CESARE F. SANTANGELO, M.D., P.C.

OBSTETRICS AND GYNECOLOGY

5530 WISCONSIN AVE., SUITE 855
CHEVY CHASE, MD 20815
(301) 656-5441

November 12, 2004

Dear Sir or Madam,

Enclosed please find my 2 passport photos as well as a photocopy of my driver's license.
My application for my medical license renewal was filed and paid for online.

Thank you for your assistance in this matter.

Sincerely,

Cesare F. Santangelo, MD

Renewal: Payment Receipt

Thank you. Your credit card payment has been successfully submitted. Your credit card statement will show a charge labeled "Promissor Inc." Print the receipt for your records. Detach the coupon at the bottom of the page and send it along with your official photographs.

PLEASE NOTE: Your renewal application is NOT complete until you send us the required information below.

1. **You must now submit TWO (2) identical, passport-size photographs (2x2 inches) on plain background, front-view, and fade-proof.** The photographs must be originals, and cannot be computer-generated copies or paper copies. In addition, we will not accept Polaroid-type photographs or any other photograph larger than the 2x2 size. Please be sure to write, on the back of each photograph, your full name and license/registration number or social security number.
2. **You must also submit us ONE (1) clear photocopy of an official photo ID, such as your valid driver's license, as proof of identity.**
3. **If you answer yes to any of the questions marked with an asterisk (*), you must send appropriate documentation to the Board.**
   Department of Health Health Professional Licensing Administration
   Board of Medicine - Renewals
   825 North Capitol Street, N.E.
   Suite 2224
   Washington, D.C. 20002

You may check the status of your renewal at: http://hpla.doh.dc.gov/weblookup.

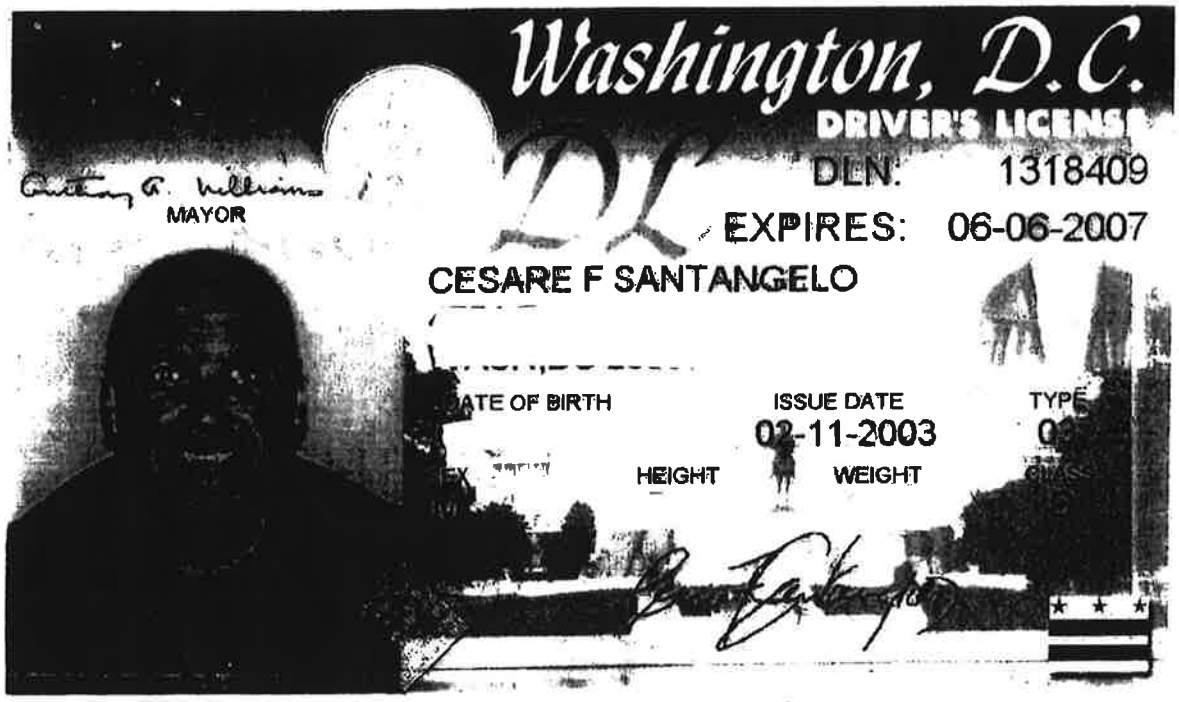
CESARE F. SANTANGELO
Renew License process
Authorization Code: 010904
Application Number: VWVC08211385

MD16815
Amount: $312.00
Received Date: 11/10/2004 11:18:04 AM
Credit Card Number: XXXX XXXX XXXX 1496

IMPORTANT: DETACH HERE AND MAIL IN THE BOTTOM PORTION OF THIS PAGE WITH YOUR PHOTOS.

CESARE F. SANTANGELO
MD16815
Renew License process

Print Receipt | Return to License Home Page


Washington, D.C.
DRIVER'S LICENSE
MAYOR
DLN: 1318409
EXPIRES: 06-06-2007
CESARE F SANTANGELO
ATE OF BIRTH
ISSUE DATE
02-11-2003
TYPE
HEIGHT
WEIGHT

259414-7

District of Columbia — Department of Health
HEALTH OCCUPATION LICENSE RENEWAL FORM

DEC 0 4 2000

GENERAL INSTRUCTIONS: The information printed in Section 1 of this form shows the current information on record for your license. Complete all sections of this form, where applicable, including the fee calculation. If more space is needed to fully answer questions, attach additional sheets. False or misleading statements will be cause for disciplinary action and may be cause for criminal prosecution. Mail the form, the required fee, and all supporting documents to: **ASI/DC DOH-MD, Metro-Plex II, Suite 400, 8201 Corporate Drive, Landover, MD 20785. This form is due back to ASI by December 31, 2000. Forms postmarked after the 31st of December must contain an additional penalty fee of $25.00.** If you have any questions call ASI at 888-204-6193.

1A. DEMOGRAPHIC INFORMATION

Please make name and address changes on the reverse side of this form.

License Number: MD000000016815
Social Security #: 1
Date of Birth:
Other Address:

CESARE F SANTANGELO

2. ADDITIONAL INFORMATION

You must complete the enclosed Clean Hands form before your renewal license application will be processed. Please complete the Clean Hands form and mail it with your completed renewal application form and fee.

YES ☑ NO ☐ ASI ONLY ☑

3. FEE CALCULATION

Please check the appropriate boxes to indicate other requests you would like to be processed with your license renewal and then total the fee column. This form will be returned unprocessed if the fee is not included or if the fee is less than required. Make check or money order payable to "Assessment Systems, Inc." CASH PAYMENTS WILL NOT BE ACCEPTED.

A.	☒ Renewal OR ☐ Paid Inactive Status Request	$120	= $	120.00
B.	☐ Cancel License (No fee)			
C.	☐ Chiropractic Ancillary Procedures	$90	= $	
D.	☐ Late Fee (if postmarked after December 31, 2000)	$25	= $	
E.	☐ Name and/or Address Changed (see reverse side)	$20	= $	
F.	☐ Duplicate License Request NUMBER OF LICENSES ☐☐	x $20	= $	
	TOTAL FEE DUE		= $	

4028
ASI ONLY
126

Make fee payable to: Assessment Systems, Inc. *A charge of $50.00 will be imposed for dishonored checks (Public Law 89-208).*

4. QUESTIONS ABOUT YOUR PRACTICE

If you have an "MD" or "DO" license prefix, please complete A-D. If you are a chiropractor ("CH" license prefix), complete A, B and E. Otherwise, complete A and B only.

A.	Are you in active practice now?	YES ☒ NO ☐
B.	If so, do you practice in the District of Columbia at all?	YES ☒ NO ☐
C.	**MD's and DO's Only** — If your practice is limited to a specialty, please indicate the code from the specialty list at the right.	CODE 08
D.	**MD's and DO's Only** — If you are certified by the American Board of any specialty, please indicate the code from the specialty list at the right.	CODE 08
E.	**Chiropractors Only** — Are you authorized to perform non-invasive ancillary procedures? (Requires additional fee of $90)	YES ☐ NO ☐

SPECIALTIES

AD	Administrative Medicine	OR	Orthopaedic Surgery
AL	Allergy & Immunology	OT	Otolaryngology
AN	Anesthesiology	PA	Pathology
CO	Colon & Rectal Surgery	PE	Pediatrics
DE	Dermatology	PH	Physical Medicine & Rehabilitation
EM	Emergency Medicine	PL	Plastic Surgery
FA	Family Practice	PR	Preventive Medicine/ Public Health
IN	Internal Medicine	PS	Psychiatry & Neurology
MG	Medical Genetics	RA	Radiology
NE	Neurological Surgery	SU	Surgery
NU	Nuclear Medicine	TH	Thoracic Surgery
OB	Obstetrics & Gynecology	UR	Urology
OP	Ophthalmology		

5. SCREENING QUESTIONS

ALL questions must be completed by all licensees. If you answer "Yes" to any of the questions below, please provide a complete explanation on a separate sheet of paper.

A.	Have you withdrawn an application (in DC or any other state/jurisdiction) to practice medicine, or has any authority taken adverse action against your license or privileges, or informed you of any pending charges not previously reported to this Board?	YES ☐	NO ☒	ASI ONLY ☐
B.	Have you been convicted of a crime (other than minor traffic violation) not previously reported to the Board?	YES ☐	NO ☒	ASI ONLY ☐
C.	Do you have a physical or medical condition that currently impairs your ability to practice your profession?	YES ☐	NO ☒	ASI ONLY ☐
D.	Since the last renewal, have you been diagnosed or treated for substance abuse?	YES ☐	NO ☒	ASI ONLY ☐
E.	Have you been involved in a malpractice suit since your last renewal? If yes, provide date of incident, allegation and disposition of case.	YES ☐	NO ☒	ASI ONLY ☐

6. SIGNATURE

All licensees are required to sign and date this form on the lines provided below. This form will be returned unprocessed if the form is not signed by the licensee. **Make a photocopy of this form for your records.**

Cesare F Santangelo — 10/2/00 — ASI ONLY ☒

LICENSEE'S SIGNATURE — DATE

ALL RENEWING LICENSEES — Please complete sections 8 and/or 9 on the back of this form to update your home or business address, preferred mailing address, SSN/Birthdate, or to report a name change. Use your license prefix and number when calling for assistance at the number listed in General Instructions or when writing to ASI or the Board.

Mail renewal form and fee to:

ASI/DC DOH-MD • Metro-Plex II, Suite 400, 8201 Corporate Drive • Landover, MD 20785

District of Columbia — Department of Health
HEALTH OCCUPATION LICENSE RENEWAL FORM

7. CONTINUING EDUCATION – (CHIROPRACTORS AND PHYSICIAN ASSISTANTS ONLY)

Check the box below if you have completed the required credit hours to renew your license. Include the certificates of completion with this application. These courses must have been completed between 1/1/98 and 12/31/00.

Physician Assistants ONLY

☐ I have completed the 40 hours of Category I and 60 hours of Category II continuing education required to renew my license.

Chiropractors ONLY

☐ I have completed the 24 hours of continuing education required to renew my license.

ASI ONLY

8. ADDRESS CHANGE

Use the boxes below to indicate a change in your home or business address. Complete **all** fields, even if the address has only partially changed.

8A. HOME ADDRESS CHANGE

Please note your apartment, suite, floor or PO Box number below if applicable. If you do not enter your complete address, your address change **cannot** be processed.

(Choose only one) ☐ APARTMENT ☐ SUITE ☐ FLOOR ☐ PO BOX — NUMBER

STREET ADDRESS LINE 1

STREET ADDRESS LINE 2

CITY — STATE — ZIP CODE

AREA – PHONE NUMBER — AREA – FAX NUMBER

8B. BUSINESS ADDRESS CHANGE

Please note your apartment, suite, floor or PO Box number below if applicable. If you do not enter your complete address, your address change **cannot** be processed.

(Choose only one) ☐ APARTMENT ☐ SUITE ☐ FLOOR ☐ PO BOX — NUMBER

STREET ADDRESS LINE 1

STREET ADDRESS LINE 2

CITY — STATE — ZIP CODE

AREA – PHONE NUMBER — AREA – FAX NUMBER

8C. INDICATE YOUR PREFERRED MAILING ADDRESS

All correspondence for this license will be sent to the preferred mailing address.

☐ HOME ☐ BUSINESS

8D. SSN/BIRTHDATE

If your Social Security Number/FEIN and Birthdate are incorrect or missing, please enter them in the spaces provided.

SSN/FEIN* — BIRTHDATE (MONTH – DAY – YEAR)

9. NAME CHANGE

If your name has changed or is incorrect, enter it below exactly as it should appear on the license. Use all fields even if only the first or last name has changed. All name changes require a copy of the legal name change document. Acceptable documents are marriage certificates, divorce decrees, or court orders.

FIRST NAME

MIDDLE NAME

LAST NAME — ASI ONLY ☐

SUFFIX (Jr., Sr., etc.)

ASI ONLY

Clerk's Initials

* Under the authority of Public Law 93-579, Section 7 (b), the Department of Customer and Regulatory Affairs requests your Social Security Number/FEIN to assist in the administration of D.C. tax laws. Disclosure is not required as a part of the licensing process and will not be made available to the public

254914

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
825 NORTH CAPITOL STREET, N.E.
WASHINGTON, DC 20002

Clean Hands Before Receiving a License or Permit Act of 1996 Certification Form

Please read this form carefully and completely before signing. Any false information provided requires that the Department of Health proceed immediately to revoke the license or permit for which you are now applying, and fine you one thousand dollars ($1,000.00). This *Certification Form* is required to be completed and submitted with any application for licensure or permit under the *Clean Hands Before Receiving a License or Permit Act of 1996*, effective May 11, 1996 (D.C. Law 11-118, D.C. Code §47-2861 et seq.).

I, _____ applying for a Health Occupation License
(name) *(type of health license)*

certify that, as of this date, do not owe more than one hundred dollars ($100.00) to the District of Columbia government as a result of

1. Fines, penalties or interest assessed pursuant to the Litter Control Administration Act of 1995, effective March 25, 1986 (D.C. Law 6-100; D.C. Code §6-2901 et seq.);
2. Fines, penalties or interest assessed pursuant to the Illegal Dumping Enforcement Act of 1994, effective May 20, 1994 (D.C. Law 10-117; D.C. Code §6-2911 et seq.);
3. X Fines, penalties or interest assessed pursuant to the Civil Infractions Act of 1985, effective October 5, 1986 (D.C. Law 6-42; D.C. Code §6-2701 et seq.); or
4. Past due taxes.

I understand that if I knowingly provide false information on this *Certification Form*, the Department of Health will move to revoke the license or permit for which I am applying and fine me one thousand dollars ($1,000.00). I further understand that the Department of Health and the Office of Tax and Revenue may conduct an investigation to ascertain the veracity of the information contained in this *Certification Form*.

I understand that this *Certification Form* is now required as part of my application for a license or permit, and that by completing it, I am not guaranteed that my license or permit will be approved.

_____ 10/24/00
Signature and Title/Responsible Officer *Date*

Social Security # *Business/Home Address*

Phone Number

white copy – Department of Health
yellow copy - Tax and Revenue, Collections Division
pink copy – applicant
ASI# 6009-03 9/00

For Tax Assistance call:
(202) 442 – 4TAX.
(4829)

33

7627

District of Columbia — Department of Health
HEALTH OCCUPATION LICENSE RENEWAL FORM

GENERAL INSTRUCTIONS: The information printed in Section 1 of this form shows the current information on record for your license. Complete all sections of this form, where applicable, including the fee calculation. If more space is needed to fully answer questions, attach additional sheets. False or misleading statements will be cause for disciplinary action and may be cause for criminal prosecution. Mail the form, the required fee, and all supporting documents to: **ASI/DC Department of Health, PO Box 13805, Philadelphia, PA 19101-3805. This form is due back to ASI by December 31, 1998. Forms postmarked after the 31st of December must contain an additional penalty fee of $25.00.** If you have any questions call ASI at 888-204-6193.

1A. DEMOGRAPHIC INFORMATION

Please make name and address changes on the reverse side of this form.

CESARE F. SANTANGELO

License Number: MD16815
Social Security #:
Date of Birth:
Other Address:

2. ADDITIONAL INFORMATION

This document is for renewal of your Health Occupation license. Please do not confuse this renewal process with the "Professional Licensing Fee" ($250 per year) administered by the Department of Finance and Revenue.
Your license will expire on December 31,1998 if you do not return this application with the fee made payable to ASI at the address shown at the bottom of the form.

3. FEE CALCULATION

Please check the appropriate boxes to indicate other requests you would like to be processed with your license renewal and then total the fee column. This form will be returned unprocessed if the fee is not included or if the fee is less than required. Make check or money order payable to "Assessment Systems, Inc." CASH PAYMENTS WILL NOT BE ACCEPTED.

A.	☒ Renewal OR ☐ Paid Inactive Status Request	$120	=	$ 120.
B.	☐ Cancel License (No fee)			
C.	☐ Chiropractic Ancillary Procedures	$90	=	$ N/A
D.	☐ Late Fee (if postmarked after December 31, 1998)	$25	=	$
E.	☐ Name and/or Address Changed (see reverse side)	$20	=	$
F.	☐ Duplicate License Request NUMBER OF LICENSES [ ]	x $20	=	$
	TOTAL FEE DUE		=	$ 120

ASI ONLY [1][2][0]

Make fee payable to: Assessment Systems, Inc. *A charge of $50.00 will be imposed for dishonored checks (Public Law 89-208).*

4. QUESTIONS ABOUT YOUR PRACTICE

If you have an "MD" or "DO" license prefix, please complete A-D. If you are a chiropractor ("CH" license prefix), complete A, B and E. Otherwise, complete A and B only.

A.	Are you in active practice now?	YES ☒ NO ☐
B.	If so, do you practice in the District of Columbia at all?	YES ☒ NO ☐
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B.	Have you been convicted of a crime (other than minor traffic violation) not previously reported to the Board?	YES ☐ NO ☒	ASI ONLY ☐
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Cesare F. Santangelo M.D. — LICENSEE'S SIGNATURE
10/1/98 — DATE
ASI ONLY ☒

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HEALTH OCCUPATION LICENSE RENEWAL FORM

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ASI ONLY

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STREET ADDRESS LINE 2

CITY — STATE — ZIP CODE

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STREET ADDRESS LINE 1

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CITY — STATE — ZIP CODE

AREA - PHONE NUMBER — AREA - FAX NUMBER

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☐ HOME ☒ BUSINESS

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SSN/FEIN* — BIRTHDATE: MONTH - DAY - YEAR

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FIRST NAME

MIDDLE NAME

LAST NAME — ASI ONLY ☐

SUFFIX (Jr., Sr., etc.)

ASI ONLY

NOV 05 1998

Clerk's Initials

* Under the authority of Public Law 93-579, Section 7 (b), the Department of Consumer and Regulatory Affairs requests your Social Security Number/FEIN to assist in the administration of D.C. tax laws. Disclosure is not required as a part of the licensing process and will not be made available to the public.