TARGET SHEET

MT - 008888 - T

LICENSE NUMBER

NAME APPLE MOP

CODE

STATE BOARD OF MEDICAL EDUCATION AND
P.O. Box 2649
Harrisburg, Pennsylvania 17105-2649

☐ Graduate

APPLICATION FOR GRADUATE MEDICAL TRAINING

Complete the entire application and submit at least sixty (60) days before the beginning date of training.

Please type or print clearly.

1. Name APPLEGATE (Last) GERALD (First) BRIAN (Middle) (Maiden) Date 4/8/86
2. Date of Birth [redacted] Male X Female
3. Premedical School (Full Name) SETON HALL UNIVERSITY
   Location SO ORANGE (City) NJ. (State) USA (County) 07079 Year of Graduation 77
4. Medical School (Full Name) UNIVERSITY OF MEDICINE + DENTISTRY NEW JERSEY
   Location NEWARK (City) NJ. (State) USA (County) Year of Graduation 81
5. Training Approval Requested: 288 L UNIV
   Name of Hospital MAGEE-WOMENS HOSP. U. OF PITT.
   Address of Hospital FORBES & HALKET ST. PITTSBURGH PA
   Specialty OB/GYN 069 Level in Specialty PG
   Dates of Training Requested 6/22/82 (Beginning Date) to 7/1/86 (Ending Date) Office use
   Name of Program Director T. TERRY HANLEY
   Signature of Program Director [redacted]
6. List all states, territories and countries in which you have ever possessed a license to practice medicine, active or inactive. NONE
7. Are you, or have you ever been, addicted to the intemperate use of alcohol or the habitual use of narcotics or other habit forming drugs? NO
8. Have you ever been convicted of a crime (exclusive of parking and traffic violations) in the courts of this Commonwealth or any other state, territory, or country? NO
9. Have you ever possessed a license to practice medicine and surgery or other professional license that was suspended, revoked or subjected to other disciplinary conditions? NO
10. Have your provider privileges ever been restricted by the Drug Enforcement Administration, Medicare or Medicaid? NO

If you have answered yes to 7, 8, 9, or 10, please provide details on an additional sheet.

MA-1605 (7/82)

CURRICULUM VITAE

Complete if training requested is any other than first year after medical school. Indicate all activities for all years since graduation from medical school. Use additional sheets if necessary.

Previous Training

Dates	Name of Hospital	Location of Hospital	Specialty
____ to ____			
____ to ____			

Other Activities

____ to ____			
____ to ____			

AFFIDAVIT

State of Pennsylvania ss:

County of Allegheny

Grace B. Applegate (applicant) being duly sworn according to law, deposes and says that he/she is the person making the foregoing application and that the statements made therein are true and complete to the best of his/her knowledge and belief.

Subscribed and sworn to before me this 26th day of April 1982

Grace A. Russell

JUDE A. [illegible] Notary Public
PITTSBURGH, ALLEGHENY COUNTY
MY COMMISSION EXPIRES [illegible]

Grace B. Applegate
Signature of Applicant

ADDITIONAL REQUIREMENTS

1. Attach $10.00 fee made payable to the Commonwealth of Pennsylvania. Personal check, certified check or money order is acceptable. Submit one fee with each application.

2. UNRESTRICTED LICENSE TO PRACTICE MEDICINE AND SURGERY IN THIS COMMONWEALTH, ANOTHER STATE, TERRITORY OR CANADA IS REQUIRED IF ENTERING THIRD YEAR/LEVEL OF TRAINING. If a license is held, attach copy of current license registration card which displays expiration date.

3. If license is not held or required, attach Certificate of Medical Education (SPOA-1407r). If graduation is pending, interim form must accompany certificate and photograph. If Certificate of Medical Education was submitted with previous application, do not submit again but indicate date submitted.

(Month)_____(Year)_____

4. If license is not held or required and if a graduate of a foreign medical school, attach ECFMG Certificate.

Your application is being returned because a discrepancy was found in the following area(s):

_____ Fee

_____ License Registration Card

_____ Certificate of Medical Education

_____ ECFMG Certificate

_____ Curriculum Vitae

_____ Specialty

_____ Training Hospital

_____ Date of Training

_____ Notarization

_____ Other

Medicine- Medical Physician and Surgeon- Application

AA0000930143

BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS
P. O. Box 2649
Harrisburg, PA 17105-2649

APPLICANT INFORMATION

PERSONAL INFORMATION

Last Name	APPLEGATE	First Name	GERALD		
Middle Name	BRIAN	Suffix			
Full Name	GERALD BRIAN APPLEGATE				
SSN	[redacted]	Date Of Birth	[redacted]	Age	62	Gender	MALE

ADDRESS DETAILS

Street Address	PO BOX 402098		
City/State/Zip	MIAMI BEACH FL 33140		
County		Country	United States

CONTACT DETAILS

Phone number	[redacted]	Mobile Phone number	
Primary Email Address	[redacted]	Secondary Email Address	

CHECKLIST ITEMS

Checklist name	Status	Submitted Date	Expiration Date
Application	Pending Review	10/29/2018	
Application Fee	Completed	10/29/2018	
Child Abuse CE	Completed	10/29/2018	

LEGAL QUESTIONS

	Questions	Answer	Document Uploaded	File Name
1	Are you submitting a name change with this renewal?	N	No	
2	First Name		No	
3	Middle Name		No	
4	Last Name		No	
5	You must submit a copy of a legal document verifying the name (s). The following are acceptable name change verification documents: (1) Marriage Certificate: (2) Divorce decree which indicates the retaking of your maiden name: (3) Other "legal" document indicating the retaking of a maiden name: (4) For a "legal" name change, a copy of the court document must be provided.		No	
6	With the exception of the one you are currently renewing, do you hold, or have you ever held, a license, certificate, permit, registration or other authorization to practice a profession or occupation in any state or jurisdiction?	Y	No	

7	Please provide the profession and state or jurisdiction.	Medical doctor-Florida; Medical doctor-New York; Medical doctor-Ohio	No	
8	Since your initial application or last renewal, whichever is later, have you had disciplinary action taken against a professional or occupational license, certificate, permit, registration or other authorization to practice a profession or occupation issued to you in any state or jurisdiction or have you agreed to voluntary surrender in lieu of discipline?	N	No	
9	Do you currently have any disciplinary charges pending against your professional or occupational license, certificate, permit or registration in any state or jurisdiction?	N	No	
10	Since your initial application or last renewal, whichever is later, have you withdrawn an application for a professional or occupational license, certificate, permit or registration, had an application denied or refused, or for disciplinary reasons agreed not to apply or reapply for a professional or occupational license, certificate, permit or registration in any state or jurisdiction?	N	No	
11	Since your initial application or last renewal, whichever is later, have you been convicted (found guilty, pled guilty or pled nolo contendere), received probation without verdict or accelerated rehabilitative disposition (ARD), as to any criminal charges, felony or misdemeanor, including any drug law violations? Note: You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court.	N	No	
12	Do you currently have any criminal charges pending and unresolved in any state or jurisdiction?	N	No	
13	Since your initial application or your last renewal, whichever is later, have you had your DEA registration denied, revoked or restricted?	N	No	
14	Since your initial application or your last renewal, whichever is later, have you had provider privileges denied, revoked, suspended or restricted by a Medical Assistance agency, Medicare, third party payor or another authority?	N	No	
15	Since your initial application or your last renewal, whichever is later, have you had practice privileges denied, revoked, suspended, or restricted by a hospital or any health care facility?	N	No	
16	Since your initial application or your last renewal, whichever is later, have you been charged by a hospital, university, or research facility with violating research protocols, falsifying research, or engaging in other research misconduct?	N	No	
17	Since your initial application or last renewal, whichever is later, have you engaged in the intemperate or habitual use or abuse of alcohol or narcotics, hallucinogenics or other drugs or substances that may impair judgment or coordination?	[redacted]	No	
18	Since your initial application or your last renewal, whichever is later, have you been the subject of a civil malpractice lawsuit?	N	No	
19	Have you previously reported the complaint to the Board?		No	
20	Provide the docket number:		No	
21	Upload a copy of the entire Civil Complaint, which must include the filing date and the date you were served.		No	
22	Have you completed at least 2 hours of Board approved continuing education in pain management, identification of addiction or the practices of prescribing or dispensing of opioids?	Y	No	
23	Do you hold a DEA number or use the registration number of another person or entity to prescribe controlled substances?		No	

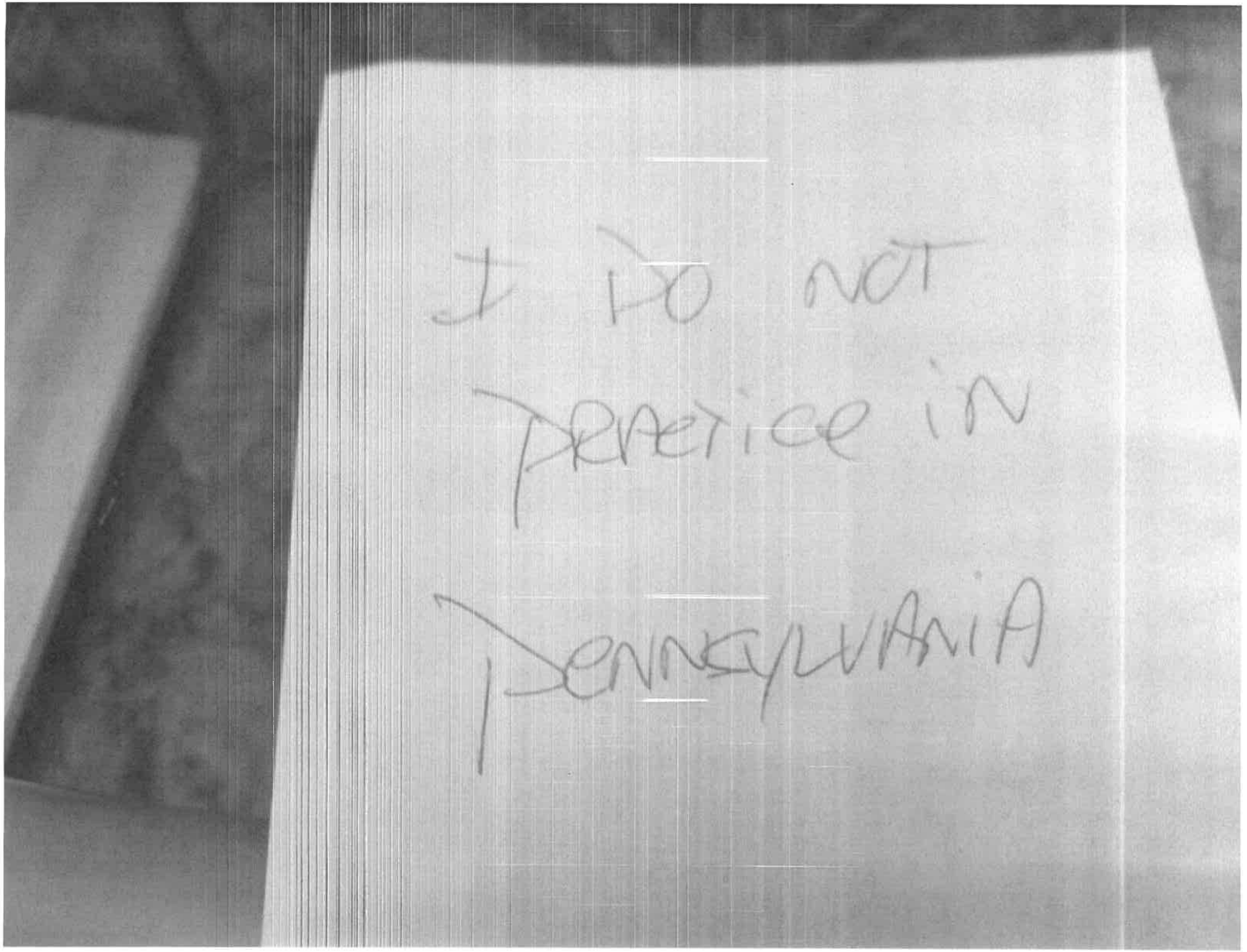
24	Have you registered with the Pennsylvania Prescription Drug Monitoring Program?	N	No	
25	I will be retiring from practice but desire to place my license on active-retired status which will allow me to treat immediate family members. I am exempt from the CME requirements, except for completion of the 2 hours of Board-approved continuing education in child abuse recognition and reporting and 2 hours of Board approved continuing education in pain management, identification of addiction or the practices of prescribing or dispensing of opioids. Renewal must be completed and fee required.	N	No	
26	Do you maintain current medical professional liability insurance in the Commonwealth of Pennsylvania?	N	No	
27	Upload an explanation or reason for an exemption request.		Yes	Blank.pages
27	Upload an explanation or reason for an exemption request.		Yes	image.jpg
28	Have you met your continuing education requirements? Please review the continuing education requirements posted on the Board's website at www.dos.pa.gov/med. Click on General Board Information. If you qualify for an exemption of the continuing education requirements, answer yes to the question. You are required to retain your official continuing education certificates of completion earned for this license renewal period until December 31, 2020.	Y	No	

Licenses/Certificates/Permits/Registrations in Any State/Jurisdiction

Profession	State/Jurisdiction
Medical doctor	Florida
Medical doctor	New York
Medical doctor	Ohio

CONFIRMATION

☑ All fees are non-refundable. Please check to continue with your transaction. (10/29/2018 14:39:04)


I DO NOT
PRACTICE IN
PENNSYLVANIA

Person Info
Name:GERALD BRIAN APPLEGATE
Address Info
Street Address [redacted] **Email** [redacted]
Phone
Fax
CityMiami Beach
StateFL
Zipcode33140
Country82
CountyMiami-Dade

Survey Response Summary
Question Response Summary

Are you submitting a name change with this renewal?	N
Do you hold a license/certificate (active, inactive or expired) to practice in any other state or jurisdiction?	Y
Since your initial application or last renewal, whichever is later, have you had disciplinary action taken against your license, certificate or registration issued to you in any profession in any other state or jurisdiction?	N
Since your initial application or last renewal, whichever is later, have you been convicted, found guilty or pleaded nolo contendere, or received probation without verdict, or accelerated rehabilitative disposition(ARD) as to any felony or misdemeanor, including any drug law violations, or do you have any criminal charges pending and unresolved in any state or jurisdiction? You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court.	N
Since your initial application or last renewal, whichever is later, have you withdrawn an application for a license, certificate or registration, had an application denied or refused, or for disciplinary reasons agreed not to reapply for a license, certificate or registration in any profession in any other state or jurisdiction?	N
Since your initial application or last renewal, whichever is later, have you been arrested for criminal homicide, aggravated assault, sexual offenses or drug offenses in any state, territory or country?	N
Since your last renewal, have you been the subject of a civil malpractice law suit? If yes, please submit a copy of the entire Civil Complaint which must include the filing date and the date you were served. If you previously reported the complaint, email or fax the docket number to	N

the Board. (email at st-medicine@state.pa.us or fax at 717-787-7769)	
Since your initial application or last renewal, whichever is later, have you had your DEA registration denied, revoked or restricted?	N
Since your initial application or last renewal, whichever is later, have you had practice privileges denied, revoked or restricted in a hospital or health care facility?	N
Since your initial application or last renewal, whichever is later, have your provider privileges been denied, revoked or restricted by any medical assistance agency for cause?	N
Do you maintain current medical professional liability insurance in the Commonwealth of Pennsylvania?	N
Have you met your current CE requirements?	Y

Education Information

Edit

Profession:	Medicine	School:	NEW JERSEY MEDICAL SCHOOL	Credit Hours:	Education Type:
From:		To:	1/1/1982		

Employment Information

No employment records

remarks
Remarks:

Continuing Education Information

No CE Course records

Person Info
Name: GERALD BRIAN APPLEGATE
Address Info
Street Address: [redacted] **Email** [redacted]
Phone
Fax
City Miami Beach
State FL
Zipcode 33140
Country 82
County Miami-Dade

Survey Response Summary	
Question Response Summary	
Are you submitting a name change with this renewal?	N
Have you completed your current CE requirements?	Y
Do you hold, or have you ever held, a license, certificate, permit, registration or other authorization to practice any health-related profession in any state or jurisdiction?	Y
If you answered yes to the above question, please provide the profession and state or jurisdiction.	NY, Ohio, Fla
Since your initial application or last renewal, whichever is later, have you had disciplinary action taken against a professional or occupational license, certificate, permit, registration or other authorization to practice a profession or occupation issued to you in any state or jurisdiction or have you agreed to voluntary surrender in lieu of discipline?	N
Do you currently have any disciplinary charges pending against your professional or occupational license, certificate, permit or registration in any state or jurisdiction?	N
Since your initial application or last renewal, whichever is later, have you withdrawn an application for a professional or occupational license, certificate, permit or registration, had an application denied or refused, or for disciplinary reasons agreed not to apply or reapply for a professional or occupational license, certificate, permit or registration in any state or jurisdiction?	N
Since your initial application or last renewal, whichever is later, have you been convicted (found guilty, pled guilty or pled nolo contendere), received probation without verdict or accelerated rehabilitative disposition (ARD), as to any criminal charges, felony or misdemeanor, including any drug law violations? Note: You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court.	N
Do you currently have any criminal charges pending and unresolved in any state or jurisdiction?	N
Since your initial application or last renewal, whichever is later, have you had your DEA registration denied, revoked or restricted?	N
Since your initial application or your last renewal, whichever is later, have you had provider privileges denied, revoked, suspended or restricted by a Medical Assistance agency, Medicare, third party payor or another authority?	N
Since your initial application or your last renewal, whichever is later, have you ever had practice privileges denied, revoked, suspended, or restricted by a hospital or any health care facility?	N
Since your initial application or your last renewal, whichever is later, have you been charged by a hospital, university, or research facility with violating research protocols, falsifying research, or engaging in other research misconduct?	N
Since your initial application or last renewal, whichever is later, have you engaged in the intemperate or habitual use or abuse of alcohol or narcotics, hallucinogenics or other drugs or substances that may impair judgment or coordination?	[redacted]
Since your initial application or your last renewal, whichever is later, have you been the subject of a civil malpractice lawsuit?	N
If yes, please submit a copy of the entire Civil Complaint, which must include the filing date and the date you were served. PLEASE NOTE: If you previously reported the complaint to the Board you will only need to provide the docket number here:	
Have you completed 2 hours of Board-approved continuing education in child abuse recognition and reporting?	N
Do you maintain current medical professional liability insurance in the Commonwealth of Pennsylvania?	N
If you answer "No", please provide an explanation or reason for an exemption request.	Practice limited to Florida
Please provide the zip code of your primary employer/practice location. This data is being collected for the purpose of identifying healthcare professionals during state emergencies and may be provided to the Pennsylvania Emergency Management Agency for official use only.	33166

Date Submitted: Wednesday, November 30, 2016

Education Info

No education records

Employment Information

No employment records

Person Info
Name:GERALD BRIAN APPLEGATE
Address Info
Street Address: [redacted] **Email** [redacted]
Phone
Fax
CityMiami Beach
StateFL
Zipcode33140
Country82
CountyMiami-Dade

Survey Response Summary

Question Response Summary

Are you submitting a name change with this renewal?	N
Have you met your current CE requirements?	Y
Have you completed 2 hours of Board-approved continuing education in child abuse recognition and reporting?	N
Do you hold, or have you ever held, a license, certificate, permit, registration or other authorization to practice a profession or occupation in any state or jurisdiction?	Y
If you answered yes to the above questions, please provide the profession and state or jurisdiction.	Florida Ohio new York
Since your initial application or last renewal, whichever is later, have you had disciplinary action taken against a professional or occupational license, certificate, permit, registration or other authorization to practice a profession or occupation issued to you in any state or jurisdiction or have you agreed to voluntary surrender in lieu of discipline?	N
Do you currently have any disciplinary charges pending against your professional or occupational license, certificate, permit or registration in any state or jurisdiction?	N
Since your initial application or last renewal, whichever is later, have you withdrawn an application for a professional or occupational license, certificate, permit or registration, had an application denied or refused, or for disciplinary reasons agreed not to apply or reapply for a professional or occupational license, certificate, permit or registration in any state or jurisdiction?	N
Since your initial application or last renewal, whichever is later, have you been convicted (found guilty, pled guilty or pled nolo contendere), received probation without verdict or accelerated rehabilitative disposition (ARD), as to any criminal charges, felony or misdemeanor, including any drug law violations? Note: You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court.	N
Do you currently have any criminal charges pending and unresolved in any state or jurisdiction?	N
Since your initial application or last renewal, whichever is later, have you had your DEA registration denied, revoked or restricted?	N
Since your initial application or your last renewal, whichever is later, have you had provider privileges denied, revoked, suspended or restricted by a Medical Assistance agency, Medicare, third party payor or another authority?	N
Since your initial application or your last renewal, whichever is later, have you ever had practice privileges denied, revoked, suspended, or restricted by a hospital or any health care facility?	N
Since your initial application or your last renewal, whichever is later, have you been charged by a hospital, university, or research facility with violating research protocols, falsifying research, or engaging in other research misconduct?	N
Since your initial application or last renewal, whichever is later, have you engaged in the intemperate or habitual use or abuse of alcohol or narcotics, hallucinogenics or other drugs or substances that may impair judgment or coordination?	[redacted]
If yes, are you currently participating in the Pennsylvania Professional Health Monitoring Program?	[redacted]
Since your initial application or your last renewal, whichever is later, have you been the subject of a civil malpractice lawsuit?	N
If yes, please submit a copy of the entire Civil Complaint, which must include the filing date and the date you were served. Submit a statement which includes complete details of the complaints that have been filed against you. PLEASE NOTE: If you previously reported the complaint to the Board you will only need to provide the docket number here:	
Do you maintain current medical professional liability insurance in the Commonwealth of Pennsylvania?	N
If you answer "No", please provide an explanation or reason for an exemption request.	Do not practice in pa

Date Submitted: Wednesday, December 03, 2014

Education Info

No education records

Employment Information

No employment records

EmailTo: [redacted]

EmailFrom:RA-STPALSNOTIFY@pa.gov

Subject: Provider Enrollment Deadline - Your Claims May Be Denied

Date Sent:06/11/2019

Provider Enrollment Deadline

Your Claims May Be Denied

The Pennsylvania Department of Human Services (DHS) has implemented the Affordable Care Act (ACA) provision requiring all CHIP network providers and practitioners who render, order, prescribe or bill for items or services to CHIP enrollees to be screened and enrolled with DHS.

Effective **July 1, 2019**, claims for services rendered to a CHIP enrollee that are submitted by a provider who does not have a PROMISe ID that corresponds to the location where the service(s) were rendered **will be denied** in accordance with DHS requirements.

If you would like to continue receiving payment for services rendered to CHIP enrollees, please complete your enrollment with the Department as soon as possible.

Enrollment information and the ability to enroll electronically are available at the following website: CHIP Provider Enrollment. **Providers are encouraged to enroll electronically.**

If you have any questions or issues with the enrollment process, contact the Provider Enrollment Hotline at 1-800-537-8862, select options 2, 4 and finally option 2 to speak to a representative.

Pennsylvania Department of Human Services
Harrisburg, Pennsylvania

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BUREAU OF PROFESSIONAL AND
OCCUPATIONAL AFFAIRS

Official Use Only 037052

MD-029271-E

APPLE RNEW

THIS IS YOUR RENEWAL NOTICE - REQUIRED FEE - $125.00

STATE BOARD OF MEDICINE
P.O. BOX 8414
HARRISBURG, PA. 17105-8414

GERALD BRIAN APPLEGATE
TOWN CENTRE SUITE 208
10475 TERRY HIGHWAY
WEXFORD, PA 15090

YOUR CURRENT LICENSE TO PRACTICE MEDICINE AND SURGERY IN PENNSYLVANIA WILL EXPIRE ON DECEMBER 31, 2000. TO RENEW YOUR LICENSE THROUGH DECEMBER 31, 2002, COMPLETE THE QUESTIONS BELOW AND RETURN WITH A CHECK OR MONEY ORDER IN THE AMOUNT OF $125.00 MADE PAYABLE TO THE "COMMONWEALTH OF PA." WRITE YOUR LICENSE NUMBER ON THE FRONT OF THE PAYMENT. A LATE FEE OF $5.00 PER MONTH WILL BE CHARGED FOR RENEWALS POSTMARKED AFTER DECEMBER 31, 2000. A PROCESSING FEE OF $20.00 WILL BE CHARGED FOR ANY CHECK OR MONEY ORDER UNPAID BY YOUR BANK, REGARDLESS OF THE REASON. IF YOU HAVE A CHANGE IN NAME AND/OR ADDRESS, INDICATE THE CHANGE NEXT TO THE PRE-PRINTED NAME AND ADDRESS ABOVE. A NAME CHANGE REQUIRES SUBMISSION OF A COPY OF A COURT ORDER, MARRIAGE CERTIFICATE, DIVORCE DECREE OR OTHER OFFICIAL DOCUMENT.

NOTICE: IF YOU PRACTICE IN PENNSYLVANIA, YOU MUST MAINTAIN THE REQUIRED AMOUNT OF PROFESSIONAL LIABILITY INSURANCE AND PAY THE REQUIRED FEE AND CAT FUND SURCHARGE. FAILURE TO DO SO WILL RESULT IN SUSPENSION OR REVOCATION OF YOUR LICENSE.

ANY DISCIPLINARY ACTION TAKEN IN ANOTHER STATE, TERRITORY OR COUNTRY SHALL BE REPORTED TO THE BOARD ON THE BIENNIAL RENEWAL NOTICE OR WITHIN 30 DAYS OF FINAL DISPOSITION, WHICHEVER IS SOONER.

THE FOLLOWING QUESTIONS MUST BE ANSWERED. IF YOU ANSWER "YES" TO QUESTIONS 2, 3, 4, OR 5 BELOW, YOU MUST PROVIDE COMPLETE DETAILS ON 8 1/2 X 11 SHEETS OF PAPER AND INCLUDE COPIES OF LEGAL DOCUMENTS, IF ANY. FAILURE TO PROVIDE DOCUMENTS WILL DELAY THE PROCESS.

YES NO

( ) (X) 1. DO YOU HOLD A LICENSE TO PRACTICE MEDICINE AND SURGERY (ACTIVE OR INACTIVE, CURRENT OR EXPIRED) IN ANY OTHER JURISDICTION? IF YES, LIST EACH ONE. Ohio, New York State

( ) (X) 2. SINCE YOUR LAST RENEWAL, HAS ANOTHER STATE, TERRITORY OR COUNTRY TAKEN ANY DISCIPLINARY ACTION (INCLUDES VOLUNTARY SURRENDER OF A LICENSE) AGAINST YOU OR FILED CHARGES AGAINST YOU THAT HAVE NOT BEEN RESOLVED IN YOUR FAVOR?

( ) (X) 3. SINCE YOUR LAST RENEWAL, HAVE YOU BEEN CONVICTED, FOUND GUILTY, PLEADED NOLO CONTENDERE, RECEIVED PROBATION WITHOUT VERDICT, OR RECEIVED ANY OTHER DISPOSITION (EXCLUDING ACQUITTAL OR DISMISSAL), WITH RESPECT TO ANY CRIMINAL OFFENSE, INCLUDING ANY DRUG LAW VIOLATIONS, OR DO YOU HAVE ANY CRIMINAL CHARGES PENDING AND UNRESOLVED IN ANY STATE OR FEDERAL COURT? (A SUMMARY TRAFFIC VIOLATION SHOULD NOT BE CONSIDERED AS A CRIMINAL OFFENSE.)

( ) (X) 4. SINCE YOUR LAST RENEWAL, FOR DISCIPLINARY REASONS HAVE YOU WITHDRAWN AN APPLICATION FOR A LICENSE, HAD AN APPLICATION FOR A LICENSE DENIED OR REFUSED, OR AGREED NOT TO REAPPLY FOR A LICENSE IN ANOTHER STATE, TERRITORY OR COUNTRY? A LICENSE INCLUDES A REGISTRATION OR CERTIFICATION.

(X) ( ) 5. SINCE YOUR LAST RENEWAL, HAVE YOU HAD PRACTICE PRIVILEGES DENIED, REVOKED, SUSPENDED, RESTRICTED, SURRENDERED IN LIEU OF DISCIPLINE OR EMPLOYMENT TERMINATED IN A HOSPITAL OR ANY HEALTH CARE FACILITY? See ATTACHED.

( ) (X) 6. SINCE YOUR LAST RENEWAL, HAVE YOU HAD YOUR DEA REGISTRATION DENIED, REVOKED OR RESTRICTED OR HAVE YOU HAD YOUR PROVIDER PRIVILEGES TERMINATED BY ANY MEDICAL ASSISTANCE AGENCY FOR CAUSE?

IF YOU WANT YOUR LICENSE PLACED ON "INACTIVE" STATUS PLACE AN "X" IN THE BLANK TO THE RIGHT. _____
NO FEE IS REQUIRED. YOU ARE STILL REQUIRED TO ANSWER THE QUESTION, SIGN AND DATE BELOW.

MY REPRESENTATIONS ON THIS [redacted] KNOWLEDGE. I UNDERSTAND THAT THEY ARE SUBJECT TO [redacted] RITIES.

SIGNATURE [redacted] DATE 10/4/00

0000 1044

GERALD B. APPLEGATE, M.D.P.C.
Specializing in Obstetrics, Gynecology, and Infertility
10475 Perry Highway
Suite 208
Wexford, Pennsylvania 15090
412-934-1231*1-800-205-2229

My clinial privileges at Magee-Womens Hospital were suspendedfor a period of 90 days due to alledged unavailability to patients and to the staff between June of 1997 and November of 1998.

The date of the action was October 11, 1999. Since then, no further incidents have occurred.

My clinical privileges have been fully restored.

PROVIDE CERTIFIED COPIES OF DOCUMENTS PERTAINING TO THE YES ANSWER #6

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS
STATE BOARD OF MEDICINE

RENEWAL APPLICATION - MD

Gerard B. Ambrogi

[redacted]

Street Address

Wexford PA 15090

City State Zip Code

RETURN TO:

State Board of Medicine
PO Box 8414
Harrisburg, PA 17105-8414

MD-029271E

License Number

☐ I will not be practicing this profession in Pennsylvania after the expiration date indicated below and request inactive status. No fee is required.

☐ I am retired from practice but desire to keep my license active to treat immediate family members. I am exempt from the medical professional liability insurance and CME requirements. Renewal must be completed and fee required.

Name Change	Address Change
Indicate new name below. Submit a photocopy of a legal document verifying name change (i.e., marriage certificate, divorce decree or legal document indicating retaking of a maiden name, etc.)	

THE FOLLOWING QUESTIONS MUST BE ANSWERED

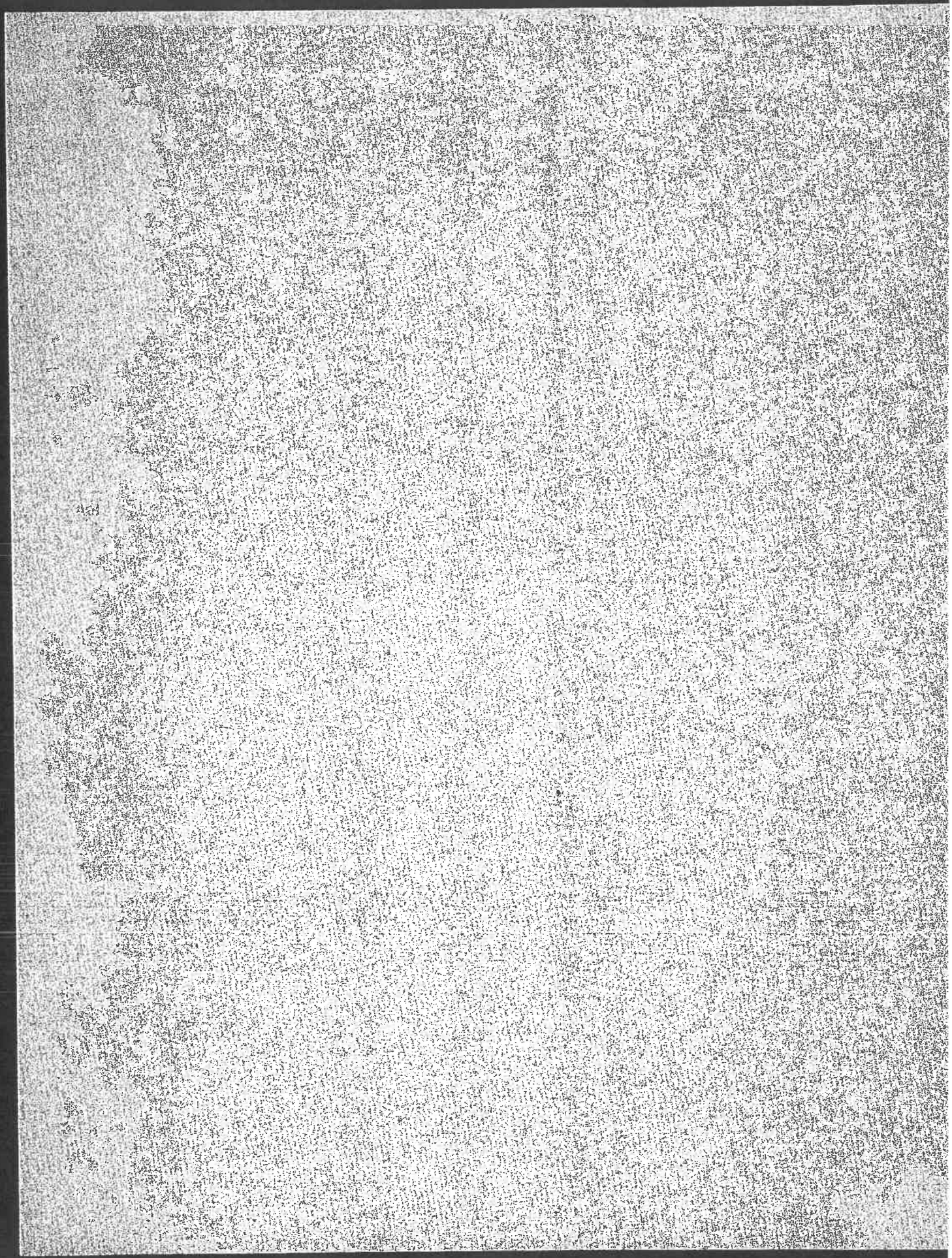
YES	NO	IF YES to question 2, 3, 4, 5, 6, 7 or 8 – provide details AND attach certified copies of legal documents	
✓		1.	Do you hold a license (active, inactive or expired) to practice in any other state or jurisdiction? List: CT, NY, New Jersey, Florida
	✓	2.	Since your initial application or your last renewal, have you had disciplinary action taken against your license in any other state or jurisdiction?
	✓	3.	Since your initial application or your last renewal, have you withdrawn an application for a license, had an application for a license denied or refused, or agreed not to reapply for a license in any state or jurisdiction?
	✓	4.	Since your initial application or your last renewal, have you been convicted, found guilty or pleaded nolo contendere, or received probation without verdict as to any felony or misdemeanor, including any drug law violations, or any criminal charges pending and unresolved in any state or jurisdiction?
	✓	5.	Since May 19, 2002, have you been arrested for criminal homicide, aggravated assault, sexual offenses or drug offenses in any state, territory or country?
✓		6.	Since your initial application or your last renewal, have you had practice privileges denied, revoked or restricted in a hospital or other health care facility?
	✓	7.	Since your initial application or your last renewal, have you had your DEA registration denied, revoked or restricted or have you had your provider privileges terminated by any medical assistance agency for cause?
	✓	8.	Since May 19, 2002, have any malpractice complaints been filed against you?
✓		9.	I am in compliance with the professional liability insurance requirements under Section 711 of the Medical Care Availability and Reduction of Error (MCare) Act No. 13 of 2002.

I verify that this form is in the original format as supplied by the Department of State and has not been altered or otherwise modified in any way. I am aware of the criminal penalties for tampering with public records or information pursuant to 18 PA C.S. 4911 and that any false statement made is subject to the penalties of 18 PA C.S. [redacted] ult in my license being disciplined.

Signature of Licensee (Mandatory): [redacted] Date: 12/16/02

EXPIRATION DATE:	December 31, 2002
FEE – Payable to "COMMONWEALTH OF PENNSYLVANIA". Write your license number on your payment. A $20.00 fee will be assessed for returned payment.	$360.00
LATE FEE - $5.00 per month, or part of a month. Late renewal fee will be assessed if postmarked after December 31, 2002	PRACTICING ON AN EXPIRED LICENSE MAY RESULT IN DISCIPLINARY ACTIONS AND ADDITIONAL MONETARY PENALITIES

Sent to Complaints



GERALD B. APPLEGATE, M.D.P.C.
Fellow of the American College of Obstetrics and Gynecology
Specializing in Obstetrics, Gynecology, and Infertility
P.O. Box 545, Wexford, Pennsylvania, 15090-0545
e-mail: jerryapple@comcast.net

October 20, 2004

Pennsylvania State Board of Medicine
Renewal Application
P.O. Box 2649
Harrisburg, Pa 17105-2649

To whom it may concern:

As of today, October 20, 2004, I have submitted my on line application for renewal of my Medical License for the state of Pennsylvania. Accordingly, I am forwarding to you supplemental information that is required in the re-application process. In February of 2003, I entered into a consent agreement with the State of Pennsylvania resulting from allegations that I had violated the requirement to adequately maintain medical records in my office practice. This action was reported to the New York State Board. Pursuant to that, although no violation at any time occurred in New York, where I do not practice but where I maintain an active medical license, I entered into a consent agreement with the New York State Board due to the Pennsylvania consent order. A copy of this order is attached.

Should you have any further questions, please do not hesitate to contact me. Thank you.

Sincerely,

[redacted]

Gerald B. Applegate, M.D.

Lic # MD-029271E

New York State Board for Professional Medical Conduct
433 River Street, Suite 303 • Troy, New York 12180-2299 • (518) 402-0863

Antonia C. Novello, M.D., M.P.H., Dr. P.H.
Commissioner
NYS Department of Health

Dennis P. Whalen
Executive Deputy Commissioner
NYS Department of Health

Dennis J. Graziano, Director
Office of Professional Medical Conduct

PUBLIC

Michael A. Gonzalez, R.P.A.
Vice Chair

Ansel R. Marks, M.D., J.D.
Executive Secretary

September 27, 2004

CERTIFIED MAIL-RETURN RECEIPT REQUESTED

Gerald Applegate, M.D.
[redacted]
Sewickley, PA 15143

Re: License No. 197471

Dear Dr. Applegate:

Enclosed please find Order #BPMC 04-221 of the New York State Board for Professional Medical Conduct. This order and any penalty provided therein goes into effect October 4, 2004.

If the penalty imposed by the Order is a surrender, revocation or suspension of this license, you are required to deliver to the Board the license and registration within five (5) days of receipt of the Order to the Board for Professional Medical Conduct, New York State Department of Health, Hedley Park Place, Suite 303, 433 River Street, Troy, New York 12180.

Sincerely,

[redacted]

Ansel R. Marks, M.D., J.D.
Executive Secretary
Board for Professional Medical Conduct

Enclosure

NEW YORK STATE DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONALMEDICAL CONDUCT

IN THE MATTER
OF
GERALD APPLEGATE, M.D.
CO-04-04-1781-A

CONSENT AGREEMENT
AND ORDER

BPMC No. 04-221

GERALD APPLEGATE, M.D., states:

That on or about October 13, 1994, I was licensed to practice as a physician in the State of New York, having been issued License No. 197471 by the New York State Education Department.

My current address is [redacted] Sewickley, PA 15143, and I will advise the Director of the Office of Professional Medical Conduct of any change of my address.

I understand that the New York State Board for Professional Medical Conduct has charged me with two (2) specifications of professional misconduct.

A copy of the Statement of Charges, is annexed hereto, made a part hereof, and marked as Exhibit A.

I do not contest Factual Allegations A and B(3) and the two (2) Specifications, in full satisfaction of the charges against me. I agree, hereby, to the following penalty:

Ninety (90) days suspension of my New York state license, stayed.

Respondent shall comply fully with the requirements of the Department of State, State Board of Medicine for the Commonwealth of Pennsylvania, February 18, 2004, Consent Agreement and Order and any extension or modification thereof.

Respondent shall provide a written authorization for the Pennsylvania Board to provide the Director of OPMC with any/all information or documentation as requested by OPMC to enable OPMC to determine whether Respondent is in compliance with the Pennsylvania Order.

Respondent shall submit semi-annually a signed Compliance Declaration to the Director of OPMC, which truthfully attests whether Respondent has been in compliance with the Pennsylvania Order during the declaration period specified.

Should I practice medicine in New York state or in any other jurisdiction where that practice is predicated on my New York state medical license to practice prior to my license being fully restored without conditions by the State of Pennsylvania, I shall provide ninety (90) days notice, in writing, to the Director, OPMC. The Director in his sole discretion, may impose whatever probation, limitation(s), term(s) or further conditions, he in his sole discretion deems reasonable.

Permanently restricted from prescribing controlled substances to himself and family members.

I further agree that the Consent Order for which I hereby apply shall impose the following conditions:

That, except during periods of actual suspension, I shall maintain current registration of my license with the New York State Education Department Division of Professional Licensing Services, and pay all registration fees. This condition shall be in effect beginning thirty days after the effective date of the Consent Order and will continue while Respondent possesses his license; and

That I shall fully cooperate in every respect with the Office of Professional Medical Conduct (OPMC) in its administration and enforcement of this Order and in its investigation of all matters regarding Respondent. I shall respond in a timely manner to each and every request by OPMC to provide written periodic verification of Respondent's compliance with the terms of this Order. I shall meet with a person designated by the Director of OPMC as directed. I shall respond promptly and provide any and all documents and information within my control upon the direction of OPMC. This condition shall be in effect beginning upon the effective date of the Consent Order and will continue while I possess my license.

I, hereby, stipulate that any failure by me to comply with such conditions shall constitute misconduct as defined by New York State Education Law §6530(29).

I agree that in the event I am charged with professional misconduct in the future, this agreement and order shall be admitted into evidence in that proceeding.

I, hereby, make this application to the State Board for Professional Medical Conduct (the Board) and request that it be granted.

I understand that, in the event that this application is not granted by the Board, nothing contained herein shall be binding upon me or construed to be an admission of any act of misconduct alleged or charged against me, such application shall not be used against me in any way and shall be kept in strict confidence during the pendency of the professional misconduct disciplinary proceeding; and such denial by the Board shall be made without prejudice to the continuance of any disciplinary proceeding and the final determination by the Board pursuant to the provisions of the Public Health Law.

I agree that, in the event the Board grants my application, as set forth herein, an order of the Chairperson of the Board shall be issued in accordance with same. I agree that such order shall be effective upon issuance by the Board, which may be accomplished by mailing, by first class mail, a copy of the Consent Order to me at the address set forth in this agreement, or to my attorney, or upon transmission via facsimile to me or my attorney, whichever is earliest.

I am making this application of my own free will and accord and not under duress, compulsion or restraint of any kind or manner. In consideration of the value to me of the acceptance by the Board of this application, allowing me to resolve this matter without the various risks and burdens of a hearing on the merits, I knowingly waive any right I may have to contest the Consent Order for which I hereby apply, whether administratively or judicially, and ask that the application be granted.

AFFIRMED

[redacted]

GERALD APPLEGATE, M.D.
Respondent

DATED Sept 15, 2004

The undersigned agree to the attached application of the Respondent and to the proposed penalty based on the terms and conditions thereof.

DATE: 16 September 2004

ROBERT BOGAN
Associate Counsel
Bureau of Professional Medical Conduct

DATE: 21 September 2004

DENNIS J. GIACCIANO
Director
Office of Professional Medical Conduct

NEW YORK STATE DEPARTMENT OF HEALTH

STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER

OF

GERALD APPLEGATE, M.D

CONSENT ORDER

Upon the proposed agreement GERALD APPLEGATE, M.D. (Respondent) for Consent Order, which application is made a part hereof, it is agreed to and

ORDERED, that the application and the provisions thereof are hereby adopted; and it is further

ORDERED, that this order shall be effective upon issuance by the Board, which may be accomplished by mailing, by first class mail, a copy of the Consent Order to Respondent at the address set forth in this agreement or to Respondent's attorney by certified mail, or upon transmission via facsimile to Respondent or Respondent's attorney, whichever is earliest.

SO ORDERED.

DATED: 9/26/07

[redacted]

MICHAEL A. GONZALEZ, R.P.A.
Vice Chair
State Board for Professional
Medical Conduct

STATE OF NEW YORK DEPARTMENT OF HEALTH

STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER OF GERALD B. APPLEGATE, M.D. CO-04-09-1781-A	STATEMENT OF CHARGES

GERALD B. APPLEGATE, M.D., the Respondent, was authorized to practice medicine in New York state on October 13, 1994, by the issuance of license number 107471 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. On or about February 18, 2004, the Commonwealth of Pennsylvania, Department of State, State Board of Medicine, (hereinafter "Pennsylvania Board"), by a Consent Agreement and Order (hereinafter "Pennsylvania Order"), SUSPENDED Respondent's license to practice medicine for ninety (90) days, STAYED the SUSPENSION in favor of PROBATION for ninety (90) days with conditions, and imposed a $5,000.00 CIVIL PENALTY, based on writing prescriptions for controlled substances for his wife on 86 occasions that were filled at eight (8) different pharmacies wherein he failed to maintain medical records for the circumstances under which the prescriptions were written.

B. The conduct resulting in the Pennsylvania Board disciplinary action against Respondent would constitute misconduct under the laws of New York state, pursuant to the following sections of New York state law:

1. New York Education Law §6530(2) (practicing the profession fraudulently);

2. New York Education Law §6530(3) (practicing the profession with negligence on more than one occasion); and/or

3. New York Education Law §6530(32) (failure to maintain a record of each patient which accurately reflects the evaluation and treatment).

SPECIFICATIONS

FIRST SPECIFICATION

Respondent violated New York Education Law §6530(9)(b) by having been found guilty of improper professional practice or professional misconduct by a duly authorized professional disciplinary agency of another state where the conduct upon which the finding was based would, if committed in New York state, constitute professional misconduct under the laws of New York state, in that Petitioner charges:

1. The facts in Paragraphs A and/or B.

SECOND SPECIFICATION

Respondent violated New York Education Law §6530(9)(d) by having disciplinary action taken by a duly authorized professional disciplinary agency of another state, where the conduct resulting in the disciplinary action would, if committed in New York state, constituted professional misconduct under the laws of New York state, in that Petitioner charges:

2. The facts in Paragraphs A and/or B.

DATED: 8/23, 2004
Albany, New York

BRIAN M. MURPHY
Chief Counsel
Bureau of Professional Medical Conduct

MD 029271 E APPLE 0000 0 0 2 0 1 9 2

THE FOLLOWING QUESTIONS MUST BE ANSWERED.

1. DO YOU HOLD A LICENSE TO PRACTICE MEDICINE AND SURGERY IN ANY OTHER STATE, TERRITORY OR COUNTRY? YES [ ] NO [X]

2. ARE YOU, OR HAVE YOU EVER BEEN, ADDICTED TO THE INTEMPERATE USE OF ALCOHOL OR TO THE HABITUAL USE OF NARCOTICS OR OTHER HABIT-FORMING DRUGS? (YOU MAY ANSWER "NO" IF YOU ARE CURRENTLY A PARTICIPANT IN THE IMPAIRED PROFESSIONAL PROGRAM) YES [redacted] NO

3. HAVE YOU EVER BEEN CONVICTED OF A CRIME (EXCLUSIVE OF PARKING AND TRAFFIC VIOLATIONS) OR RECEIVED PROBATION WITHOUT VERDICT, DISPOSITION IN LIEU OF TRIAL, OR AN ACCELERATED REHABILITATIVE DISPOSITION IN THE UNITED STATES OR ANY OTHER COUNTRY? YES [ ] NO [X]

4. HAVE YOU EVER HAD AN APPLICATION FOR A LICENSE DENIED IN ANOTHER STATE, TERRITORY OR JURISDICTION OF THE UNITED STATES OR IN ANY OTHER COUNTRY? YES [ ] NO [X]

5. HAVE YOU EVER POSSESSED A LICENSE TO PRACTICE MEDICINE AND SURGERY, OR OTHER PROFESSIONAL LICENSE , OR OTHER AUTHORIZATION TO PRACTICE A PROFESSION, THAT WAS SUSPENDED OR REVOKED OR SUBJECTED TO OTHER DISCIPLINARY CONDITIONS? YES [ ] NO [X]

6. HAVE YOU EVER HAD PROVIDER PRIVILEGES DENIED OR RESTRICTED BY THE DRUG ENFORCEMENT ADMINISTRATION, A MEDICAL ASSISTANCE AGENCY, OR OTHER AUTHORITY? YES [ ] NO [X]

7. HAVE YOU EVER HAD PRACTICE PRIVILEGES DENIED, REVOKED OR RESTRICTED IN A HOSPITAL OR OTHER HEALTH CARE FACILITY? YES [ ] NO [X]

****
**NAME INACTIVE [ ] **
** **
**STREET **
**CITY STATE ZIP **
****
SIGNATU[redacted] DATE

MD-029271-E/APPLE/025.00

GERALD BRIAN APPLEGATE
106 GERNAINE ROAD
BUTLER PA 16001

[redacted]

TARGET SHEET

Board: Medicine

Date Created:
05/17/2006

Licensee Full Name:
GERARD BRIAN APPLEGATE

License No:
MD0292711

MISC 565011

Department of State
Bureau of Professional and Occupational Affairs
STATE BOARD OF MEDICINE

Mailing Address
P O Box 2649
Harrisburg, PA 17105-2649

Courier Mail
2601 North Third Street
Harrisburg, PA 17110

Telephone 717-783-1400
Fax 717-787-7769
E-mail st-medicine@state.pa.us
Website www.dos.state.pa.us/med

REQUEST FOR CHANGE OF NAME AND/OR ADDRESS

Complete the following information and check the appropriate block below:

Current Information

Last Name: APPLEMAN

First Name: STEVEN **Middle Initial:** D

License Number: MD 029271 E

Social Security Number: [redacted]

( ) **Change of Name**

You must submit a copy of a legal document verifying your new name. The following are acceptable name change verification documents:

(1) marriage certificate
(2) divorce decree which indicates the retaking of your maiden name
(3) other legal document indicating the retaking of a maiden name
(4) for a legal name change, a copy of the court document must be provided

New Name:

Last _____ First _____ Middle _____

(✓) **Change of Address**

Old Address: [redacted]

Street Address

City: Deerfield State: FL Zip Code: 33442

New Address: [redacted]

Street Address

City: Miami Beach State: FL Zip Code: 33140

FEE: To obtain a duplicate license reflecting the change of name and/or address, you must return this application and a $5.00 fee, check or money order, payable to 'Commonwealth of PA'. Without the $5.00 fee, the change(s) will be made but no duplicate will be issued.

A processing fee of $20.00 will be charged for any check or money order returned unpaid by your bank regardless of the reason for non-payment.

SECA-201 (12/82)

3 4 7 0 4 3 0 1 3 3

TARGET SHEET

LICENSE NUMBER: MD-029271-E

NAME: APPLE

CARTRIDGE NUMBER:

CODE: APPL

8 4 0 0 4 3   0 1 3 3

Commonwealth of Pennsylvania
DEPARTMENT OF STATE
Bureau of Professional and Occupational Affairs
STATE BOARD OF MEDICAL EDUCATION AND LICENSURE
P.O. Box 2649
Harrisburg, Pennsylvania 17120

For Department Use Only
#
Date

APPLEGATE, GERALD BRIAN
Please Print — LAST NAME — FIRST NAME — MIDDLE NAME

[redacted] PITTSBURGH, PA 15232
Address Street City State Zip Code

1. APPLICATION TO PRACTICE MEDICINE

I hereby apply for licensure to practice medicine in the Commonwealth of Pennsylvania, for which an affidavit concerning age, citizenship, evidence of medical education, evidence of graduate training, a certificate of moral and ethical character, two recent photographs, and the proper fees are herewith included as required by law.

FEES	FLEX Examination	$150.00
	Endorsement	$100.00
	Limited License Professorial	$125.00

All fees must be paid by CERTIFIED CHECK OR MONEY ORDER, made payable to the Commonwealth of Pennsylvania-M.E. Application fees are not refundable

Address to which license is to be sent [redacted] PGH, PA 15232

Address for admission to FLEX

Date of Birth [redacted] Place of Birth NEWARK, NJ. U.S. Citizen YES

How secured — Visa Status: Exchange Visitor

Immigrant Immigration Petition

Do you intend to become a United States Citizen? [redacted]

Social Security Number [redacted]

Signature of Applicant in Full [redacted] Date 4/30/83

2. MEDICAL EDUCATION

Institutions	Number of Months	Date of Graduation	Degree	Dates Attended
UMDNJ - NEW JERSEY MED SCHOOL	48	5/82	M.D.	9/78 - 5/82

8888-T

Training completed beyond medical school 1 YR POST GRADUATE TRAINING MAGEE WOMEN'S HOSP PGH, PA

82/83 OBGYN

3. PREVIOUS EXAMINATIONS AND LICENSES

Have you previously taken an examination for medical license in Pennsylvania? NATIONAL BOARDS

If so, when? PASSED PARTS I, II, III

Have you previously taken an examination for medical license in another state of the United States? NO

If so, when? _____

Results _____ License(s) obtained _____

List all state(s) where you hold medical licensure NONE

Has your license in another state been suspended or revoked at any time? —

If so, give particulars —

Have you ever been convicted of a felony in the courts of this Commonwealth or any other state, territory, or country?

NO

Where and in what capacity are you now employed? MAGEE-WOMEN'S HOSP PGH, Pa

RESIDENT OB/GYN

4. FOR CANDIDATES WHO WISH TO BE ADMITTED TO THE EXAMINATION BEFORE COMPLETION OF ONE YEAR OF GRADUATE TRAINING

I hereby certify that _____, M.D. has completed six

months of graduate training in _____

from _____ to _____

at _____

(Name of Hospital) (Street Address) (City) (State)

Affidavit of Superintendent required if hospital has no seal.

_____

(Signature of Superintendent of Hospital)

NOTE: When you submit this application, detach the mimeograph blank, GRADUATE TRAINING CERTIFICATE. After completion of your one year of graduate training, have it certified by the Hospital Superintendent and forward directly to the State Board Office in Harrisburg.

8400433 0133

5. ENDORSEMENT

Applicants for licensure by endorsement must submit this section to the Licensing Board in the state where licensure was obtained by written examination. Verbatim copy of State License Certificate over Seal of State Licensing Board follows: (National Board diplomates must obtain an "Endorsement Certification" from the National Board of Medical Examiners and attach it to this section.)

(Seal of Licensing Board)

AFFIDAVIT OF SECRETARY

_____ of _____ being duly sworn,

says he is secretary of _____

and that the original of the preceding copy of state license or certificate No. _____

was issued to Dr. _____ of _____

on _____, after a written examination by this Board in the following

branches and upon obtaining a general rating of _____ percent on each subject as follows: _____

_____

_____

_____

I also certify that the enclosed photograph is a likeness of _____

and that the license or certificate above referred to has never been suspended or revoked.

_____
Secretary or President

Sworn to before me this _____ day of _____, 19____.

(Seal) _____ Notary Public

An applicant for a license by endorsement is required to have an interview with a member of the Pennsylvania State Board of Medical Education and Licensure or representative of the Board.

_____ _____
Signature of Board Member or Representative Date of Interview

6. AFFIDAVIT OF THE PRESIDENT OR SECRETARY OF A COUNTY MEDICAL SOCIETY.

State of:
County of: SS.

_____, M.D., being duly sworn that he is _____

of the Medical Society _____; that he knows the applicant to be a person of good moral character and in good standing and that the applicant is not addicted to the intemperate use of alcohol or narcotic drugs.

Sworn before me this _____ day of _____, 19__

_____ _____
Notary Public Signature of President or Secretary

My Commission expires _____

7. CERTIFICATE OF MORAL CHARACTER

To be signed by two physicians with unrestricted licensure in good standing in United States. This certifies that we have been personally acquainted with GERALD B. APPLEGATE of _____ for 1 and 1 years, respectively, that GERALD is not addicted to the intemperate use of alcohol or narcotic drugs, that we know GERALD to be of good moral character and hereby recommend GERALD to be worthy of licensure to practice medicine in the Commonwealth of Pennsylvania, pursuant to law.

(1) [redacted] June 9, 1983
Signature Date

HARRISON C. BILL, M.D. PA. MD-0114433-E
Name (printed or typed) as above State Licensed License #

(2) [redacted] 6/9/83
Signature Date

Steve N. Caritis PA. MD-011976-E
Name (printed or typed) as above State Licensed License #

8. AFFIDAVIT

State of: PENNSYLVANIA
County of: SS. ALLEGHENY

Personally appeared before me JUNE A. BRUSCHI (notary) in and for said County and State GERALD B. APPLEGATE (applicant) who being duly sworn says, that GERALD APPLEGATE is the person referred to in the above application for license to practice medicine in the Commonwealth of Pennsylvania; that the statements on page one are in GERALD'S own writing, and are strictly true in every respect; that GERALD has complied with all requirements of law, and of the laws of any state referred to therein.

June A. Bruschi [redacted]
Justice of the Peace or Notary Public Signature of Applicant

My Commission Expires _____ Date 6/9/83

SPCA-201 (12/82)

9 4 0 0 4 3 0 1 3 4

TARGET SHEET

LICENSE NUMBER: ND-029271-E

NAME: APPLE

CARTRIDGE NUMBER:

CODE: EDUC

3400433 0134

CERTIFICATE OF MEDICAL EDUCATION

Commonwealth of Pennsylvania
Department of State
Bureau of Professional and
Occupational Affairs

State Board of Medical Education
and Licensure
P.O. Box 2649
Harrisburg, Pennsylvania 17105-2649

To Be Completed By Applicant:
(Submit completed Certificate with Application)

Date 4/8/82

Name of Applicant GERALD B. APPLICATE

Signature of Applicant [redacted]

Address of Applicant 82 BLANCHARD RD. SO. ORANGE, NJ.

Name of Medical School UMDNJ- NEW JERSEY MEDICAL SCHOOL

Address of Medical School NEWARK NJ. USA.
City State Country

Beginning Date 9 / 1 / 78 Graduation Date 5 / 26 / 82
Month / Day / Year Month / Day / Year

To Be Completed By Dean or Registrar:
(Return completed Certificate to Applicant, do not submit to Board)

I hereby certify that Gerald Brian Applegate (applicant)

(1) has graduated from the named institution on the date above;
(2) has attended four graded courses of not less than thirty-two weeks of not less than thirty-five hours, each in the study of medicine;
(3) signature, as appearing above, is genuine;
(4) photograph below is a true likeness of the applicant.

Mary T. Mooney
Signature of Dean or Registrar Assistant Registrar, NJMS

April 13, 1982
Date

(Place seal over signature)

SEAL [redacted] SEAL

Note:
1. Seal must appear on a part of the photograph.
2. Two photographs are required if applying for licensure by examination.
3. One photograph is required if applying for licensure by endorsement.

(Interim Form on Reverse)

SPOA-1407r

INTERIM FORM

If Applicant desires to begin training in Pennsylvania immediately following graduation from said medical school, the training application and this Certificate of Medical Education must be submitted sixty (60) days before beginning date of training. If graduation is pending when Certificate is to be submitted, the Dean or Registrar must complete the following in addition to entire Certificate on reverse side:

Anticipated Date of Graduation May (Month) 26 (Day) 1982 (Year)

I hereby certify that Gerald Brian Applegate (applicant) has completed his/her medical education except for 1 weeks (no more than twelve). I do not foresee any problems which would provent graduation. If graduation does not occur on the anticipated date, I will contact the State Board of Medical Education and Licensure immediately.

Mary F. Mancy
Signature of Dean or Registrar
(Place seal over signature)

Date April 13, 1982

SIPOA-201 (12/82)

1 1 0 0 4 3 0 1 3 5

TARGET SHEET

LICENSE NUMBER ND-029271-E

NAME APPLE

CARTRIDGE NUMBER

CODE EVAN

0 4 0 0 4 3 0 1 3 5

NATIONAL BOARD OF MEDICAL EXAMINERS®, 3930 CHESTNUT STREET, PHILADELPHIA, PENNA. 19104

ENDORSEMENT OF CERTIFICATION

NATIONAL BOARD OF MEDICAL EXAMINERS
OF THE
UNITED STATES OF AMERICA

Gerald Brian Appleman, M.D.

having satisfied all the requirements and having successfully passed the examinations is hereby declared a Diplomate of the National Board of Medical Examiners.

Attest C. WILLIAM DAESCHNER, JR.
Chairman of the Board

SEAL

EDITHE J. LEVIT
President of the Board

Philadelphia, Pa.
07/01/83

Certificate # 261504

It is certified that the above is a facsimile of the Diplomate Certificate which has been or will be* awarded to the physician named above, who graduated from CPDMJ MCA HERSEY MED SCH in MAY, 1982 and whose birth date is [redacted]. This physician has successfully completed all examinations required for certification by the National Board of Medical Examiners. The scores obtained by this physician upon which his/her certification is based are as follows:

	Standard Score	Scale Score
PART I passed 06/80		
Anatomy, incl. histology and embryology	605	87
Physiology	600	87
Biochemistry	510	81
Pathology	615	88
Microbiology, incl. immunology	555	84
Pharmacology and Materia Medica	670	91
Behavioral Sciences	550	71
TOTAL TEST (Minimum Passing Score 380/75)	580	85
Part II passed 09/81		
Internal medicine and the medical specialties	635	89
Surgery and the surgical specialties	645	89
Obstetrics and Gynecology	530	84
Public Health and Preventive Medicine	495	82
Pediatrics	605	87
Psychiatry	600	87
TOTAL TEST (Minimum Passing Score 290/75)	610	86
PART III passed 03/83		
A General Test of Clinical Competence		
TOTAL TEST (Minimum Passing Score 290/75)	510	82.5
GENERAL AVERAGE (Parts, I, II, and III Scale Score)		84.5

*For those individuals who have not yet satisfactorily completed one full year of post-M.D. training the date shown on the facsimile is the date which has been certified by the physician's residency program director as the date on which this requirement for certification by the National Board will be fulfilled and such certification will be awarded.

Ann K. Heverling
Secretary for Certification

SEAL

06/02/83
Date

SFCA-201 (12/82)

8 4 0 0 4 3 0 1 3 6

TARGET SHEET

LICENSE NUMBER MD-029271-E

NAME APPLE

CARTRIDGE NUMBER

CODE TRNS

3 4 0 0 1 3 0 1 3 6

Commonwealth of Pennsylvania
Department of State
Commissioner of Professional
and Occupational Affairs

GRADUATE TRAINING CERTIFICATE

State Board of Medical Education
and Licensure
Box 2649, Harrisburg, Pa. 17120

Date 1/30/83

This is to certify that Gerald B. Applegate, M. D., a graduate of the
UMDNJ - New Jersey Medical School has rendered satisfactory service as a trainee at
University Health Center of Pittsburgh Hospital at Pittsburgh, PA
in an approved clinical program from 6/23/82 to 6/23/83.

We also certify that Gerald B. Applegate is a person of good moral character,
and that he has proven to be worthy of the medical profession.

The Trainee participated in the following type of program:

FLEXIBLE _____ CATEGORICAL* _____ CATEGORICAL X OTHER _____

DEPARTMENT	SPECIALTY	MONTHS	SIGNATURE OF CHIEF
Allergy-Immunology			
Anesthesiology			
Dermatology			
Family Practice		4-8-83 - 6-23-83	[redacted]
Internal Medicine	8 88-5	3 months	
Neurology	8, 84		
Nuclear Medicine			[redacted]
Obstetrics-Gynecology		6 months	T. Terry Hayashi, M.D.
Ophthalmology	82		
Otolaryngology	obg Univ		
Pathology			[redacted]
Pediatrics (Neonates)		1½ months	
Physical Medicine			
Preventive Medicine			
Psychiatry			
Public Health			
Radiology			[redacted]
Surgery		6-23-82 - 7-31-82	Henry T. Bahnson, M.D.
Urology			
Other			

Remarks _____

(Notarized affidavit required if hospital has no seal)

SPOA-1417 (1-76)

[redacted]
(SIGNATURE OF SUPERINTENDENT) (COVERED BY SEAL)

TARGET SHEET

LICENSE NUMBER: MD-029271-E

NAME: APPLE

CARTRIDGE NUMBER:

CODE: MISC

3 4 0 0 4 3 0 1 3 7

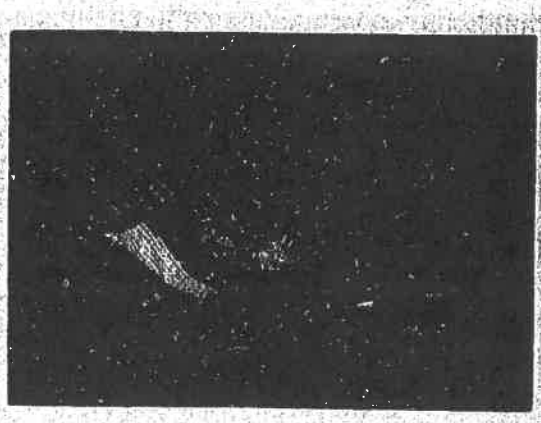
IDENTIFICATION CERTIFICATE

Commonwealth of Pennsylvania
Department of State
Bureau of Professional and
Occupational Affairs

State Board of Medical Education
and Licensure
P.O. Box 2649
Harrisburg, PA 17105-2649

Name of Applicant GERALD B. APPLEGATE
(Please Print)

This photograph is a true likeness of the applicant.



1. List all states, territories, and countries in which you have ever possessed a license to practice medicine and surgery (active or inactive) NONE

2. Are you, or have you ever been, addicted to the intemperate use of alcohol or habitual use of narcotics or other habit-forming drugs? [redacted]

3. Have you ever been convicted of a crime (exclusive of parking and traffic violations) in the courts of this Commonwealth or any other state, territory, or country? NO

4. Have you ever possessed a license to practice medicine and surgery or other professional license that was suspended, revoked or subjected to other disciplinary conditions? NO

5. Have your provider privileges ever been restricted by Drug Enforcement Administration, Medicare or any others? NO

If you have answered yes to 2, 3, 4, or 5 please provide details on an attached sheet.

6. Please explain your relationship with the two physicians who completed Section 7, Certificate of Moral Character, of your licensure application. Use an additional sheet.

Affidavit

State of PENNSYLVANIA ss:

County of ALLEGHENY

GERALD B Applegate (applicant) being duly sworn according to law, deposes and says that he/she is the person completing this form and that the statements therein are true and complete to the best of his/her knowledge and belief.

Subscribed and sworn to before me this
9th day of JUNE, 1983.

Notary

[redacted]

Signature of Applicant

3 4 9 0 4 3 0 1 3 7

University of Pittsburgh
SCHOOL OF MEDICINE
Department of Obstetrics and Gynecology
Office of the Chairman

SIRS,

THE TWO PHYSICIANS MENTIONED IN SEC 7 HAVE BOTH KNOWN ME FOR OVER YR. AND ARE FULL TIME MEMBERS OF THE U. OF PITT FACULTY AND ARE MY INSTRUCTORS IN OB/GYN.

[redacted]

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BUREAU OF PROFESSIONAL AND
OCCUPATIONAL AFFAIRS

Official Use Only 007052

M D - 0 2 9 2 7 1 - E

A P P L E R N E W

THIS IS YOUR RENEWAL NOTICE - REQUIRED FEE - $125.00

STATE BOARD OF MEDICINE
P.O. BOX 8414
HARRISBURG, PA. 17105-8414

GERALD BRIAN APPLEGATE
TOWN CENTRE SUITE 208
10475 TERRY HIGHWAY
WEXFORD, PA 15090

YOUR CURRENT LICENSE TO PRACTICE MEDICINE AND SURGERY IN PENNSYLVANIA WILL EXPIRE ON DECEMBER 31, 1998. TO RENEW YOUR LICENSE THROUGH DECEMBER 31, 2000, COMPLETE THE QUESTIONS BELOW AND RETURN WITH A CHECK OF MONEY ORDER IN THE AMOUNT OF $125.00 MADE PAYABLE TO THE "COMMONWEALTH OF PA." WRITE YOUR LICENSE NUMBER ON THE FRONT OF THE PAYMENT. A LATE FEE OF $5.00 PER MONTH WILL BE CHARGED FOR RENEWALS POSTMARKED AFTER DECEMBER 31, 1998. A PROCESSING FEE OF $20.00 WILL BE CHARGED FOR ANY CHECK OR MONEY ORDER UNPAID BY YOUR BANK, REGARDLESS OF THE REASON. IF YOU HAVE A CHANGE IN NAME AND/OR ADDRESS, INDICATE THE CHANGE NEXT TO THE PRE-PRINTED NAME AND ADDRESS ABOVE. A NAME CHANGE REQUIRES SUBMISSION OF A COPY OF A COURT ORDER, MARRIAGE CERTIFICATE, DIVORCE DECREE OR OTHER OFFICIAL DOCUMENT.

NOTICE: IF YOU PRACTICE IN PENNSYLVANIA, YOU MUST MAINTAIN THE REQUIRED AMOUNT OF PROFESSIONAL LIABILITY INSURANCE AND PAY THE REQUIRED FEE AND CAT FUND SURCHARGE. FAILURE TO DO SO WILL RESULT IN SUSPENSION OR REVOCATION OF YOUR LICENSE.

ANY DISCIPLINARY ACTION TAKEN IN ANOTHER STATE, TERRITORY OR COUNTRY SHALL BE REPORTED TO THE BOARD ON THE BIENNIAL RENEWAL NOTICE OR WITHIN 30 DAYS OF FINAL DISPOSITION, WHICHEVER IS SOONER.

THE FOLLOWING QUESTIONS MUST BE ANSWERED. IF YOU ANSWER "YES" TO QUESTIONS 2, 3, 4, OR 5 BELOW, YOU MUST PROVIDE COMPLETE DETAILS ON 8 1/2 X 11 SHEETS OF PAPER AND INCLUDE COPIES OF LEGAL DOCUMENTS, IF ANY. FAILURE TO PROVIDE DOCUMENTS WILL DELAY THE PROCESS.

YES	NO		
(√)	( )	1.	DO YOU HOLD A LICENSE TO PRACTICE MEDICINE AND SURGERY IN ANY OTHER JURISDICTION? IF YES, LIST EACH ONE BELOW. OHIO, New York
( )	(√)	2.	SINCE YOUR LAST RENEWAL, HAS ANOTHER STATE, TERRITORY OR COUNTRY TAKEN ANY DISCIPLINARY ACTION (INCLUDES VOLUNTARY SURRENDER OF A LICENSE) AGAINST YOU OR FILED CHARGES AGAINST YOU THAT HAVE NOT BEEN RESOLVED IN YOUR FAVOR?
( )	(√)	3.	SINCE YOUR LAST RENEWAL, HAVE YOU BEEN CONVICTED, FOUND GUILTY, PLEADED NOLO CONTENDERE, RECEIVED PROBATION WITHOUT VERDICT, OR RECEIVED ANY OTHER DISPOSITION (EXCLUDING ACQUITTAL OR DISMISSAL), WITH RESPECT TO ANY CRIMINAL OFFENSE, INCLUDING ANY DRUG LAW VIOLATIONS, OR DO YOU HAVE ANY CRIMINAL CHARGES PENDING AND UNRESOLVED IN ANY STATE OR FEDERAL COURT? (A SUMMARY TRAFFIC VIOLATION SHOULD NOT BE CONSIDERED AS A CRIMINAL OFFENSE.)
( )	(√)	4.	SINCE YOUR LAST RENEWAL, FOR DISCIPLINARY REASONS HAVE YOU WITHDRAWN AN APPLICATION FOR A LICENSE, HAD AN APPLICATION FOR A LICENSE DENIED OR REFUSED, OR AGREED NOT TO REAPPLY FOR A LICENSE IN ANOTHER STATE, TERRITORY OR COUNTRY? A LICENSE INCLUDES A REGISTRATION OR CERTIFICATION.
( )	(√)	5.	SINCE YOUR LAST RENEWAL, HAVE YOU HAD PRACTICE PRIVILEGES DENIED, REVOKED, SUSPENDED, RESTRICTED, SURRENDERED IN LIEU OF DISCIPLINE OR EMPLOYMENT TERMINATED IN A HOSPITAL OR ANY HEALTH CARE FACILITY?
( )	(√)	6.	SINCE YOUR LAST RENEWAL, HAVE YOU HAD YOUR DEA REGISTRATION DENIED, REVOKED OR RESTRICTED OR HAVE YOU HAD YOUR PROVIDER PRIVILEGES TERMINATED BY ANY MEDICAL ASSISTANCE AGENCY FOR CAUSE?

IF YOU WANT YOUR LICENSE PLACED ON "INACTIVE" STATUS PLACE AN "X" IN THE BLANK TO THE RIGHT. _____
NO FEE IS REQUIRED. YOU ARE STILL REQUIRED TO ANSWER THE QUESTION, SIGN AND DATE BELOW.

MY REPRESENTATIONS AND RESPONSES IN THIS DOCUMENT ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT THEY ARE SUBJECT TO THE PENALTIES OF 18 PA. C.S. 4904 RELATING TO UNSWORN FALSIFICATION TO AUTHORITIES.

SIGNATURE [redacted] DATE 9/21/98

0000 1107

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BUREAU OF PROFESSIONAL AND
OCCUPATIONAL AFFAIRS

Official Use Only 007175

MD-029271-E

APPLE RNEW

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STATE BOARD OF MEDICINE
P.O. BOX 8414
HARRISBURG, PA. 17105-8414

GERALD BRIAN APPLEGATE
TOWN CENTRE SUITE 208
10475 TERRY HIGHWAY
WEXFORD, PA 15090

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NOTICE: IF YOU PRACTICE IN PENNSYLVANIA, YOU MUST MAINTAIN THE REQUIRED AMOUNT OF PROFESSIONAL LIABILITY INSURANCE AND PAY THE REQUIRED FEE AND CAT FUND SURCHARGE. FAILURE TO DO SO WILL RESULT IN SUSPENSION OR REVOCATION OF YOUR LICENSE.

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THE FOLLOWING QUESTIONS MUST BE ANSWERED. IF YOU ANSWER "YES" TO QUESTIONS 2, 3, 4, OR 5 BELOW, PLEASE PROVIDE COMPLETE DETAILS ON 8 1/2 X 11 SHEETS OF PAPER AND INCLUDE COPIES OF LEGAL DOCUMENTS, IF ANY.

YES	NO	
X	( )	1. DO YOU HOLD A LICENSE TO PRACTICE MEDICINE AND SURGERY IN ANY OTHER JURISDICTION? IF YES, LIST EACH ONE ON THE BACK.
( )	X	2. SINCE YOUR LAST RENEWAL, HAS ANY DISCIPLINARY ACTION BEEN TAKEN AGAINST YOUR LICENSE IN ANOTHER STATE, TERRITORY OR COUNTRY?
( )	X	3. SINCE YOUR LAST RENEWAL, HAVE YOU BEEN CONVICTED, FOUND GUILTY OR NOLO CONTENDERE, OR RECEIVED PROBATION WITHOUT VERDICT AS TO ANY FELONY OR MISDEMEANOR, INCLUDING ANY DRUG LAW VIOLATION, IN ANY STATE OR FEDERAL COURT?
( )	X	4. SINCE YOUR LAST RENEWAL, HAVE YOU HAD PRACTICE PRIVILEGES DENIED, REVOKED OR RESTRICTED IN A HOSPITAL OR OTHER HEALTH CARE FACILITY?
( )	X	5. SINCE YOUR LAST RENEWAL, HAVE YOU HAD YOUR DEA REGISTRATION DENIED, REVOKED OR RESTRICTED OR HAVE YOU HAD YOUR PROVIDER PRIVILEGES TERMINATED BY ANY MEDICAL ASSISTANCE AGENCY FOR CAUSE?

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SIGN AND DATE BELOW AND PROVIDE THE REQUESTED INFORMATION

SOCIAL SECURITY NUMBER: [redacted] DATE OF BIRTH: [redacted]

NAME OF MEDICAL SCHOOL NEW JERSEY MEDICAL SCHOOL YEAR OF GRADUATION 1982

I CERTIFY THAT THE INFORMATION CONTAINED IN THIS APPLICATION IS TRUE AND CORRECT UNDER 18 PA. C.S. SECTION 4904 RELATING TO UNSWORN FA[redacted]

SIGNATURE _____ DATE 9/30/96

00000569

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BUREAU OF PROFESSIONAL AND
OCCUPATIONAL AFFAIRS

Official Use Only 007175

MD-029271-E

APPLE RNEW

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NAME OF MEDICAL SCHOOL NEW JERSEY MEDICAL SCHOOL YEAR OF GRADUATION 1982

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SIGNATURE [redacted] DATE 9/30/96

00000569