1901

F- 15518

BOARD OF OSTEOPATHIC MEDICINE
APPLICATION FOR LICENSURE (Client 1901)
Apply for your license online at www.floridasosteopathicmedicine.gov

08/06/2018 755.00
ID: 15518 Type: F
BT: 3002500
R#: 918005403

NICA Fee (check one): ☐ $0- Exempt ☑ $250- Non-participating

☐ **Military Veterans Fee Waiver**: If you were honorably discharged from the U.S. arm your application you will qualify for a waiver of the application fee and the initial licen please check the box above indicating that you are seeking a waiver and submit **a D of honorable discharge.**

☐ **Dispensing Practitioner (optional):** I plan to dispense medicinal drugs in Florida fc hereby register as required by section 456.0276, F.S. I understand that the fee to become a dispensing practitioner is $100.00 in addition to the required licensure fees and have included it with this application.

PERSONAL INFORMATION:

Name: Lefkowitz (last) Janet (first) Beth (middle) **Birth Date:** 04/17/1965 (mm/dd/yyyy)

List any other names you have been known by: Not applicable

Mailing Address: (the address where mail and your license should be sent)

1240 Heards Ferry Road
Street and number or PO Box — Suite/Apt #

Atlanta, — GA — 30328 — USA
City — State/Province — Zip/Postal Code — Country

Physical Address: A Post Office Box is not acceptable. This address will be posted on the Department of Health's website. If you do not have a current practice address, your mailing address will be used. When you obtain a practice address you will be required to update your online practitioner profile.

1968 Peachtree St NW
Street and number or PO Box — Suite/Apt #

Atlanta, — GA — 30309 — USA
City — State/Province — Zip/Postal Code — Country

Telephone: (678) 540-7025 (Primary) _____ (Alternate) (860) 922-5110 (Cell)

Email Address: janet@drlefkowitz.com
Under Florida law, email addresses are public records. If you do not want your e-mail address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.

Equal Opportunity Data: We are required to ask that you furnish the following information as part of your voluntary compliance with Section 2, Uniformed Guidelines on Employee Selection Procedure (1978) 43C FR 38295 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: White [✓] Black [ ] Hispanic [ ] Asian/Pacific Islander [ ] Native American [ ] Other [ ]
Sex: Male [ ] Female [✓]

☑ Yes ☐ No **Availability for Disaster:** Will you be available to provide health care services in special needs shelters or to help staff disaster medical assistance teams during times of emergency or major disaster?

☑ Yes ☐ No Are you using the **FCVS** to verify your core credentials? *FCVS is not a requirement for licensure. FCVS will primary source verify and provide a copy of the osteopathic medical school transcript(s), name change document(s), and national exam score report. Using this service will expedite your application only if the FCVS packet was complete prior to this application. For more information about FCVS, visit their web-site at www.fcvs.org/.*

CONFIDENTIAL AND EXEMPT FROM PUBLIC RECORDS DISCLOSURE

Name: Lefkowitz (**Last**) Janet (**First**) Beth (**Middle**)

Social Security Number: [redacted]

This page is exempt from public records disclosure. The Department of Health is required and authorized to collect Social Security Numbers relating to applications for professional licensure pursuant to Title 42 USCA § 666 (a)(13). For all professions regulated under chapter 456, Florida Statutes, the collection of Social Security Numbers is required by section 456.013 (1)(a), Florida Statutes.

HEALTH HISTORY:

[redacted]

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 for treatment of drug or alcohol abuse that occurred within the past five years?

In the last five years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental disorder or impairment?

During the last five years, have you been treated for or had a recurrence of a diagnosed mental disorder that has impaired your ability to practice medicine within the past five years?

During the last five years, have you been treated for or had a recurrence of a diagnosed physical disorder that has impaired your ability to practice medicine?

In the last five years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol/drug) disorder or, if you were previously in such a program, did you suffer a relapse within the last five years?

During the last five years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol/drug) disorder that has impaired your ability to practice medicine within the last five years?

- A "yes" answer to any of the above questions requires the following:
  - A self explanation providing accurate details (including, but not limited to, the date(s), location(s), specific circumstances, practitioners and/or treatment involved).
  - If you have been under treatment for emotional/mental illness, chemical dependency, etc., you must request that each practitioner, hospital, and program involved in your treatment submit a full, detailed report of such to the Board office, to include: treatment received, medications, and dates of treatment and, if applicable, all DSM III R/DSM IV/DSM IV-TR Axis I and II diagnosis(es) code(s), and admission and discharge summary(s).

EDUCATION / TRAINING:

Osteopathic Medical Education: List your osteopathic medical school and dates of attendance below.

College/University Name	Address	Attendance Dates (Month/Year)	
		Start	End
University of New England College of Osteopathic Medicine	11 Hills Beach Road Biddeford, ME 04005	09/1997	06/2001

- Provide the following documentation to support your osteopathic medical education: **official transcript** mailed directly from your osteopathic medical school to the Board office.

Postgraduate Training: List in chronological order from date of graduation from osteopathic medical school to the present all postgraduate training (Internship/Residency/Fellowship).

Training Program Name	City & State	Program Type (internship, residency, fellowship)	Specialty Area	AOA or ACGME Approved	Dates of Attendance		Credit Received Y or N
					Began	Ended	
Delaware County Memorial Hospital	Drexel Hill, PA	Internship	Traditional Rotating	AOA	06/2001	06/2002	Y
St. Francis Hospital	Hartford, CT	Residency	OB/GYN	AOA	07/2002	06/2006	Y

- Provide the following documentation to support your postgraduate training: **Postgraduate Training Evaluation Form** for each program completed or not completed (attached to application).

Loan History:

☐ Yes ☑ No Are you currently in default on any health education loan or scholarship obligation?

- A "yes" answer to the question above requires the following:
  - A self explanation on a separate sheet providing accurate details and
  - Documentation from the lender regarding your current repayment/default status

MILITARY HISTORY: Not Applicable

☐ Yes ☐ No Have you ever been in the United States Military or Public Health Service?

☐ Yes ☐ No Have charges ever been brought against you by any branch of the United States Military or Public Health Service?

- A "yes" answer to the above question requires the following:
  - A self explanation providing accurate details (including, but not limited to, the date(s), location(s), specific and circumstances)
  - Documentation from the military regarding the charges/event

LICENSURE HISTORY:

☑ Yes ☐ No Do you hold or have you ever held a license to practice osteopathic medicine or any other profession in any US State or territory, or foreign country? If yes, list below.

State or Country	License Number	Original Issue Date	Expiration Date	License Type
RI	DO00607	04/25/2006	06/30/2016	DO
PA	OT006951T	06/25/2001	06/23/2002	DO Training
GA	070197	06/07/2013	04/30/2019	DO
MA	251954	06/20/2012	04/17/2017	DO

*** See attached

- Provide the following documentation to support your licensure history: request **verification of licensure** status be sent directly to the Board office from the licensing entity or www.veridoc.org.

☐ Yes ☑ No Have you had any application for a license to practice any profession, including osteopathic medicine, denied by any state board or the licensing authority of any state territory or country?

☐ Yes ☑ No Are you currently under investigation in any jurisdiction for an act or offense that would constitute a violation of Section 459.015, Florida Statutes?

☐ Yes ☑ No Have you ever had any professional license or license to practice osteopathic medicine revoked, suspended, placed on probation, or other disciplinary action taken in any state, territory or country?

- A "yes" answer to any of the three questions above requires the following:
  - A self explanation on a separate sheet providing accurate details and
  - A copy of the administrative complaint/charging document, final order/document outlining sanctions, and proof of compliance with sanctions (if applicable)

PRACTICE / EMPLOYMENT HISTORY:

List the year you legally began to practice medicine: 2001 (may be the date you began postgraduate training)

☐ Yes ☑ No Has it been more than two years since you practiced osteopathic medicine in any jurisdiction? If yes, list the year you last practiced osteopathic medicine: _____

☑ Yes ☐ No Do you currently hold a **faculty appointment** at a medical school, or have you had responsibility for **graduate medical education** (GME) within the last 10 years? If yes, list below:

Name of School / Institution	Check Applicable Box(s):
Woman and Infants Hospital/ Brown University	☑ Is this a faculty appointment? ☑ Is this GME?
	[ ] Is this a faculty appointment? [ ] Is this GME?

- Faculty: Community Physician Teaching Residents

☑ Yes ☐ No Do you currently hold **staff privileges** in any hospital, health institution, clinic or medical facility? Do not include postgraduate training privileges. If yes, list below:

Name of Facility
Piedmont Hospital
Atlanta Minimally Invasive Gynecologic Surgery

Janet B. Lefkowitz, DO
1240 Heards Ferry Road
Atlanta, GA 30328

Licenses continued

State or Country	License Number	Issue Date	Expiration Date	License Type
OH	34.011269	03/25/2014	07/01/2018	DO
AL	DO.1651	08/24/2016	12/31/2018	DO
MS	24724	12/13/2016	06/30/2019	DO

For the three questions below, a "facility" is defined as a licensed hospital, health maintenance organization, pre-paid health clinic, ambulatory surgical center, or nursing home.

☐ Yes ☑ No Have you ever had any **staff privileges** denied, suspended, revoked, modified, restricted, or placed on probation, or have you been asked to resign or take a temporary leave of absence or otherwise acted against by any facility? If yes, list below

Name/Address of Facility	Action Date mm/dd/yy	Final Action	Under Appeal Y or N

☐ Yes ☑ No Have you ever had any **staff privileges** restricted or not renewed by any facility instead of disciplinary action? If yes, list below

Name/Address of Facility	Action Date mm/dd/yy	Final Action	Under Appeal Y or N

☐ Yes ☑ No Have you ever been asked, or allowed to resign, from any facility instead of disciplinary action or during any pending investigations into your practice? If yes, list below

Name/Address of Facility	Action Date mm/dd/yy	Final Action	Under Appeal Y or N

- A "yes" answer to any of the above three questions requires the following:
  - A self explanation on a separate sheet providing accurate details and
  - Supporting documents from the facility(s)

☑ Yes ☐ No Are you certified by any **specialty board** recognized by the AOA, ABMS, ABIPP, or AAPS? If yes, list below and provide verification of each certification.

Board Name	Certification / Specialty / Sub-Specialty	Certification Date
American Board of Obstetrics and Gynecology	OB/GYN	1/18/2013

☐ Yes ☑ No Have you ever had any final disciplinary action taken against you by a specialty board or other similar national organization?

☐ Yes ☑ No Have you ever been denied, or surrendered a DEA Registration?

☐ Yes ☑ No Have you ever been sanctioned by any state Medicaid program?

- A "yes" answer to any of the above questions requires the following:
  - A self explanation on a separate sheet providing accurate details and
  - Supporting documents from the applicable entity

MALPRACTICE / LIABILITY CLAIM HISTORY:

☐ Yes ☑ No Have you had a judgment entered against you for medical malpractice where the incident(s) of malpractice occurred after **November 2, 2004**?

☐ Yes ☑ No Within the last 10 years have you had any liability claims or actions for damages for personal injury settled or finally adjudicated in an amount that exceeds $100,000?

- A "yes" answer to either of the above two questions requires the following:
  - A self explanation listing your involvement in each case
  - Completed Exhibit 1 Form for each case (follows application)
  - A copy of the complaint and disposition for each case
  - **In addition to the above, for judgments occurring after November 2, 2004** the entire case record must be submitted in electronic format (either PDF or TIFF), preferably on a DVD (don not send originals). The record must include:
    - Initial and/or amended complaint
    - Trial transcripts
    - Evidentiary exhibits
    - Final judgment

CRIMINAL HISTORY:

☐ Yes ☑ No Have you ever been convicted of, or entered a plea of guilty, nolo contendre, 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 considered a minor traffic offense for purposes of this question.*

- A "yes" answer to the above question requires the following:
  - A self explanation listing accurate details (including dates, city/state, charges and final results)
  - Final disposition and arrest records for all offenses. The Clerk of the Court in the arresting jurisdiction will provide these documents. Unavailability of these documents must come in the form of a letter from the Clerk of the Court.
  - Completion of sentence documents. If unavailable with the Clerk of Courts, obtain from the Department of Corrections. The report must include the start date, end date and that the conditions were met.

ADDITIONAL CRIMINAL AND MEDICAID / MEDICARE FRAUD QUESTIONS:
Applicants for licensure, certification or registration and candidates for examination may be excluded from licensure, certification or registration if their felony conviction falls into certain timeframes as established in Section 456.0635(2), Florida Statutes.

1. ☐ Yes ☑ No Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, F.S. (relating to social and economic assistance), Chapter 817, F.S. (relating to fraudulent practices), Chapter 893, F.S. (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction? **(If you responded "no", skip to question 2.)**

a. ☐ Yes ☐ No If "yes" to 1, for the felonies of the first or second degree, has it been more than 15 years from the date of the plea, sentence and completion of any subsequent probation?

b. ☐ Yes ☐ No If "yes" to 1, for the felonies of the third degree, has it been more than 10 years from the date of the plea, sentence and completion of any subsequent probation? (This question does not apply to felonies of the third degree under Section 893.13(6)(a), Florida Statutes).

c. ☐ Yes ☐ No If "yes" to 1, for the felonies of the third degree under Section 893.13(6)(a), Florida Statutes, has it been more than 5 years from the date of the plea, sentence and completion of any subsequent probation?

d. ☐ Yes ☐ No If "yes" to 1, have you successfully completed a drug court program that resulted in the plea for the felony offense being withdrawn or the charges dismissed? (If "yes", please provide supporting documentation).

2. ☐ Yes ☑ No Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970 (relating to controlled substances) or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)? **(If you responded "no", skip to question 3.)**

a. ☐ Yes ☐ No If "yes" to 2, has it been more than 15 years before the date of application since the sentence and any subsequent period of probation for such conviction or plea ended?

3. ☐ Yes ☑ No Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes? **(If you responded "no", skip to question 4.)**

a. ☐ Yes ☐ No If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years?

4. ☐ Yes ☑ No **Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any** other state Medicaid program? **(If you responded "no", skip to question 5.)**

a. ☐ Yes ☐ No Have you been in good standing with a state Medicaid program for the most recent five years?

b. ☐ Yes ☐ No Did the termination occur at least 20 years before the date of this application?

5. ☐ Yes ☑ No Are you currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities?

- A "yes" answer to any of the above questions requires the following:
  - A self explanation for each providing accurate details (including the county and state of each termination or conviction, date of each termination or conviction)
  - Copies of supporting documentation (including court dispositions or agency orders where applicable)

FINANCIAL RESPONSIBILITY FILING FORM:

The Financial Responsibility options are divided into two categories: coverage and exemptions. Check only **one** of the ten options provided as required by s. 459.0085, Florida Statutes.

CATEGORY I: Financial Responsibility Coverage for Florida Practice Only

1. [ ] 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 FS, from a surplus lines insurer as defined under s. 626.914(2) FS, from a risk retention group as defined under s. 627.942 FS, from the Joint Underwriting Association established under s. 627.351(4) FS, or through a plan of self-insurance as provided in s. 627.357 FS.

2. [ ] I have hospital staff privileges and I have obtained and maintain 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 FS, from a surplus lines insurer as defined under s. 626.914(2) FS, from a risk retention group as defined under s. 627.942 FS, from the Joint Underwriting Association established under s. 627.351(4) FS, or through a plan of self-insurance as provided in s. 627.357 FS, or through a plan of self-insurance which meets the conditions specified for satisfying financial responsibility in s. 766.110 FS.

3. [ ] I do not have hospital staff privileges and I have obtained and maintain an unexpired, irrevocable letter of credit, established pursuant to chapter 675 FS, in an amount of not less than $100,000 per claim with a minimum aggregate availability of credit of not less than $300,000. The letter of credit shall be payable to the osteopathic physician as beneficiary upon presentment of a final judgment indicating liability and awarding damages to be paid by the osteopathic physician or upon presentment of a settlement agreement signed by all parties to such agreement when such final judgment or settlement is a result of a claim arising out of the rendering of, or the failure to render, medical care and services. Such letter of credit shall be nonassignable and nontransferable. Such letter of credit shall be issued by any bank or savings association organized and existing under the laws of this state or any bank or savings association organized under the laws of the United States that has its principal place of business in this state or has a branch office which is authorized under the laws of this state or of the United States to receive deposits in this state. **OR** I do not have hospital staff privileges and I have established and maintain an escrow account consisting of cash or assets eligible for deposit in accordance with s. 625.52 FS in the per-claim amounts specified above.

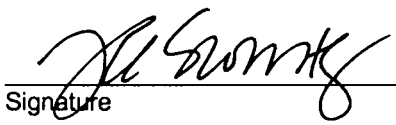
4. [ ] I have hospital staff privileges and I have obtained and maintain an unexpired, irrevocable letter of credit, established pursuant to chapter 675 FS, in an amount not less than $250,000 per claim, with a minimum aggregate availability of credit of not less than $750,000. The letter of credit shall be payable to the osteopathic physician as beneficiary upon presentment of a final judgment indicating liability and awarding damages to be paid by the osteopathic physician or upon presentment of a settlement agreement signed by all parties to such agreement when such final judgment or settlement is a result of a claim arising out of the rendering of, or the failure to render, medical care and services. Such letter of credit shall be nonassignable and nontransferable. Such letter of credit shall be issued by any bank or savings association organized and existing under the laws of this state or any bank or savings association organized under the laws of the United States that has its principal place of business in this state or has a branch office which is authorized under the laws of this state or of the United States to receive deposits in this state **OR** I have hospital staff privileges and I have established and maintain an escrow account consisting of cash or assets eligible for deposit in accordance with s. 625.52 FS in the per-claim amounts specified above.

5. [ ] I have decided not to carry malpractice insurance or otherwise demonstrate financial responsibility; however, I agree to satisfy any adverse judgments pursuant to the terms and conditions contained in s. 459.0085(5)(g), FS. I understand that I shall be required to either post notice in the form of a sign prominently displayed in the reception area and clearly noticeable by all patients or provide a written statement to any person to whom medical services are being provided. Such sign and statement shall state that: Under Florida law, osteopathic physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. YOUR OSTEOPATHIC PHYSICIAN HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This is permitted under Florida law subject to certain conditions. Florida law imposes strict penalties against noninsured osteopathic physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida law.

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 its subdivisions.
7. [ ] I hold a limited license issued pursuant to s. 459.0075, F.S., and practice only under the scope of such limited license.
8. [ ] I practice only in conjunction with my teaching duties at an college of osteopathic medicine. (Residents do not qualify for this exemption.)
9. [✓] I do not practice osteopathic medicine in the State of Florida. I will notify the department immediately before commencing practice in the state.
10. [ ] I am exempt from demonstrating financial responsibility due to meeting all of the following criteria** **See note below**:
    (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 1,000 patient contact hours per year.
    (c) I have had no more than 2 claims resulting in an indemnity exceeding $25,000 within the previous 5 year period.
    (d) I have not been convicted of, or pled nolo contendere to any criminal violation specified in s. 459, F.S., or the practice act of any other state.
    (e) I have not been subject, within the last 10 years of practice, to license revocation or suspension for any period of time, probation for a period of 3 years or longer, or a fine of $500 or more for a violation of s. 459, F.S., or the medical practice act of another jurisdiction. The regulatory agency's acceptance of an osteopathic physician's relinquishment of a license, stipulation, consent order, or other settlement, offered in response to or in anticipation of the filing of administrative charges against the osteopathic physician's license, shall be construed as action against the physician's license for the purposes of this section. I understand that I shall be required either to post notice in the form of a sign prominently displayed in the reception area and clearly noticeable by all patients or to provide a written statement to any person to whom medical services are being provided. Such sign or statement shall state that: Under Florida law, osteopathic physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. However, certain part-time osteopathic physicians who meet state requirements are exempt from the financial responsibility law. YOUR OSTEOPATHIC PHYSICIAN MEETS THESE REQUIREMENTS AND HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This notice is provided pursuant to Florida law.

**** If you select an exemption based on based on #10, you must also complete the affidavit on the following page.**



Signature

Janet B. Lefkowitz, DO
Printed Name

CONFIRMATION OF RECEIPT OF:

- **SHARING OF CRIMINAL HISTORY RECORD INFORMATION WITH SPECIFIED AGENCIES,**
- **RETENTION OF FINGERPRINTS,**
- **PRIVACY POLICY, AND**
- **RIGHT TO CHALLENGE AN INCORRECT CRIMINAL HISTORY RECORD**

Name: Janet B. Lefkowitz, DO

Profession: Osteopathic Physician Date of Birth: 04/17/1965 (MM/DD/YYYY)

Other last names: N/A

☑ Yes ☐ No I have been provided and read the statement from the Florida Department of Law Enforcement regarding the sharing, retention, privacy and right to challenge incorrect criminal history records and the "Privacy Statement" document from the Federal Bureau of Investigation.

STATEMENT OF APPLICANT

These statements are true and correct and I recognize that providing false information may result in disciplinary action against my license or criminal penalties pursuant to 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 Osteopathic Medicine any information which is material to my application for licensure.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare 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 Osteopathic 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, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it.

Signature:  Date: 7/27/18 (MM/DD/YYYY)

MEDICAL LICENSURE GROUP
4400 Bayou Blvd., Suite 32B
Pensacola, FL 32503
Tel: 850-433-4600

RELEASE AND AUTHORIZATION

I, Janet B. Lefkowitz, DO (the undersigned), have hired Medical Licensure Group, LLC ("MLG") to assist me in applying for a license to practice medicine in the United States.

To that end, I authorize all hospitals, clinics, medical institutions, medical societies, medical organizations, personal references, employers, specialty boards, business and/or professional colleagues, medical licensure boards, high school and university transcript offices, test score reporting centers, medical schools, malpractice insurance companies, attorneys that participated in any civil or criminal actions in which I was named a party that pertain to or directly affect my ability to obtain or retain a state medical license and/or practice medicine, to release to the state medical licensing board (and to MLG and MLG's agents) any information, files, or records requested by that state medical licensing board for its evaluation of my professional, educational, ethical, and physical qualifications for medical licensure.

I release the above-referenced individuals and entities from any and all liability for releasing information to the state medical licensing board (and to MLG and MLG's agents) as contemplated above.

A PHOTOCOPY OR FAX OF THIS RELEASE SHALL BE AS EFFECTIVE AS THE ORIGINAL.

Signature: _____ **Date:** 7/27/18

Janet B. Lefkowitz, DO
1240 Heards Ferry Road
Atlanta, GA 30328

July 16, 2018

State of Florida
Board of Osteopathic Medicine
PO Box 6330
Tallahassee, FL 32314

Dear State of Florida:

Enclosed are my application and supporting documents for medical licensure. I affirm that the information contained therein is complete and accurate. Requests for direct-source credentials verifications are in process.

I have engaged the services of Medical Licensure Group, LLC to assist with the licensure process and hereby authorize the State of Florida to release all correspondence relating to the processing of my application, including but not limiting acknowledgement letters, online login details, status reports, etc.

Please direct all inquiries and correspondence to my licensing specialist:

Medical Licensure Group
Attn: Jennifer Anderson
4400 Bayou Blvd., Suite 32B
Pensacola, FL 32503
Phone: 850.433.4600 ext. 106
Fax: 904.212.0886
janderson@medicallicensuregroup.com

Thank you for your consideration.

Cordially,

Janet B. Lefkowitz, DO

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Tallahassee, FL 32314

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