Rec-Fed-X
8/5/93 - 9:55 AM

APP-SENT-BY
Pre-Paid-Fed-X
8/5/93

STATE MEDICAL BOARD OF OHIO

77 South High Street, 17th Floor • Columbus, Ohio 43266-0315 • (614) 466-3934

REQUEST FOR APPLICATION FORMS
(MEDICAL OR OSTEOPATHIC)

PLEASE TYPE OR PRINT CLEARLY

I hereby submit the following information in order to receive an application:

NAME: LAST (Surname): APPLEGATE | FIRST: GERARD | MIDDLE: BRIAN | SUFFIX (Jr., II):

ADDRESS: STREET & NUMBER: 300 RUSTIN WAY

CITY: PITTSBURGH | STATE: PA | ZIP CODE: 15237 | COUNTRY: USA

TELEPHONE: BUSINESS: AREA CODE & NUMBER: (412) 366 1223 | HOME: AREA CODE & NUMBER: (412) 934 8834

BIRTH DATE: MO/DAY/YR: 6 1/6 156 | BIRTHPLACE: CITY: NEWARK | STATE: NEW JERSEY | COUNTRY: USA

MEDICAL OR OSTEOPATHIC EDUCATION

MEDICAL SCHOOL OF GRADUATION: SCHOOL NAME: NEW JERSEY MEDICAL SCHOOL

STREET ADDRESS: 100 BERGEN STREET

CITY: NEWARK | STATE: NJ | COUNTRY: USA

STATE MEDICAL BOARD OF OHIO
93 AUG -5 AM

DATES ATTENDED: FROM: MO/DAY/YR: 9 1/78 | TO: MO/DAY/YR: 6 1/82

DEGREE RECEIVED: M.D. | DATE RECEIVED: MO/DAY/YR: 6 1/82

Revised 01/11/93

OVER ⇨

OTHER MEDICAL SCHOOLS ATTENDED: (IF NONE, ENTER "NONE")

SCHOOL NAME: NONE

STREET ADDRESS

CITY | STATE | COUNTRY

DATES ATTENDED: FROM: MO/DAY/YR / / TO: MO/DAY/YR / /

REASON DEGREE NOT RECEIVED AT THIS SCHOOL:

SCHOOL NAME

STREET ADDRESS

CITY | STATE | COUNTRY

DATES ATTENDED: FROM: MO/DAY/YR / / TO: MO/DAY/YR / /

REASON DEGREE NOT RECEIVED AT THIS SCHOOL:

FIFTH PATHWAY

FIFTH PATHWAY PROGRAM AT: (IF NONE, ENTER "NONE")

HOSPITAL OR INSTITUTION: NONE

AFFILIATED WITH: NAME OF MEDICAL SCHOOL

ADDRESS: STREET & NUMBER

CITY | STATE | ZIP CODE

DATES ATTENDED: FROM: MO/DAY/YR / / TO: MO/DAY/YR / /

QUALIFYING EXAM TAKEN: DATE TAKEN: MO/DAY/YR / /

CONTINUED ⇨

GRADUATE MEDICAL EDUCATION

List ALL graduate medical education (internship, residency, or clinical fellowship), undertaken in the U.S. or Canada. If additional space is needed, please attach an extra sheet. If none, enter "NONE")

month/year	Hospital, University or Other: / Complete Street Address: / Street & Number / City / State/Country / Zip	Position & Department	Level of Training (check one only)
6 82	MAGEE WOMEN'S HOSP	INTERN OB/GYN	☑ 1st year
TO	FORBES + HALKET ST		☐ 2nd year
6 83	PITTSBURGH Pa 15213		☐ 3rd year or above
6 83	SAME	RESIDENT	☐ 1st year
TO			☑ 2nd year
6 84			☐ 3rd year or above
6 84	SAME	RESIDENT	☐ 1st year
TO			☐ 2nd year
6 85			☑ 3rd year or above
6 85	SAME	RESIDENT	☐ 1st year
TO			☐ 2nd year
6 86			☑ 3rd year or above

OVER ⇨

WRITTEN EXAMINATIONS TAKEN

List each and every written (FLEX or State Board except National Boards) exam taken whether in Ohio or any other state, territory or province. If additional space is needed, please attach an extra sheet. (If none, enter "NONE") Refer to the "Additional Eligibility Information" section for National Board information. Do not list National Board exam information in this section.

STATE	DATE TAKEN MO/YR	WRITTEN EXAM TAKEN	FINAL RESULTS	TYPE OF EXAM
PENNSYLVANIA	JULY / 1983	☐ FLEX ☑ STATE BOARD	☑ PASS ☐ FAIL	☑ FULL ☐ PARTIAL
	/	☐ FLEX ☐ STATE BOARD	☐ PASS ☐ FAIL	☐ FULL ☐ PARTIAL
	/	☐ FLEX ☐ STATE BOARD	☐ PASS ☐ FAIL	☐ FULL ☐ PARTIAL
	/	☐ FLEX ☐ STATE BOARD	☐ PASS ☐ FAIL	☐ FULL ☐ PARTIAL

LICENSES IN THE UNITED STATES & CANADA

List **ALL** states/provinces **whether the license is current or not** in which you are or have been licensed to practice medicine and surgery or osteopathic medicine and surgery. Indicate the license number, date of issuance, and the basis of licensure (e.g., FLEX, state board exam, endorsement of another state license, endorsement of diplomate status, etc.). If additional space is needed, please attach an extra sheet (If none, enter "NONE").

STATE	ISSUE DATE MO/YR	LICENSE #	BASIS OF LICENSE	LICENSE CURRENT
PENNSYLVANIA	JULY / 1983	MD-029276	STATE BOARD	☑ YES ☐ NO
	/			☐ YES ☐ NO
	/			☐ YES ☐ NO
	/			☐ YES ☐ NO

AMERICAN MEDICAL ASSOCIATION
NATIONAL PHYSICIAN CREDENTIALS VERIFICATION SERVICE

The American Medical Association (AMA) has recently implemented a National Physician Credentials Verification Service (NPCVS), which for a fee will verify a physician's possessive credentials.

Are you currently a member of the AMA'S NPCVS? ☐ YES ☑ NO

For further information contact the AMA at the address below:

AMERICAN MEDICAL ASSOCIATION
NATIONAL PHYSICIAN CREDENTIALS VERIFICATION SERVICE
515 N. STATE STREET, 4TH FLOOR
CHICAGO, IL 60610
(312)464-5000

CONTINUED ⇨

ADDITIONAL ELIGIBILITY INFORMATION - ANSWER ALL QUESTIONS

Are you a diplomate of the National Board of Medical Examiners?
❑ PENDING ☑ YES ❑ NO DATE: July / 1983
MO/YR

Are you a diplomate of the National Board of Osteopathic Medical Examiners?
❑ PENDING ❑ YES ☑ NO DATE: /
MO/YR

Are you a licentiate of the Medical Council of Canada? ❑ YES ☑ NO

Are you applying to sit for the FLEX exam in Ohio?
❑ YES ☑ NO IF YES, ❑ JUNE , OR ❑ DECEMBER YEAR: 199___

Do you have a valid ECFMG Certificate?
❑ YES ☑ NO NUMBER:_____ DATE ISSUED: /
MO/YR

If you are a graduate of a Mexican Medical School indicate degree: (CHECK ONLY ONE)
❑ ACTA ❑ TITULO ❑ MEDICO CIRUJANO

During the five (5) years immediately preceding the date of your application have you held an unrestricted license in the US? (Refer to the TSE section in the Eligibility Packet for more information) ☑ YES ❑ NO

During the five (5) years immediately preceding the date of your application have you been actively practicing medicine and surgery or osteopathic medicine and surgery in the US? (Refer to the TSE section in the Eligibility Packet for more information) ☑ YES ❑ NO

Have you applied for or taken the Test of Spoken English (TSE)* of the Educational Testing Service (ETS)?
❑ YES ☑ NO LAST DATE TAKEN OR SCHEDULED /
MO/YR

Have you achieved a score of at least two hundred ten (210) on TSE* of the ETS?
N/A ❑ YES ❑ NO SCORE:_____ DATE TAKEN: /
MO/YR

* (THE TOEFL, ECFMG EXAM, ETC., ARE NOT EQUIVALENT AND CANNOT BE SUBSTITUTED FOR THE TEST OF SPOKEN ENGLISH (TSE)

STATE MEDICAL BOARD OF OHIO
93 AUG -5 AM

CERTIFICATION

I HEREBY CERTIFY THAT I AM THE PERSON REFERRED TO IN THE FOREGOING REQUEST FOR APPLICATION FORMS AND THAT THE STATEMENTS HEREIN ARE STRICTLY TRUE IN EVERY RESPECT.

Todd B. Mendelson 8/4/93
SIGNATURE DATE

RETURN TO: STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR
COLUMBUS, OH 43266-0315

Revised 05/26/93

CONTINUED ⇨

NO APP $

1-10
68-30-11
8-17-43
325.00
[illegible]
1265

STATE MEDICAL BOARD OF OHIO

77 South High Street, 17th Floor • Columbus, Ohio 43266-0315 • (614) 466-3934

APPLICATION FOR CERTIFICATE - MEDICINE OR OSTEOPATHIC MEDICINE

PLEASE TYPE OR PRINT CLEARLY

1. Social Security Number: [redacted]

2. Full Name (Use no initials): LAST (Surname) APPLEGATE FIRST GERALD MIDDLE BRIAN SUFFIX(Jr., II)

3. Name (As you prefer it inscribed on your Ohio license): LAST (Surname) APPLEGATE FIRST GERALD MIDDLE BRIAN SUFFIX(Jr., II)

4. Maiden Name Or Other Names Used (If none, enter "NONE"): LAST (Surname) FIRST NONE MIDDLE SUFFIX(Jr., II)

5. Current Address: STREET & NUMBER 300 RUSTIN WAY
CITY WEXFORD STATE PA ZIP CODE 15909 COUNTRY USA

6. Physical Description: HEIGHT 6FT 1IN WEIGHT 200lbs HAIR COLOR BROWN EYE COLOR GREEN IDENTIFYING MARKS N/A

7. Sex: ☒ MALE ☐ FEMALE For statistics only (optional)

8. City In Ohio Where You Plan To Practice: CITY YOUNGSTOWN OR COUNTY
PLANS OF PRACTICE: COVERAGE FOR A MEDICAL CLINIC

9. Specialty Boards (U.S.A., Canada and foreign countries):

Name of Specialty Board	Board Certified Yes	Board Certified No	Year Certified	Country
OB/GYN A.C.O.G.	☒	☐	1988	USA
	☐	☐		
	☐	☐		

FOR OFFICE USE ONLY ☐ 34 ☒ 35 ☐ Examination ☐ Endorsement

PAPERCLIP (DO NOT STAPLE) YOUR CHECK OR MONEY ORDER HERE

STATE MEDICAL BOARD OF OHIO

77 South High Street, 17th Floor • Columbus, Ohio 43266-0315 • (614) 466-3934

MEDICINE OR OSTEOPATHIC MEDICINE

FORM 1 - CERTIFICATE OF RECOMMENDATION

This form is to be completed by a physician fully licensed in the STATE IN WHICH THE FORM IS NOTARIZED. The recommending physician must be sufficiently acquainted with the applicant for at least **SIX** months. Relatives may not serve as recommending physicians. Recommending physicians are strongly urged to include additional comments. This form must be notarized. ALL questions must be answered. This form is not intended to standardize the recommendation or restrict it in any way. However, its form is designed to insure that certain information is included.

DO NOT COMPLETE UNLESS A *COLOR* PHOTO OF APPLICANT IS ATTACHED TO THE BACK OF THIS FORM

BLACK & WHITE PHOTOS ARE NOT ACCEPTABLE

I, JOHN REIFER M.D., a licensed and practicing physician in the state of
(recommending physician)

PENNSYLVANIA, affirm that GERARD B. ROLLEGATE-
(state of residence) (applicant)

has been known to me personally for 10 years and that he/she is of good moral character. Further, the photograph affixed hereto is a genuine likeness of the applicant. I offer the following in support of his/her application for full licensure:

*I rate his/her medical knowledge and technique as: excellent

*His/her relationship with patients is: excellent

*I rate his/her ability to work well with peers and medical staff as: excellent

*His/her command of the English language is: excellent

*Additional comments: _____

I hereby recommend him/her for full licensure to practice in the State of Ohio.

OVER ⇨

FORM 1 - CERTIFICATE OF RECOMMENDATION - MEDICINE OR OSTEOPATHIC MEDICINE
PAGE TWO

Signature of Recommending Physician
(name stamps not acceptable)

John C. Reefer MD.
Name of Recommending Physician
(please type or print clearly)

(412) 287-7910
Telephone Number
(include area code)

1022 B North Main Street
Address of Recommending Physician
(include city, state and zip code)

PA MD 021615 E
State of Licensure & License Number of Recommending Physician
(please type or print clearly)

(NOTARY SEAL)

Subscribed and sworn to before me this 18th day of Aug., 1993.

Rachel M. Simmers
Notary Public Signature

Feb. 10, 1996
Date Commission Expires

Notarial Seal
Rachel M. Simmers, Notary Public
Butler, Butler County
My Commission Expires Feb. 10, 1996
Member, Pennsylvania Association of Notaries

Signature of Applicant

Date Photo Taken: 8 93
Mo./Yr.

RETURN TO: STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR
COLUMBUS, OH 43266-0315

Revised 05/26/92

STATE MEDICAL BOARD OF OHIO

77 South High Street, 17th Floor • Columbus, Ohio 43266-0315 • (614) 466-3934

MEDICINE OR OSTEOPATHIC MEDICINE

FORM 1 - CERTIFICATE OF RECOMMENDATION

This form is to be completed by a physician fully licensed in the STATE IN WHICH THE FORM IS NOTARIZED. The recommending physician must be sufficiently acquainted with the applicant for at least **SIX** months. Relatives may not serve as recommending physicians. Recommending physicians are strongly urged to include additional comments. This form must be notarized. ALL questions must be answered. This form is not intended to standardize the recommendation or restrict it in any way. However, its form is designed to insure that certain information is included.

DO NOT COMPLETE UNLESS A *COLOR* PHOTO OF APPLICANT IS ATTACHED TO THE BACK OF THIS FORM

BLACK & WHITE PHOTOS ARE NOT ACCEPTABLE

I, CARLOS SPINGOLA MD, a licensed and practicing physician in the state of
(recommending physician)

PENNSYLVANIA, affirm that GERARD APPLEGATE
(state of residence) (applicant)

has been known to me personally for 15 years and that he/she is of good moral character. Further, the photograph affixed hereto is a genuine likeness of the applicant. I offer the following in support of his/her application for full licensure:

*I rate his/her medical knowledge and technique as: GOOD

*His/her relationship with patients is: GOOD

*I rate his/her ability to work well with peers and medical staff as: GOOD

*His/her command of the English language is: GOOD

*Additional comments: WENT TO MED SCHOOL TOGETHER AND LATER PRACTICED IN THE SAME TOWN IN DIFFERENT SPECIALTIES.

I hereby recommend him/her for full licensure to practice in the State of Ohio.

OVER ⇨

FORM 1 - CERTIFICATE OF RECOMMENDATION - MEDICINE OR OSTEOPATHIC MEDICINE
PAGE TWO

Signature of Recommending Physician
(name stamps not acceptable)

CHARLES E SPINGOLA
Name of Recommending Physician
(please type or print clearly)

(412) 287 3787
Telephone Number
(include area code)

301 1ST ST BUTLER, PA 16001
Address of Recommending Physician
(include city, state and zip code)

PENNSYLVANIA MD-037925-E
State of Licensure & License Number of Recommending Physician
(please type or print clearly)

(NOTARY SEAL)

Subscribed and sworn to before me this 18th day of August, 1993.

Kay Ann Ecola
Notary Public Signature

Notarial Seal
Kay Ann Ecola, Notary Public
Butler, Butler County
My Commission Expires Jan. 22, 1994
Member, Pennsylvania Association of Notaries

Date Commission Expires

Signature of Applicant

Date Photo Taken: 8/93
Mo./Yr.

RETURN TO: STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR
COLUMBUS, OH 43266-0315

Revised 05/26/92

RESUME - MEDICINE OR OSTEOPATHIC MEDICINE

List **ALL** activities in chronological order from the date of medical school graduation to the present time using **MONTH** and **YEAR**. For any non-working time, you must state on the resume exactly what your activities were, such as "looking for residency program" or "vacation", as well as your permanent address for this period. If in private practice, indicate the hospitals where you hold or have held privileges and include complete dates and addresses. For any time in which you worked for an "emergency medical group" or did locum tenens, you must list all hospitals where you worked and include complete dates and addresses. If in private practice, indicate the hospitals where you hold or have held privileges and include complete dates and addresses. **DO NOT SUBSTITUTE ANY OTHER RESUME FOR THIS FORM.** Be sure to indicate the percentage of working time spent in clinical and administrative duties. If you require more space, attach separate sheets.

A.

month/year	Hospital, University or Other: / Complete Street Address: / Street & Number / City / State/Country / Zip	Position & Department	% Clinical / % Admin.
7 86	BUTLER MEMORIAL HOSPITAL	OB/GYN ATTENDING PARTNERSHIP	100% /
TO	911 E. BRADY ST		
11 92	BUTLER PA 16001		

B.

month/year	Hospital, University or Other: / Complete Street Address: / Street & Number / City / State/Country / Zip	Position & Department	% Clinical / % Admin.
11 92	BUTLER MEM. HOSPITAL	OB/GYN ATTENDING SAO	100% /
TO	911 E. BRADY ST		
7 93	BUTLER PA 16001		

C.

month/year	Hospital, University or Other: / Complete Street Address: / Street & Number / City / State/Country / Zip	Position & Department	% Clinical / % Admin.
7 93	PASSAVANT HOSPITAL	OB/GYN ATTENDING SAO	100% /
TO	9102 BABCOCK BLVD		
8 93	PGH PA 15237		

D.

month/year	Hospital, University or Other: / Complete Street Address: / Street & Number / City / State/Country / Zip	Position & Department	% Clinical / % Admin.
TO			

RESUME- MEDICINE OR OSTEOPATHIC MEDICINE
PAGE TWO

E.

month/year TO month/year	Hospital, University or Other: Complete Street Address: Street & Number City State/Country Zip	Position & Department	% Clinical % Admin.

F.

month/year TO month/year	Hospital, University or Other: Complete Street Address: Street & Number City State/Country Zip	Position & Department	% Clinical % Admin.

G.

month/year TO month/year	Hospital, University or Other: Complete Street Address: Street & Number City State/Country Zip	Position & Department	% Clinical % Admin.

H.

month/year TO month/year	Hospital, University or Other: Complete Street Address: Street & Number City State/Country Zip	Position & Department	% Clinical % Admin.

ADDITIONAL INFORMATION - MEDICINE OR OSTEOPATHIC MEDICINE
PAGE TWO

		YES	NO
8.	Have you ever voluntarily surrendered, resigned, or otherwise forfeited any professional license, certificate or registration issued to you by any board, bureau, department, agency, or other body; or have you ever withdrawn any application for licensure, relicensure, or examination, in any state (including Ohio), territory, province, or country?	☐	☑
9.	Have you ever, for any reason, been denied licensure or relicensure, application for licensure or relicensure, or the privilege of taking an examination, in any state (including Ohio), territory, province, or country?	☐	☑
10.	Have you ever been requested to appear before any board, bureau, department, agency, or other body, including those in Ohio, concerning allegations against you?	☐	☑
11.	Have you ever entered into an agreement of any kind, whether oral or written, with respect to a professional license, in lieu of or in order to avoid formal disciplinary action, with any board, bureau, department, agency, or other body, including those in Ohio?	☐	☑
12.	Have you ever been notified of any investigation concerning you by, or have you ever been notified of, any charges, allegations, or complaints filed against you with, any board, bureau, department, agency, or other body, including those in Ohio, with respect to a professional license?	☐	☑
13.	Are you now or have you ever been, addicted to or excessively used alcohol, drugs, or other substances which may cause physical or psychological dependence, or impairment of the ability to practice?	☐	☑
14.	Have you ever been a patient (voluntary or otherwise) in any institution for the treatment of emotional or mental illness, drug addiction or abuse, or an alcohol problem? If yes, you must have your treating physician(s) submit a letter directly to the Board on your behalf summarizing dates of treatment, etc.	☐	☑
15.	Have you ever been treated but not hospitalized for emotional or mental illness, drug addiction or abuse, or an alcohol problem? If yes, you must have your treating physician(s) submit a letter directly to the Board on your behalf summarizing dates of treatment, etc.	☐	☑
16.	Have you ever been denied, or surrendered, a state or federal controlled substance or drug registration; had it revoked, terminated, or restricted in any way; or been warned, reprimanded, or fined by, or been requested to appear before, the responsible agency?	☐	☑

STATE MEDICAL BOARD
2012 AUG 17 A

CONTINUED ⇨

ADDITIONAL INFORMATION - MEDICINE OR OSTEOPATHIC MEDICINE

If you answer "YES" to any of the following questions, you are required to furnish complete details, including date, place, reason and disposition of the matter. All affirmative answers must be thoroughly explained on a separate sheet of paper.

(Please place a ✔ in the yes or no box)

		YES	NO
1.	Have you ever been denied staff membership at any hospital, nursing home, clinic, health maintenance organization, or similar institution?	☐	☑
2.	Have you ever been warned, censured, disciplined, had admissions monitored, had privileges limited, had privileges suspended or terminated, been put on probation, or been requested to withdraw from or resign privileges at any hospital, nursing home, clinic, health maintenance organization, or other similar institution in which you have trained, been a staff member, or held privileges, for reasons other than failure to maintain records on a timely basis, or failure to attend staff or section meetings?	☐	☑
3.	Have you ever resigned from, withdrawn from, or terminated, or have you ever been requested to resign from, withdraw from, or otherwise been terminated from, a position with a medical partnership, professional association, corporation, health maintenance organization, or other medical practice organization, either private or public?	☐	☑
4.	Have you ever resigned from, withdrawn from, or have you ever been warned by, censured by, disciplined by, been put on probation by, been requested to withdraw from, dismissed from, been refused renewal of a contract by, or expelled from, a medical school, clinical clerkship, externship, preceptorship, or graduate medical education?	☐	☑
5.	Have you ever transferred from one graduate medical education to another?	☐	☑
6.	Have you ever, for any reason, lost specialty board certification in the U.S. or elsewhere, or been denied such certification, or denied examination for such certification?	☐	☑
7.	Has any board, bureau, department, agency or other body, including those in Ohio, in any way limited, restricted, suspended, or revoked any professional license, certificate or registration granted to you; placed you on probation; or imposed a fine, censure or reprimand against you?	☐	☑

OVER ⇨

ADDITIONAL INFORMATION - MEDICINE OR OSTEOPATHIC MEDICINE
PAGE THREE

		YES	NO
17.	Have you ever been convicted or found guilty of a violation of federal law, state law, or municipal ordinance other than a minor traffic violation?	☐	☑
18.	Have you ever forfeited collateral, bail, or bond for breach or violation of any law, police regulation, or ordinance other than for a minor traffic violation; been summoned into court as a defendant or had any lawsuit filed against you (other than a malpractice suit)?	☐	☑
19.	Have you been a defendant in a legal action involving professional liability (malpractice), or had a professional liability claim paid on your behalf, or paid such a claim yourself? If yes, include the case name, case number, court and address, date filed, and a summary of the underlying events. Indicate current status, including amount of settlement or judgment, if any.	☐	☑
20.	Have you ever been denied professional liability insurance or coverage, or had such insurance or coverage cancelled, limited, or restricted in any way?	☐	☑
21.	Have you ever been denied or relinquished participation in any third party reimbursement program, whether governmental or private, including Medicaid and Medicare; or had such participation limited, restricted, suspended, or revoked; or been warned, reprimanded, requested to appear before, or fined by the responsible body?	☐	☑
22.	Have you ever been denied privileges, or had privileges revoked, suspended, restricted, reduced, or terminated by the Department of Defense, the Veteran's Administration, or any of their respective components?	☐	☑

AFFIDAVIT AND RELEASE OF APPLICANT

The affidavit and release below MUST be completed by **ALL** applicants. The form must be notarized. Failure of any applicant to submit the affidavit completed and notarized with the application will result in your application being considered as incomplete.

ss STATE OF PENNSYLVANIA

COUNTY OF BUTLER

I, Gerard Applegate, hereby certify under oath that I am the person named in this application for a license to practice medicine or osteopathic medicine in the State of Ohio; that all statements I have or shall make with respect thereto are true, that I am the original and lawful possessor and person named in the various forms and credentials furnished or to be furnished to this Board with respect to my application; and that all documents, forms, or copies thereof furnished or to be furnished with respect to my application are strictly true in every respect.

I acknowledge that I have read the general information and instructions for all applicants and that I have answered all questions in compliance with these instructions and understand that the fee I submitted is not refundable nor transferable.

I further state that by filing this application for a license to practice medicine or osteopathic medicine in the State of Ohio, I hereby authorize and consent to have an investigation made as to my moral character, professional reputation and fitness for the practice of medicine or osteopathic medicine. I agree to give any further information which may be required in reference to my past record. I understand that I will not receive a copy of any reports or know their contents and I further understand that the contents of any investigative report will be privileged.

I further understand that my application for a license to practice medicine or osteopathic medicine in the State of Ohio is an ongoing process. I will immediately notify the State Medical Board of Ohio in writing of any changes to the answers to any of the questions contained in the ADDITIONAL INFORMATION section of the application if such a change in an answer is warranted at any time prior to licensure being granted to me by the State Medical Board of Ohio. I further understand that failure to complete this application as requested by the Board within six months can be considered abandonment of any request for licensure and that any fee I submitted is not refundable nor transferable.

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

I hereby release, discharge, and exonerate the State Medical Board of Ohio, its agents or representatives and any person furnishing information, of any and all liability of every nature and kind arising out of investigation made by the State Medical Board of Ohio. I authorize the State Medical Board of Ohio to release information, material, documents, orders or the like relating to me or to this application to any other governmental agency (local, state, federal or foreign); or to any hospital, nursing home, clinic, health maintenance organization or similar institution; or to any professional association.

I further understand that issuance of a certificate to practice medicine or osteopathic medicine in Ohio will be considered on the truth of the statements and documents contained herein or to be furnished, which if false, can subject me to denial of said certificate.

(NOTARY SEAL)

Gerard B Applegate

Signature of Applicant

Subscribed and sworn to before me this 10 day of AUGUST 1993.

Robin L. Sinchak

Notary Public Signature

Notarial Seal
Robin L. Sinchak, Notary Public
Butler, Butler County
My Commission Expires March 20, 1995
Member, Pennsylvania Association of Notaries

Date Commission Expires

STATE MEDICAL BOARD OF OHIO
93 AUG 12 AM 10:15

Revised 05/26/92

FOR BOARD USE ONLY

NAME: Applegate, Gerald B.

CERTIFICATE NO.: 65717

DATE ISSUED: 9-10, 1993

APPLICATION FOR CERTIFICATE TO PRACTICE MEDICINE OR OSTEOPATHIC MEDICINE

FILED: August 5, 1993

FEE: _____

DETERMINATION:

BOARD ACTION:

RECEIVED AUG - 9 1993

STATE MEDICAL BOARD OF OHIO

77 South High Street, 17th Floor • Columbus, Ohio 43266-0315 • (614) 466-3934

BEV

MEDICINE OR OSTEOPATHIC MEDICINE

FORM 2 - CERTIFICATE OF GRADUATE MEDICAL EDUCATION

STATE MEDICAL BOARD OF OHIO
'93 SEP 10 AM 11:2

MAIL TO HOSPITAL OR INSTITUTION OF GRADUATE MEDICAL EDUCATION IN THE U.S. OR CANADA

Dear Sir:

I am applying for a license to practice in the State of Ohio. The State Medical Board of Ohio requires that my graduate medical education be certified. Please complete the form and return it directly to the State Medical Board of Ohio.

TO BE COMPLETED BY APPLICANT

APPLEGATE GERALD B. — Name in full (last, first, middle, suffix)

06/16/56 — Date of birth (mo/day/yr)

300 RUSTIN WAY WEXFORD PA 15090 — Complete address (street, city, state & zip)

NEW JERSEY MED SCHOOL — Medical school of graduation

I HEREBY AUTHORIZE MY HOSPITAL OR INSTITUTION OF GRADUATE MEDICAL EDUCATION TO FURNISH THE FOLLOWING INFORMATION TO THE STATE MEDICAL BOARD OF OHIO.

Gerald B. Applegate — Signature of applicant

8/4/93 — Date

TO BE COMPLETED BY HOSPITAL OR TRAINING INSTITUTION

I offer the following in support of his/her application for full licensure:

During his residency:

I rate his/her medical knowledge and technique as: Above-Average

His/her relationship with patients is: Good

I rate his/her ability to work well with peers and medical staff as: Good

His/her command of the English language is: Excellent

Additional comments: Information was derived from Dr. Applegate's personnel file during his residency training and not from personal contact.

OVER ⇨

FORM 2 - CERTIFICATE OF GRADUATE EDUCATION - MEDICINE OR OSTEOPATHIC MEDICINE
PAGE TWO

This certifies that GERARD B. ABRUZZATI has successfully completed
(name of applicant)

not less than 48 months of graduate medical education through the:
- ☐ 1st year level
- ☐ 2nd year level
- ☒ 3rd year level or above

as a(n):
- ☒ intern
- ☒ resident
- ☐ clinical fellow

in Obstetrics & Gynecology
(department)

at Magee-Womens Hospital
(name of hospital)

300 Halket Street
(complete street address of hospital)

from 07/01/82 to 06/30/86.
beginning (mo/day/yr) ending (mo/day/yr)

It is further certified that the above named:
- ☐ will be awarded a certificate on} _____ mo/day/yr
- ☒ was awarded a certificate on} 06/86 mo/day/yr
- ☐ was not awarded a certificate
  please explain: _____

and that the training:
- ☒ was accredited by ACGME/AOA
- ☐ was not accredited by ACGME/AOA

I hereby recommend him/her for full licensure to practice in the State of Ohio.

(SEAL OF HOSPITAL)*

*If hospital has no seal, please indicate and have form notarized.

William R. Crombleholme, M.D.
Signature of Medical Director or Program Director
(Original signature only, names stamps will not be accepted)

William R. Crombleholme, M.D.
Name (please print or type)

September 2, 1993
Date

RETURN TO: STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR
COLUMBUS, OH 43266-0315

Revised 05/26/92

RECEIVED AUG - 9 1993

STATE MEDICAL BOARD OF OHIO

77 South High Street, 17th Floor • Columbus, Ohio 43266-0315 • (614) 466-3934

Rev.

MEDICINE OR OSTEOPATHIC MEDICINE

FORM 2 - CERTIFICATE OF GRADUATE MEDICAL EDUCATION

MAIL TO HOSPITAL OR INSTITUTION OF GRADUATE MEDICAL EDUCATION IN THE U.S. OR CANADA

Dear Sir:

I am applying for a license to practice in the State of Ohio. The State Medical Board of Ohio requires that my graduate medical education be certified. Please complete the form and return it directly to the State Medical Board of Ohio.

TO BE COMPLETED BY APPLICANT

APPLEGATE GERALD B. — Name in full (last, first, middle, suffix)

06/16/56 — Date of birth (mo/day/yr)

300 RUSTIN WAY WEXFORD PA 15909 — Complete address (street, city, state & zip)

NEW JERSEY MED SCHOOL — Medical school of graduation

STATE MEDICAL BOARD OF OHIO 93 SEP 10 AM 10

I HEREBY AUTHORIZE MY HOSPITAL OR INSTITUTION OF GRADUATE MEDICAL EDUCATION TO FURNISH THE FOLLOWING INFORMATION TO THE STATE MEDICAL BOARD OF OHIO.

Gerald B. Applegate — Signature of applicant

8/4/93 — Date

TO BE COMPLETED BY HOSPITAL OR TRAINING INSTITUTION

I offer the following in support of his/her application for full licensure:

During his residency:

I rate his/her medical knowledge and technique as: Above-Average

His/her relationship with patients is: Good

I rate his/her ability to work well with peers and medical staff as: Good

His/her command of the English language is: Excellent

Additional comments: Information was derived from Dr. Applegate's personnel file during his residency training and not from personal contact.

OVER ⇨

FORM 2 - CERTIFICATE OF GRADUATE EDUCATION - MEDICINE OR OSTEOPATHIC MEDICINE
PAGE TWO

This certifies that GERARD B. ABRUZZI has successfully completed
(name of applicant)

not less than 48 months of graduate medical education through the:
- ☐ 1st year level
- ☐ 2nd year level
- ☒ 3rd year level or above

as a(n):
- ☒ intern
- ☒ resident
- ☐ clinical fellow

in Obstetrics & Gynecology
(department)

at Magee-Womens Hospital 300 Halket Street
(name of hospital) (complete street address of hospital)

from 07/01/82 to 06/30/86.
beginning (mo/day/yr) ending (mo/day/yr)

It is further certified that the above named:
- ☐ will be awarded a certificate on} _____ mo/day/yr
- ☒ was awarded a certificate on} 06/86 mo/day/yr
- ☐ was not awarded a certificate
  please explain: _____

93 SEP 10 AM 11:20 STATE MEDICAL BOARD OF OHIO

and that the training:
- ☒ was accredited by ACGME/AOA
- ☐ was not accredited by ACGME/AOA

I hereby recommend him/her for full licensure to practice in the State of Ohio.

(SEAL OF HOSPITAL)*

*If hospital has no seal, please indicate and have form notarized.

William R. Crombleholme, M.D.
Signature of Medical Director or Program Director
(Original signature only, names stamps will not be accepted)

William R. Crombleholme, M.D.
Name (please print or type)

September 2, 1993
Date

RETURN TO: STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR
COLUMBUS, OH 43266-0315

Revised 05/26/92

Butler Memorial Hospital

September 3, 1993

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

To M. BOOTH	From M G KLEHM
Co. MEDICAL BOARD	Co. BUTLER MEM HOSP
Dept.	Phone # 412/284-4516
Fax # 614/644-8112	Fax # 412/284-4645

State Medical Board of Ohio
77 South High Street, 17th Floor
Columbus, OH 43266-0315

ATTENTION: MEDICAL BOARD
Mindy Booth, Licensure Assistant

Dear Ms. Booth:

Per your request, this is to inform you that Gerald Applegate, M.D., is currently appointed to the Medical Staff at Butler Memorial Hospital.

Sincerely,

Mary Grace Klehm, CMSC

Mary Grace Klehm, CMSC
Medical Staff Coordinator

mgk

VIA FAX TRANSMITTAL 614/644-8112

9/7/93

MINDY,

DR. APPLEGATE JUST CALLED & ADVISED THAT YOU DID NOT RECEIVE THIS INFORMATION ON THURSDAY. WE ARE RESENDING.

M. G. KLEHM

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS
P.O. BOX 2649
HARRISBURG, PA 17105-2649

GERALD BRIAN APPLEGATE
112 POINTE DRIVE
VALENCIA PA 16059

AUGUST 23, 1993

STATE BOARD OF MEDICINE

GERALD BRIAN APPLEGATE

MEDICAL PHYSICIAN AND SURGEON

TO WHOM IT MAY CONCERN:

THIS IS TO CERTIFY THAT THE ABOVE NAMED PERSON IS LICENSED IN THE COMMONWEALTH OF PENNSYLVANIA, DEPARTMENT OF STATE, STATE BOARD OF MEDICINE.

THE RECORDS OF THE PENNSYLVANIA STATE BOARD OF MEDICINE SHOW NO DEROGATORY INFORMATION AGAINST THIS LICENSE.

ORIGINAL LICENSURE DATE: JULY 08, 1983
EXPIRATION DATE: DECEMBER 31, 1994
LICENSE NUMBER: MD-029271-E

George L. Shevlin

George L. Shevlin
Commissioner

PREPARED BY CMIC

STATE MEDICAL BOARD OF OHIO

77 South High Street, 17th Floor • Columbus, Ohio 43266-0315 • (614) 466-3934

MEDICINE OR OSTEOPATHIC MEDICINE

FORM 4 - VERIFICATION OF LICENSE

I am applying for a license to practice in the State of Ohio. The State Medical Board of Ohio requires that this form be completed by each state or Canadian Province in which I hold or have held licenses, whether now current or not. Please complete the form and return it directly to the State Medical Board of Ohio.

TO BE COMPLETED BY APPLICANT

Name in full (last, first, middle, suffix)	License number	Issue date (mo/day/yr)
APPLEGATE, GERALD B	MD-029716	JULY 8 1983
Complete address (street, city, state & zip)	**Date of birth**	**Medical school of graduation**
300 RUSTIN WAY WAYNESBORO PA 15909	6/16/56	JUNE 1982 NEW JERSEY MED SCHOOL

I HEREBY AUTHORIZE THE LICENSING AGENCY OF THE STATE OR PROVINCE OF PENNSYLVANIA TO FURNISH THE INFORMATION BELOW TO THE STATE MEDICAL BOARD OF OHIO.

Signature of applicant	Date
G. Applegate	8/4/93

TO BE COMPLETED BY STATE BOARD OR CANADIAN PROVINCE

State/Province	Name of Licensee
License Number	Issue Date

Is License current: ❑ Yes ❑ No If not, please explain: _____

OVER ⇨

Is the applicant currently the subject of a pending investigation by a licensing or disciplinary authority in your state?

❑ YES ❑ NO ❑ CANNOT ANSWER UNDER CURRENT STATE LAW **If yes, please attach complete details.**

Have formal disciplinary proceedings been initiated against applicant or applicant's license by a disciplinary authority in your state?

❑ YES ❑ NO ❑ CANNOT ANSWER UNDER CURRENT STATE LAW **If yes, please attach complete details.**

Has the applicant ever been warned, censured or in any other manner disciplined or has applicant's license been revoked, suspended, or in any other manner limited by a licensing or disciplinary authority in your state?

❑ YES ❑ NO ❑ CANNOT ANSWER UNDER CURRENT STATE LAW **If yes, please attach complete details.**

(AFFIX BOARD SEAL)
(NOT VALID WITHOUT SEAL)

_____
Signature

_____
Title

_____
Date

RETURN TO: STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR
COLUMBUS, OH 43266-0315

URGENT - LICENSURE PENDING RECEIPT OF THIS FORM - PLEASE RUSH

Thank You

STATE MEDICAL BOARD OF OHIO

77 South High Street, 17th Floor • Columbus, Ohio 43266-0315 • (614) 466-3934

DATE 8/19/93

Dear Doctor:

Dr. Gerald B. Applegate who is/was Attending OB/GYN 7/93-8/93 is applying for licensure in the State of Ohio. We would appreciate your assistance in filling out the following evaluation so that we can process his/her application for licensure. **This form must be completed and returned to our office within two (2) weeks to ensure processing of the doctor's application.** Your immediate attention to this matter will be greatly appreciated by the doctor as well as by us. Information provided is considered confidential under Section 149.43(A)(2)(a), Ohio Revised Code. Thank you for your time and assistance.

(1) How long have you known the doctor? 10 years

(2) What is/was your supervisory capacity? Chief of OB/G Department

(3) At what hospital? North Hills Passavant Hospital

(4) How would you rate this doctor's medical knowledge and techniques? Excellent

(5) In your opinion, is this doctor a person of good moral and ethical character? yes

(6) Does this doctor work well with peers and medical staff? yes

(7) Does he/she relate well to patients? yes

(8) How is his/her command of the English language? (if applicable) American born.

(9) Would you recommend this doctor for licensure? yes.

Additional comments, please: (if needed, an extra sheet of paper may be used)

Please return this form to the Ohio State Medical Board at the above address,
Sincerely,

Mindy Booth

Mindy Booth
Licensure Assistant

Robert W. Ford, M.D.

Signature of Doctor, please type or print name legibly beneath

Robert W. Ford

Chairman OB/G Department.

Position

Telephone No. 412-366-1322 (Include Area Code)

NATIONAL BOARD OF MEDICAL EXAMINERS®

ENDORSEMENT OF CERTIFICATION

Note: The embossed seal of the National Board of Medical Examiners (NBME®) in the lower left corner certifies the authenticity of this document.

Diplomate Name: Gerald Brian Applegate, MD

Date of Birth: 06/16/1956

Certification Date: 07/01/1983

Certificate #: 261504

It is certified that the physician named above has successfully completed the examination, education, and training requirements for certification by the NBME as of the certification date shown above.

Exam	Test Date	Total Test	Min. Pass	Pass/ Fail	Anat	Phys	Bioc	Path	Micr	Phar	Beh Sci
NBME	Jun	580	380		605	600	510	615	555	670	350
PART I	1980	85	75	PASS	87	87	81	88	84	91	71

					Med	Surg	Ob/Gyn	PM/PH	Ped	Psych
NBME	Sep	610	290		635	645	530	495	605	600
PART II	1981	86	75	PASS	89	89	84	82	87	87

NBME	Mar	510	290	
PART III	1983	82.5	75	PASS

93 AUG 26 PM 12:22
STATE MEDICAL BOARD OF OHIO

DATE: 08/23/1993

SEE OTHER SIDE FOR SCORE INFORMATION

OH1018

This NBME *Endorsement of Certification* may include scores for Step 1 and Step 2 of the United States Medical Licensing Examination™ (USMLE™). The USMLE, established by the Federation of State Medical Boards and the NBME, is a single, uniform medical licensure examination system comprised of three Step examinations. USMLE will replace both the current Federation Licensing Examination (FLEX) and the NBME Parts I, II and III. Implementation of USMLE began with the administration of Steps 1 and 2 in 1992. The first administration of Step 3 will occur in June 1994. The NBME accepts passing scores on Parts I, II, and III as meeting the examination requirements for its certification program and the following combinations of passing scores on NBME examinations and USMLE: Part I or Step 1 **plus** Part II or Step 2 **plus** Part III or Step 3.

INTERPRETATION OF SCORES

NBME Part I and Part II Examinations Prior to June 1991

The most recent total test and subject scores are reported. The total test score is based on the total number of questions answered correctly on the entire examination and is not the average of the subject scores. There are no minimum pass requirements for individual subjects within a Part. Scores are on a three-digit scale with a mean of 500 and a standard deviation of 100, in increments of 5.

NBME Part I and Part II Examinations June 1991 and Thereafter

The most recent total test score is reported. This score is on a three-digit scale with a mean of 200 and a standard deviation of 20, in increments of 1.

Step 1 and Step 2 of the United States Medical Licensing Examination (USMLE)

The complete USMLE examination history is given. A total test score is reported on a three-digit scale with a mean of 200 and a standard deviation of 20, in increments of 1.

All NBME Part III Examinations

The most recent total test score is reported. This score is on a three-digit scale with a mean of 500 and a standard deviation of 100, in increments of 5.

Two-Digit Scores

For all examinations, an equivalent value scale score on a two-digit scale is also provided. The scale score mean is 82 and the minimum pass total scale score is 75. Scale scores are reported in increments of 1.

EXPLANATION OF COMMENTS

For USMLE Step 1 and Step 2, this document is annotated to reflect special circumstances regarding the score report.

If you wish to obtain further information about individual examinees who have notations under "Comments," please write the NBME Supervisor of Examinee Records.

Indeterminate - Results that cannot be certified as representing a valid measure of the examinee's knowledge or competence as sampled by the examination. Decisions to classify results as indeterminate may be made on the basis of factors that include, but are not limited to, inconsistency of performance within the examination or between administrations within the same Step. **No score is reported.**

Incomplete - The examinee sat for some but not all of the scheduled test books. **No score is reported.**

Irregular Behavior - Determination was made by the USMLE Committee on Irregular Behavior that the examinee engaged in such behavior. Irregular behavior includes all actions on the part of applicants and/or examinees, or by others when solicited by an applicant and/or examinee, that subvert or attempt to subvert the examination process.

Score Not Yet Available - Score not available pending further review and/or analysis.

Special Testing Accommodations - Following review and approval of a request from the examinee, special testing accommodations were provided in the administration of the examination.

University of Medicine and Dentistry of New Jersey

New Jersey Medical School

Be it known that upon the recommendation of the Faculty and by the authority of the Board of Trustees, the University of Medicine and Dentistry of New Jersey hereby confers upon

Gerald Brian Applegate

the degree of

Doctor of Medicine

with all the rights and privileges thereto.

In witness whereof we have hereunto affixed our signatures and the seal of the University in the State of New Jersey this twenty-sixth day of May, 1982.

President of the University

Dean

Stephen B. Wiley
Chairman, Board of Trustees

Stephen Rubenstein
Secretary, Board of Trustees

68-30

MEDICINE OR OSTEOPATHIC PRELIMINARY EDUCATION FORM

NAME: LAST (Surname) APPLEGATE | FIRST GERALD | MIDDLE BRIAN | SUFFIX(Jr., II)

HIGH SCHOOL OR EQUIVALENT:
SCHOOL NAME: COLUMBIA H.S. | CITY: MAPLEWOOD | STATE: N.J. | COUNTRY: USA
DATES ATTENDED: FROM: MO/DAY/YR 9/1/71 TO: MO/DAY/YR 6/1/74

UNDERGRADUATE COLLEGE OR EQUIVALENT:
SCHOOL NAME: SETON HALL UNIV. | CITY: SO. ORANGE | STATE: N.J. | COUNTRY: USA
DATES ATTENDED: FROM: MO/DAY/YR 9/1/74 TO: MO/DAY/YR 6/1/78 | DEGREE RECEIVED: B.S. BIOLOGY

R 2 B 3

SCHOOL NAME | CITY | STATE | COUNTRY
DATES ATTENDED: FROM: MO/DAY/YR / / TO: MO/DAY/YR / / | DEGREE RECEIVED

MEDICAL OR OSTEOPATHIC SCHOOL OF GRADUATION:
SCHOOL NAME: NEW JERSEY MEDICAL SCHOOL | CITY: NEWARK, | STATE: N.J. | COUNTRY: USA
DATES ATTENDED: FROM: MO/DAY/YR 9/1/78 TO: MO/DAY/YR 6/1/82 | DEGREE RECEIVED: M.D.

FOR BOARD USE ONLY

CERTIFICATE OF
PRELIMINARY EDUCATION

STATE MEDICAL BOARD OF OHIO
93 AUG -5 AM 9:55

NO: 83175 DATE ISSUED: 8-31-93

This is to certify that this applicant has met the preliminary education requirements for study in conformity with the statutes of Ohio and the regulations of the State Medical Board of Ohio.

Ray L. Bumgarner
Entrance Examiner

[illegible] M.D.
Secretary

Revised 05/28/93

DETACH HERE AND REMIT THIS PORTION WITH FEE

STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 43266 - 0315

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 1992-1994 BIENNIUM THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE OHIO STATE MEDICAL ASSOCIATION AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.

X _____ 11/5/94
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-06-5717	$250.00	05/01/94

GERALD BRIAN APPLEGATE,M.D.
9102 BABCOCK BLVD SUITE LL4
PASSAVANT PROFESSIONAL BLDG
PITTSBURGH PA 15237

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

NOT ON FILE
NOT ON FILE
NOT ON FILE

☐ SPECIALTY CODE(S) CORRECT AS LISTED

IF CORRECTIONS ARE NECESSARY, PLEASE ENTER ALL SPECIALTY CODES. CODE1: 086 CODE2: CODE3:

REPORT ANY CHANGE OF ADDRESS

STREET
STREET
CITY STATE ZIP CODE
COUNTY

:96969696 2: 0935065717 :00000 25000:

PRINCIPAL PRACTICE ADDRESS - IF DIFFERENT FROM THE ADDRESS SHOWN ON FRONT:

Street

Street

City State Zip Code

County

AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION FOR RENEWAL OF YOUR CERTIFICATE HAVE YOU :

YES NO

☐ ☒ *1.) Been found guilty of, or pled guilty or no contest to a felony or misdemeanor.*

YES NO

☐ ☒ *2.) Been found guilty of, or pled guilty or no contest to a federal or state law regulating the possession, distribution or use of any drug?*

YES NO

☐ ☒ *3.) Been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse? You may answer "no" to this question if you have successfully completed treatment at a program approved by this board and have subsequently adhered to all statutory requirements as contained in sections 4731.224 and 4731.25 O.R.C., and related provisions, or you are currently enrolled in a board approved program. Any questions concerning approval can be directed to the board offices.*

YES NO

☐ ☒ *4.) Had malpractice insurance cancelled or limited for other than failure to pay premiums?*

YES NO

☐ ☒ *5.) Had any disciplinary action taken or initiated against you by any state licensing board other than the State Medical Board of Ohio?*

YES NO

☐ ☒ *6.) Surrendered, or consented to limitation upon: a) A license to practice medicine; OR b) State or federal privileges to prescribe controlled substances?*

YES NO

☐ ☒ *7.) Had any clinical privileges suspended, restricted or revoked for reasons other than failure to maintain records or attend staff meetings?*

YES NO

☐ ☒ *8.) After January 14, 1993, referred a patient, or participated in an arrangement or scheme for referral of a patient, for clinical laboratory services to a person or facility in which either you or a member of your immediate family has an ownership or investment interest, or any compensation arrangement?*

SOCIAL SECURITY NUMBER
(Optional for purposes of identification)

DETACH HERE AND REMIT THIS PORTION WITH FEE

STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 43266 - 0315

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 1994-1996 BIENNIUM THE REQUIRED HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE OHIO STATE MEDICAL ASSOCIATION AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.

X _____ 3/15/96
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-06-5717	$250.00	05/01/96

GERALD BRIAN APPLEGATE,M.D.
9102 BABCOCK BLVD SUITE LL4
PASSAVANT PROFESSIONAL BLDG
PITTSBURGH PA 15237

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

OBG OBSTETRICS & GYNECOLOGY

PROCESSED [illegible] SPECIALTY CODE(S) CORRECTED AS LISTED

IF CORRECTIONS ARE NECESSARY, PLEASE ENTER ALL SPECIALTY CODES. CODE1 CODE2 CODE3

REPORT ANY CHANGE OF ADDRESS

10415 PERRY HIGHWAY
STREET
SUITE 208
STREET
WEXFORD PA 15090
CITY STATE ZIP CODE
ALLEGHENY
COUNTY

:96969696 2: 0935065717 #00000 25000#

PRINCIPAL PRACTICE ADDRESS - IF DIFFERENT FROM THE ADDRESS SHOWN ON FRONT:

Street

Street

City | State | Zip Code

County

AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION FOR RENEWAL OF YOUR CERTIFICATE HAVE YOU :

YES NO

1.) Been found guilty of, or pled guilty or no contest to a felony or misdemeanor.

YES NO

2.) Been found guilty of, or pled guilty or no contest to a federal or state law regulating the possession, distribution or use of any drug?

YES NO

3.) Been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse? You may answer "no" to this question if you have successfully completed treatment at a program approved by this board and have subsequently adhered to all statutory requirements as contained in Sections 4731.224 and 4731.25 O.R.C., and related provisions, or you are currently enrolled in a board approved program. Any questions concerning approval can be directed to the board offices.

YES NO

4.) Had malpractice insurance cancelled or limited for other than failure to pay premiums?

YES NO

5.) Had any disciplinary action taken or initiated against you by any state licensing board other than the State Medical Board of Ohio?

YES NO

6.) Surrendered, or consented to limitation upon: a) A license to practice medicine; OR b) State or federal privileges to prescribe controlled substances?

YES NO

7.) Had any clinical privileges suspended, restricted or revoked for reasons other than failure to maintain records or attend staff meetings?

YES NO

8.) Referred a patient, or participated in an arrangement or scheme for referral of a patient, for clinical laboratory services to a person or facility in which either you or a member of your immediate family has an ownership or investment interest, or any compensation arrangement?

SOCIAL SECURITY NUMBER
(Optional for purposes of identification)

DETACH HERE AND REMIT THIS PORTION WITH FEE

STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 43266 - 0315

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 1996-1998 BIENNIUM THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE OHIO STATE MEDICAL ASSOCIATION AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.

X _____ 3/6/98
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-06-5717-A	$371.00	05/01/98

GERALD BRIAN APPLEGATE,M.D.
10475 PERRY HIGHWAY
SUITE ~~200~~ 208
WEXFORD PA 15090

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

OBG OBSTETRICS & GYNECOLOGY

COPY

☑ SPECIALTY CODE(S) CORRECT AS LISTED

IF CORRECTIONS ARE NECESSARY, PLEASE ENTER ALL SPECIALTY CODES. CODE1 CODE2 CODE3

REPORT ANY CHANGE OF ADDRESS

10475 PERRY HWY STE 208
STREET
STREET
WEXFORD PA 15090
CITY STATE ZIP CODE
ALLEGHENY
COUNTY

:969696962: 0935065717# #0000037100#

IF DIFFERENT FROM THE ADDRESS SHOWN ON FRONT:

10475 PERRY HWY STE 208
Street
Street
WEXFORD PA 15090
City State Zip Code
ALLEGHENY
County

AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION FOR RENEWAL OF YOUR CERTIFICATE HAVE YOU:

1.) Been found guilty of, or pled guilty or no contest to a felony or misdemeanor. YES ☐ NO ☒

2.) Been found guilty of, or pled guilty or no contest to a federal or state law regulating the possession, distribution or use of any drug? YES ☐ NO ☒

3.) Been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse? You may answer "no" to this question if you have successfully completed treatment at a program approved by this board and have subsequently adhered to all statutory requirements as contained in sections 4731.224 and 4731.25 O.R.C., and related provisions, or you are currently enrolled in a board approved program. Any questions concerning approval can be directed to the board offices. YES ☐ NO ☒

4.) Had malpractice insurance cancelled or limited for other than failure to pay premiums? YES ☒ NO ☐

5.) Had any disciplinary action taken or initiated against you by any state licensing board other than the State Medical Board of Ohio? YES ☐ NO ☒

6.) Surrendered, or consented to limitation upon: a) A license to practice medicine; OR b) State or federal privileges to prescribe controlled substances? YES ☐ NO ☒

7.) Had any clinical privileges suspended, restricted or revoked for reasons other than failure to maintain records or attend staff meetings? YES ☐ NO ☒

8.) Referred a patient, or participated in an arrangement or scheme for referral of a patient, for clinical laboratory services to a person or facility in which either you or a member of your immediate family has an ownership or investment interest, or any compensation arrangement? YES ☐ NO ☒

SOCIAL SECURITY NUMBER

DETACH HERE AND REMIT THIS PORTION WITH FEE

STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 43266 - 0315

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 1998-2001 REGISTRATION PERIOD THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE OHIO STATE MEDICAL ASSOCIATION AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.

X _____ 1/16/01
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-06-5717-A	$305.00	04/01/2001

GERALD BRIAN APPLEGATE,M.D.
10475 PERRY HIGHWAY
SUITE 208
WEXFORD PA 15090

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

OBG OBSTETRICS & GYNECOLOGY

☑ SPECIALTY CODE(S) CORRECT AS LISTED

IF CORRECTIONS ARE NECESSARY, PLEASE ENTER ALL SPECIALTY CODES. CODE1 CODE2 CODE3

RESIDENCE ADDRESS-THIS MUST BE ENTERED AT EACH RENEWAL.

1601 FIELDSTONE LANE
STREET

STREET

SEWICKLEY PA 15143
CITY STATE ZIP CODE

ALLEGHENY
COUNTY

:96969696 2: 0935065717" "0000030500"

PRINCIPAL PRACTICE ADDRESS - THIS ADDRESS MUST BE ENTERED AT EACH RENEWAL.

☐ Check this Box if you have NO principle Practice address.

10475 PERRY HIGHWAY
Street

SUITE 208
Street

WEXFORD PA 15090
City State Zip Code

ALLEGHENY
County

AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION FOR RENEWAL OF YOUR CERTIFICATE :

YES ☐ NO ☑ 1.) Have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?

YES ☐ NO ☑ 2.) Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependence or abuse? **You may answer "NO" to this question if** you have successfully completed treatment at a program approved by this board and have subsequently adhered to all statutory requirements as contained in sections 4731.224 and 4731.25 O.R.C., and related provisions, or you are currently enrolled in a board approved program. Any questions concerning approval can be directed to the board offices.

YES ☐ NO ☑ 3.) Have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?

YES ☐ NO ☑ 4.) Has any board, bureau, department, agency, or other body, including those in Ohio, **other than this board,** filed any charges, allegations or complaints against you?

YES ☐ NO ☑ 5.) Have you surrendered, or consented to limitation of a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction? You may answer "NO" to this question if the only such surrender or consent was given to this board.

YES ☑ NO ☐ 6.) Have you had any clinical privileges or other similar institutional authority suspended, restricted or revoked for reasons **other than failure to maintain records on a timely basis or to attend staff meetings?**

[redacted] Redacted

SOCIAL SECURITY NUMBER

DETACH HERE AND REMIT THIS PORTION WITH FEE

STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 43215 - 6127

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 2001 - 2003 REGISTRATION PERIOD THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE
OHIO STATE MEDICAL ASSOCIATION
AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.

X _____
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE	$50 Late Fee Due After
35-06-5717-A	$305.00	UPON RECEIPT	07/01/03

GERALD BRIAN APPLEGATE,M.D.
10475 PERRY HIGHWAY
SUITE 208
WEXFORD PA 15090

MD & DO SPECIALTY CODES CURRENTLY ON RECORD
OBG OBSTETRICS & GYNECOLOGY

☑ **SPECIALTY CODE(S) CORRECT AS LISTED**

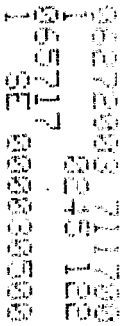
IF CORRECTIONS ARE NECESSARY, PLEASE ENTER ALL SPECIALTY CODES. CODE1 CODE2 CODE3

RESIDENCE ADDRESS-THIS MUST BE ENTERED AT EACH RENEWAL.

1601 FIELDSTONE LANE
STREET
STREET
SEWICKLEY PA 15143
CITY STATE ZIP CODE
ALLEGHENY
COUNTY

0935065717 30500

AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION FOR RENEWAL OF YOUR CERTIFICATE :



YES ☐ NO ☑ 1.) Have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?

YES ☐ NO ☑ 2.) Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse? **You may answer "NO" to this question** if you have successfully completed treatment at, or are currently enrolled in, a program approved by this Board and have adhered to all statutory requirements during and subsequent to treatment. You must answer "YES" if you have ever relapsed. Any questions concerning program approval or concerning this question can be directed to the board offices.

YES ☑ NO ☐ 3.) Have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?

YES ☑ NO ☐ 4.) Has any board, bureau, department, agency, or other body, including those in Ohio, **other than this board,** filed any charges, allegations or complaints against you?

YES ☐ NO ☑ 5.) Have you surrendered, or consented to limitation of, or to reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction? You may answer "NO" to this question if the only such surrender or consent was given to this board.

YES ☑ NO ☐ 6.) Have you had any clinical privileges or other similar institutional authority suspended, restricted or revoked for reasons **other than failure to maintain records on a timely basis or to attend staff meetings?**

PRINCIPAL PRACTICE ADDRESS - THIS ADDRESS MUST BE ENTERED AT EACH RENEWAL.

☐ Check this Box if you have NO principal Practice address.

10475 PERRY HIGHWAY
Street
SUITE 208
Street
WEXFORD PA 15090
City State Zip Code
ALLEGHENY
County

REQUIRED
[redacted] Redacted
SOCIAL SECURITY NUMBER

Date Posted: 2/9/2005 7:50:46 PM

Please review all information you have provided. Click on the "Review" button to change any information given or click on the "I Agree" button to verify that all information posted below is correct and to proceed to payment options.

Please note that knowingly providing false information may result in denial of registration.

License Information

License Number	35.065717
License Name	GERALD APPLEGATE
Email Address	

Fees

Relicensure Fee	$305.00
	========
Total Fees	**$305.00**

Specialty Codes

1. Please select one specialty from the field below
   . . . . . OBSTETRICS & GYNECOLOGY
2. Please select one specialty from the field below, if applicable.
   . . . . . GYNECOLOGY
3. Please select one specialty from the field below, if applicable.
   . . . . . *{not Answered}*

CME

1. Have you met the above CME requirements for your license?
   . . . . . YES

Discipline

1. Have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?
   . . . . . NO
2. Have you surrendered, consented to limitation of, or to suspension, reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction other than Ohio?
   . . . . . YES
3. Have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?
   . . . . . NO
4. Has any board, bureau, department, agency, or any other body, including those in Ohio **other than this board,** filed any charges, allegations or complaints against you?

. . . . . YES

5. Have you had any clinical privileges or other similar institutional authority suspended, restricted or revoked for reasons **other than failure to maintain records on a timely basis or to attend staff meetings?**

. . . . . NO

6. Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse?

. . . . . NO

Social Security Number

1.

. . . . . Redacted

Nurse Collaboration Info

1. Are you currently in a collaboration agreement with any Clinical Nurse Specialists, Certified Nurse-Midwives or Certified Nurse Practitioners?

. . . . . NO

2. List the name/names and type of licensure for each nurse with whom you are collaborating. **For example: Jane Doe, CNP; Mary Smith, CNS.**

. . . . . *{not Answered}*

I understand that submitting a false, fraudulent, or forged statement or document or omitting a material fact in obtaining licensure may be grounds for disciplinary action against my license.

Under penalty of law, I hereby swear or affirm that the information I have provided in the application is complete and correct, and that I have complied with all criteria for applying on line.

Date Posted: 6/20/2007 9:53:17 PM

Please review all information you have provided. Click on the "Review" button to change any information given or click on the "I Agree" button to verify that all information posted below is correct and to proceed to payment options.

Please note that knowingly providing false information may result in denial of registration.

License Information

License Number	35.065717
License Name	GERALD APPLEGATE
Email Address	jerryapple@comcast.net

Fees

Relicensure Fee	$305.00
	========
Total Fees	**$305.00**

Specialty Codes

1. Please select one specialty from the field below
   . . . . . OBSTETRICS & GYNECOLOGY
2. Please select one specialty from the field below, if applicable.
   . . . . . *{not Answered}*
3. Please select one specialty from the field below, if applicable.
   . . . . . *{not Answered}*

CME-Physicians

1. Have you met the above CME requirements for your license?
   . . . . . YES

Discipline

1. Have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?
   . . . . . NO
2. Have you surrendered, consented to limitation of, or to suspension, reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction other than Ohio?
   . . . . . YES
3. Have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?
   . . . . . NO
4. Has any board, bureau, department, agency, or any other body, including those in Ohio **other than this board,** filed any charges, allegations or complaints against you?

. . . . . YES

5. Have you had any clinical privileges or other similar institutional authority suspended, restricted or revoked for reasons **other than failure to maintain records on a timely basis or to attend staff meetings?**

. . . . . NO

6. Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse?

. . . . . NO

Social Security Number

1.

. . . . . Redacted

Nurse Collaboration Info

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. . . . . *{not Answered}*

I understand that submitting a false, fraudulent, or forged statement or document or omitting a material fact in obtaining licensure may be grounds for disciplinary action against my license.

Under penalty of law, I hereby swear or affirm that the information I have provided in the application is complete and correct, and that I have complied with all criteria for applying on line.

Date Posted: 2/9/2009 11:12:24 AM

Please review all information you have provided. Click on the "Review" button to change any information given or click on the "I Agree" button to verify that all information posted below is correct and to proceed to payment options.

Please note that knowingly providing false information may result in denial of registration.

License Information

License Number	35.065717
License Name	GERALD APPLEGATE
Email Address	jerryapple@comcast.net

Fees

Relicensure Fee	$305.00
	========
Total Fees	**$305.00**

Specialty Codes

1. Please select one specialty from the field below
   . . . . . OBSTETRICS & GYNECOLOGY
2. Please select one specialty from the field below, if applicable.
   . . . . . *{not Answered}*
3. Please select one specialty from the field below, if applicable.
   . . . . . *{not Answered}*

CME-Physicians

1. Have you met the above CME requirements for your license?
   . . . . . YES

Discipline

1. Have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?
   . . . . . NO
2. Have you surrendered, consented to limitation of, or to suspension, reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction other than Ohio?
   . . . . . YES
3. Have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?
   . . . . . NO
4. Has any board, bureau, department, agency, or any other body, including those in Ohio **other than this board,** filed any charges, allegations or complaints against you?

. . . . . NO

5. Have you had any clinical privileges or other similar institutional authority suspended, restricted, revoked or placed on probation for reasons **other than failure to maintain records on a timely basis or to attend staff meetings?**

. . . . . NO

6. Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse?

. . . . . NO

Social Security Number

1.

. . . . . Redacted

Nurse Collaboration Info

1. Are you currently in a collaboration agreement with any Clinical Nurse Specialists, Certified Nurse-Midwives or Certified Nurse Practitioners?

. . . . . NO

2. List the name/names and type of licensure for each nurse with whom you are collaborating. **For example: Jane Doe, CNP; Mary Smith, CNS.**

. . . . . *{not Answered}*

I understand that submitting a false, fraudulent, or forged statement or document or omitting a material fact in obtaining licensure may be grounds for disciplinary action against my license.

Under penalty of law, I hereby swear or affirm that the information I have provided in the application is complete and correct, and that I have complied with all criteria for applying on line.

Date Posted: 4/4/2011 8:13:28 PM

Please review all information you have provided. Click on the "Review" button to change any information given or click on the "I Agree" button to verify that all information posted below is correct and to proceed to payment options.

Please note that knowingly providing false information may result in denial of registration.

Address Information

CREDENTIAL MAIL ADDRESS

P O Box 402098
Miami Beach, FL 33140-0098
Out of State County
jerryapple@comcast.net

License Information

License Number 35.065717
License Name GERALD APPLEGATE

Fees

Relicensure Fee $305.00

========

Total Fees **$305.00**

Medical Board Correspondence Email

1. **Did you provide a Credential email address? Please note this information is a public record.**

. . . . . YES

Specialty Codes

1. Please select one specialty from the field below

. . . . . OBSTETRICS & GYNECOLOGY

2. Please select one specialty from the field below, if applicable.

. . . . . *{not Answered}*

3. Please select one specialty from the field below, if applicable.

. . . . . *{not Answered}*

CME-Physicians

1. Have you met the above CME requirements for your license?

. . . . . YES

Discipline

1. Have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?

. . . . . NO

2. Have you surrendered, consented to limitation of, or to suspension, reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction other than Ohio?

. . . . . NO

3. Have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?

. . . . . NO

4. Has any board, bureau, department, agency, or any other body, including those in Ohio **other than this board,** filed any charges, allegations or complaints against you?

. . . . . NO

5. Have you had any clinical privileges or other similar institutional authority suspended, restricted, revoked or placed on probation for reasons **other than failure to maintain records on a timely basis or to attend staff meetings?**

. . . . . NO

6. Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse?

. . . . . NO

Social Security Number

1.

. . . . . Redacted

Nurse Collaboration Info

1. Are you currently in a collaboration agreement with any Clinical Nurse Specialists, Certified Nurse-Midwives or Certified Nurse Practitioners?

. . . . . NO

2. List the name/names and type of licensure for each nurse with whom you are collaborating. **For example: Jane Doe, CNP; Mary Smith, CNS.**

. . . . . *{not Answered}*

Ohio Employment

1. Do you practice in Ohio?

. . . . . NO

I understand that submitting a false, fraudulent, or forged statement or document or omitting a material fact in obtaining licensure may be grounds for disciplinary action against my license.

Under penalty of law, I hereby swear or affirm that the information I have provided in the application is complete and correct, and that I have complied with all criteria for applying on line.

Date Posted: 5/4/2013 10:32:38 AM

Please review all information you have provided. Click on the "Review" button to change any information given or click on the "I Agree" button to verify that all information posted below is correct and to proceed to payment options.

Please note that knowingly providing false information may result in denial of registration.

License Information

License Number 35.065717

License Name GERALD APPLEGATE

Fees

Relicensure Fee $305.00

========

Total Fees **$305.00**

Medical Board Correspondence Email

1. **Did you provide a Credential email address? Please note this information is a public record.**

. . . . . YES

Specialty Codes

1. Please select one specialty from the field below

. . . . . OBSTETRICS & GYNECOLOGY

2. Please select one specialty from the field below, if applicable.

. . . . . *{not Answered}*

3. Please select one specialty from the field below, if applicable.

. . . . . *{not Answered}*

CME-Physicians

1. Have you met the above CME requirements for your license?

. . . . . YES

Discipline

1. Have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?

. . . . . NO

2. Have you surrendered, consented to limitation of, or to suspension, reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction other than Ohio?

. . . . . NO

3. Have any malpractice awards been paid by you or on your behalf for acts

occurring in any state other than Ohio?

. . . . . NO

4. Has any board, bureau, department, agency, or any other body, including those in Ohio **other than this board,** filed any charges, allegations or complaints against you?

. . . . . NO

5. Have you had any clinical privileges or other similar institutional authority suspended, restricted, revoked or placed on probation for reasons **other than failure to maintain records on a timely basis or to attend staff meetings?**

. . . . . NO

6. Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse?

. . . . . NO

Social Security Number

1.

. . . . . Redacted

Nurse Collaboration Info

1. Are you currently in a collaboration agreement with any Clinical Nurse Specialists, Certified Nurse-Midwives or Certified Nurse Practitioners?

. . . . . NO

2. List the name/names and type of licensure for each nurse with whom you are collaborating. **For example: Jane Doe, CNP; Mary Smith, CNS.**

. . . . . *{not Answered}*

Ohio Employment

1. Do you practice in Ohio?

. . . . . NO

NPI number

1. Please enter your current NPI number

. 1255518395

DEA number

1. Please enter your DEA number

. . . . . Ba2005898

I understand that submitting a false, fraudulent, or forged statement or document or omitting a material fact in obtaining licensure may be grounds for disciplinary action against my license.

Under penalty of law, I hereby swear or affirm that the information I have provided in the application is complete and correct, and that I have complied with all criteria for applying on line.

Date Posted: 5/20/2015 10:29:12 AM

Please review all information you have provided. Click on the "Review" button to change any information given or click on the "I Agree" button to verify that all information posted below is correct and to proceed to payment options.

Please note that knowingly providing false information may result in denial of registration.

License Information

License Number 35.065717

License Name GERALD APPLEGATE

Fees

Relicensure Fee $305.00

========

Total Fees **$305.00**

Medical Board Correspondence Email

1. **Did you provide a Credential email address? Please note this information is a public record.**

. . . . . YES

Specialty Codes

1. Please select one specialty from the field below

. . . . . OBSTETRICS & GYNECOLOGY

2. Please select one specialty from the field below, if applicable.

. . . . . *{not Answered}*

3. Please select one specialty from the field below, if applicable.

. . . . . *{not Answered}*

CME-Physicians

1. Have you met the above CME requirements for your license?

. . . . . YES

Discipline

1. **At any time since signing your last application for renewal of your certificate** have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?

. . . . . NO

2. **At any time since signing your last application for renewal of your certificate** have you surrendered, consented to limitation of, or to suspension, reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction other than Ohio?

. . . . . NO

3. **At any time since signing your last application for renewal of your certificate** have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?

. . . . . NO

4. **At any time since signing your last application for renewal of your certificate** has any board, bureau, department, agency, or any other body, including those in Ohio **other than this board,** filed any charges, allegations or complaints against you?

. . . . . NO

5. **At any time since signing your last application for renewal of your certificate** have you had any clinical privileges or other similar institutional authority suspended, restricted, revoked or placed on probation for reasons **other than failure to maintain records on a timely basis or to attend staff meetings?**

. . . . . NO

6. **At any time since signing your last application for renewal of your certificate** have you been addicted to or dependent upon alcohol or any chemical substance; relapsed, been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse?

. . . . . NO

Social Security Number

1.

. . . . . Redacted

Nurse Collaboration Info

1. Are you currently in a collaboration agreement with any Clinical Nurse Specialists, Certified Nurse-Midwives or Certified Nurse Practitioners?

. . . . . NO

2. List the name/names and type of licensure for each nurse with whom you are collaborating. **For example: Jane Doe, CNP; Mary Smith, CNS.**

. . . . . *{not Answered}*

Ohio Employment

1. Do you practice in Ohio?

. . . . . NO

NPI number

1. Please enter your current NPI number

. 1255518395

DEA number

1. Please enter your DEA number. Only enter one, or the primary DEA number.

. . . . . Ba2005898

OARRS Registration

1. Since signing your last renewal have you prescribed or personally furnished opioid analgesics or benzondiazepines while practicing in Ohio?

. . . . . NO

2. Are you registered with the Ohio Automated Rx Reporting System (OARRS)?

. . . . . NO

I understand that submitting a false, fraudulent, or forged statement or document or omitting a material fact in obtaining licensure may be grounds for disciplinary action against my license.

Under penalty of law, I hereby swear or affirm that the information I have provided in the application is complete and correct, and that I have complied with all criteria for applying on line.

Date Posted: 3/6/2017 11:15:54 AM

Please review all information you have provided. Click on the "Review" button to change any information given or click on the "I Agree" button to verify that all information posted below is correct and to proceed to payment options.

Please note that knowingly providing false information may result in denial of registration.

License Information

License Number 35.065717

License Name GERALD APPLEGATE

Fees

Relicensure Fee $305.00

========

Total Fees **$305.00**

Medical Board Correspondence Email

1. **Did you provide a Credential email address? Please note this information is a public record.**

. . . . . YES

Specialty Codes

1. Please select one specialty from the field below

. . . . . OBSTETRICS & GYNECOLOGY

2. Please select one specialty from the field below, if applicable.

. . . . . *{not Answered}*

3. Please select one specialty from the field below, if applicable.

. . . . . *{not Answered}*

CME-Physicians

1. Have you met the above CME requirements for your license?

. . . . . YES

Discipline

1. **At any time since signing your last application for renewal of your certificate** have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?

. . . . . NO

2. **At any time since signing your last application for renewal of your certificate** have you surrendered, consented to limitation of, or to suspension, reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction other than Ohio?

. . . . . NO

3. **At any time since signing your last application for renewal of your certificate** have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?

. . . . . NO

4. **At any time since signing your last application for renewal of your certificate** has any board, bureau, department, agency, or any other body, including those in Ohio **other than this board,** filed any charges, allegations or complaints against you?

. . . . . NO

5. **At any time since signing your last application for renewal of your certificate** have you had any clinical privileges or other similar institutional authority suspended, restricted, revoked or placed on probation for reasons **other than failure to maintain records on a timely basis or to attend staff meetings?**

. . . . . NO

6. **At any time since signing your last application for renewal of your certificate** have you been addicted to or dependent upon alcohol or any chemical substance; relapsed, been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse?

. . . . . NO

Social Security Number

1.

. . . . . Redacted

Nurse Collaboration Info

1. Are you currently in a collaboration agreement with any Clinical Nurse Specialists, Certified Nurse-Midwives or Certified Nurse Practitioners?

. . . . . NO

2. List the name/names and type of licensure for each nurse with whom you are collaborating. **For example: Jane Doe, CNP; Mary Smith, CNS.**

. . . . . *{not Answered}*

Ohio Employment

1. Do you practice in Ohio?

. . . . . NO

NPI number

1. Please enter your current NPI number

. 1255518395

DEA number

1. Please enter your DEA number. Only enter one, or the primary DEA number.

. . . . . BA2005898

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1. Since signing your last renewal have you prescribed or personally furnished opioid analgesics or benzondiazepines while practicing in Ohio?

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. . . . . NO

I understand that submitting a false, fraudulent, or forged statement or document or omitting a material fact in obtaining licensure may be grounds for disciplinary action against my license.

Under penalty of law, I hereby swear or affirm that the information I have provided in the application is complete and correct, and that I have complied with all criteria for applying on line.

Submission Date and Time: 6/5/2019 12:20 PM

License Renewal Application

License Type - Doctor of Medicine (MD)

Personal Information

Provide the necessary personal information in the fields to the right. All fields with (*) are required and must be completed to continue the application process. Demographic and workforce data collected for some licensed healthcare professions is used to enhance the state's capacity for healthcare workforce forecasting, policy development, and research. This data is used to analyze the supply and demand of the healthcare workforce serving Ohio. If you do not have an Individual Provider Identifier (NPI) number please enter nine zeroes.

Title
Dr.
First Name
Gerald
Middle Name
Brian
Last Name
Applegate
Maiden Name
No Response
Social Security Number
Redacted
Date of Birth
6/16/1956
Email Address
jerryapple@comcast.net
Phone Number
(412) 849-7821
Other Phone Number
(305) 285-6999
What is your U.S. Residency status related to your employment?
United States Citizen
Do you consider yourself Hispanic, Latino/a or of Spanish origin?
No
What do you consider your race?
White
List languages you personally use to communicate with patients excluding an interpreter or software
English
Other Language
No Response
Individual National Provider Identifier - if N/A enter all zeroes
1255518395
Enter home US zip-code. Enter NA if unavailable
33137

Additional Information

Provide the necessary additional information in the fields to the right. All fields with (*) are required and must be completed to continue the application process.

Do you have other aliases?
No
What is your gender?
Male
In which country were you born?
United States
In which state were you born (if United States)?
New Jersey
In which city were you born?
NEWARK

Employment Status

Demographic and workforce data collected for some licensed healthcare professions is used to enhance the state's capacity for healthcare workforce forecasting, policy development, and research. This data is used to analyze the supply and demand of the healthcare workforce serving Ohio.

What is your primary employment status
Actively working in a position(s) that does not require this license
Which of the following best describes your five-year employment plan?
Maintain practice hours as is

License Mailing Address

Select a license mailing address by clicking the appropriate checkbox to the right (this is the address used for all postal communications from the Board for this license). To add a new address, click Add Address, complete the required fields, and click Save.

P O Box 402098
Miami Beach
FL
33140-0098
null

License Public Address

Select a public license mailing address by clicking the appropriate checkbox to the right (this is the address that will be viewable by the public). To add a new address, click Add Address, complete the required fields, and click Save.

P O Box 402098
Miami Beach
FL
33140-0098
null

Military Service

If you have served in the military, provide the information for the type of service and duration of the service. Also, provide proof of your service.

Have you served in the military?
No
If you answered "Yes", are you currently serving in the military?
No Response
Has your spouse served in the military?
No
If you answered "Yes", are they currently serving in the military?
No Response
I declined to answer these questions

Secondary Email Recipient

You may define another email recipient for all automated emails you receive related to your license. You may change this recipient at any time from your dashboard.

Secondary Email Address:

Specialty Tracking Component

Please list any American Board of Medical Specialties, American Osteopathic Association, or Council on Podiatric Medical Education specialty and/or subspecialty certifications that you currently hold.

Current Employment Location(s)

Please provide the following information for all practice sites where you use this license, beginning with the locations in which you spend most of your time. If you are not actively working or volunteering in a position that requires this license (e.g. student or recent graduate) employment location information is optional.

Employment location information helps improve the accuracy and efficiency of Health Professional Shortage Area Designations and enables Ohio to identify healthcare workforce distribution.

Questions

Answer the following questions by selecting the Yes/No option for each question. Once completed, click Save and Continue.

Question - At any time since signing your last application for renewal of your certificate have you had any clinical privileges or other similar institutional authority suspended, restricted, revoked or placed on probation for reasons other than failure to maintain records on a timely basis or to attend staff meetings?
Answer - No

Question - At any time since submission of your last application for renewal have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse? You may answer NO to this question if you have successfully completed treatment at, or are currently enrolled in, a program approved by this Board and have adhered to all statutory requirements during and subsequent to treatment. You must answer YES if you have ever relapsed.
Answer - No

Question - At any time since signing your last application for renewal of your certificate have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?
Answer - No

Question - Since signing your last renewal have you prescribed opioid analgesics or benzondiazepines while practicing in Ohio?
Answer - No

Question - Are you registered with the Ohio Automated Rx Reporting System (OARRS)?
Answer - No

Question - Are you currently in a collaboration agreement with any Clinical Nurse Specialists, Certified Nurse-Midwives or Certified Nurse Practitioners?
Answer - No

Question - At any time since signing your last application for renewal of your certificate has any board, bureau, department, agency, or any other body, including those in Ohio other than this board, filed any charges, allegations or complaints against you?
Answer - No

Question - At any time since signing your last application for renewal of your certificate have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?
Answer - No

Question - At any time since signing your last application for renewal of your certificate have you surrendered, consented to limitation of, or to suspension, reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction other than Ohio?
Answer - No

Question - Do you currently supervise one or more Physician Assistants?
Answer - No

Question - Do you prescribe controlled substances?
Answer - Yes

Question - Primary DEA Number
Answer - BA2005898

Attachments

If applicable, upload the Attachments for your license application by clicking the Add Attachment button(s). If uploading an attachment as a submission, it is necessary that the name of the file attachment is less than 80 characters in length for it to be received successfully. The character limit does include the file attachment extension, such as (.doc) and (.pdf). The (.exe) and (.html) file extensions are not supported for submissions. For documentation that needs to be submitted directly to the Board or by hardcopy, please acknowledge by clicking the Attest button(s). If no attachment or attestation items appear, please click the Save and Continue button.

Review + Submit

Once the review has been processed, the license application will be completed.

Application Review - Completed

Attestation
I understand that submitting a false, fraudulent, or forged statement or document or omitting a material fact in obtaining licensure may be grounds for disciplinary action against my license. Under penalty of law, I hereby swear or affirm that the information I have provided in the application is complete and correct, and that I have complied with all criteria for applying.

Consent to Electronic Signature - **Consented**
Date/Time Stamp - 6/5/2019 12:20 PM
Type your First Name and Last Name as they appear on the application to sign electronically.
Gerald Applegate
Submit your Application -After clicking the 'Submit' button below, you will no longer be able to change this application. **PLEASE DO NOT USE THE BROWSER'S BACK BUTTON AS THAT MAY OVERWRITE YOUR DATA.** If you want to return to your application, simply log out and log back in.
If this application requires payment you will be prompted to begin the payment process. You must complete the payment process before the board will review your application. If this application does not require payment, you will be navigated back to the eLicense home page and the board will review your application.