Application

Application Detail

License Type: **Medical Doctor**

Profession Number: **1501 - Medical Doctor**

License Number: **15816**

Application: **Review, Update & Confirm Profile**

Application Date: **12/09/2019**

Addresses

Mailing Address

Address: **2106 DREW STREET, SUITE 103**

103

PINELLAS

CLEARWATER, FL

33765

US

Phone Number: **(727) 442-0445**

E-mail Address: **ammdo@hotmail.com**

Place of Practice

Address: **2106 DREW STREET**

103

PINELLAS

CLEARWATER, FL

33765

US

Education History

Provider Name: **N/A**

Type of Program:	**N/A**
Attendance From:	**01/01/1963**
Attendance To:	**01/01/1968**
Date of Graduation:	**01/01/1968**
School Name:	**UNIV. DI BOLOGNA**

Other Related Health Degrees

School Name:	**N/A**
City:	**N/A**
State and Country:	**N/A**
Attended From:	**N/A**
Attended To:	**N/A**
Degree Title:	**N/A**

Professional and Postgraduate Training 1

Program Name:	**ST BARNABUS MEDICAL CENTER**
Program Type:	**INTERNSHIP**
Specialty Area:	**GS - SURGERY**
Other Specialty Area:	**N/A**
City:	**LIVINGSTON**
State or Country:	**NEW JERSEY**
Date Attended From:	**01/01/1969**
Date Attended To:	**12/31/1969**

Professional and Postgraduate Training 2

Program Name:	**BAYFRONT MEDICAL CENTER**
Program Type:	**RESIDENCY**
Specialty Area:	**OBG - OBSTETRICS AND GYNECOLOGY**
Other Specialty Area:	**N/A**
City:	**ST PETE**
State or Country:	**FLORIDA**
Date Attended From:	**07/01/1970**
Date Attended To:	**06/30/1973**

Graduate Medical Education Responsibility and Faculty Appointments

Do you currently hold a faculty appointment at a medical school?	**No**

Graduate Education

Do you currently, or have you had, responsibility for graduate medical education within the last 10 years?	**No**

Staff Privileges

Do you currently hold staff privileges at a hospital, medical, or health institution?	**No**
City:	**N/A**
State:	**N/A**

Other State Licensure

License #:	**N/A**
Type:	**PHYSICIAN**
Original Date Issued:	**N/A**
Date of Expiration:	**N/A**
Country:	**N/A**
State:	**New York**

Specialty Board Certifications

Board:	**AMERICAN BOARD OF OBSTETRICS & GYNECOLOG**
Certification:	**OBG - OBSTETRICS AND GYNECOLOGY**

Financial Responsibility/Exemption

Financial Responsibility	**Financial Exemption**

Category II: Financial Responsibility ExemptionsIf you select an exemption based on # 9, you must also complete the affidavit that will be emailed to you upon submission of this application. 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 $25,000 within the previous five-year period; (d) I have not been convicted of or pled guilty or nolo contendere to any criminal violation specified in Chapter 458, F. S. or the medical practice act in any other state; 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. See Section 458.320(5)(f), Florida Statutes, for specific notice requirements. 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).

Financial Exemption **9. OTHER CRITERIA**

Criminal History

Have you ever been convicted or found guilty, regardless of adjudication, or pled guilty or nolo contedere (no contest) to a criminal misdemeanor or felony in any jurisdiction? **No**

If "Yes", submit the arrest and court records along with a disposition of the case to the Board.

Medicaid Program Questions 1

Have you ever been terminated for cause from participating in the Florida Medicaid Program? **No**

Have you ever been sanctioned by any state Medicaid program? **No**

Do you participate in the Medicaid program? **N/A**

Medicaid Program Questions 2

Have you ever been terminated for cause from participating in the Florida Medicaid Program? **No**

Have you ever been sanctioned by any state Medicaid program? **No**

Do you participate in the Medicaid program? **N/A**

Specialty Board Discipline History

Within the previous ten (10) years, have you ever had any final disciplinary action taken against you by a specialty board recognized by the American Board of Medical Specialties, the American Osteopathic Association, the American Chiropractic Association, or other similar national organization?	**No**

Final Disciplinary Action - Licensing

Within the previous ten (10) years, Have you ever had any final disciplinary action taken against you by the LICENSING AGENCY in this state or any jurisdiction?	**No**

Final Disciplinary Action - Institution

Within the previous ten (10) years, Have you ever had any final disciplinary action taken against you by a licensed hospital, health maintenance organization, pre-paid health clinic, nursing home, or ambulatory surgical center in this state or any jurisdiction?	**No**

Final Disciplinary Action - Facility Resignation

Within the previous ten (10) years have you ever been asked to or allowed to resign from or had any staff privileges restricted or not renewed by any medical health-related institution in lieu of or in settlement of a pending disciplinary action related to competence or character?	**No**

Committees/Memberships

Committee/Membership:	**N/A**

Professional or Community Awards

Community Service/Award/Honor:	**N/A**
Organization:	**N/A**

Publications

Article Title:	**N/A**
Publication:	**N/A**
Date of Publication:	**N/A**

Professional Web Page

Professional Web Page:	**N/A**

Languages Other Than English

Language:	**N/A**

Other Affiliations

Affiliation:	**N/A**

Attestation

I affirm that the profile information is correct.

Attestation Answer: Yes

Application

Application Detail

License Type:	**Medical Doctor**
Profession Number:	**1501 - Medical Doctor**
License Number:	**15816**
Application:	**Renew My Medical Doctor License**
Application Date:	**12/09/2019**

Suitability Question(s)

Have you reviewed and confirmed your profile?	**Yes**

Personal Detail

First Name:	**GARY**
Middle/Second Name:	**A**
Last Name/Surname:	**DRESDEN**

Addresses

Mailing Address

Address:	**2106 DREW STREET**
	SUITE 103
	PINELLAS
	CLEARWATER, FL
	33765
	US
Phone Number:	**(727) 442-0445**
E-mail Address:	**ammdo@hotmail.com**

Place of Practice

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Questions related to Section 456.0635(3), Florida Statutes	
On or after July 1, 2009, have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, F.S. (relating to social and economic assistance), Chapter 817, F.S. (relating to fraudulent practices), Chapter 893, F.S. (relating to drug abuse prevention and control) or a similar offense(s) in another state or jurisdiction?	**No**
On or after July 1, 2009, have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970 (relating to controlled substances) or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)?	**No**
On or after July 1, 2009, have you been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes?	**No**
On or after July 1, 2009, have you been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program?	**No**
Are you currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities?	**No**

Availability for Disaster	
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?	**No**

Financial Responsibility/Exemption	
Financial Responsibility	**Financial Exemption**

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Financial Exemption **9. OTHER CRITERIA**

Fees

FDLE Background Chec	**$24.00**
Active Renewal	**$360.00**
Unlicensed Activity	**$5.00**
Total Amount Due:	**$389.00**

Attestation

By submitting the appropriate renewal fees to the Department, I certify compliance with all requirements for renewal. I am responsible for knowing these requirements as set forth in the laws and rules that govern my profession.

Attestation Answer: Yes