CR#10552 2521 3-20
$120

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

OCT 24 2000

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

1A. DEMOGRAPHIC INFORMATION

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

ABOLGHASSEM GOHARI

License Number: MD[illegible]07299
Social Security #:
Date of Birth.
Other Address:

2. ADDITIONAL INFORMATION

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

YES ☒ NO ☐ ASI ONLY ☑

3. FEE CALCULATION

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

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

ASI ONLY 120

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

4. QUESTIONS ABOUT YOUR PRACTICE

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

A.	Are you in active practice now?	YES ☒ NO ☐
B.	If so, do you practice in the District of Columbia at all?	YES ☐ NO ☒
C.	**MD's and DO's Only** — If your practice is limited to a specialty, please indicate the code from the specialty list at the right.	CODE 0B
D.	**MD's and DO's Only — If you are certified by the** American Board of any specialty, please indicate the code from the specialty list at the right.	CODE 0B
E.	**Chiropractors Only** — Are you authorized to perform non-invasive ancillary procedures? (Requires additional fee of $90)	YES ☐ NO ☐

SPECIALTIES

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

5. SCREENING QUESTIONS

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

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

6. SIGNATURE

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

A.M. Gohari
LICENSEE'S SIGNATURE

10-21-00
DATE

ASI ONLY ☑

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

Mail renewal form and fee to:

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

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

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

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

Physician Assistants ONLY

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

Chiropractors ONLY

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

ASI ONLY ☐☐☐.☐

8. ADDRESS CHANGE

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

8A. HOME ADDRESS CHANGE

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

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

STREET ADDRESS LINE 1

STREET ADDRESS LINE 2

CITY STATE ZIP CODE

AREA PHONE NUMBER AREA FAX NUMBER

8B. BUSINESS ADDRESS CHANGE

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

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

STREET ADDRESS LINE 1

STREET ADDRESS LINE 2

CITY STATE ZIP CODE

AREA PHONE NUMBER AREA FAX NUMBER

8C. INDICATE YOUR PREFERRED MAILING ADDRESS

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

☐ HOME ☐ BUSINESS

8D. SSN/BIRTHDATE

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

SSN/FEIN* BIRTHDATE

MONTH DAY YEAR

9. NAME CHANGE

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

FIRST NAME

MIDDLE NAME

LAST NAME ASI ONLY ☐

SUFFIX (Jr., Sr., etc)

ASI ONLY

CK# 10552

Clerk's Initials GJ

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

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

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

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

I, ABOLGHASSEM GOHARI, applying for a Medical/Surgical,
(name) *(type of health license)*

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

1. Fines, penalties or interest assessed pursuant to the Litter Control Administration Act of 1995, effective March 25, 1986 (D.C. Law 6-100; D.C. Code §6-2901 et seq.);

2. Fines, penalties or interest assessed pursuant to the Illegal Dumping Enforcement Act of 1994, effective May 20, 1994 (D.C. Law 10-117; D.C. Code §6-2911 et seq.);

3. Fines, penalties or interest assessed pursuant to the Civil Infractions Act of 1985, effective October 5, 1986 (D.C. Law 6-42; D.C. Code §6-2701 et seq.); or

4. Past due taxes.

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

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

AM. Gohari
Signature and Title/Responsible Officer

10-21-00
Date

Social Security #

Business/Home Address

College park,
MD 20740

Phone Number

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

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

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

3085

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

1A. DEMOGRAPHIC INFORMATION

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

ABOLGHASSEM GOHARI

License Number: MD[illegible]99
Social Security #:
Date of Birth:

POTOMAC MD 20854 4477

2. ADDITIONAL INFORMATION

This document is for renewal of your Health Occupation license. Please do not confuse this renewal process with the "Professional Licensing Fee" ($250 per year) administered by the Department of Finance and Revenue.

Your license will expire on December 31,1998 if you do not return this application with the fee made payable to ASI at the address shown at the bottom of the form.

3. FEE CALCULATION

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

A.	☒ Renewal OR ☐ Paid Inactive Status Request	$120	=	$ 120.00
B.	☐ Cancel License (No fee)			
C.	☐ Chiropractic Ancillary Procedures	$90	=	$ N/A
D.	☐ Late Fee (if postmarked after December 31, 1998)	$25	=	$
E.	☐ Name and/or Address Changed (see reverse side)	$20	=	$
F.	☐ Duplicate License Request NUMBER OF LICENSES [ ]	x $20	=	$
	TOTAL FEE DUE		=	$ 120.00

ASI ONLY [120]

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

4. QUESTIONS ABOUT YOUR PRACTICE

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

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

SPECIALTIES

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

5. SCREENING QUESTIONS

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

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

6. SIGNATURE

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

A.M. Gohari — LICENSEE'S SIGNATURE

10-4-98 — DATE

ASI ONLY ☑

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

Mail renewal form and fee to:

ASI/DC Department of Health • PO Box 13805 • Philadelphia, PA 19101-3805

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

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

Check the box below if you have completed the required credit hours to renew your license. Include the certificates of completion with this application. These courses must have been completed between 1/1/97 and 12/31/98.

Physician Assistants ONLY

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

Chiropractors ONLY

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

ASI ONLY

8. ADDRESS CHANGE

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

8A. HOME ADDRESS CHANGE

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

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

STREET ADDRESS LINE 1

STREET ADDRESS LINE 2

CITY STATE ZIP CODE

AREA PHONE NUMBER AREA FAX NUMBER

8B. BUSINESS ADDRESS CHANGE

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

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

STREET ADDRESS LINE 1

STREET ADDRESS LINE 2

CITY STATE ZIP CODE

AREA PHONE NUMBER AREA FAX NUMBER

8C. INDICATE YOUR PREFERRED MAILING ADDRESS

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

☐ HOME ☐ BUSINESS

8D. SSN/BIRTHDATE

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

SSN/FEIN* BIRTHDATE

MONTH DAY YEAR

9. NAME CHANGE

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

FIRST NAME

MIDDLE NAME

LAST NAME ASI ONLY ☐

SUFFIX (Jr., Sr., etc.)

RECEIVED OCT 14 1998 BY

ASI ONLY

Clerk's Initials BB

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

District of Columbia — Board of Medicine
MEDICAL and CHIROPRACTIC LICENSE RENEWAL FORM

ALL RENEWING LICENSEES — PLEASE COMPLETE SECTIONS 7 & 8

7. HOME AND BUSINESS ADDRESS — In the conversion process, it was not possible to classify whether the mailing address for this license is a home or business address. To clarify this, please enter your home and business addresses below and indicate where you prefer your license-related mail to be sent.

7A. RESIDENCE ADDRESS — A street address MUST be provided — Complete ALL fields, even if your address has only partially changed.

STREET ADDRESS LINE 1 (If applicable, use this line to indicate APARTMENT, SUITE, or FLOOR #)

STREET ADDRESS LINE 2 (Use this line to indicate STREET NUMBER and STREET NAME)

POTOMAC — CITY — MD — STATE — 20854 — ZIP CODE

AREA CODE — RESIDENTIAL PHONE NUMBER — AREA CODE — RESIDENTIAL FAX NUMBER

7B. BUSINESS ADDRESS — A street address MUST be provided — Complete ALL fields even if your address has only partially changed.

5915 GREENBELT RD

STREET ADDRESS LINE 1 (If applicable, use this line to indicate APARTMENT, SUITE, or FLOOR #)

STREET ADDRESS LINE 2 (Use this line to indicate STREET NUMBER and STREET NAME)

COLLEGE PARK — CITY — MD — STATE — 20740-2259 — ZIP CODE

301-474-5300 — AREA CODE — BUSINESS PHONE NUMBER

301-441-3200 — AREA CODE — BUSINESS FAX NUMBER

7C. INDICATE YOUR PREFERRED MAILING ADDRESS — All correspondence for this license will be sent to the preferred mailing address.

☐ RESIDENCE ☒ BUSINESS

8. SSN/BIRTHDATE — If your Social Security Number and Birthdate are missing or inaccurate in Section 1 of this form, please enter them in the blocks provided.

8B. Social Security Number

8C. Birthdate

MONTH DAY YEAR

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

FIRST NAME — LAST NAME — M.I.

SUFFIX (Jr., Sr., etc.)

ASI ONLY ○

ASI ONLY

RECEIVED JAN 16 1997

Clerk's Initials SI

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

A. M. Gohari, M.D.
OBSTETRICS & GYNECOLOGY
5915 GREENBELT ROAD
COLLEGE PARK, MARYLAND 20740
(301) 474-5300

To whom it may concern:

In response to your request about the Health Claim,: The patient has been seen by Dr.Alan Ross on 4-30-1987 for Intra-Uterine pregnancy which she could not make a decision and returned on 5-2-87 for a Theraputic Abortion.
Dr.Ross,s record reported termination of pregnancy at 12 weeks.
She returned on 5-17-87 for follow up and I prescribed Oral Contraceptive and told her to be back in 2 weeks if she did not have her period as a routine explanation.
Later the patient was found to be pregnant and she made the decision to continue her pregnancy uneventfull.
Now after 3 years she claims expense for raising her child.
Even at a later time she had the option to terminate but she chose to continue her pregnancy to full term.

Respectfully,

A.M.Gohari,M.D.

A. M. Gohari, M.D.
OBSTETRICS & GYNECOLOGY
5915 GREENBELT ROAD
COLLEGE PARK, MARYLAND 20740
(301) 474-5300

To Whom it may concern:

Re:

The above patient underwent laparoscopy tubal ligation by Bipolar electrocautery on July 7,1994.
At the time of this procedure due to lack of training of ciculating nurse the cautery system was set in wrong mode without my knowlege.
The electrical current was on before my request.
I discovered the Bipolar forceps was firing without any activation by foot pedal, and I removed the forceps immediately and the assistant nurse and the Anesthesiologist and the circulating nurse herself saw this mishap, I requested the operating room superviser and demanded an incident report.
I have documented this in patient's post operative report.
Also I took video copy .

I have performed over hundred of this kind of procedures without a single failure and or any even minor complications.
The circulating nurse on charge at that day to my knowlege did not have no experience and or training in operating Bipolar electrocautery,and caused this complication.
She operated the system without my request,and connected to monopolar cautry mode,and turned the cautry on before I requested to correct mode and setting for proper operation.
In Bipolar mode the application forceps never fires spontaneously without activating foot pedal. She connected to monopolar mode with Bipolar forceps system that if cautery is on will operate spontaneously.

The patient went to a local ER on July 8,1994,for pain and she was given pain medication, the ER physician did not call me, and I saw her in my office on July 12,1994.
I found her with acute abdomen,due to bowel injery,I admitted her immediately to Doctors Community Hospital,and I notified Dr.Daee ,and he entirely managed her complications of bowel injery due to electrocautry.

Very truly yours,

pending

A.M.Gohari,M.D.

A. M. Gohari, M.D.
OBSTETRICS & GYNECOLOGY
5915 GREENBELT ROAD
COLLEGE PARK, MARYLAND 20740
(301) 474-5300

December 22, 1994

To whom it may Concern

RE:

The above patient came to my office on Nov. 20, 1991 and I found her to be five to six weeks pregnant and she planned for the termination of her pregnancy.
She returned to my office on 11/25/91 for termination which I did a suction D&C and was 7 weeks Lmp and 5 weeks gestation. She returned for follow up on Dec. 9 1991 and I did not recognize her to still be pregnant, and she did not say anything to me either. I placed her on oral contraceptive and I told her if she didn't have her period in two weeks she should return to my office.
She distinctly told me on 3-13-92 that she was aware of her obvious symptoms of pregnancy since Jan. 1992, she claimed that she was very busy and she knew she must have her period regularly so she could continue her oral contraceptive, in spite of her obvious knowledge of being pregnant; she did not call or come to my office till March 13,1992. At that time I found her to be 20 weeks pregnant, and I made complete arrangement to terminate her pregnancy with Dr. Chumpitazi without any charge to her. She went to his clinic, but left without terminating her pregnancy, I called her on Mar. 14, 1992 and she told me she wanted to discuss with her partner. I did not hear from her until now.
She denied her symptoms clearly and told me she knew that she was still pregnant for a long time, but she claimed that she was very busy and even by her major delay I arranged for her termination without any charge to her. She chose consciously and knowingly to continue her pregnancy.
She was definitely sure of still being pregnant before Dec. 31, 1991, because that was the time she should have her period to be able to continue with oral contraceptives.

A. M. GOHARI, MD.

AM Gohari

pending

Sincerely yours,

A.M. Gohari,M.D.
9061 Shady Grove Ct.
Gaithersburg, MD 20877

To whom it may concern,

Re: health claim arbitration

I performed therapeutic abortion on defendant on Feb 9,1991, at eight weeks gestation, as I have performed on my previous hundred thousand patients. I saw her two weeks later for her follow up and I confirmed the completion of the procedure.

On March 21, 1991, the patient was seen in the emergency department of Shady Grove Adventist Hospital with diagnosis of lower urinary infection and was treated accordingly.

On March 24, 1991, she was seen at Columbia Hospital, and in spite of negative ultrasound result and negligible Beta HCG titer, the staff gynecologist performed diagnostic laparoscopy for ruling out ectopic pregnancy. As he reported on his findings, he found some blood in the cul-de-sac and performed D&C, which showed necrotic tissue and few fragments of placenta.

The above procedures had been performed over six weeks after I had performed the therapeutic abortion on Feb 9,1991!!!

I really don't know what is my negligence in this case, the staff gynecologist had performed diagnostic laparoscopy for ruling out ectopic pregnancy. I spoke with the staff gynecologist concerning these procedures, and he responded that he was under the impression of a new pregnancy. Otherwise, the ectopic pregnancy from the Feb 9, 1991 would have been at fourteen weeks gestation ectopic pregnancy, which is medically impossible.

Sincerely,

A.M. Gohari,M.D.

DOCUMENT NO.: 1019921470521000
DATA BANK ID: 101242600003465

PRACTITIONER NOTIFICATION DOCUMENT
(PAYMENT)

PROCESS DATE: 06/04/92
PAGE 01

THE FOLLOWING INFORMATION WAS REPORTED TO THE NATIONAL PRACTITIONER DATA BANK CONCERNING YOU. TITLE IV OF PUBLIC LAW 99-660, AS AMENDED, REQUIRES THAT ANY INDIVIDUAL OR ENTITY THAT MAKES A PAYMENT UNDER AN INSURANCE POLICY, SELF-INSURANCE, OR OTHERWISE FOR THE BENEFIT OF A PHYSICIAN, DENTIST, OR OTHER LICENSED HEALTH CARE PRACTITIONER IN SETTLEMENT OF A WRITTEN CLAIM OR JUDGMENT MUST REPORT THAT INFORMATION TO THE DATA BANK.

ENTITIES AND INDIVIDUALS ARE RESPONSIBLE FOR THE ACCURACY OF INFORMATION THEY REPORT TO THE DATA BANK. THE INFORMATION REPORTED ON YOU WILL BE HELD FOR 30 CALENDAR DAYS BEFORE BEING MADE AVAILABLE FOR DISCLOSURE IN RESPONSE TO A REQUEST FOR INFORMATION FROM THE DATA BANK CONCERNING YOU. IF YOU BELIEVE THE INFORMATION IN THE REPORT TO BE INACCURATE (E.G. INCORRECT DATE OF ACT OR OMISSION). YOU SHOULD ATTEMPT TO DISCUSS YOUR DISAGREEMENT(S) DIRECTLY WITH THE ENTITY THAT SUBMITTED THE REPORT. CORRECTIONS(S) MUST BE SUBMITTED TO THE DATA BANK BY THE REPORTING ENTITY. DO NOT SUBMIT CHANGES YOURSELF.

TO DISPUTE THE ACCURACY OF THE INFORMATION IN THIS CORRECTED REPORT, YOU MUST: (1) COMPLETE AND SIGN SECTION D, (2) STIPULATE IN WRITING THE BASIS OF YOUR DISAGREEMENT(S) WITH THE FACTS IN THE REPORT, (3) RETURN THIS DOCUMENT TO THE DATA BANK WITHIN 60 DAYS OF THE PROCESS DATE IN THE UPPER RIGHT-HAND CORNER OF THIS DOCUMENT, (4) NOTIFY THE REPORTING ENTITY IN WRITING OF YOUR DISAGREEMENT AND THE BASIS FOR IT, AND (5) ATTEMPT TO RESOLVE THE DISPUTE WITH THE ENTITY. DOCUMENTS SENT THROUGH THE U.S. POSTAL SERVICE(INCLUDING EXPRESS MAIL)SHOULD BE ADDRESSED TO THE NATIONAL PRACTITIONER DATA BANK, P.O. BOX 6048, CAMARILLO, CA 93011-6048 DOCUMENTS SENT VIA NON-U.S. POSTAL SERVICE CARRIERS SHOULD BE ADDRESSED TO THE NATIONAL PRACTITIONER DATA BANK, 5151 CAMINO RUIZ, MAIL DROP E-102, CAMARILLO, CA 93012. IF YOUR DISAGREEMENT(S) CANNOT BE RESOLVED THROUGH DISCUSSIONS WITH THE REPORTING ENTITY, YOU MAY REQUEST THE SECRETARY OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES TO REVIEW THE ACCURACY OF THE REPORT BEING DISPUTED BY FOLLOWING THE DIRECTIONS ON THE DISPUTE ACKNOWLEDGEMENT DOCUMENT YOU WILL RECEIVE FROM THE DATA BANK. THE SECRETARY WILL THEN MAKE THE FINAL DETERMINATION.

A UNIQUE DATA BANK IDENTIFICATION NUMBER (ID) APPEARS IN THE UPPER LEFT-HAND CORNER OF THIS DOCUMENT. THIS DATA BANK ID IS NEVER DISCLOSED TO ANY ENTITY OR INDIVIDUAL THAT REPORTS TO OR REQUESTS INFORMATION FROM THE DATA BANK CONCERNING YOU. A DATA BANK ID IS USED TO ASSURE PROPER IDENTIFICATION OF EACH INDIVIDUAL PRACTITIONER ON WHOM INFORMATION HAS BEEN REPORTED. TO OBTAIN INFORMATION REPORTED TO THE DATA BANK CONCERNING YOU, SUBMIT A FULLY COMPLETED REQUEST FOR INFORMATION DISCLOSURE FORM TO THE DATA BANK. FORMS CAN BE OBTAINED BY CONTACTING THE DATA BANK AT 1-800-767-6732. THIS DATA BANK ID MUST BE USED WHEN REQUESTING INFORMATION FROM THE DATA BANK OR WHEN SUBMITTING ANY WRITTEN CORRESPONDENCE. ANY CORRESPONDENCE CONCERNING THE FOLLOWING INFORMATION MUST INCLUDE THE DOCUMENT NUMBER WHICH APPEARS IN THE UPPER LEFT HAND CORNER OF THIS DOCUMENT.

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SECTION A: REPORTING ENTITY INFORMATION

ENTITY NAME: MEDICAL MUTUAL LIABILITY INS SOC OF MD
STREET ADDRESS: 225 INTERNATIONAL CIRCLE
CITY, STATE, ZIP CODE: HUNT VALLEY, MD 21030

TYPE OF REPORT: INITIAL REPORT
ENTITY RELATION TO PRACTITIONER: INSURANCE COMPANY
TELEPHONE NO.: (410) 785-0050 EXT.

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SECTION B: PRACTITIONER INFORMATION REPORTED

(LAST, FIRST, MIDDLE, SUFFIX)
NAME: GOHARI, ABOLGHASSEM
OTHER NAME USED:
ORGANIZATION NAME: ABOLGHASSEM GOHARI, M.D.
WORK ADDRESS: 5915 GREENBELT ROAD
CITY, STATE, ZIP CODE: COLLEGE PARK MD 20740
HOME ADDRESS:
CITY, STATE, ZIP CODE:
LICENSE NO.: D18165
DATE OF BIRTH:
FEDERAL DEA NO.:
PROFESSIONAL SCHOOL: TEHRAN UNIVERSITY
HOSPITAL AFFILIATION:

WORK COUNTRY:
HOME COUNTRY:
STATE OF LICENSURE: MD FIELD OF LICENSURE: 010
SOCIAL SECURITY NO.: - -
FEDERAL DEA NO.: -
YEAR OF GRADUATION: 1969
CITY, STATE:

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THE FOLLOWING INFORMATION WAS REPORTED TO THE NATIONAL PRACTITIONER DATA BANK CONCERNING YOU.

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SECTION C: PAYMENT INFORMATION REPORTED

ACT/OMISSION CODE(S): 010, FAILURE TO DIAGNOSE
DATES OF ACT/OMISSION: 05/18/87 TO 05/18/87
PAYMENT DATE: 05/06/92
PAYMENT TYPE: SINGLE
PAYMENT RESULT OF: SETTLEMENT
ADJUDICATIVE BODY CASE NUMBER:
ADJUDICATIVE BODY:

AMOUNT PAID: $ 9,000.00
NO. OF PRACTITIONERS PAYMENT FOR: 001
DATE OF JUDGMENT OR SETTLEMENT: 04/14/92

ACTS/OMISSIONS DESCRIPTION:
PLT. ALLEGES INSURED FAILED TO DIAGNOSE CONTINUING PREGNANCY AFTER FAILED ABORTION.

JUDGMENT/SETTLEMENT DESCRIPTION AND CONDITIONS:
SINGLE PAYMENT ON BEHALF OF INSURED AND CO-DEFENDANT PAID $9,000 FOR TOTAL SETTLEMENT OF $18,000

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SECTION D: INITIATION OF DISPUTE

I HEREBY INFORM THE SECRETARY OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES UNDER THE PROVISIONS OF PUBLIC LAW 99-660, AS AMENDED, THAT I AM DISPUTING THE ACCURACY OF INFORMATION CONTAINED IN THE REPORT. I HEREBY REQUEST THAT THE REPORT BE ENTERED INTO A "DISPUTED" STATUS, AND THAT ALL PREVIOUS AND SUBSEQUENT INQUIRERS BE NOTIFIED OF THE "DISPUTED" STATUS. I HAVE INDICATED MY DISAGREEMENT BELOW AND THE BASIS FOR IT. I CERTIFY THAT I HAVE NOTIFIED THE REPORTING ENTITY IN WRITING OF MY DISAGREEMENT WITH THE FACTS IN THE REPORT, AND I AM ATTEMPTING TO ENTER INTO DISCUSSION WITH THE REPORTING ENTITY TO RESOLVE THE DISPUTE.

NAME _____

SIGNATURE _____ DATE _____

BASIS FOR DISPUTE: _____

_____

_____

_____

DOCUMENT CONTROL NO.: 1019941860422000 PRACTITIONER NOTIFICATION DOCUMENT PROCESS DATE: 07/13/94
DATA BANK ID: 101242600003465 (PAYMENT) PAGE 02
THE FOLLOWING INFORMATION WAS REPORTED TO THE NATIONAL PRACTITIONER DATA BANK CONCERNING YOU.

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SECTION A: REPORTING ENTITY INFORMATION

ENTITY NAME:	MEDICAL MUTUAL LIABILITY INS SOC OF MD	TYPE OF REPORT:	INITIAL REPORT
STREET ADDRESS:	225 INTERNATIONAL CIRCLE	ENTITY RELATION TO PRACTITIONER:	INSURANCE COMPANY
CITY, STATE, ZIP CODE:	HUNT VALLEY, MD 21030-	TELEPHONE NO.:	(410) 785-0050 EXT.

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SECTION B: PRACTITIONER INFORMATION REPORTED

	(LAST, FIRST, MIDDLE, SUFFIX)		
NAME:	GOHARI, ABOLGHASSEM M.		
OTHER NAME USED:			
ORGANIZATION NAME:			
WORK ADDRESS:	5915 GREENBELT ROAD	WORK COUNTRY:	
CITY, STATE, ZIP CODE:	COLLEGE PARK MD 20740		
HOME ADDRESS:		HOME COUNTRY:	
CITY, STATE, ZIP CODE:			
LICENSE NO.:	D18165	STATE OF LICENSURE:	MD FIELD OF LICENSURE: 010
DATE OF BIRTH:		SOCIAL SECURITY NO.:	
FEDERAL DEA NO.:	-	FEDERAL DEA NO.:	-
PROFESSIONAL SCHOOL:	TEHRAN UNIVERSITY	YEAR OF GRADUATION:	1973
HOSPITAL AFFILIATION:	COLUMBIA HOSPITAL FOR WOMEN	CITY, STATE:	WASHINGTON D.C.

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THE FOLLOWING INFORMATION WAS REPORTED TO THE NATIONAL PRACTITIONER DATA BANK CONCERNING YOU.

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SECTION C: PAYMENT INFORMATION REPORTED

ACT/OMISSION CODE(S): 250, IMPROPER PERFORMANCE OF SURGERY
DATES OF ACT/OMISSION: 02/09/91 TO 02/09/91
PAYMENT DATE: 05/16/94
PAYMENT TYPE: SINGLE
PAYMENT RESULT OF: JUDGEMENT
ADJUDICATIVE BODY CASE NUMBER:
ADJUDICATIVE BODY:

AMOUNT PAID: $ 10,000.00
NO. OF PRACTITIONERS PAYMENT FOR: 001
DATE OF JUDGMENT OR SETTLEMENT: 03/07/94

ACTS/OMISSIONS DESCRIPTION:
PLAINTIFF ALLEGING INSURED FAILED TO PERFORM PROPER SURGERY, LIABILITY IS DISPUTED.

JUDGMENT/SETTLEMENT DESCRIPTION AND CONDITIONS:
CASE SETTLED TO AVOID COST OF APPEAL.

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