11. FLORIDA BIRTH RELATED NEUROLOGICAL COMPENSATION ASSOCIATION

You must choose one of the three options described below. Please be sure to view the information about each exemption at www.nica.com. Check only one.

☐	☒	☐	already paid online
$5,000 Participating	$250 Non-participating	$0 Exempt	Amount enclosed

If you choose "$0 Exempt" provide appropriate documentation to the Board of Medicine and to NICA.

I have read the explanatory information provided by NICA, and I choose the option above.

Signature 1/29/2019 Date

THY NGUYEN
Name
867 E Lombard St
Street Address
Baltimore MD 21202
City, State, Zip

If you are a participating or non-participating physician, or a physician claiming exemption, you must complete, sign and date this form and return it with your payment to this address.

Board of Medicine
4052 Bald Cypress Way, #C-03
Tallahassee, FL 32399-3253

If you are a physician claiming exemption, you must also send a copy of your completed, signed, and dated form with proof of your exemption to:

NICA
2360 Christopher Place
Tallahassee, FL 32308

If you have any questions about NICA or this form, please contact NICA at www.nica.com or (850) 488-8191.

4. LICENSURE HISTORY

Request verification of licensure status directly from the licensing entity or www.veridoc.org. Request international license verification(s) if you have practiced outside of the U.S. for at least two of the previous four years.

☐ Yes ☐ No Do you now hold or have you ever held a license to practice medicine or any other profession in any US State or territory, or foreign country? Please list in table below.

Jurisdiction	Profession	License number

If you answer "yes" to any of the questions in this section, you are required to send an explanation and supporting documentation.

☐ Yes ☐ No Have you had any application for a medical license or professional license denied by any state board or other governmental agency of any state, territory, or country?

☐ Yes ☐ No Are you currently under investigation in any jurisdiction for an act or offense that would constitute a violation of Section 458.331, Florida Statutes?

☐ Yes ☐ No Have you ever had any professional license or license to practice medicine revoked, suspended, placed on probation, or other disciplinary action taken in any state, territory or country?

5. PRACTICE/EMPLOYMENT HISTORY

List the year you legally first began to practice medicine, 2005 (yyyy). This would be the year you began practicing medicine and could be the date you began your postgraduate training.

☒ Yes ☐ No Have you practiced medicine in another jurisdiction for two of the last four years **or** completed a board approved post-graduate training program within the last two years?

☐ Yes ☐ No If your answer to the question above was "No," have you passed a board approved clinical competency exam within the last year? If yes, then submit supporting documentation.

List in chronological order all employment for the last four (4) years.

Name and address of practice or employment	Type of employment	From: mm/yy	To: mm/yy
FirstChoice Family Medicine 9 Deneiset Asheville – Timonium MD	Self-physician	10/2010	present
Planned Parenthood of MD	Physician	2/2008	7/2018
Teladoc	Telemedicine	4/2014	present

Application

Application Detail

License Type:	**Medical Doctor**
Profession Number:	**1501 - Medical Doctor**
File Number:	**141459**
Application:	**Medical Doctor Endorsement Application**
Application Date:	**01/14/2019**

Suitability Question(s)

Are you an osteopathic physician?	**No**

Application Questions

Military Veteran Fee Waiver - I have been honorably discharged from a branch of the United States Armed Forces within the previous 60 months.	**No**
I am selecting NICA Non-Participating - (I understand that a $250.00 fee will be included if I select this option.)	**Yes**
I will qualify for "In Training" status at the approval of my licensure application.	**No**
I plan to dispense medicinal drugs in the State of Florida for a fee or other remuneration and hereby register as required by Section 465.0276,F.S. I understand that the fee for the Dispensing Practitioner is $100.00 over and above the required initial license fee and will submit it along with the license fee.	**No**
I completed a board approved post-graduate training program within the last two years or have practiced medicine in another jurisdiction for two of the last four years.	**No**

Military Veteran Spouse Fee Waiver - I am the spouse of a military veteran who has been honorably discharged from a branch of the United States Armed Forces within the previous 60 months.	**No**

Personal Detail

First Name:	**Thy**
Last Name/Surname:	**Nguyen**
Birthdate:	**09/25/1976**
Gender:	**Female**
Race:	**Asian**
Social Security Number:	[redacted]

Addresses

Mailing Address

Address:	**9 Deneison St** **Out of State** **Lutherville Timonium, MD** **21093** **US**
Phone Number:	**443-318-4141**
Extension:	
E-mail Address:	**firstchoicefm@gmail.com**
Home	
Fax	

Place of Practice

Address:	**9 Deneison S 9 Deneison Street** **Out of State** **LUTHERVILLE TIMONIUM, MD** **21093** **US**
Phone Number:	
Extension:	

Federal Credentials Verification Services (FCVS)

Are you using the FCVS to verify your core credentials?	**No**

Education History

School Name:	**ST. GEORGES UNIVERSITY**
Street Address Line 1:	**3500 Sunrise Highway**
Street Address Line 2:	**Bldg 300**
City:	**Great River**
State:	**NEW YORK**
Postal/Zip:	**11739**
Country:	**UNITED STATES OF AMERICA**
Date of Graduation (mm/dd/yyyy):	**05/30/2005**
Attended From (mm/dd/yyyy):	**08/01/2001**
Attended To (mm/dd/yyyy):	**05/30/2005**

Additional Education Questions

Are you currently in default on any health education loan or scholarship obligation?	**No**
Have you completed the equivalent of 2 academic years of preprofessional, postsecondary education including, courses in anatomy, biology, and chemistry prior to entering medical school?	**Yes**
Description:	**pre med at UCLA**

Fifth Pathway

Did you attend an international medical school and do not possess a valid ECFMG Certificate?	**No**
Did you receive a bachelor's degree from an accredited United States college or University?	**Yes**
Did you study at a medical school which is recognized by the World Health Organization?	**No**
Did you complete all of the formal requirement of the International medical school, except the internship or social service requirements, and pass part I of the National board of Medical examination or the Education Commission for Foreign Medical Graduates Examination equivalent?	**Yes**

Did you complete an academic year of supervised clinical training in a hospital affiliated with a medical school approved by the Council on Medical Education of the American Medical Association and upon completion passed part II of the National Board of Medical Examiners examination or the Education Commission for Foreign Medical Graduates examination Equivalent?	**Yes**

Postgraduate Training

Program Name:	**University of Maryland Family Medicine Residency**
Mailing Address:	**29 S. Paca St. Baltimore, MD 21201**
Program City:	**Baltimore**
Program State or Country:	**MARYLAND**
Program Type:	**RESIDENCY**
Specialty Area:	**FAMILY MEDICINE**
Attended From (mm/dd/yyyy):	**07/01/2005**
Attended To (mm/dd/yyyy):	**06/30/2008**
Did you receive credit?	**Yes**

Exam History

Examination:	**National Board**
Date Passed (mm/dd/yyyy):	**04/18/2018**

United States Military and/or Public Health

Have you ever been in the United States Military and/or Public Health Service?	**No**
Have you ever been disciplined by any branch of the United States Armed Services or Public Health Service?	**No**

Other State Licenses 1

Do you now hold or have you ever held a license to practice medicine or any other profession in any US State or territory, or foreign country?	**Yes**

Request verification of licensure status directly from the licensing entity or www.veridoc.org. Request international license verification(s) if you have practiced outside of the U.S. for at least two of the previous four years.

License Number:	**D066660**
Profession:	**Medical Doctor**
Jurisdiction - Country:	**UNITED STATES**

Jurisdiction - State: **MARYLAND**

Other State Licenses 2

Do you now hold or have you ever held a license to practice medicine or any other profession in any US State or territory, or foreign country? **Yes**

Request verification of licensure status directly from the licensing entity or www.veridoc.org. Request international license verification(s) if you have practiced outside of the U.S. for at least two of the previous four years.

License Number: **A104638**

Profession: **Medical Doctor**

Jurisdiction - Country: **UNITED STATES**

Jurisdiction - State: **CALIFORNIA**

Other State Licenses 3

Do you now hold or have you ever held a license to practice medicine or any other profession in any US State or territory, or foreign country? **Yes**

Request verification of licensure status directly from the licensing entity or www.veridoc.org. Request international license verification(s) if you have practiced outside of the U.S. for at least two of the previous four years.

License Number: **21394**

Profession: **Medical Doctor**

Jurisdiction - Country: **UNITED STATES**

Jurisdiction - State: **NORTH CAROLINA**

Additional Employment Questions

Have you practiced medicine in another jurisdiction for two of the last four years or completed a board approved post-graduate training program within the last two years? **No**

Have you passed a board approved clinical competency exam within the last year? **Yes**

Graduate Education

Do you currently, or have you had, responsibility for graduate medical education within the last 10 years? **No**

Initial Graduate Medical Education Responsibility and Faculty Appointments

List all institutions where you have had responsibility for graduate medical education or faculty appointment(s) at any medical school.

Name of Institution: **N/A**

Staff Privileges

Do you currently hold staff privileges in any hospital, health institution, clinic or medical facility?	**No**

Specialty Board Certifications

Are you certified by any specialty board recognized by the American Board of Medical Specialties or specialty board approved by the Florida Board of Medicine?	**Yes**
Specialty Brd:	**AMERICAN BOARD OF FAMILY MEDICINE**
Specialty Cert:	**IFP - INTERNAL MEDICINE/FAMILY PRACTICE**
Date Certified:	**06/14/2018**

DEA

Have you ever been denied, or surrendered, a DEA registration?	**No**

Criminal History

Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to, a crime in any jurisdiction other than a minor traffic offense?	**No**

You must include all misdemeanors and felonies, even if adjudication was withheld. Driving under the influence (DUI) or driving while impaired (DWI) are not minor traffic offenses for purposes of this question.

Medicaid / Medicare

1. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, F.S. (relating to social and economic assistance), Chapter 817, F.S. (relating to fraudulent practices), Chapter 893, F.S. (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction?	**No**
2. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970 (relating to controlled substances) or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)?	**No**
3. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, F.S.?	**No**
4. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program?	**No**
5. Are you currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities?	**No**

Health History

In the last five years, have you been enrolled in, required to enter into, or participated in any drug and/or alcohol recovery program or impaired practitioner program for treatment of drug or alcohol abuse that occurred within the past five years?	[redacted]
In the last five years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental disorder or impairment?	
During the last five years, have you been treated for or had a recurrence of a diagnosed mental disorder that has impaired your ability to practice medicine within the past five years?	
During the last five years, have you been treated for or had a recurrence of a diagnosed physical disorder that has impaired your ability to practice medicine?	
In the last five years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol/drug) disorder or, if you were previously in such a program, did you suffer a relapse within the last five years?	
During the last five years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol/drug) disorder that impaired your ability to practice medicine within the last five years?	

Electronic Fingerprinting

I have been provided and read the statement from the Florida Department of Law Enforcement regarding the sharing, retention, privacy and right to challenge incorrect criminal history records and the 'Privacy Statement' document from the Federal Bureau of Investigation.	**Yes**
Enter in today's date	**01/14/2019**

Medical Malpractice Question

Have you ever had a judgment entered against you for medical malpractice where the incident(s) of malpractice occurred after November 2, 2004?	**No**

Liability Claims

Within the last 10 years have you had any liability claim(s) or action(s) for damages for personal injury settled or finally adjudicated in an amount that exceeds $100,000.00?	**No**

Financial Responsibility/Exemption

Financial Responsibility	**3. LIABILITY NOT LESS THAN $100,000**

FDA Institution

Have you ever had any staff privileges denied, suspended, revoked, modified, restricted, not renewed or placed on probation, or have you been asked to resign or take a temporary leave of absence or were otherwise acted against by any facility?	**No**

FDA Licensing

Have you ever had any professional license or license to practice medicine revoked, suspended, placed on probation, received a citation, or other disciplinary action taken in any state, territory or country?	**No**

FDANP Denied

Have you had any application for a medical license or professional license denied by any state board or other governmental agency of any state, territory, or country?	**No**

FDANP Investigation

Are you currently under investigation in any jurisdiction for an act or offense that would constitute a violation of Section 458.331, Florida Statutes?	**No**

Specialty Board Discipline History

Have you ever had any final disciplinary action taken against you by a specialty board or other similar national organization?	**No**

Year Began Practice

Year Began Practice:	**07/01/2005**

Availability for Disaster

Are you willing to provide health care services in special need shelters or to work with disaster medical teams during times of emergency or major disasters?	**Yes**

Fees

Application	**$350.00**
Unlicensed Activity	**$5.00**
NICA Fee	**$250.00**
Initial License	**$350.00**
Total Amount Due:	**$955.00**

Attestation

I state that these statements are true and correct. I recognize that providing false information may result in denial of licensure, disciplinary action against my license, or criminal penalties pursuant to Sections 456.067, 775.083, and 775.084, Florida Statutes. I state that I have read Chapters 456, 458 and 766.301-.316, Florida Statutes and Chapter 64B8, Florida Administrative Code.

I hereby authorize all hospitals, institutions or organizations, 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 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. I state 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 constitutes cause for denial, suspension, or revocation of my license to practice Medicine in the State of Florida. If there are any changes to my status or any change that would affect any of my answers to this application I must notify the board within 30 days.

I understand that my records are protected under federal and state regulations governing Confidentiality of Mental Health Patient Records and cannot be disclosed without my written consent unless otherwise provided in the regulations. I understand that my records are protected under federal and state regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it.

Attestation Answer: Yes