BOARD OF MEDICAL EXAMINERS
ENDORSEMENT APPLICATION

FEE OF $250 MUST ACCOMPANY APPLICATION. NOTE: FEE IS NONREFUNDABLE. TYPE OR USE BLACK INK. ANSWER ALL QUESTIONS. IF THE ANSWER TO ANY QUESTION IS "YES", GIVE DETAILS IN A NOTARIZED AFFIDAVIT AND ATTACH TO APPLICATION (PLEASE SEE PAGE 3 OF APPLICATION INSTRUCTIONS)

On the basis of certification by the National Board of Medical Examiners X OR Federation of State Medical Boards of the United States, Inc., (FLEX) _____ I hereby, apply for licensure to practice medicine/surgery in Florida.

NAME: JEAN CAROL COCK (name as it should appear on certificate) SOCIAL SECURITY #: [redacted]

ADDRESS: 1603 NW 10th AVE (street and number) GAINESVILLE (city) FLORIDA (state) 32605 (zip)

PERMANENT ADDRESS: (C/O) (SAME) (street and number) (city) (state) (zip)

TELEPHONE NUMBER: 904-372-5726 (area code) number DATE OF BIRTH: 4 (mo.) / 12 (day) / 57 (year)

PLACE OF BIRTH: ROCHESTER (city) MINNESOTA (state) USA (country)

HAVE YOU EVER LEGALLY CHANGED YOUR NAME? Yes If so, enclose notarized copy of legal document giving change. If changed in naturalization we need proof of change.

We are required to ask that you furinsh 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 does not in any way affect candidacy for licensure.

RACE: CAUCASIAN X BLACK ____ ORIENTAL ____ NATIVE AMERICAN ____ OTHER ____

SEX: FEMALE X MALE ____

DOCTOR OF MEDICINE DEGREE WAS OBTAINED FROM: University of Florida College of Medicine (name of medical school and location)

Gainesville, Florida on May 28th 1983 (exact date)

ARE YOU OR HAVE YOU EVER BEEN LICENSED IN ANOTHER STATE? YES ____ NO X (IF YES, LIST STATE(S), LICENSURE NUMBER, AND DATE ISSUED):

* * * * * * * * * * * * * * * *

FOR OFFICE USE ONLY
PLEASE DO NOT WRITE BELOW THIS LINE

CATEGORY: _____ PHOTOGR

SCHOOL CODE: _____ PASTE

EDUCATION: 07/29/85 15 20 0598 8383029 250.00 PEIR E

Rev. 3/84

RECEIVED
Jul 29 12 44 16 PM '85
DEPARTMENT OF PROFESSIONAL REGULATION

NAME:

CAMERA #:

ARE YOU A CITIZEN OF THE UNITED STATES? YES. IF FOREIGN BORN GIVE DATE AND PLACE OF NATURALIZATION: _____

DID YOU ATTEND A COLLEGE OR UNIVERSITY? Yes IF SO, GIVE NAME AND LOCATION, DATE(S) IN ATTENDANCE: Sept 1974 → Aug. 1978 Univ. of Fla.

DID YOU RECEIVE A DEGREE OTHER THAN A M.D.? Yes - B.S.

LIST ALL PLACES OF RESIDENCE (WHERE LIVED) SINCE INITIATION OF MEDICAL TRAINING:

Gainesville Fla (city, state or country) FROM: Sept, 1979 TO: June, 1983

Washington, D.C. (Annandale, VA) (city, state or country) FROM: June, 1983 TO: June, 1984

Gainesville Fla (city, state or country) FROM: June, 1984 TO: July, 1985 (present)

_____ (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.

University of Florida, Gainesville, Florida (name of medical school/location) FROM: Sept, 1979 TO: June, 1983

_____ (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 GRADUATION TO PRESENT. NOTE: DO NOT LEAVE OUT ANY TIME. TRAINING: List chronologically residency/post graduate training. Give name and address of hospitals, exact date(s), and specify type of training. If currently in training, give name of department chief. *******

7/83 - 6/84 - George Washington Univ. Washington, D.C. → PGY I 08164N

7/84 - 7/85 (present) - University of Florida, P.O. Box J-294, JHMHC, ~~Gainesville~~, Gainesville, Fla. 32610 → PGY II 08164N

List chronologically location(s) practiced and/or employed. Give addresses, dates, specify type of practice and/or employment.

none other than above

NAME: DATE:

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

Has your application for any medical society membership been rejected? no
Have you ever had your medical society membership suspended? no
Have you ever been notified to appear before a medical society in regard to charges/complaints filed against you? no

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

List civic organizations of which you are now or ever have been a member.

Physicians for Social Responsibility

RECOMMENDATIONS: Give the names and complete addresses of two (2) physicians who are submitting letters of recommendation on your behalf. If you are in training, give two names and addresses of physicians whom you have practiced with writing letters of recommendation on your behalf. (NOTE: THESE LETTERS MUST BE ADDRESSED TO THE FLORIDA BOARD.)

(1) Dr Eduard Friedrich, Box J-294 JHMHC, UF, Gainesville Fla 32610
(2) Dr Charles Mahan, Box J-294 JHMHC, UF, Gainesville Fla 32610

* ** ** ** ** ** ** ** ** ** ** ** ** *

PLEASE NOTE: YOUR APPLICATION PROCESS WILL NOT BE CONSIDERED COMPLETE UNLESS YOU COMPLY WITH THE FOLLOWING:

ALL DOCUMENT(S) SUBMITTED MUST BE NOTARIZED AS TRUE AND CORRECT COPIES OF THE ORIGINAL DOCUMENT(S) AND STATED SO BY THE NOTARY PUBLIC. NOTARY PUBLICS MUST SEE THE ORIGINAL DOCUMENT(S) AND THE COPY IN ORDER TO STATE REQUIREMENT.

List hospital(s) where you have staff privileges. (Give addresses, date(s) of service, and chief of staff)

SHANDS HOSPITAL, Univ. of Fla, JHMHC, Gainesville, Fla 32605

July 1st 1984 → Present

Chief of Staff - Dr William C Ruffin, Jr.

Have you ever been denied staff privileges in any hospital? No Have you ever had your staff privileges suspended? No If either of these questions are answered "YES", give name(s) address(es) of hospital(s).

HAVE YOU EVER BEEN IN THE UNITED STATES MILITARY? No IF SO, ATTACH COPY OF SEPARATION FROM SERVICE _____
(branch of service, rank, dates of service)

FOREIGN MEDICAL GRADUATES: ECFMG STANDARD CERTIFICATE NUMBER _____ ISSUED _____ AFTER PASSING ENGLISH AND MEDICAL EXAMINATION. ATTACH A COPY, NOTARIZED AS TRUE AND CORRECT COPY OF THE ORIGINAL BY THE NOTARY.

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

Have you ever failed STATE BOARD/FLEX/NATIONAL BOARD EXAMINATION? No

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? No

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? No

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

Are you certified by an American Specialty Board? No 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 If "YES", state year of certification 1984

Have you ever been convicted of a felony? No ; a misdemeanor? No Have any judgements ever been entered against you? No Have you ever been sued for malpractice? No

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

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

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

Have you ever voluntarily or otherwise been a patient in an institution for the treatment of [redacted]otional illness, drug addiction/abuse, or excessive use of alcohol? [redacted]

IF THE ANSWER TO ANY OF ABOVE QUESTIONS ARE ANSWERED "YES", GIVE DETAILS INCLUDING DATES, NAMES AND ADDRESSES OF HOSPITALS, TREATING PHYSICIANS. IN ADDITION, FOR FELONY, MISDEMEANOR, MALPRACTICE APPLICANT MUST FURNISH COPY OF CERTIFIED COMPLAINT AND DISPOSITION OF SAME. FOR PSYCHOTHERAPY, APPLICANT MUST FURNISH DETAILED EVALUATION FROM TREATING PHYSICIAN(S) INCLUDING DIAGNOSIS/PROGNOSIS AND A STATEMENT THAT APPLICANT CAN PRACTICE MEDICINE WITH REASONABLE SKILL AND SAFETY.

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

* ** ** ** ** ** ** ** ** ** ** ** ** *

TO BE COMPLETED BY APPLICANT

DATE July 25th 1985 COLOR OF EYES Blue

AGE 28 COLOR OF HAIR Brown

HEIGHT 5'5" WEIGHT 130 lbs OTHER MEANS OF IDENTIFICATION

AFFIDAVIT OF APPLICANT:

I, Jean Carol Cook, 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 State Board of Medical Examiners 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 is 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.

COUNTY OF Alachua

STATE OF Florida

Jean C Cook MD
(signature of applicant)

Subscribed and sworn to before me this 25th day of July, 1985.

Joan B. Magagna
(notary public)

My commission expires NOTARY PUBLIC STATE OF FLORIDA MY COMMISSION EXPIRES AUG 5 1986 BONDED THRU GENERAL INS. UNDERWRITERS
(notary seal/stamp)

FOR USE OF BOARD SECRETARY ONLY

LICENSE NUMBER

DATE ISSUED

3189205

F 39243

05/23/2017 100.00
ID: 39243 -- Type: F
BT: 3018276
R#: 916043610

disp
orig

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

Florida

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

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

1501
L-47540

PLEASE PRINT OR TYPE THE FOLLOWING INFORMATION

Name & license No:	JEAN C COCK MD 047540		**ME**
Facility Name:	Planned Parenthood / Jacksonville Center		
Practice Location:	5978 Powers Ave	Jacksonville	Fl
☑ **Add** ☐ **Delete**	Street name and number Zip 32217	City	State
Facility Name:	Planned Parenthood / Sally Bellamy Center		
Satellite Location:	2121 W. Pensacola St	Tallahassee	Fl
☑ **Add** ☐ **Delete**	Street name and number Zip 32304	City	State

2017 MAY 24 PM 2:12
BOARD OF MEDICINE

Jean C Cockrum
Signature of Physician

5/14/17
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