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UA UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE

Uniform Application – Core Application

Applicant: Follow the instructions given in the left sidebar of each page.
Send this application to the Kansas State Board of Healing Arts,
800 SW Jackson, Lower Level - Suite A, Topeka, KS 66612

Indicate your full legal name and any other names you have used in the past. If your name has changed at any time during your life and you are not using FCVS, you must submit a copy of the legal document (marriage certificate, divorce decree, etc.) supporting your name change to the Board.

Full Name

Last name: BROSELOW Suffix: MD
First name: ANDREW
Middle name: MARTIN
Maiden name (if applicable):
All other names used/identified as:

Degree Type ☒ M.D. ☐ D.O.

Please complete all fields and indicate which address you want to use for public access and at which address you want to receive mailings from the Board. State laws vary on which address or phone number is or is not a matter of public record. Additionally, many state boards publish the Public Access address on their web sites. You may wish to contact the appropriate state licensing authority to determine which information will be a matter of public record.

Practice Address

☒ Public Access
☒ Mailings for Medical Board

Street: 619 NW 23rd
City: OKLAHOMA CITY
State/Province: OKLAHOMA
Zip code: 73103 Country: U.S.A.
Practice phone: 405-528-0221 Practice fax:
Alternate phone: Alternate fax:
Practice email: [redacted]

Home Address

☐ Public Access
☒ Mailings for Medical Board

Street: [redacted]
City: Choctaw
State/Province: OKLAHOMA
Zip code: 73020 Country: USA
Home phone: [redacted] Home fax:
Alternate phone: Alternate fax:
Home email: [redacted]

If you are not using FCVS, you must submit one of the following to the Board: certified birth certificate, notarized copy of your birth certificate, original valid passport, or notarized copy of your current valid passport. Please check the state specific instructions for more information.

Identification

Date of birth: [redacted]967 (mm/dd/yyyy) Gender: M Birth city: Philadelphia
Birth state/province: PA Birth country: US
Social Security number* [redacted] (9 digits) NPI number**: 1619930328 (10 digits) U.S. Citizen? ☒ Yes ☐ No

Be sure to list your name at the top of each following page.

*Your social security number is required to facilitate reporting to the federal Healthcare Integrity & Protection Data Bank (42 U.S.C. Sections 1320a-7e(b), 5 U.S.C. Section 552a, and 45 C.F.R. pt. 61) and for accurate identification under the federal and state child support enforcement law (42 U.S.C. Section 666 and applicable state law). It may also be used for reporting to the National Practitioner Data Bank (42 U.S.C. Section 11101 and 45 C.F.R. pt. 60) and for other investigative/enforcement purposes in compliance with state laws governing physician discipline or as otherwise required by state or federal law.

**The National Provider Identifier (NPI) is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. For more information on the NPI, visit http://www.cms.hhs.gov/NationalProvIdentStand/

Applicant Name: Andrew Martin Broselow, MD

List all medical schools you have attended, even those from which you did not graduate, in chronological order. Please copy and attach additional pages if necessary.

If you are not using FCVS, you must complete the Medical Education Verification form and send it to all medical schools you have attended. Include a copy of your diploma to which the medical school must attach their seal prior to forwarding it to the Board.

Additionally, the medical school must provide the Board with an official copy of your transcripts. If transcripts are not in English, an original, certified, and official English translation is required.

If you attended a Fifth Pathway program and are not using FCVS, you must complete the Fifth Pathway Verification form and send it to your medical school and to the institution where you completed your rotations. You must include a copy of your diploma. The medical School and institution must forward all documentation directly to the Board.

If ECFMG is applicable and you are not using FCVS, contact ECFMG and have a certified status report forwarded from them to the Board. There is a separate fee for this report.

Medical School

1. Full Name of Medical School: Texas Tech University Health Sciences Center

   Street: 3601 4th Street

   City: Lubbock State/Province: TX Zip code: 79430

   Country: US Attendance dates: From 8/91 (mm/yyyy) to 5/95 (mm/yyyy)

   Date degree conferred/issued (indicate if not applicable): MD, 5/95 (mm/dd/yyyy)

   Degree received (as stated on diploma): MD (indicate if not applicable)

2. Full Name of Medical School: _____

   Street: _____

   City: _____ State/Province: _____ Zip code: _____

   Country: _____ Attendance dates: From _____ (mm/yyyy) to _____ (mm/yyyy)

   Date degree conferred/issued (indicate if not applicable): _____ (mm/dd/yyyy)

   Degree received (as stated on diploma): _____ (indicate if not applicable)

Fifth Pathway

☒ I did not participate in a Fifth Pathway program.

Affiliated medical school that awarded the Fifth Pathway Certification

Full Name of Medical School: _____

Street: _____

City: _____ State/Province: _____ Zip code: _____

Country: _____ Attendance dates: From _____ (mm/yyyy) to _____ (mm/yyyy)

Date degree conferred/issued: _____ (mm/dd/yyyy) Degree (as stated on diploma): _____

Hospital or clinic in which you performed the required rotations

Institution name: _____

Rotation dates: From _____ (mm/yyyy) to _____ (mm/yyyy) Certificate date: _____ (mm/dd/yyyy)

ECFMG

☒ I do not have an ECFMG certificate.

Certificate number: _____ Issue date: _____ (mm/dd/yyyy)

Applicant Name: Andrew Morton Broselow, MD

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List the information for each licensure exam you have taken, whether U.S. or international (USMLE, LLMCC, NBME, etc.).

If you are not using FCVS, you must contact the appropriate examination entity and have them send a certified transcript of your scores directly to the Board.

Examination History

Examination	Most recent date taken (mm/yyyy)	Passed/Failed/Unknown	Number of attempts
FLEX Pre-1985		☐ (P) ☐ (F) ☐ (U)	
FLEX Component 1		☐ (P) ☐ (F) ☐ (U)	
FLEX Component 2		☐ (P) ☐ (F) ☐ (U)	
LMCC – Single		☐ (P) ☐ (F) ☐ (U)	
LMCC – Part I		☐ (P) ☐ (F) ☐ (U)	
LMCC – Part II		☐ (P) ☐ (F) ☐ (U)	
NBME Part I		☐ (P) ☐ (F) ☐ (U)	
NBME Part II		☐ (P) ☐ (F) ☐ (U)	
NBME Part III		☐ (P) ☐ (F) ☐ (U)	
SPEX		☐ (P) ☐ (F) ☐ (U)	
NBOME Part I		☐ (P) ☐ (F) ☐ (U)	
NBOME Part II		☐ (P) ☐ (F) ☐ (U)	
NBOME Part III		☐ (P) ☐ (F) ☐ (U)	
COMLEX-USA Level 1		☐ (P) ☐ (F) ☐ (U)	
COMLEX-USA Level 2, CE		☐ (P) ☐ (F) ☐ (U)	
COMLEX-USA Level 2, PE		☐ (P) ☐ (F) ☐ (U)	
COMLEX-USA Level 3		☐ (P) ☐ (F) ☐ (U)	
COMVEX		☐ (P) ☐ (F) ☐ (U)	
USMLE Step I	1990's - on FCVS	☑ (P) ☐ (F) ☐ (U)	
USMLE Step II, CS		☑ (P) ☐ (F) ☐ (U)	
USMLE Step II, CK		☐ (P) ☐ (F) ☐ (U)	
USMLE Step III		☑ (P) ☐ (F) ☐ (U)	
State Board Exam			
State:		☐ (P) ☐ (F) ☐ (U)	
State:		☐ (P) ☐ (F) ☐ (U)	
State:		☐ (P) ☐ (F) ☐ (U)	
State:		☐ (P) ☐ (F) ☐ (U)	

List all state and Canadian provinces where you currently hold or have ever held any type of health care related license. Please copy and attach additional pages if necessary.

You must also complete the Licensure Verification form and send it to all states in which you have held any health care license or certification. Some state boards charge a fee for this information. The verifying entity must forward all licensure documentation to the Board.

State/Province Professional Licensure

1. Practitioner license type: ☒ Full license ☐ Temporary ☐ Training ☐ Limited

☒ Doctor of Medicine
☐ Doctor of Osteopathic Medicine
☐ Doctor of Dental Surgery
☐ Doctor of Dental Medicine
☐ Doctor of Psychology
☐ Doctor of Podiatric Medicine
☐ Doctor of Chiropractic
☐ Nurse Practitioner
☐ Licensed Practical Nurse
☐ Registered Nurse
☐ Physician Assistant
☐ Emergency Medical Technician
☐ Other (please specify) _____

State/Province: Texas License number: K3559 Issue date: 1997

License status: ☒ Active ☐ Inactive ☐ Restricted ☐ Expired ☐ Limited ☐ Retired ☒ In Good Standing ☐ Probationary ☐ Revoked ☐ Suspended

Applicant Name: Andrew Marton Broselow, MD

Please copy and attach additional pages if necessary.

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2. Practitioner license type: ☒ Full license ☐ Temporary ☐ Training ☐ Limited

☒ Doctor of Medicine
☐ Doctor of Osteopathic Medicine
☐ Doctor of Dental Surgery
☐ Doctor of Dental Medicine
☐ Doctor of Psychology
☐ Doctor of Podiatric Medicine
☐ Doctor of Chiropractic
☐ Nurse Practitioner
☐ Licensed Practical Nurse
☐ Registered Nurse
☐ Physician Assistant
☐ Emergency Medical Technician
☐ Other (please specify) _____

State/Province: OK License number: 30150 Issue date: 8/15

License status: ☒ Active ☐ Inactive ☐ Restricted ☐ Expired ☐ Limited ☐ Retired ☒ In Good Standing ☐ Probationary ☐ Revoked ☐ Suspended

3. Practitioner license type: ☐ Full license ☐ Temporary ☐ Training ☐ Limited

☐ Doctor of Medicine
☐ Doctor of Osteopathic Medicine
☐ Doctor of Dental Surgery
☐ Doctor of Dental Medicine
☐ Doctor of Psychology
☐ Doctor of Podiatric Medicine
☐ Doctor of Chiropractic
☐ Nurse Practitioner
☐ Licensed Practical Nurse
☐ Registered Nurse
☐ Physician Assistant
☐ Emergency Medical Technician
☐ Other (please specify) _____

State/Province: _____ License number: _____ Issue date: _____

License status: ☐ Active ☐ Inactive ☐ Restricted ☐ Expired ☐ Limited ☐ Retired ☐ In Good Standing ☐ Probationary ☐ Revoked ☐ Suspended

4. Practitioner license type: ☐ Full license ☐ Temporary ☐ Training ☐ Limited

☐ Doctor of Medicine
☐ Doctor of Osteopathic Medicine
☐ Doctor of Dental Surgery
☐ Doctor of Dental Medicine
☐ Doctor of Psychology
☐ Doctor of Podiatric Medicine
☐ Doctor of Chiropractic
☐ Nurse Practitioner
☐ Licensed Practical Nurse
☐ Registered Nurse
☐ Physician Assistant
☐ Emergency Medical Technician
☐ Other (please specify) _____

State/Province: _____ License number: _____ Issue date: _____

License status: ☐ Active ☐ Inactive ☐ Restricted ☐ Expired ☐ Limited ☐ Retired ☐ In Good Standing ☐ Probationary ☐ Revoked ☐ Suspended

5. Practitioner license type: ☐ Full license ☐ Temporary ☐ Training ☐ Limited

☐ Doctor of Medicine
☐ Doctor of Osteopathic Medicine
☐ Doctor of Dental Surgery
☐ Doctor of Dental Medicine
☐ Doctor of Psychology
☐ Doctor of Podiatric Medicine
☐ Doctor of Chiropractic
☐ Nurse Practitioner
☐ Licensed Practical Nurse
☐ Registered Nurse
☐ Physician Assistant
☐ Emergency Medical Technician
☐ Other (please specify) _____

State/Province: _____ License number: _____ Issue date: _____

License status: ☐ Active ☐ Inactive ☐ Restricted ☐ Expired ☐ Limited ☐ Retired ☐ In Good Standing ☐ Probationary ☐ Revoked ☐ Suspended

Applicant Name: Andrew Martin Broselow, MD

List all postgraduate programs you have attended, even those you did not complete. Please copy and attach additional pages if necessary.

If you are not using FCVS, you must complete the Postgraduate Training Verification form and send it to all postgraduate training programs you have attended. You must submit a copy of your certificate of program completion to the Board. The postgraduate program must forward all documentation directly to the Board.

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Postgraduate Training

1. Full Name of Hospital: John Peter Smith Hospital
Street: 1500 S. Main St
City: Fort Worth State/Province: TX Zip code: 76104
Country: U.S. Department/Specialty: OB/Gyn
Affiliated medical school name:
Attendance dates: From 7/95 (mm/yyyy) to 6/99 (mm/yyyy) Postgraduate year (e.g., 1, 2, 3, etc.): 1-4

☐ Chief Resident	☐ Internship/Residency	☒ Residency	☐ Transitional
☐ Fellowship	☐ Junior Registrar	☐ Residency/Chief Residency	
☐ Fellowship/Research	☐ Preliminary	☐ Senior House Officer	☐ Unknown
☐ House Officer	☐ Registrar	☐ Senior Registrar	☐ Unspecified
☒ Internship	☐ Research	☐ Other:	

Successfully completed? ☒ Yes ☐ No ☐ In progress; expected completion in (mm/yyyy)

2. Full Name of Hospital:
Street:
City: State/Province: Zip code:
Country: Department/Specialty:
Affiliated medical school name:
Attendance dates: From (mm/yyyy) to (mm/yyyy) Postgraduate year (e.g., 1, 2, 3, etc.):

☐ Chief Resident	☐ Internship/Residency	☐ Residency	☐ Transitional
☐ Fellowship	☐ Junior Registrar	☐ Residency/Chief Residency	
☐ Fellowship/Research	☐ Preliminary	☐ Senior House Officer	☐ Unknown
☐ House Officer	☐ Registrar	☐ Senior Registrar	☐ Unspecified
☐ Internship	☐ Research	☐ Other:	

Successfully completed? ☐ Yes ☐ No ☐ In progress; expected completion in (mm/yyyy)

3. Full Name of Hospital:
Street:
City: State/Province: Zip code:
Country: Department/Specialty:
Affiliated medical school name:
Attendance dates: From (mm/yyyy) to (mm/yyyy) Postgraduate year (e.g., 1, 2, 3, etc.):

☐ Chief Resident	☐ Internship/Residency	☐ Residency	☐ Transitional
☐ Fellowship	☐ Junior Registrar	☐ Residency/Chief Residency	
☐ Fellowship/Research	☐ Preliminary	☐ Senior House Officer	☐ Unknown
☐ House Officer	☐ Registrar	☐ Senior Registrar	☐ Unspecified
☐ Internship	☐ Research	☐ Other:	

Successfully completed? ☐ Yes ☐ No ☐ In progress; expected completion in (mm/yyyy)

Applicant Name: Andrew Martin Broselow, MD

List ALL activities (medical, non-medical, and postgraduate training) in chronological order beginning with medical school graduation to the PRESENT date, indicating month and year.

*Also list your permanent or home address for each non-working time.

If you worked for a physician-staffing group or did locum tenens, you must list all facilities where you worked and include complete dates and addresses.

DO NOT SUBSTITUTE ANY OTHER RESUME FOR THIS SECTION.

Copy and attach additional pages as necessary.

** Clinical indicates the percentage of time spent with patients.

*** Administrative indicates the percentage of time spent on administrative tasks like paperwork, etc.

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Chronology of Activities

1. Start date: ~~6/1999~~ 6/1995 (mm/yyyy) End date: 8/1999 (mm/yyyy)

Type of Activity: ☐ Health activity (non-working time due to health reasons) ☐ Military service ☒ Postgraduate training/education ☐ Seeking employment ☐ Vacation ☐ Work

Practice/Employment Name **or** Description of non-working time*: Residency

Street: 1500 S main

City: Fort Worth State/Province: TX Zip code: 76104

Country: US Position: Resident

Department: Ob/Gyn Clinical**: 100% Administrative***: ____%

☒ Employment ☐ Staff Privileges ☐ Affiliation

☒ Other (describe your relationship with this institution): Resident

2. Start date: 8/1999 (mm/yyyy) End date: 8/2009 (mm/yyyy)

Type of Activity: ☐ Health activity (non-working time due to health reasons) ☐ Military service ☐ Postgraduate training/education ☐ Seeking employment ☐ Vacation ☒ Work

Practice/Employment Name **or** Description of non-working time*: Covenant Medical Group

Street: 3420 23rd place

City: Lubbock State/Province: TX Zip code: 79410

Country: US Position: Physician

Department: Ob/Gyn Clinical**: 100% Administrative***: ____%

☒ Employment ☒ Staff Privileges ☐ Affiliation

☐ Other (describe your relationship with this institution): ____

3. Start date: 9/2009 (mm/yyyy) End date: 6/2010 (mm/yyyy)

Type of Activity: ☐ Health activity (non-working time due to health reasons) ☐ Military service ☐ Postgraduate training/education ☐ Seeking employment ☐ Vacation ☒ Work

Practice/Employment Name **or** Description of non-working time*: Texoma Care

Street: 5012 S US Hwy 75

City: Denison, TX State/Province: TX Zip code: 75020

Country: US Position: Physician

Department: Ob/Gyn Clinical**: 100% Administrative***: ____%

☒ Employment ☒ Staff Privileges ☐ Affiliation

☐ Other (describe your relationship with this institution): ____

Applicant Name: Andrew Martin Broselow, MD

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Copy and attach additional pages as necessary.

4. Start date: 8/2010 (mm/yyyy) End date: 8/2013 (mm/yyyy)

Type of Activity: ☐ Health activity (non-working time due to health reasons) ☐ Military service ☐ Postgraduate training/education ☐ Seeking employment ☐ Vacation ☒ Work

Practice/Employment Name **or** Description of non-working time*: Hopkins County Memorial Hospital

Street: 115 Airport Road

City: Sulphur Springs State/Province: TX Zip code: 75482

Country: US Position: Physician, Chief of Department

Department: Ob/Gyn Clinical**: 90% Administrative***: 10 %

☒ Employment ☒ Staff Privileges ☐ Affiliation

☐ Other (describe your relationship with this institution):

5. Start date: 11/2013 (mm/yyyy) End date: 3/2014 (mm/yyyy)

Type of Activity: ☒ Health activity (non-working time due to health reasons) ☐ Military service ☐ Postgraduate training/education ☐ Seeking employment ☐ Vacation ☐ Work

Practice/Employment Name **or** Description of non-working time*: Fell out of attic, fracturing my femur and shoulder

Street:

City: State/Province: Zip code:

Country: Attached Position:

Department: Clinical**: ___% Administrative***: ___%

☐ Employment ☐ Staff Privileges ☐ Affiliation

☐ Other (describe your relationship with this institution):

6. Start date: 3/2014 (mm/yyyy) End date: 7/2014 (mm/yyyy)

Type of Activity: ☐ Health activity (non-working time due to health reasons) ☐ Military service ☐ Postgraduate training/education ☐ Seeking employment ☐ Vacation ☒ Work

Practice/Employment Name **or** Description of non-working time*: Midwest Regional Hospital

Street: 2825 Parklawn Dr

City: Midwest City State/Province: Ok Zip code: 73110

Country: US Position: Physician

Department: Ob/Gyn Clinical**: 100% Administrative***: ___%

☒ Employment ☒ Staff Privileges ☐ Affiliation

☐ Other (describe your relationship with this institution):

Please copy and attach additional pages as necessary.

Applicant Name: Andrew Martin Broselow, MD

Copy and attach additional pages as necessary.

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4. Start date: 8/2010 (mm/yyyy) End date: 8/2013 (mm/yyyy)

Type of Activity: ☐ Health activity (non-working time due to health reasons) ☐ Military service ☐ Postgraduate training/education ☐ Seeking employment ☐ Vacation ☒ Work

Practice/Employment Name or Description of non-working time*: Hopkins County Memorial Hospital

Street: 115 Airport Road

City: Sulphur Springs State/Province: TX Zip code: 75482

Country: US Position: Physician, Chief of Department

Department: Ob/Gyn Clinical**: 90% Administrative***: 10 %

☒ Employment ☒ Staff Privileges ☐ Affiliation

☐ Other (describe your relationship with this institution):

5. Start date: 11/2013 (mm/yyyy) End date: 3/2014 (mm/yyyy)

Type of Activity: ☒ ~~Health activity (non-working time due to health reasons)~~ ☐ Military service ☐ Postgraduate training/education ☐ Seeking employment ☐ Vacation ☐ Work

Practice/Employment Name or Description of non-working time*: Fell out of attic, fracturing my femur and shoulder

Street: 13127 Red Oak Dr

City: Choctaw State/Province: OK Zip code: 73020

Country: Position:

Department: Clinical**: ___% Administrative***: ___%

☐ Employment ☐ Staff Privileges ☐ Affiliation

☐ Other (describe your relationship with this institution):

6. Start date: 3/2014 (mm/yyyy) End date: 7/2014 (mm/yyyy)

Type of Activity: ☐ Health activity (non-working time due to health reasons) ☐ Military service ☐ Postgraduate training/education ☐ Seeking employment ☐ Vacation ☒ Work

Practice/Employment Name or Description of non-working time*: Midwest Regional Hospital

Street: 2825 Parklawn Dr

City: Midwest City State/Province: OK Zip code: 73110

Country: US Position: Physician

Department: Ob/Gyn Clinical**: 100% Administrative***: ___%

☒ Employment ☒ Staff Privileges ☐ Affiliation

☐ Other (describe your relationship with this institution):

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Please copy and attach additional pages as necessary.

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Applicant Name: Andrew Martin Broselow, MD

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Copy and attach additional pages as necessary.

4. Start date: 8/2010 (mm/yyyy) End date: 8/2013 (mm/yyyy)

Type of Activity: ☐ Health activity (non-working time due to health reasons) ☐ Military service ☐ Postgraduate training/education ☐ Seeking employment ☐ Vacation ☒ Work

Practice/Employment Name or Description of non-working time*: Hopkins County Memorial Hospital

Street: 115 Airport Road

City: Sulphur Springs State/Province: TX Zip code: 75482

Country: US Position: Physician, Chief of Department

Department: Ob/Gyn Clinical**: 90% Administrative***: 10 %

☒ Employment ☒ Staff Privileges ☐ Affiliation

☐ Other (describe your relationship with this institution):

5. Start date: 11/2013 (mm/yyyy) End date: 3/2014 (mm/yyyy)

Type of Activity: ☒ Health activity (non-working time due to health reasons) ☐ Military service ☐ Postgraduate training/education ☐ Seeking employment ☐ Vacation ☐ Work

Practice/Employment Name or Description of non-working time*: Fell out of attic, fracturing my femur and shoulder

Street:

City: State/Province: Zip code:

Country: Position:

Department: Clinical**: % Administrative***: %

☐ Employment ☐ Staff Privileges ☐ Affiliation

☐ Other (describe your relationship with this institution):

6. Start date: 3/2014 (mm/yyyy) End date: 7/2014 (mm/yyyy)

Type of Activity: ☐ Health activity (non-working time due to health reasons) ☐ Military service ☐ Postgraduate training/education ☐ Seeking employment ☐ Vacation ☒ Work

Practice/Employment Name or Description of non-working time*: Midwest Regional Hospital

Street: 2825 Parklawn Dr

City: Midwest City State/Province: Ok Zip code: 73110

Country: US Position: Physician

Department: Ob/Gyn Clinical**: 100% Administrative***: %

☒ Employment ☒ Staff Privileges ☐ Affiliation

☐ Other (describe your relationship with this institution):

Please copy and attach additional pages as necessary.

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List ALL activities (medical, non-medical, and postgraduate training) in chronological order beginning with medical school graduation to the PRESENT date, indicating month and year.

*Also list your permanent or home address for each non-working time.

If you worked for a physician-staffing group or did locum tenens, you must list all facilities where you worked and include complete dates and addresses.

DO NOT SUBSTITUTE ANY OTHER RESUME FOR THIS SECTION.

Copy and attach additional pages as necessary.

** Clinical indicates the percentage of time spent with patients.

*** Administrative indicates the percentage of time spent on administrative tasks like paperwork, etc.

Chronology of Activities

1. Start date: 7/2010 (mm/yyyy) End date: _____ (mm/yyyy)

Type of Activity: ☐ Health activity (non-working time due to health reasons) ☐ Military service ☐ Postgraduate training/education ☐ Seeking employment ☒ Vacation ☐ Work

Practice/Employment Name or Description of non-working time*: Time between Jobs in Lubbock, TX and Denison, TX

Street: Don't recall

City: Denison State/Province: TX Zip code: Don't recall

Country: USA Position: Vacation

Department: Vacation Clinical**: ___% Administrative***: ___%

☐ Employment ☐ Staff Privileges ☐ Affiliation

☐ Other (describe your relationship with this institution): _____

2. Start date: 9/2013 (mm/yyyy) End date: 11/2013 (mm/yyyy)

Type of Activity: ☐ Health activity (non-working time due to health reasons) ☐ Military service ☐ Postgraduate training/education ☐ Seeking employment ☒ Vacation ☐ Work

Practice/Employment Name or Description of non-working time*: Time between Job in Sulphur Springs, TX and Midwest City, OK

Street: 13127 Red OAK Drive

City: Choctaw State/Province: OK Zip code: 73020

Country: USA Position: vacation

Department: N/A Clinical**: ___% Administrative***: ___%

☐ Employment ☐ Staff Privileges ☐ Affiliation

☐ Other (describe your relationship with this institution): N/A

3. Start date: 8/2014 (mm/yyyy) End date: _____ (mm/yyyy)

Type of Activity: ☐ Health activity (non-working time due to health reasons) ☐ Military service ☐ Postgraduate training/education ☐ Seeking employment ☒ Vacation ☐ Work

Practice/Employment Name or Description of non-working time*: Time between Midwest City and starting at Broadway Clinic

Street: 13127 Red OAK Drive

City: Choctaw State/Province: OK Zip code: 73020

Country: USA Position: N/A

Department: _____ Clinical**: ___% Administrative***: ___%

☐ Employment ☐ Staff Privileges ☐ Affiliation

☐ Other (describe your relationship with this institution): _____

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Applicant Name: _____

List ALL activities (medical, non-medical, and postgraduate training) in chronological order beginning with medical school graduation to the PRESENT date, indicating month and year.

*Also list your permanent or home address for each non-working time.

If you worked for a physician-staffing group or did locum tenens, you must list all facilities where you worked and include complete dates and addresses.

DO NOT SUBSTITUTE ANY OTHER RESUME FOR THIS SECTION.

Copy and attach additional pages as necessary.

** Clinical indicates the percentage of time spent with patients.

*** Administrative indicates the percentage of time spent on administrative tasks like paperwork, etc.

Chronology of Activities

KSBHA

1. Start date: 4/2016 (mm/yyyy) End date: _____ (mm/yyyy)

Type of Activity:
☐ Health activity (non-working time due to health reasons)
☐ Military service ☐ Postgraduate training/education
☐ Seeking employment ☒ Vacation ☐ Work

Practice/Employment Name **or** Description of non-working time*: Time between Jobs at Broadway Clinic and PPCOK

Street: 13127 Red Oak Dr

City: Choctaw State/Province: OK Zip code: 73020

Country: USA Position: N/A

Department: _____ Clinical**: ____% Administrative***: ____%

☐ Employment ☐ Staff Privileges ☐ Affiliation
☐ Other (describe your relationship with this institution): _____

2. Start date: _____ (mm/yyyy) End date: _____ (mm/yyyy)

Type of Activity:
☐ Health activity (non-working time due to health reasons)
☐ Military service ☐ Postgraduate training/education
☐ Seeking employment ☐ Vacation ☐ Work

Practice/Employment Name **or** Description of non-working time*: _____

Street: _____

City: _____ State/Province: _____ Zip code: _____

Country: _____ Position: _____

Department: _____ Clinical**: ____% Administrative***: ____%

☐ Employment ☐ Staff Privileges ☐ Affiliation
☐ Other (describe your relationship with this institution): _____

3. Start date: _____ (mm/yyyy) End date: _____ (mm/yyyy)

Type of Activity:
☐ Health activity (non-working time due to health reasons)
☐ Military service ☐ Postgraduate training/education
☐ Seeking employment ☐ Vacation ☐ Work

Practice/Employment Name **or** Description of non-working time*: _____

Street: _____

City: _____ State/Province: _____ Zip code: _____

Country: _____ Position: _____

Department: _____ Clinical**: ____% Administrative***: ____%

☐ Employment ☐ Staff Privileges ☐ Affiliation
☐ Other (describe your relationship with this institution): _____

Andrew Martin Broselow, MD
Work History (continued)

7. 9/2014 - 3/2016
The Broadway Clinic
1801 N Broadway
Oklahoma City, Oklahoma 73103
80% Clinical
20% Administrative
Gynecology, Hormone replacement
Medical Director

8. 5/2016 – Current
Planned Parenthood Oklahoma
619 NW 23rd street
Oklahoma City, OK 73103
70% clinical
30% administrative
Associate medical Director
Gynecology

Texas Tech University
Health Sciences Center
School of Medicine

To All To Whom These Presents May Come, Greetings:
Be It Known That

Andrew Martin Braselow

having completed the studies and satisfied the requirements for the Degree of

Doctor of Medicine

has accordingly been admitted to that Degree with all the honors, rights and privileges belonging thereto.

Issued by the Board of Regents upon recommendation of the faculty at Lubbock, Texas on this twentieth day of May, A.D. Nineteen hundred ninety-five.

Edward E. Whitacre
Chairman-Board of Regents

Leonard C. Hightower
Executive Vice President

TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER

Robert Haun
President

Sheryl Matthews
Dean

This is to certify that this document is an exact copy of the diploma issued from Texas Tech University Health Sciences Center.

Tamara N. Lane
Registrar
6/24/2013

Tamara N. Lane
Registrar

SEAL VERIFIED

28137
1584

Oklahoma State Board of Medical Licensure and Supervision

101 NE 51st St.
Oklahoma City, OK 73105

PO BOX 18256
Oklahoma City, OK 73154-0265

Letter of Verification

June 21, 2016

This is to certify that the records of this Board indicate on the date of this letter the following information regarding:

Name:ANDREW MARTIN BROSELOW
Address Date:June 03, 2016
Address 1:
Address 2: [redacted]
Address 3:
City, State, ZIP:OKLAHOMA CITY, OK 73103

Profession: MEDICAL DOCTOR
Profession Type: MD
License Number: 30150
License Date: 08/12/2013
Status: ACTIVE
Status Class:
Expiration Date: 08/01/2017
Endorsed By: TEXAS
Restricted To:

Scan the image below using a smartphone to view the latest information for this licensee on our website:

Previous Licenses:

Type	Issued	Expired

Disciplinary Actions:

Date	Description

No Disciplinary Actions Taken and In Good Standing

Details of Disciplinary Action, if applicable, will be made available by photocopy from the public file upon written request only.

To expedite the verification of licensure/certification process, the above is the standard format for all professions regulated by this board.

SEAL

Teresa Mitchell

Teresa Mitchell
Director of Licensing
(405) 962-1400 ext 113
June 21, 2016

Texas Medical Board

Mailing Address: P.O. Box 2018 • Austin, Tx 78768-2018
Phone (512) 305-7010

KANSAS STATE BOARD OF HEALING ARTS
800 SW JACKSON, LOWER LEVEL STE A
TOPEKA, KS 66612-

June 10, 2016

For: KANSAS STATE BOARD OF HEALING ARTS

In response to a recent request, we verify the following information:

****

Physician:	ANDREW MARTIN BROSELOW, MD
License:	K3559
Date Issued:	09/20/1997
Licensed by:	Examination
Date of Birth:	1967
Medical School:	TEXAS TECH UNIV HLTH SCI CTR, LUBBOCK
Graduation Year:	1995
Permit Expires:	08/31/2017

Registration Status:

This is to certify that the above-named physician is licensed to practice medicine in Texas.

Disciplinary Status:

The board has not filed any formal complaints or statements of charges against this physician.

Investigation Status:

If any information is available, it has been attached to this letter.

****

If you have any further questions, please contact the Verification division

Sincerely,

Customer Information Center

BOARD SEAL

UA UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE

Affidavit and Authorization for Release of Information

RECEIVED
JUN 6 2016
KSBHA

Applicant: Follow the instructions in the left sidebar.
Send this notarized form to the Kansas State Board of Healing Arts,
800 SW Jackson, Lower Level - Suite A, Topeka, KS 66612

Applicant:

This is a separate form from the FCVS affidavit and release.

If you are using FCVS, you must complete both FCVS and UA affidavits. Send the FCVS affidavit to FCVS.

Sign this form with attached photo in the presence of a notary public.

Send this notarized affidavit to:

Kansas State Board of Healing Arts
800 SW Jackson, Lower Level - Suite A
Topeka, KS 66612

I, the undersigned, being duly sworn, hereby certify under oath that I am the person named in this application, that all statements I have made or shall make with respect thereto are true, that I am the original and lawful possessor of and person named in the various forms and credentials furnished or to be furnished with respect to my application, and that all documents, forms, or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

I acknowledge that I have read and understand the Uniform Application for Physician State Licensure and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted under appropriate federal and state laws.

I authorize and request every person, hospital, clinic, government agency (local, state, federal, or foreign), court, association, institution, or law enforcement agency having custody or control of any documents, records, and other information pertaining to me to furnish to the Board any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data, and to permit the Board or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application.

I hereby release, discharge, and exonerate the Board, its agents or representatives, and any person, hospital, clinic, government agency (local, state, federal, or foreign), court, association, institution, or law enforcement agency having custody or control of any documents, records, and other information pertaining to me of any and all liability of every nature and kind arising out of investigation made by the Board.

I will immediately notify the Board in writing of any changes to the answers to any of the questions contained in this application if such a change occurs at any time prior to a license to practice medicine being granted to me by the Board.

I understand my failure to answer questions contained in this application truthfully and completely may lead to denial, revocation, or other disciplinary sanction of my license or permit to practice medicine.

T Broselow
Applicant's signature (must be signed in the presence of a notary)

BROSELOW
Applicant's printed last name

ANDREW M
Applicant's printed first name, middle initial, and suffix (e.g., Jr.)

5/25/16
Date of signature (must correspond to date of notarization)

fold up — fold up

After folding the bottom portion upward, bring the new bottom edge to the top edge and fold to fit in a standard envelope.

Notary

State of Oklahoma, County of Oklahoma,

I certify that on the date set forth below, the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document.

The statements on this document are subscribed and sworn to before me by the applicant on this 25th day of May, 2016.

Notary Public Signature: Aaron Wilder

My Notary Commission Expires: 11/04/19

AARON WILDER NOTARY PUBLIC STATE OF OKLAHOMA #15010149 EXP. 11/04/19
(NOTARY PUBLIC SEAL)

ADDENDUM 1
KANSAS STATE BOARD OF HEALING ARTS

Select the discipline applying for and the license designation being requested.

☒ Medicine & Surgery ☐ Osteopathic Medicine & Surgery

☒ Active	A license issued to a person engaged in the practice of medicine and surgery, osteopathic medicine and surgery, chiropractic or podiatry. Individuals must maintain and submit evidence of satisfactory completion of a program of continuing education and are required to have professional liability insurance in compliance with Kansas law. Each active license may be renewed annually.
☐ Federal Active	A license issued to only a person who meets all the requirements for a license to practice the healing arts in Kansas and who practiced that branch of the healing arts solely in the course of employment or active duty in the United States government or any of its departments, bureaus or agencies or who, in addition to such employment or assignment, provides professional services as a charitable health care provider as defined under K.S.A. 75-6102. Continuing education, expiration and renewal of a license shall be applicable to a federally active license. A person who practices under a federally active license shall not be deemed to be rendering professional service as a health care provider in this state and is not required to have policy of professional liability coverage in effect.
☐ Inactive	A license issued to a person who is not regularly engaged in the practice of the healing arts in Kansas and who does not hold oneself out to the public as being professionally engaged in such practice. An inactive license shall not entitle the holder to practice the healing arts in this state. Each inactive license may be renewed annually. The holder of an inactive license shall not be required to submit evidence of satisfactory completion of a program of continuing education and is not required to have basic coverage or self-insurance in effect solely because such person is no longer engaged in rendering professional service as a health care provider.
☐ Exempt	A license issued to a person who is not regularly engaged in the practice of the healing arts or podiatry in Kansas and who does not hold oneself out to the public as being professionally engaged in such practice. Each exempt license may be renewed annually. The holder of an exempt license is entitled to all the privileges of their branch of the healing arts and (1) may serve as a coroner or as a paid employee of a local health department as defined by K.S.A. 65-241; or (2) practice as a charitable health care provider for an indigent health care clinic as defined by K.S.A. 75-6102. Additionally, the holder of an exempt license may perform administrative functions. The holder of an exempt license shall not be required to submit evidence of satisfactory completion of a program of continuing education nor are they required to have basic coverage or self-insurance in effect.

List intended professional activities: _____

Additional Information and Statement of Health:

1. Have you ever been licensed to practice the Healing Arts in Kansas? ☐ Yes ☒ No
2. Give location of intended practice in Kansas 2226 E. Central, Wichita, KS 67214
3. Primary Specialty Obstetrics and Gynecology

   American Board Certified yes (ABOG) American Board Eligible _____
4. Do you presently have any physical or mental problems or disabilities which could affect your ability to competently practice your particular branch of the healing arts or your particular specialty? ☐ Yes ☒ No

   If yes, applicant shall file with this application a detailed statement of his/her health, diagnosis and prognosis, supported by a report from his/her attending physician including any medication and treatment currently prescribed.

RECEIVED
JUN 6 2016

ADDENDUM 2
KANSAS STATE BOARD OF HEALING ARTS

Please answer each of the following questions by putting a check (✓) in the appropriate box. All "yes" answers MUST be thoroughly explained in detail in a separate signed page. You are required to furnish complete details including date, place, reason and disposition of the matter and attach all relevant documentation. All information received will be checked accordingly to verify the truth and veracity of your answers. It is imperative that you honestly and fully answer all questions, regardless of whether you believe the information requested is relevant.

If you are unsure of your response to a particular question, check (✓) the "yes" box and submit the appropriate form if required. Your responses on your application are evaluated as evidence of your candor and honesty. An honest "yes" answer to a question on your application is not definitive as to the Boards' assessment of your present moral character and fitness, but a dishonest "no" answer is evidence of a lack of candor and honesty, which may be definitive on the character and fitness issue. Please be advised that a false response to any of these questions may be grounds for denial of licensure and reported to the appropriate data banks. If a question is not applicable, then check (✓) the "no" box. It is your continuing duty to update the Board on any changes once the application has been submitted.

1. ☐ Yes ☑ No Have you ever been dropped, suspended, expelled, fined, placed on probation, allowed to resign, requested to leave temporarily or permanently, or otherwise had action taken against you by any professional training or educational program, including but not limited to medical school, prior to completing the training?

2. ☐ Yes ☑ No Have you ever had any application for any professional license refused or denied by any licensing authority?

3. ☐ Yes ☑ No Have you ever been refused or denied the privilege of taking an examination required for any professional licensure?

4. [redacted] Have you ever been warned, censured, disciplined, had admissions monitored, had privileges limited, suspended, revoked or placed on probation, or have you ever involuntarily or voluntarily (to avoid disciplinary action or investigation) resigned or withdrawn from any licensed hospital, nursing home, clinic or other health care facility in which you have trained, including but not limited to residency or postgraduate training programs, or otherwise been a staff member, been a partner or held privileges?

5. ☐ Yes ☑ No Have you ever been denied staff membership with any licensed hospital, nursing home, clinic or other health care facility?

6. ☐ Yes ☑ No Have you ever been requested to resign, withdraw or otherwise terminate your position with a partnership, professional association, corporation or other practice organization, either public or private?

7. ☐ Yes ☑ No Have you ever voluntarily surrendered any professional license?

8. ☐ Yes ☑ No Has any licensing authority ever limited, restricted, suspended, revoked, censured or placed on probation, or had any other disciplinary action taken against any professional license you have held?

9. ☐ Yes ☑ No Have you ever been notified or requested to appear before a licensing or disciplinary agency?

10. ☑ Yes ☐ No To your knowledge, have any complaints (regardless of status) ever been filed against you with any licensing agency, professional association, hospital, nursing home, clinic or other health care facility?

11 ☐ Yes ☑ No Has any professional association imposed any disciplinary action against you?

12. [redacted] Within the past 2 years, have you used any alcohol, narcotic, barbiturate, or other drug affecting the central nervous system, or other drug which may cause physical or psychological dependence, either to which you were addicted or upon which you were dependent?

13. [redacted] Within the past 2 years, have you been diagnosed or treated for any physical, emotional or mental illness or disease, including drug addiction or alcohol dependency, which limited your ability to practice the healing arts with reasonable skill and safety?

14. [redacted] Within the past 2 years, have you used controlled substances, which were obtained illegally or which were not obtained pursuant to a valid prescription order or which were not taken following the directions of a licensed health care provider?

15. [redacted] Have you ever practiced your profession while any physical or mental disability, loss of motor skill or use of drugs or alcohol, impaired your ability to practice with reasonable safety?

16 [redacted] Do you presently have any physical or mental problems or disabilities which could affect your ability to competently practice your profession?

17. ☐ Yes ☑ No Have you ever been denied a Drug Enforcement Administration (DEA) or state bureau of narcotics or controlled substance registration certificate or been called before or warned by any such agency or other lawful authority concerned with controlled substances?

18. ☐ Yes ☑ No Have you ever surrendered your state or federal controlled substances registration or had it revoked, suspended, or restricted in any way?

19. ☑ Yes ☐ No Have you ever been notified of any charges or complaints filed against you by any licensing or disciplinary agency? (See number 10)

20. ☐ Yes ☑ No Have you ever been arrested? Do not include minor traffic or parking violations or citations except those related to a DUI, DWI or a similar charge. You must include all arrests including those that have been set aside, dismissed or expunged or where a stay of execution has been issued.

21 ☐ Yes ☑ No Have you ever been charged with a crime, indicted, convicted of a crime, imprisoned, or placed on probation (a crime includes both Class A misdemeanors and felonies)? You must include all convictions including those that have been set aside, dismissed or expunged or where a stay of execution has been issued.

22. ☐ Yes ☑ No Have you ever been court-martialed or discharged dishonorably from the armed services?

23. ☑ Yes ☐ No Have you ever been a defendant in a legal action involving professional liability (malpractice), or had a professional liability claim paid in your behalf, or paid such claim yourself?

24. ☐ Yes ☑ No Have you ever been denied provider participation in any State Medicaid or Federal Medicare Programs or in a private insurance company?

25. ☐ Yes ☑ No Have you ever been terminated, sanctioned, penalized, or had to repay money to any State Medicaid or Federal Medicaid Programs or private insurance company?

Applicant Name: _____

You must complete this section to report all claims or suits for medical malpractice made against you. A claim is any formal or informal demand for payment to any person or organization.

* If private compromise or settled before initiation of civil action, state on this line.

All fields are required to be answered. Please have your information available before starting this section.

Please copy and attach additional pages if necessary.

Malpractice Liability Claims Information

RECEIVED
JUN 6 2016

☐ I have not had any malpractice claims or suits made against me.

1. Name of patient involved: Whitney Beach

In which state, territory, or province did the action take place? Lubbock, TX

Which court*? 99th District Court of Lubbock County

Case number (if applicable) 2003-523,964 Month and year of lawsuit: 2007

Month and year of event precipitating claim: 8/2006

Current claim status: ☐ Closed (settled) ☒ Dismissed (no money paid out) ☐ Open (pending) ☐ Other: _____

Amount of judgment or settlement: $[redacted] Amount paid on your behalf: $[redacted]

What is/was your status? ☑ Primary Defendant ☐ Co-Defendant ☐ Other (specify): _____

Insurance carrier at the time: Texas Medical Liability Trust

Please provide specifics in reference to the adverse event, including the allegations and your role in the event, in the space below. Use another sheet of paper or the back of this form if necessary.

[redacted]

Complete the forms on the following pages as instructed.

- ☐ UA Affidavit and Authorization for Release of Information
- ☐ UA Form #1: Licensure Verification Form
- ☐ All state-specific forms included with this core application

If you are using FCVS for credentials verification, you do not have to complete forms 2, 3, and 4.

- ☐ UA Form #2: Medical School Verification
- ☐ UA Form #3: Postgraduate Training Verification
- ☐ UA Form #4: Fifth Pathway Verification (if applicable)

Review & Submit

Please review all of your entries prior to submission. Be sure to include all forms, fees, and state addenda. You are strongly advised to keep a copy for your records.

Applicant Name: _____

You must complete this section to report all claims or suits for medical malpractice made against you. A claim is any formal or informal demand for payment to any person or organization.

* If private compromise or settled before initiation of civil action, state on this line.

All fields are required to be answered. Please have your information available before starting this section.

Please copy and attach additional pages if necessary.

Malpractice Liability Claims Information

RECEIVED
JUN 6 2016
ASBPA

☐ I have not had any malpractice claims or suits made against me.

1. Name of patient involved: Joann Douglas

In which state, territory, or province did the action take place? Lubbock, Tx

Which court*? 72nd District Court of Lubbock, County

Case number (if applicable) 2009-546,261 Month and year of lawsuit: 2009

Month and year of event precipitating claim: 2007

Current claim status: ☑ Closed (settled) ☐ Dismissed (no money paid out) ☐ Open (pending) ☐ Other: _____

Amount of judgment or settlement: $[redacted] Amount paid on your behalf: $[redacted]

What is/was your status? ☑ Primary Defendant ☐ Co-Defendant ☐ Other (specify): _____

Insurance carrier at the time: Texas medical Liability Trust

Please provide specifics in reference to the adverse event, including the allegations and your role in the event, in the space below. Use another sheet of paper or the back of this form if necessary.

[redacted]

Complete the forms on the following pages as instructed.

- ☐ UA Affidavit and Authorization for Release of Information
- ☐ UA Form #1: Licensure Verification Form
- ☐ All state-specific forms included with this core application

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- ☐ UA Form #3: Postgraduate Training Verification
- ☐ UA Form #4: Fifth Pathway Verification (if applicable)

Review & Submit

Please review all of your entries prior to submission. Be sure to include all forms, fees, and state addenda. You are strongly advised to keep a copy for your records.

Applicant Name: _____

You must complete this section to report all claims or suits for medical malpractice made against you. A claim is any formal or informal demand for payment to any person or organization.

* If private compromise or settled before initiation of civil action, state on this line.

All fields are required to be answered. Please have your information available before starting this section.

Please copy and attach additional pages if necessary.

Malpractice Liability Claims Information

RECEIVED
JUN 6 2016

☐ I have not had any malpractice claims or suits made against me.

1. Name of patient involved: Lindsey Miller

In which state, territory, or province did the action take place? Oklahoma City, OK

Which court*? _____

Case number (if applicable) CJ-2014-3982 Month and year of lawsuit: 8/2014

Month and year of event precipitating claim: 4/2014

Current claim status: ☑ Closed (settled) ☐ Dismissed (no money paid out) ☐ Open (pending) ☐ Other: [redacted]

Amount of judgment or settlement: $[redacted] Amount paid on your behalf: $_____

What is/was your status? ☐ Primary Defendant ☑ Co-Defendant ☐ Other (specify): _____

Insurance carrier at the time: CHS in house insurer

Please provide specifics in reference to the adverse event, including the allegations and your role in the event, in the space below. Use another sheet of paper or the back of this form if necessary.

[redacted]

Complete the forms on the following pages as instructed.

- ☐ UA Affidavit and Authorization for Release of Information
- ☐ UA Form #1: Licensure Verification Form
- ☐ All state-specific forms included with this core application

If you are using FCVS for credentials verification, you do not have to complete forms 2, 3, and 4.

- ☐ UA Form #2: Medical School Verification
- ☐ UA Form #3: Postgraduate Training Verification
- ☐ UA Form #4: Fifth Pathway Verification (if applicable)

Review & Submit

Please review all of your entries prior to submission. Be sure to include all forms, fees, and state addenda. You are strongly advised to keep a copy for your records.

IN THE DISTRICT COURT OF OKLAHOMA COUNTY
STATE OF OKLAHOMA

LINDSEY MILLER and CODY MILLER,

Plaintiffs,

v.

COMMUNITY HEALTH SYSTEMS, INC., d/b/a MIDWEST REGIONAL MEDICAL CENTER, RENAISSANCE WOMEN'S CENTER and RENAISSANCE PHYSICIANS MIDWEST CITY; MIDWEST REGIONAL MEDICAL CENTER, LLC; COMMUNITY HEALTH SYSTEMS PROFESSIONAL SERVICES CORPORATION; MIDWEST CITY HMA PHYSICIAN MANAGEMENT, LLC; BELINDA BROADY-SYMES, M.D.; and ANDREW BROSELOW, M.D.,

Defendants,

Case No.

CJ-2014-3982

PETITION

Plaintiffs, Lindsey and Cody Miller, for their claims against the Defendants, Community Health Systems, Inc., d/b/a Midwest Regional Medical Center and Renaissance Women's Center and Renaissance Physicians Midwest City; Midwest Regional Medical Center, LLC; Community Health Systems Professional Services Corporation; Midwest City HMA Physician Management, LLC; (collectively "MRMC"); Belinda Broady-Symes, M.D. and Andrew Broselow, M.D., state as follows:

1. Commencing on April 10, 2014, defendants, by and through their agents and/or employees, negligently rendered medical and nursing care and treatment below acceptable medical standards to Lindsey Miller, resulting in personal injuries and other damages.

2. Commencing on or about April 10, 2014, and continuing thereafter, the defendants, by and through their agents and/or employees, failed to inform the plaintiff of material risks involved in the course of treatment rendered to her; that defendants, by and through their agents and/or employees, failed to inform plaintiff of alternative treatments, the reasonably foreseeable material risks of each alternative; that plaintiff would have chosen the option of a different course of treatment had the alternative and material risks of each been made known; and that defendants' conduct resulted in the injuries and damages to plaintiff as set forth herein below.

3. Commencing on or about April 10, 2014, and continuing thereafter, Lindsey Miller sustained injuries as set forth below, resulting from an act, omission or instrumentality which was under the exclusive control and management of the defendants; that the events causing plaintiff's injuries or damages were of a kind which ordinarily do not occur in the absence of negligence on the part of the defendants.

4. At the time of the medical care and treatment provided herein, Defendants, Belinda Broady-Symes, M.D. and Andrew Broselow, M.D. were privileged, credentialed and otherwise entrusted to provide medical care and treatment to patients of MRMC.

5. MRMC was negligent in retaining, supervising, privileging and otherwise entrusting the care and treatment of its patients to Defendants, Belinda Broady-Symes, M.D. and Andrew Broselow, M.D., and as a result, Lindsey Miller suffered the damages set forth herein.

6. At all times material hereto, Belinda Broady-Symes, M.D. was an agent and/or employee of Defendants MRMC, and said defendants are therefore vicariously liable for her negligence and the damages resulting therefrom.

7. At all times material hereto, Andrew Broselow, M.D. was an agent and/or employee of Defendants MRMC, and said defendants are therefore vicariously liable for his negligence and the damages resulting therefrom.

8. As a result of defendants' conduct, plaintiff, Lindsey Miller, suffered severe, permanent, and irreversible physical injuries; she has been permanently disabled and disfigured; she has suffered, and will continue to suffer, physical and emotional pain and anguish; she has incurred, and will continue to incur, medical bills; she has lost earnings, and will continue to lose earnings, she has suffered and will continue to suffer a reduction of her quality of life; and she has been damaged in an amount in excess of $75,000.00, exclusive of interest, attorney's fees and costs.

9. As a further result of defendants' conduct, plaintiff, Cody Miller, adopts and re-pleads the foregoing allegations and further alleges and states he is the husband of Lindsey Miller, and has suffered damages for loss of services, earnings and consortium, and been damaged in an amount in excess of $75,000.00, exclusive of interest, attorneys' fees and costs.

10. Plaintiffs adopt and re-plead the foregoing allegations, and further allege and state that defendants' negligence was gross, willful and/or wanton, such that punitive or exemplary damages should be imposed in favor of plaintiffs and against defendants in amounts exceeding $75,000.00, exclusive of interest, attorneys' fees and costs.

WHEREFORE, plaintiffs seek judgment against defendants, and each of them, for compensatory and punitive damages, in amounts in excess of $75,000.00, plus costs, interest and any other relief the Court deems equitable and just.

Respectfully submitted,

Jo L. Slama, OBA #13426
Steven R. Davis, OBA #14401
SLAMA LEGAL GROUP
4301 Southwest Third Street
Oklahoma City, OK 73108
Telephone: (405) 609-1600
Facsimile: (405) 609-1601

ATTORNEYS FOR PLAINTIFFS

ATTORNEYS' LIEN CLAIMED

JURY TRIAL DEMANDED

RECEIVED
JUN 1 2016
KSBHA

ADDENDUM 3

Kansas State Board of Healing Arts

800 SW Jackson, Lower Level, Suite A
Topeka, Kansas 66612

Recommendations from Two Reputable Physicians

The KSBHA requires two (2) recommendations from licensed physicians. Persons attesting to the good character of the applicant are attesting to the fact that they have known the applicant for at least one (1) year.

Name of Applicant (Printed or Typed): ANDREW BROSELOW, MD **Date of Birth:** [redacted]/1967

Please mail this document to the Kansas State Board of Healing Arts at the address above. Thank you. DO NOT RETURN TO APPLICANT.

This is to certify that I have known Dr. BROSELOW (type or print) for 12 years; that he/she is a capable physician and is not addicted to alcohol or drugs.

I further certify that to the best of my knowledge and belief Dr. BROSELOW is a fit and proper person for endorsement for license by the Kansas State Board of Healing Arts.

(Please type or print)

Name: Jennifer Owen, MD

Street 1: 2102 Oxford Ave

Street 2:

State/Zip: Lubbock, TX 79410

Telephone: 806-725-6625

Signature: X [signature]

Date: X 5/26/16

ADDENDUM 3

Kansas State Board of Healing Arts

800 SW Jackson, Lower Level, Suite A
Topeka, Kansas 66612

Recommendations from Two Reputable Physicians

The KSBHA requires two (2) recommendations from licensed physicians. Persons attesting to the good character of the applicant are attesting to the fact that they have known the applicant for at least one (1) year.

Name of Applicant (Printed or Typed): ANDREW BROSELOW, MD **Date of Birth:** [redacted]1967

Please mail this document to the Kansas State Board of Healing Arts at the address above. Thank you. DO NOT RETURN TO APPLICANT.

This is to certify that I have known Dr. ANDREW BROSELOW (type or print) for 12 years; that he/she is a capable physician and is not addicted to alcohol or drugs.

I further certify that to the best of my knowledge and belief Dr. BROSELOW is a fit and proper person for endorsement for license by the Kansas State Board of Healing Arts.

(Please type or print)

Name: Joanna Burke, MD

Street 1: 4102 24th St, Suite 503

Street 2:

State/Zip: Lubbock, TX 79410

Telephone: 806-725-4850

Signature: X

Date: X 6/13/16

ADDENDUM 5

Kansas

WAIVER AGREEMENT AND STATEMENT
Fingerprint-Based Record Checks for Noncriminal Justice Purposes

I hereby authorize the Kansas State Board of Healing Arts to submit a set of my fingerprints to the Kansas Bureau of Investigation (KBI) for the Purpose of identifying me and accessing and reviewing Kansas and/or national criminal history records that may pertain to me. Pursuant to K.S.A. 22-4701 *et seq.* and K.S.A. 22-5001, the Kansas State Board of Healing Arts may obtain my criminal history record information for noncriminal justice purposes. By signing this waiver, it is my intent to authorize release to the Kansas State Board of Healing Arts of any Kansas and/or national criminal history record that may pertain to me. I further understand that, if applicable, the Kansas State Board of Healing Arts may choose to deny my application or grant me a limited or restricted license until the criminal history background check is completed.

I understand that, upon my request, the Kansas State Board of Healing Arts will provide me with a summary of the information contained in my Criminal History Background Report for the limited purpose of challenging the accuracy and/or completeness of the information contained in the report, but will not provide me with a complete copy of the Criminal History Background Report. I understand that I may obtain a prompt determination as to the validity of my challenge before the Kansas State Board of Healing Arts makes a final decision about my application for license to practice the healing arts. I further understand that I will not be provided access to information in my Criminal History Background Report under the following circumstances: 1) I am granted a full, unrestricted license, 2) I voluntarily withdraw an application for licensure, or 3) I am denied a license and have exhausted all my right to appeal the denial.

I have ☐ OR have not ☒ been convicted of a crime.

If convicted, describe the crime(s), the date and location of the crime(s), and the name of the convicting court:

_____

_____

Under penalty of perjury, I hereby declare that I am the person described below, and understand that any falsification of this statement constitutes a severity level 9, nonperson felony under the provisions of Title 21 Kansas Statutes Annotated, Section 3805, and may result in the denial of my application pursuant to K.S.A. 65-2836 (a).

Signature

5-24-2016
Date

Andrew Martin Broselow, MD
Printed Name

[redacted]967
Date of Birth

[redacted]
Residential Address

Choctaw OK 73020
City State Zip

Kansas State Board of Healing Arts
800 SW Jackson, Lower Level-Suite A
Topeka, KS 66612

Kansas

phone: 785-296-7413
fax: 785-368-7103
1-888-886-7205
www.ksbha.org

Kathleen Selzler-Lippert
Executive Director

Sam Brownback, Governor

September 9, 2016

Andrew Martin Broselow, MD
[redacted]
Choctaw OK 73020

Dear Doctor Broselow:

This letter is to inform you that your application for a Medical Doctor (MD) Active license in the State of Kansas was approved by the Board of Healing Arts. Your original wall certificate will be mailed in 2 to 4 weeks.

This is to serve as evidence that you have been assigned Kansas Certificate Number 04-39388 effective: 09/08/2016. Prior to cancellation 07/31/2017, a renewal notice will be mailed to your current mailing address listed with our office.

If you have moved since you made application with us, please notify our office in writing of the change of address. Your address cannot be changed until we receive this notification.

If you have any questions, please feel free to contact the Board Office.

Sincerely,

Kathleen Selzler Lippert

Kathleen Selzler Lippert
Executive Director

United States Medical Licensing Examination (USMLE)
Certified Transcript of Scores

This document was prepared by the
Federation of State Medical Boards of the United States, Inc.
Federation Place, 400 Fuller Wiser Road, Suite 300, Euless, TX 76039-3856 --Telephone (817)868-4000

Recipient: **Date:** 05/24/2016

KANSAS STATE BOARD OF HEALING ARTS

Examinee: Broselow, Andrew Martin **Examinee ID:** 40292708

Alt Name(s): **Date of Birth:** [redacted]967

Results for Steps taken by this examinee (and for which results have been reported to date) are shown below. For Steps that span more than one day, the test date reflects the day on which the examination began. Where numeric scores are reported, the recommended minimum passing score ("MP") is shown in parentheses. Pass/fail outcomes are based upon the minimum passing level in place at the time of test administration and are not altered by subsequent revisions to the minimum passing level. Effective April 1, 2013, test results are reported on a three-digit scale only; two-digit scores reported for prior administrations will no longer be reported. Test results reported as passing represent an exam score of 75 or higher on a two-digit scoring scale.

USMLE STEP 1

Test Date	Pass/Fail	Total	MP	Comments
6/8/1993	Pass	[redacted]		

USMLE STEP 2

Clinical Knowledge (CK)

Test Date	Pass/Fail	Total	MP	Comments
8/31/1994	Pass	[redacted]		

USMLE STEP 3

Test Date	Pass/Fail	Total	MP	Comments
12/3/1996	Pass	[redacted]		

NOTE: A search of the Physician Data Center of the Federation of State Medical Boards (FSMB) reveals no reported information on this examinee.

Andrew Broselow, MD, FACOG

[redacted]
Choctaw, OK 73020
[redacted]

EDUCATION

1995-1999 John Peter Smith Hospital, Fort Worth, TX

Residency in Obstetrics and Gynecology

1991-1995 Texas Tech University Health Sciences Center

Doctor of Medicine

1985-1990 University of Texas at Austin

Bachelor of Music

EXPERIENCE

May 2016-Present Planned Parenthood Great Plains

Medical Director

October 2014-February 2016 The Broadway Clinic, Oklahoma City, OK

Medical director

February 2014-July 2014 Midwest Regional Hospital, Midwest City, OK

Staff Obstetrician and Gynecologist

July 2010-August 2013 Hopkins County Memorial Hospital, Sulphur Springs, TX

Staff Obstetrician and Gynecologist

Chief of Perinatal Department 2011-2013

September 2009-May 2010 Texomacare, Denison, TX

Staff Obstetrician and Gynecologist

June 1999-August 2009 Covenant Medical Group and Hospital, Lubbock, TX

Staff Obstetrician and Gynecologist

Board Certification

American Board of Obstetrics and Gynecology

Memberships

American Medical Association

Oklahoma Medical Association

Fellow, American Congress of Obstetricians and Gynecologists (FACOG)

State Licenses

Texas

Oklahoma