July 15, 2013

[redacted]

RE: Michael Israel Hertz; ME35436

Dear [redacted]:

The Central Records Unit, Division of Medical Quality Assurance, has received your request for public information regarding the above-referenced individual.

The department has no record of any past or pending public complaints against the above referenced individuals.

The mission of the Department of Health is to protect, promote & improve the health of all people in Florida through integrated state, county, & community efforts.

If you have any questions, please contact me at (850) 245-4191.

Sincerely,

Rickey Richardson

Rickey Richardson
Deputy Agency Clerk

XXX/xx
Enclosures

cc:

Florida HEALTH

Medical Quality Assurance (MQA) Services

License Verification

Practitioner Profile

License Verification

Data As Of **7/15/2013**

MICHAEL ISRAEL HERTZ

LICENSE NUMBER: **ME35436**

General Information | Secondary Locations | Practitioner Profile

Profession
MEDICAL DOCTOR

License/Activity Status
CLEAR/ACTIVE

Controlled Substance Prescriber
NO

License Expiration Date
1/31/2015

License Original Issue Date
10/11/1979

Discipline on File
NO

Public Complaint
NO

Address of Record
NOT PRACTICING IN FLORIDA

This practitioner has indicated that they are not currently practicing their profession in the State of Florida at this time. The practitioner may choose to begin practice at anytime provided that the license status is active. If the practitioner has resumed practice, the practitioner must update their practice location address. If you have any questions, please contact the department at 850-488-0595.

The information on this page is a secure, primary source for license verification provided by The Florida Department of Health, Division of Medical Quality Assurance. This website is maintained by Division staff and is updated immediately upon a change to our licensing and enforcement database.

AC# **COPY**

STATE OF FLORIDA
DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE

DATE	LICENSE NO.	CONTROL NO.
11/04/2008	ME 35436	258228

The **MEDICAL DOCTOR**
named below has met all requirements of
the laws and rules of the state of Florida.
Expiration Date: **JANUARY 31, 2011**

MICHAEL ISRAEL HERTZ
24450 EVERGREEN ROAD
STE 220
SOUTHFIELD, MI 48075
UNITED STATES

AC#
STATE OF FLORIDA
DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE

DATE	LICENSE NO.	CONTROL NO.
11/04/2008	ME 35436	258228

The **MEDICAL DOCTOR**
named below has met all requirements of

COPY - NOT A VALID LICENSE - COPY

LICENSEE SIGNATURE

COPY - NOT A VALID LICENSE - COPY

GOVERNOR STATE SURGEON GENERAL

DISPLAY IF REQUIRED BY LAW

EXPIRATION DATE: JANUARY 31, 2011

Your license number is **ME 35436**. please use it in all correspondence with your board/council. Each licensee is solely responsible for notifying the department in writing of the licensee's current mailing address and practice location address. If you have not received your renewal notice 90 days prior to the expiration date shown on this license, please call (850) 488-0595.

Use this section to report name change. Name changes require legal documentation showing the name change. Please make sure that a photocopy of one of the following accompanies this form: a marriage license, a divorce decree or a court order. **A driver's license or social security card is not considered legal documentation.**

Medical Quality Assurance offers you the convenience of several online services. These services give you the ability to renew your license, update your mailing and practice location addresses and update your profile information.

1. Go to **www.flhealthsource.com**
2. Click on Licensee/Provider
3. Click on Practitioner Login
4. Select your profession
5. Enter the account ID and password here **(Account ID and Password are case sensit**
6. Click on Login

MAIL TO: DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE
LICENSING AND AUDITING SERVICES UNIT
P.O. BOX 6320
TALLAHASSEE, FLORIDA 32314-6320

☐ NAME CHANGE (ATTACH LEGAL DOCUMENTATION)

FROM: _____ _____ _____
LAST FIRST MIDDLE

TO: _____ _____ _____
LAST FIRST MIDDLE

DH 2103, 5/98

DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE
LICENSING AND AUDITING SERVICES UNIT
4052 BALD CYPRESS WAY, BIN #C-10
TALLAHASSEE, FLORIDA 32399-3260

MICHAEL ISRAEL HERTZ
3976 DEER GLEN DRIVE
ANN ARBOR, MI 48108
UNITED STATES

35436

PHYSICIANS PROTECTIVE TRUST FUND

2121 Ponce de Leon Boulevard, P.O. Box 149001, Coral Gables, FL 33114
Tel: (305) 442-8119 • 1-(800) 222-5115 Claims: (305) 442-4001 • 1-(800) 222-6008

September 19, 1996

RECEIVED
SEP 2 5 1996

DEPARTMENT OF BUSINESS AND
PROFESSIONAL REGULATION
1940 NORTH MONROE STREET
TALLAHASSEE FL 32301

Gentlemen:

In accordance with Florida Statute 458.320, this is to notify you that professional liability coverage with Physicians Protective Trust Fund for the physician named below has terminated on the date shown below.

Name	Florida License #	Coverage ended 12:01 A.M.
Michael I. Hertz, M.D.	0035436	09/01/96

Sincerely,

PHYSICIANS PROTECTIVE TRUST FUND

Jennifer W. Rossignol

Jennifer W. Rossignol
Underwriter

JWR/cf

CoreSTAT

1501
27401

Practitioner Participation Agreement

CoreSTAT is the Florida Department of Health's comprehensive database containing your core credentialing data CoreSTAT is a program for allopathic, osteopathic, chiropractic, and podiatric practitioners—and the healthcare organizations that credential them—s.456.047, Florida Statutes, *Standardized credentialing for health care practitioners*.

This form is required to be on file with the Florida Department of Health's Division of Medical Quality Assurance, Bureau of Operations **before** you can grant access to subscribers to view your credentialing data, or to designate an agent, such as a credentials verification organization (CVO) or a health care entity (HCE), to access and update your credentialing data. **Once the Department has your form, you may go into CoreSTAT and grant access to those organizations with whom you are or are planning to be credentialed.**

Please complete, sign, and fax this form to (850) 921-8149, or mail your completed and signed form to

Florida Department of Health
Division of Medical Quality Assurance
4052 Bald Cypress Way, Bin #C-80
Tallahassee, FL 32399-3260

If you have any questions about CoreSTAT or this form, please contact us at 850-410-3359 (press 4) or email us at: credentialing@doh.state.fl.us.

I acknowledge my participation in CoreSTAT

Michael T. Hertz — Print Name (First, Middle, Last)

0035436 — Florida License Number(s)

Michael T. Hertz 3rd — Signature

10/30/2001 — Date

Please grant authorization to the healthcare entities listed below:

Beacon Healthcare Group — Healthcare Entity Name

PPOM — Healthcare Entity Name

IBA/PAP Insurance — Healthcare Entity Name

Healthcare Entity Name

Blue Cross/Blue Shield of Michigan — Healthcare Entity Name

Healthcare Entity Name

NAME:

DATE:

CAMERA: II

ROLL #:

35436

MICHAEL I. HERTZ
22120 FAIRWAY DR.
SOUTHFIELD, MICH. 48034

777

19 October 1980

PAY TO THE ORDER OF Michigan Dept of Professional Registration $ 100.00

One Hundred and 00/100 DOLLARS

Michigan National Bank-Oakland
25800 LAHSER ROAD
16 SOUTHFIELD, MICHIGAN 48037

#35436 renewal

Michael I. Hertz MD

( ) 352-0023

NAME:

DATE:

CAMERA: II

ROLL #:

35436

Letter of Certi
Hertz, Michael S
35436
10-11-79

5700 Camino Del Sol
#107
Boca Raton, FL 33433

Roll 23
DATE

SEPTEMBER

DEPARTMENT OF PROFESSIONAL AND OCCUPATIONAL REGULATION
STATE BOARD OF MEDICAL EXAMINERS OF FLORIDA
OAKLAND BUILDING, SUITE 320
2009 APALACHEE PARKWAY
TALLAHASSEE, FLORIDA 32301

TO: MICHAEL ISRAEL HERTZ, M.D.
22120 Fairway Drive
Southfield, Michigan 48034

August 16, 1979

FROM: *GEORGE S. PALMER, M.D. Executive Director*

Your application has been received but is incomplete for failure to submit:

- ☐ copy of medical school diploma
- ☐ certified translation of medical school diploma
- ☐ $50.00 examination fee
- ☐ $100.00 endorsement fee
- ☐ copy of standard ECFMG certificate
- ☒ evidence of 1 year AMA approved internship or residency, or in lieu thereof, licensure and 5 years practice in country or state in which licensed
- ☐ certified copy of FLEX grades or National Board Certificate of Endorsement
- ☐ separation from service form
- ☐ second photograph
- ☐ proof of licensure through WRITTEN examination
- ☐ proof that said license is in good standing
- ☐ proof of practicing 4 of the 5 years immediately preceding the filing of the application
- ☐ proof of certification by one of the American Specialty Boards accredited by the American Medical Association
- ☐ Naturalization papers. Formal Declaration of intention or notarized declaration of intention to become a citizen of the United States
- ☐ proof of legal change of name (court order or marriage certificate)
- ☐ letters of recommendation
- ☐ verification of medical society membership
- ☐ accounting for ALL of the following time

OTHER:

No application will be considered complete and officially filed until all requested information has been received in the Board office.

Roll 33
DATE 8.1.79

SINAI HOSPITAL of DETROIT

6767 WEST OUTER DRIVE • DETROIT, MICHIGAN 48235 • 313 / 493-

August 22, 1979

Department of Professional & Occupational Regulations
State Board of Medical Examiners of Florida
Oakland Building - Suite 220
2009 Apalachee Parkway
Tallahassee, FL 32201

To Whom it May Concern:

This letter is written to certify that Michael I. Hertz, M.D. has completed a one-year AMA approved internship in Obstetrics/Gynecology, March 15, 1976 to March 14, 1977.

Doctor Hertz is still under contract to Sinai Hospital of Detroit, serving as a PG/4 resident in Obstetrics/Gynecology. His training program will be completed March 14, 1980.

Sydney E. Peimer
Senior Vice President/Medical Affairs

mvv

Roll
DATE

PLEASE PRINT OR TYPE

SEPT. 1979

NAME: Michael Israel Hertz, M.D.

ADDRESS: 22120 Fairway Drive
Southfield, Michigan 48034

DEC 1 11 08 AM '79

Roll [illegible]
DATE [illegible]

SEPTEMBER

DEPARTMENT OF PROFESSIONAL AND OCCUPATIONAL REGULATION
STATE BOARD OF MEDICAL EXAMINERS OF FLORIDA
OAKLAND BUILDING, SUITE 220
2009 APALACHEE PARKWAY
TALLAHASSEE, FLORIDA 32301

June 8, 1979

TO: **Drug Enforcement Administration**
1405 I Street, N.W.
Washington, D.C. 20537

FROM: George S. Palmer, M.D.
Executive Director

APPLICANT'S NAME: Michael Israel Hertz

DATE OF BIRTH: Nov. 10, 1949

PLACE OF BIRTH: Highland Park, MI

PRESENT ADDRESS: 22120 Fairway Drive Southfield, MI 48034

FORMER ADDRESS:

The subject has applied for medical licensure in Florida *and has filed with this Board a document releasing all persons from responsibility in connection with answering this inquiry.*

Will you please furnish us with a record of any and all arrests, investigations, or complaints, and reasons therefore, involving this physician?

Thank you for your cooperation.

REPLY:

DRUG [illegible] [illegible]
S.W. 7/2/79

Roll
DATE

Certificate

№ 035436

Issued to

Michael Israel Nertz m.D.

Dated 10-9 19 79

State of Florida

Department of Professional Regulation

Board of Medical Examiners

№ 035436

This Certifies that

Michael Israel Nertz m.D.

has fulfilled the requirements of Chapter 458, Florida Statutes, governing the practice of medicine and is hereby certified to practice

Medicine

in the State of Florida.

In Witness Whereof, we have hereunto subscribed our names and affixed the Seal of the Board of Medical Examiners this 9th day of October A.D., 19 79

Robert Hallenius M.D. Chairman

Vice Chairman

Governor of Florida

Roll 23

DATE 2/12/83

SEPTEMBER

DEPARTMENT OF PROFFESSIONAL AND OCCUPATIONAL REGULATION
STATE BOARD OF MEDICAL EXAMINERS OF FLORIDA
OAKLAND BUILDING, SUITE 220
2009 Apalachee Parkway
TALLAHASSEE, FLORIDA 32301
(904) 488-7614

TO: SINAI HOSPITAL OF DETROIT
Detroit, Michigan

August 29, 1979

FROM: George S. Palmer, M.D., Executive Director

Please complete the form below and return it to this office at your earliest convenience. This doctor has made application for medical licensure in Florida and is under investigation by this authority.

1. Name MICHAEL ISRAEL HERTZ, M.D.

2. Internship ____ Residency X From 3-15-77 To PRESENT

3. Professional Character (compared to physician of similar experience)

	POOR	FAIR	GOOD	SUPERIOR	DON'T KNOW
a. Basic Medical Knowledge				X	
b. Diagnostic and Clinical Ability				X	
c. Teaching Ability				X	
d. Research Potential				X	
e. Fitness for Clinical Practice				X	

4. Personal Character:

a. Motivation				X	
b. Initiative				X	
c. Responsibility				X	
d. Integrity				X	
e. Appearance				X	
f. Knowledge of English				X	

5. Relationships:

a. Teaching Staff				X	
b. Colleagues				X	
c. Nursing Staff				X	
d. Patients				X	

6. Physical Handicaps:

Comment: ____

7. PERSONALITY PROBLEMS WHICH MIGHT AFFECT PERFORMANCE:

Comment: ____

8. Overall Evaluation:

X 1. Recommend as outstanding applicant.
___ 2. Recommend as qualified and competent.
___ 3. Recommend with some reservations.
___ 4. Cannot Recommend.

Signed: Norma G. Silver
(Mrs). Norma G. Silver
Position: Associate Administrator

9. Use back of page for additional information or comment.

Roll 23
DATE 4/10/79

Wayne State University

Upon the recommendation of

The Faculty of the School of Medicine

the Board of Governors hereby confers upon

Michael J. Hertz

the degree

Doctor of Medicine

in recognition of the achievements
specified for this degree

May 23, 1979
Detroit, Michigan

Gregg B. Emerson Jr.
President of the University

Robert S. Hubbard
Secretary, Board of Governors

This will certify that this is a true copy of the original
and was presented to me this 24th day of April, 1979

VIRGINIA L. HERRERA
Notary Public, Wayne County, M
My Comm. Expires May 23, 19

Notary Public

Roll 33
DATE 4/30/79

DEPARTMENT OF PROFESSIONAL AND OCCUPATIONAL REGULATION
STATE BOARD OF MEDICAL EXAMINERS OF FLORIDA

ENDORSEMENT APPLICATION

RECEIVED
APR 27 1979
BOARD OF
MEDICAL EXAMINERS

Fee of $100.00 must accompany application. NO FEE REFUNDED.

Answer all questions. If the answer to any question is YES, give details in a notarized affidavit attached to the application. National Boards

On the basis of certification by the National Board of Medical Examiners _X_ Federation Licensure Examination (FLEX) ___ I hereby, apply for licensure to practice medicine and surgery in Florida, and in support of this submit the following information.

Name in full Michael Israel Hertz, M.D.
(Type or print. Use no initials.)

List all other names you have used. —

Have you ever legally changed your name? no If so, enclose certified copy of legal document giving change.

Residence address (at time of filing application) 22120 Fairway Drive Southfield, MI. 48034

Office address Dept. Ob/Gyn Sinai Hospital of Detroit 6767 W. Outer Drive Detroit, MI. 48235

Permanent address (if different from above) —

Intended residence —
(Print street and number, city, state, zip code)

Place of birth Highland Park, Michigan Date of birth 11-10-49

Are you a citizen of the United States? yes (If foreign born attach proof of citizenship or declaration of intention.)

Did you attend a college or university? University of Michigan Aug., 1967-Aug., 1971 Ann Arbor, Michigan
(Give name, location and dates)

Do you have any degree other than M.D.? B.A. (from above)
(Degree, date, school)

MEDICAL EDUCATION: Be specific. Account for each year.

Wayne State University Detroit, M.i from September 1972 to June 1973
(Name of medical school, location)

Wayne State University Detroit, MI. from September 1973 to June 1974
(Name of medical school, location)

Wayne State University Detroit, MI. from July 1974 to June 1975
(Name of medical school, location)

Wayne State University Detroit, MI. from July 1975 to May 1976
(Name of medical school, location)

Degree of Doctor of Medicine was obtained from Wayne State University School Of Medicine
(Name of medical school, location)

Detroit, Michigan on 23 May 1976

CERTIFICATE OF MEDICAL EDUCATION (Applicant must submit certified copy of medical diploma. Documents written in language other than English must be accompanied by a notarized translation.)

Roll 23
DATE 2/20/03

ACCOUNT FOR ALL TIME FROM DATE OF GRADUATION TO PRESENT

Training: List chronologically residency or other post-graduate training. Give name and address of hospitals, exact dates, and specify type of training. If currently in training give name of department chief.

Internship, Straight Ob/Gyn Sinai Hospital of Detroit Detroit, MI. March 15, 1976-March 14, 1977

Residency, Ob/Gyn Sinai Hospital of Detroit Detroit, MI. March 15, 1977-present

(Completion date of residency: March 14, 1980)

List chronologically locations practiced and/or employed. Give addresses, dates, specify type of practice and/or employment.

Oakland County Department of Health/Family Planning Clinic
1200 N. Telegraph Pontiac, Michigan 48053
July, 1977-present; family planning clinic

List hospitals where you have staff privileges (Give addresses, dates of service, chief of staff.)

none

Have you ever been denied staff privileges in any hospital? no

MILITARY SERVICE: (Attach copy of separation report.) none

(Branch of service, rank, dates)

FOREIGN GRADUATES: ECFMG Standard Certificate No. _____ **issued** _____ **after passing examination. (Attach notarized copy of certificate.)**

In what states are you licensed? List states giving license number and date of issuance.

Michigan #37973 issued 21 June, 1977

Have you ever studied to become, or do you hold a license in any state as a chiropractor, naturopath or osteopath? no

Have you ever a state board, FLEX or National Board examination?

Have you ever been denied an application for a license to practice medicine by any state board or other governmental agency of any state or country? no

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 of violation of the medical practice act, unprofessional or unethical conduct? no

Have you ever had a license to practice medicine and surgery revoked, suspended, or other disciplinary action taken in any state, territory, or country? no

Roll
DATE

Are you certified by an American Specialty Board? no If yes, give name of Board
(Enclose copy of Board certificate or letter verifying eligibility.)

Have you ever been convicted of a felony? no A misdemeanor? no Have any judgments ever been entered against you? no Have you ever been sued for malpractice?

Have you ever had to discontinue practice for any reason for a period of one month or longer? no

Are you now or have you ever been addicted to or excessively used alcohol, narcotics, barbiturates, or any other medication?

Are you now or have you ever been emotionally or mentally ill? Have you ever received psychotherapy?

Have you ever voluntarily or otherwise been a patient in an institution for the treatment of mental or emotional illness, drug addiction or abuse, or excessive use of alcohol?

Have you ever been treated but not hospitalized?

If any of these questions are answered yes, give details including dates, names of and addresses of hospitals and treating physicians on sworn affidavit.

Have you ever been warned or called before the Bureau of Narcotics and Dangerous Drugs? no Have you ever made an offer to compromise in connection with the Harrison Narcotic Law? no Have you ever been denied or surrendered a narcotic tax stamp? no

LIST MEDICAL SOCIETY AFFILIATIONS: State, county, national including dates and complete address (street, city, state).

American Medical Association 535 N. Dearborn St. Chicago, ILL. 60610

American College of Obstetricians/Gynecologists-Junior Fellow:December31,1977
One East Wacker Drive Chicago, Illinois 60601

Has any application for medical society membership been rejected? no

Have you ever been notified to appear before a medical society in regard to charges or complaints filed against you?
no

List civic organizations of which you are or have been a member.

FLEX Certification: (Applicant must have weighted average of or above on one complete writing of the examination to be eligible for consideration.)
Applicant is responsible for contacting FLEX and having a certified transcript of FLEX grades sent to the Florida Board. The address is: FLEX c/o The Federation of State Medical Boards, 1612 Summit Avenue, Suite 308, Fort Worth, Texas 76102.

CERTIFICATE OF NATIONAL BOARD OF MEDICAL EXAMINERS: Applicant is responsible for contacting the National Boards and having a certified copy of grades and certificate number sent to the Florida Board. The address is: National Board of Medical Examiners, 3930 Chestnut Street, Philadelphia, Pa. 19104.

Roll [illegible]

DATE [illegible]

RECOMMENDATIONS: Give the names and complete addresses of two physicians in each city where you have practiced. If in training or employed give names and addresses of physicians with whom you have worked.

Dr. Milton H. Goldroth Chairman Dept. Ob/Gyn Sinai Hospital of Detroit 6767 W. Outer Dr. Detroit, Mi. 48235

Dr. Alfred I. Sherman Dept. Ob/Gyn Sinai Hospital of Detroit 6767 W. Outer Dr. Detroit, Mi. 48235

AFFIDAVIT OF APPLICANT:

I, Michael I. Hertz, M.D., being first duly sworn, depose and say that I am the person referred to in the foregoing application and supporting documents and that the attached photograph is a true likeness of myself.

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Florida State Board of Medical Examiners any information, files or records requested by the Board in connection with the processing of this application. I further authorize the Florida State Board of Medical Examiners to release to the organizations, individuals and groups listed above any information which is material to my application.

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 the denial, suspension or revocation of my license to practice medicine and surgery in the State of Florida.

Michael I. Hertz M.D.
(Signature of Applicant)

COUNTY OF Oakland

STATE OF Michigan

Subscribed and sworn to before me this 24th day of April, 19 79.

Virginia L. Herrema
(Notary Public) VIRGINIA L. HERREMA
Notary Public, Wayne County, Mich.
My Comm. Expires May 23, 1981

My Commission Expires

(NOTARY SEAL)

TO BE COMPLETED BY APPLICANT

Date 5 March, 1979

Age 29

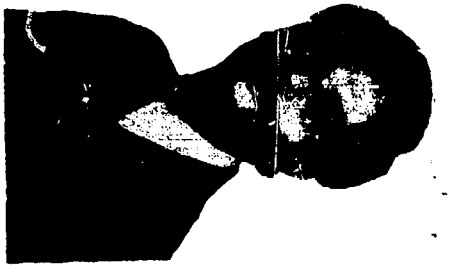
Height 5'6" Weight 140#

Color of Eyes Brown

Color of Hair Black

Other means of identification

79-00798 JJ - $100



FOR USE OF SECRETARY ONLY

Oral Examination: Yes ____ No ____

Date

Approved ____ Disapproved ____

License Number 35436

Date Issued 10-9-79

Michael Israel Hertz
Name as it appears on license.

Roll
DATE

SINAI HOSPITAL of DETROIT

6767 WEST OUTER DRIVE • DETROIT, MICHIGAN 48235 • [redacted]

493-5220

DEPARTMENT OF OBSTETRICS AND GYNECOLOGY
MILTON H. GOLDRATH, Chairman

March 12, 1979

State of Florida
Board of Medical Examiners
Oakland Building, #220
2009 Apalachee Parkway
Tallahassee, Florida 32301

RE: Michael I. Hertz, M.D.

Gentlemen:

I am writing to support the application of Dr. Michael I. Hertz for licensure to practice medicine in the State of Florida.

Dr. Hertz has been a resident on the Obstetrics/Gynecology Service for the last four years and prior to this time was a student while enrolled at Wayne State University School of Medicine. He is an exceptionally bright young man; very capable; uses extremely good judgement and is careful in his evaluation of patients.

In addition, Dr. Hertz possesses a very pleasing personality and enjoys an excellent rapport with all of his colleagues, students, nurses and administration.

I have no hesitancy whatsoever in recommending Dr. Hertz for State licensure.

Sincerely,

M. H. Goldrath

Milton H. Goldrath, M.D.

/ces

Roll 73
DATE 2/1/79

SINAI HOSPITAL of DETROIT

6767 WEST OUTER DRIVE • DETROIT, MICHIGAN 48235 • 313 / 493-5220
DEPARTMENT OF OBSTETRICS AND GYNECOLOGY
ALFRED I. SHERMAN, Director Research and Education

March 13, 1979

State of Florida
Board of Medical Examiners
Oakland Building, 0220
2009 Apalachee Parkway
Tallahassee, Florida 32301

RE: Michael I. Hertz, M.D.

Gentlemen:

Please consider this letter a recommendation on behalf of Dr. Michael I. Hertz for licensure to practice medicine in the State of Florida.

For the past four years, Dr. Hertz has been a resident in the Department of Obstetrics/Gynecology and prior to that was a senior student with our department from Wayne State University School of Medicine.

During all this time, Dr. Hertz has proven himself to be a very conscientious and dedicated physician in his chosen field of obstetrics and gynecology. His knowledge and expertise are far reaching in the treatment and evaluation of his patients. He is a well-qualified physician who uses good judgement; his relationship with his peers, students and administration is very commendable.

Sincerely,

Alfred I. Sherman, M.D., F.A.C.O.G.

/ces

Roll 23
DATE 8/30/85

ML 0035430 (7/9/849) (6203)
HERTZ, MICHAEL ISRAEL
22120 FAIRWAY DRIVE
SOUTHFIELD MI 48034

NAME: [illegible] DATE: 1-7

CAMERA: II ROLL #: #35436

Michael I. Herty, M.D.
5700 Camino Del Sol, #107
Boca Raton, Fl. 33433

address change
received 1/22/81

NAME: SHAPIRO DATE: 8/27/82

CAMERA II ROLL # 2 of 2

35436

Department of Professional Regulation

Governor
Bob Graham
Secretary
Samuel R. Shorstein

Board of Medical Examiners
130 N. Monroe Street, Tallahassee, Florida
(904) 488-0595

August 27, 1982

Michael I. Hertz, M.D.
5458 Town Center Road, # 5
Boca Raton, Florida 33432

Dear Doctor:

This letter is being written for your records in regard to your licensure in the State of Florida by endorsement.

In that you have furnished the Florida State Board of Medical Examiners with acceptable documentation that you have actively engaged in the practice of medicine in this state within three years after the issuance of your license by endorsement and continued to practice medicine in this state for the minimum period of one year, your license to practice medicine in Florida may now be deemed as permanent and subject only to those requirements pertaining to all duly licensed physicians in this state.

Sincerely,

Dorothy J. Faircloth
Executive Director

...bfc

NAME: [illegible] DATE: [illegible]

CAMERA II ROLL # [illegible]

35436

PALM BEACH COUNTY MEDICAL SOCIETY, INC.

6010 S. DIXIE/P.O. BOX 6786/WEST PALM BEACH, FLORIDA 33405/TEL. 305 – 582-4116

RECEIVED
AUG 19 4 52 AM '82
DEPARTMENT OF
PROFESSIONAL REGULATION

August 16, 1982 RECEIVED AUG 19 1982

To Whom It May Concern:

This letter is to certify that Michael I. Hertz, M.D., is a member with the Palm Beach County Medical Society in good standing. He has been a member with the society since August 1981. He was licensed in 1979 by the state of Florida. Dr. Hertz medical school was Wayne State University, which he graduated from in 1976. His office is located at 5458 Town Center Road, Boca Raton Florida.

If you need any further inforamtion, please do not hesitate to contact our office.

Sincerely,

Debra Taylor

Debra Taylor
Secretary

NAME: SHARON DATE: 8/20/82

CAMERA II ROLL # 2 of 2

35436

An Affiliate Of
Humana

600 South West Third Street
Pompano Beach, Florida
33060
305/782-2000

Cypress Community Hospital

August 17, 1982

RECEIVED AUG 2 0 1982

Department of Professional &
Occupational Regulation
Florida State Board of Medical Examiners
ATTN: Ms. Betty Blaine
130 N. Monroe Street
Tallahassee, FL 32301

Gentlemen:

We have been asked by Michael I. Hertz, M.D. to verify his affiliation with our facility.

Our records indicate that Dr. Hertz has been a member in good standing of the Medical Staff of Cypress Community Hospital from July, 1981 to the present, with privileges in Gynecology.

Should you require additional information, please feel free to contact me.

Sincerely,

C. J. Price
Executive Director

CJP/ais

NAME: [illegible] DATE: [illegible]

CAMERA II ROLL #

Department of Professional Regulation

Governor
Bob Graham

Secretary
Nancy Kelley Wittenberg

Board of Medical Examiners
130 N. Monroe Street- Tallahassee, Florida 32301
(904) 488-0595

AUG 13 882

TO: PF 0035436 (82/2471)
FEFT2, MICHAEL ISRAEL (1)
5458 TCBA CTR PC #5
BOCA RATON FL 33432

FROM: Dorothy J. Faircloth
Executive Director

SUBJECT: Medical License:
Issued:

Pursuant to Section 458.313, Florida Statutes, a license obtained by endorsement in this State shall become void and of no force and effect unless the recipient utilizes the same by actively engaging in the practice of medicine in the State of Florida within three (3) years after the issuance of the license and continues such practice in this State for a minium period of (1) one year. This practice requirement may be postponed only if and while the holder of an endorsement license is in the active military service of the United States or in an AMA approved training program.

The records of this office indicate that you were licensed by endorsement OCT 0 1979.

A current check of your license file has failed to disclose any information which would substantiate your compliance with the above cited section of the Florida Statutes. Therefore, in order to avoid the cancellation of your license by endorsement it will be necessary for you to submit proper documentation in affidavit form or properly certified to the effect that you have actively engaged in the practice of medicine in this State within the three (3) year period after issuance of your license by endorsement and that you have continued such practice in Florida for a minimum period of one (1) year.

If establishment of practice has been postponed because of training or military service it will be necessary for you to submit proper documentation in affidavit form or properly certified to the effect that you were in the armed services or in an approved training program at the time of receiving your license until (give date of discharge or termination of program).

In order to avoid the automatic cancellation of your license as contemplated by Section 458.313, Florida Statutes, such information and documentation as noted above should be provided this Board no later than sixty (60) days from the date of this letter.

NAME: [illegible] ROLL: 1X4
CAMERA: I DATE: 11-02-83

#35436

MICHAEL I. HERTZ, M.D., P.A.
GYNECOLOGY AND OBSTETRICS

7301 W. PALMETTO PARK ROAD
SUITE A-103
BOCA RATON, FLORIDA 33433
305/368-3774

RE [illegible]

29 July, 1982

State of Florida Dept. of Professional Regulation
Board of Medical Examiners
130 North Monroe Street
Tallahassee, Florida 32301

RE: Medical License Number:
035436

Dear Sir:

Please be advised that as of this date I am relocating my practice to the above address in Boca Raton, Florida.

Please send all correspondance to this address in the future, so that I will be able to maintain current licensure in Florida.

I thank you for your cooperation in this matter.

Sincerely yours,

Michael I. Hertz, M.D.

ADDRESS CHANGED ON MEDICAL FILES

8-9-83 N

NAME:

CAMERA:

ROLL:

DATE: 12-3-82

#35436

Henry Ford Hospital
Caring for People
Concern for Education
Commitment to Research

HENRY FORD HOSPITAL
FAIRLANE
CENTER

RECEIVED
DEC 3 2 08 PM '82
DEPARTMENT OF
PROFESSIONAL REGULATION

19401 Hubbard Drive
Dearborn, Michigan 48126
(313) 593-8100

RECEIVED DEC 3 1982

November 29, 1982

State of Florida Dept. of Professional Regulation
Board of Medical Examiners
130 North Monroe St.
Tallahassee, Florida 32301

RE: Medical License Number:
035436

Dear Sir:

Please be advised that as of December 1, 1982 I am relocating my practice to Henry Ford Hospital - Fairlane Center, 19401 Hubbard Drive, Dept. of Gynecology, Dearborn, Michigan 48126.

Please send all correspondance in the future to this address, so that I will be able to maintain current licensure in Florida.

I thank you for your cooperation in this matter.

Sincerely yours,

Michael E. Hertz M.D.

Michael E. Hertz, M.D.
Department of Gynecology
Fairlane Center

MEH:sak

ADDRESS CHANGED ON MEDICAL FILES

12-17-82 KT

CAMERA III OPERATOR: DATE: ROLL #

Michael I. Hertz, M.D., P.A.

RECEIVED
JUL 12 1988
MEDICAL/NATUROPATH

July 07, 1988

Board of Medical Examiners
130 North Monroe Street
Tallahassee, Fl. 32399-0750

Re: Address Change

Dear Sirs,

Please make note that I have changed the location of my office and no longer practice at the Palmetto Park Road address or the Military Trail address. Please correct you records to show that the address on my license, #ME0035436, Control #136703 should be as follows:

Michael I. Hertz, M.D., P.A.
9980 Central Park Blvd., North
Suite 318
Boca Raton, Fl. 33428

If there should be any further questions, please contact me at the above address.

Sincerely,

Michael I. Hertz, M.D., P.A.

MIH/cyb

AC# **COPY**

STATE OF FLORIDA
DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE

DATE	LICENSE NO.	CONTROL NO.
11/02/2004	ME 35436	138768

The **MEDICAL DOCTOR**
named below has met all requirements of
the laws and rules of the state of Florida.
Expiration Date: **JANUARY 31, 2007**

MICHAEL ISRAEL HERTZ
13322 N. BOULEVARD
SUITE A
VICKSBURG, MI 49097

AC# COPY
STATE OF FLORIDA
DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE
LICENSE NO. ME 35436
CONTROL NO. 138768
DATE 11/02/2004
The MEDICAL DOCTOR named below has met all requirements of the laws and rules of the state of Florida.
COPY - NOT A VALID LICENSE - COPY
LICENSEE SIGNATURE

COPY - NOT A VALID LICENSE - COPY

DISPLAY AS REQUIRED BY LAW

EXPIRATION DATE: JANUARY 31, 2007

Your license number is **ME 35436**, please use it in all correspondence with your board/council. Each licensee is solely responsible for notifying the department in writing of the licensee's current mailing address and practice location address. Use this section to report name and/or practice location address and/or mailing address changes. If you have not received your renewal notice 90 days prior to the expiration date shown on this license, please call (850) 488-0595.

Name changes require legal documentation showing the name change. Please make sure that a photocopy of one of the following accompanies this form: a marriage license, a divorce decree or a court order. **A driver's license or social security card is not considered legal documentation.**

Medical Quality Assurance offers you the convenience of several online services. These services give you the ability to renew your license, update your mailing and practice location addresses and update your profile information.

1. Go to **www.DOH-MQAServices.com**
2. Choose one of the licensee services
3. Select your profession
4. Enter the account ID and password here **(Account ID and Password are case sensitive**

To request a duplicate license, submit this form and a check or money order, payable to the **DEPARTMENT OF HEALTH**, in the amount of **$25.00**.

MAIL TO: **DEPARTMENT OF HEALTH**
DIVISION OF MEDICAL QUALITY ASSURANCE
LICENSURE SERVICES
P.O. BOX 6320
TALLAHASSEE, FLORIDA 32314-6320

☐ **NAME CHANGE (ATTACH LEGAL DOCUMENTATION)**

FROM: _____
LAST FIRST MIDDLE

TO _____
LAST FIRST MIDDLE

DH 2103, 5/98

☐ **PRACTICE LOCATION ADDRESS CHANGE**
(This address will be printed on your license and posted on the Internet.)

_____

_____

CITY STATE ZIP

☐ **MAILING ADDRESS CHANGE**
(This address will be used when mailing your license and for all other correspondance from the Department.)

_____

_____

CITY STATE ZIP

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

MICHAEL ISRAEL HERTZ
13322 N. BOULEVARD
SUITE A
VICKSBURG, MI 49097

AC# **COPY**

STATE OF FLORIDA
DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE

DATE	LICENSE NO.	CONTROL NO.
12/08/2001	ME 35436	66709

THE **MEDICAL DOCTOR**
NAMED BELOW HAS MET ALL REQUIREMENTS OF
THE LAWS AND RULES OF THE STATE OF FLORIDA.
EXPIRATION DATE: **JANUARY 31, 2005**
MICHAEL ISRAEL HERTZ
505 HAZEN STREET
#204
PAW PAW, MI 49079

STATE OF FLORIDA
DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE
AC#
DATE 12/08/2001 | LICENSE NO. ME 35436 | CONTROL NO. 66709
THE MEDICAL DOCTOR
NAMED BELOW HAS MET ALL REQUIREMENTS OF
THE LAWS AND RULES OF THE STATE OF FLORIDA.
EXPIRATION DATE: JANUARY 31, 2005
MICHAEL ISRAEL HERTZ
COPY - NOT A VALID LICENSE - COPY

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

COPY - NOT A VALID LICENSE - COPY

EXPIRATION DATE: **JANUARY 31, 2005**

YOUR LICENSE NUMBER IS **ME 35436** ,PLEASE USE IT IN ALL CORRESPONDENCE WITH YOUR BOARD/COUNCIL. EACH LICENSEE IS SOLELY RESPONSIBLE FOR NOTIFYING THE DEPARTMENT IN WRITING OF THE LICENSEE'S CURRENT MAILING ADDRESS. USE THIS SECTION TO REPORT NAME AND/OR MAILING ADDRESS CHANGES.

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

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

☐ REQUEST DUPLICATE LICENSE

_____
SIGNATURE REQUIRED

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

☐ NAME CHANGE (ATTACH LEGAL DOCUMENTATION)

FROM: _____
LAST FIRST MIDDLE

TO: _____
LAST FIRST MIDDLE

☐ MAILING ADDRESS CHANGE

_____
_____
_____
CITY STATE ZIP

DH 2103, 5/98

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

MICHAEL ISRAEL HERTZ
505 HAZEN STREET
#204
PAW PAW, MI 49079

AC#COPY

STATE OF FLORIDA
DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE

DATE	LICENSE NO.	CONTROL NO.
02/17/2000	ME 35436	42859

THE **MEDICAL DOCTOR**
NAMED BELOW HAS MET ALL REQUIREMENTS OF
THE LAWS AND RULES OF THE STATE OF FLORIDA.
EXPIRATION DATE: JANUARY 31, 2002

MICHAEL ISRAEL HERTZ
505 HAZEN STREET
#204
PAW PAW, MI 49079

AC#
STATE OF FLORIDA
DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE
DATE 02/17/2000 | LICENSE NO. ME 35436 | CONTROL NO. 42859
THE MEDICAL DOCTOR
NAMED BELOW HAS MET ALL REQUIREMENTS OF
THE LAWS AND RULES OF THE STATE OF FLORIDA.
EXPIRATION DATE: JANUARY 31, 2002
MICHAEL ISRAEL HERTZ
COPY - NOT A VALID LICENSE - COPY

COPY - NOT A VALID LICENSE - COPY

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

EXPIRATION DATE: **JANUARY 31, 2002**

YOUR LICENSE NUMBER IS **ME 35436** ,PLEASE USE IT IN ALL CORRESPONDENCE WITH YOUR BOARD/COUNCIL. EACH LICENSEE IS SOLELY RESPONSIBLE FOR NOTIFYING THE DEPARTMENT IN WRITING OF THE LICENSEE'S CURRENT MAILING ADDRESS. USE THIS SECTION TO REPORT NAME AND/OR MAILING ADDRESS CHANGES.

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

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

☐ REQUEST DUPLICATE LICENSE

_____
SIGNATURE REQUIRED

DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE
LICENSURE SERVICES
2020 CAPITAL CIRCLE, S.E., BIN #C-10
TALLAHASSEE, FLORIDA 32399-3260

☐ NAME CHANGE (ATTACH LEGAL DOCUMENTATION)

FROM: _____
MIDDLE

TO: _____
LAST FIRST MIDDLE

☐ MAILING ADDRESS CHANGE

_____

_____

_____
CITY STATE ZIP

DH 2103, 5/98

DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE
LICENSURE SERVICES
2020 CAPITAL CIRCLE, S.E., BIN #C-10
TALLAHASSEE, FLORIDA 32399-3260

MICHAEL ISRAEL HERTZ
505 HAZEN STREET
#204
PAW PAW, MI 49079

AC#**COPY**

STATE OF FLORIDA
DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE

DATE	LICENSE NO.	CONTROL NO.
01/30/2000	ME 35436	38623

THE **MEDICAL DOCTOR**
NAMED BELOW HAS MET ALL REQUIREMENTS OF
THE LAWS AND RULES OF THE STATE OF FLORIDA.
EXPIRATION DATE: JANUARY 31, 2002
MICHAEL ISRAEL HERTZ

AC# COPY
STATE OF FLORIDA
DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE
DATE | LICENSE NO. | CONTROL NO.
01/30/2000 | ME 35436 | 38623
THE MEDICAL DOCTOR
NAMED BELOW HAS MET ALL REQUIREMENTS OF
THE LAWS AND RULES OF THE STATE OF FLORIDA.
EXPIRATION DATE: JANUARY 31, 2002
MICHAEL ISRAEL HERTZ
COPY - NOT A VALID LICENSE - COPY

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

COPY - NOT A VALID LICENSE - COPY

EXPIRATION DATE: **JANUARY 31, 2002**

YOUR LICENSE NUMBER IS **ME 35436** ,PLEASE USE IT IN ALL CORRESPONDENCE WITH YOUR BOARD/COUNCIL. EACH LICENSEE IS SOLELY RESPONSIBLE FOR NOTIFYING THE DEPARTMENT IN WRITING OF THE LICENSEE'S CURRENT MAILING ADDRESS. USE THIS SECTION TO REPORT NAME AND/OR MAILING ADDRESS CHANGES.

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

TO REQUEST A DUPLICATE LICENSE SUBMIT THIS FORM AND A CHECK, PAYABLE TO THE DEPARTMENT OF HEALTH, IN THE AMOUNT OF $25.00

☐ REQUEST DUPLICATE LICENSE _____
SIGNATURE REQUIRED

DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE
LICENSURE SERVICES
2020 CAPITAL CIRCLE, S.E., BIN #C-10
TALLAHASSEE, FLORIDA 32399-3260

☐ NAME CHANGE (ATTACH LEGAL DOCUMENTATION)

FROM: _____
MIDDLE

TO: _____
LAST FIRST MIDDLE

☐ MAILING ADDRESS CHANGE

_____
_____
_____
CITY STATE ZIP

DH 2103, 5/98

DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE
LICENSURE SERVICES
2020 CAPITAL CIRCLE, S.E., BIN #C-10
TALLAHASSEE, FLORIDA 32399-3260

MICHAEL ISRAEL HERTZ
505 HAZEN STREET
#204
PAW PAW, MI 49079

AC# **COPY**

STATE OF FLORIDA
DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE

DATE	LICENSE NO.	CONTROL NO
12/21/2012	ME 35436	406858

The **MEDICAL DOCTOR**
named below has met all requirements of
the laws and rules of the state of Florida.
Expiration Date: **JANUARY 31, 2015**
MICHAEL ISRAEL HERTZ
3976 DEER GLEN DRIVE
ANN ARBOR, MI 48108

AC#
STATE OF FLORIDA
DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE
DATE 12/21/2012
LICENSE NO. ME 35436
CONTROL NO. 406858
The MEDICAL DOCTOR
named below has met all requirements of
the laws and rules of the state of Florida.
Expiration Date: JANUARY 31, 2015
COPY - NOT A VALID LICENSE - COPY
LICENSEE SIGNATURE

COPY - NOT A VALID LICENSE - COPY

GOVERNOR STATE SURGEON GENERAL

DISPLAY IF REQUIRED BY LAW

EXPIRATION DATE: JANUARY 31, 2015

Your license number is **ME 35436**, please use it in all correspondence with your board/council. Each licensee is solely responsible for notifying the department in writing of the licensee's current mailing address and practice location address. If you have not received your renewal notice 90 days prior to the expiration date shown on this license, please call (850) 488-0595.

Use this section to report name change. Name changes require legal documentation showing the name change. Please make sure that a photocopy of one of the following accompanies this form: a marriage license, a divorce decree or a court order.

Medical Quality Assurance offers you the convenience of several online services. These services give you the ability to renew your license, update your mailing and practice location addresses and update your profile information.

1. Go to **www.flhealthsource.com**
2. Click on Licensee/Provider
3. Click on Practitioner Login
4. Select your profession
5. Enter the account ID and password that was provided to you on your initial license and cli
6. If you do not know your account ID and password, click on "**Get Login Help**" or call our Customer Contact Center at (850) 488-0595 for assistance.

MAIL TO: DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE
LICENSURE SUPPORT SERVICES UNIT
P.O. BOX 6320
TALLAHASSEE, FLORIDA 32314-6320

☐ **NAME CHANGE (ATTACH LEGAL DOCUMENTATION)**

FROM: _____
LAST FIRST MIDDLE

TO: _____
LAST FIRST MIDDLE

DH 2103, 5/98

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

********** AUTO **********

MICHAEL ISRAEL HERTZ
3976 DEER GLEN DRIVE
ANN ARBOR, MI 48108

AC# COPY

STATE OF FLORIDA
DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE

DATE	LICENSE NO	CONTROL NO.
11/30/2010	ME 35436	331264

The **MEDICAL DOCTOR**
named below has met all requirements of
the laws and rules of the state of Florida
Expiration Date **JANUARY 31, 2013**

MICHAEL ISRAEL HERTZ
24450 EVERGREEN ROAD
STE 220
SOUTHFIELD, MI 48075

AC#
STATE OF FLORIDA
DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE
DATE 11/30/2010 LICENSE NO. ME 35436 CONTROL NO. 331264
The MEDICAL DOCTOR
named below has met all requirements of
COPY - NOT A VALID LICENSE - COPY
LICENSEE SIGNATURE

COPY - NOT A VALID LICENSE - COPY

GOVERNOR STATE SURGEON GENERAL

DISPLAY IF REQUIRED BY LAW

EXPIRATION DATE: JANUARY 31, 2013

Your license number is ME 35436, please use it in all correspondence with your board/council. Each licensee is solely responsible for notifying the department in writing of the licensee's current mailing address and practice location address. If you have not received your renewal notice 90 days prior to the expiration date shown on this license, please call (850) 488-0595.

Use this section to report name change. Name changes require legal documentation showing the name change. Please make sure that a photocopy of one of the following accompanies this form: a marriage license, a divorce decree or a court order. **A driver's license or social security card is not considered legal documentation.**

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1. Go to **www.flhealthsource.com**
2. Click on Licensee/Provider
3. Click on Practitioner Login
4. Select your profession
5. Enter the account ID and password that was provided to you on your initial license
6. If you do not know your account ID and password, click on **"Get Login Help"** or call for assistance.

MAIL TO: DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE
LICENSING AND AUDITING SERVICES UNIT
P.O. BOX 6320
TALLAHASSEE, FLORIDA 32314-6320

☐ NAME CHANGE (ATTACH LEGAL DOCUMENTATION)

FROM: _____
LAST FIRST MIDDLE

TO: _____
LAST FIRST MIDDLE

DH 2103, 5/98

DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE
LICENSING AND AUDITING SERVICES UNIT
4052 BALD CYPRESS WAY, BIN #C-10
TALLAHASSEE, FLORIDA 32399-3260

********** AUTO **********

MICHAEL ISRAEL HERTZ
3976 DEER GLEN DRIVE
ANN ARBOR, MI 48108

AC# COPY

STATE OF FLORIDA
DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE

DATE	LICENSE NO	CONTROL NO.
11/08/2006	ME 35436	194864

The **MEDICAL DOCTOR**
named below has met all requirements of
the laws and rules of the state of Florida.
Expiration Date: **JANUARY 31, 2009**

MICHAEL ISRAEL HERTZ
ATTN: TANIA JUDD
20755 GREENFIELD ROAD
STE 1104
SOUTHFIELD, MI 48075

STATE OF FLORIDA
DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE
AC#
LICENSE NO. ME 35436
CONTROL NO. 194864
DATE 11/08/2006
The MEDICAL DOCTOR
COPY - NOT A VALID LICENSE - COPY
LICENSEE SIGNATURE

COPY - NOT A VALID LICENSE - COPY

GOVERNOR

DISPLAY IF REQUIRED BY LAW

SECRETARY

EXPIRATION DATE: JANUARY 31, 2009

Your license number is **ME 35436**. please use it in all correspondence with your board/council. Each licensee is solely responsible for notifying the department in writing of the licensee's current mailing address and practice location address. Use this section to report name and/or practice location address and/or mailing address changes. If you have not received your renewal notice 90 days prior to the expiration date shown on this license, please call (850) 488-0595.

Name changes require legal documentation showing the name change. Please make sure that a photocopy of one of the following accompanies this form: a marriage license, a divorce decree or a court order. **A driver's license or social security card is not considered legal documentation.**

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1. Go to **www.flhealthsource.com**
2. Click on Licensee/Provider
3. Click on Practitioner Login
4. Select your profession
5. Enter the account ID and password here **(Account ID and Password are case sensit**
6. Click on Login

To request a duplicate license, submit this form and a check or money order, payable to the **DEPARTMENT OF HEALTH**, in the amount of **$25.00**.
Now that you have your license, make sure you keep it. Go to **www.doh.state.fl.us/mqa/avoid.html** to find out more.

MAIL TO: DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE
LICENSURE SERVICES
P.O. BOX 6320
TALLAHASSEE, FLORIDA 32314-6320

☐ NAME CHANGE (ATTACH LEGAL DOCUMENTATION)

FROM: _____
LAST FIRST MIDDLE

TO: _____
LAST FIRST MIDDLE

DH 2103, 5/98

☐ PRACTICE LOCATION ADDRESS CHANGE
(This address will be printed on your license and posted on the Internet.)

_____

_____

CITY STATE ZIP

☐ MAILING ADDRESS CHANGE
(This address will be used when mailing your license and for all other correspondence from the Department.)

_____

_____

CITY STATE ZIP

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

MICHAEL ISRAEL HERTZ
20755 GREENFIELD ROAD
STE 1104
SOUTHFIELD, MI 48075

Jeb Bush
Governor

FLORIDA DEPARTMENT OF
HEALTH

Robert G. Brooks, M.D.
Secretary

July 16, 2001

MICHAEL I HERTZ, M.D.
505 HAZEN STREET
#204
PAW PAW, MI-49079

Dear Dr. HERTZ

The information to be published on your practitioner profile is printed below. In carrying out our legislative mandate to publish physician profiles, we want to do everything we can to ensure the information that is published is correct. We are providing this information to you prior to its publication to give you an opportunity to review the data for any changes, corrections, and/or omissions. Under Section 456.042, Florida Statutes, you have thirty (30) days from the date you receive this letter to submit changes to 4052 Bald Cypress Way, Bin # C10, Tallahassee, Florida 32399-3260. If you have no changes, your profile will be published as it appears below on the World Wide Web. Listed below is information that you should review carefully.

First, although the law requires you to **report all disciplinary action** taken by facilities, including facilities outside Florida, the action taken by Florida licensed hospitals and ambulatory surgical centers will not be published on the profile. **Please review and identify and action, which was taken by a hospital or ambulatory surgical center licensed in Florida to ensure this discipline is not included on the published profile.**

Second, the law requires that **all criminal convictions** must be reported to the department pursuant to Section 456.039(1)(a)7, Florida Statutes. If your criminal conviction was expunged or the records were sealed, please send a copy of the court order expunging or sealing the records. If you have any questions or concerns about the criminal convictions to be published on the profile, as they are stated in this letter, please provide them in writing to the department.

◯ My profiling information is correct

◯ My profiling information is incorrect; changes are noted below.

I. Practitioner Information

License Number : 35436
Profession : Medical Doctor
License Status : ACTIVE CLEAR
Year Began Practicing : 01/01/1980

Primary Business:

505 HAZEN STREET
#204
PAW PAW MI 49079

Secondary Locations:

Staff Privileges:

Institution Name	City	State
WEST BOCA MEDICAL CENTER	BOCA RATON	FLORIDA

Faculty Appointments:

This practitioner has had the responsibility for graduate medical education within the last 10 years.

This practitioner currently holds faculty appointments at the following medical/health related institutions of higher learning:
Title : Institution : City : State
1. ASSISTANT CLINCAL PROFESSOR : MICHIGAN STATE UNIVERSITY COLLEGE OF HUMAN MEDICINE : EAST LANSING : MICHIGAN

Participates in Medicaid Program:

The practitioner did not indicate if he/she participates in the Medicaid program.

II. Education and Training

Medical School : Dates of Attendance : Graduation Date : Degree Title
1. WAYNE STATE UNIVERSITY : 01/01/1972 - 01/01/1976 : 05/01/1976 : MD

Other Health Related Degrees:

This practitioner does not hold any additional health related degrees.

III. Professional and Postgraduate Training

This practitioner has completed the following graduate medical education:
Program Name : Program Type : Specialty Area : City : State/Country : Dates Attended

1. SINAI HOSPITAL : INTERNSHIP : OBG - OBSTETRICS AND GYNECOLOGY : DETROIT : MICHIGAN : 3/1/76 - 2/1/77

2. SINAI HOSPITAL : RESIDENCY : OBG - OBSTETRICS AND GYNECOLOGY : DETROT : MICHIGAN : 3/1/77 - 3/1/80

IV. Specialty

This practitioner holds the following certifications from specialty boards recognized by the Florida board which regulates the profession for which he/she is licensed:
Specialty Board : Certification
1. AMERICAN BOARD OF OBSTETRICS & GYNECOLOGY : .....

V. Optional Information

Committees:/Memberships

This practitioner has not indicated any committees on which they serve for any health entity with which they are affiliated.

Professional or Community Service Awards

This practitioner has not provided any professional or community service activities, honors, or awards.

Publications

This practitioner has not provided any publications that he/she authored in peer-reviewed medical literature within the last ten years.

Languages Other Than English

This practitioner has not indicated that any languages other than English are used to communicate with patients, or that any translation service is available for patients, at his/her primary place of practice.

Other Affiliations

This practitioner has provided the following national, state, local, county, or professional affiliations:
1. STAFF PRV/LAKEVIEW COMMUNITY HOSPITAL/PAWPAW, MI
2. STAFF PRV/BRONSON METHODIST HOSPITAL/KALAMAZOO, MI

E-Mail Address

Not Provided

Other State Licensure

This practitioner has not indicated any additional state licensure.

VI. Financial Responsibility

I do not practice medicine in the State of Florida.

VII. Criminal Offenses

The criminal history information, if any exists, will be incomplete; federal criminal history is not available to the public. The criminal history information provided by the practitioner has not been completely verified at this time. All criminal history checks should be completed by March 2000.

This practitioner has indicated that he/she has NO criminal offenses.

VIII. Final Disciplinary Action (Within last 10 years)

Pursuant to section 455.5651(5), F.S. the profile will not include disciplinary action taken by a hospital or ambulatory surgical centers licensed under chapter 395, F.S.

This practitioner has indicated that he/she has NOT had any final disciplinary action taken against him/her within the previous 10 years by a specialty board.

This practitioner has indicated that he/she has NOT had any final disciplinary action taken against him/her within the previous 10 years by a licensing agency.

This practitioner has indicated that he/she has NOT had any final disciplinary action taken against him/her within the previous 10 years by a health maintenance organization, pre-paid health clinic, nursing home, out-of-state hospital or out-of-state ambulatory surgical center.

This practitioner has indicated that he/she has NEVER been asked to or allowed to resign from or had any medical staff privileges restricted or revoked within the previous 10 years by a health maintenance organization, pre-paid health clinic, nursing home, out-of-state hospital or out-of-state ambulatory surgical center.

IX. Liability Claims Exceeding $5,000.00 (Within last 10 years)

Settlement of a claim may occur for a variety of reasons that do not necessarily reflect negatively on the professional competence or conduct of the physician. A payment settlement of a medical malpractice action or claim should not be construed as creating a presumption that medical malpractice has occurred.

Incident Date	County	Judicial Case #	Settlement Date	Amount	Policy Amount
11/17/91	PALM BEACH	93-6113AB06	9/13/96	30000	

If you wish to make changes to the profile after it has been published, please submit them to 4052 Bald Cypress Way, Bin # C10, Tallahassee, Florida 32399-3260.

If you have any questions or comments, please call (850)488-0595, Press 6, Monday through Friday, 8:00 a.m. to 5:00 pm., ET.

Sincerely,

Bureau of Operations

I CERTIFIE WITH ALL REQUIREMENTS FOR RENEWAL INCLUDING CE CREDITS

DON TYRONE SHANNON

1/26/2004

Received Date : 1/27/04
Deposit Date : 1/28/04
Deposit # : 167544
Batch Number : 014116
Validation # : 903118748
Check Amount : $305.00
PRO_CDE : 1401

CHANGE OF ADDRESS

201 SOUTH ST. JOHNS STREET

ST AUGUSTINE FLA 32084

L-35436

AC# 0319766

STATE OF FLORIDA
DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE

DATE	LICENSE NO.	CONTROL NO.
03/06/2002	MA 35436	26750

THE **MASSAGE THERAPIST**
NAMED BELOW HAS MET ALL REQUIREMENTS OF
THE LAWS AND RULES OF THE STATE OF FLORIDA.
EXPIRATION DATE: **AUGUST 31, 2003**

DON TYRONE SHANNON
110 CERRO ST
ST AUGUSTINE, FL 32084

JEB BUSH
GOVERNOR

JOHN O. AGWUNOBI, M.D., M.B.A.
SECRETARY

DISPLAY IF REQUIRED BY LAW

0295 08066

AC# 0253405

STATE OF FLORIDA
DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE

DATE	LICENSE NO.	CONTROL NO.
11/20/1999	ME 35436	5966

THE **MEDICAL DOCTOR**
NAMED BELOW HAS MET ALL REQUIREMENTS OF THE LAWS AND RULES OF THE STATE OF FLORIDA.
EXPIRATION DATE: **JANUARY 31, 2002**
MICHAEL ISRAEL HERTZ

VOID

JEB BUSH
GOVERNOR

ROBERT G. BROOKS, M.D.
SECRETARY

DISPLAY AS REQUIRED BY LAW

AC# 0253405
STATE OF FLORIDA
DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE

DATE	LICENSE NO.	CONTROL NO.
11/20/1999	ME 35436	5966

THE MEDICAL DOCTOR
NAMED BELOW HAS MET ALL REQUIREMENTS OF THE LAWS AND RULES OF THE STATE OF FLORIDA.
EXPIRATION DATE: JANUARY 31, 2002
MICHAEL ISRAEL HERTZ

VOID

LICENSEE SIGNATURE

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

EXPIRATION DATE: **JANUARY 31, 2002**

YOUR LICENSE NUMBER IS **ME 35436** ,PLEASE USE IT IN ALL CORRESPONDENCE WITH YOUR BOARD/COUNCIL. EACH LICENSEE IS SOLELY RESPONSIBLE FOR NOTIFYING THE DEPARTMENT IN WRITING OF THE LICENSEE'S CURRENT MAILING ADDRESS. USE THIS SECTION TO REPORT NAME AND/OR MAILING ADDRESS CHANGES.

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

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

☐ REQUEST DUPLICATE LICENSE

SIGNATURE REQUIRED

DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE
LICENSURE SERVICES
2020 CAPITAL CIRCLE, S.E., BIN #C-10
TALLAHASSEE, FLORIDA 32399-3260

☐ NAME CHANGE (ATTACH LEGAL DOCUMENTATION)

FROM: ______
MIDDLE

TO: ______
LAST FIRST MIDDLE

☐ MAILING ADDRESS CHANGE

______
______
______
CITY STATE ZIP

DH 2103, 5/98

SEE REVERSE SIDE FOR OPENING INSTRUCTIONS

VOID

DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE
LICENSURE SERVICES
2020 CAPITAL CIRCLE, S.E., BIN #C-10
TALLAHASSEE, FLORIDA 32399-3260

MICHAEL ISRAEL HERTZ
505 HAZEN STREET
#204
PAW PAW, MI 49079

Florida Department of Health - Board of Medicine

License Renewal Notice

Active (group 2) Medical Doctor License # ME 35436 expires January 31, 2002.

To avoid a delinquent charge, the fee of **$598.50** and the renewal form must be postmarked or electronically submitted on or before January 31, 2002. Renewal notices/forms postmarked on or after February 1, 2002 require renewal and delinquency fees of **$791.00**.

1. CHANGE OF MAILING ADDRESS:

Current Mailing Address:

MICHAEL ISRAEL HERTZ
505 HAZEN STREET
#204
PAW PAW, MI 49079

New Mailing Address:

Licensee's Last Name First Middle Initial

Attn:

Street Address:

City: State: Zip:

Phone: ( )

DEPARTMENT USE ONLY

Received Date : 11/29/2001
Deposit Date : 12/07/2001

2. CHANGE OF PRACTICE LOCATION:

Current Practice Location:

505 HAZEN STREET
#204
PAW PAW, MI 49079

New Practice Location:

Attn:

Street Address:

City: State: Zip:

Phone: ( )

Check Amount : $598.50
PRO_CDE : 1501

3. Chapter 456, F.S., requires a background check to renew a license, please review the following data to verify that the information is correct, please make any necessary corrections. This information is critical in ensuring that background checks are attributed to the correct licensee.

Description	Department Information	Information is Accurate		Correct Information
Social Security #		◯ Yes	◯ No	
Date of Birth	11/10/49	◯ Yes	◯ No	
Sex	Data Missing	◯ Yes	◯ No	MALE
Race	Not Given	◯ Yes	◯ No	WHITE
Race Options: White, Black, Native, Asian, Other, Hispanic & not given				

4. COMPLETE THE FINANCIAL RESPONSIBILITY FORM ON THE REVERSE SIDE OF THIS FORM.

5. MILITARY STATUS:

◯ I am requesting Military Restricted Status. (Military Restricted must submit proof of active military duty. Attach a copy of your current active duty orders or a letter from your Commanding Officer.)

◯ Please remove the Military Restricted Status from my license. (Provide copy of DD214 or letter from Commanding Officer.)

6. 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

7. THERE ARE TWO RENEWAL METHODS AVAILABLE:

A. Internet E-Renewal: Web address http://www.doh.state.fl.us/erenewal

E-Renewal allows you to make address changes. E-Renewal does not allow you to renew online by adding or removing a status, such as paying a delinquency fee or changing a license status. Due to high volume, allow sufficient time to renew since **e-Renewal will not be available after midnight Eastern Time (ET) January 31, 2002**. E-Renewal will require the following information:

License Number: ME 35436

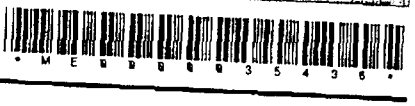
B. U.S. Mail:

Mail this completed renewal form and fee payable to the Department of Health to:

P.O. Box 6320
Tallahassee, Florida 32314-6320

8. Other Information:

File Number: 27601 20 20 Sequence Number: 3577



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 - CATEGORIES OF 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. 627.367, F.S. I further certify that I have been continuously insured with an entity as outlined above for the past two years (retroactive coverage) or if I seek insurance from a different entity providing insurance; I will purchase retroactive coverage for the two years proceeding my inception date of coverage. I further certify that in the event my coverage is terminated or that I desire to become uninsured and meet the financial responsibility requirements through other provisions in s. 458.320 or 459.0085, F.S., I will maintain coverage for incidents which may have occurred during the two years preceding my becoming uninsured.

● 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. 627.367, F .S. I further certify that I have been continuously insured with an entity as outlined above for the past two years (retroactive coverage) or if I seek insurance from a different entity providing insurance I will purchase retroactive coverage for the two years preceding my inception date of coverage. I further certify that in the event my coverage is cancelled or that I desire to become uninsured and meet the financial responsibility requirements through other provisions in s. 458.320 or 459.0085, F.S., I will maintain coverage for incidents which may have occurred during the two years preceding my becoming uninsured.

○ 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 459.008S(5)(g), F. S.

CATEGORY II - EXEMPTION CATEGORIES OF FINANCIAL RESPONSIBILITY COVERAGE:

○ 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. I understand such a sign or notice must contain the wording specified in s. 458.320(5)(t) or 459.0085(5)(t), F. S.; or

○ 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).

BRONSON METHODIST HOSPITAL
NC20

CHECK NO. 46990
VENDOR # F04924100

CONTROL NO. 2040
CHECK SEQ. NO. 7

INVOICE #	INV DATE	PURCH ORDER #	GROSS AMOUNT	DISCOUNT	NET AMOUNT
RENEWAL FOR HE	11/08/2001		598.50	0.00	598.50
		TOTALS:	598.50	0.00	598.50

*** **AUTO** *** 024_041_17566 35436-17566

MICHAEL ISRAEL HERTZ
3976 DEER GLEN DRIVE
ANN ARBOR, MI 48108

:481082707760:

Your Medical Doctor License # **ME 35436** will expire at midnight, Eastern Standard Time (EST) on **Monday, January 31, 2011**.

Please log onto **www.FLHealthsource.com** and follow these steps:

1. Click **Renew My License** and log in.
2. Click **Renew License** and select your renewal option:
    a. Renew on-line
    b. Print your renewal notice to submit with your payment via mail

You will be prompted to complete the Physician Workforce Survey online.

Renewals by mail **MUST** include the renewal form, not this postcard.

Visit **www.cebroker.com/subscribe** to purchase your **optional** subscription and track your continuing education credits.

Section 456.0635, F.S., may affect your ability to renew your license. Please visit **http://www.doh.state.fl.us/mqa/laws.html** for more information.

Remember, all renewals MUST be submitted **no later than January 31, 2011** in order to avoid a delinquent fee. Questions? Contact the MQA Call Center at (850) 488-0595.

MICHAEL ISRAEL HERTZ
3976 DEER GLEN DRIVE
ANN ARBOR, MI 48108

35436

Your Medical Doctor License # **ME 35436** will expire at midnight, Eastern Standard Time (EST) on **Saturday, January 31, 2009**. The total fee due for this renewal is **$391.00**.

Please log onto **www.FLHealthsource.com** and follow these steps:

1. Click **Renew My License** and log in.
2. Click **Renew License** and select your renewal option:
    a. Renew on-line
    b. Print your renewal notice to submit with your payment via mail

You will be prompted to complete the Physician Workforce Survey online.

Renewals by mail **MUST** include the renewal notice, not this postcard.

Remember all renewals MUST be submitted **no later than January 31, 2009**.
Questions? Contact the MQA Call Center at (850) 488-0595.

Division of Medical Quality Assurance
P.O.Box 6340
Tallahassee, Florida 32314-6340

***** Important License Information *****

HERTZ, MICHAEL ISRAEL
3976 DEER GLEN DRIVE
ANN ARBOR, MI 48108

Your license is scheduled for renewal within the next 5 months. You are required to review and, if appropriate, update your profile before renewing your license. In addition, Section 456.042, Florida Statutes, requires you to submit profile updates within 15 days of any changes.

You may review, update and confirm the accuracy of your practitioner profile information online by visiting www.FLHealthsource.com. Select LICENSEE/PROVIDER, click on VIEW PROFILE, and Login with your Account ID and Password. If you make changes to your profile, BE SURE to click on "confirm changes" to update the Department's information system.

If you have any questions, please contact the MQA Call Center at (850) 488-0595, option 3.

Florida Department of Health - Board of Medicine
LICENSE RENEWAL NOTICE

DEPARTMENT USE ONLY

Active Medical Doctor License # ME 35436 expires January 31, 2007.

The fee of **$454.00** and the renewal notice must be postmarked on or before January 31, 2007. Renewal notices postmarked on or after February 01, 2007 require renewal and delinquent fees of **$839.00**.

1. CURRENT MAILING ADDRESS:

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

MICHAEL ISRAEL HERTZ
20755 GREENFIELD ROAD
STE 1104
SOUTHFIELD, MI 48075

2. CURRENT PRACTICE LOCATION:

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

13322 N. BLVD
STE. A
VICKSBURG, MI 49097

3. PROFILE CONFIRMATION:

Florida Statutes 456.039(1) and 456.0391(1) require that you update your profile at renewal. Please review and confirm the information in your profile before completing your renewal. Each practitioner who applies for license renewal must, in conjunction with procedures adopted by the Department of Health, and in addition to any other information that may be required, furnish the mandatory reporting requirements.

Note: A practitioner must submit updates to their profile within 15 days of any changes, 456.042, F.S.

You may review/update your profiling information by visiting the following link, www.flhealthsource.com. Use the login information provided on this notice. If you still choose to manually submit your information after visiting our website, please print out your profile using the print friendly version and make any changes directly on the profile. Please include your updates, if any, along with your other renewal information.

I have reviewed and confirmed the information in my profile. ◯

4. CHANGES TO CURRENT LICENSE INFORMATION:

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

5. THERE ARE TWO RENEWAL METHODS AVAILABLE:

A. Online Renewal: Visit www.flhealthsource.com, from our main page, select **Licensee/Provider**, go to the **Practitioner Logon** box located on the left side of the page, select your profession and enter your Account ID and password. If you are requesting a status change, you will be ineligible to renew your license online. The system will be available for renewals until midnight, Eastern Standard Time (EST), January 31, 2007. To use the online system, you will need the following information:

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

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

Avoiding complaints can protect your clients and your ability to practice. Go to www.doh.state.fl.us/mqa/avoid.html to find out more.

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

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

6. OTHER INFORMATION:

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

A licensee who remains on inactive status for more than two consecutive biennial licensure cycles and who wishes to reactivate the license may be required to demonstrate the competency to resume active practice by sitting for a special purpose examination or by completing other reactivation requirements.

File Number: 27601 Sequence Number: 1301
Profession Code: 1501 20 20

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

7. CHANGES TO CURRENT LICENSE INFORMATION:

◯ **CHANGE OF NAME:**

Name changes require legal documentation showing the name change. Please make sure that a photocopy of one of the following accompanies this form: a marriage license (marriage license must indicate the original signature and seal from the cle of the court), a divorce decree indicating restoration of your maiden name, or a court order (e.g., adoption, name change, or federal identity change). Any one of these will be accepted unless the department has a question about the authenticity of the document. A driver's license or social security card is not considered legal documentation.

If the name change cannot be completed, your license will be renewed using the current name.

Last Name:

First Name:

Middle Name: Title Suffix: *(Jr, Sr, I, II, etc.)* Qualifier: *(PhD, DDS, etc.)*

◯ **CHANGE OF MAILING ADDRESS:**

Attention:

Addr1:

Addr2:

City:

State: Zip: - Phone: ( ) -

◯ **CHANGE OF PRACTICE LOCATION: (This address can not be a Post Office Box)**

Attention:

Addr1:

Addr2:

City:

State: Zip: - Phone: ( ) -

CHECKLIST FOR MAILING RENEWAL FORM:

If mailing your renewal form, use the checklist below as a guide for enclosing all the required items to ensure a smooth renewal. If renewing by mail, allow 2-4 weeks processing time.

REQUIRED:
- ◯ Renewal notice
- ◯ Check or Money order written to Department of Health
- ◯ Financial Responsibility form (check only one item on the FR form)
- ◯ Updated paper copy of Profile, if you are mailing your renewal notice
- ◯ Mail to: PO Box 6320, Tallahassee, Florida 32314-6320

If you are renewing to active status, would you be available to provide health care services in special needs shelters or to help staff disaster medical assistance teams during times of emergency or major disaster?

◯ Yes

CHANGE OF LICENSE STATUS:

◯ I wish to change my status from active to inactive. The fee for an inactive receipt is **$415.00**. The fee for inactive after January 31, 2007 is **$900.00**.

CHANGE TO MILITARY STATUS:

◯ I am requesting Military Active Status. (You must submit proof of active military duty. Attach a copy of your current active duty orders or a letter from your Commanding Officer.) The fee for military active is **$00.00**.

CHANGE TO RETIRED STATUS:

◯ I am requesting retired status. The fee for retired status is **$55.00** postmarked on or before January 31, 2007. The fee for retired status on or after February 01, 2007 is **$540.00**.

DISPENSING:

◯ I wish to dispense medicinal drugs for a fee from my practice location and I understand an annual inspection of my dispensing records will be conducted. The fee for registration as a dispensing practitioner is **$100.00** in addition to your renewal fee.

PHYSICIAN WORKFORCE QUESTIONNAIRE

The items below relate to very important questions regarding Florida's current and future physician workforce. Your responses will be instrumental in shaping Florida's health care and physician workforce policies. Secretary of the Department of Health, M. Rony François, M.D., M.S.P.H., Ph.D., and the Council of Florida Medical School Deans, Florida Graduate Medical Education Committee, Florida Medical Association and Florida Osteopathic Medical Association appreciate your time and effort in responding to the eight questions below.

Name: MICHAEL ISRAEL HERTZ **License Number:** ME 35436

1. Do you practice medicine at any time during the year in Florida?

   Note: If you check 'No' then please stop here. ◯ Yes ◯ No

2. How many months/year do you practice medicine in Florida?

   ◯ 1-4 Months ◯ 5-8 Months ◯ 9-12 Months

3. In what Florida counties do you practice?(may select up to 5 counties)
   Please note - County Names and Numeric Codes are listed on the **back side of the form.**
   Please print or type County Names and Numeric Codes below.

	County Name	Numeric Code	1-20 Hrs/Wk	21-40 Hrs/Wk	More than 40 Hrs/Wk
a.			◯	◯	◯
b.			◯	◯	◯
c.			◯	◯	◯
d.			◯	◯	◯
e.			◯	◯	◯

4. Is more than twenty percent (20%) of your practice non-clinical? (i.e. research, teaching, administration)

   ◯ Yes ◯ No

5. Are you a resident or fellow?

   ◯ Yes ◯ No

6. What is the primary specialty area(s) of your current clinical practice?(may select up to 5 different areas)
   Please note - Specialty Areas and Numeric Codes are listed on the **back side of the form.**
   Please print or type Specialty Areas and Numeric Codes below.

	Specialty Area	Numeric Code	1-20%	21-40%	41-60%	61-80%	81-100%
a.			◯	◯	◯	◯	◯
b.			◯	◯	◯	◯	◯
c.			◯	◯	◯	◯	◯
d.			◯	◯	◯	◯	◯
e.			◯	◯	◯	◯	◯

7. Do you plan to retire, relocate outside of the state of Florida, or significantly reduce the scope of your practice within the next five years?

   ◯ Yes ◯ No

8. Do you currently take emergency call or otherwise work clinically in a hospital emergency department or provide for the immediate, acute care of trauma patients?

   ◯ Yes ◯ No

County Names and Numeric Codes (Reference for question # 3)

11 ALACHUA	25 DIXIE	39 HILLSBOROUGH	53 MARTIN	67 SANTA ROSA
12 BAKER	26 DUVAL	40 HOLMES	54 MONROE	68 SARASOTA
13 BAY	27 ESCAMBIA	41 INDIAN RIVER	55 NASSAU	69 SEMINOLE
14 BRADFORD	28 FLAGLER	42 JACKSON	56 OKALOOSA	70 SUMTER
15 BREVARD	29 FRANKLIN	43 JEFFERSON	57 OKEECHOBEE	71 SUWANNEE
16 BROWARD	30 GADSDEN	44 LAFAYETTE	58 ORANGE	72 TAYLOR
17 CALHOUN	31 GILCHRIST	45 LAKE	59 OSCEOLA	73 UNION
18 CHARLOTTE	32 GLADES	46 LEE	60 PALM BEACH	74 VOLUSIA
19 CITRUS	33 GULF	47 LEON	61 PASCO	75 WAKULLA
20 CLAY	34 HAMILTON	48 LEVY	62 PINELLAS	76 WALTON
21 COLLIER	35 HARDEE	49 LIBERTY	63 POLK	77 WASHINGTON
22 COLUMBIA	36 HENDRY	50 MADISON	64 PUTNAM	78 UNKNOWN
23 DADE	37 HERNANDO	51 MANATEE	65 ST.JOHNS	79 OUT OF STATE
24 DESOTO	38 HIGHLANDS	52 MARION	66 ST.LUCIE	80 FOREIGN

Specialty Areas and Numeric Codes (Reference for question # 6)

000 NO CLINICAL PRACTICE
020 ALLERGY AND IMMUNOLOGY
040 ANESTHESIOLOGY
045 CRITICAL CARE MEDICINE
048 PAIN MEDICINE
042 PEDIATRIC ANESTHESIOLOGY
060 COLON AND RECTAL SURGERY
080 DERMATOLOGY
100 DERMATOPATHOLOGY
081 PROCEDURAL DERMATOLOGY
110 EMERGENCY MEDICINE
118 MEDICAL TOXICOLOGY
114 PEDIATRIC EMERGENCY MEDICINE
116 SPORTS MEDICINE
119 UNDERSEA AND HYPERBARIC MEDICINE
120 FAMILY MEDICINE
125 GERIATRIC MEDICINE
127 SPORTS MEDICINE
140 INTERNAL MEDICINE
141 CARDIOVASCULAR DISEASE
154 CLINICAL CARDIAC ELECTROPHYSIOLOGY
142 CRITICAL CARE MEDICINE
143 ENDOCRINOLOGY, DIABETES, AND METABOLISM
144 GASTROENTEROLOGY
151 GERIATRIC MEDICINE
145 HEMATOLOGY
155 HEMATOLOGY AND ONCOLOGY
146 INFECTIOUS DISEASE
152 INTERVENTIONAL CARDIOLOGY
148 NEPHROLOGY
147 ONCOLOGY
149 PULMONARY DISEASE
156 PULMONARY DISEASE AND CRITICAL CARE MEDICINE
150 RHEUMATOLOGY
157 SPORTS MEDICINE
130 MEDICAL GENETICS
190 MOLECULAR GENETIC PATHOLOGY
160 NEUROLOGICAL SURGERY
180 NEUROLOGY
185 CHILD NEUROLOGY
187 CLINICAL NEUROPHYSIOLOGY
183 NEUROMUSCULAR MEDICINE
186 NEURODEVELOPMENTAL DISABILITIES
181 PAIN MEDICINE
188 VASCULAR NEUROLOGY
200 NUCLEAR MEDICINE
220 OBSTETRICS AND GYNECOLOGY
240 OPHTHALMOLOGY
260 ORTHOPAEDIC SURGERY
261 ADULT RECONSTRUCTIVE ORTHOPAEDICS
262 FOOT AND ANKLE ORTHOPAEDICS
263 HAND SURGERY
270 MUSCULOSKELETAL ONCOLOGY
268 ORTHOPAEDIC SPORTS MEDICINE
267 ORTHOPAEDIC SURGERY OF THE SPINE
269 ORTHOPAEDIC TRAUMA
265 PEDIATRIC ORTHOPAEDICS
280 OTOLARYNGOLOGY
286 NEUROTOLOGY
288 PEDIATRIC OTOLARYNGOLOGY
300 PATHOLOGY-ANATOMIC AND CLINICAL
305 BLOOD BANKING/TRANSFUSION MEDICINE
306 CHEMICAL PATHOLOGY
307 CYTOPATHOLOGY
310 FORENSIC PATHOLOGY
311 HEMATOLOGY
314 MEDICAL MICROBIOLOGY
315 NEUROPATHOLOGY
316 PEDIATRIC PATHOLOGY
301 SELECTIVE PATHOLOGY
320 PEDIATRICS
321 ADOLESCENT MEDICINE
329 NEONATAL-PERINATAL MEDICINE
325 PEDIATRIC CARDIOLOGY
323 PEDIATRIC CRITICAL CARE MEDICINE
324 PEDIATRIC EMERGENCY MEDICINE
326 PEDIATRIC ENDOCRINOLOGY
332 PEDIATRIC GASTROENTEROLOGY
327 PEDIATRIC HEMATOLOGY/ONCOLOGY
335 PEDIATRIC INFECTIOUS DISEASES
328 PEDIATRIC NEPHROLOGY
330 PEDIATRIC PULMONOLOGY
331 PEDIATRIC RHEUMATOLOGY
333 PEDIATRIC SPORTS MEDICINE
336 DEVELOPMENTAL-BEHAVIORAL PEDIATRICS
340 PHYSICAL MEDICINE AND REHABILITATION
341 PAIN MEDICINE
346 PEDIATRIC REHABILITATION
345 SPINAL CORD INJURY MEDICINE
360 PLASTIC SURGERY
361 CRANIOFACIAL CURGERY
363 HAND SURGERY
380 PREVENTIVE MEDICINE
399 MEDICAL TOXICOLOGY
398 UNDERSEA AND HYPERBARIC MEDICINE
400 PSYCHIATRY
401 ADDICTION PSYCHIATRY
405 CHILD AND ADOLESCENT PSYCHIATRY
406 FORENSIC PSYCHIATRY
407 GERIATRIC PSYCHIATRY
402 PAIN MEDICINE
409 PSYCHOSOMATIC MEDICINE
420 RADIOLOGY DIAGNOSTIC
421 ABDOMINAL RADIOLOGY
429 CARDIOTHORACIC RADIOLOGY
422 ENDOVASCULAR SURGICAL NEURORADIOLOGY
426 MUSCULOSKELETAL RADIOLOGY
423 NEURORADIOLOGY
425 NUCLEAR RADIOLOGY
424 PEDIATRIC RADIOLOGY
427 VASCULAR AND INTERVENTIONAL RADIOLOGY
430 RADIATION ONCOLOGY
520 SLEEP MEDICINE
440 SURGERY-GENERAL
443 HAND SURGERY
445 PEDIATRIC SURGERY
442 SURGICAL CRITICAL CARE
450 VASCULAR SURGERY
460 THORACIC SURGERY
480 UROLOGY
485 PEDIATRIC UROLOGY
999 OTHER

Practitioner's Name MICHAEL ISRAEL HERTZ License # ME0035436

FLORIDA DEPARTMENT OF HEALTH

MANDATORY PRACTITIONER PROFILE QUESTIONNAIRE

FLORIDA DEPARTMENT OF HEALTH
Division of Medical Quality Assurance
P. O. Box 6330
Tallahassee, Florida 32314-6330

I. PRACTITIONER DATA

A. PROFESSIONAL LICENSE NUMBER: ME0035436 (check one) ☑ ME/MD ☐ OS/DO ☐ CH/DC ☐ PO/DPM

B. NAME (INCLUDE MAIDEN AND ON 2ND/3RD LINES ANY ALIASES, IF APPLICABLE):
CURRENT NAME:

HERTZ	MICHAEL	ISRAEL
(LAST)	(FIRST)	(MIDDLE AND MAIDEN NAME, IF APPLICABLE)

FORMER NAME(S):

(LAST)	(FIRST)	(MIDDLE)
(LAST)	(FIRST)	(MIDDLE)

D. MAILING ADDRESS: 505 HAZEN STREET #204 PAW PAW MI 49079
(STREET AND NUMBER) (CITY) (STATE) (ZIP CODE)

PRIMARY PRACTICE ADDRESS: (Authority: s.455.565(1)(a)3.,F.S.)

505 HAZEN STREET #204 PAW PAW MI 49079
(PRACTICE NAME) (STREET AND NUMBER) (CITY) (STATE) (ZIP CODE)

OTHER PRACTICE LOCATION(S): (OPTIONAL)
OFFICE 2: (OPTIONAL)

(PRACTICE NAME) (STREET AND NUMBER) (CITY) (STATE) (ZIP CODE)

OFFICE 3: (OPTIONAL)

(PRACTICE NAME) (STREET AND NUMBER) (CITY) (STATE) (ZIP CODE)

E. TELEPHONE: (616) 655-8101 (This will not be published as a part of the profile.)

F. YEAR BEGAN PRACTICING MEDICINE: 1980 (Authority: s. 455.565(1)(a)5., F.S.)

II. ALL MEDICAL EDUCATION

A. Name of all medical schools attended. (Authority: s. 455.565(1)(a)1., F.S.)

NAME OF SCHOOL/UNIVERSITY	DATES OF ATTENDANCE	DATE OF GRADUATION	TYPE OF DEGREE
WAYNE STATE UNIVERSITY	1972-1976	1976	MD

B. Have you completed any graduate medical education? Yes ☑ No ☐
If "YES", list in chronological order from date of graduation to the present, all completed graduate medical education. Do not include coursework taken to meet the continuing education requirement for licensure renewal. (Authority: s. 455.565(1)(a)1., F.S.)

MEDICAL TRAINING PROGRAM NAME	INTERNSHIP / RESIDENCY / FELLOWSHIP / OTHER	SPECIALTY AREA	CITY / STATE / COUNTRY	FROM MM/DD/YYYY	TO MM/DD/YYYY
SINAI HOSPITAL OF DETROIT	INTERNSHIP	OBSTETRICS & GYNECOLOGY	DETROIT MI	7/1976	7/1977
	RESIDENCY	OBSTETRICS & GYNECOLOGY	"	7/1977	7/1980

Practitioner's Name MICHAEL ISRAEL HERTZ License # ME0035436

III. OTHER HEALTH RELATED DEGREES

Do you currently hold a degree in a health related profession other than the professional degree listed In II. A. above? Yes ☐ No ☑

If "YES", list all medical/professional schools from which a degree in a health related profession other than the professional degree was obtained. (Authority: s. 455.565.(1)(a)1., F.S.)

NAME OF SCHOOL / UNIVERSITY	CITY / STATE / COUNTRY	FROM MM/DD/YYYY	TO MM/DD/YYYY	DEGREE TITLE

IV. FACULTY APPOINTMENTS:

A. Have you had the responsibility for graduate medical education within the last 10 years? (Authority: s. 455.565.(1)(a)6., F.S.) Yes ☑ No ☐

B. Do you currently hold a faculty appointment at a medical/health related institution of higher learning? (Authority: s. 455.565(1)(a)6., F.S.) Yes ☑ No ☐

If "YES", to question "B" list the title of the current appointment, name(s) and city/state of institution(s).

	TITLE	INSTITUTION	CITY/STATE
1.	ASSISTANT CLINICAL PROFESSOR	MICHIGAN STATE UNIVERSITY COLLEGE OF HUMAN MEDICINE	EAST LANSING, MI
2.			
3.			

V. STAFF PRIVILEGES:

Do you currently hold staff privileges in a hospital/medical/health institution? Yes ☑ No ☐

If "YES", list each hospital/medical/health institution at which you currently have staff privileges. (Authority: s. 455.565(1)(a)2., F.S.)

	NAME OF HOSPITAL/MEDICAL/HEALTH INSTITUTION	CITY/STATE
1.	LAKEVIEW COMMUNITY HOSPITAL	PAW PAW, MI
2.	BRONSON METHODIST HOSPITAL	KALAMAZOO, MI
3.	WEST BOCA MEDICAL CENTER	BOCA RATON, FL

VI. SPECIALTY BOARD CERTIFICATIONS:

Do you hold a certification from any specialty board recognized by the Florida board regulating the profession for which you are licensed? Yes ☑ No ☐ (Authority: s. 455.565(1)(a)4. , F.S.)

If "YES", complete section below.

	SPECIALTY BOARD NAME	CERTIFICATION / SPECIALITY / SUBSPECIALITY
1.	AMERICAN BOARD OF OBSTETRICS & GYNECOLOGY	
2.		
3.		

VII. FINAL DISCIPLINARY ACTION:

A1. Within the previous ten (10) years, have you ever had any final disciplinary action taken against you by a specialty board recognized by the American Board of Medical Specialties, the American Osteopathic Association, the American Chiropractic Association, or other similar national organization? (Authority: s. 455.565(1)(a)8., F.S.) Yes ☐ No ☑

If "YES", list name(s) of specialty board(s), date, description of violation(s), description of the final disciplinary action(s), and indicate whether the final disciplinary action is under appeal. (attach copy of notice of appeal)

	SPECIALTY BOARD NAME	DATE	DESCRIPTION OF VIOLATION	DESCRIPTION OF FINAL DISCIPLINARY ACTION	UNDER APPEAL?
1.					Y / N
2.					Y / N
3.					Y / N

A2. Within the previous ten (10) years, have you ever had any final disciplinary action taken against you by the agency regulating your license, in this state or any other jurisdiction? (Authority: s. 455.565(1)(a)8., F.S.) Yes ☐ No ☑

If "YES", list name(s) of agency(s), date, description of violation(s), description of the final disciplinary action(s), and indicate whether the final disciplinary action is under appeal. (attach copy of notice of appeal)

	AGENCY NAME	DATE	DESCRIPTION OF VIOLATION	DESCRIPTION OF ACTION	UNDER APPEAL?
1.					Y / N
2.					Y / N
3.					Y / N

Practitioner's Name MICHAEL ISRAEL HERTZ License # ME0035436

A3. Within the previous ten (10) years, have you ever had any final disciplinary action taken against you by a licensed hospital, health maintenance organization, prepaid health clinic, ambulatory surgical center, or nursing home? (Authority: s. 455.565(1)(a)8., F.S.) Yes ☐ No ☑

If "YES", list name(s) of medical institution(s), date, description of violation(s), description of the final disciplinary action(s), and indicate whether the final disciplinary action is under appeal. (attach copy of notice of appeal)

	ENTITY NAME	DATE	DESCRIPTION OF VIOLATION	DESCRIPTION OF ACTION	UNDER APPEAL?
1.					Y / N
2.					Y / N
3.					Y / N

B. Within the previous ten (10) years, have you ever been asked to or allowed to resign from or had any medical staff privileges restricted or not renewed by any medical/health-related institution in lieu of or in settlement of a pending disciplinary action related to competence or character? (Authority: s. 455.565(1)(a)8., F.S.) Yes ☐ No ☑

If "YES", list name(s) of the facility(s), date, description of violations, description of the final disciplinary action(s), and indicate whether the final disciplinary action is under appeal. (attach copy of notice of appeal)

	INSTITUTION NAME	DATE	DESCRIPTION OF VIOLATION	DESCRIPTION OF ACTION	UNDER APPEAL?
1.					Y / N
2.					Y / N
3.					Y / N

VIII. CRIMINAL OFFENSES

Have you ever been convicted or found guilty, regardless of whether adjudication of guilt was withheld, or pled guilty or nolo contendere to a criminal misdemeanor or felony in any jurisdiction? (Authority: s. 455.565 (1)(a)7., F.S.) Yes ☐ No ☑

If "YES", briefly describe the offense(s), indicate whether the conviction is under appeal, and attach copy of notice of appeal.

	DESCRIPTION OF OFFENSE	DATE	JURISDICTION	UNDER APPEAL?
1.				Y / N
2.				Y / N
3.				Y / N

IX. STATEMENT OF FINANCIAL RESPONSIBILITY (Allopathic and Osteopathic Physicians Only)

A. Hospital Privileges - (Check only one) (Authority s. 455.5651(4), F.S.)

☐ 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, 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. 627.367, F.S. I further certify that I have been continuously insured with an entity as outlined above for the past two years (retroactive coverage) or if I seek insurance from a different entity providing insurance, I will purchase retroactive coverage for the two years preceding my inception date of coverage. I further certify that in the event my coverage is terminated or that I desire to become uninsured and meet the financial responsibility requirements through other provisions in s. 458.320 or 459.0085, F.S., I will maintain coverage for incidents which may have occurred during the two years preceding my becoming uninsured.

☐ 2. 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.627.367, F.S. I further certify that I have been continuously insured with an entity as outlined above for the past two years (retroactive coverage) or if I seek insurance from a different entity providing insurance I will purchase retroactive coverage for the two years preceding my inception date of coverage. I further certify that in the event my coverage is canceled or that I desire to become uninsured and meet the financial responsibility requirements through other provisions in s. 458.320 or 459.0085, F.S., I will maintain coverage for incidents which may have occurred during the two years preceding my becoming uninsured.

☐ 3. 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.

☐ 4. 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.

☐ 5. I have elected not to carry medical malpractice; however, I agree to satisfy any adverse judgments up to the minimum amounts pursuant to s. 458.320(5)(g)1 or 459.0085(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.

B. Exemption

I am exempt from demonstrating financial responsibility because I fall into one of the categories listed below: (Check one box only)

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

☐ 2. 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;

☐ 3. 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);

☑ 4. I do not practice medicine in the State of Florida; or

Practitioner's Name MICHAEL ISRAEL HERTZ License # ME0035436

☐ 5. I meet all 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 exemption 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 show medical services are being provided, that I have decided not to carry medical malpractice insurance. I understand such a sign or notice must contain the wording specified in s. 458.320(5)(f) or 459.0085(5)(f), F.S.

X. LIABILITY CLAIMS (Allopathic, Osteopathic and Podiatric Physicians Only)

A. Are you covered by an insurer required to report pursuant to s. 627.912 F.S. Yes ☑ No ☐
(Authority: s. 455.5651(4), F.S.; s. 455.565(1)(b),F.S.)

B. Have you been insured continuously during the last ten years? Yes ☑ No ☐
(Authority: s. 455.5651(4), F.S.; s. 455.565(1)(b),F.S.)

If you answered "NO" to either A or B above, you must complete the following: (Authority: s. 455.5651(4), F.S.; s. 455.5651(1)(b),F.S.)

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 ☐ No ☐

If "YES", complete and attach a copy of EXHIBIT 1 for each occurrence. NOTE: Copies of reports previously submitted may be re-submitted with this questionnaire to satisfy this reporting requirement. (Authority: s. 455.5651(4), F.S.; s. 455.565(1)(b),F.S.)

XI. LIABILITY CLAIMS (Chiropractic Physicians Only)

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 ☐ No ☐

If "YES", complete and attach a copy of EXHIBIT 1 for each occurrence. (Authority: s. 455.5651(4), F.S.; s. 455.565(1)(b),F.S.)

XII. OPTIONAL INFORMATION:

A. PUBLICATIONS: List any publications you have authored in peer-reviewed medical literature within the previous ten years:
(Authority s. 455.565(5)(a), F.S.)

	TITLE	PUBLICATION	DATE
1.			
2.			
3.			

B. DO YOU PARTICIPATE IN THE MEDICAID PROGRAM? (Authority s. 455.565(5)(d), F.S.) Yes ☐ No ☐

C. PROFESSIONAL OR COMMUNITY SERVICE ACTIVITIES, HONORS, OR AWARDS: (Authority s.455.565(5)(b), F.S.)

	COMMUNITY SERVICE/AWARD/HONOR	ORGANIZATION		COMMUNITY SERVICE/AWARD/HONOR	ORGANIZATION
1.			2.		
3.			4.		

D. NATIONAL, STATE, LOCAL, COUNTY, PROFESSIONAL AFFILIATIONS: (Authority s.455.565(5)(b), F.S.)

	ORGANIZATION		ORGANIZATION
1.		2.	
3.		4.	

E. 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. (Authority: s. 455.565(5)(c), F.S.)

1.		2.	
3.		4.	

F. E-MAIL ADDRESS: _____

G. COMMITTEES/MEMBERSHIPS: Indicate any committees on which you serve for any health entity with which you are affiliated.

	ORGANIZATION		ORGANIZATION
1.		2.	
3.		4.	

H. OTHER STATE LICENSURE:

	STATE	PROFESSION
1.		
2.		
3.		

I affirm 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 456.024, 458.327, 458.331, 459.013, 459.015, 460.413, 461.013, 775.082, 775.083 and 775.084, Florida Statutes.

Michael I. Hertz, MD 3/16/09
(Signature of Physician) (Date)

Practitioner's Name MICHAEL ISRAEL HERTZ License # ME0035436

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 455.697 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. 455.697, F.S., (formerly s. 355.247, F.S.) may be submitted in lieu of this exhibit to satisfy this reporting requirement.

Date of occurrence: 11 / 17 / 91 Date reported to licensee: 1 / 21 / 92

Injured person's name: (last, first, middle initial) W L

Street Address: UNKNOWN AT PRESENT

City: State: FL Zip Code: 33427

Age: 25 Sex: F

Date of suit: 7 / 16 / 93

List other defendants involved in this claim:

1. WEST BOCA MEDICAL CENTER 2.
3. 4.

Date of final claim disposition: 9 / 13 / 96

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

Indemnity paid on behalf of this defendant: $ 30,000

Loss adjustment expense paid to defense counsel: $

All other loss adjustment expense paid: $

Name of institution at which the injury occurred: WEST BOCA MEDICAL CENTER BOCA RATON, FLORIDA

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. PREGNANCY; ACUTE CHORIOAMNIONITIS; STILLBIRTH

Describe misdiagnosis made, if any, of the patient's actual condition. N/A

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. N/A

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. STILLBIRTH

Safety management steps taken by the licensee to make similar occurrences less likely. APPROPRIATE USE OF FETAL MONITORING BY NURSES

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 458.624, 458.327, 458.331, 459.013, 459.015, 460.413, 461.013, 775.082, 775.083, and 775.084, Florida Statutes.

Signature of Physician: Michael Hertz MD

Our records indicate the following reported claims:

Incident Date	Settlement Date	Incident Date	Settlement Date	Incident Date	Settlement Date	Incident Date	Settlement Date	Incident Date	Settlement Date
11/17/1991		11/17/1991		03/23/1993		03/23/1993		11/17/1991	9/13/96
07/19/1993		03/24/1993							

Corrected per Donna Kirk Telephone call 3/11/99

Jeb Bush
Governor

FLORIDA DEPARTMENT OF
HEALTH

Robert G. Brooks, M.D.
Secretary

October 19, 1999

MICHAEL I HERTZ, M.D.
505 HAZEN STREET
#204
PAW PAW, MI-49079

Dear Dr. HERTZ

We have not received a response as of September 17, 1999, to a letter we sent to you asking you to verify the correctness of your profiling data which is to be published on the World Wide Web. Please review the profile information contained in this letter for any changes, corrections, and/or omissions to insure the information that will be published is correct. Even if you have no changes, check the correct box below and return it to the Department at Post Office Box 6330, Tallahassee, Florida 32314-6330. If you do have changes, please indicate them directly on this letter. If you do not respond to this request within two weeks of the date of this correspondence your profile will be published as it appears in this letter.

☐ My profiling information is correct.

☒ My profiling information is incorrect; changes are noted below.

I. Practitioner Information

License Number : 35436
Profession : Medical Doctor
License Status : ACTIVE CLEAR
Year Began Practicing : 01/01/1980

Primary Business:

FL

Secondary Locations:

Staff Privileges:

Institution Name	City	State
WEST BOCA MEDICAL CENTER	BOCA RATON	FLORIDA

Faculty Appointments:
This practitioner has had the responsibility for graduate medical education within the last 10 years.

This practitioner currently holds faculty appointments at the following medical/health related institutions of higher learning:
Title : Institution : City : State
1. ASSISTANT CLINCAL PROFESSOR : MICHIGAN STATE UNIVERSITY COLLEGE OF HUMAN MEDICINE : EAST LANSING : MICHIGAN

Participates in Medicaid Program:

The practitioner did not indicate if he/she participates in the Medicaid program.

II. Education and Training

- THIS WAS GIVEN BEFORE!!

Medical School : Dates of Attendance : Graduation Date : Degree Title

WAYNE STATE UNIVERSITY SCHOOL OF MEDICINE 1972-1976 MAY, 1976 M.D.

The parctitioner failed to provide this mandatory information

Other Health Related Degrees:

The practitioner did not provide this mandatory information.

III. Professional and Postgraduate Training

This practitioner has completed the following graduate medical education:
Program Name : Program Type : Specialty Area : City : State/Country : Dates Attended

1. MT SINAI HOSPITAL : INTERNSHIP : OBG - OBSTETRICS AND GYNECOLOGY : DETROIT : MICHIGAN : 3/1/76 - 2/1/77

2. MT SINAI HOSPITAL : RESIDENCY : OBG - OBSTETRICS AND GYNECOLOGY : DETROT : MICHIGAN : 3/1/77 - 3/1/80

IV. Specialty

This practitioner holds the following certifications from specialty boards recognized by the Florida board which regulates the profession for which he/she is licensed:
Specialty Board : Certification
1. AMERICAN BOARD OF OBSTETRICS & GYNECOLOGY : .....

V. Optional Information

Committees:/Memberships

This practitioner has not indicated any committees on which they serve for any health entity with which they are affiliated.

Professional or Community Service Awards

This practitioner has not provided any professional or community service activities, honors, or awards.

Publications

This practitioner has not provided any publications that he/she authored in peer-reviewed medical literature within the last ten years.

Languages Other Than English

This practitioner has not indicated that any languages other than English are used to communicate with patients, or that any translation service is available for patients, at his/her primary place of practice.

Other Affiliations

This practitioner has provided the following national, state, local, county, or professional affiliations:
1. LAKEVIEW COMMUNITY HOSPITAL,PAWPAW MI
2. BRONSON METHODIST HOSPITAL, KALAMAZOO,MI

E-Mail Address
Not Provided

Other State Licensure

This practitioner has not indicated any additional state licensure.

VI. Financial Responsibility

I do not practice medicine in the State of Florida.

VII. Criminal Offenses

The criminal history information, if any exists, will be incomplete; federal criminal history is not available to the public. The criminal history information provided by the practitioner has not been completely verified at this time. All criminal history checks should be completed by March 2000.

This practitioner has indicated that he/she has NO criminal offenses.

VIII. Final Disciplinary Action (Within last 10 years)

Pursuant to section 455.5651(5), F.S. the profile will not include disciplinary action taken by a hospital or ambulatory surgical centers licensed under chapter 395, F.S.

This practitioner has indicated that he/she has NOT had any final disciplinary action taken against him/her within the previous 10 years by a specialty board.

This practitioner has indicated that he/she has NOT had any final disciplinary action taken against him/her within the previous 10 years by a licensing agency.

This practitioner has indicated that he/she has NOT had any final disciplinary action taken against him/her within the previous 10 years by a health maintenance organization, pre-paid health clinic, nursing home, out-of-state hospital or out-of-state ambulatory surgical center.

This practitioner has indicated that he/she has NEVER been asked to or allowed to resign from or had any medical staff privileges restricted or revoked within the previous 10 years by a health maintenance organization, pre-paid health clinic, nursing home, out-of-state hospital or out-of-state ambulatory surgical center.

IX. Liability Claims Exceeding $5,000.00 (Within last 10 years)

Settlement of a claim may occur for a variety of reasons that do not necessarily reflect negatively on the professional competence or conduct of the physician. A payment settlement of a medical malpractice action or claim should not be construed as creating a presumption that medical malpractice has occurred.

Incident Date	County	Judicial Case #	Settlement Date	Amount	Policy Amount
11/17/91	PALM BEACH	93-6113AB06	9/13/96	30000	

If you wish to make changes to the profile after it has been published, please submit them to 2020 Capital Circle SE, Bin # C10, Tallahassee, Florida 32399-6230.

If you have any questions or comments, call (850) 410-3359 Extension 2009.

Sincerely,

Bureau of Operations

Florida Department of Health - Board of Medicine

License Renewal Notice

Active (group 2) Medical Doctor License # ME 35436 expires January 31, 2002.

To avoid a delinquent charge, the fee of **$598.50** and the renewal form must be postmarked or electronically submitted on or before January 31, 2002. Renewal notices/forms postmarked on or after February 1, 2002 require renewal and delinquency fees of **$791.00**.

1. CHANGE OF MAILING ADDRESS:

Current Mailing Address:

MICHAEL ISRAEL HERTZ
505 HAZEN STREET
#204
PAW PAW, MI 49079

New Mailing Address:

Licensee's Last Name | First | Middle Initial

Attn:

Street Address:

City | State | Zip:

Phone: ( )

DEPARTMENT USE ONLY

2. CHANGE OF PRACTICE LOCATION:

Current Practice Location:

505 HAZEN STREET
#204
PAW PAW, MI 49079

New Practice Location:

Attn:

Street Address:

City | State | Zip:

Phone: ( )

3. Chapter 456, F.S., requires a background check to renew a license, please review the following data to verify that the information is correct, please make any necessary corrections. This information is critical in ensuring that background checks are attributed to the correct licensee.

Description	Department Information	Information is Accurate		Correct Information
Social Security #		◯ Yes	◯ No	
Date of Birth	11/10/49	◯ Yes	◯ No	
Sex	Data Missing	◯ Yes	◯ No	
Race	Not Given	◯ Yes	◯ No	

Race Options: White, Black, Native, Asian, Other, Hispanic & not given

4. COMPLETE THE FINANCIAL RESPONSIBILITY FORM ON THE REVERSE SIDE OF THIS FORM.

5. MILITARY STATUS:

◯ I am requesting Military Restricted Status. (Military Restricted must submit proof of active military duty. Attach a copy of your current active duty orders or a letter from your Commanding Officer.)

◯ Please remove the Military Restricted Status from my license. (Provide copy of DD214 or letter from Commanding Officer.)

6. 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

7. THERE ARE TWO RENEWAL METHODS AVAILABLE:

A. Internet E-Renewal: Web address http://www.doh.state.fl.us/erenewal

E-Renewal allows you to make address changes. E-Renewal does not allow you to renew online by adding or removing a status, such as paying a delinquency fee or changing a license status. Due to high volume, allow sufficient time to renew since **e-Renewal will not be available after midnight Eastern Time (ET) January 31, 2002**. E-Renewal will require the following information:

License Number: ME 35436

B. U.S. Mail:

Mail this completed renewal form and fee payable to the Department of Health to:

P.O. Box 6320
Tallahassee, Florida 32314-6320

8. Other Information:

File Number: 27601 20 20 Sequence Number: 3577

MEN 0 0 0 0 3 5 4 3 6

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 - CATEGORIES OF 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. 627.367, F.S. I further certify that I have been continuously insured with an entity as outlined above for the past two years (retroactive coverage) or if I seek insurance from a different entity providing insurance; I will purchase retroactive coverage for the two years proceeding my inception date of coverage. I further certify that in the event my coverage is terminated or that I desire to become uninsured and meet the financial responsibility requirements through other provisions in s. 458.320 or 459.0085, F.S., I will maintain coverage for incidents which may have occurred during the two years preceding my becoming uninsured.

◯ 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. 627.367, F .S. I further certify that I have been continuously insured with an entity as outlined above for the past two years (retroactive coverage) or if I seek insurance from a different entity providing insurance I will purchase retroactive coverage for the two years preceding my inception date of coverage. I further certify that in the event my coverage is cancelled or that I desire to become uninsured and meet the financial responsibility requirements through other provisions in s. 458.320 or 459.0085, F.S., I will maintain coverage for incidents which may have occurred during the two years preceding my becoming uninsured.

◯ 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 459.008S(5)(g), F. S.

CATEGORY II - EXEMPTION CATEGORIES OF FINANCIAL RESPONSIBILITY COVERAGE:

◯ 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. I understand such a sign or notice must contain the wording specified in s. 458.320(5)(t) or 459.0085(5)(t), F. S.; or

◯ 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).

NAME: DATE:

CAMERA: II ROLL #:

35436

Department of Professional Regulation

Governor
Bob Graham
Secretary
Nancy Kelley Wimenberg

Board of Medical Examiners
2009 Apalachee Parkway - Tallahassee, Florida 32301
(904) 488-7614

February 10, 1981

TO WHOM IT MAY CONCERN:

This is to certify that Michael J. Hertz M.D.
is licensed to practice medicine and surgery in the State of Florida.
He was issued license No. 35436 by the
Florida State Board of Medical Examiners on 10-11-79.

This license, No. 35436, has never been suspended or revoked
and is in full force and effect.

FLORIDA STATE BOARD
OF MEDICAL EXAMINERS

Dorothy J. Faircloth
Executive Director

BOARD SEAL:

NAME: [illegible] DATE: [illegible]

CAMERA: II ROLL #: [illegible]

35436

RECEIVED MAY 1 1981

NORTH BROWARD HOSPITAL
201 SAMPLE ROAD
POMPANO BEACH, FLORIDA
33064
TELEPHONE 941-8300

George S. Palmer, M.D.
Executive Director
Florida Board of Medical Examiners
Oakland Building, Suite 220
2009 Apalachaee Parkway
Tallahassee, Florida 32301

RE: MICHAEL HERTZ, M.D.

Dear Dr. Palmer:

The above named physician has applied for membership to the Medical Staff of North Broward Hospital. It would be greatly appreciated if you could verify the information concerning his Florida License.

Thank you for your cooperation.

Sincerely,

Robert L. Kennedy
Administrator

/pj

License No. 35436
Issued: 10/11/79
Verified by: Chandra Rios
Date: 5/5/81

NAME: DATE:

CAMERA: I ROLL #:

35436

NORTH BROWARD HOSPITAL
201 SAMPLE ROAD
POMPANO BEACH, FLORIDA
33064
TELEPHONE 941-8300

March 31, 1981

George S. Palmer, M.D.
Executive Director
Florida Board of Medical Examiners
Oakland Building, Suite 220
2009 Apalachee Parkway
Tallahassee, Florida 32301

RE: MICHAEL I. HERTZ, M.D.
#35436

Dear Dr. Palmer:

The above named physician has applied for membership to the Medical Staff of North Broward Hospital. It would be greatly appreciated if you could verify the information concerning his Florida License.

Thank you for your cooperation.

Sincerely,

Robert L. Kennedy
Administrator

/pj

License No. 35436
Issued: 10.11.79
Verified by: Chandra Rice
4/24/81

Roll 23
DATE 2/10/83

SEPTEMBER

DEPARTMENT OF PROFESSIONAL AND OCCUPATIONAL REGULATION
STATE BOARD OF MEDICAL EXAMINERS OF FLORIDA
OAKLAND BUILDING, SUITE 320
2009 APALACHEE PARKWAY
TALLAHASSEE, FLORIDA 32301

AUG 31 1979

TO: MICHIGAN Board of Medicine
P.O. Box 30018
905 Southland
Lansing, Michigan 48909

August 29, 1979

FROM: George B. Palmer, M.D., Executive Director
Florida State Board of Medical Examiners

The following doctor has made application to take the examinations for medical licensure in Florida.

He states that he is licensed to practice medicine in your state. Will you please complete the form below and return it to this office at your earliest convenience?

Thank you for your cooperation

Name: MICHAEL ISRAEL HERTZ, M.D.

Graduated: Wayne State University, May 23, 1976 ok

License Number: 37973 ok Issued: June 21, 1977 ok

By written examination: National Bds. Through Reciprocity:

License is in good standing: yes

License has been revoked or suspended: no

Reason:

Derogatory information: none

Remarks:

Signed: [signature] Ex Director Secretary

Date: 8/31/79

(If additional space is needed please use back of page)

Florida Department of Health - Board of Medicine
LICENSE RENEWAL NOTICE

Active Medical Doctor License # ME 35436 expires January 31, 2005.

DUE ONLY
Received Date : 11/1/04
Deposit Date : 11/1/04

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

Check Amount : $454.00
PRO CDE : 1501

1. CURRENT MAILING ADDRESS:
This address will be used for all correspondence from the Department of Health.

MICHAEL ISRAEL HERTZ
13322 N. BOULEVARD
SUITE A
VICKSBURG, MI 49097

2. CURRENT PRACTICE LOCATION:
This address will be printed on your license and posted on the Internet.

505 HAZEN STREET
#204
PAW PAW, MI 49079

3. RENEW ON LINE TODAY!

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

4. CHANGES TO CURRENT LICENSE INFORMATION:

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

5. THERE ARE TWO RENEWAL METHODS AVAILABLE:

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

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

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

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

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

6. Other Information:

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

File Number: 27601 Sequence Number: 1655
Profession Code: 1501 20 20

ME 0 0 0 0 0 0 3 5 4 3 6

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

MQA
the road to quality health care begins here.

7. CHANGES TO CURRENT LICENSE INFORMATION:

PLEASE READ THIS SECTION CAREFULLY BEFORE MAKING ANY CHANGES:

To indicate changes in any section, complete the change indicator oval like this (X)
When providing updated information, print each character inside the box like this | A | B | C | 1 | 2 | 3 |
Use black/blue pen or No.2 pencil only for all changes.

( ) **CHANGE OF NAME:**

Name changes require legal documentation showing the name change. Please make sure that a photocopy of one of the following accompanies this form: a marriage license (marriage license must indicate the original signature and seal from the clerk of the court), a divorce decree indicating restoration of your maiden name, or a court order (e.g., adoption, name change, or federal identity change). Any one of these will be accepted unless the department has a question about the authenticity of the document. A driver's license or social security card is not considered legal documentation.

If the name change cannot be completed, your license will be renewed using the current name.

Last Name:

First Name:

Middle Name: Title: Suffix: *(Jr,Sr,I,II,etc.)* Qualifier: *(PhD,DDS,etc.)*

( ) **CHANGE OF MAILING ADDRESS:**

Attention:

Street Addr1:

Street Addr2:

City:

State: Zip: - Phone: ( ) -

(X) **CHANGE OF PRACTICE LOCATION: (This address can not be a Post Office Box)**

Attention:

Street Addr1: 13322 N. BOULEVARD

Street Addr2: SUITE A

City: VICKSBURG

State: MI Zip: 49097- Phone: (269) 649-5301

CHECKLIST FOR MAILING RENEWAL FORM

If mailing your renewal form, use the checklist below as a guide for enclosing all the required items to ensure a smooth renewal. If renewing by mail, allow 4-6 weeks processing time.

REQUIRED:
- ( ) Renewal notice
- ( ) Check or Money order written to Department of Health
- ( ) Financial responsibility form (check only one item on the FR form)
- ( ) Mail to: PO Box 6320, Tallahassee, Florida 32314-6320

If you are renewing to active status, would you be available to provide health care services in special needs shelters or to help staff disaster medical assistance teams during times of emergency or major disaster?

( ) Yes

CHANGE OF LICENSE STATUS:

( ) I wish to change my status from Active to Inactive. The fee for an inactive receipt is **$415.00**. The fee for inactive after January 31, 2005 is **$900.00**.

CHANGE OF MILITARY STATUS:

( ) I am requesting Military Restricted Status. (You must submit proof of active military duty. Attach a copy of your current active duty orders or a letter from your Commanding Officer.) The fee for military restricted is **$00.00**.

DISPENSING:

( ) I wish to dispense medicinal drugs for a fee from my practice location and I understand an annual inspection of my dispensing records will be conducted. The fee for registration as a dispensing practitioner is **$100.00** in addition to your renewal fee.

FINANCIAL RESPONSIBILITY

NAME: MICHAEL ISRAEL HERTZ, MD LICENSE NUMBER: 35436

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.

OPTION 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 an 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. 627.367, 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.627.367, F.S.

☐5. I have elected not to carry medical malpractice insurance, however, I agree to satisfy any adverse judgments up to the minimum amounts pursuant to s. 458.320(5)(g)1 or 459.0085(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.

OPTION II: Financial Responsibility Exemptions

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

☐2. 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;

☑3. I do not practice medicine in the State of Florida;

☐4. 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 $25,000 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. I understand such a sign or notice must contain the wording specified in s. 458.320(5)(g) or 459.0085(5)(g), F. S.; or

☐5. 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).

BRONSON METHODIST HOSPITAL
NC20

CHECK NO. 119891
VENDOR # D632004

CONTROL NO. 4100
CHECK SEQ. NO. 6

INVOICE #	INV DATE	PURCH ORDER #	GROSS AMOUNT	DISCOUNT	NET AMOUNT
DR M. HERTZ LI	10/18/2004		454.00	0.00	454.00
		TOTALS:	454.00	0.00	454.00

Florida Department of Health - Board of Medicine
LICENSE RENEWAL NOTICE

Active Medical Doctor License # ME 35436 expires January 31, 2005.

DEPARTMENT USE ONLY

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

1. CURRENT MAILING ADDRESS:
This address will be used for all correspondence from the Department of Health.

MICHAEL ISRAEL HERTZ
13322 N. BOULEVARD
SUITE A
VICKSBURG, MI 49097

2. CURRENT PRACTICE LOCATION:
This address will be printed on your license and posted on the Internet.

505 HAZEN STREET
#204
PAW PAW, MI 49079

3. RENEW ON LINE TODAY!

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

4. CHANGES TO CURRENT LICENSE INFORMATION:

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

5. THERE ARE TWO RENEWAL METHODS AVAILABLE:

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

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

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

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

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

6. Other Information:

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

File Number: 27601 Sequence Number: 1655
Profession Code: 1501 20 20

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

7. CHANGES TO CURRENT LICENSE INFORMATION:

PLEASE READ THIS SECTION CAREFULLY BEFORE MAKING ANY CHANGES:

To indicate changes in any section, complete the change indicator oval like this (X)
When providing updated information, print each character inside the box like this A B C 1 2 3
Use black/blue pen or No.2 pencil only for all changes.

( ) CHANGE OF NAME:

Name changes require legal documentation showing the name change. Please make sure that a photocopy of one c the following accompanies this form: a marriage license (marriage license must indicate the original signature and seal from the clerk of the court), a divorce decree indicating restoration of your maiden name, or a court order (e.g., adoption, name change, or federal identity change). Any one of these will be accepted unless the department has a question about the authenticity of the document. A driver's license or social security card is not considered legal documentation.

If the name change cannot be completed, your license will be renewed using the current name.

Last Name:
First Name:
Middle Name: Title: Suffix: *(Jr,Sr,I,II,etc.)* Qualifier: *(PhD,DDS,etc.)*

( ) CHANGE OF MAILING ADDRESS:

Attention:
Street Addr1:
Street Addr2:
City:
State: Zip: - Phone: ( ) -

( ) CHANGE OF PRACTICE LOCATION: (This address can not be a Post Office Box)

Attention:
Street Addr1:
Street Addr2:
City:
State: Zip: - Phone: ( ) -

CHECKLIST FOR MAILING RENEWAL FORM

If mailing your renewal form, use the checklist below as a guide for enclosing all the required items to ensure a smooth renewal. If renewing by mail, allow 4-6 weeks processing time.

REQUIRED:
- ( ) Renewal notice
- ( ) Check or Money order written to Department of Health
- ( ) Financial responsibility form (check only one item on the FR form)
- ( ) Mail to: PO Box 6320, Tallahassee, Florida 32314-6320

If you are renewing to active status, would you be available to provide health care services in special needs shelters or to help staff disaster medical assistance teams during times of emergency or major disaster?

( ) Yes

CHANGE OF LICENSE STATUS:

( ) I wish to change my status from Active to Inactive. The fee for an inactive receipt is **$415.00**. The fee for inactive after January 31, 2005 is **$900.00**.

CHANGE OF MILITARY STATUS:

( ) I am requesting Military Restricted Status. (You must submit proof of active military duty. Attach a copy of your current active duty orders or a letter from your Commanding Officer.) The fee for military restricted is **$00.00**.

DISPENSING:

( ) I wish to dispense medicinal drugs for a fee from my practice location and I understand an annual inspection of my dispensing records will be conducted. The fee for registration as a dispensing practitioner is **$100.00** in addition to your renewal fee.

PART B ME 35436

RENEWAL NOTICE

STATE OF FLORIDA DEPARTMENT OF HEALTH
BOARD OF MEDICINE

IMPORTANT: BY SUBMITTING THE APPROPRIATE RENEWAL FEES TO THE DEPARTMENT, A LICENSEE AFFIRMS COMPLIANCE WITH ALL REQUIREMENTS FOR RENEWAL, INCLUDING CONTINUING EDUCATION CREDITS.

Signature: Michael I. Hertz 2000

Please Indicate Mailing Address Change Below

Licensee's Last Name	First	Middle Initial
Street Address		
Street Address		
City	State	Zip

MICHAEL ISRAEL HERTZ
505 HAZEN STREET
#204

PAW PAW, MI 49079

YOUR **MEDICAL DOCTOR LICENSE**

WILL EXPIRE **JANUARY 31, 2000**

REMIT FEE OF **$355.00**

$705.00 **AFTER EXPIRATION**

ME 0000035436

FLORIDA DEPARTMENT OF HEALTH

Division of Medical Quality Assurance
P.O.Box 6340
Tallahassee, Florida 32314-6340

MAILED FROM ZIP CODE 32301 Aug 30 2012

PRSRT FIRST-CLASS
U.S. POSTAGE
PAID
TALLAHASSEE, FL-32301
PERMIT NO. 543

AUTO 35436

38:63:24815 *** **Important License Information** ***

MICHAEL ISRAEL HERTZ
3976 DEER GLEN DRIVE
ANN ARBOR, MI 48108

:481082707760:

Your license is scheduled for renewal within the next 5 months. You are required to review and, if appropriate, update your profile before renewing your license. In addition, Section 456.042, Florida Statutes, requires you to submit profile updates within 15 days of any changes.

You may review, update and confirm the accuracy of your practitioner profile information online by visiting **www.FLHealthsource.com**. Select LICENSEE/PROVIDER, click on VIEW PROFILE, and Login with your Account ID and Password. If you make changes to your profile, BE SURE to click on "confirm changes" to update the Department's information system.

If you have any questions, please contact the MQA Call Center at (850) 488-0595.

Division of Medical Quality Assurance
P.O. Box 4839
Tampa, Florida 33677-4839

*** License Renewal Notification ***
MICHAEL ISRAEL HERTZ
3976 DEER GLEN DRIVE
ANN ARBOR, MI 48108

License Renewal Notification

Your Medical Doctor License # **ME 35436** will expire at midnight, Eastern Standard Time (EST) on **Thursday, January 31, 2013**.

Please log onto **www.FLHealthsource.com** and follow these steps:

1. Click **Renew My License** and log in.
2. Click **Renew License** and select your renewal option:
    a. Renew on-line
    b. Print your renewal notice to submit with your payment via mail

You will be prompted to complete the Physician Workforce Survey online.

Renewals by mail **MUST** include the renewal form, not this postcard.

Visit **www.cebroker.com/subscribe** to purchase your **optional** subscription and track your continuing education credits.

Section 456.0635, F.S., may affect your ability to renew your license. Please visit **http://www.doh.state.fl.us/mqa/laws.html** for more information.

Remember, all renewals MUST be submitted **no later than January 31, 2013** in order to avoid a delinquent fee. Questions? Contact the MQA Call Center at (850) 488-0595.