MAR 30 1993

REVENUE

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

$460.00
$460.00
01-015-10

DPR Application Fee - $460.00 - and is non-refundable
APPLICATION SHOULD BE TYPED

NAME: DEBRA ANNE JONES
(FIRST) (MIDDLE) (LAST)

MAILING ADDRESS: 3939 RIO GRANDE BLVD. NW #66 ALBUQUERQUE NM 87107
(C/O) (STREET AND NUMBER) (CITY) (STATE) (ZIP)

PERMANENT ADDRESS: 1500 N. Dixie Highway, Suite 103 West Palm Bch, FL 33401
(C/O) (STREET AND NUMBER) (CITY) (STATE) (ZIP)

PLACE OF BIRTH WASHINGTON D.C. DATE OF BIRTH 03 14 60
(CITY) (STATE) (COUNTRY) (MO) (DAY) (YEAR)

RESIDENCE TELEPHONE: 407 686-0506 ~~(505) ...~~ OFFICE NUMBER 407 835-6768 ~~(505) ...~~ SOCIAL SECURITY NUMBER [redacted]

Have you ever legally CHANGED YOUR NAME? ___Yes X No. If so, enclose certified copy of legal document giving change, e.g. by marriage, etc.

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

RACE: Caucasian___ Black X Hispanic___ Oriental___ Native American__ Other___
SEX: Male___ Female X

DOCTOR OF MEDICINE DEGREE WAS OBTAINED FROM: WAYNE STATE UNIVERSITY SCHOOL OF MEDICINE DETROIT MI
(Medical School and Location) on 06 30 1986
(Month) (Day) (Year)

Are you or have you ever been licensed in any State, Canada, Guam, Puerto Rico or U.S. Virgin Islands? X Yes ___No (If yes, list state(s), license number(s) and date(s) of issuance.

NEW MEXICO 91-230 NOV 1991
NEW YORK 179479 AUG 1989

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FOR OFFICE USE ONLY, PLEASE DO NOT ... LINE

CATEGORY:__________ EXAM SITE:__________
SCHOOL CODE:________ EXAM DATE:__________
EDUCATION:__________ EXAM CODE:__________
CANDIDATE NO:

... HAVE BEEN TAKEN ... PRECEDING DATE ... RE ... PHOTO ON PINK

RECEIVED
MAR 31 1993
D.P.R. MEDICAL/NATUROPATH

Rev. Code 1510 DPR/ME/001 1-90

ARE YOU A CITIZEN OF THE UNITED STATES? Yes ___ No ___ IF PERSON BORN, GIVE DATE AND PLACE OF NATURALIZATION: _____

DID YOU ATTEND A COLLEGE OR UNIVERSITY? Yes X No ___ IF SO, GIVE NAME AND LOCATION:

DATES IN ATTENDANCE: WAYNE STATE UNIVERSITY DETROIT MI 1982-92

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

List degree BS BIOLOGY

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

ALBUQUERQUE NM (City, State of Country) FROM JULY ___, 19__ TO: (MAY, 1993)

DETROIT MI (City, State of Country) FROM AUG ___, 19 82 TO: JUNE ___, 19 86

DARNELL MI (City, State of Country) FROM JULY ___, 19 __ TO: JUNE ___, 19 91

(City, State of Country) FROM ___, 19__ TO: ___, 19___

MEDICAL SCHOOL: BE SPECIFIC. ATTACH SEPARATE SHEET. LIST ALL UNIVERSITIES/COLLEGES WHERE ATTENDED COURSES/RECEIVED TRAINING AS A MEDICAL STUDENT:

WAYNE STATE UNIVERSITY (Name of Medical School Location) FROM AUG ___, 19 82 TO: JUNE ___, 19 86

(Name of Medical School Location) FROM ___, 19__ TO: ___, 19___

(Name of Medical School Location) FROM ___, 19__ TO: ___, 19___

(Name of Medical School Location) FROM ___, 19__ TO: ___, 19___

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

POSTGRADUATE TRAINING - List in chronological order from date of graduation to present date, all postgraduate training (internship, residency, fellowship):

FROM: 7/1/86 TO: 6/30/88 (Exact dates of attendance) (Month, Day, Year) Interfaith Medical Center (Program/Internship/Residency/Fellowship)

1545 ATLANTIC AVE, BROOKLYN, NY 11213
(Name and Address (Street Number, City, State, Territory, Country) of Hospital, Institution (College or Sponsor) where training was received.)

FROM: 7/1/88 TO: 6/30/91 (Exact dates of attendance) (Month, Day, Year) CATHOLIC MEDICAL CENTER (Program/Internship/Residency/Fellowship)

100 NORTH 18TH AVENUE, BROOKLYN NY 11211
(Name and Address (Street Number, City, State, Territory, Country) of Hospital, Institution (College or Sponsor) where training was received.)

-2-

CLINICAL WORK BEGAN 7/22/93

[illegible] 2 for [illegible]

MATERNAL-FETAL MEDICINE

FROM: 7/1/93   TO: present
(Exact dates of attendance)   (Month/Day/Year)

NM MEXICO
Residency/Fellowship ?

2211 LOMAS AVE NE ALBUQUERQUE NM [illegible]

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

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

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

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

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

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

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

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

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

UNIVERSITY OF NEW MEXICO HOSPITAL 2211 LOMAS BLVD. NE ALBUQUERQUE
VETERANS HOSPITAL [illegible] ALBUQUERQUE NM   542 D MEDICAL GROUP/SGH KIRTLAND AIRFORCE BASE NM 87117-5300

Have you ever been in the United States Military? Yes___ No_X_. If so, attach copy of separation from service form and full discharge form.

____
(Branch of service, rank, dates of service)

Are you certified by an American Specialty Board? Yes___ No_X_. If "yes", give name of Board ____
(Enclose copy of Board certificate or letter verifying eligibility)

Are you a diplomate of the National Board of Medical Examiners? Yes_X_ No___. If "yes", state date of certification JULY 1, 1987

Foreign Medical Graduates: ECFMG standard certificate number ____

issued ____ after passing English and medical examination. Attach copy of current valid certificate.

POOR DOCUMENT

All applicants must answer the following questions:

1. Have you ever studied to become, or do you hold licensure in any state as a Chiropractor, Naturopathic or Osteopathic physician? Yes___ No__x__.

2. Have you ever failed State Board/FLEX/National Board Examination? Yes___ No__x__.

3. Have you ever been denied an application for licensure to practice medicine by any state board or other governmental agency of any state or country? Yes___ No__x__.

4. Have you ever been notified to appear before any licensing agency for a hearing on a complaint of any nature, including, but not limited to, a charge or violation of the medical practice act, unprofessional or unethical conduct? Yes___ No__x__.

5. Have you ever had a license to practice medicine/surgery/revoked, suspended, or other disciplinary action taken in any state, territory or country? Yes___ No__x__.

6. Have you ever been convicted of a felony? Yes___ No__x__; a misdemeanor? Yes___ No__x__. Have any judgments ever been entered against you? Yes___ No__x__. Have you ever been sued for malpractice? Yes___ No__x__.

7. Have you ever had to discontinue practice for any reason for a period of one month or longer? Yes___ No__x__.

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

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

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

11. Have you ever been denied staff privileges in any hospital? Yes___ No__x__. Have you ever had your staff privileges suspended, revoked, modified, restricted, placed on probation, or otherwise acted against (explain "otherwise" actions)? Yes___ No__x__.

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

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

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

12. Have you ever been allowed to resign from any hospital, institution, clinic or medical facility in lieu of disciplinary action? Yes___ No__x__.

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

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

13. Has an application for medical society membership ever been rejected? Yes___ No_x_.
Have you ever had your medical society membership suspended? Yes___ No_x_.
Have you ever been notified to appear before a medical society in regard to charges/complaints filed against you? Yes___ No_x_.

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

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

AMERICAN COLLGE OF OBSTETRICS AND GYNECOLOGY 409 12th Street,SW Washington DC 20024

SOCIETY OF PERINATOLOGISTS 409 12th St. SW Washington DC 20024

14. Have you ever been warned or called before the Bureau of Narcotics and Dangerous Drugs? Yes___ No_x_. Have you ever been made an offer to compromise in connection with the Harrison Narcotic Law? Yes___ No_x_. Have you ever been denied, or surrendered, a narcotic tax stamp? Yes___ No_x_.

****

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

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

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

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

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

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

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

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

TO BE COMPLETED BY APPLICANT:

DATE 3/17/93 COLOR OF EYES BROWN

AGE 33 COLOR OF HAIR BROWN

HEIGHT 5'7" WEIGHT 140 OTHER MEANS OF IDENTIFICATION _____

AFFIDAVIT OF APPLICANT:

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

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

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

Debra Anne Jones
(signature of applicant)

COUNTY OF Bernalillo

State of New Mexico

Subscribed and sworn to me before this 22nd day of March, 1993

Kristie Krieger
(notary public)

My commission expires 12-20-95
(notary seal/stamp)

06/02/93 10:16 ☎505 2726385 UNM DEPT OBGYN 001/003

POOR DOCUMENT

MAR 30 1993

REVENUE

DPR

DEPARTMENT OF PROFESSIONAL REGULATION
BOARD OF MEDICINE

Northwood Centre, 1940 North Monroe Street
Tallahassee, Florida 32399-0770
(904)488-0595

ENDORSEMENT APPLICATION

03/31/93 $460.00
BT: 92010709 RC: 920299006
01-015-10 $460.00

Application Fee - $460.00 - and is non-refundable
APPLICATION SHOULD BE TYPED

NAME: DEBRA (FIRST) ANNE (MIDDLE) JONES (LAST)

MAILING ADDRESS: (C/O) 3939 RIO GRANDE BLVD. NW [illegible] (STREET AND NUMBER) ALBUQUERQUE (CITY) NM (STATE) 87[illegible] (ZIP)

PERMANENT ADDRESS: (C/O) 1500 N. DIXIE HIGHWAY, SUITE 103 (STREET AND NUMBER) WEST PALM BEACH (CITY) FLA (STATE) 33402 (ZIP)

PLACE OF BIRTH WASHINGTON D.C. (CITY) (STATE) (COUNTRY) DATE OF BIRTH 03 (MO) 14 (DAY) 60 (YEAR)

RESIDENCE TELEPHONE: (505) [illegible]-0842 OFFICE NUMBER (505) 272-[illegible] [redacted]BER

Have you ever legally CHANGED YOUR NAME? ___Yes x No. If so, enclose certified copy of legal document giving change, e.g. by marriage, etc.

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

RACE: Caucasian___ Black x Hispanic___ Oriental___ Native American___ Other___
SEX: Male___ Female x

DOCTOR OF MEDICINE DEGREE WAS OBTAINED FROM: WAYNE STATE UNIVERSITY
SCHOOL OF MEDICINE DETROIT MI (Medical School and Location)
on 06 (Month) 03 (Day) 1986 (Year)

Are you or have you ever been licensed in any State, Canada, Guam, Puerto Rico or U.S. Virgin Islands? x Yes ___No (If yes, list state(s), license number(s) and date(s) of issuance.

NEW MEXICO 91-239 NOV 1991
NEW YORK 179474 AUG 1989

****

FOR OFFICE USE ONLY, PLEASE DO NOT [redacted] LINE
CATEGORY: [illegible] SITE: [redacted] HAVE BEEN TAKEN
SCHOOL CODE: [illegible] DATE: [redacted] RECEDING DATE
EDUCATION: EXAM CODE:
CANDIDATE NO:

RECEIVED
MAR 31 1993

Rev. Code 1510 DPR/ME/001 1-90

DPR MEDICAL/NATUROPATH

Post-it brand fax transmittal memo 7671 # of pages 3
To MR. OCCIE GILLIS From DR. DEBRA JONES
Co. DPR, BOARD OF MED Co. UNMH
Phone 505-272-6136
Fax 904-922-3040 Fax 505-272-6385

POOR DOCUMENT

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

MAR 30 1993

REVENUE

ENDORSEMENT APPLICATION

03/31/93 $460.00
DPR Application Fee - $460.00 - and is non-refundable BT: 520015709 RC: 920298006
APPLICATION SHOULD BE TYPED 01-015-10 $460.00

NAME: DEBRA (FIRST) ANNE (MIDDLE) JONES (LAST)

MAILING ADDRESS: 3939 RIO GRANDE BLVD. NW #66 (C/O) (STREET AND NUMBER) ALBUQUERQUE (CITY) NM (STATE) 87107 (ZIP)

PERMANENT ADDRESS: 1500 N. DIXIE HIGHWAY - SUITE 103 (C/O) (STREET AND NUMBER) WEST PALM BEACH (CITY) FLA (STATE) 33401 (ZIP)

PLACE OF BIRTH WASHINGTON D.C. (CITY) (STATE) (COUNTRY) DATE OF BIRTH 09 14 69 (MO) (DAY) (YEAR)

RESIDENCE TELEPHONE: (505) 343- 0832 OFFICE NUMBER (505) 272 - 6136 [redacted]ER

Have you ever legally CHANGED YOUR NAME? ___Yes ___No. If so, enclose certified copy of legal document giving change, e.g. by marriage, etc.

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

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

DOCTOR OF MEDICINE DEGREE WAS OBTAINED FROM: WAYNE STATE UNIVERSITY SCHOOL OF MEDICINE DETROIT MI (Medical School and Location) on 06 03 1986 (Month) (Day) (Year)

Are you or have you ever been licensed in any State, Canada, Guam, Puerto Rico or U.S. Virgin Islands? x Yes ___No (If yes, list state(s), license number(s) and date(s) of issuance.

NEW MEXICO 91 - 230 NOV 1991
NEW YORK 179474 AUG. 1984

****

FOR OFFICE USE ONLY, PLEASE DO NOT [redacted] LINE
CATEGORY: ___ SITE: ___
SCHOOL CODE: ___ DATE: ___ HAVE BEEN TAKEN
RECEDING DATE

EDUCATION: ___ EXAM CODE: ___
CANDIDATE NO: ___

RECEIVED
MAR 31 1993

Rev. Code 1510 DPR/ME/001 1-90

D.P.R. MEDICAL/NATUROPATH

Post-it™ brand fax transmittal memo 7671 | # of pages ▸ 1

To MR. OCCIE GILLIS	From DR. DEBRA JONES
Co. DPR, BOARD OF MED.	Co. UNMH
Dept.	Phone # 505-272-6136
Fax # 904-922-3040	Fax # 505-272-6385

RECEIVED
MAR 30 1993

REVENUE
DPR

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

ENDORSEMENT APPLICATION

03/31/93 $460.00
BT: 92010709 RC: 92029006
01-015-10 $460.00

Application Fee - $460.00 - and is non-refundable
APPLICATION SHOULD BE TYPED

NAME: DEBRA (FIRST) ANNE (MIDDLE) JONES (LAST)

MAILING ADDRESS: (C/O) 3939 RIO GRANDE BLVD. NW #66 (STREET AND NUMBER) ALBUQUERQUE (CITY) NM (STATE) 87107 (ZIP)

PERMANENT ADDRESS: (C/O) 1500 N. Dixie Highway, Suite 103 (STREET AND NUMBER) West Palm Beach (CITY) FL (STATE) 33401 (ZIP)

PLACE OF BIRTH WASHINGTON D.C. (CITY) (STATE) (COUNTRY) **DATE OF BIRTH** 03 (MO) 14 (DAY) 60 (YEAR)

RESIDENCE TELEPHONE: 401 686-0506 ~~(505) 343-0832~~ **OFFICE NUMBER** 855-674 [redacted] (505) 272-6136 **CITY NUMBER**

Have you ever legally **CHANGED YOUR NAME?** ___Yes X No. If so, enclose certified copy of legal document giving change, e.g. by marriage, etc.

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

RACE: Caucasian___Black X Hispanic___Oriental___Native American___Other___
SEX: Male___Female X

DOCTOR OF MEDICINE DEGREE WAS OBTAINED FROM: WAYNE STATE UNIVERSITY (Medical School and Location)

SCHOOL OF MEDICINE DETROIT MI on 06 (Month) 30 (Day) 1985 (Year)

Are you or have you ever been licensed in any State, Canada, Guam, Puerto Rico or U.S. Virgin Islands? X Yes___No (If yes, list state(s), license number(s) and date(s) of issuance.

NEW MEXICO 91 - 230 NOV 1991
NEW YORK 179474 AUG. 1989

****

FOR OFFICE USE ONLY, PLEASE DO NOT [illegible] **LINE**

CATEGORY:_____ EXAM SITE:_____ [illegible] HAVE BEEN TAKEN
SCHOOL CODE:_____ EXAM DATE:_____ [illegible] RECEDING DATE

EDUCATION:_____ EXAM CODE:_____ [illegible] ERE
CANDIDATE NO:_____ [illegible] PHOTO ON PINK

RECEIVED
MAR 31 1993

Rev. Code 1510 DPR/ME/001 1-90

D.P.R. MEDICAL/NATUROPATH

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

DID YOU ATTEND A COLLEGE OR UNIVERSITY? Yes X No ___ IF SO, GIVE NAME AND LOCATION,

DATE(S) IN ATTENDANCE: WAYNE STATE UNIVERSITY DETROIT MI 1977- 1982

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

List degree BS BIOLOGY

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

ALBUQUERQUE , NM (city, state or country) FROM JULY ___, 19 91 TO: (MAY, 19 1993)

DETROIT MI (city, state or country) FROM AUG ___, 19 82 TO: JUNE ___, 19 86

BROOKLYN NY (city, state or country) FROM JULY ___, 19 86 TO: JUNE ___, 19 91

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

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

WAYNE STATE UNIVERSITY (Name of medical school/location) FROM AUG ___, 19 82 TO: JUNE ___, 19 86

(Name of medical school/location) FROM ___, 19__ TO: ___, 19___

(Name of medical school/location) FROM ___, 19__ TO: ___, 19___

(Name of medical school/location) FROM ___, 19__ TO: ___, 19___

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

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

FROM: 7/1/86 (Exact dates of attendance) TO: 6/7/88 (Month/Day/Year) Interfaith Medical Center (Program(Internship/Residency/Fellowship)

1545 ATLANTIC AVE. BROOKLYN , NY 11213
Name and Address (Street Number, City, State, Territory, Country) of Hospital, Institution (Program Sponsor) where training was received.

FROM: 7/1/88 (Exact dates of attendance) TO: 6/30/91 (Month/Day/Year) CATHOLIC MEDICAL CENTER (Program(Internship/Residency/Fellowship)

170 KINGSLAND AVENUE, BROOKLYN NY 11213
Name and Address (Street Number, City, State, Territory, Country) of Hospital, Institution (Program Sponsor) where training was received.

CLINICAL WORK BEGAN 7/22/93 — See response to 6/2/93 memo (dated 6/9/93) re 2 yr correction Dean

MATERNAL-FETAL MEDICINE

FR: 7/1/93 TO: present (Month/Day/Year)

(5) dates of attendance — IN MEXICO residency/Fellowship ?

2211 LOMAS AVE NE ALBUQUERQUE NM 8[illegible]

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

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

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

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

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

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

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

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

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

UNIVERSITY OF NEW MEXICO HOSPITAL 2211 LOMAS BLVD. NE ALB. NM 87131
VETRANS HOSPITAL KAFB ALBUQUERQUE NM 542 D MEDICAL GROUP/SGH KIRTLAND
AIRFORCE BASE NM 87117-5300

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

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

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

Are you a diplomate of the National Board of Medical Examiners? Yes X No ___. If "yes", state date of certification JULY 1, 1987

Foreign Medical Graduates: ECFMG standard certificate number _____

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

POOR DOCUMENT

All applicants must answer the following questions:

1. Have you ever studied to become, or do you hold licensure in any state as a Chiropractor, Naturopathic or Osteopathic physician? Yes___ No_x_.

2. Have you ever failed State Board/FLEX/National Board Examination? Yes___ No_x_.

3. Have you ever been denied an application for licensure to practice medicine by any state board or other governmental agency of any state or country? Yes___ No_x_.

4. Have you ever been notified to appear before any licensing agency for a hearing on a complaint of any nature, including, but not limited to, a charge or violation of the medical practice act, unprofessional or unethical conduct? Yes___ No_x_.

5. Have you ever had a license to practice medicine/surgery/revoked, suspended, or other disciplinary action taken in any state, territory or country? Yes___ No_x_.

6. Have you ever been convicted of a felony? Yes___ No_x_; a misdemeanor? Yes___ No_x_. Have any judgments ever been entered against you? Yes___ No_x_. Have you ever been sued for malpractice? Yes___ No_x_.

7. Have you ever had to discontinue practice for any reason for a period of one month or longer? Yes___ No_x_.

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

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

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

11. Have you ever been denied staff privileges in any hospital? Yes___ No_x_. Have you ever had your staff privileges suspended, revoked, modified, restricted, placed on probation, or otherwise acted against (explain "otherwise" actions)? Yes___ No_x_.

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

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

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

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

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

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

13. Has an application for medical society membership ever been rejected? Yes___ No_x_.
Have you ever had your medical society membership suspended? Yes___ No_x_.
Have you ever been notified to appear before a medical society in regard to charges/complaints filed against you? Yes___ No_x_.

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

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

AMERICAN COLLGE OF OBSTETRICS AND GYNECOLOGY 409 12th Street,SW Washington DC 20024

SOCIETY OF PERINATOLOGISTS 409 12th St. SW Washington DC 20024

14. Have you ever been warned or called before the Bureau of Narcotics and Dangerous Drugs? Yes___ No_x_. Have you ever been made an offer to compromise in connection with the Harrison Narcotic Law? Yes___ No___. Have you ever been denied, or surrendered, a narcotic tax stamp? Yes___ No_x_.

****

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

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

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

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

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

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

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

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

TO BE COMPLETED BY APPLICANT:

DATE 3/17/93 COLOR OF EYES BROWN

AGE 33 COLOR OF HAIR BROWN

HEIGHT 5'7" WEIGHT 140 OTHER MEANS OF IDENTIFICATION _____

AFFIDAVIT OF APPLICANT:

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

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

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

Debra Anne Jones
(signature of applicant)

COUNTY OF Bernalillo

State of New Mexico

Subscribed and sworn to me before this 22nd day of March, 19 93

Kristi Kruger
(notary public)

My commission expires 12-20-95
(notary seal/stamp)