222487-1

APR 2 1 2000

DISTRICT OF COLUMBIA
BOARD OF MEDICINE
ENT APPLICATION FOR MEDICINE AND OSTEOPATHY

S

y section of this application (front and back) and submit the original application and all required supporting documents. s application to be processed. If more space is needed to fully answer questions, attach additional sheets with typed atements will be cause for disciplinary action and could be cause for criminal prosecution pursuant to DC Code 22-2514.

If you have any questions, call ASI Customer Service at 888-204-6193.

If five (5) years have passed since this license was active, a new license must be applied for using a New License Application Form.

1. TYPE OF APPLICATION AND FEES

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.**

Reinstatement Application for: ☒ Medicine and Surgery (MD) ☐ Osteopathy and Surgery (DO)

TOTAL FEE DUE = $300.00

MAKE FEE PAYABLE TO: ASSESSMENT SYSTEMS, INC.

A charge of $50.00 will be imposed for dishonored checks (Public Law 89-208)

2A. NAME

Enter your name exactly as it appears on your license.

MYRON | ROSE

FIRST NAME | LAST NAME | MI.

2B. NAME CHANGE

If your name has changed since your license was last active, enter it exactly as it should appear on the license. Be sure to fill in all applicable fields even if only the first or last name has changed. You must provide a notarized copy of the legal name change document (marriage certificates, divorce decrees, or court orders.)

FIRST NAME | LAST NAME | MI. SUFFIX (Jr, Sr, etc.)

ASI ONLY ☐

2C. SOCIAL SECURITY NUMBER *

2D. DATE OF BIRTH

MONTH DAY YEAR

2E. ORIGINAL LICENSE NUMBER AND EXPIRATION YEAR

NUMBER: 4063 EXPIRATION YEAR: 1997

3A. HOME ADDRESS

A street address MUST be provided. If applicable, choose only one box below and write the number in the boxes provided. Complete ALL fields, even if your address has only partially changed.

☐ APARTMENT ☐ SUITE ☐ ROOM ☐ FLOOR NUMBER

STREET ADDRESS LINE 1

STREET ADDRESS LINE 2

CITY STATE ZIP CODE

AREA CODE HOME PHONE NUMBER AREA CODE HOME FAX NUMBER

3B. BUSINESS ADDRESS

A street address MUST be provided. If applicable, choose only one box below and write the number in the boxes provided. Complete ALL fields, even if your address has only partially changed.

☐ APARTMENT ☐ SUITE ☐ ROOM ☐ FLOOR NUMBER

7 VANDERBILT COURT

STREET ADDRESS LINE 1

STREET ADDRESS LINE 2

ROCKVILLE | MD | 20850-4692

CITY STATE ZIP CODE

301-987-2795 AREA CODE BUSINESS PHONE NUMBER

301-987-2796 AREA CODE BUSINESS FAX NUMBER

3C. INDICATE YOUR PREFERRED MAILING ADDRESS

All correspondence for this license will be sent to the preferred mailing address. ☒ HOME ☐ BUSINESS

MAIL FORM AND FEE TO:

ASI/DC Board of Medicine • PO Box 13805 • Philadelphia, PA 19101-3805

* Under the authority of Public Law 93-579, Section 7 (b), the Department of Consumer and Regulatory Affairs requests your Social Security Number/ITIN 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.

ASI 6609-36 5/97ed.

DC REINSTATEMENT APPLICATION FOR MEDICINE AND OSTEOPATHY

4. MEDICAL LICENSES IN OTHER STATES/JURISDICTIONS

List all states and jurisdictions in which you are currently licensed or have been licensed since your last DC Renewal. You must request verification of licensure for each of these licenses.

JURISDICTION	DATE LICENSE WAS FIRST OBTAINED	LICENSE NUMBER
MARYLAND	1973	D 0015175
VIRGINIA	1997	0101 051880

5. REASON FOR NOT RENEWING

Provide a written explanation for why you did not renew your license. If more space is required, please attach additional sheets.

Relocation of office to Maryland.

6. INTERIM EMPLOYMENT HISTORY

Account for all employment, periods of unemployment, and all medical practice since the last date of licensure. Indicate the name, business address and telephone number of such employment and/or medical practices. If more space is required, please attach additional sheets.

DATES	EMPLOYER	ADDRESS	PHONE
April 1979 to March 2000	Hagerstown Reproductive Health Services, Inc.	160 West Washington St. Hagerstown, MD 21740-4778	(301) 733-2400

7. SUPPORTING DOCUMENTS

The following documents must be submitted with the application. Please indicate whether they have been enclosed. Keep a photocopy of all supporting documents for your records.

A. Two (2) passport type photographs.	☒ YES	☐ NO	ASI ONLY ☒
B. Verification(s) of licensure - These should be provided in a sealed envelope from the issuing jurisdiction for each medical license held and identified in Section 4.	☒ YES	☐ NO	ASI ONLY ☒
C. More than 6 months have passed since the expiration of my license and I have submitted a request for Disciplinary Inquiries from the Federation of State Medical Boards, which will be sent under separate cover.	☒ YES	☐ NO	ASI ONLY ☒

8. 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?	☐ YES	☒ NO	ASI ONLY ☐
B. 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 ☐
C. Have you been arrested, indicted or convicted of a crime (other than minor traffic violations) not previously reported to the Board?	☐ YES	☒ NO	ASI ONLY ☐
D. Do you owe more than $100 to the District of Columbia Government in back taxes or in fines, penalties or interest under the Litter Control Administration Action of 1985, the Illegal Dumping Enforcement Act of 1994 or the Department of Consumer and Regulatory Affairs Civil Infractions Act of 1995?	☐ YES	☒ NO	ASI ONLY ☐
E. Do you have a physical or medical condition that currently impairs your ability to practice your profession?	☐ YES	☒ NO	ASI ONLY ☐
F. Has the use of drugs and/or alcohol resulted in an impairment of your ability to practice your profession?	☐ YES	☒ NO	ASI ONLY ☐
G. Have you been involved in a malpractice suit since your last renewal?	☐ YES	☒ NO	ASI ONLY ☐
H. Have you practiced medicine in the District since your license expired?	☐ YES	☒ NO	ASI ONLY ☐

9. AFFIDAVIT OF APPLICANT

This form will be returned unprocessed if the form is not signed by the applicant and notarized. Keep a photocopy of this form for your records.

I, MYRON ROSE, MD, *being duly sworn, deposes and says: That the information given in this application, including all writings and exhibits attached hereto, is true and complete.*

Myron Rose — APPLICANT'S SIGNATURE

4-19-00 — DATE

ASI ONLY ☒

State: Maryland

Subscribed and sworn to before me this 19th *day of* April, *19* 2000 *by the affiant, who personally appeared before me.*

Karen M Mazzeo — NOTARY PUBLIC SIGNATURE

10/31/01 — MY COMMISSION EXPIRES

ASI ONLY ☒

ASI ONLY
#300 CK# 6812
Clerk's Initials MCW

(NOTARY SEAL)

CONTROLLED SUBSTANCE REGISTRATION CERTIFICATE

UNITED STATES DEPARTMENT OF JUSTICE

DRUG ENFORCEMENT ADMINISTRATION
WASHINGTON, D.C. 20537

AUG 21 2000

Sections 304 and 1008 (21 U.S.C. 824 and 958) of the Controlled Substances Act of 1970, as amended, provide that the Attorney General may revoke or suspend a registration to manufacture, distribute, dispense, import or export a controlled substance.

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
AR9468720	04-30-2002	$210.00

SCHEDULES	BUSINESS ACTIVITY	DATE ISSUED
2,2N,3,3N,4,5	PRACTITIONER	04-2[illegible]-1999

ROSE, MYRON MD
HAGERSTOWN REPRODUCTION
HEALTH SERVICE
160 WEST WASHINGTON STREET
HAGERSTOWN, MD 21740

Form DEA-223 (10/96)

THIS CERTIFICATE IS NOT TRANSFERABLE ON CHANGE OF OWNERSHIP, CONTROL, LOCATION, BUSINESS ACTIVITY, OR VALID AFTER THE EXPIRATION DATE.

JOHN W. HASTY
DIRECTOR

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF HEALTH PROFESSIONS

6606 WEST BROAD STREET
4th FLOOR
RICHMOND, VA 23230-1717

APR 2 1 2000

BOARD OF MEDICINE
CLARKE RUSS, M.D., PRESIDENT

EXPIRES	LICENSE TO PRACTICE	NUMBER
09-30-2000	MEDICINE AND SURGERY	0101 051880

MYRON ROSE, MD
160 WEST WASHINGTON STREET
SUITE 100
HAGERSTOWN, MD 21740

TO PROVIDE INFORMATION OR FILE A COMPLAINT ABOUT A LICENSEE, CALL: 1-800-533-1560

(SEE REVERSE SIDE FOR NAME AND ADDRESS CHANGE)

State of Maryland

63036

Martin P. Wasserman, M.D., J.D.
Secretary

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
DIVISION OF DRUG CONTROL
4201 PATTERSON AVE. BALTIMORE, MD 21215

THIS CERTIFIES THAT THE APPLICANT LISTED BELOW IS REGISTERED TO *DISPENSE*

CONTROLLED DANGEROUS SUBSTANCES AS PER APPLICATION.

This registration is granted pursuant to Article 27, Sections 276 et seq. of the Annotated Code of Maryland, as amended, and is subject to all applicable statutes, rules, and regulations regarding Controlled Dangerous Substances.

CDS REG. NO.
M14444

MYRON ROSE MD
160 W WASHINGTON STREET
HAGERSTOWN MD 21740-4778

06/30/00
Expiration Date

Martin P. Wasserman MD
Martin P. Wasserman, M.D., J.D.
Secretary of Health and Mental Hygiene

Jack Freedman
Jack Freedman
Chief, Division of Drug Control

DHMH 1237

(Not Transferable)

POST IN A CONSPICUOUS PLACE

DUPLICATE

APR 21

GOVERNMENT
OF THE
DISTRICT OF COLUMBIA

OPLA - 103 (Rev. 9/91)

License No. 4063
CLASS: 3NB

DEPARTMENT OF CONSUMER AND REGULATORY AFFAIRS
OCCUPATIONAL AND PROFESSIONAL LICENSING ADMINISTRATION
BOARD OF MEDICINE

Be it known that

MYRON ROSE

has met all requirements prescribed by law and regulations and is hereby authorized to practice

MEDICINE AND SURGERY

in accordance with D.C. Law 6-99, District of Columbia Health Occupations Revision Act of 1985.

In witness whereof, the said Board caused this certificate to be granted and attested by the official seal of the District of Columbia, this 11TH *day of* OCTOBER, 1968.

Director
Department of Consumer & Regulatory Affairs

President, Board of Medicine

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF CONSUMER AND REGULATORY AFFAIRS
OCCUPATIONAL AND PROFESSIONAL LICENSING ADMINISTRATION
BOARD OF MEDICINE
614 H Street, NW, Room 108
Washington, DC 20001

APR 2 1

DISCIPLINARY INQUIRIES
Federation of State Medical Boards
400 Fuller-Wiser Road
Suite 300
Euless, Texas 76039-3855

The District of Columbia Board of Medicine requests a disciplinary search concerning the following individual:

ROSE, MYRON — *Name (Last, First, MI)*
— *SSN*
4063 — *License No.*

Street Address (Business)

City, State, Zip Code
Date of Birth

University of Missouri
Columbia, Missouri — *Medical School of Graduation and Branch Location*
June 1967 — *Date of Graduation*

Please mail the response to the following address:
ASI/DC Board of Medicine
PO Box 13805
Philadelphia, PA 19104-3805

Myron Rose M.D. — *Signature*
4-19-09 — *Date*

NOTE: This Letter can be folded and mailed to the FSMB in a #10 window envelope.

1/97

COMMONWEALTH of VIRGINIA

B 44842-18
SSN 129-28-8991

APR 2 8 2000

VERIFICATION

Re: **Myron Rose**

From: Virginia Board of Medicine

Subj: Licensure Verification

Date: April 24, 2000

This is to certify that the above named individual was issued a license to practice by the Virginia Board of Medicine:

Licensed in/as a:	**Medicine & Surgery**
License:	**0101051880**
Issued on:	**12/01/1994**
Expires:	**09/30/2000**

This license has not been the subject of an administrative proceeding. If you have any questions, please call 804-662-9388.

The information above is the only verification provided by this board. If other information is needed, please do not hesitate to contact this office. To expedite the verification process, the above format is the standard format prepared for all professions regulated by this board.

Verifications may also be obtained from our website at www.dhp.state.va.us or our interactive phone system at 804-662-7636 with fax back option.

Sincerely,

M. Ola Powers

April 20, 2000

Virginia Board of Medicine
6606 West Broad street, 4th floor
Richmond, VA 23230-1717

APR 2 8 2000

Dear Sirs

This letter is to request that you send a verification of my licensure to Assessment Systems, Inc. at the following address:

Metro-Plex II
8201 Corporate Drive, Suite 400
Landover, MD 20785
Attn.: Gloria Jones

I am applying for reinstatement of my license in the District of Columbia. The fee is enclosed.

This letter is also to inform you of my new office address as follows:

7 Vanderbilt Court
Rockville, MD 20850-4692

Thank you for your prompt assistance.

Sincerely,

Myron Rose M.D.

Myron Rose, M.D.
License No. 0101 05/880
Expiration Date: 9/30/00

002337

BOARD OF PHYSICIAN QUALITY ASSURANCE RECEIVED

2000 APR 24 AM 9:48

April 20, 2000

Maryland Board of Physician Quality Assurance
P.O. Box 2571
4201 Patterson Avenue
Baltimore, MD 21215

APR 28 2000

PAID 150 -

Dear Sir:

This letter is to request that you send a verification of my licensure to Assessment Systems, Inc. at the following address:

Metro-Plex II
8201 Corporate Drive, Suite 400
Landover, MD 20785
Attn.: Gloria Jones

I am applying for reinstatement of my license in the District of Columbia. The fee is enclosed.

This letter is also to inform you of my new office address as follows: 7 Vanderbilt ~~Drive~~ Court
Rockville, MD 20850-4692

Thank you for your prompt assistance.

Sincerely,

Myron Rose M.D.

Myron Rose, M.D.
License No. D 0015175
Exp. Date: 9/30/01

MARYLAND BOARD OF PHYSICIAN QUALITY ASSURANCE
P.O. Box 2571
4201 Patterson Avenue
Baltimore, MD 21215-0095
(410) 764-4777
Fax (410) 358-2252
e-mail: bpqa@erols.com

APR 2 8 2000

April 26, 2000

Requested by: DISTRICT OF COLUMBIA

The following is available under the Maryland Public Information Act, State Government Article, Section 10-617(h), regarding the following practitioner:

ROSE, MYRON
7 VANDERBILT COURT
ROCKVILLE, MD 20850

License Number:	D0015175
Date Issued:	June 07, 1973
Current Status:	Active
Expiration Date:	September 30, 2001
Medical School:	UNIV OF MO, COLUMBIA SCH OF MED
Licensed By:	
Specialty:	Obstetrics & Gynecology
Charges:	0
Disciplinary Actions:	NONE

No Maryland Health Claims Arbitration Office malpractice claims filed since July 1, 1986

Felecia Sivells

Verification Clerk

04/26/2000

Date

This is a computer generated form which is acceptable by other states.
Licensing examination scores should be requested directly from the examining authority.

DISTRICT OF COLUMBIA -- DEPARTMENT OF HEALTH
HEALTH OCCUPATION LICENSE RENEWAL FORM

#304 #312

IONS: The information printed Section 1 of this form shows the current information on record for your license. Complete all sections of this form, g the fee calculation. If more space is needed to fully answer questions, attach additional sheets. False or misleading statements will be cause for uld be cause for criminal prosecution. Mail the form, the required fee, and all supporting documents to: **Department of Health, Health Professional Board of Medicine, 825 North Capitol Street, NE, Suite 2224, Washington, D.C. 20002. This form is due back to HPLA by December 31, 2004. the 31st of December must contain an additional late fee of $65.00. If you have any questions, call HPLA Customer Service at 1-888-204-6193.**

C INFORMATION

d address changes on the reverse side of this form.

DCD

NOV 02 2004

Preferred mailing address:

MYRON ROSE

License Number MD4063
***Social Security**
Birth Date
Internet Pin:

Other Address Unknown NA 00000

*Pursuant to D.C. Official Code Section 3-1205.5 (b) (2001) (Health Occupations Revisions Act), **applicants are required to provide a Social Security Number (SSN)** on applications for a professional license. Please provide your Social Security Number in Section 5 of this form. If a Social Security Number is not available, a sworn affidavit stating that you do not have a Social Security Number must be submitted on a separate notarized letter.

2. SPECIAL INSTRUCTIONS

- Your license expires December 31, 2004.
- Renewal applications submitted after December 31, 2004 will be required to pay a $65.00 late fee.
- If you are unable to renew your license by December 31, 2004 or within the 60-day late renewal period, you will then be required to apply for reinstatement of your license.
- In addition, you must submit your pictures no later than the 60-day late renewal period. Failure to do so will result in your license lapsing and you will have to apply for reinstatement of your license. **You may not practice your profession in the District of Columbia until you reinstate your license.**
- You may reinstate your license in the District within 5 years of the expiration date of your license. Once the 5-year reinstatement period has ended, you must apply as a new applicant. You will receive a new license number upon approval.

IMPORTANT NOTICE: In compliance with 17 DCMR 4001.1(c), please submit two (2) identical, recent passport-size photographs (2x2 inches in size) on a plain background, which are front-view and fade-proof. The photos must be original photos and cannot be computer-generated copies or paper copies. In addition, we will not accept 3x3 or larger Polaroid - type photos. Please be sure to mail in your two photos and write on the back of the photos your full name and either your license number or Social Security Number. Please send the photos along with your Renewal Application form. Photos will be placed on the pocket license. You will also need to submit one (1) **clear photocopy of a government issued photo ID**, such as your valid driver's license, as proof of identity. **Your application is not complete and your license will not be renewed until your photos are received.**

INTERNET INSTRUCTIONS: This is a reminder that if you decide to register online, remember to register at: http://www.dchealth.dc.gov. You must use the PIN that has been assigned to you.

If you renew online, you are still required to mail in two (2) 2x2 photographs as stated above. **Your license will not be renewed until your photos are received.**
Your PIN is: 283200v2

Be sure to keep a copy of this renewal form and your payment for your records. Remember that you are required by law to notify your professional board of any address change within 30 days of the change. You may send address changes to the address in the GENERAL INSTRUCTIONS above. This will help ensure that you receive your next renewal notice in a timely manner.

3. LICENSE RENEWAL AND FEES – Select the type of action you wish to take for your license.

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 your check or money order payable to "Promissor." CASH PAYMENTS WILL NOT BE ACCEPTED.

A.	☒ Renewal **OR** ☐ Paid Inactive Status Request **(SEE #1&2)**	$ 312.00 =	$ 312.00
B.	☐ Cancel License (No Fee) **(SEE #3)**	$ 0.00 =	$
C.	☐ Late Fee (if postmarked after December 31, 2004) **(SEE #4)**	$ 65.00 =	$
D.	☐ Name and/or Address Changed (see reverse side)	$ 20.00 =	$
E.	☐ Duplicate License Request	QTY: ____ x $ 26.00 =	$
		TOTAL FEE DUE =	**$ 312.00**

Make check or money order payable to **Promissor.**
Mail to:
Department of Health
Health Professional Licensing Administration
Board of Medicine – Renewals
825 North Capitol Street, NE
Suite 2224
Washington, D.C. 20002

A Charge of $65.00 will be imposed for dishonored checks (Public Law 89-208)

4. QUESTION 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? **(SEE #5 – MDs/DOs Section)**	Yes ☒ No ☐
B. If so, do you practice in the District of Columbia at all? ❖ If YES, what % of time? _____ %	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.	0 B Code
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.	0 B Code
E. Chiropractors Only – Are you authorized to perform non-invasive ancillary procedures?	Yes ☐ No ☐

SPECIALTIES

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

5. CONTINUING EDUCATION

Check the box below if you have completed the required credit hours to renew your license. These courses must have been completed between 1/1/03 and 12/31/04.
Include the copies of certificates of completion with this application.

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.
SEE # 5 FOR REQUIREMENT DETAILS

Chiropractors ONLY

☐ I have completed the 24 hours of continuing education required to renew my license.
SEE # 5 FOR REQUIREMENT DETAILS

Official Only

District of Columbia
DEPARTMENT OF HEALTH – HEALTH PROFESSIONAL LICENSING ADMINISTRATION
LICENSE RENEWAL APPLICATION

6. NAME CHANGE

If you are changing your name, you must provide legal documentation of the name change. Acceptable documentation for individuals includes a copy of marriage certificate, divorce decree, or court order.

Changed to current name by: ☐ Marriage ☐ Divorce ☐ Court Order

FIRST NAME | MI | LAST NAME | SUFFIX (Jr, Sr, etc.)

M M – D D – Y Y Y Y
DATE OF BIRTH CORRECTION

SSN/FEIN CORRECTION * (Required)

Official Only ☐

7A. HOME ADDRESS CHANGE

☐ APARTMENT ☐ SUITE ☐ FLOOR ☐ PO BOX NUMBER

HOME STREET ADDRESS 1 (If applicable, use this line for additional building information. Otherwise, use this line to indicate STREET NUMBER and STREET NAME)

HOME STREET ADDRESS 2 (If additional space is needed, use this line to indicate STREET NUMBER and STREET NAME)

CITY | E-MAIL (OPTIONAL)

STATE | ZIP CODE + 4 | HOME PHONE NUMBER | HOME FAX NUMBER

7B. BUSINESS ADDRESS CHANGE

Please note: This information will be made available to the public.

COMPANY NAME

☐ APARTMENT ☐ SUITE ☐ FLOOR ☐ PO BOX NUMBER

BUSINESS STREET ADDRESS 1 (If applicable, use this line for additional building information. Otherwise use this line to indicate STREET NUMBER and STREET NAME)

BUSINESS STREET ADDRESS 2 (If additional space is needed, use this line to indicate STREET NUMBER and STREET NAME)

CITY | E-MAIL (OPTIONAL)

STATE | ZIP CODE + 4 | BUS PHONE NUMBER | BUS FAX NUMBER

7C. PREFERRED MAILING ADDRESS

Indicate your preferred mailing address by placing an "X" in the appropriate box. This will be the address to which all future licensing documents will be mailed.

☒ HOME ☐ BUSINESS

8. QUESTIONS – Applicant MUST answer all of the following questions.

Please answer questions A through H by placing an "X" in the appropriate boxes. If you answer "Yes" to questions A through G below, you must provide full information and complete details **on a separate sheet of paper, including copies** of relevant court documents, and attach to this form.

Official Only

A. **Clean Hands Before Receiving a License or Permit Act of 1996 Certification Form Requirement.**

Please read the information below carefully before responding to this yes or no question, as any false information provided requires that the Department of Health proceed immediately to revoke your License or Permit for which you are now applying, and fine you one thousand dollars ($1,000.00), pursuant to D.C. Official Code § 47-2864 (2001).

IF YOU ANSWER "YES" TO THIS QUESTION, PLEASE SUBMIT PROOF OF THE ARRANGEMENTS YOU HAVE MADE TO PAY THE OUTSTANDING DEBT. IF YOU DO NOT HAVE AN APPROVED PAYMENT SCHEDULE TO PAY THE AMOUNT YOU OWE OR IF NO APPEAL IS PENDING, THE LAW REQUIRES THAT YOUR RENEWAL APPLICATION BE DENIED.

As of this date, do you owe more than one hundred dollars ($100.00) to the District of Columbia Government as a result of any of the following: Yes ☐ No ☒ — Y ☐ N ☐

1. Fines, penalties, or interest assessed pursuant to D.C. Official Code Title 8, Chapter 8 (Litter Control Administrative Act of 1985);
2. Fines or interest assessed pursuant to D.C. Official Code Title 8, Chapter 9 (Illegal Dumping Enforcement Act of 1994);
3. Fines, penalties, or interest assessed pursuant to D.C. Official Code Title 2, Chapter 18 (Civil Infractions Act of 1985);
4. Past due taxes;
5. Past due District of Columbia Water and Sewer Authority service fees; or
6. Fines or penalties assessed pursuant to D.C. Official Code Title 50, Chapter 23 (Traffic Adjudication)?

The information presented above is in compliance with the requirement to submit with your 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.)

		Official Only
B. Since your last renewal, have you been convicted or arrested for a crime (other than minor traffic violations) not previously reported to the Board?	YES ☐ NO ☒	☐
C. Since your last renewal: (1) Have you withdrawn an application (in D.C. or any other state/jurisdiction) to practice your profession? (2) Has any authority or peer review board taken adverse action against your license or privileges? (3) Are you currently under investigation or were you investigated by any authority or peer review board for any violation of state, federal, or local law? (4) Has any authority or peer review board informed you of any pending charges(s) or investigation not previously reported to this Board?	YES ☐ NO ☒	☐
D. Do you have a physical or mental condition that currently impairs your ability to practice your profession?	YES ☐ NO ☒	☐
E. Since your last renewal, have you been diagnosed or treated for substance abuse?	YES ☐ NO ☒	☐
F. Since your last renewal, have you been involved in a malpractice suit? (See #6)	YES ☐ NO ☒	☐
G. Have you ever been terminated or asked to resign from employment since the last renewal or since obtaining your license if this is your first renewal?	YES ☐ NO ☒	☐

9. LICENSEE AFFIDAVIT

I hereby attest that the information given in this application, including all writings and exhibits attached hereto, is true and complete to the best of my knowledge. I understand that the making of a false statement on this application, including all writings and exhibits attached hereto, is punishable by criminal penalties.

Official Only ☐

Myron Rose — **LICENSEE SIGNATURE**

MYRON ROSE, M.D. — **LICENSEE NAME (Please print)**

10-27-04 — **DATE**

MDRE120808A11

DISTRICT OF COLUMBIA -- DEPARTMENT OF HEALTH
HEALTH OCCUPATION LICENSE RENEWAL FORM

e information printed Section 1 of this form shows the current information on record for your license. Complete all sections of this form, calculation. If more space is needed to fully answer questions, attach additional sheets. False or misleading statements will be cause for se for criminal prosecution. Mail the form, the required fee, and all supporting documents to: **Department of Health, Health Professional Medicine, 717 14th Street NW, 6th Floor, Washington, D.C. 20005. This form is due back to HPLA by December 31, 2008. Forms nber must contain an additional late fee of $85.00. If you have any questions, call HPLA Customer Service at 1-888-204-6193.**

1. ORMATION

ss changes on the reverse side of this form.

MYRON ROSE

License Number MD4063
***Social Security**
Birth Date

Other Address

*Pursuant to D.C. Official Code Section 3-1205.5 (b) (2001) (Health Occupations Revisions Act), applicants are required to provide a Social Security Number (SSN) on applications for a professional license. Please provide your Social Security Number in Section 5 of this form. If a Social Security Number is not available, a sworn affidavit stating that you do not have a Social Security Number must be submitted on a separate notarized letter.

2. SPECIAL INSTRUCTIONS

- Your license expires December 31, 2008.
- Renewal applications submitted after December 31, 2008 will be required to pay a $85.00 late fee.
- If you are unable to renew your license by December 31, 2008 or within the 60-day late renewal period, you will then be required to apply for reinstatement of your license.
- In addition, you must submit your pictures no later than the 60-day late renewal period. Failure to do so will result in your license lapsing and you will have to apply for reinstatement of your license. **You may not practice your profession in the District of Columbia until you reinstate your license.**
- You may reinstate your license in the District within 5 years of the expiration date of your license. Once the 5-year reinstatement period has ended, you must apply as a new applicant. You will receive a new license number upon approval.

IMPORTANT NOTICE: In compliance with 17 DCMR 4001.1(c), please submit two (2) identical, recent passport-size photographs (2x2 inches in size) on a plain background, which are front-view and fade-proof. The photos must be original photos and cannot be computer-generated copies or paper copies. In addition, we will not accept 3x3 or larger Polaroid - type photos. Please be sure to mail in your two photos and write on the back of the photos your full name and either your license number or Social Security Number. Please send the photos along with your Renewal Application form. Photos will be placed on the pocket license. You will also need to submit one (1) clear photocopy of a government issued photo ID, such as your valid driver's license, as proof of identity. **Your application is not complete and your license will not be renewed until your photos are received.**

INTERNET INSTRUCTIONS: This is a reminder that if you decide to register online, remember to register at: http://www.hpla.doh.dc.gov.

If you renew online, you are still required to mail in two (2) 2x2 photographs as stated above. **Your license will not be renewed until your photos are received.**

Be sure to keep a copy of this renewal form and your payment for your records. Remember that you are required by law to notify your professional board of any address change within 30 days of the change. You may send address changes to the address in the GENERAL INSTRUCTIONS above. This will help ensure that you receive your next renewal notice in a timely manner.

3. LICENSE RENEWAL AND FEES – Select the type of action you wish to take for your license.

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 your check or money order payable to "DC Treasurer" CASH PAYMENTS WILL NOT BE ACCEPTED.

A. ☒ Renewal **OR** ☐ Paid Inactive Status Request

B. Renewal License Fees:

- Medical Doctors or Doctors of Osteopathy = $500.00
- Chiropractors = $203.00
- Chiropractors – Ancillary Procedures = $153.00
- Physician Assistants = $145.00
- Acupuncturists = $145.00
- Surgical Assistants = $145.00
- Anesthesiology Assistants = $145.00
- Naturopathic Physicians = $145.00

Renewal Fee (Select from the list on "B") = $500.00

C. ☐ Cancel License (No Fee) **(SEE #3)** $0.00 = $_____

D. ☐ Late Fee (if postmarked after December 31, 2008) **(SEE #4)** $85.00 = $_____

E. ☐ Name and/or Address Changed *(see reverse side)*

F. ☐ Duplicate License Request QTY: _____ x $34.00 = $_____

TOTAL FEE DUE = $500.00

Make check or money order payable to **DC TREASURER.**
Mail to:
Department of Health
Health Professional Licensing Administration
Board of Medicine – Renewals
717 14th Street NW, 6th Floor
Washington, D.C. 20005

A Charge of $65.00 will be imposed for dishonored checks (Public Law 89-208)

4. QUESTION 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? **(SEE #5 – MDs/DOs Section)**	Yes ☒	No ☐
B. If so, do you practice in the District of Columbia at all? ❖ If YES, what % of time? _____%	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.	0B Code	
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	0B	

SPECIALTIES

AD Administrative Medicine
Surgery
AL Allergy & Immunology
AN Anesthesiology
CO Colon & Rectal Surgery
DE Dermatology
EM Emergency Medicine
OR Orthopedic
OT Otolaryngology
PA Pathology
PE Pediatrics
PH Physical Medicine & Rehabilitation

E. Chiropractors Only – Are you authorized to perform non-invasive ancillary procedures?	Yes ☐ No ☐	IN Internal Medicine MG Medical Genetics NE Neurological Surgery NU Nuclear Medicine OB Obstetrics & Gynecology OP Ophthalmology PR Preventive Medicine/ Public Health PS Psychiatry & Neurology RA Radiology SU Surgery TH Thoracic Surgery UR Urology

5. CONTINUING EDUCATION

Check the box below if you have completed the required credit hours to renew your license. These courses must have been completed between 1/1/07 and 12/31/08.

Physician Assistants ONLY	Chiropractors ONLY	Official Only
☐ I have completed the 40 hours of Category I and 60 hours of Category II continuing education required to renew my license. **SEE # 5 FOR REQUIREMENT DETAILS**	☐ I have completed the 24 hours of continuing education required to renew my license. **SEE # 5 FOR REQUIREMENT DETAILS**	☐☐☐.☐

MD and DO ONLY

		Official Only Yes	Official Only No
1. I have completed 50 hours of AMA or AOA- approved CME since January 1, 2007.	☒	☐	☐
2. I am exempt from the CME requirement because I am deployed in the armed forces or serving in the US congress.	☐	☐	☐
3. I am exempt because I elected inactive status and understand that I can not practice in the District of Columbia.	☐	☐	☐
4. I am exempt because this is my first renewal of a license obtained by examination.	☐	☐	☐
5. I am exempt because I was enrolled in a ACGME or AOA – approved postgraduate training program during the past two years.	☐	☐	☐
6. The Board exempted me due to disability (copy of exemption letter attached).	☐	☐	☐
7. I have not completed the required 50 hours of CME since January 1, 2007	☐	☐	☐

SECTION 6 NAME CHANGE

If you are changing your name, you must provide legal documentation of the name change. Acceptable documentation for individuals includes a copy of marriage certificate, divorce decree, or court order.

Changed to current name by: ☐ Marriage ☐ Divorce ☐ Court Order

FIRST NAME | MI | LAST NAME | SUFFIX (Jr, Sr, etc.)

M M – D D – Y Y Y Y
DATE OF BIRTH CORRECTION

SSN/FEIN CORRECTION * (Required)

OFFICE USE ONLY ☐

SECTION 7A HOME ADDRESS CHANGE

☐ APARTMENT ☐ SUITE ☐ FLOOR ☐ PO BOX NUMBER

HOME STREET ADDRESS 1 (If applicable, use this line for additional building information. Otherwise, use this line to indicate STREET NUMBER and STREET NAME)

HOME STREET ADDRESS 2 (If additional space is needed, use this line to indicate STREET NUMBER and STREET NAME)

CITY | E-MAIL (OPTIONAL)

STATE | ZIP CODE + 4 | HOME PHONE NUMBER | HOME FAX NUMBER

SECTION 7B BUSINESS ADDRESS CHANGE

Please note: This information will be made available to the public.

COMPANY NAME

☐ APARTMENT ☐ SUITE ☐ FLOOR ☐ PO BOX NUMBER

BUSINESS STREET ADDRESS 1 (If applicable, use this line for additional building information. Otherwise use this line to indicate STREET NUMBER and STREET NAME)

BUSINESS STREET ADDRESS 2 (If additional space is needed, use this line to indicate STREET NUMBER and STREET NAME)

CITY | E-MAIL (OPTIONAL)

STATE | ZIP CODE + 4 | BUS PHONE NUMBER | BUS FAX NUMBER

Indicate your preferred mailing address by placing "X" in the appropriate box. This will be the address to which all future licensing documents will be mailed.

☒ HOME ☐ BUSINESS

DISTRICT OF COLUMBIA – DEPARTMENT OF HEALTH
HEALTH OCCUPATION LICENSE RENEWAL FORM

SECTION 8. QUESTIONS – Applicants MUST answer all of the following questions.

Please answer questions A through H by placing an "X" in the appropriate boxes. If you answer "Yes" to questions A through G below, you must provide full information and complete details on a separate sheet of paper, including copies of relevant court documents, and attach to this form.

OFFICE USE ONLY

A. **Clean Hands Before Receiving a License or Permit Act of 1996 Certification Form Requirement.**

Please read the information below carefully before responding to this yes or no question, as any false information provided requires that the Department of Health proceed immediately to revoke your License or Permit for which you are now applying, and fine you one thousand dollars ($1,000.00), pursuant to D.C. Official Code § 47-2864 (2001).

IF YOU ANSWER "YES" TO THIS QUESTION, PLEASE SUBMIT PROOF OF THE ARRANGEMENTS YOU HAVE MADE TO PAY THE OUTSTANDING DEBT. IF YOU DO NOT HAVE AN APPROVED PAYMENT SCHEDULE TO PAY THE AMOUNT YOU OWE OR IF NO APPEAL IS PENDING, THE LAW REQUIRES THAT YOUR APPLICATION BE DENIED.

As of this date, do you owe more than one hundred dollars ($100.00) to the District of Columbia Government as a result of any of the following: Yes ☐ No ☒

1. Fines, penalties, or interest assessed pursuant to D.C. Official Code Title 8, Chapter 8 (Litter Control Administrative Act of 1985);
2. Fines or interest assessed pursuant to D.C. Official Code Title 8, Chapter 9 (Illegal Dumping Enforcement Act of 1994);
3. Fines, penalties, or interest assessed pursuant to D.C. Official Code Title 2, Chapter 18 (Civil Infractions Act of 1985);
4. Past due taxes;
5. Past due District of Columbia Water and Sewer Authority service fees; or
6. Fines or penalties assessed pursuant to D.C. Official Code Title 50, Chapter 23 (Traffic Adjudication)?

The information presented above is in compliance with the requirement to submit with your 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.).

Y ☐ N ☐

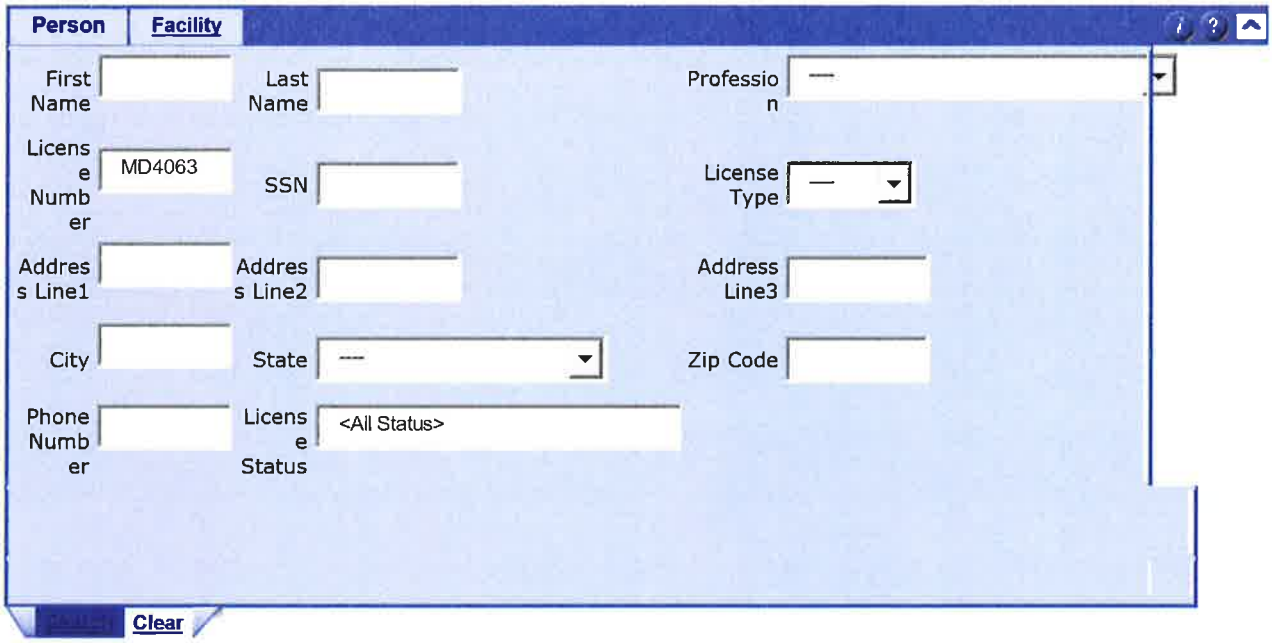
	YES	NO	OFFICE USE ONLY
B. Since your last renewal, have you been convicted or arrested for a crime or misdemeanor (other than minor traffic violations) not previously reported to the Board?	☐	☒	☐
C. Since your last renewal:			
(1) Have you withdrawn an application for licensure/certification/registration to practice your profession in any jurisdiction?	☐	☒	
(2) Has any authority or peer review board taken adverse action against your license or privileges?	☐	☒	☐
(3) Have you been or are you currently being investigated by any authority or peer review board for any violation of state, federal, or local law?	☐	☒	
(4) Has any authority or peer review board informed you of any pending charge(s) or investigation not previously reported to this Board?	☐	☒	
D. Do you have a physical or mental condition that currently impairs your ability to practice your profession?	☐	☒	☐
E. Since your last renewal, have you been diagnosed or treated for substance abuse?	☐	☒	☐
F. Since your last renewal, have you been involved in a malpractice suit? If yes, provide date of incident, allegation, and disposition of case	☐	☒	☐
G. Since your last renewal, have you ever been terminated or asked to resign from employment?	☐	☒	☐
H. Do you currently practice your profession in the District of Columbia?	☐	☒	☐
I. I have completed the continuing education that is required for renewal or indicated why I am exempt on Section 6.	☒	☐	☐

SECTION 9. LICENSEE AFFIDAVIT

I hereby attest that the information given in this application, including all writings and exhibits attached hereto, is true and complete to the best of my knowledge. I understand that the making of a false statement on this application, including all writings and exhibits attached hereto, is punishable by criminal penalties.

LICENSEE SIGNATURE	LICENSEE NAME (Please print)	DATE	OFFICE USE ONLY
Myron Rose M.D.	MYRON ROSE, M.D.	12/04/08	


DL
Class C
Driver's License
Maryland
LIC #:
MYRON ROSE
BIRTH DATE:
EXPIRES: 09-19-2010
Sex: M HT: 6-00 WT 185
Restr: Type N
Issue Date 05-04-2005
09-19-1936



Search Results Page 1 of 1

Name / License Type	Address	Subtype	License Number	Hold/Alert	Issue Date	Expiration Date	License
ROSE, MYRON **MEDICINE AND SURGERY**	Unknown NA 00000		MD4063		10/11/1968	12/31/2010	Expi

All Licenses held by - ROSE, MYRON

License Type	Address	Sub Type	License Number	Hold/Alert	Status
MEDICINE AND SURGERY	Unknown NA 00000		MD4063		Expired
MEDICINE AND SURGERY	Unknown NA 00000		MD043975		Active
CONTROLLED SUBSTANCE	CAPITAL WOMEN'S SERVICES Washington DC 20011	Practitioner - Physician	CS1700591		Active

Archive | Reinstate | Complaints

Person

First Name:	MYRON
Middle Name:	
Last Name:	ROSE
Suffix:	
Date of Birth:	
Place Of Birth:	
Gender:	M
SSN:	
Address Line	
Address Line 2:	
Address Line 3:	
Address Line 4:	
Date Deceased:	
Registration Code:	23112511

License

License Number:	MD4063
License Type:	MEDICINE AND SURGERY
Renewal Id:	
Profession:	MEDICINE
Sub Type:	
Date This Status:	02/25/2016
Status:	Expired
Effective Date:	01/01/2009
Reason Changed:	Expired
Expiration Date:	12/31/2010
Issue Date:	10/11/1968
from Country:	
State/Prov:	
Application Recd Date:	
Obtained By:	National Examination (English)
Reinstatment App Recd Date:	
Date Last Renewal:	12/08/2008
Disciplinary Limit Flag:	N
Last Reprint Date:	

Facility

Full Name:	MYRON ROSE
PersonId:	96380
Owner/Manager:	
Address Line1:	
Address Line2:	
Address Line3:	
Address Line4:	

Practice Information

Details

In Active Practice Now?:	
Practice In DC:	
Active Practice in DC: Hours per week?:	

Alias

Last Name	Date Changed	Alias Type Label
No Data		

Employers for License

No Data

License Bond

No Data

Specialties

Authority Code Label	Is Primary	Issue Date	Expiration Date
Obstetrics & Gynecology - Board Cert			

Employment

No Data

Education

School Name	School Type	Date Graduated	Degree Certificate
University of Missouri	College / University	06/01/1967	Doctorate

Requirements

Name	Status	Date
No Data		

CE Credits By Cycle

No Data

Prerequisites

Name	License Type	License Number	Status
No Data			

Schedules

No Data

Inspection

No Data

CBC Override

Details

Date to Override:	Comments:
No Data	

Exam

Exam Date	Exam State	Exam Type Label	Exam Score
No Data			

Inital/Renewal Question Answers

Group Name	Group Response
No Data	

Person Photo ID

Criminal Background Check

Details

FBI Result	FBI Result Date	State Result	State Result Date
Negative	08/22/2016	Negative	08/23/2016

Person Or Facility Document

Date Uploaded	Description	Category	Amendments
01/30/2015		Person	N
02/25/2016		Person	N

Summary

Name	Address	License Type	License Number	License Status
MYRON ROSE	Unknown NA 00000	MEDICINE AND SURGERY	MD4063	Expired

License Summary

Profession	License Type	License Number	Status	from Country	State/Prov	Obtained By	Issue Date
MEDICINE	MEDICINE AND SURGERY	MD4063	Expired			National Examination (English)	10/11/1968

Remarks List

Date Last updated	Remarks	Updated By
03/28/2003 10:06:06 AM	3/2/10 SC Boar dof Med 110 Centerview Dr Ste 306 P O B 12517 Columbia SC 29211 arw 4/8/13 NC Board of Medical P O Box 20007 Raleigh NC arw 06/12/07 - Verification sent to Georgia Board -- MG Jul 21, 1998 NEW LICENSE Created new license DC faxed approval 7-21-98, Batch #-86866....VBW Dec 15, 1998 1999 RENEWAL BTRS Record 131227-29: Changed Home Address. Added Business Address. Renewed License, Batched MDLICPRT. Dec 01, 2000 RENEWAL/ADDRESS ADDRESS CHANGE VIA TO FAX/ALSO REQUESTED THAT A RENEWAL FORM BE SENT OUT TO THIS INDIVIDUAL.....SMB Dec 04, 2000 PRINT RENEWAL print renewal on 12/04/00...ls Dec 28, 2000 RENEWAL REQUEST caller statesd he requested renewal once before one was never sent out , renewal requested on log sheet plus in arms....LD Dec 29, 2000 PRINT RENEWAL mail renewal on 12/29/00...lsmall Jan 11, 2001 RENEWAL BTRS Record 265638-12: Inserted Flag DCPRACTICE. Added Authority SU. Changed Business Address. Changed Preferred Mailing Address Flag to BUSINESS. License Renewed , Batched MDLICPRT. Feb 16, 2001 LIC REPRINT caller stated he never rec'vd his lic/submitted another request for a lic reprint....jm Feb 19, 2001 DUPLICATE LICENSE REQUEST Batch #265638-12 was entered and closed in BTRS by another processor, according to ARMS license was mailed out on 01/11/01, license wasn't received, request duplicate print ..... KDD Feb 21, 2001 LICENSE PRINT per D. Smith, single printing license to be express out today, licensee is up for review by employer tomorrow, will send out license once it is brought to me...fam. Feb 26, 2001 ESCALATED CALL never received any prints sent....ds Feb 27, 2001 UPSET CALLER caller wanted to speak with Derrick Smith/stated to caller Derrick was on another line/caller wanted to hold/stated to caller I would give the message to D.S.; per D.S. stated as soon as he rec've the lic in his had he would mail it out to Dr. Zulu....jm Mar 01, 2001 LICPRT SENT mailed out.....ds Nov 22, 2002 RENEWAL BTRS Record 389309-5: Added Authority SUA. Added Home Address. License Renewed , Batched MDLICPRT.	

Enforcement Status

Medical Case Log – Pending Action – License MD043975

Rose, Myron - Maryland action 11/29/16 - failed CME audit – Date 8/7/2017 - Bd voted fine via CO. To Bd 11/29/17. CME recd 11/16/17. CME audit ltr sent 10/13/17. Date 11/29/2017- Status – pending reciprocal action by the DC board.

There have been no complaints on record for Dr. Myron Rose.