1501 MEDICAL DOCTOR
APPLICATION FOR LICENSURE

Read instructions before and while you complete this application.
(Failure to do so may result in delays in processing your application)

1. U.S. Social Security Number:

CONFIDENTIAL AND EXEMPT FROM PUBLIC RECORDS DISCLOSURE*

Florida Department of Health
Board of Medicine

Name: DEAN (Last) MAI (First) CARROLL (Middle)

Social Security Number: [redacted]

* This page is exempt from public records disclosure pursuant to subparagraph 119.071(5)(a)2., Florida Statutes, which provides in relevant part: "An agency that collects social security numbers shall also segregate that number on a separate page from the rest of the record, or as otherwise appropriate, in order that the social security number be more easily redacted, if required, pursuant to a public records request."

Received Date : 2/14/2008
Deposit Date : 2/15/2008
Deposit # : 167336
Batch Number : 001015263
Validation # : 907158440
Check Amount : $757.00
PRO_CDE : 1501

1501 MEDICAL DOCTOR APPLICATION FOR LICENSURE

NEED FP 2/18/08 F-99879

Read instructions before and while you complete this application.
(Failure to do so may result in delays in processing your application)

2. Application category/applicable fees: Client 1501
[ ] Endorsement (1021) [X] Examination (1024)

3. Name: DEAN (Last) MAI (First) CARROLL (Middle)

3a. Have you ever changed your name through marriage, naturalization or action of a court? [✓] YES [ ] NO
If yes; list original name(s) and date(s) of changes in mm/dd/yy.

Last	(Date of change)	First	(Date of change)	Middle	(Date of change)
CARROLL	07/25/07	THANH	07/25/07	MAI	07/25/07

3b. Have you ever been known by any other names (aliases)? [✓] YES [ ] NO

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

4. Mailing address: ✓

(Street and number or PO Box)	(City)	(State/Province)	(Zip/Postal Code)	(Country)
135 NE 3rd St.	GAINESVILLE	FLORIDA	32601	USA

5. Primary practice/physical address (current practice location address):

(Street and number)	(City)	(State/Province)	(Zip/Postal Code)	(Country)
625 SW 4th Ave.	GAINESVILLE	FL	32601	USA

6. Telephone (352) 281-0628 (Home: Area Code/Phone Number) (352) 392-6771 (Work: Area Code/Phone Number)
( ) (Cellular: Area Code/Phone Number)

2008 FEB 18 PM 2:20 MEDICINE BOARD

7. E-mail address: MAI@UFL.EDU

8. Are you a citizen of the United States? ✓ [✓] YES [ ] NO

Birth Date: 05/22/77 Birth Place: GAINESVILLE, FL Naturalization Date: ____

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

Race: [ ] Caucasian [ ] Black [ ] Hispanic [X] Asian [ ] Native American [ ] Other

Sex: [ ] Male [X] Female

10. Disaster Registry: As a Florida licensed physician, are you willing to provide health care services in special need shelters or to work with disaster medical teams during times of emergency or major disasters? [X] YES [ ] NO

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

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

11a. Have charges ever been brought against you by any branch of the United States Military and/or Public Health Service? [ ] YES [X] NO
If yes, explain the circumstances on a separate sheet.

12. Education: Undergraduate, graduate, medical, and professional education – Starting with undergraduate education, list in chronological order all schools, colleges, and universities attended, whether completed or not. Submit on a separate sheet if needed.

College and University Name and Address	Major and Degree	From: mm/yy	To: mm/yy	Date Degree Received
AMHERST COLLEGE P.O. Box 5000 Amherst, MA 01002-5000	FRENCH, B.A.	09/95	05/99	05/99
CENTER FOR UNIVERSITY PROGRAMS ABROAD P.O. Box 9611 North Amherst, MA 01059	Semester in Paris, France	01/98	06/98	
UNIVERSITY OF FLORIDA 222 Criser Hall, P.O. Box 114000 Gainesville, FL 32611-4000	Summer Classes	06/97	08/97	
" "	Summer Classes	06/98	08/98	
" "	Post-baccalaureate Classes	08/00	05/01	
UNIVERSITY OF FLORIDA COLLEGE OF MEDICINE Health Science Center, P.O. Box 100216 Gainesville, FL 32610-0216	M.D.	08/02	05/06	05/06

For items 12a-d, if yes explain on a separate sheet providing accurate details.

12a. Have you ever been dropped, suspended, placed on probation, asked to resign, or expelled from **any** school, college or university? [ ] YES [X] NO

12b. Did you attend medical school for a period other than the normal curriculum, or were you required to repeat **any** of your medical education including classes, test/exams, lectures or any other part of the curriculum? [ ] YES [X] NO

12c. Did you take **any** type of break or leave of absence for any reason during medical school? [ ] YES [X] NO
(Including maternity/paternity, medical leave or any other type of break or leave.)

12d. Have you ever defaulted on any health education loan or scholarship obligation? [ ] YES [X] NO

12e. If you are an international medical graduate, did you perform your core clerkships in the United States? [ ] YES [ ] NO N/A
If 'yes', list on a separate sheet core clerkship, institution, address, and date of each rotation.

13. Postgraduate Training: In the table below list, in chronological order, all postgraduate training from date you graduated from medical school to present (Internship/Residency/Fellowship).

Program Name and Full Mailing Address	Specialty Area	From: mm/yy	To: mm/yy	Did you receive credit? Yes or No
UNIVERSITY OF FLORIDA FAMILY MEDICINE RESIDENCY 625 S.W. 4th AVE. Gainesville, FL 32601	FAMILY MEDICINE	07/06	present	Yes

For items 13a-c, if yes, explain on a separate sheet providing accurate details.

13a. Have you ever been dropped, suspended, placed on probation, asked to resign or expelled from **any** postgraduate training program? [ ] YES [X] NO

13b. Was attendance in a postgraduate training program for a period other than the established timeframe or were you required to repeat **any** of your postgraduate training including classes, test/exams, lectures or any other part of the curriculum? [ ] YES [X] NO

13c. Did you take **any** type of break or leave of absence for any reason during your postgraduate training? (Including maternity/paternity, medical leave or any other type of break or leave.) [ ] YES [X] NO

14. Licensing Examination: State Board (prior to 1974), State Board (after 1974) & SPEX, LMCC & SPEX, NBME, FLEX, USMLE III, or Combination (prior to 2000)

Exam taken USMLE STEP 3 Date passed 02/26/07 (mm/dd/yy)

15. List the date you legally first began to practice medicine. 07/01/06 (mm/dd/yy)

16. Licensure: In the table below, list **any** type of license to practice medicine that you have in **any** jurisdiction.

State or Country	License number	State or Country	License number
FLORIDA	TRN 9931 FL (training license)		

For items 16a-e, if yes, explain on a separate sheet providing accurate details.

16a. Have you had **any** application for a medical license or professional license denied by **any** state board or other governmental agency of **any** state, territory, or country? [ ] YES [X] NO

16b. Have you ever been allowed to withdraw an application for medical licensure for **any** reason or during a pending investigation in **any** jurisdiction in lieu of your license being denied? [ ] YES [X] NO

16c. Are you currently under investigation in any jurisdiction for an act or offense that would constitute a violation of Chapter 458.331, Florida Statutes? [ ] YES [X] NO

16d. Have you ever been notified, invited or required to appear before **any** licensing agency for a hearing on a complaint of **any** nature including, but not limited to, a charge or violation of the Medical Practice Act, involving unprofessional or unethical conduct? [ ] YES [X] NO

16e. Have you ever had **any** professional license or license to practice medicine revoked, suspended, placed on probation, received a citation, or other disciplinary action taken in **any** state, territory or country? [ ] YES [X] NO

17. Practice/Employment: In the table below, list in chronological order **all** employment, non-employment, and/or **any** unaccounted period of time from date you graduated medical school to present.
If needed, continue on a separate sheet of paper.

Name and full mailing address of employment or activity	Type of employment or activity	From: mm/yy	To: mm/yy
	VACATION	05/06	07/06
Univ. of Florida Family Medicine Dept. 625 S.W. 4th Ave. Gainesville, FL 32601	INTERNSHIP/RESIDENCY	07/06	PRESENT

For items 17a-b, if yes, explain on a separate sheet providing accurate details.

17a. Have you ever had employment terminated for cause? [ ] YES [X] NO

17b. Have you ever been asked, or allowed to resign from any facility instead of disciplinary action or during any pending investigations into your practice? [ ] YES [X] NO

17c. In the table below, list **all** hospital(s), health institution(s), clinic(s), or medical facilities where you currently hold staff privileges. Do not list training privileges.

Name/mailing address of facility	Chief of staff	Type of privileges	From: mm/yy	To: mm/yy

For items 17d-e, if yes, explain on a separate sheet providing accurate details.

17d. Have you ever had any staff privileges denied, suspended, revoked, modified, restricted, or placed on probation, or have you been asked to resign or take a temporary leave of absence or otherwise acted against by any facility? [ ] YES [X] NO

17e. Have you ever had any staff privileges restricted or not renewed by any facility instead of disciplinary action? [ ] YES [X] NO

18. Have you had responsibility for graduate medical education within the last 10 years? [ ] YES [X] NO
If yes, list in the table below.

19. Do you currently hold a faculty appointment at a medical or health-related institution of higher learning? [ ] YES [X] NO
If yes, list in the table below.

20. In the table below, list any hospital, health institution, clinic or medical facility where you have or had faculty appointment(s) of higher learning.

Name of institution	Full mailing address	Title of appointment

21. American Board of Medical Specialties: Are you certified by any specialty board recognized by the American Board of Medical Specialties, or specialty board approved by the Florida Board of Medicine? [ ] YES [X] NO
If yes, list in the table below.

Board Name	Certification/ Specialty/Sub-Specialty	Date of Certification mm/yy

For items 21a-30, if yes, explain on a separate sheet providing accurate details.

21a. Have you ever failed to receive specialty board certification or re-certification for any reason? [ ] YES [X] NO

21b. Have you ever had any sanctions taken against you by a specialty board or other similar national organization? [ ] YES [X] NO

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

23. Have you ever been made an offer to compromise or entered into any arrangement plea, or agreement instead of a federal prosecution for a drug violation regulated by DEA? [ ] YES [X] NO

24. Have you ever been denied or surrendered a DEA registration? [ ] YES [X] NO

25. Have you ever been denied or been excluded from Medicare and/or state health care programs? [ ] YES [X] NO

26. Have you ever had an application for membership denied by a medical society or association or had a medical society or association membership suspended? [ ] YES [X] NO

27. Have you ever been notified to appear before a medical society or association about charges or complaints filed against you? [ ] YES [X] NO

28. Have you ever had a judgment entered against you for medical malpractice where the incident(s) of malpractice occurred after November 2, 2004? [ ] YES [X] NO

29. Within the last 10 years have you had any liability claim(s) or action(s) for damages for personal injury settled or finally adjudicated in an amount that exceeds $5,000? [ ] YES [X] NO
If yes, explain on a separate sheet providing accurate details and complete Exhibit 1 for each occurrence.

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

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

32. Have you lost your civil rights? [ ] YES [X] NO

32a. If yes, date when civil rights were restored _____

For items 33-36, if yes, explain on a separate sheet providing accurate details.

Within the last five years:

33. Have you been enrolled in, required to enter into, or participated in any drug and/or alcohol recovery program or impaired practitioner program?

34. Have you been treated for or had a recurrence of a diagnosed mental disorder or impairment?

35. Have you been treated for or had a recurrence of a diagnosed physical disorder that has impaired your ability to practice medicine?

36. Have you been treated for or had a recurrence of a diagnosed substance-related (alcohol and/or drug) disorder?

[redacted]

The application instructions provide information about documents needed to support your explanation of the 'yes' responses.

37. Prevention of Medical Errors:

[X] I hereby certify that since June 1, 2002, I have completed a minimum of two (2) hours of Prevention of Medical Errors continuing medical education as defined by s. 456.013(7), Florida Statutes. The education must meet requirements defined in § 456.013(7), Florida Statutes and be completed prior to the issuance of your license number. Please contact the Florida Medical Association (FMA) at (850) 224-6496 or www.fmaonline.org for a list of providers of CME. Other resources for CME are the American Medical Association (AMA) at (312) 464-4952, or Medical Education Group Learning Systems (MEGLAS) at 800-547-0308 or www.informed.cme.edu.

* SEE ENCLOSED LETTER FOR DOCUMENTATION

38. Dispensing Practitioner Registration:

This is optional and for physicians whose primary practice is in the State of Florida. Dispensing relates to physicians who maintain a "mini-pharmacy" in their private office for profit. Section 465.0276, F. S., requires that licensees of the Board of Medicine who dispense medicinal drugs pay a fee of $100.00 at the time of such registration and upon each renewal of the practitioner's license. It is unlawful for any person to sell samples or complimentary packages of drug products. A practitioner who confines his/her activities to dispensing complimentary packages of medicinal drugs to patients in the regular course of his/her practice is **not** required to register.

Check if applicable to you.

[ ] I plan to dispense medicinal drugs in the State of Florida for a fee or other remuneration and hereby register as required by Section 465.0276, F. S. I understand that the fee for the Dispensing Practitioner is $100.00 **over and above** the required initial license fee and will submit it along with the license fee.

UF | UNIVERSITY of FLORIDA

College of Medicine
Department of Community Health and Family Medicine
UF/Shands at AGH Family Medicine Residency Program
www.chfm.ufl.edu/residency

625 Southwest 4th Avenue
Gainesville, FL 32601
352-392-4541
352-392-7766 Fax

November 28, 2007

As an approved sponsor, this program has been reviewed and is acceptable for up to 1 prescribed credit hours by the AAFP. AAFP Prescribed credit is accepted by the AMA as equivalent to AMA PRA category 1 credit for the Physician's Recognition Award. When applying for AMA PRA, Prescribed credit hours must be reported as Prescribed, not as category 1.

ATTENDEE: Mai Carroll Dean, M.D.

TOTAL CME HOURS: 2 Hours (Medical Errors ONLY)

FROM: October 2006 – December 2006

October 11, 2006	1 HRS	"Medical Errors: Part I", Siegfried Schmidt, MD
December 13, 2006	1 HRS	"Medical Errors: Part III", Siegfried Schmidt, MD

Tina Engstrom
Physician Services Manager
University of Florida/Shands at AGH
Family Medicine Residency Program

39. Financial Responsibility

The Financial Responsibility options are divided into two categories, coverage and exemptions. Check only **one** option of the ten provided as required by s. 458.320, Florida Statutes.

Category I: Financial Responsibility Coverage

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

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

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

☐ **5.** I have elected not to carry medical malpractice insurance however, I agree to satisfy any adverse judgments up to the minimum amounts pursuant to s. 458.320(5)(g)1, F. S. I understand that I must either post notice in a sign prominently displayed in my 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), F. S.

Category II: Financial Responsibility Exemptions

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

☐ **7.** I hold a limited license issued pursuant to s. 458.317, 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, F. S.; and

(e) I have not been subject, within the past ten years of practice, to license revocation, suspension, or probation for a period of three years or longer, or a fine of $500 or more for a violation of Chapter 458, 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 is construed as action against a license. I understand if I am claiming an exception under this section that I must either post notice in a sign prominently displayed in my reception area or provide a written statement to any person to whom medical services are being provided that I have decided not to carry medical malpractice insurance.

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

40. Optional Information:

a. List all medical or professional society or association memberships:

American Academy of Family Physicians (AAFP)

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

(Title) (Publication) (Date)

(Title) (Publication) (Date)

(Title) (Publication) (Date)

(Title) (Publication) (Date)

c. Do you participate in the Medicaid program? [ ] YES [X] NO
If yes list:

(Type of Provider) (State)

(Type of Provider) (State)

d. Professional or community service activities, honors, or awards:

(Activity/Honor/Award) (Organization)

(Activity/Honor/Award) (Organization)

e. Languages other than English: List languages other than English that you use to communicate with patients and any translation service available for patients at your primary place of practice.

BASIC MEDICAL SPANISH SKILLS

f. Comments and additional information: List comments or information that you want the board to be aware of.

41. Florida Birth Related Neurological Compensation Association

You must choose one of the three options described below. Please be sure to read the enclosed information about each exemption. Check only one.

[ ]	[ ]	[X]	
$5,000	$250	$0	Ø
Participating	Non-participating	Exempt	Amount enclosed

If you choose "$0 Exempt" provide appropriate documentation to the Board of Medicine and to NICA. See attachment for explanation.

I have read the explanatory information provided by NICA, and I choose the option above.

Signature: [signature] Date: 1/14/08

Name: MAI DEAN

Street Address: 135 NE 3rd St.

City, State, Zip: Gainesville, FL 32601

If you are a participating or non-participating physician, or a physician claiming exemption, you must complete, sign and date this form and return it with your payment to this address.

Department of Health
Board of Medicine
4052 Bald Cypress Way, #C-03
Tallahassee, FL 32399-3253

If you are a physician claiming exemption, you must also send a copy of your completed, signed, and dated form with proof of your exemption to:

NICA
2360 Christopher Place
Tallahassee, FL 32308

If you have any questions about NICA or this form, please contact NICA at www.nica.com or (850) 488-8191.

1005164
Stella

UF UNIVERSITY of FLORIDA

College of Medicine
Department of Community Health and Family Medicine
UF/Shands at AGH Family Medicine Residency Program
www.chfm.ufl.edu/residency

625 Southwest 4th Avenue
Gainesville, FL 32601
352-392-4541
352-392-7766 Fax

January 22, 2008

2008 JAN 31 A11:00 MEDICINE BOARD

Florida Board of Medicine
Department of Health,
4052 Bald Cypress Way, #C03
Tallahassee, FL 32399-3253

RE: **NICA Fee Exemption for Mai Carroll Dean, M.D.**

Dear Florida Board of Medicine:

Dr. Mai Carroll Dean is a resident in family medicine at the University of Florida/Shands at Alachua General Hospital Family Medicine Residency Program. Dr. Dean (Carroll) entered our program on 07/01/06, and is expected to complete her residency training 06/30/09.

I hope this information has been of assistance to you.

Sincerely,

Karen E. Hall, M.D.
Associate Professor and Program Director
Family Medicine Residency Program
Dept. of Community Health and Family Medicine
College of Medicine
University of Florida

KLH/kkz

cc: NICA
2360 Christopher Place
Tallahassee, FL 32308

42. Affidavit of Applicant:

I affirm that these statements are true and correct. I recognize that providing false information may result in denial of licensure, disciplinary action against my license, or criminal penalties pursuant to Sections 456.067, 775.083, and 775.084, Florida Statutes. I affirm that I have read Chapters 456, 458 and 766.301-.316, Florida Statutes and Chapter 64B8, Florida Administrative Code.

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

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind. 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 constitutes cause for denial, suspension, or revocation of my license to practice Medicine in the State of Florida. If there are any changes to my status or any change that would affect any of my answers to this application I must notify the board within 30 days. I understand that my records are protected under federal and state regulations governing Confidentiality of Mental Health Patient Records and cannot be disclosed without my written consent unless otherwise provided in the regulations. I understand that my records are protected under federal and state regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it and that in any event this consent expires automatically as follows:

_____

(Specify the date, event, or condition upon which this content expires.)

MAI CARROLL DEAN

(Please print your name.)

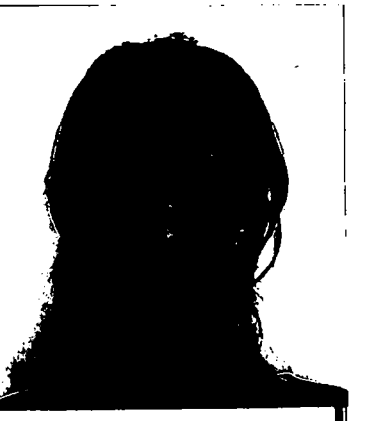
_____ 1/14/08

(Signature of applicant required.) (Date signed required.)

Personal Data:

Height: 5 feet 9 inches Weight: 140 LBS.

Eye Color: BROWN Hair Color: BLACK



OK

REGISTRATION APPLICATION FOR INTERN/RESIDENT/FELLOW OR HOUSE PHYSICIAN

(Client 1510)

f-13814

Received Date : 4/20/06
Deposit Date : 4/20/06
Deposit # : 187636
Batch Number : 001024999
Validation # : 905281731
Check Amount : $200.00
PRO_CDE : 1510

RECEIVED APR 20 2006 BOARD OF MEDICINE

Registration Method (Check only one)

☑ I AM APPLYING FOR REGISTRATION TO PARTICIPATE IN A TRAINING PROGRAM INTERN/RESIDENT/FELLOW/OTHER TRAINING ☐ RENEWAL

☐ I AM APPLYING FOR HOUSE PHYSICIAN REGISTRATION NOT A TRAINING PROGRAM ☐ RENEWAL

INITIAL REGISTRATION FEE FOR INTERN/RESIDENT/FELLOW- $200.00
INITIAL REGISTRATION FEE FOR HOUSE PHYSICAN - $300.00
HOUSE PHYSICIAN RENEWAL REGISTRATION FEE - $220.00
Registration fees are non-refundable

APPLICATION SHOULD BE TYPED

1. Employment Date: 7/1/06 University/Hospital: UF / AGH
   Program Specialty: Family Medicine Director of Medical Education: K. Hall, M.D.
   Program Address: 1600 SW Archer Rd Suite N107 Clinical Sites: 625 SW 4th Ave
   Name/Telephone# of Administrator: Judy Walch 273-5147 Gainesville, FL 32601

2. Social Security Number: [redacted]

3. Name: THANH (First) MAI (Middle) CARROLL (Last)

4. Mailing Address: C/O Tearetha Thomas PO Box 100005 G/ville, FL 32610
   135 NE 3rd St. (No & Street) GAINESVILLE (City) FL (State) 32601 (Zip)

5. Place of Birth GAINESVILLE/FL/USA (City/State/Country) Date of Birth 5/22/77 (Month/Day/Year)

6. Telephone Number: 352-281-0628 (Residence-area code/number) _____ (Office-area code/number)

7. Medical Degree was obtained from: UF (Medical School) GAINESVILLE, FL, USA (City, State & Country) 5/20/06 (Month/Day/Year)

APR 20 2006

8. List in chronological order **from date of graduation from medical school to the present** all postgraduate training/employment/non-employment. If additional space is needed please attach to application:

EMPLOYMENT/ HOSPITAL	ADDRESS	EMPLOYMENT DATES		POSITION
		FROM	TO	
november				

9. Are you or have you ever held **any** professional/medical license in any State in the U.S., including Canada, Guam, Puerto Rico or U.S. Virgin Islands? Yes____ No X

(If yes, list profession(s), state(s), license number(s) and date(s) of issuance)

10. Was attendance in Medical school for a period other than the normal curriculum? Yes____ No X

a. Did you take a leave of absence during medical school? Yes____ No X

b. Were you required to repeat any of your medical education? Yes____ No X

11. During your medical education and/or postgraduate training were you ever on probation, restrictions, suspension, or otherwise acted against? Yes____ No X

12. Have you ever been requested to leave, temporarily or permanently, a postgraduate program prior to completion of training? Yes____ No X

13. Have you ever had any application for professional license, registration or any application to practice medicine/surgery denied by any state, territory or country? Yes____ No X

14. In the last 5 years, have you been enrolled in, required to enter into, or participated in any drug or alcohol recovery program or impaired practitioner program?

15. In the last 5 years, have you been treated for or had a recurrence of a diagnosed mental disorder or impairment?

16. In the last 5 years, have you been treated for or had a recurrence of a diagnosed with any physical impairment?

17. In the last 5 years, have you been treated for or had a recurrence of a diagnosed addictive disorder?

[redacted]

18. Have you ever been criminally or civilly charged with any intentional or negligent action related to the use or misuse of drugs, alcohol, or illegal chemical substances? Yes____ No X

19. Have you ever been convicted of, or entered a plea of guilty, nolo contender or no contest to, a crime in any jurisdiction other than a minor traffic offense? You must include all misdemeanors and felonies, even if adjudication was withheld by the court so that you would not have a record of conviction. Driving under the influence or driving while impaired is not a minor traffic offense for purposes of this question. Yes___ No X

20. Are you under investigation in any jurisdiction for an act that would constitute the basis for imposing a disciplinary action specified in s. 458.331(2)(b), F.S.? Yes___ No X

21. Have you ever had employment terminated for cause? Yes___ No X

ALL AFFIRMATIVE ANSWERS FOR QUESTIONS 9-21 MUST BE EXPLAINED IN DETAIL ON A SEPARATE SHEET. DOCUMENTATION SUBSTANTIATING THE EXPLANATION IS REQUIRED.

22. Physical Description: COLOR OF EYES: BROWN WEIGHT 140 lbs.
COLOR OF HAIR: BLACK HEIGHT 5'9"
OTHER MEANS OF IDENTIFICATION: _____

23. AFFIDAVIT OF APPLICATION

I, THANH MAI CARROLL, affirm that I am the person referred to in the foregoing registration application and supporting documentation, and that the attached photograph is a true likeness of myself.

I hereby authorized all hospital(s), institution(s) or organization(s), my references, personal physicians, employers, (past and present), and all government agencies and instrumentality's (local, state, federal or foreign) to release to the Florida Board of Medicine any information which is material to my registration application pursuant to 458.345, F.S.

I have carefully read the questions in the foregoing registration 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 registration application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of my registration as a physician in the State of Florida.

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

_____
(specification of date, event or condition upon which this consent expires)

_____ 4/2/06
(Signature of Applicant) *(Date)*

REV: 10/03
MQA1032

UNIVERSITY OF
FLORIDA

College of Medicine
Office of the Dean
Student Affairs and Registration
Health Science Center

PO Box 100216
Gainesville, Florida 32610-0216
Tele: (352) 392-3071
Fax: (352) 846-0622

March 31, 2006

The Department of Health
Florida Board of Medicine
4052 Bald Cypress Way BIN C03
Tallahassee FL 32399-3253

To Whom It May Concern:

This is to certify that Thanh Mai Carroll is currently enrolled as a full-time medical student in good standing at the University of Florida College of Medicine. The anticipated date of graduation will be May 20, 2006. ✓

Thanh Mai Carroll's matriculation dates at the University of Florida College of Medicine are:

First Year	08/19/02 to 06/06/03
Second Year	08/18/03 to 05/14/04
Third Year	07/06/04 to 06/18/05
Fourth Year	07/11/05 to ***05/19/06 ~ Anticipated***

Sincerely,

Rita M. Rygler

Rita M. Rygler
Senior Registrar Officer
Office of Student Affairs and Registration

:rmf

IN THE CIRCUIT COURT OF THE EIGHTH JUDICIAL CIRCUIT,
IN AND FOR ALACHUA COUNTY, FLORIDA

Case No.: 01-07-DR-2930
Division: F

IN RE: THE NAME CHANGE OF

Thanh Mai Carroll
Petitioner.

RECORDED IN OFFICIAL RECORDS
INSTRUMENT # 2359401 1 PG
2007 JUL 30 09:51 AM BK 3649 PG 1107
J. K. "BUDDY" IRBY
CLERK OF CIRCUIT COURT
ALACHUA COUNTY, FLORIDA
CLERK25 Receipt#340338

FINAL JUDGMENT OF CHANGE OF NAME (ADULT)

This cause came before the Court on *(date)* July 25, 2007 for a hearing on Petition for Change of Name (Adult) under section 68.07, Florida Statutes, and it appearing to the Court that:

1. Petitioner is a bona fide resident of Alachua County, Florida;

2. Petitioner's request is not for any ulterior or illegal purpose; and

2359401

3. granting this petition will not in any manner invade the property rights of others, whether partnership, patent, good will, privacy, trademark, or otherwise; it is

ORDERED that Petitioner's present name, Thanh Mai Carroll, is changed to Mai Carroll Dean, by which Petitioner shall hereafter be known.

ORDERED ON July 25, 2007

James P Nelson
CIRCUIT JUDGE

COPIES TO: 7/25/2007
Petitioner
Donna Haygood
Judicial Assistant

J.K. "BUDDY" IRBY
CLERK OF COURTS
ALACHUA COUNTY FL

2007 JUL 26 AM 10:42

FILED
CK 47

J.K. "Buddy" Irby, Clerk of the Circuit & County Court, Eighth Judicial Circuit of Florida, in and for Alachua County, hereby certify this to be a true and correct copy of the document now of record in this office. Witness my hand and seal this 27 day of July 2007
J.K. "Buddy" Irby, Clerk
By: Deputy Clerk

Case: 2007 DR 002930
0004141424
Dft: FJ28-N

The University of Florida

has conferred on

Thanh Mai Carroll

the degree

Doctor of Medicine

and all the rights and privileges thereunto appertaining.
In Witness Whereof, this diploma, duly signed, has been issued
and the seal of the University affixed.

Issued by the Board of Trustees upon recommendation of the Faculty of

The College of Medicine

at Gainesville, this twentieth day of May, 2006.

Governor

Chairman, Board of Trustees

President

Dean

1005164

THE DEPARTMENT OF HEALTH
FLORIDA BOARD OF MEDICINE
4052 BALD CYPRESS WAY, BIN # C03
TALLAHASSEE, FLORIDA 32399-3253

Medical Degree Verification Form

The physician listed below submitted an application for Florida licensure and is under investigation by this authority. Verify items 1 through 3, complete items #4 through #7, and return directly to the Board of Medicine. Thank you.

2009 JAN 31 PM 2:42 MEDICINE BOARD

Applicant completes items #1 through #3.

1. To: UF COLLEGE OF MEDICINE
Name of medical school

PO BOX 100216, Health Science Center
Address of medical school

GAINESVILLE, FL 32610-0216 USA
City - State - Zip - Country

2. Name: MAI CARROLL DEAN (Formerly THANH MAI CARROLL) S.S.# [redacted]

3. Date of Birth: 5/22/~~07~~ 77 error

Medical School: Verify items #1 through #3 and complete items #4 through #7. Authenticate by signature and school seal. Thank you!

4. Type of Degree: M.D. Date Degree Received: 05-20-2006

5. Was the above referenced physician ever dropped, suspended, placed on probation, or asked to resign? [ ] YES [X] NO

6. Did the above referenced physician attend medical school for a period other than the normal curriculum, or was he/she required to repeat any of his/her medical education? [ ] YES [X] NO

7. Did the above referenced physician take any type of break or leave of absence for any reason during medical school? [ ] YES [X] NO

8. Comments:

Amelia E. Jaworski
1-24-2008
Verified by
AMELIA E. JAWORSKI
SENIOR REGISTRAR OFFICER FOR MEDICINE

SEAL

Name

DH-MQA 1000 07/06