REDACTED COPY

Updated

Application #: 253433

RECEIVED
JAN 2 3 2013
Board of Registration in Medicine

Board of Registration in Medicine
200 Harvard Mill Square, Suite 330 - Wakefield, MA 01880
Telephone: (781) 876-8210 Fax: (781) 876-8383 www.mass.gov/massmedboard

FULL LICENSE APPLICATION

Application Fee: Please enclose a check or money order in the amount of $600.00 made payable to the Commonwealth of Massachusetts. The application fee is non-refundable.

Type of License ☒ Initial Full License ☐ Administrative License ☐ Volunteer License

Check One: ☒ U.S./Canadian Graduate ☐ International Graduate

Legal Name (do not use nicknames or initials, unless they are part of your legal name)

Edwards	Louis	Jerry	
Last Name (type or print clearly)	First	Middle	Suffix (Jr., etc.)

☒ M.D. ☐ D.O. ☐ Ph.D ☐ Other degree _____ ☒ Male ☐ Female

Other Name(s) Used - List any other name(s) you have used which may appear on your identifying documents, such as medical education and examination records. If not applicable, check here ☒

N/A			
Entire Last Name (type or print clearly)	First	Middle	Suffix (Jr., etc.)

Date of Birth: ___ ___ ___ (Month Day Year) Social Security Number: _____

Place of Birth: Dallas (City) TX (State/Province/Territory) (Country if not USA)

*Mailing Address: _____ (Number and Street) _____ Telephone: ___ ___ ___

___ (City) _____ (State/Province/Territory) _____ (Zip (or postal) Code)

Home Address: _____ (Number and Street) _____ Telephone: ___ _____

_____ (City) MA (State/Province/Territory) _____ (Zip (or postal) Code)

Business Address: _____ (Number and Street) _____ Telephone: _____ ___

___ (City) MA (State/Province/Territory) _____ (Zip (or postal) Code)

E-mail Address: ___ _____ Fax number: 925-364-3937

Are you applying for licensure through FCVS? (See instructions page 12) ☐ Yes ☒ No

*** The Board will use your Mailing Address for all correspondence**

Pre-medical School

			From	To
Facility: Rice University	Degree: BA		09/__/59	12/__/1965
Street: 6100 Main Street, MS	City: Houston	State: TX		
Facility:	Degree:		__/__/__	__/__/__
Street:	City:	State:		

Medical School

			From	To
Facility: University of Texas Southwestern Medical School at Dallas	Degree: MD		09/__/65	06/__/1969
Street: 5323 Harry Hines Blvd.	City: Dallas	State: TX		
Facility:	Degree:		__/__/__	__/__/__
Street:	City:	State:		

Date of medical school graduation: 06 / 1969
Month Year

Note: U.S. graduates must include a written explanation for the duration of medical education longer than four (4) years, and for any breaks in medical education. International graduates must provide a written explanation for the duration of medical education longer than six (6) years and any breaks in medical education.

Postgraduate Education:

List all postgraduate training in chronological order from medical school to the present. Include the name and address of the facility, your position, e.g. PGY 1, 2, fellow, etc. and dates of affiliation. You must account for all periods of training or postgraduate work from the time you graduated from medical school.

				From	To
Facility: Baylor College of Medicine Program	Position: Intern			07/01/69	06/30/70
Street: 6621 Fannin Street	City: Houston		State: TX		
Facility: Baylor College of Medicine Program	Position: Intern			07/01/70	09/30/70
Street: 6651 Main Street	City: Houston		State: TX		
Facility: Baylor College of Medicine Program	Position: Resident			10/01/70	01/03/77
Street: 6651 Main Street, Suite 1020	City: Houston		State: TX		
Facility:	Position:			__/__/__	__/__/__
Street:	City:		State:		
Facility:	Position:			__/__/__	__/__/__
Street:	City:		State:		

** Internship extended due to having not yet selected a residency program
** Residency extended due to active military duty from 06/23/1972 - 11/01/1975.

Examination History

Please contact the appropriate examination entity and have certified transcript of your scores sent directly to this Board. If you are using FCVS, your examination scores will be sent to the Board with your credentials packet.

List each licensure examination, U.S. or international, you have taken (USMLE, NBME, NBOME, LMCC, Etc.).If additional space is necessary, please enclose a separate sheet with your application and include all the information below. If you answer "yes" to question #5 on the Full Supplement, you must also complete the required information.

Examination	Most Recent Date taken (Month/Year)	Passed (P) or Failed (F)		Number of attempts
USMLE Step I		☐ P	☐ F	
USMLE Step II		☐ P	☐ F	
USMLE Step III		☐ P	☐ F	
NBME Part I	06/20/1967	☒ P	☐ F	1
NBME Part II	04/22/1969	☒ P	☐ F	1
NBME Part III	03/11/1970	☒ P	☐ F	1
FLEX Component 1		☐ P	☐ F	
FLEX Component 2		☐ P	☐ F	
FLEX Pre-1985		☐ P	☐ F	
NBOME Part I		☐ P	☐ F	
NBOME Part II		☐ P	☐ F	
NBOME Part III		☐ P	☐ F	
COMLEX Level 1		☐ P	☐ F	
COMLEX Level 2		☐ P	☐ F	
COMLEX Level 3		☐ P	☐ F	
COMVEX		☐ P	☐ F	
LMCC – Single		☐ P	☐ F	
LMCC – Part I		☐ P	☐ F	
LMCC – Part II		☐ P	☐ F	
State Board Exam	(State of examination)	☐ P	☐ F	

Hospital Affiliations and Employment

List hospital appointments, in chronological order, where you had active staff privileges. Include the name and address of the facility, your position and dates of affiliation. Also include periods of unemployment or employment outside of medicine. Attach a separate sheet of paper if necessary.

			From	To
Facility: Bayou City Medical Center	Position: OB/GYN		02 / 01 / 77	12 / 31 / 82
Street: 4200 Portsmouth Street	City: Houston	State: TX		
Facility: Baylor College of Medicine	Position: Research Physician* Asst. Clinical Professor		04 / 01 / 77	06 / 30 / 00
Street: One Baylor Plaza	City: Houston	State: TX		
*Research Physician employment 04/01/77 - 12/31/1981				
Facility: Woman's Hospital of Texas	Position: Gynecologist		07 / 27 / 82	08 / 27 / 98
Street: 7600 Fannin Street	City: Houston	State: TX		
Facility: See Attachment	Position:		/ /	/ /
Street:	City:	State:		

1. List other states (abbreviations) where you are currently or have ever had a full license: AR, TX, UT, WA

2. a) Are you certified by the American Board of Medical Specialties? ☒ Yes ☐ No
   b) Are you certified by the American Board of Osteopathic Medicine? ☐ Yes ☒ No

3. List Board Certification(s): American Board of Obstetrics & Gynecology Certification date: 01 / 01 / 80
   Recertification: 12/31/2001
   Certification date: / /

4. List your practice specialt(ies) Obstetrics & Gynecology

5. Have you completed the Opioid and Pain Management training (see Full Instructions, page 5) ☒ Yes ☐ No

6. Reason for requesting a Massachusetts medical license:
   Retired from practice in Arkansas, moved to Massachusetts and plan to apply at Planned Parenthood clinic in Boston.

7. Name of Facility: Planned Parenthood
   Address: 1055 Commonwealth Ave City: Boston

8. Anticipated starting date in Massachusetts: Unknown /

9. Curriculum vitae (CV) listing activities by month and year must be enclosed with your application.

Under the penalties of perjury, I declare that I have examined this full application and all its accompanying instructions, forms and statements, and to the best of my knowledge and belief, the information contained herein is true, correct and complete. As an applicant for a full license to practice medicine, I understand that a criminal record check may be conducted for conviction and pending criminal case information from the Criminal History Systems Board only and that it will not necessarily disqualify me from licensure.

Louis J Edwards — 1 / 19 / 2013

Signature of Applicant — Month / Day / Year

(Continued on page 5)

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Type of License ☒ Initial Full License ☐ Administrative License ☐ Volunteer License

Check One: ☒ U.S./Canadian Graduate ☐ International Graduate

Legal Name (do not use nicknames or initials, unless they are part of your legal name)

Edwards	Louis	Jerry	
Last Name (type or print clearly)	First	Middle	Suffix (Jr., etc.)

☒ M.D. ☐ D.O. ☐ Ph.D ☐ Other degree _____ ☒ Male ☐ Female

Other Name(s) Used - List any other name(s) you have used which may appear on your identifying documents, such as medical education and examination records. If not applicable, check here ☒

Jerry Edwards	L. Jerry	Edwards	
Entire Last Name (type or print clearly)	First	Middle	Suffix (Jr., etc.)

Date of Birth: ___ ___ ___ (Month Day Year) Social Security Number: _____ _____

Place of Birth: Dallas (City) TX (State/Province/Territory) (Country if not USA)

*Mailing Address: _____ (Number and Street) Telephone: _____

_____ (City) _____ (State/Province/Territory) _____ (Zip (or postal) Code)

Home Address: _____ (Number and Street) Telephone: _____

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E-mail Address: _____ Fax number: (501) 225-8705

Are you applying for licensure through FCVS? (See instructions page 12) ☐ Yes ☒ No

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Pre-medical School

			From	To
Facility: Rice University	Degree: BA		09/ /59	12/ /1965
Street: 6100 Main Street, MS 57	City: Houston	State: TX		
Facility:	Degree:		/ /	/ /
Street:	City:	State:		

Medical School

			From	To
Facility: University of Texas Southwestern Medical School at Dallas	Degree: MD		09/ /65	06/ /1969
Street: 5323 Harry Hines Blvd.	City: Dallas	State: TX		
Facility:	Degree:		/ /	/ /
Street:	City:	State:		

Date of medical school graduation: 06 / 1969
Month Year

Note: U.S. graduates must include a written explanation for the duration of medical education longer than four (4) years, and for any breaks in medical education. International graduates must provide a written explanation for the duration of medical education longer than six (6) years and any breaks in medical education.

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Facility: Baylor College of Medicine Program	Position: Intern		07/01/70	09/30/70
Street: 6651 Main Street	City: Houston	State: TX		
Facility: Baylor College of Medicine Program	Position: Resident		10/01/70	01/03/77
Street: 6651 Main Street, Suite 1020	City: Houston	State: TX		
Facility:	Position:		/ /	/ /
Street:	City:	State:		
Facility:	Position:		/ /	/ /
Street:	City:	State:		

** Internship extended due to having not yet selected a residency program
** Residency extended due to active military duty from 06/23/1972 - 11/01/1975.

Examination History

Please contact the appropriate examination entity and have certified transcript of your scores sent directly to this Board. If you are using FCVS, your examination scores will be sent to the Board with your credentials packet.

List each licensure examination, U.S. or international, you have taken (USMLE, NBME, NBOME, LMCC, Etc.).If additional space is necessary, please enclose a separate sheet with your application and include all the information below. If you answer "yes" to question #5 on the Full Supplement, you must also complete the required information.

Examination	Most Recent Date taken (Month/Year)	Passed (P)	Failed (F)	Number of attempts
USMLE Step I		☐ P	☐ F	
USMLE Step II		☐ P	☐ F	
USMLE Step III		☐ P	☐ F	
NBME Part I	06/20/1967	☒ P	☐ F	1
NBME Part II	04/22/1969	☒ P	☐ F	1
NBME Part III	03/11/1970	☒ P	☐ F	1
FLEX Component 1		☐ P	☐ F	
FLEX Component 2		☐ P	☐ F	
FLEX Pre-1985		☐ P	☐ F	
NBOME Part I		☐ P	☐ F	
NBOME Part II		☐ P	☐ F	
NBOME Part III		☐ P	☐ F	
COMLEX Level 1		☐ P	☐ F	
COMLEX Level 2		☐ P	☐ F	
COMLEX Level 3		☐ P	☐ F	
COMVEX		☐ P	☐ F	
LMCC – Single		☐ P	☐ F	
LMCC – Part I		☐ P	☐ F	
LMCC – Part II		☐ P	☐ F	
State Board Exam	(State of examination)	☐ P	☐ F	

Hospital Affiliations and Employment

List hospital appointments, in chronological order, where you had active staff privileges. Include the name and address of the facility, your position and dates of affiliation. Also include periods of unemployment or employment outside of medicine. Attach a separate sheet of paper if necessary.

		From	To
Facility: Bayou City Medical Center	Position: OB/GYN	02/01/77	12/31/82
Street: 4200 Portsmouth Street	City: Houston	State: TX	
	Research Physician*		
Facility: Baylor College of Medicine	Position: Asst. Clinical Professor	04/01/77	06/30/00
Street: One Baylor Plaza	City: Houston	State: TX	
*Research Physician employment 04/01/77 - 12/31/1981			
Facility: Woman's Hospital of Texas	Position: Gynecologist	07/27/82	08/27/98
Street: 7600 Fannin Street	City: Houston	State: TX	
Facility: See Attachment.	Position:	/ /	/ /
Street:	City:	State:	

1. List other states (abbreviations) where you are currently or have ever had a full license: AR, TX, UT, WA

2. a) Are you certified by the American Board of Medical Specialties? [X] Yes [ ] No
   b) Are you certified by the American Board of Osteopathic Medicine? [ ] Yes [X] No

3. List Board Certification(s): American Board of Obstetrics & Gynecology Certification date: 01/01/80
   Recertification: 12/31/2001
   Certification date: / /

4. List your practice specialt(ies) Obstetrics & Gynecology

5. Have you completed the Opioid and Pain Management training (see Full Instructions, page?) [X] Yes [ ] No

6. Reason for requesting a Massachusetts medical license:
   Retired from practice in AR, moved to MA and plans to apply to work at Planned Parenthood clinic in Boston

7. Name of Facility: Planned Parenthood
   Address: 1055 Commonwealth Ave City: Boston

8. Anticipated starting date in Massachusetts: / / → UNKNOWN AT THIS TIME

9. Curriculum vitae (CV) listing activities by month and year must be enclosed with your application.

Under the penalties of perjury, I declare that I have examined this full application and all its accompanying instructions, forms and statements, and to the best of my knowledge and belief, the information contained herein is true, correct and complete. As an applicant for a full license to practice medicine, I understand that a criminal record check may be conducted for conviction and pending criminal case information from the Criminal History Systems Board only and that it will not necessarily disqualify me from licensure.

Signature of Applicant

6 / 1 / 2012
Month Day Year

(Continued on page 5)

NATIONAL PROVIDER IDENTIFIER (NPI)

The primary purpose of the NPI is to uniquely identify health care providers as "health care providers" in HIPAA standard transactions. The NPI will replace all other identifiers assigned to health care providers, such as those assigned by health plans, government programs and health care purchasers for purposes of conducting these business transactions. Under the final HIPAA NPI Rule, all individual and organization covered providers **were required to obtain an NPI by May 23, 2007.**

You must supply the Board of Registration in Medicine with your valid NPI. If you do not have an NPI number, you can apply for an NPI directly by using the NPPES web site at www.NPPES.cms.hhs.gov.

My current NPI is: | 1 | 2 | 4 | 5 | 3 | 2 | 6 | 0 | 3 | 2 |

Penalties for Falsifying Information on the National Provider Identifier Application

18 U.S.C. 1001 authorizes criminal penalties against an individual who in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or makes any false, fictitious or fraudulent statements or representations, or makes any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry. Individual offenders are subject to fines of up to $250,000 and imprisonment for up to five years. Offenders that are organizations are subject to fines of up to $500,000. 18 U.S.C. 3571(d) also authorizes fines of up to twice the gross gain derived by the offender if it is greater than the amount specifically authorized by the sentencing statute.

Please sign and date to confirm that all of the information on this form is true and accurate.

Signature: Eric J Edwards Date: 1/19/13

NATIONAL PROVIDER IDENTIFIER (NPI)

The primary purpose of the NPI is to uniquely identify health care providers as "health care providers" in HIPAA standard transactions. The NPI will replace all other identifiers assigned to health care providers, such as those assigned by health plans, government programs and health care purchasers for purposes of conducting these business transactions. Under the final HIPAA NPI Rule, all individual and organization covered providers **were required to obtain an NPI by May 23, 2007.**

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Penalties for Falsifying Information on the National Provider Identifier Application

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Please sign and date to confirm that all of the information on this form is true and accurate.

Signature: _____ Date: 6/1/12

SUPPLEMENT FORM

PRINT NAME: Louis J. Edwards DATE: 1/19/2013

IMPORTANT NOTE: If you answer "yes" to any of these questions, you must provide the additional information on pages 4-10.

QUESTIONS	YES	NO
1. Since your enrollment in college, have you been subject to any disciplinary action (see definition) at an academic institution?		
2-A. Have you ever been terminated or granted a leave of absence by a medical school or any postgraduate training program or have you ever withdrawn from a medical school or any postgraduate training program or had to repeat a year of postgraduate training?		
2-B. Have you ever, for any reason, been placed on probation or remediation by a medical school or any postgraduate training program?		
3. If you are a US or Canadian graduate, did you take more than four (4) years to complete medical school; or if you are an international medical graduate, did you take more than six (6) years to complete medical school?		
4. Since your enrollment in college, have you been denied the privilege of taking or finishing an examination or been accused of cheating and/or improper conduct during an examination?		
5. Have you ever failed any of the following examinations: any Step of the USMLE, NBOME, FLEX, any State Board examination, any part of the National Boards, or have you failed to gain certification from the National Board of Medical Examiners, any other certification body or any foreign licensing or certification body?		
6-A. Have you ever, for any reason, been denied a medical license, whether full, limited, temporary, or have you withdrawn an application for medical licensure?		
6-B. Have you ever voluntarily surrendered a license to practice medicine or any healing art?		
7. Have you ever, for any reason, lost American Board of Medical Specialty or been denied required recertification by one or more specialty boards?		
8-A. Are any formal disciplinary charges pending against you, or do you have knowledge of any pending investigation into your professional competence or conduct by any governmental authority, health care facility, group practice or professional medical society or association (international, national, state or local)? (See definition).		
8-B. Has any disciplinary action ever been taken against you for violation of laws, rules, by-laws, or standards of practice by any governmental authority, healthcare facility, group or professional medical society or association (national, state or local)?		

Applicant's Signature: Louis J Edwards Date: 1/19/2013

	YES	NO
9-A. Have you ever voluntarily relinquished any medical staff membership?		
9-B. Has your medical staff membership, medical privileges or medical staff status at any hospital been limited, suspended, revoked, not renewed or subject to probationary conditions or has processing toward any of those ends been instituted or recommended by a medical staff committee or governing board?		
9-C. Have you ever been denied medical staff membership, or advancement in medical staff status, or has such denial been recommended by a standing medical staff committee or governing body?		
9-D. Have you ever, for any reason, withdrawn an application for hospital privileges or appointment?		
10. Have you ever been charged with any criminal offense, other than a minor traffic offense?		
11. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, restricted or surrendered, or have you ever been called before or warned by any state or other jurisdiction including a federal agency regarding such privileges?		
12. Has any professional liability insurance provider ever restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage or have you ever voluntarily restricted, limited or terminated your insurance coverage in response to any inquiry by a professional liability insurance provider?		
13. Have you ever been the subject of any termination, suspension or probation proceedings instituted by any third-party payor, Medicare or Medicaid; or have you ever been restricted from receiving payments from any Medicare, Medicaid (any state), or third party payors?		
14. Have you ever had an application for membership as a participating provider rejected by any third-party payor?		
15-A. In the past ten (10) years, has any medical malpractice claim been made against you, whether or not a lawsuit was filed in relation to the claim or has such a suit been settled, adjudicated or otherwise resolved?		
15-B. In the past ten (10) years, has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or has such a suit been settled, adjudicated or otherwise resolved?		

Applicant's Signature: Lori A Ehrlich **Date:** 1/19/2013

Board of Registration in Medicine
200 Harvard Mill Square, Suite 330 - Wakefield, MA 01880
Telephone: (781) 876-8210 Fax: (781) 876-8383 www.mass.gov/masssmedboard

MALPRACTICE HISTORY

Applicant's Instructions: Complete this waiver for release of information and forward a copy to each of your current and past liability carrier(s) over the past ten (10) years. If you have been in a training program within the past ten (10) years, a copy of this form must be forwarded to your training program risk management office. You must account for any gaps in your claims history. If you have additional liability carriers, you may photocopy this form. **Please return the completed Malpractice History form(s) with your original signature to the Board of Registration in Medicine.**

Waiver for Release of Information
I authorize my professional liability carrier(s) listed below to release to the Commonwealth of Massachusetts, Board of Registration in Medicine, my malpractice history and any and all claims or actions for damages, including the following:

1. the name(s) of the claimant(s)
2. nature and date of claim(s)
3. amounts paid, if any, and
4. other disposition or information in its possession, custody or control on my current policy number, and/or any other policy I have had with this or any other carrier
5. dates of policy coverage must be included.

Liability Carrier's Instructions: If the applicant has any open or closed cases that have gone to trial, whether or not monies were paid, a copy of the complaint or summons, disposition or judgment and amount of monies paid on behalf of the applicant must be forwarded directly to the Board. IF THE APPLICANT DOES NOT HAVE ANY CLAIMS HISTORY, PLEASE CONFIRM THAT THERE ARE "NO CLAIMS" ON YOUR LETTERHEAD WITH THE DATES OF COVERAGE AND FORWARD TO THE BOARD. TRAINING PROGRAMS ARE ALSO REQUIRED TO PROVIDE THE MALPRACTICE HISTORY AND DATES OF COVERAGE.

Liability Carrier: National Fire & Marine — From: 02 / 2009 To: 02 / 2013
City: Omaha State: NE — Policy Number: 92RKB102263

Liability Carrier: Catlin Insurance — From: 02 / 2005 To: 02 / 2009
City: Lawrenceville State: GA — Policy Number: 500399

Liability Carrier: PLIC Insurance — From: 02 / 2002 To: 05 / 2005
City: Hamilton HM Bermuda State: — Policy Number: PL 03-0508828-9-1

Applicant's signature: _____ ____/____/____ Date

Print Name: Louis Edwards, MD

Address: _____ City: _____

State: _____ Zip code: _____

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200 Harvard Mill Square, Suite 330 - Wakefield, MA 01880
Telephone: (781) 876-8210 Fax: (781) 876-8383 www.mass.gov/masssmedboard

MALPRACTICE HISTORY

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1. the name(s) of the claimant(s)
2. nature and date of claim(s)
3. amounts paid, if any, and
4. other disposition or information in its possession, custody or control on my current policy number, and/or any other policy I have had with this or any other carrier
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Liability Carrier: PLIC Insurance — From: 02 / 2002 To: 05 / 2005
City: Hamilton HM Bermuda State: — Policy Number: PL 03-0508828-9-1

N/A

Applicant's signature: Louis Edwards MD — 12 / 11 / 12 Date

Print Name: Louis Edwards, MD

Address: ____ City: ____

State: ____ Zip code: ____

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2. nature and date of claim(s)
3. amounts paid, if any, and
4. other disposition or information in its possession, custody or control on my current policy number, and/or any other policy I have had with this or any other carrier
5. dates of policy coverage must be included.

Liability Carrier's Instructions: If the applicant has any open or closed cases that have gone to trial, whether or not monies were paid, a copy of the complaint or summons, disposition or judgment and amount of monies paid on behalf of the applicant must be forwarded directly to the Board. IF THE APPLICANT DOES NOT HAVE ANY CLAIMS HISTORY, PLEASE CONFIRM THAT THERE ARE "NO CLAIMS" ON YOUR LETTERHEAD WITH THE DATES OF COVERAGE AND FORWARD TO THE BOARD. TRAINING PROGRAMS ARE ALSO REQUIRED TO PROVIDE THE MALPRACTICE HISTORY AND DATES OF COVERAGE. ***CARRIER: USI Midwest/Oakbrook, Oakbrook Terr, IL, From: 02/2013 - 02/2014*** Verification Pending

Liability Carrier: National Fire & Marine — From: 02 / 2009 To: 02 / 2013
City: Omaha State: NE — Policy Number: 92RKB102263

Liability Carrier: Catlin Insurance — From: 02 / 2005 To: 02 / 2009
City: Lawrenceville State: GA — Policy Number: 500399

Liability Carrier: PLIC Insurance — From: 02 / 2002 To: 05 / 2005
City: Hamilton HM Bermuda State: — Policy Number: PL 03-0508828-9-1

Applicant's signature: Louis Edwards, 5/17/13
Date

Print Name: Louis Edwards, MD

Address: ___ City: ___

State: ___ Zip code: ___

Board of Registration in Medicine
200 Harvard Mill Square, Suite 330 - Wakefield, MA 01880
Telephone: (781) 876-8210 Fax: (781) 876-8383

MEDICAL EDUCATION VERIFICATION

APPLICANT INSTRUCTIONS: Please complete the waiver for release of information and forward this form to your university/medical school(s) or university of graduation for verification.

I authorize the medical school/university listed below to provide any and all information pertaining to my medical education at your institution.

Applicant's Signature: See Release Date of Birth

Print or Type Name: Edwards (Last name) Louis (First Name) Jerry (Middle Initial) Social Security No: –

Other Name(s) Not Applicable. (Please type or print name(s))

Name of Medical School: University of Texas Southwestern Medical School at Dallas

Address: 5323 Harry Hines Blvd. City: Dallas State or Province: TX

INSTRUCTIONS TO THE DEAN OR DESIGNATED OFFICIAL OF MEDICAL SCHOOL

Please complete this form and forward it, together with a copy of the official transcript (which indicates courses taken, dates and hours of attendance, and scores, grades, or evaluations) and mail it to the Board of Registration in Medicine.

APPLICANT'S EDUCATIONAL HISTORY

If name of institution was different from the above named institution when applicant attended, please enter name below:
The University of Texas Southwestern medical school

Premedical Education: Does your school have a premedical school education requirement? ☑ Yes ☐ No

If "yes," indicate where the applicant completed premedical school.

Applicant's Undergraduate School: Rice University

Undergraduate School Address: Houston, TX

(Continued on page 2)

Full License Application

Enrollment and Participation: Our records indicate that

(type or print the applicant's name):	Edwards	Louis	Jerry
	(Last name)	(First name)	(Middle initial)

attended our medical school on the following dates (indicate the month, day and year in the section below):

ATTENDANCE DATES:	FROM	TO	FROM	TO
	9/13/65	6/14/66	9/9/68	5/31/69
	9/12/66	6/13/67	/ /	/ /
	9/11/67	6/7/68	/ /	/ /

The applicant attended 166 total weeks *or* _____ total months (must be included) of not less than 32 weeks in each academic year of continuing on-campus education.

check one

☑ was awarded a degree in MD on (month/day/year) 6/12/1969

☐ was NOT awarded degree. Please explain reason(s). _____

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the applicant's medical education.

All questions must be answered. **If you answer "YES" to any of the questions below, please enclose an explanation.**

	YES	NO
1. Did the applicant take any leaves of absence or breaks from his/her medical education?		
2. Was the applicant ever placed on probation?		
3. Was the applicant ever disciplined or under investigation?		
4. Were any negative reports ever filed by instructors regarding the applicant?		

COMMENTS: note no dean's letter was available for review.

AFFIX INSTITUTIONAL SEAL HERE

(if the institution does not have a seal, this form must be notarized) INTERNATIONAL MEDICAL SCHOOLS MUST ATTACH A COPY OF THE MEDICAL SCHOOL DIPLOMA AND A TRANSCRIPT OR PROVIDE AN EXPLANATION.

Signature: J. Wayne

Print Name: James M. Wayne, M.D.

Title: Assoc. Dean for Student Affairs

Date: 7/27/12 Telephone: (214) 648-2168

E-mail address: james.wayne@utsouthwestern.edu

This form will not be accepted unless it is stamped with the institutional seal or notarized.

Seal Verified
6/12
CH
TMLS:

51

11/29/1135

RECEIVED
AUG 27 2012
Board of Registration in Medicine

MALPRACTICE HISTORY

Board of Registration in Medicine
200 Harvard Mill Square, Suite 330 - Wakefield, MA 01880
Telephone: (781) 876-8210 Fax: (781) 876-8383 www.mass.gov/masssmedboard

MALPRACTICE HISTORY

Applicant's Instructions: Complete this waiver for release of information and forward a copy to each of your current and past liability carrier(s) over the past ten (10) years. If you have been in a training program within the past ten (10) years, a copy of this form must be forwarded to your training program risk management office. You must account for any gaps in your claims history. If you have additional liability carriers, you may photocopy this form. **Please return the completed Malpractice History form(s) with your original signature to the Board of Registration in Medicine.**

Waiver for Release of Information
I authorize my professional liability carrier(s) listed below to release to the Commonwealth of Massachusetts, Board of Registration in Medicine, my malpractice history and any and all claims or actions for damages, including the following:

1. the name(s) of the claimant(s)
2. nature and date of claim(s)
3. amounts paid, if any, and
4. other disposition or information in its possession, custody or control on my current policy number, and/or any other policy I have had with this or any other carrier
5. dates of policy coverage must be included.

Liability Carrier's Instructions: If the applicant has any open or closed cases that have gone to trial, whether or not monies were paid, a copy of the complaint or summons, disposition or judgment and amount of monies paid on behalf of the applicant must be forwarded directly to the Board. IF THE APPLICANT DOES NOT HAVE ANY CLAIMS HISTORY, PLEASE CONFIRM THAT THERE ARE "NO CLAIMS" ON YOUR LETTERHEAD WITH THE DATES OF COVERAGE AND FORWARD TO THE BOARD. TRAINING PROGRAMS ARE ALSO REQUIRED TO PROVIDE THE MALPRACTICE HISTORY AND DATES OF COVERAGE.

Liability Carrier: National Fire & Marine Insurance Co From: 02 / 12 To: 02 / 13
City: _____ State: _____ Policy Number: 92RKB102263

Liability Carrier: National Fire & Marine Ins Co From: 08 / 11 To: 12 / 12
City: Wakefield State: TX Policy Number: 92RKB102263

Liability Carrier: National Fire & Marine Ins Co From: 08 / 10 To: 08 / 11
City: Houston State: TX Policy Number: 92RKB102263

Applicant's signature: See Release 06 / 27 / 12
Date

Print Name: Louis Edwards, MD

Address: _____ City: _____

State: _____ Zip code: _____

MALPRACTICE HISTORY

Board of Registration in Medicine
200 Harvard Mill Square, Suite 330 - Wakefield, MA 01880
Telephone: (781) 876-8210 Fax: (781) 876-8383 www.mass.gov/masssmedboard

MALPRACTICE HISTORY

Applicant's Instructions: Complete this waiver for release of information and forward a copy to each of your current and past liability carrier(s) over the past ten (10) years. If you have been in a training program within the past ten (10) years, a copy of this form must be forwarded to your training program risk management office. You must account for any gaps in your claims history. If you have additional liability carriers, you may photocopy this form. **Please return the completed Malpractice History form(s) with your original signature to the Board of Registration in Medicine.**

Waiver for Release of Information
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1. the name(s) of the claimant(s)
2. nature and date of claim(s)
3. amounts paid, if any, and
4. other disposition or information in its possession, custody or control on my current policy number, and/or any other policy I have had with this or any other carrier
5. dates of policy coverage must be included.

Liability Carrier's Instructions: If the applicant has any open or closed cases that have gone to trial, whether or not monies were paid, a copy of the complaint or summons, disposition or judgment and amount of monies paid on behalf of the applicant must be forwarded directly to the Board. IF THE APPLICANT DOES NOT HAVE ANY CLAIMS HISTORY, PLEASE CONFIRM THAT THERE ARE "NO CLAIMS" ON YOUR LETTERHEAD WITH THE DATES OF COVERAGE AND FORWARD TO THE BOARD. TRAINING PROGRAMS ARE ALSO REQUIRED TO PROVIDE THE MALPRACTICE HISTORY AND DATES OF COVERAGE.

Liability Carrier: Professional Liability Insurance Company, Ltd. From: 02 / 02 To: 05 / 05
City: Hamilton State: HM Policy Number: PL 03-0508828-9-1

Liability Carrier: Professional Liability Insurance Company, Ltd. From: 02 / 02 To: 05 / 05
City: Hamilton State: HM Policy Number: 03-050828-9

Liability Carrier: _____ From: ____/____ To: ____/____
City: _____ State: _____ Policy Number: _____

Applicant's signature: See Release _____/_____/_____
Date

Print Name: Louis Edwards MD

Address: _____ City: _____

State: _____ Zip code: _____

11/29/12

Board of Registration in Medicine
200 Harvard Mill Square, Suite 330 - Wakefield, MA 01880
Telephone: (781) 876-8210 Fax: (781) 876-8383 www.mass.gov/masssmedboard

MALPRACTICE HISTORY

Applicant's Instructions: Complete this waiver for release of information and forward a copy to each of your current and past liability carrier(s) over the past ten (10) years. If you have been in a training program within the past ten (10) years, a copy of this form must be forwarded to your training program risk management office. You must account for any gaps in your claims history. If you have additional liability carriers, you may photocopy this form. **Please return the completed Malpractice History form(s) with your original signature to the Board of Registration in Medicine.**

Waiver for Release of Information
I authorize my professional liability carrier(s) listed below to release to the Commonwealth of Massachusetts, Board of Registration in Medicine, my malpractice history and any and all claims or actions for damages, including the following:

1. the name(s) of the claimant(s)
2. nature and date of claim(s)
3. amounts paid, if any, and
4. other disposition or information in its possession, custody or control on my current policy number, and/or any other policy I have had with this or any other carrier
5. dates of policy coverage must be included.

Liability Carrier's Instructions: If the applicant has any open or closed cases that have gone to trial, whether or not monies were paid, a copy of the complaint or summons, disposition or judgment and amount of monies paid on behalf of the applicant must be forwarded directly to the Board. IF THE APPLICANT DOES NOT HAVE ANY CLAIMS HISTORY, PLEASE CONFIRM THAT THERE ARE "NO CLAIMS" ON YOUR LETTERHEAD WITH THE DATES OF COVERAGE AND FORWARD TO THE BOARD. TRAINING PROGRAMS ARE ALSO REQUIRED TO PROVIDE THE MALPRACTICE HISTORY AND DATES OF COVERAGE.

Liability Carrier: National Fire & Marine — From: 02 / 2009 To: 02 / 2013
City: Omaha State: NE — Policy Number: 92RKH102263

Liability Carrier: Carlin Insurance — From: 02 / 2005 To: 02 / 2009
City: Lawrenceville State: GA — Policy Number: 500399

Liability Carrier: PLIC Insurance — From: 02 / 2002 To: 05 / 2005
City: Hamilton HM Bermuda State: — Policy Number: PL 03-0508828-9-1

Applicant's signature: Louis Edwards MD — 12 / 11 / 12 Date

Print Name: Louis Edwards, MD

Address: — City: —

State: — Zip code: —

ST 11/23/138

Board of Registration in Medicine
200 Harvard Mill Square, Suite 330 - Wakefield, MA 01880
Telephone: (781) 876-8210 Fax: (781) 876-8383

POSTGRADUATE TRAINING VERIFICATION

APPLICANT'S AUTHORIZATION: I authorize the release of information from my postgraduate training program listed below, as requested by the Massachusetts Board of Registration in Medicine.

Applicant's Signature: See Release Date: _____

Print or Type Name: Louis Edwards, MD

Name of Institution: Baylor College of Medicine Program Department of Obstetrics/Gynecology

INSTRUCTIONS TO THE PROGRAM DIRECTOR

Please complete this form and forward it to the applicant in a **sealed envelope, signed across the seal**. If the department was a "rotating" or "transitional" program, please submit documentation of the rotations, dates and hours of training.

Name of Institution: BAYLOR COLLEGE OF MEDICINE If name of Institution was different when applicant attended, please enter name: _____

Enrollment and Participation: Our records indicate that LOUIS JERRY EDWARDS (Print applicant's name) participated in the following program:

(List each year separately with from and to dates)

Program Type (internship, residency, fellowship)	PGY (1,2,3,4)	Department or type of specialty training	Dates Attended (MONTH/DAY/YEAR) FROM	TO	Completed (YES/NO)	Accredited By (ACGME, RSC, AOA or not accredited
RESIDENCY	2	OB GYN	10/1/1970	9/30/1971	YES	ACGME
RESIDENCY	3	OB GYN	10/1/1971	6/23/1972	YES	ACGME
RESIDENCY	4	OB GYN	11/1/1975	01/31/1977	YES	ACGME

(Continued on page 2)

APPLICANT'S NAME: Louis Edwards, MD

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the applicant's medical education. Please circle the appropriate response. **If you answer yes to any of these questions, please enclose an explanation.**

QUESTIONS	YES	NO
1. Did the applicant take any leaves of absence or breaks from his/her post-graduate training?		
2. Was the applicant ever placed on probation?		
3. Was the applicant ever disciplined or under investigation?		
4. Were any negative reports ever filed by instructors regarding the applicant?		
5. Were any limitations or special requirements imposed on the applicant because of questions of academic incompetence or disciplinary problems?		

6. During the applicant's participation, our postgraduate medical training ☒ was accredited by: ☒ ACGME ☐ Other: _____

COMMENTS: *See attached letter

Seal Verified
DATE: 8/12
INITIALS: CH

Certification: I hereby certify that the above information is correct, to the best of my knowledge.

Program Director's Signature: _____

Print Name: Susan Raine JD MD LLM

Academic Title: Assoc. Prof/ Program Director /VC of Education

Telephone: (832) 826-7376 Today's Date: 8/20/12

E-mail address: Sraine@bcm.edu

AFFIX INSTITUTIONAL SEAL HERE

(If the institution does not have a seal, this form must be notarized by a notary public).

PLEASE RETURN THIS COMPLETED FORM TO THE APPLICANT IN A SEALED ENVELOPED WITH YOUR SIGNATURE ACROSS THE SEAL OF THE ENVELOPE.

EMILY VINAS
NOTARY PUBLIC STATE OF TEXAS
COMMISSION EXPIRES
12-12-2012

8/20/12

RECEIVED
AUG 17 2012

Board of Registration in Medicine
200 Harvard Mill Square, Suite 330 - Wakefield, MA 01880
Telephone: (781) 876-8210 Fax: (781) 876-8383

POSTGRADUATE TRAINING VERIFICATION

APPLICANT'S AUTHORIZATION: I authorize the release of information from my postgraduate training program listed below, as requested by the Massachusetts Board of Registration in Medicine.

Applicant's Signature: See Release Date: 6/27/2012

Print or Type Name: Louis Edwards, MD

Name of Institution: Baylor College of Medicine Program/Texas Children's Hospital

INSTRUCTIONS TO THE PROGRAM DIRECTOR

Please complete this form and forward it to the applicant in a **sealed envelope, signed across the seal**. If the department was a "rotating" or "transitional" program, please submit documentation of the rotations, dates and hours of training.

Name of Institution: _____ If

name of Institution was different when applicant attended, please enter name: _____

Enrollment and Participation: Our records indicate that _____ participated in the following program:
(Print applicant's name)

(List each year separately with from and to dates)

Program Type (internship, residency, fellowship)	PGY (1,2,3,4)	Department or type of specialty training	Dates Attended (MONTH/DAY/YEAR) FROM	TO	Completed (YES/NO)	Accredited By (ACGME, RSC, AOA or not accredited

(Continued on page 2)

APPLICANT'S NAME: Louis Edwards, MD

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the applicant's medical education. Please circle the appropriate response. **If you answer yes to any of these questions, please enclose an explanation.**

QUESTIONS	YES	NO
1. Did the applicant take any leaves of absence or breaks from his/her post-graduate training?		
2. Was the applicant ever placed on probation?		
3. Was the applicant ever disciplined or under investigation?		
4. Were any negative reports ever filed by instructors regarding the applicant?		
5. Were any limitations or special requirements imposed on the applicant because of questions of academic incompetence or disciplinary problems?		

6. During the applicant's participation, our postgraduate medical training ☐ was accredited by: ☐ ACGME ☐Other:_____

COMMENTS:_____

_____

Certification: I hereby certify that the above information is correct, to the best of my knowledge.

AFFIX INSTITUTIONAL SEAL HERE

(If the institution does not have a seal, this form must be notarized by a notary public).

Program Director's Signature: _____

Print Name: _____

Academic Title: _____

Telephone: (____)_____Today's Date: ____/____/_____

E-mail address: _____

PLEASE RETURN THIS COMPLETED FORM TO THE APPLICANT IN A SEALED ENVELOPED WITH YOUR SIGNATURE ACROSS THE SEAL OF THE ENVELOPE.

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Louis J Edwards, M.D. **License No.:** 253433

Current Status: Active **License Expiration Date:** 3/24/2014

1) **Activity Status:** Active

2) **Address & Contact Information**

Mailing Address:

Home Address:

Business Address:
4 Office Park Dr
Little Rock
Arkansas - 72211
United States of America
(501) 412-2075

3) **Email Address:**

4) **Fax Number:** (925) 364-3937

5) **Specialties**
Gynecology

6) **Current American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA) Information**

ABMS/AOA	Board Name	Certification	Subspecialty
ABMS	Obstetrics & Gynecology	Obstetrics and Gynecology	

7) **Drug License Numbers**

Massachusetts	Federal (DEA)	Federal (DEA) XS

8) **Other states where you are now licensed to practice**
Arkansas

9) **States where you were previously licensed**
Texas
Utah
Washington

10) **Work Sites**
List of all work sites in Massachusetts, including health care facilities (where you are credentialed), private office, clinics, nursing homes, etc

WorkSite	Location
	None Reported

11) Care of patients in Massachusetts
Average weekly hours involved in: **a) inpatient care** 0 hrs/wk
b) outpatient care 0 hrs/wk

12) Medical Liability Insurance Information

I am not required to have malpractice insurance.

Not involved with direct or indirect patient care in Massachusetts.

13) Do you perform any surgery in your Massachusetts office?

14) Claims Made
a) New: Have you received notification of a claim, whether or not a lawsuit was filed on that claim, or has any medical malpractice claim been made against you during this time period?
b) Pending: Are there any unresolved malpractice claims against you today, i.e., any claims that have not been resolved, settled or adjudicated during this time period?

15) Claims Closed
Has any medical malpractice claim against you (whether or not a lawsuit was filed on that claim) been resolved, settled, or adjudicated during this time period?

16) Other Civil Lawsuits
Question 16 refers to claims or actions related to your competency to practice medicine or your professional conduct in the practice of medicine.
a) New: Have there been any claims, other than medical malpractice claims, filed against you during this time period?
b) Resolved: Have you resolved, settled or adjudicated any lawsuits, other than medical malpractice claims, during this period?

17) Criminal Charges
a) Have you been charged with any criminal offense during this period?
b) Have any criminal offenses/charges against you been resolved during this time period?
c) Are there any criminal charges pending against you today?
d) Are any Application of Issuance of Process pending against you?

18) Other Issues
a) Have you withdrawn an application to any governmental authority, health care facility, group practice employer or professional association?
b) Have you ever taken a leave of absence from any health care facility, group practice or employer?
c) Have you been the subject of an investigation by any governmental authority, including the Massachusetts Board of Registration in Medicine or any other state medical board, health care facility, group practice, employer or professional association?
d) Have you been the subject of a disciplinary action taken by any governmental authority, health care facility, group practice, employer or professional association?

19) Have your privileges to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted by or surrendered to any state or federal agency?

20) Have you withdrawn an application for a medical license, allowed a license application to become obsolete or have you been denied a medical license for any reason?

21) Has any medical liability insurance carrier restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage, or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a medical liability insurance carrier?

22) Have you completed all CPD requirements (100 hours of CPD of which 10 hours must be in risk management. Requirement: 40 hours credit in Category 1 and 60 hours in Category 2) for this renewal period? (If you are in an approved Residency/ Fellowship program, or if your are renewing your license for the first time, please answer Yes)

23) Do you have a medical condition that interferes in any way or limits your ability to practice medicine?

24) Have you used any chemical substance(s) which in any way interferes with your ability to practice medicine?

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Louis J Edwards, M.D. **License No.:** 253433

Compliance with Legal Responsibilities

Online profile:
[X] I have reviewed my Physician Profile and confirm that the information is accurate.

1) I understand and agree to comply with my obligations to report abuse or neglect of children pursuant to M.G.L. c. 119 sec. 51A and I understand the punishment for failure to comply.

2) I understand and agree to comply with my obligations to report abuse or neglect of disabled persons pursuant to M.G.L. c. 19C sec. 10 and I understand the punishment for failure to comply.

3) I understand and agree to comply with my obligations to report abuse, neglect or Financial exploitation of elderly persons pursuant to M.G.L. c. 19A sec. 15 and I understand the punishment for failure to comply.

4) I understand and agree to comply with my obligations to report the treatment of wounds, burns and other injuries pursuant to M.G.L. c. 112 sec. 12A and I understand the punishment for failure to comply.

5) I understand and agree to comply with my obligations to report the treatment of victims of rape or sexual assault pursuant to M.G.L. c. 112 sec. 12A 1/2 and I understand the punishment for failure to comply.

6) I understand and agree to comply with my obligations to report a physician to the Board of Medicine pursuant to M.G.L. c. 112 sec. 5F, when I have a reasonable basis to believe that a person violated any provisions of M.G.L. c. 112 sec. 5 or any Board regulation.

7) I understand and agree to comply with my obligations related to charging and collecting fees from Medicare beneficiaries in accordance with the Medicare fee schedule, pursuant to M.G.L. c. 112 sec. 2.

8) I understand and have complied with my obligations to file Massachusetts tax returns and to pay Massachusetts taxes and I understand that, pursuant to M.G.L. c. 62C sec. 49A, my license shall not be issued or renewed unless I make this certification under penalties of perjury.

9) I understand and agree to comply with my obligations related to the reporting of the wages of employees and contractors pursuant to M.G.L. c. 62E Sec. 2.

10) I understand and agree to comply with my obligations related to the withholding and remitting of child support payments pursuant to M.G.L. c. 119A.

11) I understand and agree to comply with my obligations to file an Incident Report with the Board when certain adverse events occur in my private office, pursuant to M.G.L c. 112 sec. 5 and 243 CMR 3.00 et seq. and I understand that the Patient Care Assessment (PCA) programs at the health care facilities where I practice report certain Major Incidents to the Board.

12) I understand and agree to comply with my obligations to disclose ownership interest in any partnership, corporation, firm or other legal entity to which I have referred a patient for physical therapy services, pursuant to M.G.L c. 112 sec. 12AA.

13) I am aware of my obligations and responsibilities under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including the requirement that I obtain and provide to the Board a National Provider Identifier (NPI) number.

14) I understand and am in compliance with HIPAA and all other federal and state obligations placed upon me as a physician.

15) I understand that as an applicant for a license renewal to practice medicine a criminal record check may be conducted for conviction and pending criminal case information only from the Criminal History Systems Board and that it will not necessarily disqualify me.

[X] **I have reviewed the above statements and certify that I understand my requirement to comply with the responsibilities and obligations of each and agree to do so.**

[X] **Under penalties of perjury, I declare that I have examined this renewal application and all of its accompanying instructions, forms and statements, and to the best of my knowledge and belief, I certify that the information contained herein is true, accurate, and complete.**

Louis Jerry Edwards, M.D.

Curriculum Vitae

Current through May 7, 2130

Name:	Louis Jerry Edwards
Names Used:	Jerry Edwards, L. Jerry Edwards
Date of Birth:	
Place of Birth:	Dallas, Texas USA
Social Security Number:	
Medicare:	
UPIN	
NPI	1245326032
Medical Education Number:	
Employer ID:	

Education:

University:	Rice University, Houston, Texas: Bachelor of Arts (BA) Major History, June, 1964
Medical School:	University of Texas Southwestern Medical School Dallas, Texas, M.D. June 1969
Internship:	Pediatrics, Baylor College of Medicine, Houston, Texas July 1969-June 70 Chairman of Department, Ralph Feigin, M.D.
Residency:	Obstetrics and Gynecology, Baylor College of Medicine, Houston, Texas October 1970-June 72; October 1975-January 1977 Chairman of Department, Joe Leigh Simpson, M.D.

Military Service:

USAR , July 1972- October 1975, General Medical Officer, Department of Obstetrics and Gynecology, 130th General Hospital, Nuremberg Germany; Honorable Discharge,

Discharge Rank Major

Professional History (Timeline):

Semi-Retired Per Diem abortion provider, Little Rock Family Planning Services *February 2010-May 7, 2013*

In January 2010 I sold the clinic to my associate of 5 years, Dr. Tom Tvedten. I continued to work for Dr. Tvedten providing services at the clinic as a per diem provider. I continue to monitor the clinical data on Early Surgical Abortion am collaborating with Dr. Kristina Tocce documenting the success of a procedure I developed for vaginal injection of Digoxin in 2nd trimester abortion cases. In December of 2010 I moved from Little Rock Arkansas to Plymouth Massachusetts to live in a retirement community.

Owner/Medical Director Little Rock Family Planning Services *April 1999-2010*

I purchased the clinic from Curtis Stover, M.D. Dr Stover was the first abortion provider in Arkansas after *Roe v Wade* in 1973. Along with my colleague and wife Ann Osborne, PA-C the clinic has become a prime referral center for the University of Arkansas for genetics abnormality cases. The clinic provides services from 3 to 21 weeks gestation. The clinic is an important referral center for Tennessee, Mississippi, Oklahoma and Missouri for second trimester abortion services. I had an appointment as a Assistant Clinical Professor in the Department of Obstetrics and Gynecology, University of Arkansas for Medical Sciences during this time and was on the medical staff of the University Hospital.

Sabbatical to complete chapter in textbook, per diem provider at clinics in Texas and New York *July 1998 to March 1999*

During this time and I worked on completing a chapter in the textbook "A Clinician's Guide to Medical and Surgical Abortion." I was employed part time as a per diem provider for medical clinics in South Texas for Nova Health Systems, San Antonio, Texas. I also worked in Buffalo New York at Buffalo Womenservices under an emergency license from the state of New York in order to allow services to not be interrupted at the clinic at which Dr. Bernard Slepian and had been assassinated.

Medical Director/Abortion Provider Planned Parenthood of Houston and Southeast Texas, Houston, Texas *September 1991 to June 1998*

At the onset of my clinical practice at Planned Parenthood of Houston in 1991, the clinic volume was comprised of 1,800 surgical cases a year. Surgical Services were that were offered only local anesthesia and were limited to gestations of 14 weeks and under. While serving as Medical Director the clinic its volume expanded to over 5,500 surgical cases a year. Under my leadership, intravenous sedation with pulse oximetry monitoring was introduced and subsequently chosen by 85% of the patient population. As Medical Director, I expanded the scope of abortion services to include a gestational age range of surgical procedures to 20 w 6 d (BPD 5.0).

The clinic became a training site for resident physicians in the Obstetrics and Gynecology and Family Practice programs of Baylor College of Medicine and the University of Texas Medical School at Houston. Additionally, the clinic was recognized as a training site for other Planned Parenthood Abortion Providers.

During my tenure there was a major disruption at the clinic by anti-choice groups during the 1992 Republican Convention. I actively participated in the preparation for the demonstrations, organized a coalition of local abortion providers, and was a major witness in the subsequent litigation which resulted in a 1.2 million dollar judgment against Operation Rescue and other anti-choice organizations.

The clinic was one of the 17 national sites for the Mifepristone trials sponsored by the Population

Council in 1994-1995. I was principal investigator for the Planned Parenthood clinical study of Methotrexate as an abortifacient. Also, I participated with Drs. Sherman Elias, M.D., Joe Leigh Simpson, M.D. and Russell Deter, M.D. of the Department of Obstetrics and Gynecology Baylor College of Medicine on research projects. I collaborated with Dr. Hunter Hamill, M.D. at Baylor College of Medicine in the provision of abortion services to HIV positive women.

In 1994 I developed and introduced a protocol for early abortion services (see publications) that allowed women to have the option of surgical abortion procedure as soon as 8 days after conception. After introduction of this protocol over 25% of surgical cases seen at the clinic were less than 6 weeks gestation. This protocol also detected 18 undiagnosed, asymptomatic ectopic pregnancies in our patient population. During my tenure the clinic became a regional referral center for other abortion providers to send difficult or medically complicated cases.

Clinical Faculty/Assistant Professor Baylor College of Medicine Department of Obstetrics and Gynecology, Houston, Texas *February 1977 to August1998*

I maintained my teaching position with Baylor College of Medicine and as a member of the staff of Ben Taub Hospital, the school's teaching hospital. My activities have included staffing cases and scrubbing on cases at the teaching hospital, teaching and allowing residents major responsibility for my private surgical patients, giving resident lectures, and conducting a teaching service in the Surgical Services Clinic at Planned Parenthood of Houston.

Obstetrics and Gynecologist/Managing Partner of *January 1983 to June 1992*
Professional Association The Woman's Associates, P.A., Houston Texas
In January 0f 1993 I moved my practice from a suburban hospital to the Texas Medical Center. This move was made in light of the opportunities afforded by practicing surgery in a hospital with a level III nursery, an association with gynecologic surgeons with a national reputation and an academic association with Baylor College of Medicine. While practicing in this environment, I routinely managed high risk Obstetrics patients and accepted transport of high risk patients from outlying hospitals. I learned advanced gynecologic surgical techniques including advanced laproscopic techniques and hysteroscopic surgery. I offered outpatient abortion through 14 weeks and became a major referral resource for physicians who did not offer this procedure.
I was the managing partner for the practice with three other associated Ob/Gyn physicians.

Gynecologist, National DES Adenosis (DESAD) *April 1977 to December 1981*
Research Project Baylor College of Medicine, Department of Obstetrics and Gynecology, Houston, Texas -

I was employed in a part time position with Dr. Raymond Kaufman, M.D. conducting the Colposcopy Clinic and compiling data for the federally funded project to study women exposed to Diethylstilbestrol (DES) in utero.

General Obstetrics and Gynecology Sharpstown Obstetrics and Gynecology Associates, P.A., Houston, Texas *February 1977 to December1982*
After finishing residency established practice with a 5 person Obstetrics and Gynecology group in suburban hospital in Houston, Texas. Helped establish high volume program (SOGA, P.A.) to provide laproscopic sterilization under state and federal grants for low and mid income women

Third and fourth year resident Department of OB/GYN Baylor College of Medicine, Houston Texas *October 1975- January 1977*

After finishing tour of duty in U.S. Army reserve I returned to Houston to complete my residency in OB/GYN at the Baylor affiliated hospitals in Houston Texas.

Active duty Service in US Army reserve *July 1972- October 1975*

General Medical Officer, Department of Obstetrics and Gynecology, 130th General Hospital, Nuremberg Germany; Honorable Discharge, Discharge Rank Major

First and second year resident Department of OB/GYN Baylor College of Medicine, Houston Texas *October 1970-June 72*

After extending my internship for three months as a rotating intern I applied for the residency program at Baylor College of Medicine and was accepted and began my internship the following month. I received a draft notice in May 1972 and reporting for active duty at Fort Sam Houston, San Antonio Texas in July 1972.

Rotating internship Baylor College of Medicine Houston Texas *July 1970 – September 1970*

After finishing my straight pediatrics internship I was undecided as to which residency I wanted and requested to extend my rotations until I could make a final decision.

Straight Pediatrics internship, Baylor College of Medicine, Houston, Texas *July 1969-June 70*

Medical School University of Texas Southwestern Medical School Dallas, Texas *September 1965- June 1969*

I received M.D. degree June 1969. Medical license in state of Texas received in June 1969.

Research assistant in biochemistry M.D. Anderson Hospital, Houston Texas *January 1965-May 1965*

I did research in histone chemistry and published my research as follows: Studies on him nuclear proteins. II. Qualitative distribution of histone fractions in various tissues; Hnilica LS., Edwards LJ., Hey AE., Biochimica et Biophysica Acta. 124(1):109-17, 1966 Jul 27

Undergraduate education Rice University, Houston, Texas: Bachelor of Arts (BA) Major History, June, 1964 *September 1960-December 1964*

Although I graduated in June 1964, I required additional prerequisites courses for medical school and continued to take courses in the fall of 1964.

Kermit high school, Kermit, Texas *September 1956-June 1960*

License and Certification:

Arkansas License, E-2099, 1999

Diplomat National Board of Medical Examiners, 1970

Board Certified, American Board of Obstetrics and Gynecology, 1980, Re certified 2001

DEA Number-AE6771504

Membership in professional associations:

Fellow American College of Obstetricians and Gynecologists 1980-present

Harris County Medical Association, 1977-99

Houston Gynecology and Obstetrics Society, 1977-99

National Abortion Federation, 1991-present

National Positions:

Medical Advisory Committee, Planned Parenthood Federation of America, 1997 to 1999

Board member, National Abortion Federation, 1998 to 2000

Medical School Affiliation:

Baylor College of Medicine Department of Obstetrics and Gynecology-Clinical Assistant Professor 1976-1998

University of Arkansas For Medical Sciences, Department of Obstetrics and Gynecology-Clinical Assistant Professor 2000-2010

Hospital Affiliation:

University Hospital of Arkansas 2001-2010

The Woman's Hospital of Texas, active staff, 1981-1992

Harris County Hospital District, Ben Taub Hospital, voluntary staff, 1977-1998

Publications:

Textbook: *A Clinician's Guide to Medical and Surgical Abortion*, National Abortion Federation, Chapter 9 Surgical Abortion in the First Trimester, Copyright © 1999 by Churchill Livingstone

New Technologies Permit Safe Abortion at Less than Six Weeks Gestation and Provide Timely Detection of Ectopic Gestation, Edwards J, Carson SA, American Journal of Obstetrics and Gynecology, 176(5): 1101-6, 1997, May

Early Abortion—Surgical and Medical Options; Creinin MD, Edwards J, Current Problems in Obstetrics, Gynecology and Fertility, Vol 20 No. 1, January/February 1997, Pages 1-32

Gordon's syndrome in pregnancy; Kirshon B., Edwards J., Cotton DB., American Journal of Obstetrics and Gynecology, 156(5):1110-1, 1987, May

Studies on nuclear proteins. II. Qualitative distribution of histone fractions in various tissues; Hnilica LS., Edwards LJ., Hey AE., Biochimica et Biophysica Acta. 124(1):109-17, 1966 Jul 27

NAF Bio April 13

Jerry Edwards, M.D. was Medical Director of Little Rock Family Planning Services in Little Rock, Arkansas until January, 2010 when he retired and moved to Plymouth Massachusetts. He did his OB/GYN residency at Baylor College of medicine Houston Texas and is a board certified OB/GYN. In 1992 Dr. Edwards left his private OB/GYN practice to become Medical Director and the primary abortion provider at Planned Parenthood of Houston. During his tenure at Planned Parenthood Dr. Edwards developed and published a protocol that allowed abortion to be safely accomplished in the earliest stage of pregnancy (7 days after conception) and resulted in the early detection of asymptomatic ectopic pregnancy. In 1999 Dr. Edwards and his wife Ann Osborne PA-C moved to Little Rock to become owners, Medical Director and Clinic Director of Little Rock Family Planning Services. Their clinic is the only abortion clinic in Arkansas and offers abortion services from the time the pregnancy test is positive until 21 weeks. In addition to his work developing a protocol for early surgical abortion Dr. Edwards is known for developing a technique for vaginal injection of digoxin for second trimester termination of pregnancy. Dr. Edwards is currently a plaintiff in a lawsuit against the state of Arkansas for their attempt to restrict abortion services after 12 weeks of pregnancy.

Career Profile
Jerry Edwards, M.D.

Jerry Edwards, M.D. is an Assistant Clinical Professor in the Division of Gynecology of the Department of Obstetrics and Gynecology. Dr. Edwards was been a member of the Baylor College of Medicine faculty from 1977 to 1998. He was in private practice at The Woman's Hospital of Texas for 14 years. He was in private practice of Obstetrics and Gynecology at The Woman's Hospital of Texas for 14 years. In 1992 Dr. Edwards left his private practice to become Medical Director and primary abortion provider at Planned Parenthood of Houston and Southeast Texas. During his tenure at Planned Parenthood Dr. Edwards was active in applying modern medical technology to increase the comfort and safety of pregnancy termination. He was active in teaching the resident staff of the Baylor College of Medicine and The University of Texas Medical School at Houston. Additionally, he has participated in the national clinical trials of Mifepristone (RU-486) and in studies by the Foundation for Blood Research entitled "First Trimester Screening for Downs Syndrome." Dr. Edwards is co-author of the chapter on first trimester abortion in the National Abortion Federation's abortion textbook project. In April 1999

Dr. Edwards moved to Little Rock, Arkansas to become owner and medical director of Little Rock Family Planning Services.

Dr. Edwards received a Bachelor of Arts Degree in History from Rice University in 1964. In 1965 he worked in the Department of Biochemistry at M.D. Anderson Hospital in Houston doing research on histone chemistry. He received a M.D. Degree from the University of Texas Southwestern Medical School at Dallas in 1969. He completed his internship in Pediatrics at Baylor Affiliated hospitals in Houston 1969-70. He served in the U.S. Army from 1972-75 and completed his military career as a major USAR. He completed his residency in Obstetrics and Gynecology at Baylor College of Medicine in 1977. He became board certified in Obstetrics and Gynecology in 1980. Dr. Edwards is a Fellow of the American College of Obstetricians and Gynecologists. Dr. Edwards has been invited speaker at the annual meetings of the National Abortion Federation and the national medical committee of the Planned Parenthood Federation of America.
Dr. Edwards was a member of the National Medical Committee of Planned Parenthood Federation of America and served as a Board Member of the National Abortion Federation.