STATE OF OHIO

THE STATE MEDICAL BOARD

Application for Examination for Certificate to Practice Medicine

FORM I.

I hereby make application for a license to practice Medicine and Surgery in the State of Ohio, and submit the following statement regarding my preliminary and medical education.

1. Name RUBINSTEIN, LEE IRWIN (Full Name) 2. Place and date of birth McKEESPORT, PA 2-10-27

3. Intended Ohio residence CLEVELAND, (City) CUYAHOGA (County)

4. Where certificate is to be sent 23525 E FARRINGDON AV. - EUCLID 230

The Applicant Must Give Full Answers to the Following:

5. PRELIMINARY EDUCATION.

(Name and location of Institution Attended and Degree Received)	(Period and Date of Study)
UNIV. of PITTSBURGH, PITTSBURGH, PA	1946-1949

Received Ohio Medical Student's Certificate No. ~~#20812~~, from OHIO STATE MED. BD (Date) 5-16-49 #20812

6. MEDICAL EDUCATION.

Give the date and source of each medical credential, diploma, license or degree which you will hold M.D.

6-10-53 WESTERN RESERVE UNIV.

Attended ..... full courses of medical lectures as follows, to-wit:

1st Course at SCHOOL of MED. - WRU from SEPT. 1949 to JUNE 1950

2nd Course at " " from " 1950 to JUNE 1951

3rd Course at " " from " 1951 to MAY 1952

4th Course at " " from AUG. 1952 to JUNE 1953

5th Course at ..... from ..... to .....

~~Was~~ Will be granted a diploma by WESTERN RESERVE UNIV. (Name of Medical College), located at CLEVELAND, State of OHIO, on the 10th day of JUNE, 1953

7. Time of practice NONE (Give Places and Dates)

8. I am not, and never have been, an itinerant or advertising physician, and hereby pledge my solemn assurance never to become such in any capacity if under this application a license is granted to me.

9. It will be my endeavor to become an active member of a medical society as soon as I am eligible for such.

10. PHYSICAL DESCRIPTION OF APPLICANT.

Race CAUCASIAN Native of USA ~~(or other Country)~~ Complexion RUDDY

Color of hair BROWN Color of eyes BROWN Height 5' 11"

{~~Stout~~ / Medium / ~~Thin~~} Weight 165 Marks NONE

(Cross out words not answering description.)

11. I desire to be classed as a {Regular / ~~Homeopathic~~ / ~~Eclectic~~} Physician.

(Cancel two of these names.)

Applicants are examined in Materia Medica and Therapeutics, and Principles and Practice of Medicine by the member or members of the Board representing the school of medicine in which he or she desires to practice.

*AFFIDAVIT

STATE OF OHIO, }
} ss.
COUNTY OF Cuyahoga }

On this 27th day of May, 1953, personally appeared before me Notary Public within and for the County and State aforesaid Lee Irwin RUBINSTEIN, who being duly sworn says that he is the person referred to in the foregoing application for certificate to practice medicine in the State of Ohio; that the statements herein contained are strictly true in every respect, that he is the person named on the accompanying diploma, and is the lawful possessor of the same, and that he *has read and understands this Affidavit.*

Lee I. Rubinstein
Signature of Applicant.

Signed and sworn to before me this 27th day of May, 1953

(SEAL)

Ruth P. Horr
Official designation of officer administering oath.
Notary Public

My Commission expires on February 18, 1955.

* Must be sworn to before an officer authorized to administer oaths in Ohio.

Preliminary Educational Requirement

From the General Code of Ohio

Sec. 1270. * The state medical board shall appoint an entrance examiner who shall not be directly or indirectly connected with a medical college and who shall determine the sufficiency of the preliminary education of an applicant for admission to the examination. The minimum requirement shall be two years of collegiate work in an approved college of arts and sciences in addition to high school graduation. Provided, however, that students already matriculated and enrolled in their professional colleges shall not be required to have the aforesaid two years of college work but shall comply only with the preliminary requirements as heretofore existing and in effect at the time of their enrollment in their said colleges, and that high school graduation shall be deemed the minimum requirement for applicants graduating prior to 1920. In the absence of the foregoing qualifications, the entrance examiner may examine the applicant to overcome deficiencies. When the entrance examiner finds the preliminary education of the applicant sufficient, he shall issue a certificate of preliminary examination upon the payment to the treasurer of the state medical board of a fee of three dollars. Such certificate shall be attested by the secretary of the board.**

The applicant must also produce a diploma from a medical institution in the United States in good standing as defined by the board at the time the diploma was issued * or a diploma or license approved by the board which conferred the full right to practice all branches of medicine or surgery in a foreign country. [118 V. S97 § 1.]**

Sec. 1271. At the time of his application the applicant shall present such diploma or license with his affidavit that he is the person named therein and is the lawful possessor thereof, stating his age, residence, the college or colleges at which he obtained his medical education, the time spent in each, the time spent in the study of medicine * and such other facts as the state medical board requires. If engaged in the practice of medicine or surgery *** the affidavit shall state the period during which and the place where he has been so engaged. [99 V. 498 § 28.]**

Sec. 1272. * The state medical board shall admit to the examination an applicant holding the credentials set forth in section 1270. [118 V. S97 § 1.]**

Certificate of Preliminary and Medical Education

This certificate must be properly made out and signed by the president, dean or secretary of the medical school of which the applicant is a graduate.

It is hereby certified that Lee Irwin RUBINSTEIN

holding Ohio State Medical Board Certificate of Preliminary Education # 20812

dated: May 16, 1949 as evidence of preliminary education on

the tenth day of June, 1953, received from

Western Reserve University

a diploma conferring on him the degree of doctor of medicine and that he previously studied medicine

at least four full years, including four regular courses of lectures as follows:

MONTH	YEAR		MONTH	YEAR	NAME OF INSTITUTION
September	1949	to	June	1950	School of Medicine Western Reserve University
September	1950	to	June	1951	" " "
September	1951	to	May	1952	" " "
August	1952	to	June	1953	" " "
	1	to		1	

Dated at Cleveland, Ohio

John L. Caughey, Jr., M.D., Associate Dean

June 10, 1953

(SEAL OF COLLEGE)

Certificate of Good Moral Character

(Signed by not less than two registered physicians in good standing.)

This certifies that we have been personally acquainted with Dr. Lee I. Rubenstein *for (4) (4) years, that we know* him *to be of good moral character, and hereby recommend* him *to the State Medical Board of the State of Ohio as entirely worthy to be licensed to practice medicine in the State of Ohio, pursuant to law.*

Carl C. Francis, M.D.

P. O. Address 2109 Adelbert Rd. Cleveland 6, Ohio

Graduate (in the year 1930 *) of* School of Medicine, Western Reserve Univ

* *Certificate No.* 7669

John L. Caughey, Jr.

P. O. Address 2109 Adelbert Road, Cleveland 6, Ohio

Graduate (in the year 1930 *) of* Harvard Medical School

* *Certificate No.* 14456

---

* Physicians signing should give number of their certificate from this Board.
Parties signing certificate must be registered physicians in Ohio.

WRU
'53

FOR USE OF SECRETARY ONLY

State Certificate No. 18994

Issued 8-25-53

Application for Examination for Certificate to Practice Medicine, by The State Medical Board, State of Ohio

40-17-eh(e)

RUBINSTEIN, Lee Irwin, M. D.

Filed 6/12/53

Receipt No. Fee, $25.00

Examination No. 357 Date

Approved
Rejected
Withdrawn

Fee returned

REVIEWED
H. M. PLATTER, Secy.

The following facts are stated for the information of those desiring to practice medicine or surgery in the State of Ohio.

1. No person can lawfully practice medicine in the State of Ohio unless licensed to do so by the State Medical Board.

2. Certificates entitling the holder to practice medicine and surgery in Ohio are issued only after examination by the Board, except in the following case:

> Sec. 1282. *** When a physician or surgeon licensed by the licensing department of another state a territory or the District of Columbia or a diplomate of the national board of medical examiners wishes to remove to this state to practice his profession, the state medical board may, in its discretion, issue to him a certicate to practice medicine or surgery in Ohio without requiring the applicant to submit to examination, provided he meets the requirements for entrance as set forth in section 1270 and section 1272. The fee for registration in this manner shall be fifty dollars. Application shall be made on a form prescribed by the board.

3. Examinations will be held in June and December of each year.

4. Completed applications must be filed with the Secretary of the Board at least ten days prior to the day set for the examination which the applicant desires to enter.

5. A fee of twenty-five dollars must accompany each application. Personal checks not accepted. Send certified check, draft or money order.

6. Only graduates in medicine from colleges recognized by the State Medical Board are admitted to the examinations.

7. The examination is written and must be in the English language. It includes Anatomy, Physiology, Pathology, Chemistry, Materia Medica and Therapeutics, the Principles and Practice of Medicine, Diagnosis, Surgery, Obstetrics, and such other subjects as the Board requires. The applicant is examined in the Materia Medica and Therapeutics and the Principles and Practice of Medicine, of the school of medicine with which he desires to be classed.

8. Copies of questions which have been used in previous examinations will not be furnished under any circumstances.

9. Persons failing in one examination may be re-examined within one year without the payment of an additional fee.

10. The applicant's diploma must in every case accompany his application papers. After certifying the diploma the Secretary will return it by express, collect.

11. All correspondence should be addressed to The State Medical Board, Wyandotte Building, Columbus 15, Ohio. Postage should be inclosed for answer.

12. Applicants must be at least 21 years of age and citizens of the United States.

STATE OF OHIO
THE STATE MEDICAL BOARD

STATE MEDICAL BOARD
OF OHIO
90 SEP 17 PM 1:46

WAIVER

State of Ohio

County of Cuyahoga

I herey authorize all individuals, hospitals, institutions or organizations, personal physicians, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local,state, federal, and foreign) to release to the Ohio State Medical Board any information, files, or records requested by the Board in connection with request for exemption. I further authorize the Ohio State Medical Board to release to the organizations, individuals or groups listed above any information which is material to my request.

[signature]

(Signature of Affiant)

Subscribed and sworn to this 14th day of September, 1990.

[signature]

(Signature of Official Administering Oath)

*Must be sworn to before a notary public or other person authorized to administer oaths.

KATHRYN A. BRYSON
Notary Public, State of Ohio
Recorded in Lake County
My Comm. Expires 03-10-91

STATE OF OHIO
THE STATE MEDICAL BOARD

STATE MEDICAL BOARD OF OHIO
90 SEP 17 PM 1:46

AFFIDAVIT

State of Ohio SS:

County of Cuyahoga

Before me personally appeared DR. LEE RUBINSTEIN

(Affiant)

who being suly sworn says that he is the person referred to in the foregoing request for exemption from Continuing Medical Education requirements; that the statements therein are strictly true in every respect, and that he has read and understands this Affidavit.

Lee Rubinstein

(Signature of Affiant)

Subscribed and sworn to this 14th day of September, 1990.

Kathryn A. Bryson

(Signature of Official Administering Oath)

KATHRYN A. BRYSON
Notary Public, State of Ohio
Recorded in Lake County
My Comm. Expires 03-10-91

LEE RUBINSTEIN, M.D. INC. MT. SINAI MEDICAL BUILDING • 26900 CEDAR ROAD
TELEPHONE 831-3474 • BEACHWOOD, OHIO 44122

January 20, 1990

The State of Ohio
The State Medical Board
77 South High Street, 17th Floor
Columbus, Ohio 43266-0315

To Whom It May Concern:

As per instructions, I am requesting and exemption application to be mailed to me for completion.

Thank you for your response.

Sincerely,
Lee I. Rubinstein
Lee Rubinstein, M.D.

Spoke w/ Secretary 2-2-90 + She indicates that the Dr. has done. She thought he need an application because he was over the amount.

2-2-90 She called back - Dr. Was in Germany last yr. Send CME forms due to illness

Clj

STATE MEDICAL BOARD OF OHIO
90 JAN 25 PM 2:46

STATE MEDICAL BOARD OF OHIO

77 South High Street, 17th Floor • Columbus, Ohio 43266-0315 • (614) 466-3934

November 26, 1990

Lee Rubinstein, M.D.
26900 Cedar Rd.
Beachwood, OH 44122

Dear Doctor:

This is in reference to your Illness, waiver application.

Please be advised that the Secretary of the State Medical Board of Ohio, has approved your waiver application request. However, the entire 100 hour CME requirement cannot be waived. You are therefore, required to complete at least 18 hours in Category I and 33 hours in Category II by December 31, 1990.

I have enclosed for your completion, your renewal application card for the 1991-1992 biennium. Upon your completing the required number of credit hours as indicated above, please complete the renewal card, sign it and submit it directly to the Treasurer State of Ohio, in the enclosed envelope.

Should you have any questions, please do not hesitate to contact me at the above address.

Sincerely,

Debra L. Jones

Debra L. Jones, Chief
CME, Records & Renewal

DLJ/mm

encls:

Spoke w/ Dr.
9-12+13, would be
sending waiver
ASAP.
dj

STATE OF OHIO
THE STATE MEDICAL BOARD
Suite 510
65 South Front Street
Columbus, Ohio 43215

February 2, 1990

Lee Rubinstein, MD
26900 Cedar Rd.
Beachwood, OH 44122

Rubinstein, Lee

Dear Doctor:

This in in response to your recent inquiry concerning exemption from Continuing Medical Education requirements.

There are currently no existing provisions for a physician to waive the entire CME requirement. It is possible to waive a portion of the required credits.

In order to be eligible for consideration, you must have been ill or disabled for a least six consecutive months. The CME requirement is then reduced according to the duration and circumstances of the illness or disability.

Enclosed are the forms which must be completed in order to review your request for exemption from CME requirements. Both the waiver and affidavit must be properly completed and notarized.

You will be promptly notified when a decision is reached concerning your request.

Sincerely,

Debra L. Jones

Debra L. Jones, Chief
CME, Records & Renewal

DJ/mm

STATE OF OHIO
THE STATE MEDICAL BOARD

STATE MEDICAL BOARD OF OHIO
90 SEP 17 PM 1:45

Request for Partial Exemption
from Continuing Medical Education Requirements
Due to Physical Illness/Disability

I, LEE I. RUBINSTEIN, hereby request exemption from part of the Continuing Medical Education requirement for relicensure contained in Section 4731.281, Ohio Revised Code, due to physical illness/disability. I understand the entire requirement cannot be waived.

I provide the following information in relation to the above request:

1. Nature of illness/disability

   RUPTURE RT. ACHILLES TENDON WITH REPAIR AND TOTAL WOUND DEHISCENCE

2. Is illness/disability temporary X permanent _____?

3. Name and address of attending physician or physicians:

   M16 9-28-90
   DR. M. BRAHMS – 26900 CEDAR RD. BEACHWOOD, O 44122
   DR. B. GUYRON 29017 CEDAR RD. CLEVELAND O 44122

4. Please answer the following questions:
   * PLEASE Give the EXACT BEGINNING + ENDING dates

   a. Length of time during which you were unable to pursue Continuing Medical Education due to the above illness. 10-30-88 → ~~SEPT.~~, 1989*
      *ABLE TO ATTEND SOME MEETINGS ON A LIMITED BASIS
   b. Are you currently engaged in the practice of medicine? YES
   c. If yes, approximate date you resumed your medical practice
      ~~MAR~~, 1989 ON LIMITED BASIS
   d. If no, approximate date you plan to resume your medical practice
      —
   e. How many patient visits did you have during the last year? SEVERAL HUNDRED ??
   f. If you prescribe any Controlled Substances, name the specific drugs that were prescribed.
      FIORINAL #3, TYLENOL #3

(Reverse side may be used for additional comments)

+ PLEASE list on reverse side ANY Category I credit you may have EARNED BEGINNING JAN 1, 1989 – DEC. 31, 1990.

STATE OF OHIO
THE STATE MEDICAL BOARD
Suite 510
65 South Front Street
Columbus, Ohio 43215

STATE MEDICAL BOARD
OF OHIO
90 OCT 31 PM 3:51

Sept. 28, 1990

Avrum Froinson, MD
26900 Cedar Rd.
Beachwood, OH 44122

Dear Doctor:

Dr. Lee Rubinstein MD has requested partial exemption from Continuing Medical Education requirements for licensure by reason of illness or disability.
Dr. Rubinstein indicates you were a treating physician. In order that this request can be evaluated, it would be appreciated if you could provide us with information concerning the illness and an evaluation as to Dr. Rubinstein's capability of pursuing CME during this biennium, January 1, 1989 through December 31, 1990.
Please complete this form and return it to our office at the above address.
A copy of Dr. Rubinstein's waiver authorizing release of information is enclosed.
Thank you for your consideration in this matter.

Regarding Dr. Rubinstein

1. Nature of Illness/Disability

_____

_____

_____

a. Is illness/disability temporary _____ permanent _____?

2. If you have prescribed medicine for Dr. Rubinstein, name the specific drugs that were prescribed and identify which of these are still being prescribed:

_____

_____

3. Dr. Rubinstein has requested exemption from CME activities for the period 10-88 to 9-89.
Please give the medical reasons why Dr. Rubinstein is not/was not able to engage in CME activities for the time period indicated:

_____

_____

4. Please give any additional comments regarding this patient:
(Use the reverse side or attach additional pages if more space is needed)

_____

_____

5. _____
Name and Address of Attending Physician

_____
Signature Date

STATE OF OHIO
THE STATE MEDICAL BOARD
Suite 510
65 South Front Street
Columbus, Ohio 43215

Sept. 28, 1990

Malcolm Brahms, MD
26900 Cedar Rd.
Beachwood, OH 44122

Dear Doctor:

Dr. Lee Rubinstein MD has requested partial exemption from Continuing Medical Education requirements for licensure by reason of illness or disability.
Dr. Rubinstein indicates you were a treating physician. In order that this request can be evaluated, it would be appreciated if you could provide us with information concerning the illness and an evaluation as to Dr. Rubinstein's capability of pursuing CME during this biennium, January 1, 1989 through December 31, 1990.
Please complete this form and return it to our office at the above address.
A copy of Dr. Rubinstein's waiver authorizing release of information is enclosed.
Thank you for your consideration in this matter.

Regarding Dr. Rubinstein

1. Nature of Illness/Disability

_____

_____

_____

a. Is illness/disability temporary _____ permanent _____?

2. If you have prescribed medicine for Dr. Rubinstein, name the specific drugs that were prescribed and identify which of these are still being prescribed:

_____

_____

3. Dr. Rubinstein has requested exemption from CME activities for the period 10-88 to 9-89.
Please give the medical reasons why Dr. Rubinstein is not/was not able to engage in CME activities for the time period indicated:

_____

_____

4. Please give any additional comments regarding this patient:
(Use the reverse side or attach additional pages if more space is needed)

_____

_____

5. _____
Name and Address of Attending Physician

_____
Signature Date

STATE MEDICAL BOARD OF OHIO
90 OCT 11 PM 4:47

STATE OF OHIO
THE STATE MEDICAL BOARD
Suite 510
65 South Front Street
Columbus, Ohio 43215

Sept. 28, 1990

Melvin M. Reydman, MD
21400 Cedar Rd.
Beachwood, OH 44122

Dear Doctor:

Dr. Lee Rubinstein, MD has requested partial exemption from Continuing Medical Education requirements for licensure by reason of illness or disability.
Dr. Rubinstein indicates you were a treating physician. In order that this request can be evaluated, it would be appreciated if you could provide us with information concerning the illness and an evaluation as to Dr. Rubinstein's capability of pursuing CME during this biennium, January 1, 1989 through December 31, 1990.
Please complete this form and return it to our office at the above address.
A copy of Dr. Rubinstein's waiver authorizing release of information is enclosed.
Thank you for your consideration in this matter.

Regarding Dr. Rubinstein

1. Nature of Illness/Disability

ulceration + fatal breakdown of right achilles tendon repair

a. Is illness/disability temporary X permanent _____?

2. If you have prescribed medicine for Dr. Rubinstein, name the specific drugs that were prescribed and identify which of these are still being prescribed:

3. Dr. Rubinstein has requested exemption from CME activities for the period 10-88 to 9-89.
Please give the medical reasons why Dr. Rubinstein is not/was not able to engage in CME activities for the time period indicated:

Pt had extreme pain + difficulty in walking + required daily dressing changes for almost one year

4. Please give any additional comments regarding this patient:
(Use the reverse side or attach additional pages if more space is needed)

Pt required moist to dry dressings over area of ulceration + was essentially immobilized for 1 year

5. _____
Name and Address of Attending Physician

Melvin M. Reydman MD 10-12-90
Signature -- Date

STATE MEDICAL BOARD OF OHIO
90 OCT 16 PM 1:47

STATE OF OHIO
THE STATE MEDICAL BOARD
Suite 510
65 South Front Street
Columbus, Ohio 43215

Sept. 28, 1990

Randall Yetman, MD
Cleveland Clinic
9500 Euclid Ave.
Cleveland, OH 44106

Dear Doctor:

Dr. Lee Rubinstein MD has requested partial exemption from Continuing Medical Education requirements for licensure by reason of illness or disability.
Dr. Rubinstein indicates you were a treating physician. In order that this request can be evaluated, it would be appreciated if you could provide us with information concerning the illness and an evaluation as to Dr. Rubinstein's capability of pursuing CME during this biennium, January 1, 1989 through December 31, 1990.
Please complete this form and return it to our office at the above address.
A copy of Dr. Rubinstein's waiver authorizing release of information is enclosed.
Thank you for your consideration in this matter.

Regarding Dr. Rubinstein

1. Nature of Illness/Disability

s/p repair of rt. achilles tendon (11/7/88) Developed wound separation approximately 3-4 weeks post-op. Seen February 23, 1989 regarding small amount of exposed tendon.

a. Is illness/disability temporary _____ permanent _____?

2. If you have prescribed medicine for Dr. Rubinstein, name the specific drugs that were prescribed and identify which of these are still being prescribed:

none

3. Dr. Rubinstein has requested exemption from CME activities for the period 10-88 to 9-89.
Please give the medical reasons why Dr. Rubinstein is not/was not able to engage in CME activities for the time period indicated:

4. Please give any additional comments regarding this patient:
(Use the reverse side or attach additional pages if more space is needed)

The patient was seen on two occasions (2/23/89 and 3/16/89) for an open wound of the right foot which made ambulating difficult.

5. Randall Yetman, M.D. Cleveland Clinic, 1 Clinic Center Drive, Cleve, OH 44195
Name and Address of Attending Physician

Randall Yetman
Signature

October 10, 1990
Date

STATE OF OHIO
THE STATE MEDICAL BOARD
Suite 510
65 South Front Street
Columbus, Ohio 43215

STATE MEDICAL BOARD OF OHIO
90 OCT -9 PM 2:07

Raymond Gouyuron, MD
29017 Cedar Rd.
Cleveland, OH 44124

Sept. 28, 1990

Dear Doctor:

Dr. Lee Rubinstein, MD has requested partial exemption from Continuing Medical Education requirements for licensure by reason of illness or disability.
Dr. Rubinstein indicates you were a treating physician. In order that this request can be evaluated, it would be appreciated if you could provide us with information concerning the illness and an evaluation as to Dr. Rubinstein's capability of pursuing CME during this biennium, January 1, 1989 through December 31, 1990.
Please complete this form and return it to our office at the above address.
A copy of Dr. Rubinstein's waiver authorizing release of information is enclosed.
Thank you for your consideration in this matter.

Regarding Dr. Rubinstein

1. Nature of Illness/Disability
Infected ulcer of the heel following Tendon surgery.

a. Is illness/disability temporary X permanent _____?

2. If you have prescribed medicine for Dr. Rubinstein, name the specific drugs that were prescribed and identify which of these are still being prescribed:

3. Dr. Rubinstein has requested exemption from CME activities for the period 10-88 to 9-89.
Please give the medical reasons why Dr. Rubinstein is not/was not able to engage in CME activities for the time period indicated:
He was not allowed the Keep the feet in a pending position

4. Please give any additional comments regarding this patient.
(Use the reverse side or attach additional pages if more space is needed)

5. RAYMOND J. GOUYURON, M.D. 29017 CEDAR
Name and Address of Attending Physician

Raymond Gouyuron 10/1/90 ROAD HYNDHURST,
Signature Date OHIO 44124

LEE RUBINSTEIN, M.D.

MT. SINAI MEDICAL BUILDING
26900 CEDAR ROAD
BEACHWOOD, OHIO 44122
TELEPHONE 831-3474

September 14, 1990

Debra L. Jones
CME, Records, & Renewal
State of Ohio
The State Medical Board
65 South Front Street
Columbus, Ohio 43215

Dear Ms. Jones:

I do not feel this form adequately covers the specifics of my problem. In November, 1988, I suffered a complete tear of the right Achilles tendon. A surgical repair was performed 11/8/88 and I wore a cast and used crutches for the next 2 months. When the final cast was removed, there was a total separation of the incision with infection. A graft was contemplated but could not be done because the tendon was exposed. This ultimately took over a year to close completely, required wound dressings 2 to 3 a day for that entire year, and prolonged antibiotic therapy. I still have a shortened tendon and large keloid.

I was seen in consultation during this time by other orthopedists and plastic surgeons. I am listing their names so you may consult them to verify these facts. The doctor in charge of my case was the orthopedist who did the original surgical repair.

Dr. Malcolm Brahms
26900 Cedar Road
Beachwood, Ohio 44122
(216) 831-7855

I was also seen by:

Dr. B. Guyuron
Plastic Surgeon
29017 Cedar Road
Cleveland, ohio 44124
(216) 461-7999

Dr. A. Froimson
Orthopedic Surgeon
26900 Cedar Road
Beachwood, Ohio 44122
(216) 831-7131

MIO 9-28-90

LEE RUBINSTEIN, M.D.

MT. SINAI MEDICAL BUILDING
26900 CEDAR ROAD
BEACHWOOD, OHIO 44122
TELEPHONE 831-3474

Dr. M. Reydman
General Surgeon
26900 Cedar Road
Beachwood, Ohio 44122
(216) 831-5025

mld. 9-28-90

Dr. R. Yetman
Plastic Surgeon
Cleveland Clinic Foundation
9500 Euclid Avenue
Cleveland, ohio 44106
(216) 444-6990

Needless to say, the seriousness of this injury and the ensuing complications made me curtail and modify all my activities, both in and out of medicine. I had to wear a special boot which made driving very difficult and I was unable to keep up with my regular CME activities. I would appreciate some appropriate exemption for the year or so following this injury.

Thank you for your consideration.

Sincerely,

Lee Rubinstein M.D.

MALCOLM A. BRAHMS, M.D.
RICHARD D. PARKER, M.D.
BRUCE T. COHN, M.D.

ORTHOPAEDIC SURGERY, SPORTS MEDICINE
FOOT SURGERY, ARTHROSCOPIC SURGERY
TOTAL JOINT RECONSTRUCTION

DRS. TRAMER & BRAHMS, INC.
MOUNT SINAI SUBURBAN MEDICAL BUILDING
26900 CEDAR ROAD • BEACHWOOD, OHIO 44122
(216) 831-7855
FAX (216) 831-5320

October 9, 1990

State of Ohio
The State Medical Board
65 South Front Street
Suite 510
Columbus, Ohio 43215

RE: Lee Rubinstein, M.D.

Gentlemen:

On 7 November 1988 the above-named patient was treated surgically for a torn Achilles tendon of his right lower extremity.

A complication of an area of skin necrosis and breakdown resulted in the need for a long period of immobilization and plastic surgery to obtain skin coverage.

There was a total of one year of treatment necessary in cast and/or an orthotic DonJoy brace. Because of the need for his use of external aids, the patient virtually was unable to carry out his practice in a normal fashion and was unable to attend CME Courses.

I am in agreement with a request for an exemption from CME activities for a period from October 1988 to September 1989.

Your attention to this matter is appreciated.

Sincerely yours,

Malcolm A. Brahms, M.D.

dk

c.c Lee Rubinstein, M.D.

RUBINSTEIN, Lee, M.D. 19709
Patient's Name #

STATE MEDICAL BOARD
90 OCT 31 PM 3:51

AVRUM I. FROIMSON, M.D., Inc.
Orthopaedic and Hand Surgery
26900 CEDAR ROAD, SUITE 300
BEACHWOOD, OHIO 44122
(216) 831-7131

Lee Rubinstein, M.D.
1650 South Belvoir Blvd.
South Euclid, OH 44118

Need chart (if have one.)

No Chart!

Lee
Seen as consult
not treating Dr.
cannot find records
see treating MD
to fill this out
AF.

STATEMENT

DATE	PROFESSIONAL SERVICE	CHARGE	PAID	BALANC
	BALANCE FORWARD →			

1603sp PAY LAST AMOUNT IN BALANCE COLUMN

IE - INITIAL EXAMINATION
OV - OFFICE VISIT
INJ - INJECTION
CONS - CONSULTATION
HC - HOSPITAL CARE
FxRx - FRACTURE TREATMENT
ER - EMERGENCY TREATMENT
ROA - RECEIVED ON ACCOUNT
INS - INSURANCE
MM - MEDICAL MUTUAL
MC - MEDICARE
BWC - WORKMAN'S COMP.

STATE OF OHIO
THE STATE MEDICAL BOARD

STATE MEDICAL BOARD

90 SEP 17 PM 1:46

WAIVER

State of Ohio

County of Cuyahoga

I herey authorize all individuals, hospitals, institutions or organizations, personal physicians, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local,state, federal, and foreign) to release to the Ohio State Medical Board any information, files, or records requested by the Board in connection with request for exemption. I further authorize the Ohio State Medical Board to release to the organizations, individuals or groups listed above any information which is material to my request.

Lee Ann Lucas

(Signature of Affiant)

Subscribed and sworn to this 14th day of September, 1990.

Kathryn A. Bryson

(Signature of Official Administering Oath)

*Must be sworn to before a notary public or other person authorized to administer oaths.

KATHRYN A. BRYSON
Notary Public, State of Ohio
Recorded in Lake County
My Comm. Expires 03-10-91

STATE MEDICAL BOARD OF OHIO
90 OCT 31 PM 3:51

1 Lee I. Rubinstein
Signature of Applicant.

2 Lee I. Rubinstein
Signature of Applicant.

I hereby certify that the photograph on the reverse side to which this slip is pasted is a genuine likeness of

LEE I. RUBINSTEIN

who was recommended by me to the State Medical Board for a license to practice in Ohio.

5-27-53 1
Date

Carl C Francis M.D.
Signature of First Endorser.

5-27-53 2
Date

John L Laughlin Jr
Signature of Second Endorser.

STATE OF OHIO STATE MEDICAL BOARD

65 SOUTH FRONT ST., SUITE 510 COLUMBUS, OHIO 43215

I CERTIFY, UNDER PENALTY OF THE LOSS OF MY RIGHT TO PRACTICE MEDICINE AND SURGERY IN THE STATE OF OHIO, THAT I HAVE COMPLETED DURING THE LAST BIENNIUM THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE OHIO STATE MEDICAL ASSN AND APPROVED BY THE STATE MEDICAL BOARD AND HEREBY MAKE APPLICATION FOR RENEWAL.

X _____ 10/1/84
(SIGNATURE OF APPLICANT) (DATE)

APPLICATION FOR BIENNIAL LICENSE RENEWAL TO PRACTICE AS A
DOCTOR OF MEDICINE

IDENTIFICATION NUMBER
35-01-8994

LEE I. RUBINSTEIN
26900 CEDAR RD
BEACHWOOD OH 44122

MD & DO SPECIALTY CODES			
SPECIALTY CODES CURRENTLY ON RECORD → 39			
IF NECESSARY TO CORRECT, ENTER ALL SPECIALTY CODE NUMBERS →			
(SEE LIST ON ENCLOSED CARD)		(LIMIT OF 3)	

AMOUNT DUE $100.00

DATE DUE 11/15/84

INSTRUCTIONS

1. DO NOT FOLD OR STAPLE THIS CARD.
2. REVERSE SIDE MUST BE COMPLETED.
3. MAKE CHECK OR MONEY ORDER PAYABLE TO: TREASURER, STATE OF OHIO
4. PUT IDENTIFICATION NUMBER ON CHECK.
5. MARK CORRECT SPECIALTY CODE(S) BELOW.
6. SEND PAYMENT (DO NOT SEND CASH) AND THIS APPLICATION IN ENCLOSED ENVELOPE TO: TREASURER, STATE OF OHIO BOX 2438 COLUMBUS, OHIO 43216

REPORT ANY CHANGE OF ADDRESS OF RECORD

(PLEASE PRINT)

LAST NAME | FIRST NAME | INITIAL

STREET ADDRESS

CITY | STATE | ZIP CODE

COUNTY

TO RECEIVE YOUR RENEWAL CARD BY DECEMBER 31ST, RETURN THIS APPLICATION AND FEE BY DUE DATE.

THE ADDRESS SHOWN ON THE FRONT OF THIS CARD WILL BE MAINTAINED AS YOUR ADDRESS OF RECORD WITH THE BOARD.

PRINCIPAL PRACTICE ADDRESS — IF DIFFERENT FROM THAT SHOWN ON FRONT
(PLEASE PRINT)

RUBINSTEIN LEE
LAST NAME FIRST NAME INITIAL

26900 CEDAR ROAD #305
STREET ADDRESS

BEACHWOOD OHIO 44124
CITY STATE ZIP CODE

CUYAHOGA

SOCIAL SECURITY NUMBER REDACTED

SECTION 4731.281, OHIO REVISED CODE REQUIRES THAT A RESPONSE BE GIVEN TO THE FOLLOWING QUESTION. PLEASE MARK THE CORRECT BOX.

SINCE YOU LAST RENEWED YOUR OHIO MEDICAL LICENSE, HAVE YOU BEEN CONVICTED OF OR PLEAD NOLO CONTENDERE TO:

YES	NO	
☐	☒	a.) a felony,
☐	☒	b.) a misdemeanor committed in the course of your practice, or
☐	☒	c.) a federal or state law regulating the possession, distribution or use of any drug?

AT ANY TIME SINCE THE LAST RENEWAL OF YOUR CERTIFICATE HAVE YOU:

YES	NO		YES	NO	
☐	☒	1). Been addicted to or dependent upon alcohol or any chemical substance?	☐	☒	3). Surrendered or consented to limitation of license to practice medicine, or state or federal privileges to prescribe controlled substances?
☐	☒	2). Had any disciplinary action taken or initiated against you by a state licensing agency?	☐	☒	4). Had any hospital privileges suspended or revoked?

0345-B

STATE MEDICAL BOARD OF OHIO

65 SOUTH FRONT ST., SUITE 510 COLUMBUS, OHIO 43215

I CERTIFY, UNDER PENALTY OF THE LOSS OF MY RIGHT TO PRACTICE MEDICINE AND SURGERY IN THE STATE OF OHIO. THAT I HAVE COMPLETED DURING THE LAST BIENNIUM THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE OHIO STATE MEDICAL ASSN AND AI 'ROVED BY THE STATE MEDICAL BOARD AND HEREBY MAKE APPLICATION FOR RENEWAL.

(SIGNATURE OF APPLICANT) 10/6/86 (DATE)

APPLICATION FOR BIENNIAL LICENSE RENEWAL TO PRACTICE AS A
DOCTOR OF MEDICINE

IDENTIFICATION NUMBER
35-01-8994

1 LEE I. RUBINSTEIN
26900 CEDAR RD
BEACHWOOD OH 44122

MD & DO SPECIALTY CODES

ENTER ALL SPECIALTY CODES → 50 (LIMIT OF 3)

(SEE LIST ON ENCLOSED CARD)

AMOUNT DUE $100.00

DATE DUE 11/15/86

INSTRUCTIONS

1. DO NOT FOLD OR STAPLE THIS CARD.
2. REVERSE SIDE MUST BE COMPLETED.
3. MAKE CHECK OR MONEY ORDER PAYABLE TO: TREASURER, STATE OF OHIO
4. PUT IDENTIFICATION NUMBER ON CHECK.
5. MARK CORRECT SPECIALTY CODE(S) BELOW.
6. SEND PAYMENT (DO NOT SEND CASH) AND THIS APPLICATION IN ENCLOSED ENVELOPE TO:

TREASURER, STATE OF OHIO
BOX 2438 COLUMBUS, OHIO 43216

REPORT ANY CHANGE OF ADDRESS OF RECORD

(PLEASE PRINT)

LAST NAME FIRST NAME INITIAL

STREET ADDRESS

CITY STATE ZIP CODE

COUNTY

TO RECEIVE YOUR RENEWAL CARD BY DECEMBER 31ST, RETURN THIS APPLICATION AND FEE BY NOVEMBER 15

THE ADDRESS SHOWN ON THE FRONT OF THIS CARD WILL BE MAINTAINED AS YOUR ADDRESS OF RECORD WITH THE BOARD.

PRINCIPAL PRACTICE ADDRESS – IF DIFFERENT FROM THAT SHOWN ON FRONT

(PLEASE PRINT)

LAST NAME _____ FIRST NAME _____ INITIAL _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

COUNTY _____

SOCIAL SECURITY NUMBER _____

SECTION 4731.281, OHIO REVISED CODE REQUIRES THAT A RESPONSE BE GIVEN TO THE FOLLOWING QUESTION. PLEASE MARK THE CORRECT BOX.

SINCE YOU LAST RENEWED YOUR OHIO MEDICAL LICENSE, HAVE YOU BEEN FOUND GUILTY OR PLEAD GUILTY OR NO CONTEST TO:

YES	NO	
☐	☒	a.) a felony.
☐	☒	b.) a misdemeanor committed in the course of your practice, or
☐	☒	c.) a federal or state law regulating the possession, distribution or use of any drug?

AT ANY TIME SINCE THE LAST RENEWAL OF YOUR CERTIFICATE HAVE YOU:

YES	NO	
☐	☒	1.) Been addicted to or dependent upon alcohol or any chemical substance?
☐	☒	2.) Had any disciplinary action taken or initiated against you by a state licensing agency?
☐	☒	3.) Surrendered or consented to limitation upon a license to practice medicine, or state or federal privileges to prescribe controlled substances?
☐	☒	4.) Had any hospital privileges suspended or revoked?

EDM-14946-B

STATE MEDICAL BOARD OF OHIO

I CERTIFY, UNDER PENALTY OF THE LOSS OF MY RIGHT TO PRACTICE MEDICINE AND SURGERY IN THE STATE OF OHIO, THAT I HAVE COMPLETED DURING THE LAST BIENNIUM THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE OHIO STATE MEDICAL ASSN AND APPROVED BY THE STATE MEDICAL BOARD AND HEREBY MAKE APPLICATION FOR RENEWAL.

Lee I. Rubinstein
(SIGNAURE OF APPLICANT) (DATE)

APPLICATION FOR BIENNIAL LICENSE RENEWAL TO PRACTICE AS A; DUCTOR OF MEDICINE

IDENTIFICATION NUMBER 35-01-8994

1 LEE I. RUBINSTEIN
26900 CEDAR RD
BEACHWOOD OH 44122

MD & DO SPECIALTY CODES	AMOUNT DUE	DATE DUE
SPECIALTY CODES CURRENTLY ON RECORD IF NECESSARY TO CORRECT, ENTER ALL SPECIALTY CODE NUMBERS (SEE LIFE ON ENCLOSED CARD) (LIMIT OF 3) 5p	$100.00	11/01/88

TO RECEIVE YOUR RENEWAL CARD BY DECEMBER 31ST, RETURN THIS APPLICATION AND FEE BY NOVEMBER 1.

INSTRUCTIONS

1. DO NOT FOLD OR STAPLE THIS CARD.
2. REVERSE SIDE MUST BE COMPLETED.
3. MAKE CHECK OR MONEY ORDER PAYABLE TO: TREASURER, STATE OF OHIO
4. PUT IDENTIFICATION NUMBER ON CHECK.
5. UPDATE SPECIALTY IF NEEDED.
6. SEND PAYMENT (DO NOT SEND CASH) AND THIS APPLICATION IN ENCLOSED ENVELOPE TO: TREASURER, STATE OF OHIO BOX 2438, COLUMBUS, OHIO 43216

REPORT ANY CHANGE OF ADDRESS OF RECORD

(PLEASE PRINT)

LAST NAME FIRST NAME INITIAL

STREET ADDRESS

CITY STATE ZIP CODE

COUNTY

THE ADDRESS SHOWN ON THE FRONT OF THIS CARD WILL BE MAINTAINED AS YOUR ADDRESS OF RECORD WITH THE BOARD.

PRINCIPAL PRACTICE ADDRESS—IF DIFFERENT FROM THAT SHOWN ON FRONT
(PLEASE PRINT)

LAST NAME FIRST NAME INITIAL

STREET ADDRESS

CITY STATE ZIP CODE

COUNTY

SOCIAL SECURITY NUMBER

SECTION 4731.281, OHIO REVISED CODE REQUIRES THAT A RESPONSE BE GIVEN TO THE FOLLOWING QUESTION. PLEASE MARK THE CORRECT BOX.

SINCE YOU LAST RENEWED YOUR OHIO MEDICAL LICENSE, HAVE YOU BEEN FOUND GUILTY OR PLEAD GUILTY OR NO CONTEST TO:

YES	NO	
☐	☑	a.) a felony
☐	☑	b.) a federal or state law regulating the possession, distribution or use of any drug?

AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION FOR RENEWAL OF YOUR CERTIFICATION HAVE YOU:

YES	NO	
☐	☑	1.) Been addicted to or dependent upon alcohol or any chemical substance? You may answer no to this question if you have successfully completed treatment at a program approved by this Board and have subsequently adhered to all statuatory requirements as contained in Section 4731.224, O.R.C., and related provisions; or are currently enrolled in a Board approved program.
☐	☑	2.) Had any disciplinary action taken or initiated against you by a state licensing agency?
☐	☑	3.) Surrendered or consented to limitation upon a license to practice medicine state or federal privileges to prescribe controlled substances?
☐	☑	4.) Had any clinical privileges suspended or revoked for other than failure to maintain records or attend staff meetings.

QT-00224-OB

DETACH HERE AND REMIT THIS PORTION WITH FEE

STATE MEDICAL BOARD OF OHIO

77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 43266 - 0315

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED DURING THE LAST BIENNIUM THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE OHIO STATE MEDICAL ASSOCIATION AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.

X Lee Rubinstein 12-10-90

(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER:	AMOUNT DUE	DATE DUE
35018994	$160.00	11/01/90

LEE I. RUBINSTEIN, M.D.
26900 CEDAR RD
BEACHWOOD OH 44122

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

50 PATHOLOGY, RADIOISOTOPIC

☑ SPECIALTY CODE(S) CORRECT AS LISTED

IF THE SPECIALTY CODE(S) ARE IN ERROR, ENTER ALL SPECIALTY CODE NUMBERS. CODE1 CODE2 CODE3

CHANGE OF ADDRESS

STREET

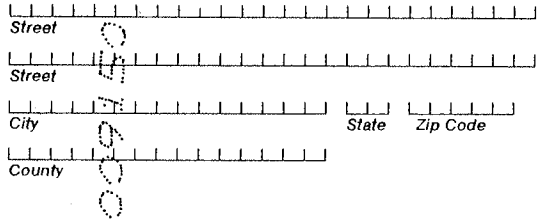
STREET

CITY STATE ZIP CODE

COUNTY

:96969696 21: 09350189941 "00000160001"

PRINCIPAL PRACTICE ADDRESS - IF DIFFERENT FROM THE ADDRESS SHOWN ON FRONT:



HAVE YOU BEEN FOUND GUILTY OF, OR PLEAD GUILTY OR NO CONTEST TO :

YES NO

☐ ☐ *A.) A felony*

☐ ☐ *B.) A federal or state law regulating the possession, distribution or use of any drug?*

AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION FOR RENEWAL OF YOUR CERTIFICATE HAVE YOU :

YES NO

☐ ☐ *1.) Been addicted to or dependent upon alcohol or any chemical substance? You may answer "no" to this question if you have successfully completed treatment at a program approved by this board and have subsequently adhered to all statutory requirements as contained in section 4731.224, O.R.C., and related provisions, or you are currently enrolled in a board approved program. Any questions concerning approval can be directed to the board offices.*

YES NO

☐ ☐ *2.) Had any disciplinary action taken or initiated against you by any state licensing board?*

YES NO

☐ ☐ *3.) Surrendered, or consented to limitation upon: a) A license to practice medicine; OR b) State or federal privileges to prescribe controlled substances?*

YES NO

☐ ☐ *4.) Had any clinical privileges suspended or revoked for reasons other than failure to maintain records or attend staff meetings?*

SOCIAL SECURITY NUMBER

(Optional for purposes of identification)

Rec'd 2-11-91

STATE MEDICAL BOARD OF OHIO

77 South High Street, 17th Floor • Columbus, Ohio 43266-0315 • (614) 466-3934

STATE MEDICAL BOARD OHIO
91 FEB 15 PM 2:46

February 4, 1991

Lee I. Rubinstein, M.D.
26900 Cedar Rd.
Beachwood, OH 44122

Dear Doctor:

We have received your application for renewal of your Ohio license.

Please be advised that in reviewing your renewal application card we noted that you failed to answer all of the following questions. In order to continue processing your renewal we must have your response to each of these questions. Check the correct response to each question, sign and date this form as provided below, and return it directly to the Board offices at, 77 South High Street, 17th Floor, Columbus, Ohio, 43266-0315.

HAVE YOU BEEN FOUND GUILTY OF, OR PLEAD GUILTY OR NO CONTEST TO:

YES	NO		
[ ]	[✓]	A)	A felony
[ ]	[✓]	B)	A federal or state law regulating the possession, distribution or use of any drug?

AT ANY TIME SINCE SIGNING YOU LAST APPLICATION FOR RENEWAL OF YOUR CERTIFICATE HAVE YOU:

YES	NO		
[ ]	[✓]	1.	Been addicted to or dependent upon alcohol or any chemical substance? You may answer "no" to this question if you have successfully completed treatment at a program approved by this Board and have subsequently adhered to all statutory requirements as contained in Section 4731.224, O.R.C., and related provisions, or you are currently enrolled in a Board approved program. Any questions concerning approval can be directed to the Board offices.

YES NO

[ ] [✓] 2. Had any disciplinary action taken or initiated against you by any state licensing board?

YES NO

[ ] [✓] 3. Surrender, or consented to limitation upon: a) A license to practice medicine; OR b) State or federal privileges to prescribe controlled substances?

YES NO

[ ] [✓] 4. Had any clinical privileges suspended or revoked for reasons other than failure to maintain records or attend staff meetings?

I certify, that the information provided above is true and correct.

_____
Signature of Applicant

12-11-91
_____
Date

****

If your response is not received in this office within 15 days from the date of mailing of this notice, your Ohio license will be automatically suspended at that time.

Should you have any questions concerning the above, please do not hesitate to contact me at the above address.

Sincerely,

Debra L. Jones

Debra L. Jones, Chief
CME, Records and Renewal

DLJ:men

DETACH HERE AND REMIT THIS PORTION WITH FEE

STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 43266 - 0315

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED DURING THE LAST BIENNIUM THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE OHIO STATE MEDICAL ASSOCIATION AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.

X [signature] 6-10-92
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-01-8994	$160.00	07/01/92

LEE I. RUBINSTEIN,M.D.
26900 CEDAR RD
BEACHWOOD OH 44122

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

21 GYNECOLOGY

PLEASE [X] SPECIALTY CODE(S) CORRECT AS LISTED

IF THE SPECIALTY CODE(S) ARE IN ERROR, ENTER ALL SPECIALTY CODE NUMBERS. CODE1 CODE2 CODE3

CHANGE OF ADDRESS

STREET
STREET
CITY STATE ZIP CODE
COUNTY

:96969696 21: 0935018994 II' 1'00000160001'

PRINCIPAL PRACTICE ADDRESS - IF DIFFERENT FROM THE ADDRESS SHOWN ON FRONT:

Street

Street

City State Zip Code

County

HAVE YOU BEEN FOUND GUILTY OF, OR PLED GUILTY OR NO CONTEST TO :

YES NO

☐ ☑ A.) A felony or misdemeanor.

☐ ☑ B.) A federal or state law regulating the possession, distribution or use of any drug?

AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION FOR RENEWAL OF YOUR CERTIFICATE HAVE YOU :

YES NO

☐ ☑ 1.) Been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse? You may answer "no" to this question if you have successfully completed treatment at a program approved by this board and have subsequently adhered to all statutory requirements as contained in section 4731.224, O.R.C., and related provisions, or you are currently enrolled in a board approved program. Any questions concerning approval can be directed to the board offices.

YES NO

☐ ☑ 2.) Had a license denied by or had any disciplinary action taken or initiated against you by any state licensing board other than the State Medical Board of Ohio?

YES NO

☐ ☑ 3.) Surrendered, or consented to limitation upon: a) A license to practice medicine; OR b) State or federal privileges to prescribe controlled substances?

YES NO

☐ ☑ 4.) Had any clinical privileges suspended, limited or revoked for reasons other than failure to maintain records or attend staff meetings?

SOCIAL SECURITY NUMBER

(Optional for purposes of identification)

DETACH HERE AND REMIT THIS PORTION WITH FEE

STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 43266 - 0315

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 1994-1996 BIENNIUM THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE OHIO STATE MEDICAL ASSOCIATION AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.

X Lee Rubinstein 4-12-96
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-01-8994	$250.00	05/01/96

LEE I. RUBINSTEIN,M.D.
26900 CEDAR RD
BEACHWOOD OH 44122

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

GYN GYNECOLOGY

PLEASE ☒ SPECIALTY CODE(S) CORRECT AS LISTED

IF CORRECTIONS ARE NECESSARY, PLEASE ENTER ALL SPECIALTY CODES. CODE1 CODE2 CODE3

REPORT ANY CHANGE OF ADDRESS

STREET
STREET
CITY STATE ZIP CODE
COUNTY

:96969696 21: 0935018994 :00000 25000:

PRINCIPAL PRACTICE ADDRESS - IF DIFFERENT FROM THE ADDRESS SHOWN ON FRONT:

Street

Street

City | State | Zip Code

County

AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION FOR RENEWAL OF YOUR CERTIFICATE HAVE YOU :

YES NO

☐ ☑ 1.) Been found guilty of, or pled guilty or no contest to a felony or misdemeanor.

YES NO

☐ ☑ 2.) Been found guilty of, or pled guilty or no contest to a federal or state law regulating the possession, distribution or use of any drug?

YES NO

☐ ☑ 3.) Been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse? You may answer "no" to this question if you have successfully completed treatment at a program approved by this board and have subsequently adhered to all statutory requirements as contained in sections 4731.224 and 4731.25 O.R.C., and related provisions, or you are currently enrolled in a board approved program. Any questions concerning approval can be directed to the board offices.

YES NO

☐ ☑ 4.) Had malpractice insurance cancelled or limited for other than failure to pay premiums?

YES NO

☐ ☑ 5.) Had any disciplinary action taken or initiated against you by any state licensing board other than the State Medical Board of Ohio?

YES NO

☐ ☑ 6.) Surrendered, or consented to limitation upon: a) A license to practice medicine; OR b) State or federal privileges to prescribe controlled substances?

YES NO

☐ ☑ 7.) Had any clinical privileges suspended, restricted or revoked for reasons other than failure to maintain records or attend staff meetings?

YES NO

☐ ☑ 8.) Referred a patient, or participated in an arrangement or scheme for referral of a patient, for clinical laboratory services to a person or facility in which either you or a member of your immediate family has an ownership or investment interest, or any compensation arrangement?

SOCIAL SECURITY NUMBER
(Optional for purposes of identification)

STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 43266 - 0315

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 1998-2000 REGISTRATION PERIOD THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE
OHIO STATE MEDICAL ASSOCIATION
AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.

X _____ 12-9-99
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-01-8994-R	$305.00	01/01/00

LEE I. RUBINSTEIN,M.D.
26900 CEDAR RD
BEACHWOOD OH 44122

I wish to apply for Emeritus status: ☐

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

GYN GYNECOLOGY

☐ **SPECIALTY CODE(S) CORRECT AS LISTED**

IF CORRECTIONS ARE NECESSARY, PLEASE ENTER ALL SPECIALTY CODES. CODE1 CODE2 CODE3

REPORT ANY CHANGE OF ADDRESS

STREET
STREET
CITY STATE ZIP CODE
COUNTY

:969696962: 0935018994 00000305001

PRINCIPAL PRACTICE ADDRESS - IF DIFFERENT FROM THE ADDRESS SHOWN ON FRONT: THIS ADDRESS MUST BE ENTERED AT EACH RENEWAL.

Street

Street

City | State | Zip Code

County

AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION FOR RENEWAL OF YOUR CERTIFICATE HAVE YOU :

YES ☐ NO ☑ *1.) Been found guilty of, or pled guilty or no contest to, or received treatment in lieu of conviction of, a felony or misdemeanor?*

YES ☐ NO ☑ *2.) Been found guilty of, or pled guilty or no contest to a federal or state law regulating the possession, distribution or use of any drug?*

YES ☐ NO ☑ *3.) Been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse? You may answer "no" to this question if you have successfully completed treatment at a program approved by this board and have subsequently adhered to all statutory requirements as contained in sections 4731.224 and 4731.25 O.R.C., and related provisions, or you are currently enrolled in a board approved program. Any questions concerning approval can be directed to the board offices.*

YES ☐ NO ☑ *4.) Had malpractice insurance cancelled or limited for other than failure to pay premiums?*

YES ☐ NO ☑ *5.) Been notified by any board, bureau, department, agency, or other body including those in Ohio, other than this board, of any investigation concerning you, or any charges, allegations or complaints filed against you?*

YES ☐ NO ☑ *6.) Surrendered, or consented to limitation in any jurisdiction: a) A license to practice medicine;OR b) State or federal privileges to prescribe controlled substances?*

YES ☐ NO ☑ *7.) Had any clinical privileges or other authority to practice suspended,restricted or revoked for reasons other than failure to maintain records or attend staff meetings?*

[redacted]

SOCIAL SECURITY NUMBER
(Optional for purposes of identification)

DETACH HERE AND REMIT THIS PORTION WITH FEE

STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 43215 - 6127

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 1999-2001 REGISTRATION PERIOD THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE OHIO STATE MEDICAL ASSOCIATION AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.

X _____ 11-26-01
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE	$50 Late Fee Due After
35-01-8994-R	$305.00	01/01/02	04/01/02

LEE I. RUBINSTEIN,M.D.
26900 CEDAR RD
SUITE 306
BEACHWOOD OH 44122

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

GYN GYNECOLOGY

☐ SPECIALTY CODE(S) CORRECT AS LISTED

IF CORRECTIONS ARE NECESSARY, PLEASE ENTER ALL SPECIALTY CODES. CODE1 CODE2 CODE3

RESIDENCE ADDRESS-THIS MUST BE ENTERED AT EACH RENEWAL.

37500 JACKSON ROAD
STREET

STREET

CHAGRIN FALLS OH 44023
CITY STATE ZIP CODE

CUYAHOGA
COUNTY

0935018994 30500

AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION FOR RENEWAL OF YOUR CERTIFICATE :

YES	NO	
☐	☒	1.) Have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?
☐	☒	2.) Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse? **You may answer "NO" to this question** if you have successfully completed treatment at, or are currently enrolled in, a program approved by this Board and have adhered to all statutory requirements during and subsequent to treatment. You must answer "YES" if you have ever relapsed. Any questions concerning program approval or concerning this question can be directed to the board offices.
☐	☒	3.) Have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?
☐	☒	4.) Has any board, bureau, department, agency, or other body, including those in Ohio, **other than this board,** filed any charges, allegations or complaints against you?
☐	☒	5.) Have you surrendered, or consented to limitation of, or to reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction? You may answer "NO" to this question if the only such surrender or consent was given to this board.
☐	☒	6.) Have you had any clinical privileges or other similar institutional authority suspended, restricted or revoked for reasons **other than failure to maintain records on a timely basis or to attend staff meetings?**

PRINCIPAL PRACTICE ADDRESS - THIS ADDRESS MUST BE ENTERED AT EACH RENEWAL.

☐ Check this Box if you have NO principal Practice address.

26900 CEDAR ROAD
Street

SUITE 306
Street

BEACHWOOD | OH | 44122
City | State | Zip Code

CUYAHOGA
County

REQUIRED: [redacted] REDACTED
SOCIAL SECURITY NUMBER

DETACH HERE AND REMIT THIS PORTION WITH FEE

STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 43215 - 6127

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 2002 - 2004 REGISTRATION PERIOD THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE
OHIO STATE MEDICAL ASSOCIATION
AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.

X [signature] 3-13-04
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE	$50 Late Fee Due After
35-01-8994-R	$305.00	01/01/04	04/01/04

LEE I. RUBINSTEIN,M.D.
37500 JACKSON ROAD
CHAGRIN FALLS OH 44022

0935018994 30500

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

GYN GYNECOLOGY

☐ SPECIALTY CODE(S) CORRECT AS LISTED

IF CORRECTIONS ARE NECESSARY, PLEASE ENTER ALL SPECIALTY CODES. CODE1 CODE2 CODE3

RESIDENCE ADDRESS-THIS MUST BE ENTERED AT EACH RENEWAL.

37500 JACKSON RD
STREET
STREET
CHAGRIN FALLS OH 44022
CITY STATE ZIP CODE
CUYAHOGA
COUNTY

AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION FOR RENEWAL OF YOUR CERTIFICATE :

YES ☐ NO ☑ 1.) Have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?

YES ☐ NO ☑ 2.) Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse? **You may answer "NO" to this question** if you have successfully completed treatment at, or are currently enrolled in, a program approved by this Board and have adhered to all statutory requirements during and subsequent to treatment. You must answer "YES" if you have ever relapsed. Any questions concerning program approval or concerning this question can be directed to the board offices.

YES ☐ NO ☑ 3.) Have any malpractice awards or settlements been paid by you or on your behalf for acts occurring in any state other than Ohio?

YES ☐ NO ☑ 4.) Has any board, bureau, department, agency, or other body, including those in Ohio, **other than this board**, filed any charges, allegations or complaints against you?

YES ☐ NO ☑ 5.) Have you surrendered, or consented to limitation of, or to reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction? You may answer "NO" to this question if the only such surrender or consent was given to this board.

YES ☐ **NO** ☑ 6.) Have you had any clinical privileges or other similar institutional authority suspended, restricted or revoked for reasons **other than failure to maintain records on a timely basis or to attend staff meetings?**

PRINCIPAL PRACTICE ADDRESS - THIS ADDRESS MUST BE ENTERED AT EACH RENEWAL.

☐ Check this Box if you have NO principal Practice address.

26900 CEDAR RD
Street

Street

BEACHWOOD OH 44122
City State Zip Code

CUYAHOGA
County

REQUIRED: [redacted] RECEIVED DATE
SOCIAL SECURITY NUMBER

Date Posted: 12/25/2005 6:46:14 PM

Please review all information you have provided. Click on the "Review" button to change any information given or click on the "I Agree" button to verify that all information posted below is correct and to proceed to payment options.

Please note that knowingly providing false information may result in denial of registration.

License Information

License Number	35.018994
License Name	LEE RUBINSTEIN
Email Address	

Fees

Relicensure Fee	$305.00
	========
Total Fees	**$305.00**

Specialty Codes

1. Please select one specialty from the field below

. . . . . GYNECOLOGY

2. Please select one specialty from the field below, if applicable.

. . . . . *{not Answered}*

3. Please select one specialty from the field below, if applicable.

. . . . . *{not Answered}*

CME-Physicians

1. Have you met the above CME requirements for your license?

. . . . . YES

Discipline

1. Have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?

. . . . . NO

2. Have you surrendered, consented to limitation of, or to suspension, reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction other than Ohio?

. . . . . NO

3. Have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?

. . . . . NO

4. Has any board, bureau, department, agency, or any other body, including those in Ohio **other than this board,** filed any charges, allegations or complaints against you?

. . . . . NO

5. Have you had any clinical privileges or other similar institutional authority suspended, restricted or revoked for reasons **other than failure to maintain records on a timely basis or to attend staff meetings?**

. . . . . NO

6. Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse?

. . . . . NO

Social Security Number

1.

. . . . . REDACTED

Nurse Collaboration Info

1. Are you currently in a collaboration agreement with any Clinical Nurse Specialists, Certified Nurse-Midwives or Certified Nurse Practitioners?

. . . . . NO

2. List the name/names and type of licensure for each nurse with whom you are collaborating. **For example: Jane Doe, CNP; Mary Smith, CNS.**

. . . . . *{not Answered}*

I understand that submitting a false, fraudulent, or forged statement or document or omitting a material fact in obtaining licensure may be grounds for disciplinary action against my license.

Under penalty of law, I hereby swear or affirm that the information I have provided in the application is complete and correct, and that I have complied with all criteria for applying on line.

Date Posted: 12/26/2007 10:48:23 AM

Please review all information you have provided. Click on the "Review" button to change any information given or click on the "I Agree" button to verify that all information posted below is correct and to proceed to payment options.

Please note that knowingly providing false information may result in denial of registration.

Address Information

BUSINESS ADDRESS	26900 Cedar Rd SUITE 306 Delete, OH 44122 Cuyahoga County

License Information

License Number	35.018994
License Name	LEE RUBINSTEIN
Email Address	pgrantr@aol.com

Fees

Relicensure Fee	$305.00
	========
Total Fees	**$305.00**

Specialty Codes

1. Please select one specialty from the field below

. . . . . GYNECOLOGY

2. Please select one specialty from the field below, if applicable.

. . . . . *{not Answered}*

3. Please select one specialty from the field below, if applicable.

. . . . . *{not Answered}*

CME-Physicians

1. Have you met the above CME requirements for your license?

. . . . . YES

Discipline

1. Have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?

. . . . . NO

2. Have you surrendered, consented to limitation of, or to suspension, reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction other than Ohio?

. . . . . NO

3. Have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?

. . . . . NO

4. Has any board, bureau, department, agency, or any other body, including those in Ohio **other than this board,** filed any charges, allegations or complaints against you?

. . . . . NO

5. Have you had any clinical privileges or other similar institutional authority suspended, restricted or revoked for reasons **other than failure to maintain records on a timely basis or to attend staff meetings?**

. . . . . NO

6. Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse?

. . . . . NO

Social SecurityNumber

1.

. . . . . REDACTED

Nurse Collaboration Info

1. Are you currently in a collaboration agreement with any Clinical Nurse Specialists, Certified Nurse-Midwives or Certified Nurse Practitioners?

. . . . . NO

2. List the name/names and type of licensure for each nurse with whom you are collaborating. **For example: Jane Doe, CNP; Mary Smith, CNS.**

. . . . . *{not Answered}*

I understand that submitting a false, fraudulent, or forged statement or document or omitting a material fact in obtaining licensure may be grounds for disciplinary action against my license.

Under penalty of law, I hereby swear or affirm that the information I have provided in the application is complete and correct, and that I have complied with all criteria for applying on line.

Date Posted: 12/3/2009 12:38:28 PM

Please review all information you have provided. Click on the "Review" button to change any information given or click on the "I Agree" button to verify that all information posted below is correct and to proceed to payment options.

Please note that knowingly providing false information may result in denial of registration.

License Information

License Number	35.018994
License Name	LEE RUBINSTEIN

Fees

Relicensure Fee	$305.00
	========
Total Fees	**$305.00**

Specialty Codes

1. Please select one specialty from the field below
   . . . . . OBSTETRICS & GYNECOLOGY
2. Please select one specialty from the field below, if applicable.
   . . . . . GYNECOLOGY
3. Please select one specialty from the field below, if applicable.
   . . . . . *{not Answered}*

CME-Physicians

1. Have you met the above CME requirements for your license?
   . . . . . YES

Discipline

1. Have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?
   . . . . . NO
2. Have you surrendered, consented to limitation of, or to suspension, reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction other than Ohio?
   . . . . . NO
3. Have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?
   . . . . . NO

4. Has any board, bureau, department, agency, or any other body, including those in Ohio **other than this board,** filed any charges, allegations or complaints against you?

. . . . . NO

5. Have you had any clinical privileges or other similar institutional authority suspended, restricted, revoked or placed on probation for reasons **other than failure to maintain records on a timely basis or to attend staff meetings?**

. . . . . NO

6. Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse?

. . . . . NO

Social Security Number

1.

. . . . . REDACTED

Nurse Collaboration Info

1. Areyou currently in a collaboration agreement with any Clinical Nurse Specialists, Certified Nurse-Midwives or Certified Nurse Practitioners?

. . . . . NO

2. List the name/names and type of licensure for each nurse with whom you are collaborating. **For example: Jane Doe, CNP; Mary Smith, CNS.**

. . . . . *{not Answered}*

I understand that submitting a false, fraudulent, or forged statement or document or omitting a material fact in obtaining licensure may be grounds for disciplinary action against my license.

Under penalty of law, I hereby swear or affirm that the information I have provided in the application is complete and correct, and that I have complied with all criteria for applying on line.

Date Posted: 2/10/2012 11:24:46 AM

Please review all information you have provided. Click on the "Review" button to change any information given or click on the "I Agree" button to verify that all information posted below is correct and to proceed to payment options.

Please note that knowingly providing false information may result in denial of registration.

Address Information

BUSINESS ADDRESS

4269 Pearl Road
SUITE 411
Cleveland, OH 44109
Cuyahoga County
United States of America
216-295-3330
Carolw1690@gmail.com

License Information

License Number 35.018994
License Name LEE RUBINSTEIN

Fees

Relicensure Fee $305.00

========

Total Fees **$305.00**

Medical Board Correspondence Email

1. **Did you provide a Credential email address? Please note this information is a public record.**

. . . . . YES

Specialty Codes

1. Please select one specialty from the field below

. . . . . GYNECOLOGY

2. Please select one specialty from the field below, if applicable.

. . . . . GYNECOLOGY

3. Please select one specialty from the field below, if applicable.

. . . . . OBSTETRICS & GYNECOLOGY

CME-Physicians

1. Have you met the above CME requirements for your license?

. . . . . YES

Discipline

1. Have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?

. . . . . NO

2. Have you surrendered, consented to limitation of, or to suspension, reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction other than Ohio?

. . . . . NO

3. Have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?

. . . . . NO

4. Has any board, bureau, department, agency, or any other body, including those in Ohio **other than this board,** filed any charges, allegations or complaints against you?

. . . . . NO

5. Have you had any clinical privileges or other similar institutional authority suspended, restricted, revoked or placed on probation for reasons **other than failure to maintain records on a timely basis or to attend staff meetings?**

. . . . . NO

6. Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse?

. . . . . NO

Social Security Number

1.

. . . . . REDACTED

Nurse Collaboration Info

1. Are you currently in a collaboration agreement with any Clinical Nurse Specialists, Certified Nurse-Midwives or Certified Nurse Practitioners?

. . . . . NO

2. List the name/names and type of licensure for each nurse with whom you are collaborating. **For example: Jane Doe, CNP; Mary Smith, CNS.**

. . . . . *{not Answered}*

Ohio Employment

1. Do you practice in Ohio?

. . . . . YES

Ohio Workforce Questions

1. "Clinical" - direct patient care

. 10-14

2. "Research" - study of a treatment, procedure or medication done in a medical setting or for a medical purpose

. 15-19

3. "Administration" - activities related generally to patient care other than direct contact with a patient (e.g. recordkeeping, clerical tasks, chart review, prior authorizations with insurers, claims, billing issues, etc.)

. 10-14

4. "Education" - preceptor, mentor, etc.

. 20-24

5. "Volunteering" - providing medical and medical-related services at no cost

. 1-4

6. "Other" - medical professional activities not included in above categories

. 10-14

Clinical - Practice setting

1. Enter the number of hours per week spent in "Office/Clinic/Ambulatory care" (out-patient care).

. 10-14

2. Enter the number of hours per week spent in "Hospital (in-patient care)".

. 0

3. Enter the number of hours per week spent in "Emergency Room".

. 0

4. Enter the number of hours per week spent in "Urgent Care".

. 0

5. Enter the number of hours per week spent in "Other".

. 1-4

Workforce Counties

1. Enter the first zip code:

. 44109

2. Enter the first county:

. . . . . Cuyahoga

3. Enter the second zip code:

. . . . . *{not Answered}*

4. Enter the second county:

. . . . . *{not Answered}*

5. Enter the third zip code:

. . . . . *{not Answered}*

6. Enter the third county:

. . . . . *{not Answered}*

Practice Arrangement (size)

1. Solo practitioner

. . . . . NO

2. Single-specialty Group

. 2-5

3. Multi-specialty Group

. . . . . N/A

4. Employee of a clinical facility or hospital? (Clinical facility is an urgent care, industrial clinic or similar entity)

. . . . . NO

Workforce Language Question

1. Do practitioners or staff in your practice communicate in sign language or in a language other than spoken English?

. . . . . YES

Languages

1. Select a language from the drop down list.

. . . . . Spanish

2. Select a language from the drop down list.

. . . . . *{not Answered}*

3. Select a language from the drop down list.

. . . . . *{not Answered}*

ABMS Certified

1. Are you certified by an ABMS Board?

. . . . . NO

I understand that submitting a false, fraudulent, or forged statement or document or omitting a material fact in obtaining licensure may be grounds for disciplinary action against my license.

Under penalty of law, I hereby swear or affirm that the information I have provided in the application is complete and correct, and that I have complied with all criteria for applying on line.

Date Posted: 11/20/2013 11:23:30 AM

Please review all information you have provided. Click on the "Review" button to change any information given or click on the "I Agree" button to verify that all information posted below is correct and to proceed to payment options.

Please note that knowingly providing false information may result in denial of registration.

Address Information

CREDENTIAL MAIL ADDRESS	37500 JACKSON ROAD CHAGRIN FALLS, OH 44022 Cuyahoga County Carolw1690@gmail.com

License Information

License Number	35.018994
License Name	LEE RUBINSTEIN

Fees

Relicensure Fee	$305.00
	========
Total Fees	**$305.00**

Medical Board Correspondence Email

1. **Did you provide a Credential email address? Please note this information is a public record.**

. . . . . YES

Specialty Codes

1. Please select one specialty from the field below

. . . . . GYNECOLOGY

2. Please select one specialty from the field below, if applicable.

. . . . . GYNECOLOGY

3. Please select one specialty from the field below, if applicable.

. . . . . GYNECOLOGY

CME-Physicians

1. Have you met the above CME requirements for your license?

. . . . . YES

Discipline

1. Have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?

. . . . . NO

2. Have you surrendered, consented to limitation of, or to suspension, reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction other than Ohio?

. . . . . NO

3. Have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?

. . . . . NO

4. Has any board, bureau, department, agency, or any other body, including those in Ohio **other than this board,** filed any charges, allegations or complaints against you?

. . . . . NO

5. Have you had any clinical privileges or other similar institutional authority suspended, restricted, revoked or placed on probation for reasons **other than failure to maintain records on a timely basis or to attend staff meetings?**

. . . . . NO

6. Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse?

. . . . . NO

Social Security Number

1.

. . . . . REDACTED

Nurse Collaboration Info

1. Are you currently in a collaboration agreement with any Clinical Nurse Specialists, Certified Nurse-Midwives or Certified Nurse Practitioners?

. . . . . NO

2. List the name/names and type of licensure for each nurse with whom you are collaborating. **For example: Jane Doe, CNP; Mary Smith, CNS.**

. . . . . *{not Answered}*

Ohio Employment

1. Do you practice in Ohio?

. . . . . YES

Ohio Workforce Questions

1. "Clinical" - direct patient care

. 1-4

2. "Research" - study of a treatment, procedure or medication done in a medical setting or for a medical purpose

. 1-4

3. "Administration" - activities related generally to patient care other than direct contact with a patient (e.g. recordkeeping, clerical tasks, chart review, prior authorizations with insurers, claims, billing issues, etc.)

. 5-9

4. "Education" - preceptor, mentor, etc.

. 1-4

5. "Volunteering" - providing medical and medical-related services at no cost

. 0

6. "Other" - medical professional activities not included in above categories

. 1-4

Clinical - Practice setting

1. Enter the number of hours per week spent in "Office/Clinic/Ambulatory care" (out-patient care).

. 5-9

2. Enter the number of hours per week spent in "Hospital (in-patient care)".

. 0

3. Enter the number of hours per week spent in "Emergency Room".

. 0

4. Enter the number of hours per week spent in "Urgent Care".

. 0

5. Enter the number of hours per week spent in "Other".

. 0

Workforce Counties

1. Enter the first zip code:

. 44109

2. Enter the first county:

. . . . . Cuyahoga

3. Enter the second zip code:

. . . . . *{not Answered}*

4. Enter the second county:

. . . . . *{not Answered}*

5. Enter the third zip code:

. . . . . *{not Answered}*

6. Enter the third county:

. . . . . *{not Answered}*

7. Do you have more than one practice location?

. . . . . NO

Practice Arrangement (size)

1. Solo practitioner

. . . . . NO

2. Single-specialty Group

. 2-5

3. Multi-specialty Group

. . . . . N/A

4. Employee of a clinical facility or hospital? (Clinical facility is an urgent care, industrial clinic or similar entity)

. . . . . NO

Workforce Language Question

1. Do practitioners or staff in your practice communicate in sign language or in a language other than spoken English?

. . . . . NO

ABMS Certified

1. Are you certified by an ABMS Board?

. . . . . NO

NPI number

1. Please enter your current NPI number

. 1669548764

DEA number

1. Please enter your DEA number. Only enter one, or the primary DEA number.

. . . . . AR2917322

I understand that submitting a false, fraudulent, or forged statement or document or omitting a material fact in obtaining licensure may be grounds for disciplinary action against my license.

Under penalty of law, I hereby swear or affirm that the information I have provided in the application is complete and correct, and that I have complied with all criteria for applying on line.

Date Posted: 2/29/2016 1:45:37 PM

Please review all information you have provided. Click on the "Review" button to change any information given or click on the "I Agree" button to verify that all information posted below is correct and to proceed to payment options.

Please note that knowingly providing false information may result in denial of registration.

Address Information

BUSINESS ADDRESS

3461 Warrensville Center Road
SUITE 202
Shaker Heights, OH 44122
Cuyahoga County
United States of America
216-295-3330
Carolw1690@gmail.com

License Information

License Number 35.018994
License Name LEE RUBINSTEIN

Fees

Relicensure Fee $305.00

========

Total Fees **$305.00**

Medical Board Correspondence Email

1. **Did you provide a Credential email address? Please note this information is a public record.**

. . . . . YES

Specialty Codes

1. Please select one specialty from the field below

. . . . . GYNECOLOGY

2. Please select one specialty from the field below, if applicable.

. . . . . GYNECOLOGY

3. Please select one specialty from the field below, if applicable.

. . . . . GYNECOLOGY

CME-Physicians

1. Have you met the above CME requirements for your license?

. . . . . YES

Discipline

1. **At any time since signing your last application for renewal of your certificate** have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?

   . . . . . NO

2. **At any time since signing your last application for renewal of your certificate** have you surrendered, consented to limitation of, or to suspension, reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction other than Ohio?

   . . . . . NO

3. **At any time since signing your last application for renewal of your certificate** have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?

   . . . . . NO

4. **At any time since signing your last application for renewal of your certificate** has any board, bureau, department, agency, or any other body, including those in Ohio **other than this board,** filed any charges, allegations or complaints against you?

   . . . . . NO

5. **At any time since signing your last application for renewal of your certificate** have you had any clinical privileges or other similar institutional authority suspended, restricted, revoked or placed on probation for reasons **other than failure to maintain records on a timely basis or to attend staff meetings?**

   . . . . . NO

6. **At any time since signing your last application for renewal of your certificate** have you been addicted to or dependent upon alcohol or any chemical substance; relapsed, been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse?

   . . . . . NO

Social Security Number

1.

. . . . . REDACTED

Nurse Collaboration Info

1. Are you currently in a collaboration agreement with any Clinical Nurse Specialists, Certified Nurse-Midwives or Certified Nurse Practitioners?

. . . . . NO

2. List the name/names and type of licensure for each nurse with whom you are collaborating. **For example: Jane Doe, CNP; Mary Smith, CNS.**

. . . . . *{not Answered}*

Ohio Employment

1. Do you practice in Ohio?

. . . . . YES

Ohio Workforce Questions

1. "Clinical" - direct patient care

. 1-4

2. "Research" - study of a treatment, procedure or medication done in a medical setting or for a medical purpose

. 1-4

3. "Administration" - activities related generally to patient care other than direct contact with a patient (e.g. recordkeeping, clerical tasks, chart review, prior authorizations with insurers, claims, billing issues, etc.)

. 1-4

4. "Education" - preceptor, mentor, etc.

. 0

5. "Volunteering" - providing medical and medical-related services at no cost

. 0

6. "Other" - medical professional activities not included in above categories

. 0

Clinical - Practice setting

1. Enter the number of hours per week spent in "Office/Clinic/Ambulatory care" (out-patient care).

. 1-4

2. Enter the number of hours per week spent in "Hospital (in-patient care)".

. 0

3. Enter the number of hours per week spent in "Emergency Room".

. 0

4. Enter the number of hours per week spent in "Urgent Care".

. 0

5. Enter the number of hours per week spent in "Other".

. 1-4

Workforce Counties

1. Enter the first zip code:

. 44122

2. Enter the first county:

. . . . . Cuyahoga

3. Enter the second zip code:

. . . . . *{not Answered}*

4. Enter the second county:

. . . . . *{not Answered}*

5. Enter the third zip code:

. . . . . *{not Answered}*

6. Enter the third county:

. . . . . *{not Answered}*

7. Do you have more than one practice location?

. . . . . NO

Practice Arrangement (size)

1. Solo practitioner

. . . . . NO

2. Single-specialty Group

. 2-5

3. Multi-specialty Group

. . . . . N/A

4. Employee of a clinical facility or hospital? (Clinical facility is an urgent care, industrial clinic or similar entity)

. . . . . NO

Workforce Language Question

1. Do practitioners or staff in your practice communicate in sign language or in a language other than spoken English?

. . . . . NO

ABMS Certified

1. Are you certified by an ABMS Board?

. . . . . NO

NPI number

1. Please enter your current NPI number

. 1669548764

DEA number

1. Please enter your DEA number. Only enter one, or the primary DEA number.

. . . . . AR2917322

OARRS Registration

1. Since signing your last renewal have you prescribed or personally furnished opioid analgesics or benzondiazepines while practicing in Ohio?

. . . . . NO

2. Are you registered with the Ohio Automated Rx Reporting System (OARRS)?

. . . . . NO

I understand that submitting a false, fraudulent, or forged statement or document or omitting a material fact in obtaining licensure may be grounds for disciplinary action against my license.

Under penalty of law, I hereby swear or affirm that the information I have provided in the application is complete and correct, and that I have complied with all criteria for applying on line.

Contact Audit Trail for RUBINSTEIN LEE

Date	User	Table	Field	New	Old
2/29/2016 2:39:54 PM	Bates, J	CONTACTADDRESS	ZIPCODE	44122	44109
2/29/2016 2:39:54 PM	Bates, J	CONTACTADDRESS	CITY	Shaker Heights	Cleveland
2/29/2016 2:39:54 PM	Bates, J	CONTACTADDRESS	ADDRESS2	SUITE 202	SUITE 411
2/29/2016 2:39:54 PM	Bates, J	CONTACTADDRESS	ADDRESS1	3461 Warrensville Center Road	4269 Pearl Road
2/10/2012 2:48:44 PM	Vest, P	CONTACTADDRESS	COUNTRYIDNT	United States of America	
2/10/2012 2:48:44 PM	Vest, P	CONTACTADDRESS	PHONE	216-295-3330	
2/10/2012 2:48:44 PM	Vest, P	CONTACTADDRESS	ADDRESS2	SUITE 411	SUITE 306
2/10/2012 2:48:44 PM	Vest, P	CONTACTADDRESS	CITY	Cleveland	Delete
2/10/2012 2:48:44 PM	Vest, P	CONTACTADDRESS	ZIPCODE	44109	44122
2/10/2012 2:48:44 PM	Vest, P	CONTACTADDRESS	ADDRESS1	4269 Pearl Road	26900 Cedar Rd
12/26/2007 4:03:18 PM	Vest, P	CONTACTADDRESS	CITY	Delete	BEACHWOOD
12/26/2007 4:03:17 PM	Vest, P	CONTACTADDRESS	ADDRESS1	26900 Cedar Rd	26900 CEDAR ROAD