STATE OF FLORIDA **DEPARTMENT OF HEALTH DIVISION OF MEDICAL QUALITY ASSURANCE**

DATE	LICENSE NO.	CONTROL NO.
09/20/2002	ME 86058	100270

THE MEDICAL DOCTOR

NAMED BELOW HAS MET ALL REQUIREMENTS OF THE LAWS AND RULES OF THE STATE OF FLORIDA.

EXPIRATION DATE: JANUARY 31, 2005

MATTHIAS GOTTERIED MUENZER SEACOAST OB/GYN 24 MORRILL PLACE AMESBURY, MA 01913

STATE OF ELORIDA DEPARTMENT OF HEALT DIVISION OF MEDICAL Q

MATTHIAS GOTTERIED MIJENZER COPY - NOT A VALID LICENSE - COPY

AT LEAST 90 DAYS PRIOR TO THE EXPIRATION DATE SHOWN ON THIS LICENSE, A NOTICE OF RENEWAL WILL BE SENT TO YOUR LAST KNOWN ADDRESS. IF YOU HAVE NOT RECEIVED YOUR NOTICE 60 DAYS PRIOR TO THE EXPIRATION DATE, PLEASE CALL (850) 410-3359.

THE MEDICAL DOCTOR
NAMED BELOW HAS MET ALL REQUIREMENTS OF
THE LAWS AND RULES OF THE STATE OF FLORIDA.

JANUARY 31, 2005

EXPIRATION DATE:

CONTROL

QUALITY ASSURANCE 9 86058 LICENSE

M

DATE

COPY - NOT A VALID LICENSE - COPY

EXPIRATION DATE: JANUARY 31, 2005
YOUR LICENSE NUMBER IS ME 86058, PLEASE USE IT IN ALL CORRESPONDENCE WITH YOUR BOARD/COUNCIL. EACH LICENSEE IS SOLELY RESPONSIBLE FOR NOTIFYING THE DEPARTMENT IN WRITING OF THE LICENSEE'S CURRENT MAILING ADDRESS. USE THIS SECTION TO REPORT NAME AND/OR MAILING ADDRESS CHANGES.

NAME CHANGES REQUIRE LEGAL DOCUMENTATION SHOWING THE NAME CHANGE. PLEASE MAKE SURE THAT A PHOTOCOPY OF ONE OF THE FOLLOWING ACCOMPANIES THIS FORM: A MARRIAGE LICENSE (MARRIAGE LICENSE MUST INDICATE THE ORIGINAL SIGNATURE AND SEAL FROM THE CLERK OF THE COURT), A DIVORCE DECREE INDICATING RESTORATION OF YOUR MAIDEN NAME, OR A COURT ORDER(E.G., ADOPTION, NAME CHANGE, OR FEDERAL IDENTITY CHANGE). ANY ONE OF THESE WILL BE ACCEPTED UNLESS THE DEPARTMENT HAS A QUESTION ABOUT THE AUTHENTICITY OF THE DOCUMENT. A DRIVER'S LICENSE OR SOCIAL SECURITY CARD IS NOT CONSIDERED LEGAL DOCUMENTATION.

TO REQUEST A DUPLICATE LICENSE SUBMITTHIS FORM AND A CHECK, PAYABLE TO THE DEPARTMENT OF HEALTH, IN THE AMOUNT OF \$25.00.

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	REQUEST DUPI	LICATE LICENSE				
			DEPARTMENT OF	HEALTH		
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	NAME CHANG	E (ATTACH LEGAL DOCU	•		ADDRESS CHANGE	
FROM						
	LAST	FIRST	MIDDLE			
TO:		510.07				
	LAST	FIRST	MIDDLE			
DH 21	03, 5/98			CITY	STATE	ZIP

DEPARTMENT OF HEALTH **DIVISION OF MEDICAL QUALITY ASSURANCE** LICENSURE SERVICES 4052 BALD CYPRESS WAY, BIN #C-10 TALLAHASSEE, FLORIDA 32399-3260

> **MATTHIAS GOTTFRIED MUENZER 87 GLEN ROAD BROOKLINE, MA 02445**

Florida Department of Health - Board of Medicine LICENSE RENEWAL NOTICE

Active Medical Doctor License # ME 86058 expires January 31, 2005.

The fee of **\$454.00** and the renewal notice must be postmarked on or before <u>January 31, 2005</u>. Renewal notices postmarked on or after February 1, 2005 require a renewal fee of **\$839.00**.

1. CURRENT MAILING ADDRESS:

This address will be used for all correspondence from the Department of Health.

MATTHIAS GOTTFRIED MUENZER ATTN: MATTHIAS G. MUENZER, MD ELL POND MEDICAL ASSOCIATES 101 MAIN ST, SUITE 214 MEDFORD. MA 02155

2. CURRENT PRACTICE LOCATION:

This address will be printed on your license and posted on the Internet.

DEPARTMENT USE ONLY

ELL POND MEDICAL ASSOCIATES 101 MAIN ST, SUITE 214 MEDFORD, MA 02155

3. RENEW ON LINE TODAY!

Go to www.doh-mqaservices.com and renew your license, change your address, update profile information, and confirm information maintained by the Department. Listed below is your user id and password for online services. If you renew online, you will receive a temporary license upon successful completion of your renewal. Online renewals are processed immediately and your license status is updated online within seven business days.

4. CHANGES TO CURRENT LICENSE INFORMATION:

If you have any changes to the name, mailing address, practice location address, license status or military status information associated with your license, please provide the updated information in the appropriate fields of section 7 on the back of this form.

5. THERE ARE TWO RENEWAL METHODS AVAILABLE:

A. Online Renewal: Visit www.doh-mqaservices.com go to the Practitioner Logon box, select your profession and enter your ID and password. If you are requesting a status change you will be ineligible to renew your license online. The system will be available for renewals until midnight, Eastern Standard Time (EST), January 31, 2005. To use the online system, you will need the following information:

(Note: Account Id and Password must be entered exactly as they appear.)

The online renewal system will allow practitioners to update their addresses, update profile information and to confirm licensee information maintained by the Department. Practitioners will receive a temporary license upon successful renewal before logging out of the system.

B. U.S. Mail: Mail completed form and fee payable to the Department of Health to the following address:

Department of Health
Division of Medical Quality Assurance
PO Box 6320
Tallahassee, FL 32314-6320

6. Other Information:

By submitting the appropriate renewal fees to the Department, a licensee certifies compliance with all requirements for renewal, including continuing education credits.

File Number: 79785 Sequence Number: 163
Profession Code: 1501 20 20



Please make changes to your license information in section 7 on the BACK of this form.

When providing updated information, print each character inside the box like this Use black/blue pen or No.2 pencil only for all changes. CHANGE OF NAME: Name changes require legal documentation showing the name change. Please make sure that a photocopy of one the following accompanies this form: a marriage license (marriage license must indicate the original signature and seal from the clerk of the court), a divorce decree indicating restoration of your maiden name, or a court order (e.g., adoption, name change, or federal identity change). Any one of these will be accepted unless the department has a question about the authenticity of the document. A driver's license or social security card is not considered legal documentation. If the name change cannot be completed, your license will be renewed using the current name. Last Name: Last Name:		PLE/ To ind					*******		se	ctic	n.	cor	lar	ete	the	ch:	and	e in	dicat		oval	lik	e tł	nis		()											
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Check or Money order written to Department of Health Financial responsibility form (check only one item on the FR form) Mail to: PO Box 6320, Tallahassee, Florida 32314-6320 If you are renewing to active status, would you be available to provide health care services in special needs shelters or to help staff disaster medical assistance teams during times of emergency or major disaster? Yes CHANGE OF LICENSE STATUS: I wish to change my status from Active to Inactive. The fee for an inactive receipt is \$415.00. The fee for inactive after													IIO\	N 4·	.D M	/eei	(s p	roce	SSII	ng t	ıme	€.															
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