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 1 9 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
$100.00

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

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#E-302, Miami, Fl., 33172~~
(c/o) (Street & No.) (City) (State) (Zip)

PERMANENT ADDRESS: 1000 West Ave #1724 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.

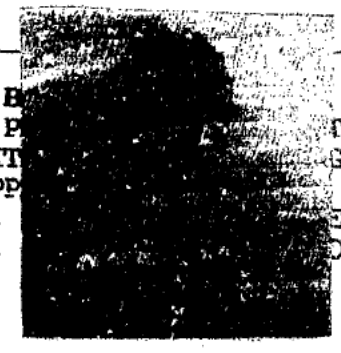
We are required to ask that you furnish the following information as part of your voluntary compliance with Section 2, Uniformed Guidelines on Employee Selection Procedure (1978) 43 FR38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any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

RECEIVED AUG 11 1988 DPR REVENUE

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

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)



**********

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.

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.

**PRACTICE/EMPLOYMENT** - List in chronological order from date of graduation to present date, all practice experience and/or employment.

FROM: N/A TO: _____ _____
(Month/Day/Year) (Month/Day/Year) (Type of Practice and/or Employment)

_____
Name and Address (Street Number, City, State, Territory, Country) of Employment and/or practice setting.

FROM: _____ TO: _____ _____
(Month/Day/Year) (Month/Day/Year) (Type of Practice and/or Employment)

_____
Name and Address (Street Number, City, State, Territory, Country) of Employment and/or practice setting.

FROM: _____ TO: _____ _____
(Month/Day/Year) (Month/Day/Year) (Type of Practice and/or Employment)

_____
Name and Address (Street Number, City, State, Territory, Country) of Employment and/or practice setting.

List hospital(s) where you have staff privileges. (Give addresses, date(s) of service and chief of staff) (Do not list privileges as an intern/resident in ACGME training)

_____

_____

_____

Have you ever been in the United States Military? Yes ___ No X . If so, attach copy of separation from service form and full discharge form.

_____
(branch of service, rank, dates of service)

Are you certified by an American Specialty Board? Yes ___ No X . If "yes", give name of Board _____
(enclose copy of Board certificate or letter verifying eligibility)

Are you a diplomate of the National Board of Medical Examiners? Yes ___ No X . If "yes", state date of certification _____

**Foreign Medical Graduates:** ECFMG standard certificate number N/A

issued _____ after passing english and medical examination. Attach copy of current valid certificate.

**All applicants must answer the following questions:**

1. Have you ever studied to become, or do you hold licensure in any state as a Chiropractor, Naturopathic or Osteopathic physician? Yes___ No__X__.

2. Have you ever failed State Board/FLEX/National Board Examination? Yes___ No__X__.

3. Have you ever been denied an application for licensure to practice medicine by any state board or other governmental agency of any state or country? Yes___ No__X__.

4. Have you ever been notified to appear before any licensing agency for a hearing on a complaint of any nature, including, but not limited to, a charge or violation of the medical practice act, unprofessional or unethical conduct? Yes___ No__X__.

5. Have you ever had a license to practice medicine/surgery/revoked, suspended, or other disciplinary action taken in any state, territory or country? Yes___ No__X__.

6. Have you ever been convicted of a felony? Yes___ No__X__; a misdemeanor? Yes___ No__X__. Have any judgments ever been entered against you? Yes___ No__X__. Have you ever been sued for malpractice? Yes___ No__X__.

7. Have you ever had to discontinue practice for any reason for a period of one month or longer? Yes___ No__X__.

8. Are you now or have you ever be[redacted]ly ill?[redacted] Have you ever received psychotherapy[redacted]

9. Are you now or have you ever been addicted to or excessively used alcohol, narcotics, barbiturates, or any other medication?[redacted]

10. Have you ever voluntarily or otherwise been a patient in a hospital, institution, clinic or medical facility for the treatment of mental/emotional illness, drug addiction/abuse, or excessive use of alcohol[redacted]

11. Have you ever been denied staff privileges in any hospital?___Yes__X__No. Have you ever had your staff privileges suspended, revoked, modified, restricted, placed on probation, or otherwise acted against (explain "otherwise" actions)?___Yes__X__No.

If "YES", list name(s) and address(es) of hospital(s)

If "YES", list name(s) and address(es) of hospital(s)

If "YES", list name(s) and address(es) of hospital(s)

12. Have you ever been allowed to resign from any hospital, institution, clinic or medical facility in lieu of disciplinary action?___YES__X__NO.

If "YES", please explain and list name(s) and address(es) of practice setting from which you resigned.

If "YES", please explain and list name(s) and address(es) of practice setting from which you resigned.

13. Has an application for medical society membership ever been rejected? Yes___ No X__.
Have you ever had your medical society membership suspended? Yes___ No X__.
Have you ever been notified to appear before a medical society in regard to charges/complaints filed against you? Yes___ No X__.

IF ANY OF THESE QUESTIONS ARE ANSWERED "YES", GIVE NAME(S) AND ADDRESS(ES) OF MEDICAL SOCIETY.

_____

_____

LIST MEDICAL AFFILIATIONS: State, county, national, including date(s) and complete address (street, city, state)

N/A

_____

_____

_____

_____

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

**********

If any of the questions numbered 1) through 14) are answered "YES", applicant must submit affidavit under oath explaining in detail, the basis for such answer.

In addition to applicant's affidavit, the reports listed below are also required:

a) Applicants who have a history of emotional/mental illness, treatment, psychotherapy, chemical dependency, etc., are required to have their treating physician/program submit to this office, a report of such treatment to include diagnosis/prognosis. In addition, such applicants may be required to undergo current psychiatric evaluation by a board approved physician independent of applicant's treating physician.

b) Malpractice Suits - Notarized Copy of Complaint and Judgment. If litigation is pending, statement from applicant's attorney, explaining current status of complaint.

c) Misdemeanor/Felony/Convictions - Certified Copy of Charges/Indictment and Judgment.

**Once the application process has been fully completed, the applicant may be required to make a personal appearance before the Credentials Committee and/or The Board of Medicine.**

**Please Note: Copies of all documents submitted with the application must be certified by a Notary Public as being true and correct copies of the original documents which the Notary Public has compared. (Notary Public must see the original document and the copy in order to make such a comparison).**

**If adequate space is not provided on the application form to respond to the requested information, please attach additional sheets as may be required.**

TO BE COMPLETED BY APPLICANT

DATE 6/1/88 COLOR OF EYES Brown

AGE 28 COLOR OF HAIR Brown

HEIGHT 6'2" WEIGHT 175 lbs OTHER MEANS OF IDENTIFICATION Birth mark on left of mouth, glasses

AFFIDAVIT OF APPLICANT:

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

I hereby authorize all hospital(s), institution(s) or organization(s), 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 any 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, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of my license to practice medicine/surgery in the State of Florida.

Paul M. Norris MD
(signature of applicant)

COUNTY OF Dade

State of Florida

Subscribed and sworn to me before this 9th day of August, 1988

Jena Dufresne
(notary public)

My commission expires

(notary seal/stamp)
Notary Public, State of Florida
My Commission Expires Sept. 3, 1990
Bonded Thru Troy Fain - Insurance Inc.

Date: July 15, 2005

To: Board of Medicine

From: Mary Alice S. Yoham, MSN, ARNP BC

Re: Dissolution of ARNP Protocol

To Whom It May Concern:

Please find enclosed **Dissolution** of the ARNP Collaborative Practice Protocol for Mary Alice S. Yoham, ARNP. Copies were sent to the Board of Nursing and are on file at the practice site referenced below and at my home address.

I would like to request a letter of confirmation to indicate that the documents enclosed are complete and acceptable. Enclosed is a self addressed, stamped envelope for your convenience.

Please do not hesitate to contact me with any questions or concerns.

Respectfully yours,

Mary Alice S. Yoham, MSN, ARNP BC

University of Miami, Dept of Medicine
Division of Clinical Pharmacology
1500 NW 12th Avenue, JMT 15 West
Miami, FL 33136
305.243.5930

Home: 10550 SW 103 Ave
Miami, FL 33176

**Dissolution of the Physicians Collaborative Practice Agreement with Mary Alice S. Yoham, MSN ARNP**

| Name | License # | DEA# | MD Signature |
|---|---|---|---|
| Richard A. Preston, M.D. | Fl ME39080 31096 | AP1330074 | |
| Kevin K. Ng, M.D. | Fl ME 41710 33630 | AN 221313C | |
| Paul Norris, M.D. | Fl ME56314 47243 | 8N1916773 | |

The Above physicians and license numbers have dissolved the supervisory agreement with Mary Alice S. Yoham, MSN, ARNP, Florida License # 348932. Date 7/15/05

Mail to:

Department of Health
Board of Nursing
4052 Bald Cypress Way, BIN C03
Tallahassee, FL 32399

# PROFESSION CODE

Paul Norris

1501

---

# FILE NUMBER

41243

---

# LICENSE NUMBER

56314

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# UPDATES

**STATE OF FLORIDA**
**DEPARTMENT OF HEALTH**
**INVESTIGATIVE SERVICES**
**4052 Bald Cypress Way, BIN # C70 • Tallahassee, FL 32399-3270**
WWW.DOH.STATE.FL.US

## IMMEDIATE RESPONSE REQUESTED

12 SEP -4 PM 4:3[illegible] MEDICINE BOARD

According to Agency records, you have registered with your licensing board as a DISPENSING PRACTITIONER. You are currently registered as:

**Dr. Paul Michael Norris– ME 56314**
**1690 S Treasure Drive**
**Miami Beach, FL 33141 (305) 868-4084**

Chapter 465.0276, Florida Statutes, requires this Department inspect any practitioner who is dispensing. **Dispensing is defined as selling medicinal drugs to patients in the office.** A practitioner who is only providing complimentary professional samples or who writes prescriptions for a patient to fill at another location is **NOT** dispensing and does not have to register as a dispensing practitioner.

Please complete the ONE portion of this form that is applicable, (A, B, or C) and return the entire form to the address below as soon as possible.

### A. IF YOU ARE NOT DISPENSING AND WISH TO BE REMOVED FROM THE LIST

Date _____
To the Board:
**This is to advise you that I request to have my name removed from the Dispensing Practitioner Register as of the above date. I DO NOT dispense medicinal drugs for a fee or remuneration of any kind at this time. My practice address is:**

_____

_____
**Signature of Practitioner ONLY**

### B. IF YOU ARE NOT DISPENSING, BUT WISH TO REMAIN ON THE LIST:

Date _____

**To the Board:**
This is to advise you that I DO NOT dispense medicinal drugs for a fee, but wish to remain on the dispensing list. My current practice address is: _____

_____
**Signature of Practitioner ONLY**

### C. Bread + Roses IF YOU ARE DISPENSING:

LOCATION OF DISPENSING PRACTICE:
Indian Rocks Womans Health Ctr
Print Practice Name
1560 S. Highland Ave, Clearwater
Street Address
727-446-2690 33756
Telephone

I am currently dispensing medicinal drugs

OFFICE HOURS:
Monday _____
Tuesday _____
Wednesday _____
Thursday _____
Friday _____ Saturday 9-5

_____
**Signature of Practitioner ONLY**

**Florida Department of Health, MQA**
**8350 NW 52nd Terrace, Ste. 400**
**Doral, FL 33166**
**Phone: (305)470-5800**
**Fax: (305) 499-2090**

Received
Investigative Services
AUG 31 [illegible]
DOH/MQA
Tallahassee HQ

**STATE OF FLORIDA**
**DEPARTMENT OF HEALTH**
**INVESTIGATIVE SERVICES**
**4052 Bald Cypress Way, BIN # C70 • Tallahassee, FL 32399-3270**

FLORIDA DEPARTMENT OF HEALTH
WWW.DOH.STATE.FL.US

12 SEP -4 PM 4:38
MEDICINE BOARD

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_____

_____
**Signature of Practitioner ONLY**

### B. IF YOU ARE NOT DISPENSING, BUT WISH TO REMAIN ON THE LIST:

Date _____

**To the Board:**

This is to advise you that I DO NOT dispense medicinal drugs for a fee, but wish to remain on the dispensing list. My current practice address is: _____

_____
**Signature of Practitioner ONLY**

### C. IF YOU ARE DISPENSING:

LOCATION OF DISPENSING PRACTICE:
Tampa Womans Health Ctr
Print Practice Name
2010 E Fletcher, Tampa 33612
Street Address
813-977-6176
Telephone

I am currently dispensing medicinal drugs

OFFICE HOURS:
Monday _____
Tuesday _____
Wednesday _____
Thursday _____
Friday 9-3

Saturday 9-3

_____
**Signature of Practitioner ONLY**

**Florida Department of Health, MQA**
**8350 NW 52nd Terrace, Ste. 400**
**Doral, FL 33166**
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**Fax: (305) 499-2090**

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STATE OF FLORIDA
DEPARTMENT OF HEALTH
INVESTIGATIVE SERVICES
4052 Bald Cypress Way, BIN # C70 • Tallahassee, FL 32399-3270 • WWW.DOH.STATE.FL.US

FLORIDA DEPARTMENT OF HEALTH

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_____

_____
**Signature of Practitioner ONLY**

### B. IF YOU ARE NOT DISPENSING, BUT WISH TO REMAIN ON THE LIST:

Date _____

**To the Board:**

This is to advise you that I DO NOT dispense medicinal drugs for a fee, but wish to remain on the dispensing list. My current practice address is: _____

_____
**Signature of Practitioner ONLY**

### C. IF YOU ARE DISPENSING:

LOCATION OF DISPENSING PRACTICE:
St Pete Womens Health Ctr
Print Practice Name
3401 66th St N, St Pete FL 33710
Street Address
727-381-6620
Telephone

I am currently dispensing medicinal drugs

OFFICE HOURS:
Monday _____
Tuesday _____
Wednesday _____
Thursday _____
Friday 9-3
Saturday 9-12

_____
**Signature of Practitioner ONLY**

**Florida Department of Health, MQA**
**8350 NW 52nd Terrace, Ste. 400**
**Doral, FL 33166**
**Phone: (305)470-5800**
**Fax: (305) 499-2090**

Received
Investigative Services
AUG 31
DOH/MQA
Tallahassee HQ

**STATE OF FLORIDA**
**DEPARTMENT OF HEALTH**
**INVESTIGATIVE SERVICES**
**4052 Bald Cypress Way, BIN # C70 • Tallahassee, FL 32399-3270**

FLORIDA DEPARTMENT OF HEALTH
WWW.DOH.STATE.FL.US



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_____

_____
**Signature of Practitioner ONLY**

### B. IF YOU ARE NOT DISPENSING, BUT WISH TO REMAIN ON THE LIST:

Date _____

**To the Board:**
This is to advise you that I DO NOT dispense medicinal drugs for a fee, but wish to remain on the dispensing list. My current practice address is: _____

_____
**Signature of Practitioner ONLY**

### C. IF YOU ARE DISPENSING:

LOCATION OF DISPENSING PRACTICE:
Presidential Womens Center
Print Practice Name
100 N Dixie Hwy, WPB 33407
Street Address
561-686-3859
Telephone

I am currently dispensing medicinal drugs

OFFICE HOURS:
Monday _____
Tuesday _____
Wednesday _____
Thursday _____
Friday _____ Saturday 9-5

_____
**Signature of Practitioner ONLY**

RECEIVED
AUG 28 2012
DOH/MIAMI
INVESTIGATIVE SERVICES

**Florida Department of Health, MQA**
**8350 NW 52nd Terrace, Ste. 400**
**Doral, FL 33166**
**Phone: (305)470-5800**
**Fax: (305) 499-2090**

f 47243

1740869

**Mission:**
To protect, promote & improve the health of all people in Florida through integrated state, county & community efforts.

Florida HEALTH

**Vision:** To be the Healthiest State in the Nation

**Rick Scott**
Governor

**John H. Armstrong, MD, FACS**
State Surgeon General & Secretary

# PHYSICIAN DISPENSING REGISTRATION

OFFICE USE ONLY

NOTE: YOU MAY NOT DISPENSE UNTIL THIS REGISTRATION HAS BEEN APPROVED.

**Important** – Complete one form per licensee.

A dispensing practitioner shall not dispense a controlled substance listed in Schedule II or III as provided in Section 893.03, F.S. unless exempted from this section by s. 465.0276, FS.

**Dispensing** – is defined as selling medicinal drugs to patients in the office. A practitioner who writes prescriptions or provides complimentary professional samples is not a "dispensing practitioner," and therefore does not need to register with the department.

**Dispensing fee** – The fee for registration as a dispensing practitioner is **$100.00** over and above the required license renewal fee. An annual inspection of your dispensing records will be conducted.
Dispensing Approval – You cannot begin dispensing until you are registered

**PLEASE PRINT OR TYPE THE FOLLOWING INFORMATION**

| | | |
|---|---|---|
| **Name & license No:** | Paul M Notti | ME56314 |
| **Facility Name:** | Miami Beach Ob/Gyn Associates | |
| **Practice Location:** | 400 Arthur Godfrey Rd Suite 508 | |
| ☐ **Add** ☐ **Delete** | Street name and number: 400 Arthur Godfrey Rd Suite 508 / City: Miami Beach / State: FL / Zip: 33140 | |
| **Facility Name:** | | |
| **Satellite Location:** | | |
| ☐ **Add** ☐ **Delete** | Street name and number / City / State / Zip | |

Signature of Physician — 4-22-2013 Date of signature

☐ **PLEASE CANCEL MY DISPENSING STATUS EFFECTIVE** _____ Effective Date

DH-MQA 1070, Rules 64B8-4.029 and 1.007, FAC, Revised 7/2011

Sig First check ZP

Date: 10-13

Sig second check by M.H. Hole

| | | |
|---|---|---|
| Application all questions answered: | | |
| RT | | |
| Fee | 100.00 ✓ | |
| M.D. Diploma | ✓ | |
| Translation/foreign | | |
| Training approved | ✓ | |
| School Form McPhee ✓ | | |
| ECFMG: | | |
| 1. Standard | Irrelevant ✓ | |
| 2. 5th PW | | |
| 3. Verified | | |
| 5th Pathway Approved | | |
| Undergrad degree | | |
| Social Service (ACTA) | | |
| 2 Ltrs. recommend | ✓ | |
| AMA verification 9-2 | ✓ | |
| FMG Form | | PA required |
| FLEX FORM-Exam | | |
| Data Profile | | |
| Grades-Endorsement | | |
| FLEX | | |
| National Bds 7/64 [redacted] | ✓ | 3-66 [redacted] |
| Separation from Service | | |
| Legal Change of Name | | |
| Name Form | | |
| Account of time: | | |
| States where licensed None | | |
| Staff Privileges None | | |
| Denied Privileges | | |
| Training Res 6/63-present-Loyola Mercy Hosp | ✓ | 9-79 |
| Affidavit & Contracts | ✓ | |
| Malpractice/Felony/Misdemeanor | | |
| Dr. P. Approval | | |
| Psychotherapy (show Margaret) | | |
| Impaired Physician | | |
| Photo (2) Exam (1) ECFMG | ✓ | ✓ |

(12)

DEPARTMENT OF PROFESSIONAL REGULATION
BOARD OF MEDICINE
EXAMINATION APPLICATION

Please check appropriate box:

[X] I am applying for li[illegible] of passage of the FLEX examination or Part [illegible] National Board of Medical Examiners within 10 years imm[illegible] is application. Application Fee is $100.

[ ] I am applying to take the FLEX Examination in Florida. Total fee is $600 (Application Fee is $100; Examination Fee is $500).

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

08/11/88 8755986 $100.00
80975
$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#E-302, Miami, Fl., 33172
(c/o) (Street & No.) (City) (State) (Zip)

PERMANENT ADDRESS: 1000 West Ave #1224 M. Am. 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 affect your candidacy for licensure.

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

AUG 11 1988

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

REVENUE DPR

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)

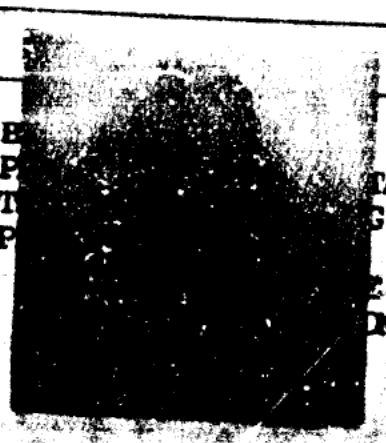
RECEIVED
AUG 1[illegible]

**********

FOR OFFICE USE ONLY, PLEASE DO NOT WRITE B[illegible]

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

NOTE: P[illegible] TAKEN WIT[illegible] G DATE OF APP[illegible]
1.
2.



Rev. Code 1510 DPR/ME/001 October 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 (city, state or country) 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____

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)

_____ (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____

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 (Exact dates of attendance) TO: ~~6/24/88~~ Present (Month/Day/Year) Ob/Gyn Internship / Residency 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: _____ (Exact dates of attendance) TO: _____ (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.

To DPR - Office of Licensure
From Paul Michael Norris MD
re: application for Licensure

RECEIVED
JAN 19 1989
MEDICAL / NATUROPATH

Dear Gentlmen.

You asked for my place of residency since medical school. (6/87 - 1/89) After graduating from The Medical College of Ohio (6/87) I moved to Florida for residency at Jackson Memorial Hospital where my address was: 9359 Fontainbleau Blvd # F 302 Miami FL 33172

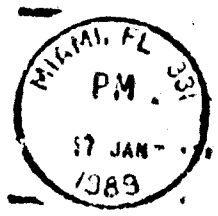
Now I have just moved to: * 1000 West Ave # 224 Miami Bch FL 33139

and am continuing my residency at Jackson Hospital.

Sincerly
Paul M. Norris

(Paul Norris)

Paul Norris
1000 West Ave 1224
Miami Bch FL 33139




DPR
of Florida Board
of Medicine
130 N. Monroe St
Tallahassee FL 32399
0750

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.

PRACTICE/EMPLOYMENT - List in chronological order from date of graduation to present date, all practice experience and/or employment.

FROM: N/A TO: _____ _____
(Month/Day/Year) (Month/Day/Year) (Type of Practice and/or Employment)

_____
Name and Address (Street Number, City, State, Territory, Country) of Employment and/or practice setting.

FROM: _____ TO: _____ _____
(Month/Day/Year) (Month/Day/Year) (Type of Practice and/or Employment)

_____
Name and Address (Street Number, City, State, Territory, Country) of Employment and/or practice setting.

FROM: _____ TO: _____ _____
(Month/Day/Year) (Month/Day/Year) (Type of Practice and/or Employment)

_____
Name and Address (Street Number, City, State, Territory, Country) of Employment and/or practice setting.

List hospital(s) where you have staff privileges. (Give addresses, date(s) of service and chief of staff) (Do not list privileges as an intern/resident in ACGME training)

_____

_____

_____

Have you ever been in the United States Military? Yes ___ No X . If so, attach copy of separation from service form and full discharge form.

_____
(branch of service, rank, dates of service)

Are you certified by an American Specialty Board? Yes ___ No X . If "yes", give name of Board _____
(enclose copy of Board certificate or letter verifying eligibility)

Are you a diplomate of the National Board of Medical Examiners? Yes ___ No X . If "yes", state date of certification _____

Foreign Medical Graduates: ECFMG standard certificate number N/A

issued _____ after passing english and medical examination. Attach copy of current valid certificate.

**All applicants must answer the following questions:**

1. Have you ever studied to become, or do you hold licensure in any state as a Chiropractor, Naturopathic or Osteopathic physician? Yes___ No X .

2. Have you ever failed State Board/FLEX/National Board Examination? Yes___ No X .

3. Have you ever been denied an application for licensure to practice medicine by any state board or other governmental agency of any state or country? Yes___ No X .

4. Have you ever been notified to appear before any licensing agency for a hearing on a complaint of any nature, including, but not limited to, a charge or violation of the medical practice act, unprofessional or unethical conduct? Yes___ No X .

5. Have you ever had a license to practice medicine/surgery/revoked, suspended, or other disciplinary action taken in any state, territory or country? Yes___ No X .

6. Have you ever been convicted of a felony? Yes___ No X ; a misdemeanor? Yes___ No X . Have any judgments ever been entered against you? Yes___ No X . Have you ever been sued for malpractice? Yes___ No X .

7. Have you ever had to discontinue practice for any reason for a period of one month or longer? Yes___ No X .

8. Are you now or have you ever been emotionally/mentally ill? [redacted] Have you ever received psychotherapy? [redacted]

9. Are you now or have you ever been addicted to or excessively used alcohol, narcotics, barbiturates, or any other medication? [redacted]

10. Have you ever voluntarily or otherwise been a patient in a hospital, institution, clinic or medical facility for the treatment of mental/emotional illness, drug addiction/abuse, or excessive use of alcohol? [redacted]

11. Have you ever been denied staff privileges in any hospital? ___Yes X No. Have you ever had your staff privileges suspended, revoked, modified, restricted, placed on probation, or otherwise acted against (explain "otherwise" actions)? ___Yes X No.

If "YES", list name(s) and address(es) of hospital(s)

If "YES", list name(s) and address(es) of hospital(s)

If "YES", list name(s) and address(es) of hospital(s)

12. Have you ever been allowed to resign from any hospital, institution, clinic or medical facility in lieu of disciplinary action? ___YES X NO.

If "YES", please explain and list name(s) and address(es) of practice setting from which you resigned.

If "YES", please explain and list name(s) and address(es) of practice setting from which you resigned.

13. Has an application for medical society membership ever been rejected? Yes___ No X_. Have you ever had your medical society membership suspended? Yes___ No X_. Have you ever been notified to appear before a medical society in regard to charges/complaints filed against you? Yes___ No X_.

IF ANY OF THESE QUESTIONS ARE ANSWERED "YES", GIVE NAME(S) AND ADDRESS(ES) OF MEDICAL SOCIETY.

LIST MEDICAL AFFILIATIONS: State, county, national, including date(s) and complete address (street, city, state)

N/A

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

**********

If any of the questions numbered 1) through 14) are answered "YES", applicant must submit affidavit under oath explaining in detail, the basis for such answer.

In addition to applicant's affidavit, the reports listed below are also required:

a) Applicants who have a history of emotional/mental illness, treatment, psychotherapy, chemical dependency, etc., are required to have their treating physician/program submit to this office, a report of such treatment to include diagnosis/prognosis. In addition, such applicants may be required to undergo current psychiatric evaluation by a board approved physician independent of applicant's treating physician.

b) Malpractice Suits - Notarized Copy of Complaint and Judgment. If litigation is pending, statement from applicant's attorney, explaining current status of complaint.

c) Misdemeanor/Felony/Convictions - Certified Copy of Charges/Indictment and Judgment.

Once the application process has been fully completed, the applicant may be required to make a personal appearance before the Credentials Committee and/or The Board of Medicine.

Please Note: Copies of all documents submitted with the application must be certified by a Notary Public as being true and correct copies of the original documents which the Notary Public has compared. (Notary Public must see the original document and the copy in order to make such a comparison).

If adequate space is not provided on the application form to respond to the requested information, please attach additional sheets as may be required.

TO BE COMPLETED BY APPLICANT

DATE 5/1/88 COLOR OF EYES Brown

AGE 28 COLOR OF HAIR Brown

HEIGHT 6'2" WEIGHT 175 lbs OTHER MEANS OF IDENTIFICATION Birth mark on left of mouth, glasses

AFFIDAVIT OF APPLICANT:

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

I hereby authorize all hospital(s), institution(s) or organization(s), 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 any 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, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of my license to practice medicine/surgery in the State of Florida.

Paul M. Norris MD
(signature of applicant)

COUNTY OF Dade

State of Florida

Subscribed and sworn to me before this 9th day of August, 1988

Jean Dufresne
(notary public)

My commission expires

(notary seal/stamp)
Notary Public, State of Florida
My Commission Expires Sept. 3, 1989
Bonded Thru Tory Fain - Insurance Inc.

# MEDICAL COLLEGE OF OHIO AT TOLEDO

Certified to be a true copy.
Dated at Miami, Florida, this 9th August, 1988.
Lena DeQuattro
Notary Public
Notary Public, State of Florida
My Commission Expires Sept. 3, 1988
Bonded Thru Troy Fain - Insurance Inc.

THE FACULTY AND THE BOARD OF TRUSTEES OF THE MEDICAL COLLEGE OF OHIO AT TOLEDO

HEREBY CONFER THE DEGREE OF

DOCTOR OF MEDICINE

UPON

**PAUL MICHAEL NORRIS**

WHO HAS COMPLIED WITH ALL REQUIREMENTS OF THE MEDICAL COLLEGE OF OHIO AT TOLEDO AND IS ENTITLED TO ALL THE HONORS, RIGHTS AND PRIVILEGES PERTAINING THEREUNTO.

IN TESTIMONY WHEREOF, THIS DEGREE IS CONFERRED, SEALED WITH THE SEAL OF THE MEDICAL COLLEGE OF OHIO AT TOLEDO, OHIO, THIS 5TH DAY OF JUNE, 1987.

CHAIRMAN OF THE BOARD OF TRUSTEES

SECRETARY OF THE BOARD OF TRUSTEES

MEDICAL COLLEGE OF OHIO AT TOLEDO · 1964 ·

PRESIDENT

DEAN

# MEDICAL COLLEGE OF OHIO AT TOLEDO

Certified to be a true copy.
Dated at Miami, Florida, this 9th Augus 198
Lena DeQuattro
Notary Public
Notary Public, State of Florida
My Commission Expires Sept. 3, 1988
Bonded Thru Tory Fain - Insurance Inc.

THE FACULTY AND THE BOARD OF TRUSTEES OF THE MEDICAL COLLEGE OF OHIO AT TOLEDO

HEREBY CONFER THE DEGREE OF

## DOCTOR OF MEDICINE

UPON

## PAUL MICHAEL NORRIS

WHO HAS COMPLIED WITH ALL REQUIREMENTS OF THE MEDICAL COLLEGE OF OHIO AT TOLEDO AND IS ENTITLED TO ALL THE HONORS, RIGHTS AND PRIVILEGES PERTAINING THEREUNTO.

IN TESTIMONY WHEREOF, THIS DEGREE IS CONFERRED, SEALED WITH THE SEAL OF THE MEDICAL COLLEGE OF OHIO AT TOLEDO, OHIO, THIS 5TH DAY OF JUNE, 1987.

CHAIRMAN OF THE BOARD OF TRUSTEES

SECRETARY OF THE BOARD OF TRUSTEES

MEDICAL COLLEGE OF OHIO AT TOLEDO • 1964 •

PRESIDENT

DEAN

Bob Martinez
Governor
Larry Gonzalez
Secretary
(904) 488-0595

# FLORIDA DEPARTMENT OF PROFESSIONAL REGULATION

*Assuring Professionalism In Florida*
130 N. Monroe Street • Tallahassee, Florida 32399-0750

## BOARD OF MEDICINE

March 15, 1989

Paul M. Norris, M.D.
1000 West Ave #1224on
Miami Beach, FL 33139

Dear Dr. Norris:

This is in reference to your application for Medical licensure in the state of Florida. The following items are still needed to complete your file.

1) In order to fully verify your position as a resident at the Jackson Memorial Hospital, you must submit properly notarized copies of your contracts with the hospital.

Thank you for your cooperation in this matter. If you have any questions please contact me at the number listed below.

Sincerely,

Bil Mitchell
Board of Medicine
(904)488-0595

Certified to be true copy.

Dated at Miami, Florida, 23rd March, 1989.

Notary Public, State of Florida
My Commission Expires Sept. 3, 1989
Bonded Thru Troy Fain - Insurance Inc.

RECEIVED

MAR 30 1989

**JACKSON MEMORIAL HOSPITAL, MIAMI, FLORIDA**
**GRADUATE MEDICAL EDUCATION PROGRAM AGREEMENT** CAL / NATUROPATH

Dear Doctor Paul M. Norris : We are pleased to inform you that in accordance with the recommendation of William A. Little, M.D., Chief of OB/GYN we offer you an appointment as PGY-1 at the Public Health Trust. This appointment will begin June 24, 1987 and Terminate June 23, 1988

**CONDITIONS AND AGREEMENTS**

1. This Agreement entered into this 9th day of April, 19 87 by and between Dr. Paul M. Norris hereinafter referred to as **"APPOINTEE"**, and the Public Health Trust of Dade County, Florida, and agency and instrumentality of Dade County, Florida, hereinafter referred to as the **"TRUST"**, which operates Jackson Memorial Hospital Medical Center, hereinafter referred to as the **"MEDICAL CENTER"**.

2. In consideration of the promises and mutual convenants and agreements contained herein, the parties agree as follows:

A. **APPOINTEE** will abide by the rules and regulations of the **TRUST** and the Medical Staff By Laws and **MEDICAL CENTER** policies and procedures.

B. The schedule of assignments of an **APPOINTEE** is controlled by the Chief of the Service to which he/she is assigned.

C. As outlined by the laws of the State of Florida, the **TRUST** will provide liability protection for **APPOINTEE** for services which involve the discharging of responsibilities under this Agreement. This will cover any subsequent claims that might be processed after termination of this Agreement for action that occurred during the term of duty at the **TRUST** relating to activities as a part of the training program. This protection does not apply to claims arising out of work performed at any institution outside the **MEDICAL CENTER.**

D. If **APPOINTEE** is assigned outside of the premises of the **MEDICAL CENTER** he/she shall be covered solely by the outside institution where he/she is assigned and shall not be insured under this Agreement.

3. **APPOINTEE** agrees to the terms and conditions of this agreement regarding stipend, hours, working conditions and rules and regulations as set forth in the attachments "1. Personnel relations and disciplinary actions" and "2. Stipend and benefits" or "3. Special **APPOINTEE** information" which are attached hereto and incorporated herein by reference and made a part of this contract and the **APPOINTEE** agrees to comply with the provisions contained therein. **APPOINTEE** further agrees to provide uninterrupted service to the **TRUST** to the best of his/her abilities.

4. No part of **APPOINTEE'S** stipend will be paid until this Agreement has been approved and signed.

5. Unless otherwise provided by contract between the **TRUST** and an affiliated hospital, if **APPOINTEE** is assigned to other affiliated hospitals he /she will receive his /her stipend and benefits from the hospital to which he /she is assigned.

6. No other benefits accrue to **APPOINTEE** other than those mentioned in this Agreement and its attachments.

7. In the event any provisions of this Agreement are held invalid the remainder of this Agreement shall not be affected by such invalidity.

Witness

Signature of **APPOINTEE**

Chief of Service

President of the Public Health Trust

Certified to be a true copy.

Dated at Miami, Florida, 23rd March, 1989.

Notary Public, State of Florida
My Commission Expires Sept. 3, 1989
Bonded Thru Gary Fain - Insurance Inc.

# JACKSON MEMORIAL HOSPITAL, MIAMI, FLORIDA
# GRADUATE MEDICAL EDUCATION PROGRAM AGREEMENT

Dear Doctor Paul M. Norris : We are pleased to inform you that in accordance with the recommendation of William A. Little, M.D., Chief of OB/GYN we offer you an appointment as PGY-2 at the Public Health Trust. This appointment will begin July 1, 1988 and terminate June 30, 1989.

## CONDITIONS AND AGREEMENTS

1. This Agreement entered into this 7 day of April, 19 83 by and between Dr. Paul M. Norris hereinafter referred to as "APPOINTEE", and the Public Health Trust of Dade County, Florida, an agency and instrumentality of Dade County, Florida, hereinafter referred to as "TRUST", which governs and operates Jackson Memorial Hospital, hereinafter referred to as "HOSPITAL", and other designated facilities.

2. In consideration of the promises and mutual covenants and agreements contained herein, the parties agree as follows:

A. APPOINTEE will abide by the rules and regulations of the TRUST and the HOSPITAL'S policies, procedures and medical staff bylaws. APPOINTEE also agrees to fulfill responsibilities assigned to him/her, including those outlined in Attachment 2 or 3.

B. The schedule of assignments of an APPOINTEE is controlled by the Chief of the Service to which he/she is assigned.

C. With respect to liability for negligence occurring during the term of this Agreement, APPOINTEE'S activities in discharge of responsibilities under this Agreement are governed by Section 768.23(9) (a), Florida Statutes. APPOINTEE may be held personally liable for injuries or damages resulting from any act of omission or commission performed in bad faith or with malicious purpose or in a manner exhibiting wanton or willful disregard of human rights, safety or property. The TRUST itself is self-insured. The protection provided under Section 768.28(9) (a), Florida Statutes, does not apply to claims arising out of activities performed at any institution not governed and operated by the TRUST.

D. If APPOINTEE is assigned outside of the premises of the TRUST, his/her activities shall be covered solely by the outside institution where he/she is assigned.

3. APPOINTEE agrees to the terms and conditions of this agreement regarding stipend, hours, working conditions and rules and regulations as set forth in the attachments "1. Personnel relations and disciplinary actions" and "2. Stipend and benefits" or "3. Special APPOINTEE information" which are attached hereto and incorporated herein by reference and made a part of this contract and the APPOINTEE further agrees to provide uninterrupted services to the TRUST to the best of his/her abilities.

4. No part of APPOINTEE'S stipend will be paid until this Agreement has been approved and signed.

5. Unless otherwise provided by contract between the TRUST and an affiliated health care facility, if APPOINTEE is assigned to another affiliated health care facility he/she will receive his/her stipend and benefits from the facility to which he/she is assigned.

6. No other benefits accrue to APPOINTEE other than those mentioned in this Agreement and its attachments.

7. In the event any provisions of this Agreement are held invalid the remainder of this agreement shall not be affected by such invalidity.

Witness

Signature of Appointee

Chief of Service,
Jackson Memorial Hospital

President of the
Public Health Trust

155765

JACKSON MEMORIAL HOSPITAL
1611 N.W. 12TH AVENUE
MIAMI, FLORIDA 33136-1094

MIAMI FLA MAR23'89 U.S.POSTAGE 0.45 P.B. METER 6601764

FORWARDING AND ADDRESS CORRECTION REQUESTED

Department of Professional Regulation
Board of Medicine
130 North Monroe Street
Tallahassee, Florida 32399-0750

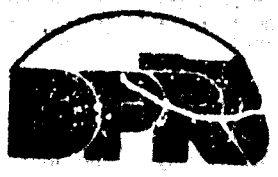
RECEIVED
MAR 29 10 45 AM '89
PROFESSIONAL REGULATION

Bob Martinez
Governor

Larry Gonzalez
Secretary

(904) 488-0595

# FLORIDA DEPARTMENT OF PROFESSIONAL REGULATION



*Assuring Professionalism In Florida*

130 N. Monroe Street • Tallahassee, Florida 32399-0750

## BOARD OF MEDICINE

August 18, 1988

William F. Little, M.D.
Chief of Service
Jackson Memorial Hospital
1611 N.W. 12th Ave.
Miami, FL. 33136

Dear Dr. Little:

Re: Paul Michael Norris. M.D.
DOB 9/17/59

This is in reference to the letter submitted by you November 8, 1988, per our request. We are aware of the accreditation of the Obstetrics/ Gynecology program with Jackson Memorial Hospital. We are requesting confirmation of Dr. Norris having participated in an accredited, approved position with the program from June 24, 1986 through the present.

Please submit an affidavit, sworn to before a notary, verifying that Dr. Norris had an accredited, approved, allocated position with the Department of Obstetrics/Gynecology at Jackson Memorial Hospital. Please submit properly notarized copies of the contracts. In the event that this request is negated, please submit a letter of refusal.

Thank you for your continued cooperation.

Sincerely,

Bil Mitchell
Board of Medicine
(904)488-0595

JACKSON MEMORIAL HOSPITAL
1611 N.W. 12TH AVENUE MIAMI, FLORIDA 33136



February 21, 1989

Department of Professional Regulation
Board of Medicine
130 North Monroe Street
Tallahassee, Florida 32399-0750

RE: PAUL M. NORRIS, M.D.

Dear Sir:

This letter is written to confirm that Dr. Paul Norris is in training at the University of Miami/Jackson Memorial Hospital. The Department of Obstetrics and Gynecology is approved by the Accreditation Council for Graduate Medical Education for residency training.

Dr. Norris began his residency in an approved, accredited position as a PGY-1 on June 24, 1987 and completed his internship on June 23, 1988. At this time, Dr. Norris is in his second year of residency.

If any additional information is required, please feel free to contact me.

Sincerely,

William A. Little, M.D.
Chief of Service

WAL/vl

STATE OF FLORIDA
COUNTY OF DADE

Before me personally appeared William A. Little, M.D. to me well known and known to me to be the person described in and who executed the foregoing instrument, and acknowledged to and before that he executed said instrument for the purposes therein expressed.

WITNESS my hand and official seal, this 27th February, 1989.

Notary Public
State of Florida

My commission expires:

Notary Public, State of Florida
My Commission Expires Sept. 3, 1989
Bonded Thru Gen Ins. Und.

JACKSON MEMORIAL HOSPITAL
1611 N.W. 12TH AVENUE MIAMI, FLORIDA 33136



November 8, 1988

State of Florida
Department of Professional Regulation
Board of Medicine
130 North Monroe Street
Tallahassee, Florida 32301

RE: PAUL MICHAEL NORRIS, M.D.

Dear Sir:

This letter is written to confirm that Dr. Paul Norris is in training at the University of Miami/Jackson Memorial Hospital. The Department of Obstetrics and Gynecology is approved by the Accreditation Council for Graduate Medical Education for residency training.

Dr. Norris began his residency in an approved, accredited position as a PGY-1 on June 24, 1987 and completed his internship on June 23, 1988. At this time, Dr. Norris is in his second year of residency.

If any additional information is required, please feel free to contact me.

Sincerely,

William A. Little, M.D.
Chief of Service

WAL/vl

CAMERA 1 NAME: Carolyn Smith DATE: 10-27 ROLL# 2-25

# Department of Professional Regulation

Governor
Bob Martinez
Secretary
~~Kirk Tyson~~ L.Gonzalez

130 North Monroe Street
Tallahassee, Florida 32399-0750

Board of Medicine
(904) 488-0595

THE DOCTOR'S APPLICATION DEPENDS UPON THE RETURN OF THIS EVALUATION PLEASE RUSH

TO: Medical College of Ohio
at Toledo
P. O. Box 6190
Toledo, OH 43614

FROM: Examination Section

The individual listed below has applied to the Florida Board of Medicine for licensure in the profession indicated. A diploma from your school was submitted as proof of having completed educational prerequisites for licensure. Please authenticate by signature and seal(school of notary) that the following information is true and correct according to your records.

Name: Paul Michael Norris

Profession: MEDICAL

Date of Birth: 9/17/59

Type of Degree: M.D.

Date Degree Granted: 6/5/87

Comments:

Verified by Marilyn A Fryzel
Signature

SEAL

Marilyn Fryzel
Name

Registrar
Title

RECEIVED
OCT 25 1988
MEDICAL/NATUROPATH

DPR/ME/009(3-85)

OBSTETRICS AND GYNECOLOGY
W.A. Little, M.D.
Professor and Chairman
A.G.W. McLeod, M.D.
Professor and Vice Chairman

UNIVERSITY OF Miami
SCHOOL OF MEDICINE

PERINATAL DIVISION
M.J. O'Sullivan, M.D., Director
S.N. Beydoun, M.D.
G. Burkett, M.D.
A.R. Lai, M.D.
A.G.W. McLeod, M.D.
S. Yasin, M.D.

June 6, 1988

DPR - Florida Board of Medicine
130 N. Monroe Street
Tallahassee, FL 32399-0750

RE: PAUL NORRIS, M.D.

TO WHOM IT MAY CONCERN:

Dr. Paul Norris is well known to me as a PGY-I in the residency in Obsatetrics and Gynecology at Jackson Memorial Hospital/University of Miami School of Medicine.

Dr. Norris is a very polite, pleasant, intelligent physician who has functioned as an intern in an excellent capacity, and has the potential for a very bright future.

I do not have any hesitation whatsoever in recommending Dr. Norris as ethically sound, moral, upstanding, and free from the use of drugs to best of my knowledge.

Sincerely,

Mary Jo O'Sullivan, M.D.
Professor
Director of Obstetrics

MJO/cs

RE [illegible]
MEDICAL [illegible]

Department of Obstetrics & Gynecology (R-136)
P.O. Box 016960
Miami, Florida 33101
(305) 549-6950

UNIVERSITY OF Miami
SCHOOL OF MEDICINE

RECEIVED
JUN 21 1988
MEDICAL / NATUROPATH

June 10, 1988

Florida Board of Medicine
Dept of Professional Regulations
130 North Monroe Street
Tallahassee, FLA 32399-0750

RE: Paul Norris, MD

Dr. Norris has been in the Obstetrics and Gynecological Internship Program at Jackson Memorial Hospital since June 24, 1987. He is now in the process of completing his Internship satisfactorily.

Dr. Norris has the highest standards in ethics both personal and professional. He gets on well with his colleagues and has a very pleasant approach toward patients.

I have no hesitation in recommending Dr. Norris for your consideration.

Yours sincerely,

Euan G. Robertson, MD
Professor of Obstetrics
and Gynecology

EGR/gj

Department of Obstetrics-Gynecology
Division of Gynecology (D-50)
Location: Jackson Memorial Hospital, East Tower, 1611 N.W. 12th Avenue
P.O. Box 016960
Miami, Florida 33101

Paul Norris

UNIVERSITY OF Miami
SCHOOL OF MEDICINE

August 2, 1968

Florida Board of Medical Examiners
130 North Monroe Street
Suite 100
Tallahassee, Florida 32301

RECEIVED
AUG 10 1968
MEDICAL / NAT...

Dear Gentleman;

It is with pleasure that I am unreservedly recommending Dr. Paul Norris for licensure in the state of Florida.

Dr. Norris is known to me as a result of his internship-residency training after graduating from the Medical College of Ohio.

Currently, Paul is continuing his residency training at the University of Miami/Jackson Memorial Hospital which is totally satisfactory in all respects. He is an enthusiastic and delightful colleague who demonstrates superb ability. At all times, his pleasant personality, appearance and gentlemanly manner is very evident. He conducts himself with proper decorum.

Dr. Norris is sincere, honest and gets along extremely well with his peers, patients and contemporaries. He has certainly impressed me very favorably with his competence and knowledge.

Without reservations, I recommend his application for licensure. I feel that Dr. Paul Norris will prove to be a valuable asset to the medical profession and I wish him continued success.

Sincerely,

Irvin Seaman, M.D.
Irvin Seaman, M.D.

Department of Obstetrics-Gynecology
Division of Gynecology (D-50)
Location: Jackson Memorial Hospital, East Tower, 1611 N.W. 12th Avenue
P.O. Box 016960
Miami, Florida 33101

University of Miami
SCHOOL OF MEDICINE

Department of Obstetrics Gynecology
Division of Gynecologic Oncology (D-52)
P.O. Box 016960
Miami, Florida 33101

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US POSTAGE 025

Florida Board of Medicla Examiners
130 North Monroe Street
Suite 100
Tallahassee, Florida 32301

AMA PHYSICIAN PROFILE

AMERICAN MEDICAL ASSOCIATION
535 NORTH DEARBORN STREET
CHICAGO, ILLINOIS 60610

DIVISION OF SURVEY AND DATA RESOURCES
DEPARTMENT OF DATA RELEASE SERVICES

DATE: 09-23-88
TIME: 1:17 PM

NAME: NORRIS,PAUL MICHAEL, M.D.
ADDRESS: 9359 FOUNTAINBLEAU-F302
MIAMI FL 33172
BIRTHPLACE: DAYTON,OH
BIRTHDATE: 09/17/59
MEMBER OF AMA: 1988 ACTIVE MEMBER
MEDICAL SCHOOL
MED COLL OF OHIO AT TOLEDO, TOLEDO OH 43699
YEAR OF GRADUATION: 1987
LICENSES (INITIAL YEAR GRANTED BY STATE):
NONE REPORTED TO DATE
NATIONAL BOARD CERTIFICATION: NONE REPORTED TO DATE
SPECIALTY BOARD CERTIFICATION: NONE REPORTED TO DATE

PHYSICIAN'S PROFESSIONAL ACTIVITIES: RESIDENT
SELF DESIGNATED SPECIALTIES
PRIMARY: OBSTETRICS AND GYNECOLOGY
SECONDARY: UNSPECIFIED
TERTIARY: UNSPECIFIED

CURRENT MEDICAL TRAINING: INTERN
HOSPITAL: JACKSON MEM HOSP MIAMI FL 33136
DATES OF TRAINING: 07/87-06/88 -- (BEING RE-CONFIRMED)
SPECIALTY: OBSTETRICS AND GYNECOLOGY
SPECIALTY: UNSPECIFIED

PRIOR MEDICAL TRAINING: NONE REPORTED TO DATE

FELLOWSHIP: NONE REPORTED TO DATE

THE FOLLOWING IS HISTORICAL. CHECK WITH PRIMARY SOURCES FOR CURRENT STATUS:

NATIONAL SCIENTIFIC MEDICAL SOCIETIES: NONE REPORTED TO DATE

PROFESSORIAL APPOINTMENT: NONE REPORTED TO DATE

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AMERICAN MEDICAL ASSOCIATION
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NATIONAL SCIENTIFIC MEDICAL SOCIETIES: NONE REPORTED TO DATE

PROFESSORIAL APPOINTMENT: NONE REPORTED TO DATE

NATIONAL BOARD OF MEDICAL EXAMINERS® • 3930 CHESTNUT STREET, PHILADELPHIA, PA 19104

# ENDORSEMENT OF CERTIFICATION

NATIONAL BOARD OF MEDICAL EXAMINERS
OF THE
UNITED STATES OF AMERICA

Paul Michael Norris, M.D.

having satisfied all the requirements and having successfully passed the examinations is hereby declared a Diplomate of the National Board of Medical Examiners.

Attest L. THOMPSON BOWLES, M.D., PH.D.
Chairman of the Board

SEAL ROBERT L. VOLLE, PH.D.
President of the Board

Philadelphia, Pa.
07/01/88

Certificate # 339416

It is certified that the above is a facsimile of the Diplomate Certificate which has been or will be* awarded to the physician named above, who graduated from MED COLL OHIO AT TOLEDO in JUNE 1987 and whose birth date is 09/17/1959. This physician has successfully completed all examinations required for certification by the National Board of Medical Examiners. The scores obtained by this physician upon which his/her certification is based are as follows:

| | Standard Score | Scale Score |
|---|---|---|
| PART I passed 05/85 | | |
| Anatomy | [redacted] | |
| Physiology | | |
| Biochemistry | | |
| Pathology | | |
| Microbiology | | |
| Pharmacology | | |
| Behavioral Sciences | | |
| TOTAL TEST (Minimum Passing Score 380/75 | | |
| PART II passed 04/87 | | |
| Internal Medicine | | |
| Surgery | | |
| Obstetrics and Gynecology | | |
| Public Health and Preventive Medicine | | |
| Pediatrics | | |
| Psychiatry | | |
| TOTAL TEST (Minimum Passing Score 380/75 | | |
| PART III passed 03/88 | | |
| A General Test of Clinical Competence | | |
| TOTAL TEST (Minimum Passing Score 380/75 | | |
| GENERAL AVERAGE (Parts I, II, and III Scale Score) | | |

*For those individuals who have not yet satisfactorily completed one full year of post-M.D. training the date shown on the facsimile is the date which has been certified by the physician's residency program director as the date on which the requirements for certification by the National Board will be fulfilled and such certification will be awarded.

RECEIVED
JAN 30 1988
MEDICAL EXAMINERS

Melanie Valente
Secretary for Certification
01/25/89
Date

CAMERA 1 NAME: Carolyn Scarb DATE: 9-27 ROLL# 225

FROM: Department of Professional Regulation
Florida Board of Medicine
130 N. Monroe St. Tallahassee, FL 32399-0750 (904)488-0595
Medical Endorsement/Examination Section

Date: September 27, 1988

TO: William A. Little
Jackson Memorial Medical Center
1611 NW 12th Ave.
Miami, Florida 33136

Please complete the form below and return to this office as soon as possible. This physician made application for medical licensure in Florida and is under investigation by this authority.

1. Name: Paul Michael Norris

2. Internship XX Residency XX From: 6/87 To: present

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

| | Poor | Fair | Good | Superior | Don't Know |
|---|---|---|---|---|---|
| a. Basic Medical Knowledge | | | | X | |
| b. Diagnostic and clinical Ability | | | | X | |
| c. Teaching Ability | | | X | | |
| d. Research Potential | | | X | | |
| e. Fitness for Clinical Practice | | | | X | |

4. Personal Character:

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

5. Professional Relationship with:

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

6. Physical Handicap: [redacted]
Comments:

7. Personality Problems which might affect performance: Yes: No: X
Explain:

8. Overall evaluation: ***If item 3 or 4 is checked, please provide a written explanation on the reverse side of this form.

X 1. Recommended as outstanding applicant.
2. Recommended as qualified and competent.
3. Recommended with some reservation.
4. Cannot recommend.

Signed: W. Little
William A. Little, M.D.
Position: Chief of Service

RECEIVED
OCT 18 1988
MEDICAL/NATUROPATHIC

THE DOCTOR'S APPLICATION DEPENDS UPON THIS RETURN OF THIS DOCUMENT

DPR/MR/008/3/85

DEPARTMENT OF PROFESSIONAL REGULATION
BOARD OF MEDICINE
130 NORTH MONROE STREET
TALLAHASSEE, FL 32399-0750 (904)488-0595

TO:

Paul M. Norris, M.D.
9359 Fontainbleau #F-302
Miami, FL 33172

DATE: October 13, 1968

FROM:

Bil Mitchell

NO APPLICATION WILL BE CONSIDERED COMPLETE UNTIL ALL REQUESTED INFORMATION HAS BEEN RECEIVED IN THE BOARD OFFICE.

ALL DOCUMENTS TO BE NOTARIZED MUST BE CERTIFIED AS TRUE AND CORRECT COPIES OF THE ORIGINAL AND STATED SO BY THE NOTARY. THE NOTARY MUST SEE THE ORIGINAL AND THE COPY IN ORDER TO MAKE THIS STATEMENT.

YOUR APPLICATION HAS BEEN RECEIVED, BUT IS INCOMPLETE FOR FAILURE TO SUBMIT:

_____ Copy of medical school diploma, notarized as stated above.

_____ Translation of medical school diploma, prepared by a certified translator.

_____ $100.00 applicationn fee for licensure by examination.
_____ $500.00 examination fee.
_____ $350.00 endorsement fee.

_____ Copy of current valid standard ECFMG certificate, notarized as stated above.

_____ Copy of 5th pathway certificate, notarized as stated above.

_____ Undergraduate degree, notarized as stated above.

_____ Copy of ACTA/Social Service degree, notarized as stated above.

XXX Proof of 1 year ACGME accredited postgraduate training (internship/residency).

XXX Copy of FLEX or National Board scores, direct from the Federation of State Medical Boards or National Board of Medical Examiners.

_____ Separation from service form, notarized as stated above.

_____ Current letters of recommendation which must be addressed to the Florida Board of Medicine.

_____ Photographs, (polaroid or polacolor photographs are not accepted).

_____ Proof of legal change of name (court order or marriage certificate, notarized as stated above).

XXX Accounting for all of the following time.

_____ Completion of FLEX Application, Part A.

_____ Completion of Data profile form.

XXX Please indicate your place of residence during your post grad training.

_____ Copy of misdemeanor/felony charges and judgment or sentence; malpractice complaints and disposition of same; notarized as stated above.

XXX OTHER: Your application will remain incomplete for the above, as well as verification of licensure status in other states, medical education and postgraduate training, staff privileges, ECFMG certification, etc., if applicable to you.

DPR/ME/005/REV-12-86 Awaiting response to the above as indicated. Inquiries sent 9/29.

State of Florida

# Department of Professional Regulation

## Board of Medicine

56314

**This Certifies that**

Paul M. Norris

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

**Medicine**

in the State of Florida.

In Witness Whereof, we have hereunto subscribed our names and affixed the Seal of the Board of Medicine this 10 day of [illegible] A.D., 19 [illegible]

Bob Martinez
Governor of Florida

_____ Chairman

_____ Vice Chairman

# FLORIDA DEPARTMENT OF HEALTH

## CONFIRMATION OF LICENSE AT RENEWAL

| | |
|---|---|
| **NAME:** | **PAUL MICHAEL NORRIS** |
| **PROFESSION:** | **MEDICAL DOCTOR** |
| **LICENSE NUMBER:** | **ME56314** |
| **EFFECTIVE DATE:** | 01/13/2017 |
| **FEE PAID:** | $489.00 |
| **MAILING ADDRESS:** | 400 ARTHUR GODFREY RD; STE 508<br>SUITE 508<br><br>MIAMI BEACH, FL 33140 |
| **ATTENTION:** | |
| **PRACTICE ADDRESS:** | 400 ARTHUR GODFREY RD; STE 508<br>SUITE 508<br><br>MIAMI BEACH, FL 33140 |
| **ATTENTION:** | |

**NOTE:**
This document confirms receipt of a timely renewal application and fee for the above-named practitioner. You should receive your renewed license in the mail within 5-7 business days. Confirmation of your renewal can be viewed by visiting http://www.FLHealthsource.gov and selecting "Verify A License". This document has been issued from a secure online site and provides authorization for practice until you receive your printed certificate.