FLORIDA
DEPARTMENT OF HEALTH
BOARD OF MEDICINE
4052 Bald Cypress Way, Bin #C03
Tallahassee, Florida 32399-3253
(850) 245-4131

RECEIVED
JAN 13 2004
DEPARTMENT OF HEALTH
BOARD OF MEDICINE

Received Date : 01/09/2004
Deposit Date : 01/12/2004
Deposit # : 167500
Batch Number : 012893
Validation # : 903106750
Check Amount : $1,152.00
PRO_CDE : 1501

1501 MEDICAL DOCTOR APPLICATION FOR LICENSURE

READ INSTRUCTIONS FOR IMPORTANT INFORMATION

1. APPLICATION CATEGORY/APPLICABLE FEES: CLIENT 1501
(TYPE OR PRINT LEGIBLY IN BLACK INK– CHECK APPROPRIATE LICENSURE AVENUE)

[X] ENDORSEMENT (1021) [ ] C-SPEX (1022) [ ] STATE BOARD EXAM (1022) [ ] EXAMINATION (1024)

2. U.S. SOCIAL SECURITY NUMBER: [redacted]

3a. NAME: JONAS (Last) CECIL (First) RODWELL (Middle)

3b. Have you ever changed your name through marriage or through action of a court? [ ] YES [X] NO

If 'yes', list name(s) (Last, First, Middle) and Date(s) of changes

3c. Have you ever been known by any other name (aliases)? [ ] YES [X] NO

If 'yes', list name(s) (Last, First, Middle, and Suffix)

4. MAILING ADDRESS (where you receive mail):

4272 SW 186th AVE MIRAMAR FL. 33029
(Street and number or PO Box) (City) (State/Province) (Zip/Postal Code) (Country)

5. PRIMARY PRACTICE/PHYSICAL ADDRESS (where you can be located):

4272 SW 186th AVE MIRAMAR FL. 33029
(Street and number) (City) (State/Province) (Zip/Postal Code) (Country)

6. TELEPHONE: (954) 438-9943 ( )
Home: Area Code/Phone Number Work: Area Code/Phone Number

7. E-MAIL ADDRESS: cjonas@bellsouth.net

8. PERSONAL DATA:
HEIGHT: 6' WEIGHT: 198
EYE COLOR: BL HAIR COLOR: GRAYING

We are required to ask that you furnish the following information as part of your voluntary compliance with Section 2, Uniform Guidelines on Employee Selection Procedure (1978) 43 FR38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

RACE: Caucasian [ ] Black [X] Hispanic [ ] Asian [ ] Native American [ ] Other [ ]
SEX: Male [X] Female [ ]

As a Florida licensed physician, are you willing to provide health care services in special need shelters or to help staff disaster medical assistance teams during times of emergency or major disaster?
[X] Yes [ ] No

51. Have you ever had an application for membership denied by a Medical Society or Association or had a Medical Society or Association Membership suspended? [ ] YES [X] NO
(If 'yes', see application instructions for required documentation to submit)

52. Have you ever been notified to appear before a Medical Society or Association regarding charges/complaints filed against you? [ ] YES [X] NO
(If 'yes', see application instructions for required documentation to submit)

53. Affidavit for completion of the HIV/AIDS, Domestic Violence Course and Prevention of Medical Errors or request for extensions.

HIV/AIDS Affidavit OR Request for Extension:

[X] I hereby certify that subsequent to January 1, 1988, I have completed a minimum of three hours HIV/AIDS, AMA Category I, American Medical Association, Continuing Medical Education which meets Florida requirements.

[ ] I hereby certify that subsequent to January 1, 1988, I have **not** completed a minimum of three hours, HIV/AIDS AMA Category I, American Medical Association, Continuing Medical Education. As I have not completed the required course for initial licensure, **I understand that the six months extension is based on the date the Board of Medicine approved/certified my application for licensure** and I request an extension of up to 6 months to complete this requirement.

Domestic Violence Affidavit or Request for Extension:

[X] I hereby certify that subsequent to July 1, 1995, I have completed a minimum of one hour of Domestic Violence, Continuing Medical Education, as defined in s. 456.01, Florida Statutes.

[ ] I hereby certify that subsequent to July 1, 1995, I have **not** completed a minimum of one hour, Continuing Medical Education, in domestic violence. As I have not completed the required course for initial licensure, **I understand that the six months extension is based on the date the Board of Medicine approved/certified my application for licensure** and I request an extension of up to 6 months to complete this requirement.

Prevention of Medical Errors:

[ ] I hereby certify that subsequent to June 1, 2002, I have completed a minimum of two (2) hours of Prevention of Medical Errors, Continuing Medical Education, as defined by s. 456.013(7), Florida Statutes.

[X] I hereby certify that subsequent to June 1, 2002, I have **not** completed a minimum of two (2) hours of Prevention of Medical Errors, Continuing Medical Education, as defined by s. 456.013(7), Florida Statutes. As I have not completed the required course for initial licensure, I understand that the six months extension is based on the date the Board of Medicine approved/certified my application for licensure and I request an extension of up to 6 months to complete this requirement.

54. Dispensing Practitioner Registration: This is optional and for physicians whose primary practice is in the State of Florida.
Dispensing relates to physicians who maintain a "mini-pharmacy" in their private office for profit.

Section 465.0276, F.S., requires that licensees of the Board of Medicine who dispense medicinal drugs pay a fee of $100.00 at the time of such registration and upon each renewal of the practitioner's license. It is unlawful for any person to sell samples or complimentary packages of drug products. A practitioner who confines his/her activities to dispensing complimentary packages of medicinal drugs to patients in the regular course of his/her practice shall **not** be required to register.

[ ] I plan to dispense medicinal drugs in the State of Florida for a fee or other remuneration and hereby register pursuant to Section 465.0276, F.S. I understand that the fee for the Dispensing Practitioner is $100.00 OVER AND ABOVE the required initial license fee.

58. AFFIDAVIT OF APPLICANT:

I affirm that these statements are true and correct and recognize that providing false information may result in disciplinary action against my license or criminal penalties pursuant to Sections 456.067, 775.083 and 775.084, Florida Statutes.

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present) and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Florida Board of Medicine information which is material to my application for licensure.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of my license to practice Medicine in the State of Florida.

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

_____

(Specification of date, event or condition upon which this content expires)

CECIL RODWELL JONAS

(Please Print Your Name)

_____ _____

(Signature of Applicant required) (Date Signed required)

9. Are you a citizen of the U.S.? [X] YES [ ] NO
(Please provide your date and place of birth regardless of citizenship below)

Birth Date: 05 05 1936 (Month/Day/Year) Birth Place: GEORGETOWN, GUYANA (City)(State/Province)(Country)

a. If you are a Naturalized citizen please provide date and place of Naturalization:

08/22/1972 (Month/Day/Year) & DETROIT, MICHIGAN (City/State/Province/Country)

b. If you are not a U.S. citizen, please provide alien number: _____

10. Have you ever been in the United States Military and/or Public Health Service? [ ] YES [X] NO

_____
If 'yes' list branch of service, rank, dates of service (Enclose copy of discharge form)

10a. Have charges, now or ever, been brought against you by any branch of the United States Military and/or Public Health Service? [ ] YES [X] NO
If 'yes' explain on a separate sheet, providing accurate details.

11. Do you hold or have you ever held a license to practice Medicine in any state in the US, Canada, Guam, Puerto Rico, Virgin Islands? [X] YES [ ] NO
If 'yes' list State or Country/Profession/License Number (provide an attachment for additional information)
Verification of each license must be received directly from the licensing authority, regardless of status of license.

MICHIGAN #31003 U/S 9/8/72
State or Country/License Number/Issue Date

State or Country/License Number/Issue Date

ARIZONA #16633
State or Country/License Number/Issue Date

State or Country/License Number/Issue Date

12. List the year and state/province/country where you legally first began to practice medicine?

1969 (Year) MICHIGAN (State/Province/Country)

13. EDUCATION: UNDERGRADUATE/GRADUATE MEDICAL EDUCATION (includes medical school) – Starting with undergraduate education, list all schools, colleges and universities attended, whether completed or not, in chronological order. Submit a separate sheet of paper if needed.

College/University Name/Address	Major/Minor Course of Study	From: MM/YY	To: MM/YY	Degree Received
HOWARD UNIV WASH. DC	CHEMISTRY/ PHYSICS	9/1957	06/60	BSc
GEORGE WASHINGTON MEDICAL SCHOOL WASH, DC	MEDICINE	09/61	06/65	MD

9. Are you a citizen of the U.S.? [X] YES [ ] NO
(Please provide your date and place of birth regardless of citizenship below)

Birth Date: 05 05 1936 (Month/Day/Year) Birth Place: GEORGETOWN, GUYANA (City)(State/Province)(Country)

a. If you are a Naturalized citizen please provide date and place of Naturalization:

08/22/1972 (Month/Day/Year) & DETROIT, MICHIGAN (City/State/Province/Country)

b. If you are not a U.S. citizen, please provide alien number: _____

10. Have you ever been in the United States Military and/or Public Health Service? [ ] YES [X] NO

_____
If 'yes' list branch of service, rank, dates of service (Enclose copy of discharge form)

10a. Have charges, now or ever, been brought against you by any branch of the United States Military and/or Public Health Service? [ ] YES [X] NO
If 'yes' explain on a separate sheet, providing accurate details.

11. Do you hold or have you ever held a license to practice Medicine in any state in the US, Canada, Guam, Puerto Rico, Virgin Islands? [X] YES [ ] NO
If 'yes' list State or Country/Profession/License Number (provide an attachment for additional information)
Verification of each license must be received directly from the licensing authority, regardless of status of license.

MICHIGAN #31003 U/S 9/8/72
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College/University Name/Address	Major/Minor Course of Study	From: MM/YY	To: MM/YY	Degree Received
HOWARD UNIV WASH. DC	CHEMISTRY/ PHYSICS	9/1957	06/60	BSc

14. Doctor of Medicine Degree was obtained from:

GEORGE WASHINGTON MED SCH (MD) on JUNE 6, 1965

(Name of School/Institution) (Degree Title) (Month, Day, Year)

15. Have you ever been dropped, suspended, placed on probation, expelled or requested to resign from any school, college or university? [ ] YES [X] NO
(If 'yes', explain on a separate sheet providing accurate details.)

16. Was attendance in Medical school for a period other than the normal curriculum or were you required to repeat any of your medical education? [ ] YES [X] NO
(If 'yes', explain on a separate sheet providing accurate details.)

17. Did you take a leave of absence during medical school? [ ] YES [X] NO
(If 'yes', explain on a separate sheet providing accurate details.)

18. Have you ever taken the National Board Medical Examination, FLEX, and/or USMLE? [X] YES [ ] NO

NATIONAL BOARD 7/1/66
(list the examination and date taken)

18a. If you are using a combination of National Boards, FLEX, and/or USMLE completed prior to the year 2000, please list which examinations and dates on the line listed below:

19. PROFESSIONAL/POSTGRADUATE EDUCATION: List in chronological order from date of graduation from Medical school, to present, all professional/postgraduate training (Internship/Residency/Fellowship). If you are an International Graduate, please complete #19a and #19b on page #4.

Program Name and full mailing address required	Specialty Area	From: MM/YY	To: MM/YY	Did you receive credit? (Yes) or No
WAYNE STATE UNIV DEPT. OB/GYN (RESIDENT) 4070 BEAUBIEN ST. DET. MI 48201	OB/GYN	06/65	06/69	/ MD

ONLY INTERNATIONAL MEDICAL GRADUATES NEED TO COMPLETE #19a AND #19b

19a. INTERNATIONAL MEDICAL GRADUATES PROVIDE THE FOLLOWING: CLERKSHIP(S) Be specific: Account for each clerkship. List specific date(s), type of rotation, and name and location of hospital, institution or individual where clerkship was performed or supervised. List affiliate University/College.

Medical School Rotation; Institution/Individual	Address/City/State/Country	Affiliate Program	From: MM/YY	To: MM/YY

19b. ECFMG standard certificate or results letter number (list number) _____

(issue date) _____

20. Have you ever been dropped, suspended, placed on probation, expelled or requested to resign from any postgraduate training program? [ ] YES [X] NO
(If 'yes', explain on a separate sheet providing accurate details.)

21. Was attendance in a postgraduate training program for a period other than the established timeframe or were you required to repeat any of your postgraduate training? [ ] YES [X] NO
(If 'yes', explain on a separate sheet providing accurate details.)

22. Did you take a leave of absence during a postgraduate training? [ ] YES [X] NO
(If 'yes', explain on a separate sheet providing accurate details.)

23. PRACTICE/EMPLOYMENT: List in chronological order from date of graduation from medical school to present, all employment, non-employment and/or any unaccounted period of time. (if needed, continue on back of page or a separate page)

Name and full mailing address of employment	Type of Employment	From: MM/YY	To: MM/YY
C.R. JONAS MD PC 27177 LAHSER RD #107 SOUTHFIELD, MI 48034	OB/GYN PRACTICE	6/69	11/2001

24. Have you had responsibility for graduate medical education within the last 10 years? [X] YES [ ] NO

25. Do you currently hold a faculty appointment at a Medical/health-related institution of higher learning? [ ] YES [X] NO
(If 'yes', complete section #28)

26. List any hospital/health institution/clinic or medical facility where you have faculty appointment:

Name of Institution	Full mailing address	Title of Appointment
—		

27. Do you currently hold staff privileges in any hospital, health institution, clinic or medical facility? (If 'yes' complete section 30) [ ] YES [X] NO

28. List any hospital/health institution/clinic or medical facility where you hold staff privileges (Do Not List Training Privileges).

Name/mailing address of Facility	Chief of Staff	Type of Privileges	From: MM/YY	To: MM/YY

29. Have you ever had any staff privileges denied, suspended, revoked, modified, restricted, placed on probation, asked to resign or asked to take a temporary leave of absence or otherwise acted against by any facility? [ ] YES [X] NO
(If 'yes', list below and see application instructions for required documentation to submit)

Name of Institution	Date: MM/DD/YY	Violation	Final Action	Under Appeal? Y/N

30. Have you ever been asked, or allowed to resign from any facility in lieu of disciplinary action or during any pending investigations into your practice? [ ] YES [X] NO
(If 'yes', list below and see application instructions for required documentation to submit)

Name/Address of Facility	Date: MM/DD/YY	Violation/Investigation	Reason for Resignation

31. Have you ever had any staff privileges restricted or not renewed by any facility in lieu of disciplinary action?
(If 'yes', list below and see application instructions for required documentation to submit)

[ ] YES [X] NO

Name/Address of Facility	Date: MM/DD/YY	Circumstances	Final Action

32. CERTIFICATION: Are you certified by any Specialty Board recognized by the American Board of Medical Specialties, or specialty board approved by the Florida Board of Medicine?
(If 'yes', list below and enclose a copy of each certification or letter of verification)

[X] YES [ ] NO

Board Name	Certification/ Specialty/Sub-Specialty	Date of Certification MM/YY
ABOG	OB/GYN	12/71

33. Have you ever applied for, taken an examination for, or failed to receive specialty board certification or recertification for any reason?
(If 'yes', explain on a separate sheet, providing full details.)

[ ] YES [X] NO

34. Have you ever had any sanctions taken against you by a specialty board or other similar national organization?
(If 'yes', list below and see application instructions for required documentation to submit)

[ ] YES [X] NO

Name of Specialty Board	Date: MM/DD/YY	Circumstances	Final Action	Under Appeal? Y/N

ALL AFFIRMATIVE ANSWERS FOR QUESTIONS 20-34 MUST BE EXPLAINED IN DETAIL ON A SEPARATE SHEET. DOCUMENTATION SUBSTANTIATING THE EXPLANATION IS REQUIRED.

35. Have you had any application for professional license or any application to practice Medicine denied by any state board or other governmental agency of any state, territory, or country? [ ] YES [X] NO

36. Have you ever been notified to appear before any licensing agency for a hearing on a complaint of any nature including, but not limited to, a charge or violation of the Medical practice act, unprofessional or unethical conduct? [ ] YES [X] NO

37. Have you ever had any professional license or license to practice Medicine revoked, suspended, placed on probation, received a citation, or other disciplinary action taken in any state, territory or country? [ ] YES [X] NO

Name of Agency	Date: MM/DD/YY	Circumstances	Final Action	Under Appeal? Y/N

38. Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to, a crime in any jurisdiction other than a minor traffic offense? you must include all misdemeanors and felonies, even if adjudication was withheld by the court so that you would not have a record of conviction. Driving under the influence or driving while impaired is not a minor traffic offense for purposes of this question. (If 'yes', list below and see application instructions for required documentation to submit) [ ] YES [X] NO

Offense	Date: MM/DD/YY	Jurisdiction	Final Action	Under Appeal? Y/N

39. Have you ever been criminally or civilly charged with any intentional or negligent action related to use or misuse of drugs, alcohol, or illegal chemical substances? [ ] YES [X] NO

40. Have you ever had employment terminated for cause? [ ] YES [X] NO

41. Have you ever been warned or called before the United States Drug Enforcement Agency (DEA)? [ ] YES [X] NO

42. Have you ever been made an offer to compromise or entered into any other arrangement or other plea or agreement in lieu of a Federal prosecution for a drug violation regulated by the DEA? [ ] YES [X] NO

43. Have you ever been denied, or surrendered a DEA Registration? [ ] YES [X] NO

44. In the last five years, have you been enrolled in, required to enter into, or participated in any drug or alcohol recovery program or impaired practitioner program?

45. In the last five years, have you been treated for or had a recurrence of a diagnosed mental disorder or impairment?

46. In the last five years, have you been treated for or had a recurrence of a diagnosed physical impairment?

47. In the last five years, have you been treated for or had a recurrence of a diagnosed addictive disorder?

[redacted]

48. MALPRACTICE/LIABILITY CLAIMS:
Within the previous ten years have you had a liability claim or action for damages for personal injury settled or finally adjudicated in an amount that exceeds $5,000? [ ] YES [X] NO
(If "yes", complete Exhibit 1 on the next page for each occurrence)

49. Have you ever been the subject of a lawsuit or insurance claim, settled or pending, regardless of the result, arising from your professional activity and brought against you or any partner, associate, or employee? [X] YES [ ] NO
(If 'yes', list below and see application instructions for required documentation to submit)

Date of Occurance	Location	Claimant	Amount	Date of Final Disposition
6/18/93	DET. MICH	KRISTAN BROWN	NONE	7/8/95
3/18/93	DET. MICH	LESLIE BARGON	NONE	11/16/95
7/14/98	DET, MICH	CAMECA WILSON	NONE	11/2001
3/4/98	DET, MICH	DAMECA WILLIAMS	NONE	6/8/01
10/11/94	DET, MICH	RAYMOND COGAN	NONE	3/6/00
4/8/96	DET, MICH	NINA HUDSON	NONE	6/19/98
3/31/94	DET, MICH	LONDON SAMPSON	NONE	6/30/94
10/8/94	DET, MICH	SONJA EVERETT	NONE	4/05/00

50. List all Medical/Professional Society or Association Memberships:

Name of Society/Association	Mailing Address	Dates of Affiliation: From/To
AMA	CHICAGO, ILL	1968-> PRESENT
MSMS	EAST LANSING, MICH	1970-2004
National Medical	WASH DC	1970-2004

Practitioner's Name CR JONAS MD

EXHIBIT 1 – REPORT ON PROFESSIONAL LIABILITY CLAIMS AND ACTIONS

Include information relating to liability actions occurring within the previous 10 years. The actions are required to be reported under section 456.0391 F.S. You must submit a completed form for each occurrence. For Allopathic, Osteopathic, and Podiatric physicians, copies of reports previously submitted under the requirements of s. 456.0391, F.S., may be submitted in lieu of this exhibit to satisfy this reporting requirement.

Date of occurrence: ___/___/___ Date reported to licensee: ___/___/___

Injured person'sname:(last,first,middleinitial)_____

StreetAddress: SEE ENCLOSED

City: _____ State: _____ Zip Code: _____

Age: _____ Sex: _____

Date of suit: ___/___/___

List other defendants involved in this claim:

1 _____ 2. _____

3. _____ 4. _____

Date of final claim disposition: ___/___/___

Was there an itemized verdict? ☐Yes ☐ No (If "YES", attach copy of settlement verdict)

Indemnity paid on behalf of this defendant: $_____

Loss adjustment expense paid to defense counsel: $_____

All other loss adjustment expense paid: $_____

Name of institution at which the injury occurred:

_____

Location of injury occurrence:

____Patient's Room ____Physical Therapy Dept. ____Radiology ____Labor & Delivery Room

____Operating Suite ____Nursery ____Emergency Room ____Special Procedure Room

____Recovery Room ____Critical Care Unit ____Other _____

Final diagnosis for which treatment was sought or rendered. _____

_____

Describe misdiagnosis made, if any, of the patient's actual condition. _____

_____

Describe the operation, diagnostic or treatment procedure causing the injury. Use nomenclature and/or descriptions of the procedures used. Include method of anesthesia, or name of drug used for treatment, with detail of administration. _____

_____

Describe the principal injury giving rise to the claim. Use nomenclature and/or descriptions of the injury. Include type of adverse effect from drugs where applicable.

_____

_____

Safety management steps taken by the licensee to make similar occurrences less likely. _____

_____

I represent that these statements are true and correct pursuant to s. 837.06, Florida Statutes. I recognize that providing any false statements made in writing with the intent to mislead the Department staff in the performance of their official duties, shall be punishable as provided in s. 775.083 and 775.083, Florida Statute.

Signature of Physician: _____

55. FINANCIAL RESPONSIBILITY

The Financial Responsibility options are divided into two categories, coverage and exemptions. Choose only ONE option of the ten provided pursuant to s.458.320, Florida Statutes.

CATEGORY I: FINANCIAL RESPONSIBILITY COVERAGE

☐ **1.** I do not have hospital staff privileges and I have established an irrevocable letter of credit or an escrow account in an amount of $100,000/$300,000, in accordance with Chapter 675, F. S., for a letter of credit and s. 625.52, F. S., for an escrow account.

☐ **2.** I have hospital staff privileges and I have established an irrevocable letter of credit or escrow account in an amount of $250,000/$750,000, in accordance with Chapter 675, F. S., for a letter of credit and s. 625.52, F. S., for an escrow account.

☐ **3.** I do not have hospital staff privileges and I have obtained and maintain professional liability coverage in an amount not less than $100,000 per claim, with a minimum annual aggregate of not less than $300,000 from an authorized insurer as defined under s. 624.09, F. S., from a surplus lines insurer as defined under s. 626.914(2), F.S., from a risk retention group as defined under s. 627.942, F.S., from the Joint Underwriting Association established under s. 627.351(4), F. S., or through a plan of self-insurance as provided in s. 627.357, F.S.

☐ **4.** I have hospital staff privileges and I have professional liability coverage in an amount not less than $250,000 per claim, with a minimum annual aggregate of not less than $750,000 from an authorized insurer as defined under s. 624.09, F. S., from a surplus lines insurer as defined under s. 626.914(2), F. S., from a risk retention group as defined under s. 627.942, F.S., from the Joint Underwriting Association established under s. 627.351(4), F. S., or through a plan of self insurance as provided in s.627.357, F .S.

☐ **5** I have elected not to carry medical malpractice insurance, however, I agree to satisfy any adverse judgements up to the minimum amounts pursuant to s. 458.320(5)(g) 1 or 459.008S(5)(g)1, F. S. I understand that I must either post notice in the form of a "sign" prominently displayed in the reception area or provide a written statement to any person to whom medical services are being provided that I have decided not to carry medical malpractice insurance. I understand that such a sign or notice must contain the wording specified in s. 458.320(5)(g) or 459.0085(5)(g), F. S.

Category II: Financial Responsibility Exemptions

☐ **6.** I practice medicine exclusively as an officer, employee, or agent of the federal government, or of the state or its agencies or subdivisions;

☐ **7.** I hold a limited license issued pursuant to s. 458.317 or 459.0075, F. S., and practice only under the scope of the limited license;

☒ **8.** I do not practice medicine in the State of Florida;

☒ **9.** I meet all of the following criteria:

(a) I have held an active license to practice in this state or another state or some combination thereof for more than 15 years;

(b) I am retired or maintain part time practice of no more than 1000 patient contact hours per year;

(c) I have had no more than two claims resulting in an indemnity exceeding $10,000 within the previous five-year period;

(d) I have not been convicted of or pled guilty or nolo contendere to any criminal violation specified in Chapter 458 or 459, F. S.; and

(e) I have not been subject, within the past ten years of practice, to license revocation or suspension, probation for a period of three years or longer, or a fine of $500 or more for a violation of Chapter 458 or 459, F.S., or the medical practice act of another jurisdiction. A regulatory agency's acceptance of a relinquishment of license stipulation, consent order or other settlement offered in response to or in anticipation of filing of administrative charges against a license shall be construed as action against a license. I understand if I am claiming an exception under this section that I must either post notice in the form of a sign, prominently displayed in the reception area or provide a written statement to any person to whom medical services are being provided, that I have decided not to carry medical malpractice insurance.

☐ **10.** I practice only in conjunction with my teaching duties at an accredited medical school or its teaching hospitals. (Interns and residents do not qualify for this exemption).

56. OPTIONAL INFORMATION:

a. PUBLICATIONS: List any publications you have authored in peer-reviewed medical literature within the previous ten years.

(Title)	(Publication)	(Date)
(Title)	(Publication)	(Date)
(Title)	(Publication)	(Date)
(Title)	(Publication)	(Date)

b. DO YOU PARTICIPATE IN THE MEDICAID PROGRAM? [ ] YES [X] NO

If yes list:

(Type of Provider)	(state)
(Type of Provider)	(state)

c. PROFESSIONAL OR COMMUNITY SERVICE ACTIVITIES, HONORS OR AWARDS:

(Activity/Honor/Award)	(Organization)
(Activity/Honor/Award)	(Organization)
(Activity/Honor/Award)	(Organization)
(Activity/Honor/Award)	(Organization)

d. LANGUAGES OTHER THAN ENGLISH: Indicate languages other than English used by you to communicate with patients and any translation service available for patients at your primary place of practice.

e. COMMENTS/ADDITIONAL INFORMATION: Any comments/information you want the board to be aware of.

A

FLORIDA
DEPARTMENT OF HEALTH
BOARD OF MEDICINE
4052 Bald Cypress Way, Bin #C03
Tallahassee, Florida 32399-3253
(850) 245-4131

RECEIVED
MAY 07 2002
DEPARTMENT OF HEALTH
BOARD OF MEDICINE

Received Date : 05/06/2002
Deposit Date : 05/06/2002
Deposit # : 167921
Batch Number : 021270
Validation # : 901205981 ✓
Check Amount : $460.00 ✓
Validation # : 901205982
Check Amount : $43.00 ✓
PRO_CDE : 1501

FR

1501 MEDICAL DOCTOR APPLICATION FOR LICENSURE

READ INSTRUCTIONS FOR IMPORTANT INFORMATION (Application fee is non-refundable)

1. **APPLICATION CATEGORY/APPLICABLE FEES: CLIENT 1501**
(TYPE OR PRINT LEGIBLY IN BLACK- CHECK APPROPRIATE LICENSURE AVENUE)

[ ] EXAMINATION (1024) (application fee $410, background check $43) Total $453.00
[ ] C-SPEX (1022) (application fee $410, background check $43) Total $453.00
[ ] STATE BOARD EXAM (Prior to 1974) (1022) (application fee $410, background check $43) Total $453.00
[X] ENDORSEMENT (1021) (application fee $460, background check $43) Total$503.00

2. **SOCIAL SECURITY NUMBER:** [redacted]

3. **NAME:** JONAS (Last) CECIL (First) RODWELL (Middle)

a. Have you ever changed your name through marriage or through action of a court? [ ] YES [X] NO

If 'yes', list name(s) (Last, First, Middle) and Date(s) of changes

b. Have you ever been known by any other name (aliases)? [ ] YES [X] NO

If 'yes', list name(s) (Last, First, Middle, and Suffix)

4. **MAILING ADDRESS** (where you receive mail):

4272 SW 186th AVE (Street and number or PO Box) MIRAMAR (City) FL (State/Province) 33029 (Zip/Postal Code) USA (Country)

a. **PRIMARY PRACTICE/PHYSICAL ADDRESS** (where you can be located):

4272 SW 186th AVE (Street and number) MIRAMAR (City) FL (State/Province) 33029 (Zip/Postal Code) USA (Country)

b. **TELEPHONE:** (954) 438-9943 (Home: Area Code/Phone Number) ( ) (Work: Area Code/Phone Number)

c. **E-MAIL ADDRESS:** crjonas@bellsouth.net

5. **PERSONAL DATA:**
HEIGHT: 6' 0 WEIGHT: 194
EYE COLOR: BLACK HAIR COLOR: BLACK

We are required to ask that you furnish the following information as part of your voluntary compliance with Section 2, Uniform Guidelines on Employee Selection Procedure (1978) 43 FR38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

RACE: Caucasian [ ] Black [X] Hispanic [ ] Asian [ ] Native American [ ] Other [ ]
SEX: Male [X] Female [ ]

5a. Staple one (1) photo here

PLEASE DO NOT GLUE, TAPE OR PASTE PHOTOS

(Print name on back of photograph)

6. Are you a citizen of the U.S.? Please give your date/place of birth regardless of citizenship below. [X] YES [ ] NO

Birth Date: 05/05/36 (Month/Day/Year) Birth Place: GEORGETOWN, GUYANA (City)(State/Province)(Country)

a. If you are a Naturalized citizen please provide date and place of Naturalization:

AUG 22, 1972 (Month/Day/Year) & DETROIT, MICH, USA (City/State/Province/Country)

b. If you are not a U.S. citizen, please provide alien number: _____

7. Have you ever been in the United States Military and/or Public Health Service? [ ] YES [X] NO

_____

If 'yes' list branch of service, rank, dates of service (Enclose copy of discharge form)

7a. Have charges, now or ever, been brought against you by any branch of the United States Military and/or Public Health Service? [ ] YES [X] NO
If 'yes' explain on a separate sheet, providing accurate details.

8. Do you hold or have you ever held a license to practice Medicine or any other profession in any US, or foreign country? [X] YES [ ] NO
If 'yes' list State or Country/Profession/License Number (use back of page or attachment)
Verification of each license must be received directly from the licensing authority, regardless of status of license.

MICHIGAN / MEDICINE / 31063 / 9/8/1972
State or Country/Profession/License Number/Issue Date

ARIZONA / MEDICINE / 16633 / 1/2/ 1987
State or Country/Profession/License Number/Issue Date

8a. List the year and state/province/country where you legally first began to practice medicine?

1969 (Year) MICHIGAN USA (State/Province/Country)

9. EDUCATION: UNDERGRADUATE/GRADUATE MEDICAL EDUCATION – Starting with undergraduate education, list all schools, colleges and universities attended, whether completed or not, in chronological order. Submit a separate sheet of paper if needed.

College/University Name/Address	Domicile	Major/Minor Course of Study	From: MM/YY	To: MM/YY	Degree Received
		ATTACHED C.V.			

10. Doctor of Medicine Degree was obtained from:

GEORGE WASHINGTON , MD on 6-6-1965
(Name of School/Institution) (Degree Title) (Month, Day, Year)

11. Have you ever been dropped, suspended, placed on probation, expelled or requested to resign from any school, college or university? [ ] YES [X] NO
(If 'yes', explain on a separate sheet providing accurate details.)

12. Was attendance in Medical school for a period other than the normal curriculum? [ ] YES [X] NO
(If 'yes', explain on a separate sheet providing accurate details.)

12a. Did you take a leave of absence during medical school? [ ] YES [X] NO
(If 'yes', explain on a separate sheet providing accurate details.)

12b. Were you required to repeat any of your medical education? [ ] YES [X] NO
(If 'yes', explain on a separate sheet providing accurate details.)

13. If you are an International Graduate, please complete questions #13 and #13a on page #4.

14. Have you ever taken the National Board Medical Examination, FLEX, and/or USMLE? [X] YES [ ] NO

14a. If 'yes' to question #14, list dates and Examinations taken NATIONAL BOARD 7-1-66 (#82146)

14b. If you are using a combination of National Boards, FLEX, and/or USMLE completed prior to the year 2000, please list which examinations and dates on the line listed below:

15. **PROFESSIONAL/POSTGRADUATE EDUCATION:** List in chronological order from date of graduation from Medical school, to present, all professional/postgraduate training (Internship/Residency/Fellowship).

Program Name and full mailing address required	Specialty Area	From: MM/YY	To: MM/YY	Did you receive credit? Yes or No
HARPER HOSPITAL 4801 BRUSH ST. DET, MICH 48201	1965- INTERNSHIP	6/65	6/66	YES.
WSU. DEPT OB/GYN HUTZEL HOSP. 4707 ST. ANTOINE DET. MI 48201	RESIDENT OB/GYN	6/66	6/69	YES.

ONLY INTERNATIONAL MEDICAL GRADUATES NEED TO COMPLETE #13 AND #13A

13. INTERNATIONAL MEDICAL GRADUATES PROVIDE THE FOLLOWING: CLERKSHIP(S) Be specific: Account for each clerkship. List specific date(s), type of rotation, and name and location of hospital, institution or individual where clerkship was performed or supervised. List affiliate University/College.

Medical School Rotation; Institution/Individual	Address/City/State/Country	Affiliate Program	From: MM/YY	To: MM/YY

13a. ECFMG standard certificate or results letter number (list number) _____

(date of issuance)_____

15a. Have you ever been dropped, suspended, placed on probation, expelled or requested to resign from a postgraduate training program? [ ] YES [X] NO
(If 'yes', explain on a separate sheet providing accurate details.)

15b. Was attendance in a postgraduate training program for a period other than the established timeframe? [ ] YES [X] NO
(If 'yes', explain on a separate sheet providing accurate details.)

15c. Did you take a leave of absence during a postgraduate training? [ ] YES [X] NO
(If 'yes', explain on a separate sheet providing accurate details.)

15d. Were you required to repeat any of your postgraduate training? [ ] YES [X] NO
(If 'yes', explain on a separate sheet providing accurate details.)

16. PRACTICE/EMPLOYMENT: List in chronological order from date of graduation from medical school to present, all employment, non-employment and/or any unaccounted period of time. (if needed, continue on back of page or a separate page)

Name and full mailing address of employment	Type of Employment	From: MM/YY	To: MM/YY
JOINED SOLO MD Dr ADDISON JENCE OB/GYN (NOW DECEASED)	PARTNERSHIP	1969	1973
SOLO PRACTICE OB/GYN 4727 ST. ANTOINE DET 48201	SOLO PRACTICE	1972	1988
WOODLAND GROUP PRACTICE 27207 LAHSER RD SOUTHFIELD MI 48034	LARGE MULTI SPEC. GROUP	1988	1990
C.R. JONAS MD PC 27177 LAHSER STE 100 SOUTHFIELD MI 48034	SOLO OB/GYN	1990	PRESENT

17a. Have you had responsibility for graduate medical education within the last 10 years? [X] YES [ ] NO

17b. Do you currently hold a faculty appointment at a Medical/health-related institution of higher learning? [X] YES [ ] NO
(If 'yes', complete section 17c)

17c. List any hospital/health institution/clinic or medical facility where you have faculty appointment:

Name of Institution	Full mailing address	Title of Appointment
WAYNE STATE UNIV DEPT OB/GYN 4701 ST. ANTOINE BLVD DET MI 48201	4701 ST. ANTOINE BLVD DET, MI 48201	ASST. CLINICAL PROF. OB/GYN

15a. Have you ever been dropped, suspended, placed on probation, expelled or requested to resign from a postgraduate training program? [ ] YES [X] NO
(If 'yes', explain on a separate sheet providing accurate details.)

15b. Was attendance in a postgraduate training program for a period other than the established timeframe? [ ] YES [X] NO
(If 'yes', explain on a separate sheet providing accurate details.)

15c. Did you take a leave of absence during a postgraduate training? [ ] YES [X] NO
(If 'yes', explain on a separate sheet providing accurate details.)

15d. Were you required to repeat any of your postgraduate training? [ ] YES [X] NO
(If 'yes', explain on a separate sheet providing accurate details.)

16. PRACTICE/EMPLOYMENT: List in chronological order from date of graduation from medical school to present, all employment, non-employment and/or any unaccounted period of time. (if needed, continue on back of page or a separate page)

Name and full mailing address of employment	Type of Employment	From: MM/YY	To: MM/YY
JOINED SOLO MD Dr ADDISON PLINCE	PARTNERSHIP	07/ 1969	02/ 1973
OB/GYN (NOW DECEASED)			
SOLO PRACTICE OB/GYN 4727 ST. ANTOINE	SOLO PRACTICE	11/ 1972	05/ 1984
DET 48201 WOODLAND GROUP	LARGE MULTISPEC.	05/ 1984	03/ 1990
PRACTICE 27207 LAHSER RD	GROUP		
SOUTHFIELD MI 48034 C.R. JONAS MD PC	SOLO OB/GYN	03/ 1990	11/01 PRESENT
27177 LAHSER STE 100 SOUTHFIELD MI 48034			

17a. Have you had responsibility for graduate medical education within the last 10 years? [X] YES [ ] NO

17b. Do you currently hold a faculty appointment at a Medical/health-related institution of higher learning? [X] YES [ ] NO
(If 'yes', complete section 17c)

17c. List any hospital/health institution/clinic or medical facility where you have faculty appointment:

Name of Institution	Full mailing address	Title of Appointment
WAYNE STATE UNIV DEPT OB/GYN	4701 ST. ANTOINE BLVD DET, MI 48201	ASST. CLINICAL PROF. OB/GYN
4701 ST. ANTOINE BLVD DET MI 48201		

18a. Do you currently hold staff privileges in any hospital, health institution, clinic or medical facility? (If 'yes' complete section 18b). [X] YES [ ] NO

18b. List any hospital/health institution/clinic or medical facility where you hold staff privileges (Do Not List Training Privileges).

Name/mailing address of Facility	Chief of Staff	Type of Privileges	From: MM/YY	To: MM/YY
HARPER HOSPITAL 4801 BRUSH ST. DET. MI 48201	AUGUSTUS ARBULU MD	FULL SR. STAFF	6/69	CURRENT
GRACE HOSPITAL	JOHN ITHAPINIE	SR STAFF	198?	CURRENT
PROVIDENCE HOSP 16001 W. NINE MI. RD, SOUTHFIELD MI 48037	- MI D.O. FREDDY SOSA	FULL FULL	1990	CURRENT
ST JOHN NORTHEAST COMMUNITY HOSP. 4777 E. OUTER DR. DET. MI 48234	JITENDER JAIN MD	FULL FULL	1999 1969	CURRENT CURRENT
HUTZEL HOSP 4701 ST. ANTOINE DET, MI 48201	HARSAN AMIRUKA MD			

18c. Have you ever had any staff privileges denied, suspended, revoked, modified, restricted, placed on probation, asked to resign or asked to take a temporary leave of absence or otherwise acted against by any facility? [ ] YES [X] NO
(If 'yes', list below and see application instructions for required documentation to submit)

Name of Institution	Date: MM/DD/YY	Violation	Final Action	Under Appeal? Y/N

18d. Have you ever been asked, or allowed to resign from any facility in lieu of disciplinary action or during any pending investigations into your practice? [ ] YES [X] NO
(If 'yes', list below and see application instructions for required documentation to submit)

Name/Address of Facility	Date: MM/DD/YY	Violation/Investigation	Reason for Resignation

18e. Have you ever had any staff privileges restricted or not renewed by any facility in lieu of disciplinary action? [ ] YES [X] NO
(If 'yes', list below and see application instructions for required documentation to submit)

Name/Address of Facility	Date: MM/DD/YY	Circumstances	Final Action
	4/12/91		

19a. CERTIFICATION: Are you certified by any Specialty Board recognized by the American Board of Medical Specialties, or specialty board approved by the Florida Board of Medicine? [X] YES [ ] NO
(If 'yes', list below and enclose a copy of each certification or letter of verification)

Board Name	Date: MM/DD/YY	Certification/ Specialty/Sub-Specialty	Date of Certification
ABOG OB/GYN	11/12/71	OB/GYN	1971/1981
	6/26/81		

19b. Have you ever applied for, taken an examination for, or failed to receive specialty board certification or recertification for any reason? [ ] YES [X] NO
(If 'yes', explain on a separate sheet, providing full details.)

19c. Have you ever had any sanctions taken against you by a specialty board or other similar national organization? [ ] YES [X] NO
(If 'yes', list below and see application instructions for required documentation to submit)

Name of Specialty Board	Date: MM/DD/YY	Circumstances	Final Action	Under Appeal? Y/N

ALL AFFIRMATIVE ANSWERS FOR QUESTIONS 20-34 MUST BE EXPLAINED IN DETAIL ON A SEPARATE SHEET. DOCUMENTATION SUBSTANTIATING THE EXPLANATION IS REQUIRED.

20. Have you had any application for professional license or any application to practice Medicine denied by any state board or other governmental agency of any state, territory, or country? [ ] YES [X] NO

21. Have you ever been notified to appear before any licensing agency for a hearing on a complaint of any nature including, but not limited to, a charge or violation of the Medical practice act, unprofessional or unethical conduct? [ ] YES [X] NO

22. Have you ever had any professional license or license to practice Medicine revoked, suspended, placed on probation, received a citation, or other disciplinary action taken in any state, territory or country? [ ] YES [X] NO

Name of Agency	Date: MM/DD/YY	Circumstances	Final Action	Under Appeal? Y/N

23. Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to, a crime in any jurisdiction other than a minor traffic offense? you must include all misdemeanors and felonies, even if adjudication was withheld by the court so that you would not have a record of conviction. Driving under the influence or driving while impaired is not a minor traffic offense for purposes of this question. (If 'yes', list below and see application instructions for required documentation to submit) [ ] YES [X] NO

Offense	Date: MM/DD/YY	Jurisdiction	Final Action	Under Appeal? Y/N

24. Have you ever been criminally or civilly charged with any intentional or negligent action related to use or misuse of drugs, alcohol, or illegal chemical substances? [ ] YES [X] NO

25. Have you ever had employment terminated for cause? [ ] YES [X] NO

26. Have you ever been warned or called before the United States Drug Enforcement Agency (DEA)? [ ] YES [X] NO

27. Have you ever been made an offer to compromise or entered into any other arrangement or other plea or agreement in lieu of a Federal prosecution for a drug violation regulated by the DEA? [ ] YES [X] NO

28. Have you ever been denied, or surrendered a DEA Registration? [ ] YES [X] NO

29. In the last five years, have you been enrolled in, required to enter into, or participated in any drug or alcohol recovery program or impaired practitioner program?

30. In the last five years, have you been treated for of had a recurrence of a diagnosed mental disorder or impairment?

31. In the last five years, have you been treated for or had a recurrence of a diagnosed physical impairment?

32. In the last five years, have you been treated for or had a recurrence of a diagnosed addictive disorder?

[redacted]

33. **LIABILITY CLAIMS:**

Within the previous ten years have you had a liability claim or action for damages for personal injury settled or finally adjudicated in an amount that exceeds $5,000? [ ] YES [X] NO
(If "yes", complete Exhibit I on the next page for each occurrence)

34. Have any actions in bankruptcy court or any civil judgements ever been entered against you arising from your professional activity? [ ] YES [X] NO

(If 'yes', list below and see application instructions for required documentation to submit)

Date of Occurance	Location	Claimant	Amount	Date of Final Disposition

35. Have you ever been the subject of a lawsuit or insurance claim, settled or pending, regardless of the result, arising from your professional activity and brought against you or any partner, associate, or employee?
(If 'yes', list below and see application instructions for required documentation to submit)

[X] YES [ ] NO

Date of Occurance	Location	Claimant	Amount	Date of Final Disposition
Dec 18, 1998	Detroit. Mich	Pamela Wilson	—	5/11/2001
Pt. appealed 5/24/2001	SUMMARY JUDGEMENT BY CIRCUIT COURT. — NO FOLLOW UP SO FAR.			
1997	DETROIT, MICH.	ATT. WILLIAMS	DISMISSED.	2001

36a. List all Medical/Professional Society or Association Memberships:

Name of Society/Association	Mailing Address	Dates of Affiliation: From/To
AMA	515 NORTH STATE STR. CHICAGO, ILLINOIS 60610	1990 TO PRESENT
NMA	P.O BOX 63106 BALTIMORE MD 21263	1976 → PRESENT
MSMS	120 W. SAGINAW ST EAST LANSING. MI 48826-0950	1970 → PRESENT
WCMS	1010 ANTIETAM Rd DETROIT, MI 48207	1970 → PRESENT
BROWARD COUNTY / FMA		2002

36b. Have you ever had an application for membership denied by a Medical Society or Association?
(If 'yes', see application instructions for required documentation to submit)

[ ] YES [X] NO

36c. Have you ever had a Medical Society or Association membership suspended?
(If 'yes', see application instructions for required documentation to submit)

[ ] YES [X] NO

36d. Have you ever been notified to appear before a Medical Society or Association regarding charges/complaints filed against you?
(If 'yes', see application instructions for required documentation to submit)

[ ] YES [X] NO

37. **OPTIONAL INFORMATION:**

a. PUBLICATIONS: List any publications you have authored in peer-reviewed medical literature within the previous ten years.

(Title)	(Publication)	(Date)
(Title)	(Publication)	(Date)
(Title)	(Publication)	(Date)
(Title)	(Publication)	(Date)

b. DO YOU PARTICIPATE IN THE MEDICAID PROGRAM? [ ] YES [X] NO

If yes list:

(Type of Provider)	(state)
(Type of Provider)	(state)

c. PROFESSIONAL OR COMMUNITY SERVICE ACTIVITIES, HONORS OR AWARDS:

(Activity/Honor/Award)	(Organization)
ALUMNI AWARD	HOWARDITE OF THE YEAR HOWARD U.
WAYNE COUNTY MED. SOC.	PRESIDENT 1994-1995
WAYNE STATE UNIV. OB/GYN	OUTSTANDING ATTENDING AWARD
CERTIFICATE OF APPRECIATION	MICH STATE MED. SOC.

d. LANGUAGES OTHER THAN ENGLISH: Indicate languages other than English used by you to communicate with patients and any translation service available for patients at your primary place of practice.

e. COMMENTS/ADDITIONAL INFORMATION: Any comments/information you want the board to be aware of.

SEE ENCLOSED RESUME'

38. AFFIDAVIT OF APPLICANT:

I affirm that these statements are true and correct and recognize that providing false information may result in disciplinary action against my license or criminal penalties pursuant to Sections 456.067, 775.083 and 775.084, Florida Statutes.

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present) and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Florida Board of Medicine information which is material to my application for licensure.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of my license to practice Medicine in the State of Florida.

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

4/30/03
Date of Expiration

CECIL R. JONAS

(Signature of Applicant required) 4/30/02 (Date Signed required)