA AVENUE SUITE 514 TULSA OK 74104-4018	-	50 50 50 50 50 50 50 50 50 50 50 50 50 5	i i
Have you met the Oklahoma CME requirement?			X	YE	s	_NO
DO YOU WISH TO APPLY FOR PHYSICIAN EMER if "YES", Enclose a \$50 processing fee. There will be The Following Restrictions apply to Physician Emeri A) You may continue to use the title "DOCTOR" a EX: John Doe, MD (RET) B) You cannot practice medicine in any form. You	e no tus (F and s	rene FUL uffix	ewal fee. LY RETIRED) Physicians: ‹ "MD", but must indicate your i	retired	status.	_NO
The following information is mandatory and info Since the last renewal or initial licensure (which	rmat ever i	ion is m	provided may be investigate	d furt	her. YES	NO
lave you been the subject of disciplinary action by a ederal, state, or local?	ıny go	over	nmental or licensing authority,		1,50	_X
lave you been charged with or convicted of a felony	or m	nisde	emeanor?	.		×
Are you now using any drug or chemical substance impact on your ability to practice your profession?	nclud	liņg	alcohol which has an adverse			
Do you have a mental disorder which has an adverse profession?	e imp	act	on your ability to practice your			X.
lave you been reported to the National Practitioner I of the report received from the NPDB.	Data	Вап	k (NPDB)? if "yes", enclose a	сору		<u> </u>
łave you voluntarily surrendered any medical licenso	e or r	arc	otic permit (State or Federal)?			X
lave you been denied privileges, lost privileges or re professional medical organization?	ceive	ed d	iscipline by any hospital or othe	er		
las a malpractice claim been filed against you?			•			\overline{x}
łave you had a major illness or been hospitalized wi	thin t	he p	past year?			X
ou are required pursuant to 59O.S. S.S.355.1(B) to ppropriate response. Any Medical Doctor who desire tharmacy Law, must register annually with the Board rescribing, administering, or the giving of samples.	es to	פוח	PENSE "dangerous druge" oc	م دائمه		
WISH TO BE REGISTERED TO DISPENSE DANG	3ER(DUS	DRUGS.			X
(COMPLET	FRA	CK (OF FORM			

991120: MDRENEW

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-#482 77.5/4 TULSA, OK 74104-4018

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 m	andatory and renewal will NOT be accepted if incomplete
or blank		
LICENSE	NUMBER: 13761	SOCIAL SECURITY NUMBER:
I DO ⊠	DO NOT WISH TO BE REGISTERE	D TO DISPENSE DANGEROUS DRUGS.
Licensing	NARY ACTION: Have you ever been properly Authority, Federal, State, or Local?_xplain briefly:	n the subject of disciplinary action by any Governmental or
·	PRACTICE ADDRESS	OTHER STATES IN WHICH YOU ARE OR HAVE
	S. UTICA E 482	
	JUL: '	TATE BOARD OF
		LICENSURE PERVISION DKIAHOMA STATE BOARD OF MEDICAL LICENSURE MEDICAL LICENSURE AND SUPERVISION

DO YOU WISH TO APPLY FOR PHYSICIAN EMERITUS (FULLY RETIRED) STATUS? YES IN IN IT "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 POLLOWING 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.

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 #482 TULSA, OK 74104-4018

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

NOTE: The information on this page is n	nandatory and renewal will NOT be accepted if incomplete
or blank.	
LICENSE NUMBER: 13761	SOCIAL SECURITY NUMBER:
I DO 🗷 DO NOT 🗆 WISH TO BE REGISTERE	ED TO DISPENSE DANGEROUS DRUGS.
DISCIPLINARY ACTION: Have you ever bee Licensing Authority, Federal, State, or Local?_ If yes, explain briefly:	en the subject of disciplinary action by any Governmental or
	SEPRIME IN
PRACTICE ADDRESS	OTHER STATES IN WHICH YOU ARE OR HAVE
1145 S. UTICA	BEEN LICENSED TO PRACTICE MEDICINE:
V 1145 3: 5:25A	
SUITE 482	Manara State BOARD # JUN 9 1993
TULSA, OK 74104	AND SUPERVISION OKLAHOMA STATE BOARD OF
	MEDICAL LICENSURE
	AND SUPERVISION

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

- 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.

0

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 #482 TULSA, OK 74104-4018

IF "YES":

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 m	andatory and renewal will NOT be accepted if incomplete
or blank.	•
LICENSE NUMBER: 13761	
I DO 🖼 DO NOT 🗀 WISH TO BE REGISTERE	D TO DISPENSE DANGEROUS DRUGS.
DISCIPLINARY ACTION: Have you ever be Licensing Authority, Federal, State, or Local?_ If yes, explain briefly:	
PRACTICE ADDRESS	OTHER STATES IN WHICH YOU ARE OR HAVE BEEN LICENSED TO PRACTICE MEDICINE:
V 1145 S. UTICA	
SUITE 462	
TULSA, OK 74104	

- 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 IDENTIFY-ING YOU AS PHYSICIAN EMERITUS.)

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

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

- 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.

(2

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		PRACTICE ACTIVITY STATUS (X)
\mathcal{D}	KATHLEEN ANN GLAZE, M.D.		<pre>Currently practicing Not currently practicing</pre>
	1145 S UTICA AVE #462	•	Retired
	TULSA, OK 74104-4018	,	<pre> Semi-Retired 30 hrs or less/wł Other (specify)</pre>
COMPL ADD A	ETE BOTH SIDES OF THIS FORM. MAK NY MISSING INFORMATION TO PROTECT	KE APPROPRIATE CORRECT THE ACCURACY OF YO	CTIONS TO THE INFORMATION AND DUR PUBLIC FILE.
LICENS	E NUMBER: 13761	SOCIAL SECURITY	NIIMRER.
1 00	DO NOTWISH TO BE REGIST	ERED TO DISPENSE CONT	ROLLED DANGEROUS DRUGS.
SPECIA	LITIES:		
1. Pr 2	imary (greater than 50% time spent) OBSTETRICS AND GY	NECOLOGY
BOARD AM	CERTIFICATIONS (CURRENT): Add Boar ERICAN BOARD OF OBSTETRICS AND GYN	rds by exact name-give	
DISCIPL or Lice	INARY ACTION: Have you ever been to ensing Authority, Federal, State, o	the subject of disciplor Local? <u>No</u> lf	inary action by any Governmental yes, explain briefly:
POST-G	RADUATE TRAINING (CURRENT):		
Type of	training:	Hospital:	
	tered:Dat	te expected to complet	e:
Employe	E INFORMATION (CURRENT): PRIVATE PRACTICE		
Lity, S Type of	tate/Country: TULSA, OKLAHOMA practice or specialty: OB-GYN		
. , pc 0,	practice or specialty: OB-GYN		Date started: 07/85
	PRACTICE ADDRESS	OTHER STATES IN	I MILIOU VOLL ADD OF THE
1144	S. UTICA	LICENSED TO PRA	WHICH YOU ARE OR HAVE BEEN
	E 462	•	- DPGD3-
TULS	SA, OR 74104		REGERVEN
			MAY 14 1990
			OKLAHUMA STATE BOARD OF MEDICAL LICENSURE
			AND SUPERVISION



AMA PHYSICIAN PROFILE

STATE BOARD MEDICAL EXAMINERS

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

2:25 PM TIME:

AME: GLAZE, KATHLEEN ANN, M.D.

TULSA OK

74135

DDRESS: 4012 E 42ND PLACE IRTHPLACE: OKLAHOMA, OK

BIRTHDATE: 05/02/52

EDICAL EDUCATION (SCHOOL YEAR):

UNIV OF OKLAHOMA COLL MED, OKLAHOMA CITY OK 73104 ATIONAL BOARD CERTIFICATION: NONE REPORTED TO DATE

1981

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

OPYRIGHT 1982 AMERICAN MEDICAL ASSOCIATION **AMA FILES CHECKED** SEE REVERSE

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 mor blank.	anditory and renewal will NOT be accepted if incomplete
LICENSE NUMBER: 13761	SOCIAL SECURITY NUMBER:
PRACTICE ADDRESS:	OTHER STATES IN WHICH YOU ARE OR HAVE
1145 SOUTH UTICA AVENUE	BEEN LICENSED TO PRACTICE MEDICINE:
SUITE 514	
TULSA, OK 74104-4018	

DO YOU WISH TO APPLY FOR PHYSICIAN EMERITUS (FULLY RETIRED) STATUS? YES \square NO \boxtimes 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 IDENTIFY-ING 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 (MINCHEVER 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.)		V
ARE YOU NOW USING ANY DRUG OR CHEMICAL SUBSTANCE INCLUDING ALCOHOL WHICH HAS AN ADVERSE IMPACT ON YOUR ABILITY TO PRACTICE MEDICINE AND SURGERY?		V
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.		V
HAVE YOU VOLUNTARILY SURRENDERED ANY MEDICAL LICENSE OR NARCOTIC PERMIT (STATE OR FEDERAL)?		V
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?		V
HAVE YOU HAD A MAJOR ILLNESS OR BEEN HOSPITALIZED WITHIN THE PAST YEAR?		V

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 no or blank.	nanditory and renewal will NOT be accepted if incomplete
LICENSE NUMBER: 13761	SOCIAL SECURITY NUMBER:
PRACTICE ADDRESS:	OTHER STATES IN WHICH YOU ARE OR HAVE BEEN LICENSED TO PRACTICE MEDICINE:
SUITE 514 TULSA, OK 74104-4018	None

DO YOU WISH TO APPLY FOR PHYSICIAN EMERITUS (FULLY RETIRED) STATUS? YES \square NO \boxtimes IF "YES":

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- 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 HITTAL 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?		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)?	11	X
HAVE YOU BEEN DENIED PRIVILEGES, LOST PRIVILEGES OR RECEIVED DISCIPLINE BY ANY HOSPITAL OR OTHER PROFESSIONAL MEDICAL ORGANIZATION?	11	X
HAS A MALPRACTICE CLAIM BEEN FILED AGAINST YOU?	-	X
HAVE YOU HAD A MAJOR ILLNESS OR BEEN HOSPITALIZED WITHIN THE PAST YEAR?	++	X

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

HAS A MALPRACTICE CLAIM BEEN FILED AGAINST YOU?

HAVE YOU HAD A MAJOR ILLNESS OR BEEN HOSPITALIZED WITHIN THE PAST YEAR?

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.

LICENSE NUMBER: 13761	SOCIAL SECURITY NUMBER:	
DISCIPLINARY ACTION: Have you be used to be	rou ever been the subject of disciplinary action by any governments, or Local? <u>No</u>	tal or
PRACTICE ADDRE	OTHER STATES IN WHICH TOU ARE UK I	HAVE
1145 SOUTH UTICA AVENUE	BEEN LICENSED TO PRACTICE MEDICINE	:
SUITE 514		
TULSA, OK 74104-4018		
A) YOU MAY CONTINUE TO DICATE YOUR RETIRED B) YOU CANNOT PRACTICE C) YOU CANNOT PRESCRIBE	S APPLY TO PHYSICIAN EMERITUS (FULLY RETIRED PHYSICIAN DUSE THE TITLE "DOCTOR" AND THE SUFFIX "M.D.", BUT MUST STATUS. EXAMPLE: DOCTOR JOHN DOE, M.D. (RET.) MEDICINE IN ANY FORM. BE, DISPENSE OR ADMINISTER DRUGS. S MANDATORY AND INFORMATION PROVIDED MAY BE INVESTIGATIVE A NOTARIZED, DETAILED STATEMENT.	IS).
		ATED
INCE THE LAST RENEWAL OR INITIAL LI	CENSURE (WHICHEVER IS MOST RECENT) YES	NO
INCE THE LAST RENEWAL OR INITIAL LI	ICENSURE (WHICHEVER IS MOST RECENT) A FELONY OR MISDEMEANOR?	
HAVE YOU BEEN CONVICTED OF	CENSURE (WHICHEVER IS MOST RECENT) YES	NO
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12-

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 MISS-ING INFORMATION TO PROTECT THE ACCURACY OF YOUR PUBLIC FILE.

LIGHTON AND ADDRESS OF THE PARTY OF THE PART	cory and renewal will NOT be accepted if incomplete
SC	OCIAL SECURITY NUMBER:
DISCIPLINARY ACTION: Have you ever been the Licensing Authority, Federal, State, or Local? <u>No.</u> If yes, explain briefly:	subject of disciplinary action by any Governmental or
PRACTICE ADDRESS	OTHER STATES IN WHICH YOU ARE OR HAVE
1145 SOUTH UTICA AVENUE	BEEN LICENSED TO PRACTICE MEDICINE:
SUITE 514	
TULSA, OK 74104-4018	

OO 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 IDENTIFY-ING 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.

YES	NO
	χ
	×
	X
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	X
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-+	<u>×</u>
	YES

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 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 UT!CA AVENUE SUITE 514 TULSA, OK 74104-4018

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

LICENSE NUMBER: 13761 SOCIAL	SECURITY NUMBER:			
DISCIPLINARY ACTION: Have you ever been the subjectionsing Authority, Federal, State, or Local? Albert 1998, explain briefly:	act of disciplinary action by a	ny Gover	nmenta	d or
PRACTICE ADDRESS	OTHER STATES IN WHICH Y	OII ADD	OP H	
1145 SOUTH UTICA AVENUE	BEEN LICENSED TO PRACTIC	E MEDIO	CINE:	TVE
SUITE 514				_
TULSA, OK 74104-4018	<u>>취</u> 조 유무의	<u>용</u>		
-		3 3		
DO YOU WISH TO APPLY FOR PHYSICIAN EMERITUS IF "YES":	(FULLY RETIRED) STATUS?		NO IS	 }
A) ENCLOSE A \$50.00 PROCESSING FEE. THERE Y B) RETURN TO THIS BOARD YOUR WALLET CARI ING YOU AS PHYSICIAN EMERITUS.)		ယ		
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DICATE YOUR RETIRED STATUS. EXAMPLE: B) YOU CANNOT PRACTICE MEDICINE IN ANY FO C) YOU CANNOT PRESCRIBE, DISPENSE OR ADMIT THE FOLLOWING INFORMATION IS MANDATORY AND INITIAL PROPERTY. BINCE THE LAST RENEWAL OR INITIAL DEPOSITION OF MISDEME. ARE YOU BEEN CONVICTED OF A FELONY OR MISDEME. ARE YOU NOW USING ANY DRUG OR CHEMICAL SUBSTANTIAS AN ADVERSE IMPACT ON YOUR ABILITY TO PRACTICE OF PRACTICE MEDICINE AND SURGERY? LAVE YOU BEEN REPORTED TO THE NATIONAL PRACTITION OF YOUR ADVENUE AND SURGERY? LAVE YOU BEEN REPORTED TO THE REPORT RECEIVED FROM AVE YOU VOLUNTARILY SURRENDERED ANY MEDICAL LICETATE OR FEDERAL)? AVE YOU BEEN DENIED PRIVILEGES, LOST PRIVILEGES OF OSPITAL OR OTHER PROFESSIONAL MEDICAL ORGANIZAT	FORMATION PROVIDED MAY BE ALLED STATEMENT. ST RECENT: ANOR? VERSE IMPACT ON YOUR ABIL! NER DATA BANK(NPDB)? MY THE NPDB. CENSE OR NARCOTIC PERMIT	", BUT MET.) BE INVEST	TIGATI YES NO	N-
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APPLICATION FOR ENDORSEMENT

Oklahoma State Board of Medical Examiners

(Read Entire Blank Carefully)

	(FOR	OFFICE	USE	ONLY)	
ame					
pplication	ı Requ	ested			
pplication	sent.				

PRINT OR TYPE ANSWERS TO ALL G	UESTIONS ON THIS F	ORM IN FULL	
License Certificate No. 252969	having been issued to	me by the National Board of M	ledical Evaminars OR the Board
of Medical Examiners for the State of.		on the lab day of	July 1982
I hereby apply for license to practice Me	dicine and Surgery in th		
12.11.1	een Hon	Glaze	Age 29
2. My nationality is U.S. A.	(First, middle and last nam	e must be given)	and write the English language.
3. My present post office address is	4012 E. 42n	d Place Tulsa sta	te of Oklahoma
4. I was born at Oklahow		and City) of 1	May 1952
5. I intend to locate at Tulsa	Medical Col	lege in Tul	Sa County.
6. Type of Practice Residen	+ / Obstet	rics & Bynecolog	L - PGIL
Specialty Certification		Member Spec. Board	
Basic Science Exam. Yes X No_	Where <u>0U - C</u>		ine
Military Commission (Active Service)	From	то
	(Rank	and Branch)	
Height 5 '7" Weight	14516s R		lair
Color Hair Blonde Color Ex	72 1.	- Our production	fair
(Strawherry)	V	arks or Scars MOVE	
7. HIGHSCHOOL MUSKBGEE CER			DENCY OR FELLOWSHIP, CONT.
CITY MALSKOGESTATE OKLO		affiliated nesp. Hosp_ 2 STATE OKIA, CITY	STATE
FROM 1967 TO 1970	FROM 7/1/5	TO 6/31/82 FROM	то
ніднясноог	SPECIAL WORK	OB-Gift PG-1 SUPERVIS	
FROMTO		134 6 +11 :	WORK
DATE OF GRAD.	POST GRAD. COLL		STATE
Randolph-Macon W	FROM 1974	TO 1976 FROM	
CITY MACHINES	#.3Ana+	27/M C SOFERVIS	
FROM 1970 TO 72 1973	HOSP	Y OR FELLOWSHIP	
REMARKS (A.B. / Biology)		HOSP	STATE
PRE-MED. COLLEGE DAVIDSON COL CITY DAVIDSON STATE N. C.	SPECIAL WORK	FROM	то
FROM 1972 to 1973		SUPERVIS	
REMARKS			
9. MEDICAL EDUCATION (Give exact	77	1/2 -0	-10 ··· 0
First Year From 8/29	,19/, to	19 /8, in	DU - MUX College
Second Year From 8/28	, 19 <u>/0</u> , to	6/1, 19/7, in	Oll - Mid College
Fourth Year From 1/10	, 19 / 1, to	1980, in	OU - TWC College
10. THE DEGREE, Doctor of	, 19 <u>00</u> , to	, 19 <u>01,</u> in	College College
Oklahoma. Colle	as of madia	was conferred on me	by the University o
13.	1	E RECORD	<u>1981</u>
	TRACTIC		
FROM TO CITY	STATE	CLINIC HOSP, GOVT, OR STATE AGENCIES OR NON-PROFIT ORG.	TYPE PRACTICE
- Name of the last			
			4
	_		

17. RECOMMENDATION OF COUNTY MEDICAL SOCIETY.
We, the undersigned, President and Secretary of theCounty Medical Society,
(Fall Name of Application 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
Torritoble months of wall to the second seco
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?
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 resk
5. Are you now or have you ever been directly or indirectly associated with an advertising physician or an
advertising medical office?
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
. 11 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?
9. Are you now or have you ever been addicted to the excessive use of alcohol parcetter harbiturates on habit
forming drugs? No
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 decided
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.
state where and whether you were convicted, fined, placed on probation, or exonerated. Have you ever been
in sworn affidavit. Have you ever been charged with any crime or learning that answer is yes, explain fully
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. 15. Have you ever surrendered your Narcotic Tax Stamp? NO. If answer is yes, explain fully in sworn affidavit.
13. Have you ever been denied membership in one County as all a
17. Have you ever hear denied Staff Mambanahin in
fully in sworn affidavit. 18. Have you ever been warned or capsured by an appropriate of the state of the st
 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:
I hold, or have held, licenses in the following States:
APPLICANT'S OATH.
I, Kathleen A Glaze M.B., hereby certify under oath that I am the person named in is application for license to practice medicine and surgery in the State of Oklahoma, that all statements I have better here in the that I am the person named in the Medical Diploma or photographic reproduction thereof better that I am the original and the lawful possessor of said diploma; that the otograph attached to this application is a true resemblance of me and that it was productions; that the
and herein are true; that I am the person named in the Medical Dipioma or photographic reproduction thereof bmitted herewith, as a credential, and that I am the original and the lawful possessor of said diploma; that the otograph attached to this application is a true resemblance of me and that it was made within the last sixty lahoma, I hereby pledge that I shall abstain from deceptive or fraudulent methods of practice and from immal association with, or acting as a shield for, an unlicensed practice in Oklahoma, to abstain from professat violation of this pledge shall constitute cause for the revocation of my medical license and the withdrawal the rights and privileges that accrued to me thereunder.
Val. 0 / 1 / 1 / a a
Subscribed and sworn to before me, this day of March 19.82
Connie 1. Deurs
commission expires on the 18 day of February, 1984. Notary Public.
U .

21. The applicant must paste an unmounted photograph of himself, or herself, in the space below. It must earry 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 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).



State of OKJahoma County of TUNSA

8

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

-, 10 & 2. on this Corried J. Dans Dean/Registrar/Secretary. Subscribed and sworn to before Notary Public, in and for Tulsa County, State of OKlahona day of March

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

My Commission expires 2-18-8-4 (Seal)

Oklahoma State Board	MEDICAL EXAMINERS	For Use of Secretary Only	Sethlern arms of applicants (Freezent Addréss of Applicants)	Application for Certificate Through Endorsement. With	State Certificate No. 252169 Granted 7-1-82	Application received $3-11$ 19 82	1-5- bad	Rejected Withdrawn Fee returned	lificate Issued 7-/	No. / 5 7 6 /	
NC	TE-If no	ot a me	mber of Medical	Society or Sta	te Associatio	on explai	in why s	and furni	sh at leas	t three (3)

letters from reputable physicians duly licensed, as to	character, professional standing, etc
22. CERTIFICATE FROM THE SECRETARY OF TH	E STATE MEDICAL ASSOCIATION.
I hereby certify that the records of my office sho	ow that Dr of
, has been a member in	good standing of theState
Medical Association for the pastyears, and	
	State Medical this
day of, 19	
(SEAL)	SecretaryState Medical Association,
	Address
	mpany application. In case of rejection, \$85.00 will be ion of your Medical Diploma must accompany application
Applicant must supply a certified photograph of it Applicants may be required to appear before the B	nimself/herself as directed on this application.
ADDICART IS required to exhaut lottom from the	Chief-of-State, any hospital or clinic in which he/she
Applicants who graduated in 1933 and thereafter r training. A 6x8-inch photo of postgraduate certificate r	nust show evidence of one-year of approved postgraduate
A photostatic copy of discharge from military serv	rice must accompany this application
Address all communications and make all remitt Oklahoma City, Oklahoma.	ances payable to: BOARD OF MEDICAL EXAMINERS,
If license is issued, please mail it to me at 40	(Street or P.O. Box No.)
Tulsa Ok	lahoma 74/35

4. HEALTH CERTIFICATE.	10		51.0 o
•	a legally qualified physic	LO 48_A	911. 01
ereby certify that I have made a careful hom I know to be the identical person m ne in the State of Oklahoma, and it is and mentally able to safely engage in th	aking the above and foregoin my opinion that he/she is in	g application for licens	e to practice medi- and is physically
COPY OF LICENSE UPON WHICH EN	NDORSEMENT IS ASKED.		
(A photostatic or typewritten copy of l	icense upon which Endorseme	nt is based must appear	ar in space below.)
•			
s. CERTIFICATE OF SECRETARY.	, Secretary of the	(State or National)	Board of
, here	by certify that the foregoing		nd correct copy of
ertificate or Medical License No	issued to Dr		, of
	llowing qualifications:	and	i a Diploma from
upon the 10	(Approve	ed college or examination)	•
(Name of Medical College)	dated the	day of	, 19
nd that on thedays o	of19	, in his/her written	examination before
is Board made a general average of	per cent, as shown by	the following items:	
SUBJECT	GRADE	SUBJECT	GRADE
		1	
·		·	
I further certify that this License has			
rofessional or Unethical Conduct now p			
ecords of this office show, Dr	;	is justly	entitled to receive
is Endorsement to the Board of Medica	al Examiners of the State of	Oklahoma.	•
Given under my hand, and seal this	day of	, 1	9
BEAL)	·		, M.D.
 -			•
	Secretary	Board of	

Address

SPECIALTIES:	
	GYNECOLOGY
	3
OARD CERTIFICATIONS (CURRENT):	Add Boards by exact name.
AMERICAN BOARD OF OBSTETRICS AND	GYNECOLOGY
URRENT POST-GRADUATE TRAINING	
	Hospital:
ocation:ate entered:	Date expected to complete:
816 BII(BI BU	
URRENT PRACTICE INFORMATION:	
mployer: PRIVATE PRACTICE	
ity, State/Country: TULSA, OKLAHOMA ype of practice or specialty: GYNECOLO	GY
ate started: 07/85	
PLEASE INDICATE BELOV	N BOW THE MAJORITY OF YOUR TIME IS SPENT:
RIMARY PRACTICE TYPE (Check only one)	
Solo Practice	✓ Office/Clinic ☐ Hospital Staff(Name)
☐ Group or Partnership ☐ Medical School	Resident/Training
Hospital Based(Name)	Nursing Home Staff
Federal Government:	Medical Teaching
Military Service	☐ Administration
Civil Service Veterens Administration	Other
Indian Health Service	(Specify)
Public Health Service	
State Government	PRACTICE ACTIVITY STATUS (X)
☐ County Government ☐ Local Government	Currently practicing
Other	Not currently practicing
(Specify)	Retired (30 hrs/week or less)
	Other
	(Specify)
	2002 VES
HAVE YOU PRACTICED MEDICINE GREAT	TER THAN 50% OF THE TIME SINCE JULY 1, 19947 YES
IOTAL AMOUNT OF TIME SPENT IN PRA	ACTICE (50) (hours per week) U SPEND IN DIRECT PATIENT CARE IN AN AVERAGE WEEK? (80%)
WHAT PERCENT OF YOUR TIME DO TO	O SPEND IN DIRECT PATIENT CARE IN AN AVERAGE WEEK SOM
If you are practicing in OKLAHOMA, ple	pase 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.	
-ACILITY/LOCATION: Hillerest Medic	cal Center 14150 OK STATUS: HET; VE
FACILITY/LOCATION: 57, John III	STATUS:
ACILITY/LOCATION:	STATUS:
You are required pursuant to 590.S. S.S.35	5.1(B) to indicate your preference. Please read and check the appropriate
box.	
Any medical doctor who desires to DI	SPENSE "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.	
	CONTROL DISPENSE DANCEPOLIC DELICE
DO 🗆 DO NOT 🔀 WISH TO BE REGI	STERED TO DISPENSE DANGEROUS DRUGS
	is assumete and descriptive at my mentioned estimates
I certify that all information on this for	m is accurate and descriptive of my professional activities.
NAME OF PHYSICIAN: Xathleen	A. GLAZE MD
NAIVIE OF PHISICIANE.	(Print or Type)
YAN A A	40, ynd - 6/11/95
SIGNATURE: MThleen U/	Slar 11/10 DATE 0/21/73
· · · · · · · · · · · · · · · · · · ·	state Board of Medical Licensure and Supervision
MART ADDITE ATION TO Okishoms S	INTE MONTO OF MEDICAL LICENSUIC AND DUDCIVISION

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

1. Primary (greater than 50% time spent) GYNECOLOG	;Y
2	_3
BOARD CERTIFICATIONS (CURRENT): Add Boards	by exact name.
AMERICAN BOARD OF OBSTETRICS AND GYNECOLOG	•
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	E MAJORITY OF YOUR TIME IS SPENT
PRIMARY PRACTICE TYPE (Check only one)	
Solo Practice	PRIMARY PRACTICE SETTING (Check only one)
Group or Partnership	Hospital Staff(Name)
Medical School Hospital Based(Name)	Resident/Training Nursing Home Staff
Federal Government:	Medical Teaching
☐ Military Service ☐ Civil Service	☐ Administration ☐ Research
Veterans Administration	Other
☐Indian Health Service ☐Public Health Service	(Specify)
State Government	PRACTICE ACTIVITY STATUS (X)
☐ County Government☐ Local Government	Currently practicing
Other	☐ Not currently practicing ☐ Retired
(Specify)	Semi-Retired (30 hrs/week or less)
	Uther (Specify)
HAVE YOU PRACTICED MEDICINE GREATER THAN 5 TOTAL AMOUNT OF TIME SPENT IN PRACTICE 50	10% OF THE TIME SINCE JULY 1, 19947 <u>yes</u>
WHAT PERCENT OF YOUR TIME DO YOU SPEND IN	_I (nours per wask) DIRECT PATIENT CARE IN AN AVERAGE WEEK? 20%
If you are practicing in OKLAHOMA, please list the	hospitals at which you are currently a member of the
statt. When indicating status, please use one of the OTHER.	following: ACTIVE, INACTIVE, RESTRICTED, COURTESY,
FACILITY/LOCATION: Hillarest Medieal Cen	iter status: Active
FACILITY/LOCATION: St. John Medical Cer	oter status: Courtesus
FACILITY/LOCATION:	STATUS:
You are required pursuant to 59O.S. S.S.355.1(B) to indibox.	icate your preference. Please read and check the appropriate
, ,	
Any medical doctor who desires to DISPENSE "dar	ngerous drugs" as defined in the Pharmacy Law, must
register annually with the board. Into is for dispensi or the giving of samples.	ing only and does not include prescribing, administering,
I DO 🗔 DO NOT 🔀 WISH TO BE REGISTERED TO I	DISPENSE DANGEROUS DRUGS
I certify that all information on this form is accurate	and descriptive of my professional activities.
NAME OF PHYSICIAN: Xathleen A. Glaz	e MD
	(Print or Type)
SIGNATURE Kathleen a. Hall	DATE: 4/26/96
	
MAIL APPLICATION TO: Oklahoma State Board of	Medical Licensure and Supervision

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

1. Primary (greater than 50% time spent) GYNECOLOGY 2.	
BOARD CERTIFICATIONS (CURRENT): Add Boards I AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY	
CURRENT POST-GRADUATE TRAINING:	
Type of training:	Hannital.
Location:	nospital:
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)	
▼ Solo Practice	PRIMARY PRACTICE SETTING (Check only one)
Group or Partnership	Moffice/Clinic Hospital Staff(Name)
Medical School	Resident/Training
Hospital Based(Name)	Nursing Home Staff
Military Service	Medical Teaching Administration
Civil Service	Research
☐ Veterans Administration ☐ Indian Health Service	Other
Public Health Service	(Specify)
State Government	PRACTICE ACTIVITY STATUS (X)
☐ County Government ☐ Local Government	Currently practicing
Other	Not currently practicing
(Specify)	Retired
	Semi-Retired (30 hrs/week or less) Other
	(Specify)
HAVE YOU PRACTICED MEDICINE GREATER THAN 509 TOTAL AMOUNT OF TIME SPENT IN PRACTICE 60 WHAT PERCENT OF YOUR TIME DO YOU SPEND IN D	(nours per week)
If you are practicing in OKLAHOMA, please list the histaff. When indicating status, please use one of the foother.	ospitals at which you are currently a member of the ollowing: ACTIVE, INACTIVE, RESTRICTED, COURTESY,
FACILITY/LOCATION: <u>Hillerest Medical Center</u> FACILITY/LOCATION: St John Med. Center	Tulsa ok status: Active
FACILITY/LOCATION:	STATUS: COLITES &
FACILITY/LOCATION:	STATUS:
You are required pursuant to 590.S. S.S.355.1(B) to indicabox.	te your preference. Please read and check the appropriate
Any medical doctor who desires to DISPENSE "dangeregister annually with the Board. This is for dispensing or the giving of samples.	erous drugs" as defined in the Pharmacy Law, must gonly and does not include prescribing, administering,
I DO 🗆 DO NOT 🖾 WISH TO BE REGISTERED TO DIS	SPENSE DANGEROUS DRUGS
certify that all information on this form is accurate a	1 00 0
NAME OF PHYSICIAN: 10 ATT 160, 17. 61	(Print or Type)
SIGNATURE: Sattleen U/Hay I)	DATE 5/15/91
MAIL APPLICATION TO: Oklahoma State Board of M	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
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 590.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: 1.6/022
SIGNATURE Jothleen a. Slave MD Print or Type) 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
	<u>F):</u> Add Boards by exact name and attach copy of certificate. AND GYNECOLOGY
CURRENT POST-GRADUATE TRAINI	NG:
Type of training:	Hospital:
	Date expected to complete:
67/1605	
You are required pursuant to 590.S. S.S.:	355.1(B) to indicate your preference. Please read and check the appropriate
Any medical doctor who desires to register annually with the Board. This or the giving of samples.	DISPENSE "dangerous drugs" as defined in the Pharmacy Law, must is for dispensing only and does not include prescribing, administering,
I DO 🗆 DO NOT 🔀 WISH TO BE RE	GISTERED TO DISPENSE DANGEROUS DRUGS
	orm is accurate and descriptive of my professional activities.
NAME OF PHYSICIAN: Yath lee	n A. Glaze
SIGNATURE Yethlien C	A Slaze Ma DATE 5/7/99

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 ORGANIZA-TION, SUCH LICENSE TO USE AND POSSESS THE PROFILE SHALL BE AUTOMATIC-ALLY 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)	PRACTICE SETTING (check only one)
Solo Practice	
Group or Partnership	Office/Clinic Hospital Staff
Medical School	Resident/Training
Hospital Based	Nursing Home Staff
Federal Government :	Medical Teaching
Military Service	Administration
Civil Service	Research
Indian Health Serv.	Other
Public Health Serv.	(Specify)
State Government	_
County Government	
Local Government	
Other	
(Specify)	_
TOTAL AMOUNT OF TIME SPENT IN PRACTICE 65 WHAT % OF YOUR TIME DO YOU SPEND IN DIRECT F	PATIENT CARE IN AN AVERAGE WEEK? & C / C
PLEASE LIST THE HOSPITALS AT WHICH YOU ARE CURR PLEASE USE ONE OF THE FOLLOWING: ACTIVE INAC	RENTLY A STAFF MEMBER. WHEN INDICATING STATUS,
NAME/LOCATION_ft///erest //)edical (en	iter Mulea STATUS Anding
NAME/LOCATION St. John Med. Center /	TULSA STATUS MATERIA
NAME/LOCATION	
TOTAL PEOPLE TOTAL	STATUS
RETTRED PHYSICIAN.) THE FOLLOWING RESTRICTIONS APPLY TO FULLY RET	AND YOUR CERTIFICATE OF LICENSURE. ISSUED IDENTIFYING YOU AS A FULLY FIRED PHYSICIANS. YSICIAN", BUT MUST INDICATE YOUR RETIRED)) ORM.
	Kathleen A. GLAZE
	NAME OF PHYSICIAN (please type or print)
certify that all information on this form is accurate a signature.	mil
MAIL APPLICATION TO : BOARD OF MEDICAL LICENSE	URE AND SUPERVISION, STATE OF OKLAHOMA HOMA CITY, OK 73154-0256
THE DON TOLDO UNLA	10/10 01 11 UN /3154~0250

FORM BMEDGS 01-80

BOARD CERTIFICATION	NS (CURRENT): Add Bo	oards by exact name and give mailing address of Board Office.
AMERICAN BOARD OF OBSTE	TRICS AND GYNECOLOGY	_ADDRESS
		_ADDRESS
		_ADDRESS
CURRENT POST-GRADU	JATE TRAINING	
Location:		Hospital:
		Date expected to complete:
CURRENT PRACTICE II	NFORMATION:	
Employer: PRIVATE PRACTIC	CE	·
City, State/Country: TULSA.	OKLAHOMA	
Type of practice or specialty:	OB-GYN	
Date started: 07/85		
DECAME II.	THICATTE BELOW HOW	THE MAJORITY OF YOUR TIME IS SPENT
		THE MATCRILL OF YOUR LIME IS SPENT
PRIMARY PRACT	TICE TYPE (Check only one	PRIMARY PRACTICE CETTING (C)
Solo P		THE COLITIVAL (CHECK ONLY ONE)
	or Partnership	Office/Clinic Hospital Staff
	al School	Resident/Training
☐ Hospita	al Based	Nursing Home Staff
Federal	l Government:	Medical Teaching
☐ Milit	tary Service	Administration
☐ Civil	Service	Research
☐ Vete	erans Administration	Other
	an Health Service	
	ic Health Service	(Specify)
	Sovernment	
☐ County	Government	PRACTICE ACTIVITY STATUS (X)
	Sovernment	Currently practicing
		Z Carrently practicing
		Not currently practicing
☐ Local G ☐ Other	y)	Not currently practicing
☐ Local G ☐ Other	y)	Not currently practicing Retired
☐ Local G ☐ Other	у)	☐ Not currently practicing ☐ Retired ☐ Semi-Retired (30 hrs/week or less)
☐ Local G ☐ Other	γ)	 Not currently practicing ☐ Retired ☐ Semi-Retired (30 hrs/week or less) ☐ Other
☐ Local G ☐ Other	γ)	☐ Not currently practicing ☐ Retired ☐ Semi-Retired (30 hrs/week or less)
Local G Other (Specifi		Not currently practicing Retired Semi-Retired (30 hrs/week or less) Other (Specify)
Local G Other (Specify TOTAL AMOUNT OF TIME	E SPENT IN PRACTICE TO	Not currently practicing Retired Semi-Retired (30 hrs/week or less) Other (Specify)
Local G Other (Specify TOTAL AMOUNT OF TIME	E SPENT IN PRACTICE TO	Not currently practicing Retired Semi-Retired (30 hrs/week or less) Other (Specify)
Local G Other (Specify TOTAL AMOUNT OF TIME	E SPENT IN PRACTICE TO	Not currently practicing Retired Semi-Retired (30 hrs/week or less) Other (Specify)
Local G Other (Specify TOTAL AMOUNT OF TIME WHAT PERCENT OF YOU	E SPENT IN PRACTICE [] R TIME DO YOU SPEND	Not currently practicing Retired Semi-Retired (30 hrs/week or less) Other (Specify) Other (Specify) Nours per week) IN DIRECT PATIENT CARE IN AN AVERAGE WEEK?
Local G Other (Specify TOTAL AMOUNT OF TIME WHAT PERCENT OF YOU	E SPENT IN PRACTICE [] IR TIME DO YOU SPEND	Not currently practicing Retired Semi-Retired (30 hrs/week or less) Other (Specify) Other (Specify) Nours per week) IN DIRECT PATIENT CARE IN AN AVERAGE WEEK?
Local G Other (Specify TOTAL AMOUNT OF TIME WHAT PERCENT OF YOU f you are practicing in C staff. When indicating sta	E SPENT IN PRACTICE [] R TIME DO YOU SPEND	Not currently practicing Retired Semi-Retired (30 hrs/week or less) Other (Specify) Other (Specify) Nours per week) IN DIRECT PATIENT CARE IN AN AVERAGE WEEK?
Local G Other (Specify TOTAL AMOUNT OF TIME WHAT PERCENT OF YOU f you are practicing in C staff. When indicating sta	E SPENT IN PRACTICE [2] IR TIME DO YOU SPEND OKLAHOMA, please list to atus, please use one of to atus.	Not currently practicing Retired Semi-Retired (30 hrs/week or less) Other (Specify) Other (Specify) Nours per week) IN DIRECT PATIENT CARE IN AN AVERAGE WEEK? Sometime of the hospitals at which you are currently a member of the the following: ACTIVE, INACTIVE, RESTRICTED, COURTESY,
Local G Other (Specify TOTAL AMOUNT OF TIME WHAT PERCENT OF YOU f you are practicing in C staff. When indicating sta	E SPENT IN PRACTICE [2] IR TIME DO YOU SPEND OKLAHOMA, please list to atus, please use one of to atus.	Not currently practicing Retired Semi-Retired (30 hrs/week or less) Other (Specify) Other (Specify) Nours per week) IN DIRECT PATIENT CARE IN AN AVERAGE WEEK?

1. Primary (g 2. <u>OBSTETR</u>	pater than 50% time spent) GYNECOLOGY SE discontinued 9/92 3.1
AMERICAN I	RTIFICATIONS (CURRENT): Add Boards by exact name and give mailing address of Board Office
AMERICAN E	ARD OF OBSTETRICS AND GYNECOLOGY ADDRESS
	ADDRESSADDRESSADDRESSADDRESSADDRESSADDRESSADDRESSADDRESSADDRESSADDRESSADDRESSADDRESS
CURRENT	OST-GRADUATE TRAINING:
Type of traini	g:
Location:	g:Hospital:
Date entered:	Dete
CHEPRINT	Date expected to complete:
33300211	RACTICE INFORMATION:
City State (0)	IVATE PRACTICE
Type of pro-4	ntry: TULSA, OKLAHOMA
Date started	e or specialty:OB-GYN 07/85
- are started:_	/// 65
<u> </u>	
	PLEASE INDICATE BELOW HOW THE MAJORITY OF YOUR TIME IS SPENT.
PRI	IART PRACTICE TVDP (A)
	Solo Pression
	Group or Partnership
	Medical School
	Hospital Based Resident/Training
•	Federal Government: Military Service Nursing Home Staff Medical Teaching
	☐ Military Service ☐ Medical Teaching ☐ Civil Service ☐ Administration
	Veterans Administration
	Indian Health Service
	Public Health Service (Specify)
	State Government
	UCounty Government PRACTICE ACTIVITY STATUS (N)
	Turrently prosting
.•	Other Not currently practicing (Specify)
Pag.	Retired
	Semi-Retired (30 hrs/week or less)
	☐ Other (Specify)
MYE VOLL D	
OTAL AMOL	ACTICED MEDICINE GREATER THAN 50% OF THE TIME SINCE JULY 1, 1992? Les
VHAT PERCE	NT OF TIME SPENT IN PRACTICE 50 (hours per week)
	IT OF YOUR TIME DO YOU SPEND IN DIRECT PATIENT CARE IN AN AVERAGE WEEK? 75%
	TO AVERAGE WEEK! 75 %
NOU SE DE	Michael Marchael List the homitals of the second
5	electring status, please use energy the hospitals at which your are City of the recent as
	A STATE OF THE PARTY OF THE PAR
THER.	II. I COUNTEST.
ACILITY/LOCATI	N: Till Crest Wed. Contin
THER. CILITY/LOCATI CILITY/LOCATI CILITY/LOCATI	N: Till Crist Wed. Center - Tulsa status: Active

ne and give mailing address of Board Offic to complete: OP YOUR TIME IS SPENT.
to complete:
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
RACTICE SETTING (Check only one)
ice/Clinic
spital Staff
ident/Training
sing Home Staff dical Teaching
ninistration
earch
er ·
ecify)
CTIVITY STATUS (X)
ently practicing
currently practicing
red
i-Retired (30 hrs/week or less) or
cify)

SPECIALTIES:	•	
List specialty you spend great	er than 50% of your time in #1.	
1. Counecology		
2.		
3.		
4		
5	· ·	
BOARD CERTIFICATIO	NS (CURRENT):	
	nd attach a copy of certificate if new certification.	
<u>-</u>	OBSTETRICS AND GYNECOLOGY	
_		
POST GRADUATE TRA	INING (CURRENT):	
Type of Training:		
Hospital:	•	
Location:		
DateFrom		
Expected Completion Date:		
PRACTICE INFORMATI	ON (CURRENT):	
Employer:	PRIVATE PRACTICE	
City, State/Country:	TULSA, OK	
Type of practice or specialty:	GYNECOLOGY	
Date Started:	7 / 1985	
Other States in which y	ou are licensed to practice Medicine:	
		77 TOWNSON
I, the undersigned, have to the I hereby state that the information of Applicant:	e best of my knowledge, complied with the laws and rules relation contained in this application is true and correct. Date:	gulating my profession. $5/1/2 000$

Specialties: ist Specialty you spend greater	than 50% of your time in #4
. Gynecology	than 50% or your time in #1.
. Cyncoology	
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oard Certifications (Cur	rent):
dd Boards by exact name and	attach a copy of certificate if new certification.
AMERICAN BOARD OF OBS	TETRICS AND GYNECOLOGY
Post Graduate Training (
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Hospital:	
Location:	
Date Entered:	
Expected Completion Date:	
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Practice Information (Cui Employer:	rrent): PRIVATE PRACTICE
City, State, Country:	
Type of Practice or Specialty:	
Date Started:	
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ther States in which you	u are licensed to practice Medicine:
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M.	YES
	Have you been named as a defendant in a civil suit (including malpractice)?
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.)
Э.	Have you had a major illness or been hospitalized within the past year?
D	O YOU WISH TO APPLY FOR PHYSICIAN EMERITUS (FULLY RETIRED) STATUS? YES
f "Υ Γhe	ES", Enclose a \$50 processing fee. There will be no renewal fee. 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.
pe	cialties:
	Specialty you spend greater than 50% of your time in #1.
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	rd Certifications (Current):
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<u> </u>	IERICAN BOARD OF OBSTETRICS AND GYNECOLOGY
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	Hospital:
	Location:
	Date Entered:
Ехр	ected Completion Date:
	ctice Information (Current):
	Employer: PRIVATE PRACTICE
	City, State, Country: TULSA, OK
Ty	pe of Practice or Specialty: GYNECOLOGY
	Date Started: 7/1985

D. Heve you have nowed as a first of the same of the s	YES	NO
R. Have you been named as a defendant in a civil suit (including malpractice)?	····	<u>×</u>
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?	res 🖌	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 B) You cannot practice medicine in any form. You cannot prescribe, dispense or administer dri	l status	
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List Specialty you spend greater than 50% of your time in #1.		
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Post Graduate Training (Current): Type of Training:		
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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		
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Other States in which you are licensed to practice Medicine:		
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, the undersigned, have to the best of my knowledge, complied with the laws and rules regulating mereby state that the information contained in this application is true and correct.	ny profess	ion.
Signature of Applicant: Alfulux U / Slave // // Date: 6//7/L	15	

	YES N
R.	Have you been named as a defendant in a civil suit (including malpractice)?
S.	Have you been reported to the National Practitioner Data Bank (NPDB) or to the Healthcare Integrity and Protection Data Bank (HIPDB)?
T.	Have you had a major illness or been hospitalized within the past year?
[OO YOU WISH TO APPLY FOR PHYSICIAN EMERITUS (FULLY RETIRED) STATUS? YESXN
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	Employer: PRIVATE PRACTICE
	City, State, Country: TUI SA OK
-	Type of Practice or Specialty: GYNECOLOGY
	Date Started: 7/1985
Otł	ner States in which you are licensed to practice Medicine:
	a undersigned have to the best of the last
i, uii I hei	e undersigned, have to the best of my knowledge, complied with the laws and rules regulating my profession reby state that the information contained in this application is true and correct.
Sign	nature 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)?	<u>x</u>
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?	<u>X</u>
1	DO YOU WISH TO APPLY FOR PHYSICIAN EMERITUS (FULLY RETIRED) STATUS? YESX	NO
If "	YES", Enclose a \$50 processing fee. There will be no renewal fee. e 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.	
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	ard Certifications (Current):	•
	Boards by exact name and attach a copy of certificate if new certification.	
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Po	ost Graduate Training (Current): Type of Training:	
	Hospital:	
	Location:	
	Date Entered:	
Ex	pected Completion Date:	
Pr	actice Information (Current): Employer: PRIVATE PRACTICE	
	City, State, Country: TULSA, OK USA	
	Type of Practice or Specialty: GYNECOLOGY	_
	Date Started: 7/1985	
	Date Started. 7/1985	_
Oti	ner States in which you are licensed to practice Medicine:	
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l, th I he	e undersigned, have to the best of my knowledge, complied with the laws and rules regulating my profess reby state that the information contained in this application is true and correct.	ion.
	nature of Applicant: Renewed Online Date: 05/05/2005 Time: 9:42:03 pm	

_	YES	NO
K.	Have you been named as a defendant in a civil suit (including malpractice)?	
S.	Have you been reported to the National Practitioner Data Bank (NPDB) or to the Healthcare integrity and Protection Data Bank (HIPDB)?	_ <u>X</u> _
T.	Have you had a major illness or been hospitalized within the past year?	<u> x</u>
I	DO YOU WISH TO APPLY FOR PHYSICIAN EMERITUS (FULLY RETIRED) STATUS? YES $_$ X	NO
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	pard Certifications (Current): d Boards by exact name and attach a copy of certificate if new certification.	
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	Hospital:	
	Location:	
	Date Entered:	
Ex	pected Completion Date:	
Pr	actice Information (Current):	
	Employer: PRIVATE PRACTICE	
	City, State, Country: TULSA, OK USA	
•	Type of Practice or Specialty: GYNECOLOGY	
	Date Started: 7/1985	
Otl	her States in which you are licensed to practice Medicine:	
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l, th	ne undersigned, have to the best of my knowledge, complied with the laws and rules regulating my profess reby state that the information contained in this application is true and correct. This form is Public Informa	sion.
	nature 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)?	-
S.	Have you been reported to the National Practitioner Data Bank (NPDB) or to the Healthcare Integrity and Protection Data Bank (HIPDB)?	
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	K NO
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Pr	ractice Information (Current):	
	Employer PRIVATE PRACTICE	
	City, State, Country: TULSA, OK USA	
	Type of Practice or Specialty: GYNECOLOGY	<u> </u>
•	Date Started: 7/1985	
Ot	her States in which you are licensed to practice Medicine:	
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I, th	ne undersigned, have to the best of my knowledge, complied with the laws and rules regulating my profesereby state that the information contained in this application is true and correct. This form is Public Information	ession.
Sig	nature of Applicant: Renewed Online Date: 05/26/2007 Time: 8:22:03 a	<u>m</u>

020116:MDRENEW

	YES I
Ο.	Have you been the subject of an investigation or disciplinary action, including probation, by a hospital, clinic, practice group, or residency program?
г.	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)?
	DO YOU WISH TO APPLY FOR PHYSICIAN EMERITUS (FULLY RETIRED) STATUS?YES _X_ I
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l. A	MERICAN BOARD OF OBSTETRICS AND GYNECOLOGY
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	st Graduate Training (Current): Type of Training:
	Hospital:
	Location:
	Date Entered:
Ex	pected Completion Date:
Pra	actice Information (Current):
	Employer: PRIVATE PRACTICE
	City, State, Country: TULSA, OK USA
7	Type of Practice or Specialty: GYNECOLOGY
	Date Started: 7/1985
Oth	er States in which you are licensed to practice Medicine:
, the	e undersigned, have to the best of my knowledge, complied with the laws and rules regulating my profession
110	beby state that the information contained in this application is true and correct. This form is Public Information
Sign	ature 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 Seretary, 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 that the before a Notary Public for certifica-

MEDICAL EXAMINERS Oklahoma State Board

For Use of Secretary Only



Application for Certificate Through Endorsement. State of OX append County of TUNEA

1-82

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Granted

State Certificate No.

With

SS.

rect likeness of Dr.Kathilten fl. Glaze Whose name appears elsewhere on this application. This is to certify that the above is a cor-

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

48-81-6 Notary Public. My Commission expires.

NOTE: Seal of the school or Medical Board may be affixed on picture in lieu of Notarization. Comme J. Rawn Dean/Registrar/Secretary. 19 2d 7/-Application received 3-11 Certificate Issued. Fee, \$100.00 paid Fee returned ... Rejected Withdrawn

No.

B

NOTE—If not a member of Medical Society or letters from reputable physicians duly licensed, as t		
22. CERTIFICATE FROM THE SECRETARY OF T		
I hereby certify that the records of my office s	how that Dr	, of
, has been a member	in good standing of the_	State
Medical Association for the pastyears, a		
Given under my hand and the seal of the	State Medica	
day of, 19		
(SEAL)	Secretary	State Medical Association,
The reciprocity fee is \$100.00 which must accrefunded.		
A 6x8-inch photographic or photostatic reprodu for the office file.	ction of your Medical Dipl	oma must accompany application
Applicant must supply a certified photograph of	f himself/herself as directe	ed 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, Hoppital administrator, Chief in hing vice 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_	<u>4012</u> E. 42110	Place
	(Street or P.O. Bo	x No.)
lictsa	Okla homa	74 135
(City)		74-4-1