

CREDENTIALING UNIT TRANSMITTAL SHEET

FILE COMPLETED _____ <small>(DATE)</small>		SUBMITTED FOR REVIEW <u>9/4/05</u> <small>(DATE)</small>	
FILE APPROVED <input checked="" type="checkbox"/> <small>(SEE WORKSHEET FOR SIGNATURE)</small>	FILE INCOMPLETE <input type="checkbox"/>	FILE RETURNED _____	
ITEMS IDENTIFIED AS INCOMPLETE/INCORRECT:			
			ITEM RECEIVED
●	_____	_____
●	_____	_____
●	_____	_____
●	_____	_____
FILE RE-SUBMITTED FOR REVIEW _____		EXCEL REPORT UPDATED <input type="checkbox"/> <small>(LAST DOCUMENT DATE)</small>	
FILE APPROVED <input type="checkbox"/> <small>(SEE WORKSHEET FOR SIGNATURE)</small>	FILE INCOMPLETE <input type="checkbox"/>	FILE RETURNED _____	
ITEMS IDENTIFIED AS INCOMPLETE/INCORRECT:			
			ITEM RECEIVED
●	_____	_____
●	_____	_____
FILE RE-SUBMITTED FOR REVIEW _____		EXCEL REPORT UPDATED <input type="checkbox"/> <small>(LAST DOCUMENT DATE)</small>	
FILE APPROVED <input type="checkbox"/> <small>(SEE WORKSHEET FOR SIGNATURE)</small>	FILE INCOMPLETE <input type="checkbox"/>	FILE RETURNED _____	
ADDITIONAL COMMENTS:			

EDICAL BOARD
bje1303
INDIVIDUAL NAME
LAST HERTZ
FIRST MICHAEL
MIDDLE I

ASSESSMENT SYSTEMS, INC.
REAL SYSTEM
(JR, SR, III)

03-22-05
02:50:40 PM
V2.5.74
REFERENCE # MC00017174
SOC SEC NUM 1 - DOH Licensee Social Security Number -...

RESIDENCE INFORMATION
298 EAST SALISBURY ST
PITTSBORO NC 27312

PHONE: () - COUNTY: 51
() - LGL ST:

NOTES

+--ADDITIONAL INFORMATION-----+
SEX M = MARRIED Y =
OTHER NAME
CORP. OFFICER =
TRUST ACCOUNT
BIRTH PLACE HIGHLAND PARK MI
DATE 11-10-1949
SCHOOL CODE 023040
CE UNITS 0.00 REQD BY - -
+-----+

+-----+
CURRENT STATUS: U EXPIRATION DATE: - - FIRST ISSUE DATE: - -
RENEWAL STATUS: LAST ACTIVE DATE: - - LAST RENEWAL DATE: - -
COMPLAINTS O/C: 0/0 AUTHORITY:
+-----+

1GO BACK 2NAM&ADDR 3EDUCATE 4LIC FUNC 5INVESTG 6 7OTHR DAT 8EXTD N

DEFICIENCY LETTER LOG SHEET

ITEM	Calendar Date	Julian Date
Application Received		
Deficiency Letter 1	MAR 23 ⁹	
Deficiency Letter 2		
Deficiency Letter 3		
Deficiency Letter 4		
Deficiency Letter 5		
Deficiency Letter 6		
Deficiency Letter 7		
Deficiency Letter 8		
Deficiency Letter 9		
Deficiency Letter 10		
Deficiency Letter 11		
Deficiency Letter 12		
Deficiency Letter 13		
Deficiency Letter 14		
Deficiency Letter 15		
Deficiency Letter 16		
Deficiency Letter 17		
Deficiency Letter 18		
Deficiency Letter 19		
Deficiency Letter 20		

DATE	TELEPHONE LOG	INITIALS
4-13-05	Rep called to check app status.	EB

Medical Quality Assurance Commission Physician Application Worksheet

Name HERTZ MICHAEL Date of Birth 11/10/1949
 Date Received 03/17/2005 Candidate Number 17774 License Number _____

Background Check Fee Photo Data 1-13 AIDS Attest SSN

Chronology Complete Missing: _____
 GARFIELD CHECK Number: _____
 3/18/05 FSMB 3/18/05 AMA ECFMG Archive File

Personal Data "Yes"s	Documentation Received	Malpractice Cases	Synopsis	Disposition
#9		1	X	X
		2	X	X
		3	X	X
		4	X	X

Medical School WAYNE STATE School Code _____ U.S. Canadian International
 Name WAYNE STATE Year of Degree 1976 Translations _____

Examination Type National Boards FLEX USMLE State Exam LMCC 2/28/05

5/3	SINKI 3/76-3/80				

<input checked="" type="checkbox"/> MI	<input checked="" type="checkbox"/> LAKEVIEW
<input checked="" type="checkbox"/> FL	3/16/05 BRONSON METHODIST VICKSBURG
	3/16/05 BRONSON METHODIST KALAMAZOO

Signature Michael A. Lopez Date 5/10/05

Comments:
Pre: Malpractice case approved by Bill Cruwell MD

MEDICAL QUALITY ASSURANCE COMMISSION

STAFF MEDICAL CONSULTANT REVIEW

APPLICANT NAME: Hertz, Michael DATE REVIEWED 5/6/05

SUBMITTED BY: Boez

MEDICAL CONSULTANT,
PLEASE REVIEW THE MALPRACTICE INFORMATION IN THE ATTACHED
APPLICATION FILE.

APPROVED: DISAPPROVED: DATE: May 10, 2005

SIGNATURE: Bone Marrow PA-C

COMMENTS: _____



325-

PHYSICIAN & SURGEON

REVENUE SECTION

PRINT NAME

Hertz, M.

RETURN THIS PORTION
WITH CHECK & APPLICATION

1F 0252090000 00236

001621 03/16/2005

32500

OS0751621

MAR 17 2005

6 ✓

Investigative Service of Health

FOR OFFICE USE ONLY	
ISSUANCE DATE	
LICENSE #	45003

LICENSE #

Application For License To Practice Medicine Applicable For MD's Only

- National Boards Other State Exam LMCC (must have been obtained after 1969)
 FLEX Examination USMLE Examination

Please Type or Print Clearly—Follow carefully all instructions in the general instructions provided. It is the responsibility of the applicant to submit or request to have submitted all required supporting documents. Failure to do so could result in a delay in processing your application.

NOTE: Application fees are non-refundable. Make remittance payable to the Department of Health.

1. Demographic Information

APPLICANT'S NAME	LAST HERTZ	FIRST MICHAEL	MIDDLE INITIAL I
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ADDRESS
298 EAST SALISBURY ST.

CITY PITTSBORO	STATE NC	ZIP 27312	COUNTY CHATHAM
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NOTE: The mailing address you provide will be the address of record. Your license document will show this address and all correspondence from the Department will be sent to this address until you notify us in writing of a change. Pursuant to WAC 246-12-310, it is your responsibility to maintain a current mailing address on file with the Department.

TELEPHONE (ENTER THE NUMBER AT WHICH YOU CAN BE REACHED DURING NORMAL BUSINESS HOURS.) (269) 649-5301	SOCIAL SECURITY NUMBER (Required for license under 42 USC 666 and Chapter 26.23 RCW) 1 - DOH Licensee Social Security Number - RCW 42.56.350(1)
--	--

GENDER <input type="checkbox"/> Female <input checked="" type="checkbox"/> Male	BIRTHDATE (MO/DAY/YEAR) 11-10-49	PLACE OF BIRTH (CITY/STATE) HIGHLAND PARK MI
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HPOA RECEIVED

Have you previously applied for a Washington State license or limited license? Yes No MAR 17 2005

Have you ever been known under any other name(s)? Yes No

If yes, list name(s): N/A

HEIGHT 5'6"	WEIGHT 170
----------------	---------------

EYE COLOR BROWN	HAIR COLOR BLACK
--------------------	---------------------

MEDICAL SCHOOL WAYNE STATE UNIVERSITY SCHOOL OF MEDICINE	YEAR OF GRADUATION 1976
---	----------------------------

MEDICAL SPECIALITY
OB/GYN



1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain. **NO**

"Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

1a. If you answered "yes" to question 1, please explain whether and how the limitations or impairments caused by your medical condition are reduced or eliminated because you receive ongoing treatment (with or without medications).

1b. If you answered "yes" to question 1, please explain whether and how the limitations and impairments caused by your medical condition are reduced or eliminated because of your field of practice, the setting or the manner in which you have chosen to practice.

(If you answered "yes" to question 1, the licensing authority (Board/Commission or Department as appropriate) will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition, the treatment ongoing, and the factors in "1b" so as to determine whether an unrestricted license should be issued, whether conditions should be imposed or whether you are not eligible for licensure.)

2. Do you currently use chemical substance(s) in any way which impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain. **NO**

"Currently" means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, and includes at least the past two years.

"Chemical substances" includes alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

3. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism or frotteurism? **NO**

4. Are you currently engaged in the illegal use of controlled substances? **NO**

"Currently" means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, and includes at least the past two years.

"Illegal use of controlled substances" means the use of controlled substances obtained illegally (e.g., heroin, cocaine) as well as the use of legally obtained controlled substances, not taken in accordance with the directions of a licensed health care practitioner.

Note: If you answer "yes" to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders.

5. Have you ever been convicted, entered a plea of guilty, nolo contendere or a plea of similar effect, or had prosecution or sentence deferred or suspended, in connection with: **NO**

a. the use or distribution of controlled substances or legend drugs?

b. a charge of a sex offense?

c. any other crime, other than minor traffic infractions? (Including driving under the influence and reckless driving)

6. Have you ever been found in any civil, administrative or criminal proceedings to have: **NO**

a. possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes, diverted controlled substances or legend drugs, violated any drug law, or prescribed controlled substances for yourself?

b. committed any act involving moral turpitude, dishonesty or corruption?

c. violated any state or federal law or rule regulating the practice of a health care professional?

7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", explain and provide copies of all judgments, decisions, and agreements.

8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority, or have you ever surrendered such credential to avoid or in connection with action by such authority?

9. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence or malpractice in connection with the practice of a health care profession? **YES**

- NO
10. Have you ever had hospital privileges, medical society, other professional society or organization membership revoked, suspended, restricted or denied?
11. Have you ever been the subject of any informal or formal disciplinary action related to the practice of medicine?
12. To the best of your knowledge, are you the subject of an investigation by any licensing board as to the date of this application?
13. Have you ever agreed to restrict, surrender, or resign your practice in lieu of or to avoid adverse action?

3. Education And Experience

Provide a chronological listing of your educational preparation and post-graduate training.
(Attach additional 8 1/2 X 11 sheets if necessary.)

Schools Attended (Location if other than U.S., quote names of schools in original language and translate to English.)	Number of Years Attended	Dates Attended		Diploma or Degree Obtained (Quote titles in original language and translate to English.)
		From (mo/yr)	To (mo/yr)	
Medical Education (List all Medical Schools Attended) WAYNE STATE UNIVERSITY SCHOOL OF MEDICINE	4	9/72	5/76	M.D.
Post-Graduate Training (List all Programs Attended)				
SINKI HOSPITAL OF DETROIT	4	3/76	3/80	

4. Professional Experience

In chronological order list all professional experience received since graduation from medical school to the present.
(Exclude activities listed under other sections, identify any periods of time break of 30 days or more.)
(Attach additional 8 1/2 X 11 sheets if necessary.)

PLEASE SEE ENCLOSED LIST	Dates of Experience	
	From (mo/yr)	To (mo/yr)

5. Hospital Privileges

List hospitals in the U.S. or Canada where hospital privileges have been granted within the past five (5) years.
(Attach additional 8 1/2 X 11 sheets if necessary.)

NAME OF HOSPITAL (For locum tenens, enter only those of a 30 day or longer duration. See instructions regarding reports and verification.)	Dates	
	Beginning (mo/yr)	Ending (mo/yr)
LAKEVIEW COMMUNITY HOSPITAL - PAWPAW, MI	7/97	Present
BRONSON METHODIST HOSPITAL - VICKSBURG, MI	7/97	Present
BRONSON METHODIST HOSPITAL - KALAMAZOO, MI	7/97	Present

Michael Hertz, M.D.

Section 4: Professional Experience:

9/72 - 5/76	Medical School: Wayne State University School of Medicine Detroit, MI
3/15/76 - 3/14/80	Internship and Residency, OB/GYN: Sinai Hospital of Detroit 6767 West Outer Drive Detroit, MI 48235
3/15/80 - 11/30/80 <i>(12/80 - MOVE TO FLORIDA)</i>	Private Practice, OB/GYN and Infertility: Southfield, MI (NOW CLOSED)
1/1/81 - 11/1/82	Private Practice, OB/GYN and Infertility: Boca Raton, FL (NOW CLOSED)
11/82 - 7/83	Senior Attending Staff, OB/GYN: Henry Ford Hospital 2799 West Grand Blvd. Detroit, MI 48202
7/1/83 - 6/30/97	Private Practice, OB/GYN and Infertility: Boca Raton, FL (NOW CLOSED)
7/7/97 - 10/15/04	Physician, OB/GYN and Infertility: Bronson Women's Service / Bronson Methodist Hospital 601 John St. Kalamazoo, MI 49007
11/15/04 - Present	Physician, OB/GYN: Vicksburg Women's Healthcare / Bronson Methodist Hospital 13322 North Boulevard #A Vicksburg, MI 49097


Michael Hertz, M.D.


Date

To: Washington Dept. of Licensing
From: Michael I. Hertz, M.D.

Re: Internship Training Dates

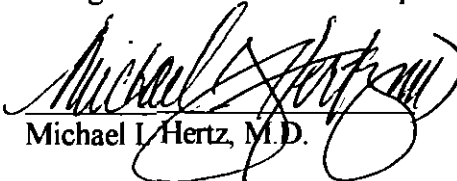
I attended medical school during the following time period:

9/72 - 5/76 Medical School:
Wayne State University School of Medicine
Detroit, MI

My internship and residency training dates are as follows:

3/15/76 - 3/14/80 Internship and Residency, OB/GYN:
Sinai Hospital of Detroit
Detroit, MI

There is an overlap of my medical education and training dates. I was permitted to begin my internship training at the Sinai Hospital of Detroit prior to obtaining my MD degree, in May of 1976. I have completed all the course requirements for medical school graduation by February of 1976. Sinai Hospital of Detroit was part of the teaching program at Wayne State University School of Medicine. By beginning this program in March, I did not have to participate in the national matching program. Also, since I began my training early, this arrangement benefited the hospital by ensuring that they would fill this training position.


Michael I. Hertz, M.D.


Date

List all licenses to practice medicine in any state, Canadian province or other country.
(Include whether active or inactive.)

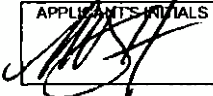
State, County or Province	Date License Issued	License Number	Basis of Licensure		Status of License		Any Limitations on License
			Examination (Date Passed)	Endorsement	Active	Inactive	
MICHIGAN	6-21-77	4301037973	NBME 1977		✓		<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
FLORIDA	10-11-79	ME 35436		✓	✓		<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
							<input type="checkbox"/> No <input type="checkbox"/> Yes
							<input type="checkbox"/> No <input type="checkbox"/> Yes

7. Fifth Pathway (foreign-trained applicants only) (Attach additional 8 1/2 X 11 sheets if necessary.)

Name and Location of Fifth Pathway Program	Name and Location of Hospital	Dates Attended	
		Beginning (mo/yr)	Ending (mo/yr)
NOT APPLICABLE			

8. AIDS Affidavit

I certify I have completed the minimum of four hours of education in the prevention, transmission and treatment of AIDS, which included the topics of etiology and epidemiology, testing and counseling, infectious control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and the psychosocial issues to include special population considerations. I understand I must maintain records documenting said education for two (2) years and be prepared to submit those records to the Department if requested. I understand that should I provide any false information, my registration may be denied, or if issued, suspended or revoked.

APPLICANT'S INITIALS 	DATE 2/25/05
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9. Applicant's Attestation

I, MICHAEL ISRAEL HERTZ, MD, certify that I am the person described and identified in
Name of Applicant

this application; that I have read RCW 18.130.170 and 180 of the Uniform Disciplinary Act; and that I have answered all questions truthfully and completely, and the documentation provided in support of my application is, to the best of my knowledge, accurate. I further understand that the Department of Health may require additional information from me prior to making a determination regarding my application, and may independently validate conviction records with official state or federal databases.

I hereby authorize all hospitals, institutions or organizations, my references, 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 Department any information files or records required by the Department in connection with processing this application.

I further affirm that I will keep the Department informed of any criminal charges and/or physical or mental conditions which jeopardize the quality of care rendered by me to the public.

Should I furnish any false or misleading information on this application, I hereby understand that such act shall constitute cause for the denial, suspension, or revocation of my license to practice in the State of Washington.


Signature of Applicant

Date

Official Use Only

Washington State Records Center



Medical Quality Assurance Commission
 PO Box 47866
 Olympia, WA 98504-7866
 (360) 236-4785 (A-L)
 (360) 236-4784 (M-Z)

Washington State Medical Quality Assurance Commission

Applicant's Professional Liability Action History

Applicant's Name: MICHEL ISRAEL HERTZ, MD

Today's Date: 2/25/09

Please submit a **separate form for each past or current professional liability claim or lawsuit** which has been filed against you. (Photocopy this page as needed.) Only a legible and signed narrative which addresses all of the following details will be accepted.

- 1) Provide a detailed summary of the events of the case. Include the date of occurrence, your specific involvement, and the patient's clinical outcome. (Please submit additional pages of narrative if necessary.)

Date of occurrence: 9-15-92 Details: Please see attached statement
re: Christine (Krieg) McGrath

- 2) Date suit or claim was filed: MARCH, 1994 Name and address of Insurance Carrier that handled the claim: PHYSICIANS PROTECTIVE TRUST FUND
6365 NW 6th Way, Suite 150, Ft. Lauderdale, FL 33309

3) Your status in the legal action (primary defendant, co-defendant, other): PRIMARY DEFENDANT

4) Current status of suit or other action: Settled out-of-court for \$45,000

5) Date of settlement, judgment, or dismissal: 9-21-94

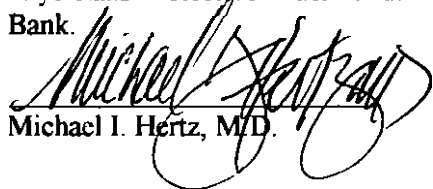
6) If the case was settled out-of-court, or with a judgment, settlement amount attributed to you, please disclose amount. (You must enclose a copy of final disposition of case—this includes dismissals.) \$

I verify the information contained in this form is correct and complete to the best of my knowledge:

Signature Michael Hertz

Date 2/25/09

Christine (Krieg) McGrath underwent an 2 - Healthcare Information Readily Identifiable to a Person - RC... for the treatment of 2 - Healthcare Information Readily Identifiable to a Person - RCW 4... at the Boca Raton Outpatient Surgery and Laser Center on September 15, 1992. A 2 - Healthcare Information Readily Identifiable to a Person - ... and the patient was discharged home after an 2 - Healthcare Information Readily Identifiable to a Person ... Later the same evening, she was admitted through the emergency department of West Boca Medical Center because of 2 - Healthcare Information Readily Identifiable to ... Early the next morning she was taken to the 2 - Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.07... and the patient discharged to home care after an 2 - Healthcare Information Readily Identifiable to a Person - A suit was filed in March, 1994 in Palm Beach County court and was settled in the amount of \$45,000 by Physicians Protective Trust Fund. This case is listed in the National Practitioners Data Bank.


Michael I. Hertz, M.D.


Date

IN THE CIRCUIT COURT OF THE 15TH
JUDICIAL CIRCUIT OF FLORIDA, IN
AND FOR PALM BEACH COUNTY.

CHRISTINE McGRATH,

CASE NO. CL 94-2170 AB

Plaintiff,

vs.

MICHAEL I. HERTZ., M.D., P.A.,
and MICHAEL I. HERTZ, M.D.,
individually.


Defendants.


STIPULATION FOR DISMISSAL WITH PREJUDICE

Plaintiff, CHRISTINE McGRATH, by and through her undersigned counsel, and Defendants, MICHAEL I. HERTZ, M.D., P.A., and MICHAEL I. HERTZ, M.D., individually, by and through their undersigned counsel, jointly stipulate and agree that this cause shall be dismissed with prejudice, as against MICHAEL I. HERTZ, M.D., P.A. and MICHAEL I. HERTZ, M.D., individually, as same has been amicably settled, with each party to bear its own costs and attorneys' fees herein. The parties further jointly request that the annexed Order of Dismissal With Prejudice be entered.

STIPULATED AND AGREED by counsel for Plaintiff this 27th day of September, 1994; and

STIPULATED AND AGREED by counsel for Defendants this 28th day of September, 1994.


Joel E. Kaplan, Esq.
Kaplan & Freedman
Florida Bar No.
9420 S.W. 77th Avenue
2nd Floor
Miami, FL 33156
Attys. for Plaintiff
(305) 274-7533


A. Russell Bobo, Esq.
Bobo, Spicer, et al.
Florida Bar No. 172203
222 Lakeview Avenue
Esperanté-- 6th floor
West Palm Beach, FL 33401
Attys. for Defendant Villareal
(407) 684-6600

10-5-94
QA

ORDER GRANTING DISMISSAL WITH PREJUDICE

THIS CAUSE, having come before the Court upon the foregoing Stipulation for Dismissal With Prejudice and the Court, having considered same and being fully advised in the premises, it is hereby

ORDERED AND ADJUDGED that the above action against MICHAEL I. HERTZ, M.D., P.A. and MICHAEL I. HERTZ, M.D., individually be, and the same is hereby dismissed with prejudice, with each party to bear its own costs and attorneys' fees herein.

DONE AND ORDERED in Chambers at West Palm Beach, Palm Beach County, Florida, this 3rd ^{October} day of ~~September~~, 1994.

JAMES R. STEWART, JR.

Circuit Court Judge

Conformed copies furnished to:

A. Russell Bobo, Esq., atty. for Defendants
Joel L. Kaplan, Esq., atty. for Plaintiff

arb132001531\settlestip.ord

RELEASE AND INDEMNITY AGREEMENT

KNOW ALL MEN BY THESE PRESENTS THAT I, the undersigned, for the consideration of Forty-Five Thousand Dollars and no cents (\$45,000.00) paid by PHYSICIANS PROTECTIVE TRUST FUND, for and on behalf of MICHAEL I. HERTZ, M.D., MICHAEL I. HERTZ, M.D., P.A., and PHYSICIANS PROTECTIVE TRUST FUND, receipt whereof is hereby acknowledged, do for myself and my agents, servants, heirs, personal representatives, successors and assigns, forever release, acquit and discharge MICHAEL I. HERTZ, M.D., MICHAEL I. HERTZ, M.D., P.A. and PHYSICIANS PROTECTIVE TRUST FUND, their agents, servants, heirs, personal representatives, successors and assigns and any other person, corporation, association, or partnership which might be charged with responsibilities by or through the above-named, from all causes of action, debts, contracts, torts, damages, judgments, decrees, claims and demands, including claims for attorney fees, whether due or not, direct or contingent, liquidated or unliquidated, known or unknown at the time of the execution of this Release and whether the consequences were foreseen or unforeseen, that I ever had or now have against the aforementioned person(s) or entity(s) by reason of the medical care administered by MICHAEL I. HERTZ, M.D. to CHRISTINE MCGRATH which precipitated a lawsuit, Case No. CL 94-2176 AB, filed in the Circuit Court of the 15th Judicial Circuit in and for Palm Beach County, Florida.

This agreement is a compromise of a disputed claim and is not an admission of liability by MICHAEL I. HERTZ, M.D., MICHAEL I. HERTZ, M.D., P.A. or PHYSICIANS PROTECTIVE TRUST FUND. Said Defendants and their insurer specifically deny any liability and intend only to avoid further litigation.

As further consideration for the payment of said sum, I hereby agree to indemnify and hold harmless the aforesaid MICHAEL I. HERTZ, M.D., MICHAEL I. HERTZ, M.D., P.A. and PHYSICIANS PROTECTIVE TRUST FUND, their agents, servants, heirs, personal representatives, successors and assigns, any other person, corporation, association, or partnership which might be charged with responsibilities by or through the above-named, against any and all further claims for damages, costs, expenses that I may have and/or liens arising out of services performed on my behalf or compensation paid to me arising out of the above-mentioned incident; specifically, but not limited to any liens by any health care providers, attorneys or entities providing collateral source benefits regardless of whether entitled to a right of subrogation.

Further, the RELEASOR states that while I hereby release any and all claims against the RELEASEES and their heirs, executors, administrators, agents, employees, successors, and assigns, for both past and future losses, including medical expenses, health care and related expenses, the necessity for future medical treatment and expenses incurred is speculative and unknown at this time and, therefore, as a result, RELEASOR reserves her right to pursue and recover all future medical expenses, health care and related expenses, from any person, firm, or organization who may be responsible for payment of such expenses, including any first-party health or automobile insurance coverage, but such reservation does not include the parties released herein.

The undersigned has read this Release in the presence of an attorney in this cause and understands the intent, tenure and effect of this Release. This Release contains the entire agreement between the parties hereto and there is no part of the agreement between them in respect of the premises which is not fully, completely, accurately and truly set forth. The terms of this Release are contractual and not a mere recital.

IN WITNESS WHEREOF, I have set my hand and seal this 21 day of September, 1994.

Christine McGrath
Christine McGrath

Laura W. Sanford
Witness

STATE OF FLORIDA

COUNTY OF Broward

The foregoing document was acknowledged before me, an officer duly authorized in the State and County aforesaid, to take acknowledgements, this 21 day of SEPTEMBER, 1994, by Christine McGrath, who:

- is personally known to me; or
- has produced _____ as identification; and who:
- did or
- did not, take an oath,

and who executed the within document, and who acknowledged the within document to be freely and voluntarily executed for the purposes therein recited.

[Signature]
Notary Public, State of Florida at Large
My Commission expires:

NOTARY PUBLIC STATE OF FLORIDA
MY COMMISSION EXPIRES AUG. 18, 1995
BONDED THRU GENERAL INS. UND.



Medical Quality Assurance Commission
 PO Box 47866
 Olympia, WA 98504-7866
 (360) 236-4785 (A-L)
 (360) 236-4784 (M-Z)

Washington State Medical Quality Assurance Commission

Applicant's Professional Liability Action History

Applicant's Name: MICHEL ISRAEL HERTZ, MD

Today's Date: 2/25/05

Please submit a **separate form for each past or current professional liability claim or lawsuit** which has been filed against you. (Photocopy this page as needed.) Only a legible and signed narrative which addresses all of the following details will be accepted.

- 1) Provide a detailed summary of the events of the case. Include the date of occurrence, your specific involvement, and the patient's clinical outcome. (Please submit additional pages of narrative if necessary.)

Date of occurrence: 11-17-91 Details: Please see attached statement

RE: LISA WIK

- 2) Date suit or claim was filed: NOVEMBER, 1993 Name and address of Insurance Carrier that handled the claim: PHYSICIANS PROTECTIVE TRUST FUND
6365 NW 6th WAY, Suite 150, Ft. Lauderdale, FL 33309

3) Your status in the legal action (primary defendant, co-defendant, other): PRIMARY DEFENDANT

4) Current status of suit or other action: SETTLED OUT-OF-COURT FOR \$30,000

5) Date of settlement, judgment, or dismissal: 9-24-94

6) If the case was settled out-of-court, or with a judgment, settlement amount attributed to you, please disclose amount. (You must enclose a copy of final disposition of case—this includes dismissals.) \$

I verify the information contained in this form is correct and complete to the best of my knowledge:

Michael Hertz MD
 Signature

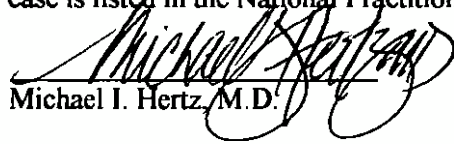
2/25/05
 Date

Lisa Wik was a 27 year old 2 - Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RC...

2 - Healthcare Information Readily Identifiable to ... **and was admitted to the** 2 - Healthcare Information Readil... **Unit of West
Boca Medical Center on November 17, 1991, late in the evening.** 2 - Healthcare Information Readily...

2 - Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1)

2 - Healthcare Information Readily Identifia... **A suit was filed in Palm Beach County court, most of which was
disallowed by the court on two separate occasions. A settlement was reached in the
remainder of the case in the amount of \$30,000 by Physicians Protective Trust Fund. This
case is listed in the National Practitioners Data Bank.**


Michael I. Hertz, M.D.

2/25/05
Date

Washington State Medical Quality Assurance Commission Applicant's Professional Liability Action History

Applicant's Name: MICHEL ISRAEL HERTZ, MD

Today's Date: 2/25/05

Please submit a **separate form for each past or current professional liability claim or lawsuit** which has been filed against you. (Photocopy this page as needed.) Only a legible and signed narrative which addresses all of the following details will be accepted.

- 1) Provide a detailed summary of the events of the case. Include the date of occurrence, your specific involvement, and the patient's clinical outcome. (Please submit additional pages of narrative if necessary.)

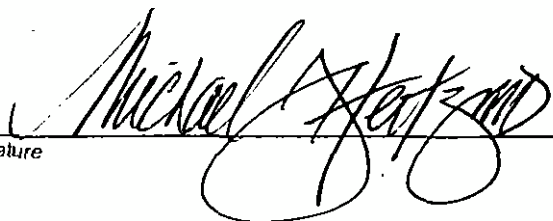
Date of occurrence: AROUND 1994 Details: PLEASE SEE ATTACHED STATEMENT

RE: LOUISE SMITH

- 2) Date suit or claim was filed: 1994 Name and address of Insurance Carrier that handled the claim: PHYSICIANS PROTECTIVE TRUST FUND
6365 NW 6th WAY, FT. LAUDERDALE, FL 33309
- 3) Your status in the legal action (primary defendant, co-defendant, other): PRIMARY DEFENDANT
- 4) Current status of suit or other action: DISMISSED WITH NO PAYMENT TO PLAINTIFF
- 5) Date of settlement, judgment, or dismissal: 1995
- 6) If the case was settled out-of-court, or with a judgment, settlement amount attributed to you, please disclose amount. (You must enclose a copy of final disposition of case—this includes dismissals.) \$

I verify the information contained in this form is correct and complete to the best of my knowledge:

Signature



Date

2/25/05

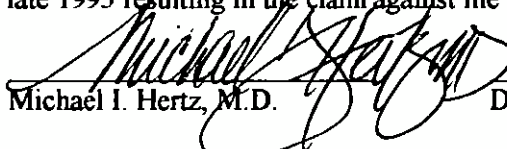
Louise Smith was a 2 - Healthca... patient who 2 - Healthcare Information Readily Identifiable to a Person - RCW 42.56...

2 - Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1) at West Boca

Medical Center. 2 - Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1)

2 - Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.02... The case was settled in mediation in

late 1995 resulting in the claim against me being dismissed.

 2/25/05

Michael I. Hertz, M.D. Date



Medical Quality Assurance Commission
 PO Box 47866
 Olympia, WA 98504-7866
 (360) 236-4785 (A-L)
 (360) 236-4784 (M-Z)

Washington State Medical Quality Assurance Commission Applicant's Professional Liability Action History

Applicant's Name: MICHEL ISRAEL HERTZ, MD

Today's Date: 2/25/05

Please submit a **separate form for each past or current professional liability claim or lawsuit** which has been filed against you. (Photocopy this page as needed.) Only a legible and signed narrative which addresses all of the following details will be accepted.

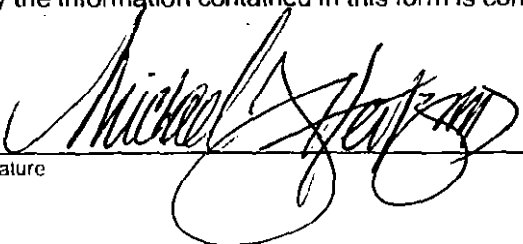
- 1) Provide a detailed summary of the events of the case. Include the date of occurrence, your specific involvement, and the patient's clinical outcome. (Please submit additional pages of narrative if necessary.)

Date of occurrence: ~~1995~~ 1995 1994 Details: Please see attached statement

RE: MAUREEN KANTOR

- 2) Date suit or claim was filed: 1995 Name and address of Insurance Carrier that handled the claim: PHYSICIANS PROTECTIVE TRUST FUND
6365 NW 6th WAY, SUITE 150, FT. LAUDERDALE, FL 33309
- 3) Your status in the legal action (primary defendant, co-defendant, other): CO-DEFENDANT
- 4) Current status of suit or other action: DISMISSED WITH NO PAYMENT TO THE PLAINTIFF
- 5) Date of settlement, judgment, or dismissal: 1995
- 6) If the case was settled out-of-court, or with a judgment, settlement amount attributed to you, please disclose amount. (You must enclose a copy of final disposition of case—this includes dismissals.) \$

I verify the information contained in this form is correct and complete to the best of my knowledge:

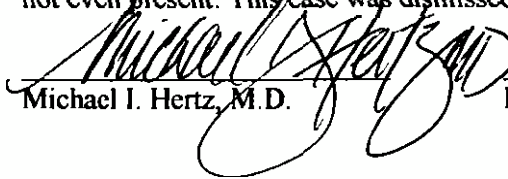


 Signature

2/25/05

 Date

A case was filed in June, 1995 by Maureen Kantor, a patient of a colleague (Dr. Steven Birnbach). I assisted at this patient's 2 - Healthcare Information R... The patient later 2 - Healthcare Information R... at which I was not even present. This case was dismissed by the trial court.

 2/25/05

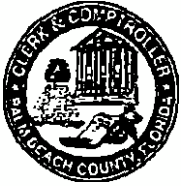
Michael I. Hertz, M.D. Date

Michael I. Hertz, M.D.

RE: Malpractice Claim Documentation

Please note that I have enclosed copies of the dismissal and settlement release for Christine (Krieg) McGrath claim. However, I do not have copies of the complaint, answer, or any other court documents pertaining to this claim. I also have no copies of any court records pertaining to the three other claims that were filed against me.

I have been in contact with the court in which these claims were filed. They have informed me that, because these claims were closed so long ago, their records on them have been destroyed. Per instructions from your office, I have asked the court to provide an official statement confirming that these records are no longer available. Copies of these official statements are attached.



Sharon R. Bock
Clerk & Comptroller
Palm Beach County

OFFICE OF THE

CLERK OF THE CIRCUIT COURT

FIFTEENTH JUDICIAL CIRCUIT • PALM BEACH COUNTY

Please respond to:

Circuit Civil Division • P.O. Box 4667 • West Palm Beach, FL 33402-4238
(561)355-2986 • FAX (561)355-4643

March 1, 2005

Re: 1993CA006113

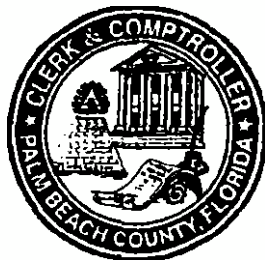
Andrew Wik, et al, v Michael Hertz, et al.

To Whom it may concern:

The Clerk and Comptroller's record retention policy is governed by the Florida Statutes as administered through the Florida Bureau of Library and Archives.

Pursuant to the General Record Schedule issued by the State of Florida, the above case met the full retention period required by the State of Florida, and the Clerk and Comptroller of Palm Beach County carried out her ministerial function of destroying the above listed case.

If you have any questions, please do not hesitate to contact me at (561) 355 -3957.



Sincerely,

Michael S. Collins, Supervisor
Circuit Civil Division



Sharon R. Bock
Clerk & Comptroller
Palm Beach County

OFFICE OF THE

CLERK OF THE CIRCUIT COURT

FIFTEENTH JUDICIAL CIRCUIT • PALM BEACH COUNTY

Please respond to:

Circuit Civil Division • P.O. Box 4667 • West Palm Beach, FL 33402-4238
(561)355-2986 • FAX (561)355-4643

March 1, 2005

Re: 1994CA002170

Christine McGrath v Michael I Hertz, M.D.

To Whom it may concern:

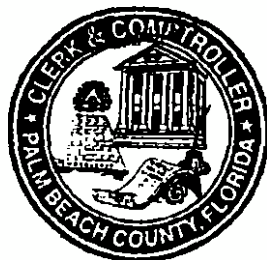
The Clerk and Comptroller's record retention policy is governed by the Florida Statutes as administered through the Florida Bureau of Library and Archives.

Pursuant to the General Record Schedule issued by the State of Florida, the above case met the full retention period required by the State of Florida, and the Clerk and Comptroller of Palm Beach County carried out her ministerial function of destroying the above listed case.

If you have any questions, please do not hesitate to contact me at (561) 355 -3957.

Sincerely,

Michael S. Collins, Supervisor
Circuit Civil Division





Sharon R. Dock
Clerk & Comptroller
Palm Beach County

OFFICE OF THE

CLERK OF THE CIRCUIT COURT

FIFTEENTH JUDICIAL CIRCUIT • PALM BEACH COUNTY

Please respond to:

Circuit Civil Division • P.O. Box 4667 • West Palm Beach, FL 33402-4238
(561)355-2986 • FAX (561)355-4643

March 1, 2005

Re: 1994CA007706

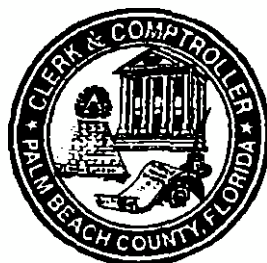
Gregory Smith, et al., v NME Hospital Inc., etc., et al.

To Whom it may concern:

The Clerk and Comptroller's record retention policy is governed by the Florida Statutes as administered through the Florida Bureau of Library and Archives.

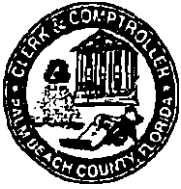
Pursuant to the General Record Schedule issued by the State of Florida, the above case met the full retention period required by the State of Florida, and the Clerk and Comptroller of Palm Beach County carried out her ministerial function of destroying the above listed case.

If you have any questions, please do not hesitate to contact me at (561) 355 -3957.



Sincerely,

Michael S. Collins, Supervisor
Circuit Civil Division



Sharon R. Bock
Clerk & Comptroller
Palm Beach County

OFFICE OF THE

CLERK OF THE CIRCUIT COURT

FIFTEENTH JUDICIAL CIRCUIT • PALM BEACH COUNTY

Please respond to:
Circuit Civil Division • P.O. Box 4667 • West Palm Beach, FL 33402-4238
(561)355-2986 • FAX (561)355-4643

March 1, 2005

Re: 1995CA005056

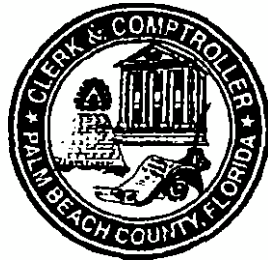
Maureen Kantor, et vir., v Michael I. Hertz, M.D., et al.

To Whom it may concern:

The Clerk and Comptroller's record retention policy is governed by the Florida Statutes as administered through the Florida Bureau of Library and Archives.

Pursuant to the General Record Schedule issued by the State of Florida, the above case met the full retention period required by the State of Florida, and the Clerk and Comptroller of Palm Beach County carried out her ministerial function of destroying the above listed case.

If you have any questions, please do not hesitate to contact me at (561) 355 -3957.



Sincerely,

Michael S. Collins, Supervisor
Circuit Civil Division



NATIONAL BOARD OF MEDICAL EXAMINERS® (NBME®) Endorsement of Certification

This document was prepared by
National Board of Medical Examiners® (NBME®)
3750 Market Street, Philadelphia, PA 19104-3190 - Telephone (215) 590-9592

Recipient: Washington Med Quality Assurance Comm
PO Box 47866
Olympia, WA 98504-7866

Date: 02/09/2005

RECEIVED

Examinee: Michael Israel Hertz

FEB 23 2005 ID: 3-167-226-4

Date of Birth: 11/10/1949

NBME Certification Date: 05/02/1977

DEPARTMENT OF HEALTH
HEALTH PROFESSIONS 5
Certificate#: 167226

It is certified that the physician named above successfully completed the examination, education and training requirements for certification by the NBME as of the certification date shown above. This record shows only passing scores for each NBME Part examination reported on this document. If applicable, results for all USMLE Steps taken by this examinee (and for which scores have been reported to date) are also shown.

NBME PART I

Test Date	Pass/Fail	Score Scale	Total		Individual Subject Scores						
			Score	(Min.Pass)	Anat	Phys	Bioc	Path	Micr	Phar	Beh Sci
06/11/1974	Pass	Three-Digit	570	(380)	525	555	505	605	550	645	530
		Two-Digit	84	(75)	82	84	81	88	84	90	83

NBME PART II

Test Date	Pass/Fail	Score Scale	Total		Individual Subject Scores					
			Score	(Min.Pass)	Med	Surg	ObGyn	Prev	Peds	Psych
09/23/1975	Pass	Three-Digit	525	(290)	520	625	570	450	485	490
		Two-Digit	83	(75)	83	88	86	80	81	82

NBME PART III

Test Date	Pass/Fail	Score Scale	Total	
			Score	(Min.Pass)
03/09/1977	Pass	Three-Digit	610	(290)
		Two-Digit	86.1	(75)



Authenticity of NBME Endorsement of Certification

An original, certified NBME Endorsement of Certification is printed using black ink on burgundy safety paper and is produced only by the National Board of Medical Examiners. The TamperSafe® Hologram in the lower left corner certifies the authenticity of this document. Alteration or forgery of the NBME Endorsement of Certification may result in appropriate legal action or other action consistent with applicable policies, and/or a determination of irregular behavior, as described below.

To Test for Authenticity: Touch, rub or breathe on TouchSafe® Fingerprint and the word **VALID** will appear. When liquid bleach is applied to the face of the document, the paper will turn brown. Also, when photocopied, a security statement containing the words **UNOFFICIAL COPY, NOT AN ORIGINAL DOCUMENT**, will appear prominently across the face of the entire document.

INTERPRETATION OF SCORES

NBME Part I and Part II Examinations Prior to June 1991

Unless otherwise noted, the most recent total test and subject scores are reported. The total test score is based on the total number of questions answered correctly on the entire examination and is not the average of the subject scores. There are no minimum pass requirements for individual subjects within a Part. Scores are on a scale with a mean of 500 and a standard deviation of 100, in increments of 5. Most scores fall between 250 and 750.

NBME Part I and Part II Examinations June 1991 and Thereafter

Unless otherwise noted, the most recent total test and subject scores are reported. This score is on a scale with a mean of 200 and a standard deviation of 20, in increments of 1. Most scores fall between 145 and 260.

All NBME Part III Examinations

Unless otherwise noted, the most recent total test and subject scores are reported. This score is on a scale with a mean of 500 and a standard deviation of 100, in increments of 5. Most scores fall between 250 and 750.

Two-Digit NBME Scores

For all NBME scores, an equivalent value scale score on a two-digit scale is also provided. The scale score mean is 82 and the minimum pass total scale score is 75. Scale scores are reported in increments of 1.

USMLE Step 1, Step 2 and Step 3 INTERPRETATION OF RESULTS

USMLE transcripts include a complete results history and notations of any examinations for which the examinee sat and no results were reported, e.g., "Incomplete." On those Step examinations for which numeric scores are reported, two different scales are used. The first is a three-digit score scale on which most scores fall between 140 and 280. The recommended minimum passing score is shown on the front of the transcript next to the examinee's score for each administration. The second is a two-digit scale on which a score of 75 is the recommended minimum passing score. The level of proficiency required to meet the recommended minimum passing level for each USMLE Step is reviewed periodically and is subject to change.

For examinations with reported scores, the Standard Error of Measurement (SEM) provides an index of the variation that would be expected to occur if an examinee were tested repeatedly using different sets of items covering similar content. The SEM is usually in the range of 4 to 8 points on the three-digit scale and 1 to 2 points on the two-digit scale.

STEP 2 CLINICAL SKILLS (CS)

The Clinical Skills (CS) component of Step 2 was introduced in 2004 and the USMLE transcript has been modified to reflect this change. The Step 2 examination that existed prior to the introduction of Step 2 CS continues to be administered as the Clinical Knowledge (CK) component of Step 2. The label "Step 2 CK" is used for this examination whether taken before or after the introduction of the Step 2 CS component.

Step 2 CS results are reported as pass or fail. Had the two-digit reporting scale been used, examinees would have had to achieve a score of 75 or higher in order to pass.

Some individuals may be required to take and pass Step 2 CS prior to registering for Step 3. Transcript users can find information on eligibility requirements for all USMLE examinations in the *USMLE Bulletin of Information* and from periodic CS updates, available at the USMLE website (www.usmle.org).

ANNOTATIONS APPEARING UNDER "COMMENTS"

Circumstances in connection with an administration shown on this transcript may result in one or more annotations listed next to the score. A description of each "Comment" is provided below:

Indeterminate - Results that cannot be certified as representing a valid measure of the examinee's knowledge or competence as sampled by the examination. Decisions to classify results as indeterminate may be made on the basis of factors that include, but are not limited to, unexplained inconsistency of performance within the examination or between administrations of the same Step. **No score is reported.** Information regarding the nature of the indeterminate score and the determination of the Committee on Score Validity is available. If such information is not enclosed with this transcript, it may be obtained by contacting the organization from which you received the transcript or the USMLE Secretariat, 3750 Market Street, Philadelphia, PA 19104, telephone (215) 590-9700.

Incomplete - The examinee sat for some, but not all, of the scheduled examination. **No score is reported.**

Irregular Behavior - The Committee on Irregular Behavior determined that the examinee engaged in irregular behavior. Examples of irregular behavior are described in the current edition of the *USMLE Bulletin of Information*. Information regarding the nature of the irregular behavior and the determination of the Committee is available. If such information is not enclosed with this transcript, it may be obtained by contacting the organization from which you received the transcript or the USMLE Secretariat, 3750 Market Street, Philadelphia, PA 19104, telephone (215) 590-9700.

Score Not Available - The score is not available. Further review and/or analysis may be pending, or it may have been determined that the score cannot be reported.

Test Accommodations - Following review and approval of a request from the examinee, test accommodations were provided in the administration of the examination.

ANNOTATIONS APPEARING AS "NOTE"

Circumstances not in connection with an administration shown on this transcript may result in one or more annotations and an explanation or instructions to contact the appropriate individual or organization. The "Note" will appear at the end of the document.

BOARD ACTION DATA BANK INFORMATION APPEARING AS "NOTE"

The Board Action Data Bank of the Federation of State Medical Boards (FSMB) contains actions reported to the FSMB by U.S. licensing and disciplinary boards, Canadian licensing authorities, the U.S. Armed Forces, the U.S. Department of Health and Human Services, and other credentialing entities. To be included in the Data Bank, an action must be a matter of public record or be legally releasable to state medical boards or other entities with recognized authority to review physician credentials. Certain actions reported to and released by the Board Action Data Bank are not disciplinary or otherwise prejudicial in nature. Such actions are reported to ensure that records are complete and to assist in preventing misrepresentation or the use of lost or stolen credentials by unauthorized persons. Once reported to the FSMB, an action becomes part of the permanent record of the individual physician, and the existence of such an action may be indicated on the USMLE transcript by a "Note".



Wayne State University School of Medicine

DETROIT, MICHIGAN 48201

Academic Record of	Social Security Number	Date Admitted
Hertz, Michael Israel	1 - DOH Licensee Social Security Number - ...	9-11-72

Permanent Address

987 Arden Lane Birmingham, Michigan 48009

Place of Birth	Date of Birth	Parent or Guardian
Highland Park, Michigan	11-10-49	Dr. & Mrs. Sidney S. Hertz

College(s) Attended	Dates of Attendance	Degree(s) Earned
University of Michigan	9/67 - 6/71	B.A.
Eastern Michigan University	SS/71	

RECEIVED

APR 19 2005

DEPARTMENT OF HEALTH
HEALTH PROFESSIONALS

<p>Year I Structure and Function of the Normal Human</p> <p>Academic Year <u>9/11/72 - 6/13/73</u></p> <p>Cell-Tissue Gross Anatomy of the Back and Limbs Neurobiology Cardiovascular Pulmonary-Renal Digestive Tract Endocrinology Social and Behavioral Sciences</p> <p>COMPREHENSIVE EVALUATION <u>S</u></p>	<p>Year II Abnormalities in Human Structure and Function</p> <p>Academic Year <u>9/4/73 - 5/30/74</u></p> <p>Introduction to Abnormal Biology Cardiovascular-Respiratory-Renal Systems Gastro-Intestinal System Endocrinology-Reproductive Nervous System Skin-Locomotor-Connective Tissue Clinical Medicine Abnormal Human Behavior</p> <p>COMPREHENSIVE EVALUATION <u>S</u></p>
---	---

<p>Year III Clerkships</p> <p>Academic Year <u>7/22/74 - 6/7/75</u></p> <table style="width: 100%; border-collapse: collapse;"> <tr><td>Community Medicine</td><td style="text-align: right;">S</td></tr> <tr><td>Gynecology-Obstetrics</td><td style="text-align: right;">S</td></tr> <tr><td>Medicine</td><td style="text-align: right;">H</td></tr> <tr><td>Pediatrics</td><td style="text-align: right;">S</td></tr> <tr><td>Psychiatry</td><td style="text-align: right;">S</td></tr> <tr><td>Surgery</td><td style="text-align: right;">S</td></tr> </table> <p>COMPREHENSIVE EVALUATION <u>S</u></p>	Community Medicine	S	Gynecology-Obstetrics	S	Medicine	H	Pediatrics	S	Psychiatry	S	Surgery	S	<p>Year IV Electives</p> <p>Academic Year <u>6/30/75 - 5/21/76</u></p> <table style="width: 100%; border-collapse: collapse;"> <tr><td>Obstetrics/Gynecology II (8 wks.)</td><td style="text-align: right;">H</td></tr> <tr><td>Neonatology</td><td style="text-align: right;">S</td></tr> <tr><td>Radiology-Pontiac General Hospital</td><td style="text-align: right;">H</td></tr> <tr><td>Pontiac, Michigan</td><td></td></tr> <tr><td>Clinical Dermatology</td><td style="text-align: right;">S</td></tr> <tr><td>Cardiology - William Beaumont</td><td style="text-align: right;">H</td></tr> <tr><td>Hospital, Royal Oak, Michigan</td><td></td></tr> <tr><td>General Medicine (8 wks.)</td><td style="text-align: right;">H</td></tr> </table>	Obstetrics/Gynecology II (8 wks.)	H	Neonatology	S	Radiology-Pontiac General Hospital	H	Pontiac, Michigan		Clinical Dermatology	S	Cardiology - William Beaumont	H	Hospital, Royal Oak, Michigan		General Medicine (8 wks.)	H
Community Medicine	S																												
Gynecology-Obstetrics	S																												
Medicine	H																												
Pediatrics	S																												
Psychiatry	S																												
Surgery	S																												
Obstetrics/Gynecology II (8 wks.)	H																												
Neonatology	S																												
Radiology-Pontiac General Hospital	H																												
Pontiac, Michigan																													
Clinical Dermatology	S																												
Cardiology - William Beaumont	H																												
Hospital, Royal Oak, Michigan																													
General Medicine (8 wks.)	H																												

GRADING SYSTEM: H = Honors S = Satisfactory U = Unsatisfactory I = Incomplete

REMARKS:

Doctor of Medicine Degree: May 23, 1976

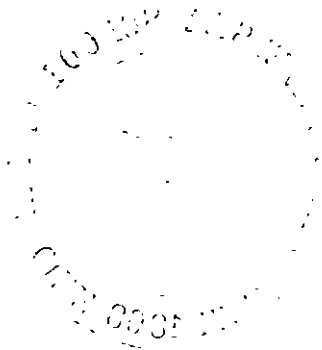
MAR 31 2005

Official transcripts bear the School Seal and the signature of the Recorder or Registrar.

(SEAL)

0121410

In accordance with the Federal Family Educational Rights and Privacy Act of 1974, you are advised that this information is provided upon the condition that you, your agents, or employees will not permit any other party to have access to such information, in personally identifiable form, without first obtaining written consent of the student.



WAYNE STATE
UNIVERSITY

SCHOOL OF MEDICINE

Records and Registration

540 E. Canfield

Detroit, MI 48201

RESORTS
FIRST CLASS



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Washington Dept. of Licensing
P.O. Box 1099
Olympia, WA 98504-1099

BI QAEMP

98504



TO: Post Graduate Training Program Director

HPOA RECEIVED

SINAI HOSPITAL OF DETROIT FACILITY NAME MAY 03 2005
6767 WEST OUTER DRIVE ADDRESS
DETROIT, MI 48235

RE: Verification/Evaluation of Training

I am applying for a license to practice medicine in the state of Washington and before my application can be reviewed, a verification and evaluation of the post-graduate training performed in your institution is required. I am authorizing the release of and would appreciate you providing the information and returning it, at your earliest convenience, directly to the address shown below. All questions must be answered.

MICHAEL ISRAEL HERTZ APPLICANT (PRINT OR TYPE)

11-10-49 BIRTHDATE

Please see enclosed release SIGNATURE OF APPLICANT

1. MICHAEL ISRAEL HERTZ is or was engaged in postgraduate training in our program

from 3-15-76 to 3-14-80 BEGINNING DATE (MONTH & YEAR) ENDING DATE (MONTH & YEAR)

in the field of OB/GYN

2. At the time this individual was in training, was this program accredited through the Accreditation Council for Graduate Medical Education, the Royal College of Physicians and Surgeons, or the College of Family Physicians of Canada? [X] Yes [] No

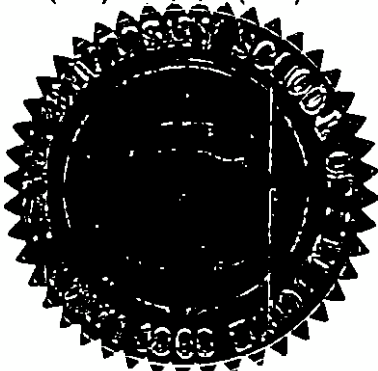
3. Was the participant ever restricted, suspended, terminated or requested to voluntarily resign his/her participation in the program? [] Yes [X] No

If yes, please explain

Return to:

Medical Quality Assurance Commission PO Box 47866 Olympia, WA 98504-7866 (360) 236-4785 (A-L) (360) 236-4784 (M-Z)

Signature Mary Z. Eitk Title Director, GME Hospital Detroit Medical Center PLEASE TYPE OR PRINT Address 4201 St. Antoine Detroit, MI 48201 Date 4/20/05 Telephone (313) 745-5147





STATE OF MICHIGAN

DEPARTMENT OF COMMUNITY HEALTH
LANSING

JENNIFER M. GRANHOLM
GOVERNOR

JANET OLSZEWSKI
DIRECTOR

**VERIFICATION OF LICENSURE
MICHIGAN BOARD OF MEDICINE
VERIFICATION OF LICENSURE AS OF 03/23/2005**

MPDA
RECEIVED

MAR 31 2005

WASHINGTON DEPT OF LICENSING
PO BOX 1099
OLYMPIA WA 98504-1099

NAME: Michael Israel Hertz
ADDRESS: 13322 N Boulevard Suite-A
Vicksburg MI 49097

SSN: 1 - DOH Licensee Social ...
BIRTHDATE: 11/10/1949

TYPE: Medical Doctor **ORIGINAL DATE:** 06/21/1977
LICENSE NUMBER: 4301037973 **STATUS:** Active **EXPIRATION DATE:** 01/31/2007
OBTAINED BY: Examination

DISCIPLINARY ACTION NONE

OPEN FORMAL COMPLAINTS NONE

CAROLYN F. PARKINSON

FLORIDA CERTIFICATION PART - I

March 28, 2005

Washington Medical Quality Assurance Commission
PO Box 1099
Olympia, WA 98504-1099

RE: Michael Israel Hertz, M.D.

To Whom It May Concern:

This is to certify the records of the Department of Health indicating the following for the above noted Medical Doctor:

MEDICAL LICENSE NUMBER:	ME 35436
CERTIFICATION:	10/11/1979
EXPIRATION DATE:	01/31/2007
CURRENT STATUS OF LICENSE:	Clear, Active
BOARD ACTION:	Refer to Part II provided by Central Records Unit (850)245-4121

To expedite the verification process, the above format is the standard format prepared for all Medical Doctors. The information above is the only verification document provided by this Department. A copy of this request is being forwarded to the Agency Clerk for research and response regarding the existence of any derogatory information.

Tammy Chester
Staff Assistant
(850) 245-4444 Ext. 3561

RECEIVED
APR 06 2005
DEPARTMENT OF HEALTH
HEALTH PROFESSIONALS



Job Bush
Governor

John O. Agwunobi, M.D., M.B.A., M.P.H.
Secretary

Florida Certification - Part II

STATE: WA

DATE: March 29, 2005

RE: Michael Israel Hertz

A search of the Department of Health computer files revealed the following complaint history on the above-referenced individual.

CURRENT COMPLAINT INFORMATION

Medical License Number: ME35436

*Case Open/Pending Complaint(s): None

**Case Closed/Probable Cause Found: None

***Closed Medical Malpractice Claims: 3

Case Dismissed/Probable Cause Not Found: 199300410 - Insufficient evidence to prosecute.

State Certification processor might receive a request from a State Board requesting this information. If the licensee should call regarding this information refer the caller to the Consumer Services Unit for Charlene Willboughby. Cases that are Dismissed without a finding of Probable Cause are **CONFIDENTIAL AND MAY NOT BE RELEASED TO ANYONE**. The licensee may or may not have been notified of dismissed cases. If this information is released, it could result in your state not receiving confidential information in the future.

If you have any questions, please contact Central Records Unit at (850) 245-4121.

*To obtain information on pending complaints, please write to Joy Moore, DOH, Bureau of Health Care Practitioner Regulation-Legal, Prosecution Services Unit, 4052 Bald Cypress Way, Bin #C-65, Tallahassee, Florida 32399-3265, telephone (850) 414-8126 or fax (850) 414-1989.

**Documentation enclosed / will follow by regular mail.

***To obtain information on closed medical malpractice claims, please write to Florida Department of Financial Services, Document Processing Office, Post Office Box 5320, Tallahassee, Florida 32314-5320. If you have any questions, please contact the Department of Financial Services at (850) 413-3149 or fax (850) 488-3429.

9



TO: Hospital Administration

LakeView Community Hospital
HOSPITAL NAME

408 Hazen Street
ADDRESS

Paw Paw, MI 49079

RECEIVED
APR 18 2005
DEPARTMENT OF HEALTH
HEALTH PROFESSIONALS

RE: Verification and Evaluation of Privileges

I am applying for a license to practice medicine in the state of Washington and before my application can be reviewed, a verification of my employment, with evaluations, is required. I am authorizing the release of and would appreciate you providing the information **directly** to the address shown below at your earliest convenience. **All questions must be answered.**

MICHAEL ISRAEL HERTZ, M.D.
APPLICANT (PRINT OR TYPE)

11/10/49
BIRTH DATE

Please see enclosed release
SIGNATURE OF APPLICANT

1 MICHAEL ISRAEL HERTZ, M.D.

now has/has had admitting or specialty privileges at this hospital

from 5/21/97 to present
BEGIN DATE MONTH/YEAR ENDING DATE MONTH/YEAR

2 Have those privileges ever been restricted, suspended or revoked by the medical staff or administration?

Yes No

If yes, please explain

3 Has the applicant ever been asked to resign?

Yes No

If yes, please explain

Return to:

Medical Quality Assurance Commission
PO Box 47860
Olympia, WA 98504-7866
(360) 236-4785 (A-E)
(360) 236-4734 (M-Z)

Signature Susan Postup
Title Credentialing Specialist
Hospital LakeView Community Hospital

Address 408 Hazen Street
Paw Paw, MI 49079

Date _____

Telephone 269-657-1656

SEAL: no seal



TO: Hospital Administration

Bronson Methodist Hospital
HOSPITAL NAME

133266 North Boulevard
ADDRESS

Vicksburg, MI 49097

RECEIVED

MAR 16 2005

DEPARTMENT OF HEALTH
HEALTH PROFESSIONS

RE: Verification and Evaluation of Privileges

I am applying for a license to practice medicine in the state of Washington and before my application is reviewed, a verification of my employment, with evaluations, is required. I am authorizing the release of and would appreciate you providing the information **directly** to the address shown below at your earliest convenience. **All questions must be answered.**

Michael Israel Hertz, M.D.

11/10/49

APPLICANT (PRINT OR TYPE)

BIRTHDATE

Please see enclosed release.

SIGNATURE OF APPLICANT

1. Michael Israel Hertz, M.D. now has/has had admitting or speciality privileges at this hospital

from 9/23/2004 to Present (3/2005)
BEGINNING DATE (MONTH & YEAR) ENDING DATE (MONTH & YEAR)

2. Have those privileges ever been restricted, suspended or revoked by the medical staff or administration?

Yes No

If yes, please explain

3. Has the applicant ever been asked to resign?

Yes No

If yes, please explain

Return to:

Medical Quality Assurance Commission
PO Box 47866
Olympia, WA 98504-7866

(360) 236-4785 (A-L)
(360) 236-4784 (M-Z)

Signature Laura Howard
Title Director of Operations
Hospital Bronson Methodist Hospital
PLEASE TYPE OR PRINT

Address 133266 North Boulevard
Vicksburg, MI 49097

Date 3/11/2005

Telephone (269) 649-9110

(SEAL)

no seal available



TO: Hospital Administration

Bronson Methodist Hospital
HOSPITAL NAME
601 John St.
ADDRESS
Kalamazoo, MI 49007

RECEIVED
MAR 16 2005
DEPARTMENT OF HEALTH
HEALTH PROFESSIONALS

RE: Verification and Evaluation of Privileges

I am applying for a license to practice medicine in the state of Washington and before my application can be reviewed, a verification of my employment, with evaluations, is required. I am authorizing the release of and would appreciate you providing the information directly to the address shown below at your earliest convenience. All questions must be answered.

Michael Israel Hertz, M.D.

11/10/49

APPLICANT (PRINT OR TYPE)

BIRTHDATE

Please see enclosed release.

SIGNATURE OF APPLICANT

1. Michael Israel Hertz, M.D. now has/had admitting or speciality privileges at this hospital

Bronson
METHODIST
from

7/1997

to Present (3/2005)

BEGINNING DATE (MONTH & YEAR)

ENDING DATE (MONTH & YEAR)

2. Have those privileges ever been restricted, suspended or revoked by the medical staff or administration?

Yes No

If yes, please explain

3. Has the applicant ever been asked to resign?

Yes No

If yes, please explain

Return to:

Medical Quality Assurance Commission
PO Box 47866
Olympia, WA 98504-7866
(360) 236-4785 (A-L)
(360) 236-4784 (M-Z)

(SEAL)

Signature

Title

BELOW

Hospital Bronson Methodist Hospital

PLEASE TYPE OR PRINT

Address 601 John St

Kalamazoo, MI 49007

Date 3-11-2005

Telephone (269) 341-8256

Scott D. Larson, M.D.
Sr., VPMA, Chief Medical Officer
Bronson Methodist Hospital
601 John Street, Box 39
Kalamazoo, MI 49007

American Medical Association

Physicians dedicated to the health of America

Division of Database Products and Licensing
515 North State Street
Chicago, Illinois 60610
<http://www.ama-assn.org/go/amaprofiles>



AMA Physician Profile

Name and Mailing Address:

MICHAEL ISRAEL HERTZ MD
STE A
13322 N BLVD
VICKSBURG MI 49097-1525

Primary Office Address:

SAME AS MAILING ADDRESS

Phone: 1-269-649-5301

Birthdate: 11/10/1949

Birthplace: HIGHLAND PARK, MI UNITED STATES OF AMERICA

Physician's Major Professional Activity: HOSPITAL BASED FULL-TIME PHYSICIAN STAFF

Practice Specialties Self Designated by the Physician*:

Primary Specialty: OBSTETRICS & GYNECOLOGY

Secondary Specialty: UNSPECIFIED

**Self-Designated Practice Specialties/Areas of Practice (SDPS) listed on the AMA Physician Profile do not imply "recognition" or "endorsement" of any field of medical practice by the Association, nor does it imply, certification by a Member Medical Specialty Board of the American Board of Medical Specialties, or that the physician has been trained or has special competence to practice the SDPS.*

AMA membership: NON MEMBER

————— All Information from this Point Forward is Provided by the Primary Source —————

Current and/or Historical Medical School:

WAYNE STATE UNIV SCH OF MED, DETROIT MI 48201

Degree Awarded: Yes

Reported Year of Graduation 1976

American Medical Association

Physicians dedicated to the health of America

Division of Database Products and Licensing
515 North State Street
Chicago, Illinois 60610
<http://www.ama-assn.org/go/amaprofiles>



AMA Physician Profile

Current and/or Historical Post Graduate Medical Training Programs Accredited by the Accreditation Council for Graduate Medical Education (ACGME):

Future training dates, as reported by the program, should be interpreted as "in progress" or "current" with projected date of completion. If the training program indicates that training for a physician in a particular specialty was not completed at their institution, the training segment will be identified as "INCOMPLETE TRAINING".

Institution: SINAI-GRACE HOSP/SINAI HOSP
Specialty : OBSTETRICS & GYNECOLOGY

State: MICHIGAN
03/1976 - 02/1977
(VERIFIED)

Institution: SINAI-GRACE HOSP/SINAI HOSP
Specialty : OBSTETRICS & GYNECOLOGY

State: MICHIGAN
03/1977 - 02/1979
(VERIFIED)

Institution: SINAI-GRACE HOSP/SINAI HOSP
Specialty : OBSTETRICS & GYNECOLOGY

State: MICHIGAN
04/1979 - 03/1980
(VERIFIED)

Note: If you have discrepant information, please submit a Request for Investigation to the AMA so that we may verify the information with the primary source(s). See the last page of this Profile for instructions on how to report a data discrepancy.

NATIONAL BOARD OF MEDICAL EXAMINERS (NBME) CERTIFICATION YEAR: MD: 1977

Current and/or Historical Medical Licensure:

<u>Jurisdiction</u>	<u>MD/ DO</u>	<u>Date Granted</u>	<u>Expiration Date</u>	<u>Status</u>	<u>License Type</u>	<u>Last Reported</u>
FLORIDA	MD	10/11/1979	01/31/2007	ACTIVE	UNLIMITED	01/27/2005
MICHIGAN	MD	06/21/1977	01/31/2007	ACTIVE	UNLIMITED	02/01/2005

Note: When the specific month and day are unknown, the date will display the default value of "01." Not all licensing boards maintain or provide full date values. Please contact the appropriate licensing board directly for this information.

ECFMG Certification:

Applicant Number:

Note: The Educational Commission for Foreign Medical Graduates (ECFMG) applicant identification number does not imply current ECFMG certification status. To verify ECFMG status, contact the ECFMG Certification Verification Service in writing at P.O. Box 13679, Philadelphia, PA 19101.

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Division of Database Products and Licensing
515 North State Street
Chicago, Illinois 60610
<http://www.ama-assn.org/go/amaprofiles>



AMA Physician Profile

Federal Drug Enforcement Administration:

* Only the last three characters of active DEA number(s) are displayed.

<u>DEA Number *</u>	<u>Schedule</u>	<u>Expiration Date</u>	<u>Last Reported</u>
XXXXXX158	22N 33N 4 5	10/31/2007	02/01/2005
XXXXXX475	22N 33N 4 5	10/31/2006	02/01/2005

Note: Many states require their own controlled substances registration/license. Please check with your state licensing authority for requirement information as the AMA does not maintain this information.

Specialty Board Certification(s)*:

Specialty Board Certification(s) by one or more of the 24 boards recognized by the American Board of Medical Specialties (ABMS) and the American Medical Association (AMA) through the Liaison Committee on Specialty Boards, as reported by the ABMS:

The AMA Physician Profile has been designated by the ABMS as an official "display agent" of the ABMS Specialty Board Certification data. Therefore, the ABMS Board Certification information on the AMA Physician Profile is considered a designated equivalent source in regard to credentialing standards set forth by accrediting bodies such as the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) and National Committee for Quality Assurance (NCQA).

Certifying Board: AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

Certificate: OBSTETRICS & GYNECOLOGY

Certificate Type: GENERAL

<u>Duration</u>	<u>Effective</u>	<u>Expiration</u>	<u>Occurrence</u>	<u>Last Reported</u>
LIFETIME	01/01/1983		INITIAL	03/09/2005

Note: For certification dates, a default value of "01" appears in the day or month field if data were not provided to AMA. Please contact the appropriate specialty board directly for this information. (**) Indicates an expired certificate.

*This information is proprietary data maintained in a copyrighted database compilation owned by the American Board of Medical Specialties. Copyright 2004 American Board of Medical Specialties. All right reserved.

Medicare/Medicaid Sanction(s):

TO DATE, THERE HAVE BEEN NO SUCH SANCTIONS REPORTED TO THE AMA BY THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.

Other Federal Sanction(s):

TO DATE, THERE HAVE BEEN NO FEDERAL SANCTIONS REPORTED TO THE AMA BY ANY BRANCH OF THE US MILITARY, THE VETERAN'S ADMINISTRATION OR THE US PUBLIC HEALTH SERVICE.

American Medical Association

Physicians dedicated to the health of America

Division of Database Products and Licensing
515 North State Street
Chicago, Illinois 60610
<http://www.ama-assn.org/go/amaprofiles>



AMA Physician Profile

Additional Information:

TO DATE, THERE IS NO ADDITIONAL INFORMATION FOR THIS PHYSICIAN ON FILE.

The content of the AMA Physician Profile is intended to assist with credentialing. Appropriate use of the AMA Physician Masterfile data contained on this Profile by an organization would meet the primary source verification requirements of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the American Accreditation HealthCare Commission/URAC. The Physician Masterfile meets the National Committee for Quality Assurance (NCQA) standards for verification of medical education, post graduate medical training, board certification, DEA status, and Medicare/Medicaid sanctions.

If you note any discrepancies, please log onto our web site and go to the order detail page, select the D following the physician's name and enter the data in question. Or you can mark the issues on a copy of the profile and mail or fax to:

Division of Database Products and Licensing
Attn: Credentialing Products
515 N. State Street
Chicago, IL 60610
800- 665-2882
312 464-5900 (fax)

**The Federation of State Medical Boards
of the United States, Inc**
PO Box 619850
Dallas, Texas 75261-9850
Telephone: (817)868-4000
FAX (817)868-4099

BOARD ACTION CLEARANCE REPORT

March 18, 2005

Attn: Blake Maresh, Exec Dir.
Washington Quality Med Assur
310 Israel Road SE
PO Box 47860
Tumwater, WA 98501

Re: Board Action Query Dated: March 18, 2005
Your Reference Number:
FSMB Batch Number: BQ1102432

The following is a report of the search results from the Board Action Data Bank as of March 18, 2005 for practitioners submit above-referenced batch for which NO board actions were identified.

Practitioners Cleared with No Actions as of March 18, 2005

Item	Name	DOB	School	Yr/Grad
1	Ahmadian, Mandana	12/01/1967	408015	1995
3	Bardman, Nelly	04/13/1958	913855	1981
4	Beardsley, Bryan	01/14/1975	005060	2000
6	Bittles, Mark	02/09/1973	043030	2001
5	Branstetter, Vanessa	02/13/1975	029010	2002
7	Braunstein, Rachel	10/21/1970	010020	1996
10	Carlson, Molly	01/04/1975	048010	2002
8	Chen, Ann	02/22/1974	014020	2002
27	Courter, Joanna	02/21/1976	048010	2002
11	Dudetsky, Alexander	09/26/1952	913855	1976
13	Falicov, Alexis	02/11/1968	022020	1999
12	Farjah, Farhood	09/19/1975	038010	2002
14	Goldberg, Marshall	06/16/1947	034040	1973
16	Grossman, Daniel	04/12/1954	033146	1985
15	Guralnick, Daniel	02/21/1972	001010	1998
19	Haq, Abid	03/28/1953	915030	1983
18	Haq, Ayesha	08/28/1862	305010	1999
21	Hassankhani, Alvand	01/16/1967	031010	1994
20	Hertz, Michael	11/10/1949	023040	1976
22	Kaneshiro, Bliss	03/22/1975	012010	2001
23	Klimant, Eiko	08/25/1963	409030	1992
24	Kuhnley, Edward	08/14/1951	047030	1976
26	Lanier, Keith	09/28/1946	006010	1971
25	Larson, Bruce	12/18/1973	044010	2001
28	Levy, Matthew	01/02/1969	009020	1995

MEDICAL LICENSING SERVICES, INC

298 East Salisbury St.
Pittsboro, NC 27312
Phone: 919-542-5079
FAX: 919-542-4518

3/10/05

Washington Dept. of Licensing
P.O. Box 1099
Olympia, WA 98504-1099

RE: Michael I. Hertz, M.D.

To Whom It May Concern:

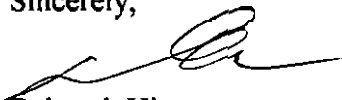
Enclosed please find Dr. Michael I. Hertz' application for medical licensure. Attached to his application please find:

- a check for \$325.00
- a release giving your office permission to discuss his application with Medical Licensing Services

If you have any questions, please call me at 1-919-542-5079.

Thank you for your time.

Sincerely,

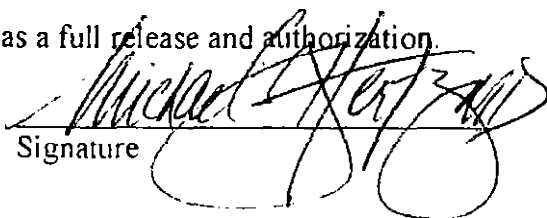


Deborah Hinton

I hereby authorize all hospitals, medical institutions or organizations, personal references, physicians, attorneys, employers, medical malpractice insurance carriers, business and professional associates, the National Board of Medical Examiners, the Federation of State Medical Boards, the ECFMG, the National Practitioners Data Bank, all medical school, all educational institutions and their transcript offices, all state medical boards, and all state, local, federal or foreign government agencies and instrumentalities to release to state medical boards, to Medical Licensing Services and/or to any entity to which I am applying for employment for privileges any information, files, transcripts, or records required by those particular entities or state medical boards for their evaluation of my professional, ethical, and physical qualifications for licensure, employment, or privileges. I release all of the above individuals and organizations, as well as Medical Licensing Services, from any liability for any damages which may result from issuing this information.

I hereby give permission for representatives of Medical Licensing Services to discuss my application with entities to which I am applying for licensure, employment, or privileges. I hereby waive any privilege for confidentiality of such information for the purposes indicated herein.

The original or a copy thereof shall operate as a full release and authorization.


Signature

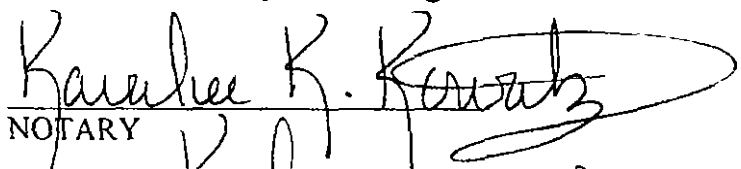
ACKNOWLEDGMENT

STATE OF Michigan
COUNTY OF Kalamazoo

On this 2 day of February, 2005.

personally appeared before me Michael J. Hertz MD
(physician's name)

who signed of the foregoing Release and Authorization, who duly acknowledged that he/she executed the same.


NOTARY

Residing at: Kalamazoo, MI

My commission expires: 10/12/11



STATE OF WASHINGTON
DEPARTMENT OF HEALTH

Olympia, Washington 98504

March 23, 2005

Michael Hertz MD
298 East Salisbury St
Pittsboro NC 27312

Dear Dr Hertz

This is to acknowledge receipt of your application for licensure as a physician and surgeon in the state of Washington.

Your application and fee of \$325.00 was received on March 17 2005

MISSING ITEMS

Post Graduate Training Verification
Medical School Transcripts
State License Verifications—MI and FL
Hospital Privilege Verification Lakeview

A deficiency letter will be sent about every four weeks until the application is considered complete. Please understand deficiency letters are our way of notifying you what is lacking in your file. **An over abundance of phone calls simply slows the process down as it diverts staff resources from application processing. We appreciate your consideration of staff resources and your patience with the process.**

Please note: while this information was contained in the application packet you had been sent and is stipulated in Washington Administrative Code (WAC) 246-12-020(3), let me reiterate that upon approval, your initial license will be issued *only* to your next birthday after the approval date – unless your birthday falls within 90 days of approval, in which case it will expire on your second birthday following approval.

If you have any further questions or need additional information, email me at **betty.elliott@doh.wa.gov**, or write to me at Department of Health, Medical Quality Assurance Commission, P O Box 47866, Olympia, WA 98504-7866.

Sincerely,

Betty Elliott, Licensing Representative



Redaction Summary (27 redactions)

2 Privilege / Exemption reasons used:

- 1 -- "DOH Licensee Social Security Number - RCW 42.56.350(1)" (4 instances)
- 2 -- "Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1)" (23 instances)

Redacted pages:

- Page 2, DOH Licensee Social Security Number - RCW 42.56.350(1), 1 instance
- Page 9, DOH Licensee Social Security Number - RCW 42.56.350(1), 1 instance
- Page 16, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 9 instances
- Page 23, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 6 instances
- Page 25, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 5 instances
- Page 27, Healthcare Information Readily Identifiable to a Person - RCW 42.56.360(2), RCW 70.02.020(1), RCW 42.56.070(1), 3 instances
- Page 35, DOH Licensee Social Security Number - RCW 42.56.350(1), 1 instance
- Page 39, DOH Licensee Social Security Number - RCW 42.56.350(1), 1 instance