DEPARTMENT OF PROFESSIONAL REGULATION
BOARD OF MEDICINE
EXAMINATION APPLICATION

Please check appropriate box:

[X] I am applying for li... of passage of the FLEX examination or Part ...nal Board of Medical Examwithin 10 years imme... is application. Application fee is $100.

AUG 19 1988

[ ] I am applying to take the FLEX Examination in Florida. Total fee is $600 (Application Fee is $100; Examination Fee is $500). 08/11/88 8755986 $100.00
80975

Application FEE is non-refundable. Examination fee is refundable if applicant is determined ineligible to take the FLEX examination. APPLICATION SHOULD BE TYPED. $100.00

NAME: Paul (FIRST) Michael (MIDDLE) Norris (LAST)
(Type your name as it should appear on your wall certificate and license)

MAILING ADDRESS: ~~9359 Fontainbleau Blvd., Apt#F-302, Miami, Fl., 33172~~
(c/o) (Street & No.) (City) (State) (Zip)

PERMANENT ADDRESS: 1000 West Ave #1224 Miami Beach, FL 33139
(c/o) (Street & No.) (City) (State) (Zip)

PLACE OF BIRTH: Dayton Ohio (City) (State) (Country) DATE OF BIRTH: 9/17/59 (Mo.) (Date) (Yr.)

RESIDENCE TELEPHONE NUMBER: 305/221-7056 (area code number) OFFICE 305/549-6944 (area code number) SOCIAL SECURITY NUMBER [redacted]

HAVE YOU EVER LEGALLY CHANGED YOUR NAME? YES ___ NO X . IF SO, ENCLOSE CERTIFIED COPY OF LEGAL DOCUMENT GIVING CHANGE, e.g. by marriage, etc.

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

RECEIVED AUG 11 1988 DPR

RACE: Caucasian X Black ___ Hispanic ___ Oriental ___ Native American ___ Other ___
SEX: Male X Female ___

REVENUE

DOCTOR OF MEDICINE DEGREE WAS OBTAINED FROM: Medical College Of Ohio, Toledo
(Name of Medical School and Location)
C.S. 10008, Toledo Ohio, 43699 on 6/7/87
(Month) (Date) (Year)

Are you or have your ever been licensed in any State, Canada, Guam, Puerto Rico or U.S. Virgin Islands? Yes ___ No X (If Yes, list state(s), license number(s) and date(s) of issuance)

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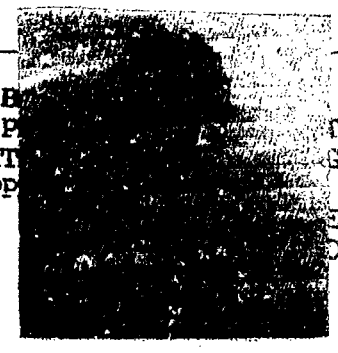

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FOR OFFICE USE ONLY, PLEASE DO NOT WRITE B...

CATEGORY: ___ EXAM SITE: ___
SCHOOL CODE: ___ EXAM DATE: ___
EDUCATION: ___ EXAM CODE: ___
CANDIDATE NO. ___

NOTE: P... TAKEN WIT... G DATE OF APP...
1. ...E
2. ...ON

Rev. Code 1510 DPR/ME/001 ...ober 87

ARE YOU A CITIZEN OF THE UNITED STATES? YES X NO ____. IF FOREIGN BORN, GIVE DATE AND PLACE OF NATURALIZATION: _____

DID YOU ATTEND A COLLEGE OF UNIVERSITY? YES X NO ____. IF SO, GIVE NAME AND LOCATION, DATE(S) IN ATTENDANCE: Wright State Univ., Dayton, Ohio 8/78 to 6/83

DID YOU RECEIVE A DEGREE OTHER THAN A M.D. DEGREE? X Yes _____ No.

List degree B.S.

LIST ALL PLACES OF RESIDENCE (WHERE LIVED) DURING ALL PERIODS OF MEDICAL SCHOOL/TRAINING:

Toledo, Ohio FROM 8, 1983 TO: 6, 1987
(city, state or country)

_____ FROM ____, 19__ TO: ____, 19____
(city, state or country)

_____ FROM ____, 19__ TO: ____, 19____
(city, state or country)

_____ FROM ____, 19__ TO: ____, 19____
(city, state or country)

MEDICAL EDUCATION: BE SPECIFIC. ACCOUNT FOR EACH YEAR. LIST ALL UNIVERSITIES/COLLEGES WHERE ATTENDED CLASSES/RECEIVED TRAINING AS A MEDICAL STUDENT:

Medical College of Ohio / Toledo, Ohio FROM 8, 1983 TO: 6, 1987
(name of medical school/location)

_____ FROM ____, 19__ TO: ____, 19____
(name of medical school/location)

_____ FROM ____, 19__ TO: ____, 19____
(name of medical school/location)

_____ FROM ____, 19__ TO: ____, 19____
(name of medical school/location)

ACCOUNT FOR ALL TIME FROM DATE OF GRADUATION FROM MEDICAL SCHOOL TO PRESENT. DO NOT LEAVE OUT ANY TIME.

TRAINING - List in chronological order from date of graduation to present date, all postgraduate training (Internship, Residency, Fellowship):

FROM: 6/24/87 TO: ~~6/23/88~~ Present Ob/Gyn Internship / Residency
(Exact dates of attendance) (Month/Day/Year) Program (Internship/Residency/Fellowship)

Jackson Memorial Hosp., 1611 NW 12th Ave., Miami, Fl. 33136
Name and Address (Street Number, City, State, Territory, Country) of Hospital, Institution (Program Sponsor) where training was received.

FROM: _____ TO: _____ _____
(Exact dates of attendance) (Month/Day/Year) Program (Internship/Residency/Fellowship)

_____
Name and Address (Street Number, City, State, Territory, Country) of Hospital, Institution (Program Sponsor) where training was received.