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DEPARTMENT OF PROFESSIONAL REGULATION
BOARD OF MEDICINE
Northwood Centre, 1940 North Monroe Street
Tallahassee, Florida 32399-0770
(904)488-0595

MEDICAL/NATUROPATH — ENDORSEMENT APPLICATION

APPLICATION FEE - $450. APPLICATION FEE IS NON-REFUNDABLE.
APPLICATION SHOULD BE TYPED.

NAME: David (FIRST) Steven (MIDDLE) Brown (LAST) Brown
(Full legal name as it should appear on your wall certificate and license)

MAILING ADDRESS: 3450 Wayne Avenue, #23P Bronx NY 10467
(c/o) (Street & No.) (City) (State) (Zip)

PERMANENT ADDRESS: 33 Farragut Ave. Bay Shore NY 11706
(c/o) (Street & No.) (City) (State) (Zip)

PLACE OF BIRTH: Bay Shore, NY U.S.A. **DATE OF BIRTH:** 03-24-59
(City) (State) (Country) (Mo.) (Day) (Yr.)

RESIDENCE TELEPHONE NUMBER: (212) 231-7191 (area code number)
OFFICE NUMBER: (212) 920-5321 (area code number)
SOCIAL SECURITY NUMBER: [redacted] $450.00
86885
01-15-10 $450.00

HAVE YOU EVER LEGALLY **CHANGED YOUR NAME?** YES ___ NO X . IF SO, ENCLOSE CERTIFIED COPY OF LEGAL DOCUMENT GIVING CHANGE, e.g. by marriage, etc.

We are required to ask that you furnish the following information as part of your voluntary compliance with Section 2, Uniform Guidelines on Employee Selection Procedure (1978) 43 FR38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

RACE: Caucasian ___ Black X Hispanic ___ Oriental ___ Native American ___ Other ___
SEX: Male X Female ___

DOCTOR OF MEDICINE DEGREE WAS OBTAINED FROM: Temple University School of Medicine
(Name of Medical School and Location)
3400 N. Broad Street
Philadelphia, PA 19140 on 05-27-87
(Month) (Day) (Year)

Are you now or have your ever been licensed in any State, Canada, Guam, Puerto Rico or U.S. Virgin Islands? Yes ___ No X . (If Yes, list state(s), license number(s) and date(s) of issuance)

APR 05 1990

Currently applying for N.Y. State Licensure

MEDICAL/NATUROPATH

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FOR OFFICE USE ONLY, PLEASE DO NOT LINE

NOTE: PHOTO MUST HAVE BEEN TAKEN W
PRECEDING DATE OF APPLICATION
1. PASTE ONE PHOTO in the bla
space to the right.

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Rev. Code 1510 DPR/ME/003 1-90

ARE YOU A CITIZEN OF THE UNITED STATES? Yes X No ____. IF FOREIGN BORN, GIVE DATE AND PLACE OF NATURALIZATION: ____

DID YOU ATTEND A COLLEGE OR UNIVERSITY? Yes X No ____. IF SO, GIVE NAME AND LOCATION, DATE(S) IN ATTENDANCE: State University of New York, Stonybrook 9-77-6-83

DID YOU RECEIVE A DEGREE OTHER THAN AN M.D., TO INCLUDE UNDERGRADUATE DEGREE? Yes X No ____.

List degree Bachelor of Science, SUNY Stonybrook 5/81 Master of Science 6/83

LIST ALL PLACES OF RESIDENCE (WHERE LIVED) DURING ALL PERIODS OF MEDICAL SCHOOL AND POSTGRADUATE TRAINING:

Philadelphia, Pennsylvania (city, state or country) FROM August, 1983 TO: June, 1987

Bronx, NY (city, state or country) FROM July, 1987 TO: March, 1990

____ (city, state or country) FROM ____, 19__ TO: ____, 19____

____ (city, state or country) FROM ____, 19__ TO: ____, 19____

MEDICAL SCHOOL: BE SPECIFIC. ACCOUNT FOR EACH YEAR. LIST ALL UNIVERSITIES/COLLEGES WHERE ATTENDED CLASSES/RECEIVED TRAINING AS A MEDICAL STUDENT:

Temple University School of Med., Phila. PA (name of medical school/location) FROM August, 1983 TO: May, 1987

____ (name of medical school/location) FROM ____, 19__ TO: ____, 19____

____ (name of medical school/location) FROM ____, 19__ TO: ____, 19____

____ (name of medical school/location) FROM ____, 19__ TO: ____, 19____

ACCOUNT FOR ALL TIME FROM DATE OF GRADUATION FROM MEDICAL SCHOOL TO PRESENT. DO NOT LEAVE OUT ANY TIME.

POSTGRADUATE TRAINING - List in chronological order from date of graduation to present date, all postgraduate training (Internship, Residency, Fellowship):

FROM: June 28th, 1987 (Exact dates of attendance) TO: June 30th, 1988 (Month/Day/Year) Internship Program(Internship/Residency/Fellowship)

Montefiore Medical Center, 111 E. 210th Street, Bronx, NY U.S.A.
Name and Address (Street Number, City, State, Territory, Country) of Hospital, Institution (Program Sponsor) where training was received.

FROM: July 1, 1988 (Exact dates of attendance) TO: Present (Month/Day/Year) Residency in Internal Medicine Program(Internship/Residency/Fellowship)

Montefiore Medical Center 111 E. 210th Street, Bronx, NY U.S.A.
Name and Address (Street Number, City, State, Territory, Country) of Hospital, Institution (Program Sponsor) where training was received.

FROM: Not applicable TO: _____ _____
(Exact dates of attendance) (Month/Day/Year) Program(Internship/Residency/Fellowship)

_____
Name and Address (Street Number, City, State, Territory, Country) of Hospital, Institution (Program Sponsor) where training was received.

PRACTICE/EMPLOYMENT - List in chronological order from date of graduation to present date, all practice experience and/or employment.

FROM: Not applicable TO: _____ _____
(Month/Day/Year) (Month/Day/Year) (Type of Practice and/or Employment)

_____
Name and Address (Street Number, City, State, Territory, Country) of Employment and/or practice setting.

FROM: _____ TO: _____ _____
(Month/Day/Year) (Month/Day/Year) (Type of Practice and/or Employment)

_____
Name and Address (Street Number, City, State, Territory, Country) of Employment and/or practice setting.

FROM: _____ TO: _____ _____
(Month/Day/Year) (Month/Day/Year) (Type of Practice and/or Employment)

_____
Name and Address (Street Number, City, State, Territory, Country) of Employment and/or practice setting.

List hospital(s) where you have staff privileges. (Give addresses, date(s) of service and chief of staff) (Do not list privileges as an intern/resident in ACGME training)

Not applicable

_____

_____

Have you ever been in the United States Military? Yes ___ No X . If so, attach copy of separation from service form and full discharge form.

_____
(branch of service, rank, dates of service)

Are you certified by an American Specialty Board? Yes ___ No X . If "yes", give name of Board _____
(enclose copy of Board certificate or letter verifying eligibility)

Are you a diplomate of the National Board of Medical Examiners? Yes X No ____. If "yes", state date of certification July 1st, 1989

Foreign Medical Graduates: ECFMG standard certificate number not applicable

issued _____ after passing english and medical examination. Attach copy of current valid certificate.

All applicants must answer the following questions:

1. Have you ever studied to become, or do you hold licensure in any state as a Chiropractor, Naturopathic or Osteopathic physician? Yes ___ No X .

2. Have you ever failed State Board/FLEX/National Board Examination? Yes X No ___ .

3. Have you ever been denied an application for licensure to practice medicine by any state board or other governmental agency of any state or country? Yes ___ No X .

4. Have you ever been notified to appear before any licensing agency for a hearing on a complaint of any nature, including, but not limited to, a charge or violation of the medical practice act, unprofessional or unethical conduct? Yes ___ No X .

5. Have you ever had a license to practice medicine/surgery/revoked, suspended, or other disciplinary action taken in any state, territory or country? Yes ___ No X .

6. Have you ever been convicted of a felony? Yes ___ No X ; a misdemeanor? Yes ___ No X . Have any judgments ever been entered against you? Yes ___ No X . Have you ever been sued for malpractice? Yes ___ No X .

7. Have you ever had to discontinue practice for any reason for a period of one month or longer? Yes ___ No X .

8. Are you now or have you ever been emotionally/mentally ill? [redacted] Have you ever received psychotherapy? [redacted]

9. Are you now or have you ever been addicted to or excessively used alcohol, narcotics, barbiturates, or any other medication? [redacted]

10. Have you ever voluntarily or otherwise been a patient in a hospital, institution, clinic or medical facility for the treatment of mental/emotional illness, drug addiction/abuse, or excessive use of alcohol? [redacted]

11. Have you ever been denied staff privileges in any hospital? Yes ___ No X . Have you ever had your staff privileges suspended, revoked, modified, restricted, placed on probation, or otherwise acted against (explain "otherwise" actions)? Yes ___ No X .

If "YES", list name(s) and address(es) of hospital(s)

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12. Have you ever been allowed to resign from any hospital, institution, clinic or medical facility in lieu of disciplinary action? Yes ___ No X .

If "YES", please explain and list name(s) and address(es) of practice setting from which you resigned.

If "YES", please explain and list name(s) and address(es) of practice setting from which you resigned.

13. Has an application for medical society membership ever been rejected? Yes___ No X . Have you ever had your medical society membership suspended? Yes___ No X . Have you ever been notified to appear before a medical society in regard to charges/complaints filed against you? Yes___ No X .

IF ANY OF THESE QUESTIONS ARE ANSWERED "YES", GIVE NAME(S) AND ADDRESS(ES) OF MEDICAL SOCIETY.

LIST MEDICAL AFFILIATIONS: State, county, national, including date(s) and complete address (street, city, state)

Not applicable

14. Have you ever been warned or called before the Bureau of Narcotics and Dangerous Drugs? Yes___ No X . Have you ever been made an offer to compromise in connection with the Harrison Narcotic Law? Yes___ No X . Have you ever been denied, or surrendered, a narcotic tax stamp? Yes___ No X .

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If any of the questions numbered 1) through 14) are answered "YES", applicant must submit affidavit under oath explaining in detail, the basis for such answer.

In addition to applicant's affidavit, the reports listed below are also required:

a) Applicants who have a history of emotional/mental illness, treatment, psychotherapy, chemical dependency, etc., are required to have their treating physician/program submit to this office, a report of such treatment to include diagnosis/prognosis. In addition, such applicants may be required to undergo current psychiatric evaluation by a board approved physician independent of applicant's treating physician.

b) Malpractice Suits - Notarized Copy of Complaint and Judgment. If litigation is pending, statement from applicant's attorney, explaining current status of complaint.

c) Misdemeanor/Felony/Convictions - Certified Copy of Charges/Indictment and Judgment.

Once the application process has been fully completed, the applicant may be required to make a personal appearance before the Credentials Committee and/or The Board of Medicine.

Please Note: Copies of all documents submitted with the application must be certified by a Notary Public as being true and correct copies of the original documents which the Notary Public has compared. (Notary Public must see the original document and the copy in order to make such a comparison).

If adequate space is not provided on the application form to respond to the requested information, please attach additional sheets as may be required.

TO BE COMPLETED BY APPLICANT:

DATE 3-20-90 COLOR OF EYES Brown

AGE 30 COLOR OF HAIR Brown

HEIGHT 5'9" WEIGHT 170lbs. OTHER MEANS OF IDENTIFICATION ____________

AFFIDAVIT OF APPLICANT:

I, DAVID S. BROWN, being first duly sworn, depose and say that I am the person referred to in the foregoing application and supporting documents, and that the attached photograph is a true likeness of myself.

I hereby authorize all hospital(s), institution(s) or organization(s), my references, personal physicians, employers, (past and present), and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Florida Board of Medicine any information which is material to my application for licensure.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of my license to practice medicine/surgery in the State of Florida.

David S. Brown M.D.
(signature of applicant)

COUNTY OF Phila.

State of Penna.

Subscribed and sworn to me before this 24th day of March, 19 90

[signature]
(notary)

Notary Public, Phila., Phila. Co
My commission expires: My Commission Expires Dec 18 1991
(notary seal/stamp)