Application Summary

Application Detail

License Type:	**Medical Doctor**
Profession Number:	**1501 - Medical Doctor**
License Number:	**82602**
Application:	**Renew My Medical Doctor License**
Application Date:	**12/19/2017**

Personal Detail

Title:	**Dr.**
First Name:	**GERALD**
Middle/Second Name:	**BRIAN**
Last Name/Surname:	**APPLEGATE**
Suffix:	**MD**

Addresses

Mailing Address

Address:	**P.O. BOX 402098** **MIAMI-DADE** **MIAMI BEACH, FL** **33140-0098** **US**
Phone Number:	**(305) 285-6999**
Extension:	
E-mail Address:	**jerryapple@comcast.net**
Home	

Place of Practice

Address:	**Suite 575 EVE MEDICAL CENTER** **MIAMI-DADE** **DORAL, FL** **33166** **US**

Phone Number:

Extension:

Satellite Location

Address: **EVE MEDICAL CENTER-DADELAND TO**

MIAMI-DADE

KENDALL, FL

33158

US

Phone Number:

Extension:

E-mail Address:

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**

Financial Responsibility/Exemption

Financial Responsibility	**5. NOT TO CARRY MEDICAL MALPRACTICE**

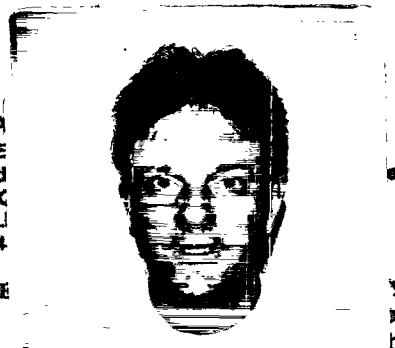
Fees

FDLE Background Chec	**$24.00**
Active Renewal	**$350.00**
Unlicensed Activity	**$5.00**
Total Amount Due:	**$379.00**

Attestation

By submitting the appropriate renewal fees to the Department, I certify compliance with all requirements for renewal. I am responsible for knowing these requirements as set forth in the laws and rules that govern my profession.

Attestation Answer: Yes



2-23-2000

FEB 23. '00

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Y EXAM INDICATE TYPE)

☐ $410, background check $43) Total $453

☐ background check $43) Total $453

☒ ENDORSEMENT (application fee $460, background check $43) Total $503

☐ PUBLIC HEALTH CERTIFICATE (application fee $210 background check on renewal)

☐ PUBLIC PSYCHIATRY CERTIFICATE (application fee $210 background check on renewal)

APPLICATION SHOULD BE TYPED

APPLICATION FEES ARE NON-REFUNDABLE

2 SOCIAL SECURITY NUMBER: [redacted]

3 CURRENT NAME: Gerald (FIRST) Brian (MIDDLE) Applegate, M.D. (LAST)

Have you ever legally CHANGED YOUR NAME? Yes ___ No ✓.

FORMER NAME: ___ (FIRST) ___ (MIDDLE) ___ (LAST)

4 MAILING ADDRESS: 1601 Fieldstone Lane - Sewickley, PA 15143
(STREET AND NUMBER) (CITY) (STATE) (ZIP)

PRIMARY PRACTICE ADDRESS: 10475 Perry Highway, Suite 208 Towne Centre Wexford, PA 15090
(STREET AND NUMBER) (CITY) (STATE) (ZIP)

5 PLACE OF BIRTH Newark, New Jersey (CITY) USA (STATE) COUNTRY) DATE OF BIRTH 6/16/56 (MO) (DAY) (YEAR)

6 TELEPHONE: 412-741-0387 AREA CODE HOME # 724-934-1231 AREA CODE OFFICE #

7 DOCTOR OF MEDICINE DEGREE WAS OBTAINED FROM: University of Medicine & Dentistry, New Jersey (Medical School) Medical School.

Newark, New Jersey (Location) on May 26, 1982 (Month) (Day) (Year)

8. YEAR BEGAN PRACTICING MEDICINE 1983

9 Are you or have you ever held any professional/medical license in any State in the U.S., to include Canada, Guam, Puerto Rico or U.S. Virgin Islands? Yes X No ___.

Physician-Pennsylvania # MD-029271E - Issued 7/8/83

(If yes, list profession(s), state(s), license number(s) and date(s) of issuance.)

Physician-Ohio # 35065717 - Issued 9/10/93 Physician- New York #197471- Issued 10/13/94

(If yes, list profession(s), state(s), license number(s) and date(s) of issuance.)

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 ___ Hispanic ___ Oriental ___ Native American ___ Other ___
SEX: Male ___ Female ___

		Rev. Code 1510 AHCA/ME/001 1-90;07/94 DOH/ME/031/1-90, Rev 07/94; 1/95; 10/97; 2/99

1501/f#77066

RECEIVED
FEB 23 '00
MAR 02 2000

03/06/2000 $503.00
ID: 1501-77066 Type: F
BT: H08944 DP: 168464
VL: 990070594

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APPLICATION SHOULD BE TYPED **APPLICATION FEES ARE NON-REFUNDABLE**

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3 CURRENT NAME: Gerald (FIRST) Brian (MIDDLE) Applegate, M.D. (LAST)

Have you ever legally CHANGED YOUR NAME? Yes ___ No ✓

FORMER NAME: (FIRST) (MIDDLE) (LAST)

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(STREET AND NUMBER) (CITY) (STATE) (ZIP)

PRIMARY PRACTICE ADDRESS: 10475 Perry Highway, Suite 208 Towne Centre Wexford, PA 15090
(STREET AND NUMBER) (CITY) (STATE) (ZIP)

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(CITY) (STATE) COUNTRY (MO) (DAY) (YEAR)

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Physician-Pennsylvania # MD-029271E - Issued 7/8/83
(If yes, list profession(s), state(s), license number(s) and date(s) of issuance.)

Physician-Ohio # 35065717 - Issued 9/10/93 Physician- New York #197471- Issued 10/13/94
(If yes, list profession(s), state(s), license number(s) and date(s) of issuance.)

MEDICINE BOARD
2000 FEB 16 AM 9:10

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

10

UNDERGRADUATE/GRADUATE EDUCATION

NAME COLLEGE/UNIVERSITY	CITY/STATE/COUNTRY	FROM:	TO:	MAJOR/MINOR COURSE OF STUDY	DID YOU GRADUATE	DEGREE RECEIVED
Seton Hall University	South Orange, New Jersey, USA	7/74	5/78	BIOLOGY	Yes	BS

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PROFESSIONAL/MEDICAL EDUCATION; e.g. JD, Ed.D., Ph.D., RN, PA, MD, DO, DDS, DC, etc.

Did you receive advanced standing into Medical School? Yes ____ No X

If "yes" explain:_____

_____

Was attendance in Medical School for a period other than the normal curriculum? Yes ____ No X

If "yes" explain:_____

_____

MEDICAL EDUCATION:
List all medical schools and universities attended, whether completed or not.

NAME SCHOOL/UNIVERSITY	ADDRESS & CITY STATE/COUNTRY	FROM:	TO:	DOMICILE ADDRESS & CITY/STATE/COUNTRY	DID YOU GRADUATE	DEGREE RECEIVED
University of Medicine & Dentistry-New Jersey				82 BLANCHARD RD		
Medical School	185 S. Orange Ave Newark, NJ 07103	7/78	5/82	SO. ORANGE, NJ 07079	Yes	M.D

All applicants must complete questions 15 through 44:

15

PROFESSIONAL/POSTGRADUATE TRAINING -
List all professional/postgraduate training program(s) began, whether completed or not.

During any postgraduate training were you ever on probation, restrictions, suspension, revocation, modification, or otherwise acted against (explain "otherwise" actions)? Yes ___ No X.

If "YES", list name(s) and address(es) of postgraduate training institution(s)

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

Have you ever been requested to leave, temporarily or permanently, a medical training program prior to completion of training? Yes ___ No X.

If "yes" explain ___

List in chronological order from date of graduation from medical school all professional/postgraduate training (Internship, Residency, Fellowship) to the present.

Program(Internship/Residency/Fellowship) and Specialty Area	Program Address (street #, address, city state, zip) (Internship/Residency/Fellowship)	MONTH/YEAR FROM		TO		Credit Received Yes	No
Internship - Obstetrics & Gynecology	Magee Women's Hospital* 300 Halket St., Pittsburgh, PA	7	82	6	83	X	
Residency- Obstetrics & Gynecology	Magee Women's Hospital* 15213 300 Halket St., Pittsburgh, PA	7	83	6	86	X	
	15213						

* Send to Attn: Diana Brucha

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PRACTICE/EMPLOYMENT - List in chronological order from date of graduation to present date, all practice employment, non-employment and/or any unaccounted period of time from date of matriculation into medical school.

(Type of Practice and Employment or Non-Employment)	Name and Address of practice setting (Street #, address, City, State, Territory, Country) of Non-employment, Employment and/or Practice Setting	MONTH/YEAR FROM		TO	
Magee Women's Hospital - Intern & Residen	Attn: Diane Brucha 300 Halket St., Pittsburgh, PA 15213	7	82	6	86
Women's Health Services-Staff Physician	221-225 5th Ave., Pittsburgh, PA 15222	1	84	Present	
Magee Women's Hospital-Attending Physician	Attn: Amy Angil 300 Halket St., Pittsburgh, PA 15213	7	86	Present	
Butler Mem. Hospital-Attending Physician	9114 E. Brady, Pittsburgh, PA 16001	7	86	7	94
Passavant Hospital-Attending Physician	Attn: Med. Staff Svcs - 9100 Babcock Blvd Pittsburgh, PA 15237	7	94	Present	
Mahoning Women's Center-Medical Director	4025 Market St., Youngstown, OH 44512	10	93	Present	
Allegheny Women's Center-Medical Director	121 N. Highland Ave, Pittsburgh, PA 15206	10	94	Present	

STAFF PRIVILEGES -

Have you ever been denied any staff privileges? Yes ___ No X

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

Have you ever been asked to or 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.

Have you ever had any staff privileges suspended, revoked, modified, restricted, Placed on probation, asked to resign or asked to take a temporary leave of absence or otherwise acted against (explain "otherwise" actions)?. Yes X No ___.

UPMC MAGEE WOMENS HOSPITAL, PITTSBURGH PA

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

UPMC PASSAVANT HOSPITAL, PITTSBURGH PA

Have you ever been asked, or allowed to resign from any hospital, institution, Clinic or medical facility in lieu of disciplinary action or during any pending investigations into your practice? Yes ___ No X.

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

Do you currently hold a Medical Faculty Appointment)?. Yes ___ No X

If "YES", list title, name of institution, city and state

Within the most recent 10 years have you had responsibility for graduate medical education. Yes X No ___.

MAGEE WOMENS HOSPITAL, FORBES AND HALKS ST PGH, PA

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

List any hospital(s) where you have staff privileges (Do Not List Training Privileges).

(Name of Hospital)	Mailing Address + (City/State/Zip)	MONTH/YEAR FROM		TO	
Butler Memorial Hospital	Attn: Kris Bowser - Medical Staff Office 911 E. Brady, Butler, PA 16001	7	86	7	94
Magee Women's Hospital	Att: Amy Angil 300 Halket St., Pittsburgh, PA 15213	7	86	Present	
Passavant Hospital	Attn: Medical Staff Services 9100 Babcock Ave., Pittsburgh, PA 15237	7	94	Present	

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MEDICAL AFFILIATIONS

Have you ever had an application for membership rejected for medical society membership? Yes ___ No X.

If "yes" explain: _____

Have you ever had a medical society membership suspended? Yes ___ No X.

If "yes" explain: _____

Have you ever been notified to appear before a medical society in regard to charges/complaints filed against you? Yes ___ No X.

IF "YES", GIVE NAME(S) AND ADDRESS(ES) OF MEDICAL SOCIETY.

IF "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 COLLEGE OB/GYN, PITTSBURGH OB/GYN SOCIETY

19 IF FOREIGN BORN, give date and place of Naturalization: _____

20 Are you a citizen of the United States? Yes X No ___.

21 Have you ever been in the United States Military and/or Public Health Service? Yes ___ No X.

(IF "YES" LIST BRANCH OF SERVICE, RANK, DATES OF SERVICE > > > ENCLOSE COPY OF DISCHARGE FORM)

22 a Are you a Diplomate of the National Board of Medical Examiners? Yes X No ___.

b If "yes", state date of certification 1983

23 Have you ever failed State Board/FLEX/National Board/USMLE Examination? Yes ___ No X.

24 a Are you certified by the American Board of Medical Specialty Board; Subspecialty (ABMS)? Yes X No ___.

American College of Obstetrics & Gynecology

b If "yes", list name, date of certification or recertification. (ENCLOSE COPY OF EACH CERTIFICATE OR LETTER VERIFYING ELIGIBILITY) December 1988, 1998 & 2000

c Have you ever applied for, taken an examination for, or failed to receive specialty board certification or recertification for any reason? Yes ___ No X

If "yes" explain on a separate sheet, providing accurate details.

d Within the past 10 years, have your ever had any final disciplinary action taken against you by the ABMS or other similar national organization. Yes ___ No X.

If "yes" explain on a separate sheet, list the date of action, the number of action(s) including a detailed summary of each action. Attach a copy of each action as instructed

25 Have you ever studied to become, or do you hold any other professional license in any state, e.g. JD, Ed.D., Ph.D., RN, PA, DO, DDS, DC, etc.? Yes ___ No X.

If "yes" list profession: _____

26 Have you had any application for professional license or any application to practice medicine/surgery denied by any state board or other governmental agency of any state or country? Yes ___ No X.

If "yes" explain: _____

27 a 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 X No ___.

If "yes" explain: THE CHARGE WAS DISMISSED.

b Have you ever been required by any licensing jurisdiction to enter into an impaired practitioner program? Yes ___ No X.

If "yes" explain: _____

28 Have you ever had any professional license or license to practice medicine/surgery revoked, suspended, or other disciplinary action taken in any state, territory or country? Yes ERROR No X.

If "yes" explain: _____

29 Regardless of adjudication have you ever been convicted of a violation of, or pled Nolo Contendere, to, any Federal, State, Local statute, regulation or ordinance, or entered into any plea, negotiated plea, bargain, or settlement relating to a misdemeanor or felony? Yes ___ No X

If "yes" explain: _____

30 Have any actions in bankruptcy court or any civil judgments ever been entered against you? Yes ___ No X.

If "yes" explain on a separate sheet, the date of each occurance(s), filing date(s), the number of complaint(s) and a detailed summary of your involvement on each.

31 Have you ever been sued for malpractice? Yes X No ___.

If "yes" explain: _____

32 a Have you ever discontinued practice for any reason for a period of one month or longer? Yes ___ No X.

If "yes" explain: _____

32 b Have you ever had employment terminated for cause? Yes ~~X~~ No X

If "yes" explain: OTHER

33 Do you have a chronic medical condition that might affect your ability to practice your profession? [redacted]

If "yes" explain on a separate sheet. List each condition including the diagnosis and prognosis, and provide requsite documentation.

34 During the course of your medical education and training or practice experience, have you undergone counseling, therapy, or treatment for any mental or physical illness or condition that impacted your ability to function in any educational or practice setting? [redacted]

If "yes" explain on a separate sheet. List the condition of each including the diagnosis and prognosis, and provide documentation required in instructions.

35 Have you ever declined to follow the recommendation or request of a physician, counselor, employer, supervisor, or medical training program director or representative that you enter therapy or treatment for any mental or physical condition? [redacted]

If "yes" explain: _____

36 Do you have any mental or physical condition which effects your ability to safely perform any procedure or task within the scope of the practice of medicine?

If "yes" explain: _____

37 Have you ever been criminally or civilly charged with any intentional or negligent action related to use or misuse of drugs, alcohol, or illegal chemical substances?

If "yes" explain: _____

38 Within [redacted] u ever been hospitalized for any physical or mental condition or injury?

If "yes" explain: _____

39 Have you ever been warned or called before the Drug Enforcement Agency (DEA)? Yes ___ No X

If "yes" explain: _____

40 Have you ever been made an offer to compromise or entered into any other arrangement for other plea or agreement in lieu of a Federal prosecution for a drug violation regulated by the DEA? Yes ___ No X

If "yes" explain: _____

41 Have you ever been denied, or surrendered, a DEA Registration? Yes ___ No X

If "yes" explain: _____

42 PERSONAL DATA:

DATE: _____

AGE: 43

HEIGHT: 6FT 1 inch

OTHER MEANS OF IDENTIFICATION: N/A

COLOR OF EYES: GREEN

COLOR OF HAIR: BROWN

WEIGHT: 200 lbs

XV. OPTIONAL INFORMATION:

A. PUBLICATIONS: List any publications you have authored in peer-reviewed medical literature within the previous ten years: (Optional) (Authoritys. 455.565(5)(a), F.S.)

TITLE DATE	PUBLICATION
1.	
2.	
3.	
4.	

A. DO YOU PARTICIPATE IN THE MEDICAID PROGRAM ? (Optional)
(Authority s. 455.565(5)(d), F.S.)
YES [X] NO [ ]

B. PROFESSIONAL OR COMMUNITY SERVICE ACTIVITIES, HONORS, OR AWARDS: (Optional)
(Authority s.455.565(5)(b), F.S.)

COMMUNITY SERVICE/AWARD/HONOR	ORGANIZATION
1.	
2.	
3.	
4.	

D. LANGUAGES, OTHER THAN ENGLISH: Indicate languages other than English used by you to communicate with patients and any translation service available for patients at your primary place of practice. (Optional) (Authority: s. 455.565(5)(c), F.S.)

1.

2.

3.

4.

E. TELEPHONE: (727) 934-1231
OFFICE NUMBER: AREA CODE AND NUMBER

F. E-MAIL ADDRESS:

3

43 AFFIDAVIT OF APPLICANT:

I, Gerald Brian Applegate, M.D. , 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.

I understand that my records are protected under the 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 the Federal and State Regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR 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 on it, and that in any event this consent expires automatically as follows:

_____

(specification of date, event or condition upon which this consent expires)

_____

(Signature of Applicant)

The foregoing instrument was acknowledged before me this 22 day of November, 19 19, by Gerald B. Applegate, who is personally known to me or who has produced as known to me as identification and did/did not take an oath.

_____ Commission No. 123754

Signature of Notary

My Commission Expires: 5/28/2001

ELIZABETH A. SPEARLINE

Name of Notary Typed, Printed or Stamped

SEAL

Notarial Seal
Elizabeth A. Spearline, Notary Public
McCandless Twp., Allegheny County
My Commission Expires May 28, 2001
Member, Pennsylvania Association of Notaries

Attention Notary: Although the information requested below is OPTIONAL, it could prevent fraudulent attachment of this certificate to an unauthorized document.

THIS CERTIFICATE MUST BE ATTACHED TO THE DOCUMENT DESCRIBED AT RIGHT:

Title or Type of Document Application for Medical Licensure-Florida

Number of Pages _____ Date of Document _____

Signer(s) Other than Names Above _____