ARKANSAS STATE MEDICAL BOARD

LICENSURE DEPARTMENT
1401 W. Capitol Ave., Suite 340, Little Rock, AR 72201
Phone (501) 296-1802 Fax (501) 296-1972 www.armedicalboard.org
Emails with attachments must be sent in PDF format to support@armedicalboard.org

Are you utilizing FCVS for your Arkansas license? ☑ Yes ☐ No
Are you a current or former member of the U.S. military or a spouse of a current or former member of the U.S. military? ☑ Yes ☐ No

APPLICATION FOR MEDICAL LICENSURE IN ARKANSAS
& Centralized Credentials Verification Service

1. Please read the IMPORTANT INFORMATION and ALL INSTRUCTIONS included in the application packet.
2. Type or print legibly (in dark blue or black ink) all application documents. (One sided documents only.)
3. Provide exact dates whenever possible, in *mm/dd/yyyy* format.
4. All questions must be answered. If a question does not apply to you, please write "n/a" in the space provided.
5. Give careful thought to each answer because you are certifying that the information you provide is truthful, complete and correct.
6. If you answer "Yes" to any question in Parts IV or V of the application, you MUST submit a signed and dated explanation.
7. Failure to answer all questions completely and accurately; omitting or falsifying information, may be cause for denial of your application or disciplinary action if you are subsequently granted a license. *When in doubt, disclose and explain all information.*

TYPE OF LICENSE YOU ARE APPLYING FOR (check one)

☑ Medicine/Surgery (MD) ☐ Osteopathic Medicine/Surgery (DO) ☐ Educational License

Are you requesting that a temporary license be issued prior to full licensure? ☐ Yes ☐ Not at this time

PART I - PERSONAL IDENTIFICATION INFORMATION

1a. Full Legal Name (Last, First, Middle, Suffix, Degree)
DENAPOLES, CHRISTOPHER, ROMANO

1b. Other Names Used (including Maiden Name)

2a. Social Security Number	2b. Driver's License State & Number	2c. Gender	2d. Date of Birth (mm/dd/yyyy)
	FL S14-116-86-002-0	☑ Male ☐ Female	

3a. Place of Birth	3b. Country of Citizenship
Stamford, CT	USA

3c. Immigration Status (if not U.S. citizen)	3d. How long have you been in the U.S.? (if not U.S. citizen)

3e. Ethnicity	3f. Race
☑ Non-Hispanic ☐ Hispanic	☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☑ White ☐ Hawaiian/Pacific Islander ☐ Hispanic

4a. Public Address (Street, City, State, Zip Code)
341 S. Garcon Point RD Milton, FL 32583

4b. Private Address (Street or PO Box, City, State, Zip Code)
SAME

4c. Private Phone #	4d. Work Phone #	4e. Fax #	4f. Mobile Phone #

4g. Personal E-mail Address	5a. If not currently living in Arkansas, do you plan to relocate?
(	☐ No ☑ Yes - Approx. date: 11/2019

5b. Intended Practice Location in Arkansas: Name and Address of Hospital, Clinic, Group or Private Practice
Locums Hospitalist Fayetteville AR

5c. Will you be providing telemedicine services from outside the state of Arkansas?
☑ No ☐ Yes - Name of Telemedicine Contract Firm: _____ Phone _____

6a. NPI Number	6b. Accept Medicaid/Medicare Patients?
1578973715	☐ Medicare ☐ Medicaid ☐ Neither ☑ Unknown/Undecided

FOR ASMB USE ONLY

Name Christopher Romano Denapoles, M.D.
License Number
License Issued
Basis for License Exam

Application Received 7-11-19
Fees Received $ 500.00
Application Declined
PHIDNo. ASMB 216093

PART II - EDUCATION

MEDICAL SCHOOL EDUCATION

List all medical school(s) you attended (attach additional sheets if necessary). If you attended more than one medical school, provide the reason you changed medical schools on a separate sheet of paper, signed and dated by you. If you completed medical school in more or less than four years, provide the reason on a separate sheet of paper, signed and dated by you.

7a. Institution Name	7b. Country of Medical School
Trinity School of Medicine	St. Vincent

7c. Mailing Address (Street Address, City, State/Country, Zip Code): 925 Woodstock RD Roswell, GA 30075

7d. Start Date	7e. End Date	7f. Graduated?	7g. Degree Awarded
09/01/2009	06/30/2013	☒ Yes ☐ No	☒ M.D. (or foreign equivalent) ☐ D.O. ☐ None

8a. Institution Name	8b. Country of Medical School
~~Stamford Hospital / Columbia University~~	

8c. Mailing Address (Street Address, City, State/Country, Zip Code):

8d. Start Date	8e. End Date	8f. Graduated?	8g. Degree Awarded
/ /	/ /	☐ Yes ☐ No	☐ M.D. (or foreign equivalent) ☐ D.O. ☐ None

POSTGRADUATE EDUCATION, US OR FOREIGN

List internships, residencies, fellowships and other postgraduate training chronologically (attach additional sheets if necessary). If you did not complete a program or changed schools between years, provide the reason on a separate sheet of paper, signed and dated by you. If program still in process, enter anticipated completion date as end date.

9a. Full Name of Training Program	9b. Program ID (if known)
Stamford Hospital / Columbia University	

9c. Program Type (Internship, Residency, etc)	9d. Specialty/Subspecialty	9e. Department Name
Internship & Residency	Family medicine	Family Medicine

9f. Mailing Address (Street Address, City, State/Country, Zip Code): 1 Hospital Plaza Stamford, CT 06902

9g. Start Date	9h. End Date	9i. Anticipated End Date	9j. Completed?	9k. Chief resident?
06/25/2014	06/30/2017	/ /	☒ Yes ☐ No ☐ In Process	☒ Yes ☐ No

9a. Full Name of Training Program	9b. Program ID (if known)

9c. Program Type (Internship, Residency, etc)	9d. Specialty/Subspecialty	9e. Department Name

9f. Mailing Address (Street Address, City, State/Country, Zip Code):

9g. Start Date	9h. End Date	9i. Anticipated End Date	9j. Completed?	9k. Chief resident?
/ /	/ /	/ /	☐ Yes ☐ No ☐ In Process	☐ Yes ☐ No

9a. Full Name of Training Program	9b. Program ID (if known)

9c. Program Type (Internship, Residency, etc)	9d. Specialty/Subspecialty	9e. Department Name

9f. Mailing Address (Street Address, City, State/Country, Zip Code):

9g. Start Date	9h. End Date	9i. Anticipated End Date	9j. Completed?	9k. Chief resident?
/ /	/ /	/ /	☐ Yes ☐ No ☐ In Process	☐ Yes ☐ No

9a. Full Name of Training Program	9b. Program ID (if known)

9c. Program Type (Internship, Residency, etc)	9d. Specialty/Subspecialty	9e. Department Name

9f. Mailing Address (Street Address, City, State/Country, Zip Code):

9g. Start Date	9h. End Date	9i. Anticipated End Date	9j. Completed?	9k. Chief resident?
/ /	/ /	/ /	☐ Yes ☐ No ☐ In Process	☐ Yes ☐ No

Denapoles, Christopher Romano, M.D. - Education - Other Graduate - Entity Placeholder

Jul 25 2019 3:07PM
Christopher Romano Denapoles, M.D.: The MHA was not completed due to starting medical residency. This schooling can be removed from my application as it has not yet been completed.
Please let me know if there are any questions.
Thank you,
Dr. DeNapoles

Jul 23 2019 2:43AM
System Administrator: THIS IS AN AUTOMATED MESSAGE:

This verification is still needed. It is your responsibility to ensure that this has been requested from the source and/or provide any requested response. This record will be closed upon receipt of this item.

Jul 15 2019 3:38PM
Gracia Wallace: (Masters in Healthcare Administration)Has this verification been requested to be sent directly to the Arkansas State Medical Board? Verifications can be sent by mail, emailed as a PDF to support@armedicalboard.org Attn: Licensing, or faxed to 501-296-1972 Attn: Licensing. This record will be closed upon receipt of this item.

EXAMINATION HISTORY

Please specify exam series USMLE, NBME, FLEX, NBOME, COMLEX, LMCC (or State Exam prior to 1975). *If you failed any step of any examination, even once, you must submit a separate, signed and dated explanation of the circumstances.* Attach additional sheets if necessary.

10a. Exam Series & Step	10b. Number of Attempts	10c. Number of times failed	10d. Date PASSED
STEP 1	1	0	9/21/11
STEP 2 CS	1	0	8/14/12
STEP 2 CK	2	1	10/2/12
STEP 3	1	0	8/1/13

10e. Have you ever taken the SPEX or COMVEX examination? ☐ Yes ☒ No If Yes, you must provide a signed and dated explanation.

11a. If you are an International medical graduate, do you hold an ECFMG certification? ☒ Yes ☐ No ☐ N/A (If No, you must provide a signed and dated explanation)	11b. ECFMG Certificate No.	11c. Date Issued
	08240160	6/11/13

SPECIALTY/ BOARD CERTIFICATION

Please list all specialties, including self-designated. Attach additional sheets if necessary.

12a. Primary Practice Specialty/Subspecialty	12b. Board Certified?	12c. Certification Type	
Family Medicine	☒ Yes ☐ No	☐ Lifetime ☒ Time-Limited ☐ MOC	
12d. Name of Specialty Board, if certified	**12e. Certification Date**	**12f. Recertification Date**	**12g. Expiration Date**
ABFM	7/1/17	/ /	7/1/2027
13a. Secondary Specialty/Subspecialty	13b. Board Certified?	13c. Certification Type	
	☐ Yes ☐ No	☐ Lifetime ☐ Time-Limited ☐ MOC	
13d. Name of Specialty Board, if certified	**13e. Certification Date**	**13f. Recertification Date**	**13g. Expiration Date**
	/ /	/ /	/ /
14a. Tertiary Specialty/Subspecialty	14b. Board Certified?	14c. Certification Type	
	☐ Yes ☐ No	☐ Lifetime ☐ Time-Limited ☐ MOC	
14d. Name of Specialty Board, if certified	**14e. Certification Date**	**14f. Recertification Date**	**14g. Expiration Date**
	/ /	/ /	/ /

PART III - PROFESSIONAL ACTIVITIES

PROFESSIONAL LICENSURE

List all states or territories of the United States or other countries in which you hold or have **ever held** a medical license. Include all temporary, instructional and training permits/licenses. Attach additional sheets if necessary. If none, enter "N/A."

15a. Jurisdiction (State, Country)	15b. License No.	15c. Issue Date	15d. Expiration Date	15e. Current Status
OK	34683	4/12/19	4/1/20	Active
AL	38134	4/4/19	12/31/19	Active
FL	132255	4/26/17	1/31/21	Active
CT	055624	8/15/16	1/31/18	Inactive
		/ /	/ /	
		/ /	/ /	
		/ /	/ /	
		/ /	/ /	

MILITARY SERVICE Submit a copy of your separation papers (DD Form 214) with your application. If Active Duty, have the Verification of Current Military Service sent to this office or have your current Commanding Officer submit a verification letter directly to this office.

16a. Have you ever been in the armed forces? ☒ Yes ☐ No

16b. Country & Branch of Service	16c. Date of Entry	16d. Date of Discharge	16e. Type of Discharge
USAF	8 / 1 / 2014	/ /	Reserve
16b. Country & Branch of Service	16c. Date of Entry	16d. Date of Discharge	16e. Type of Discharge
	/ /	/ /	

WORK HISTORY Please provide a chronological listing for all medical and non-medical work history and other activities, including hospitals, faculty appointments, private practice, employment corporations, military assignments, government agencies, locum tenens and telemedicine assignments, and leaves of absence since graduation from medical school. Do not include Medical School or Postgraduate Education/Training. **Do not write, "See CV;" you must complete this section AND attach your curriculum vitae. If none, enter "N/A."**

17a. Date From	17b. Date To	17c. Type of Affiliation, (Primary or Previous Practice, Employment, Staff Appointment, etc.)
9 / 1 / 2017	Current	Primary

17d. Name of Institution/Facility ☒ Primary Practice ☐ Previous
Practice West Florida Hospital

17e. Institution Mailing Address (Street or PO Box, City, State/Country, Zip Code)
8383 Davis Hwy Pensacola FL 32514

17f. Title/Position/Staff Category	17g. Specialty practiced or granted privileges in
Physician	Family Medicine

17a. Date From	17b. Date To	17c. Type of Affiliation (Practice, Employment, Staff Appointment, etc.)
10 / 1 / 2018	Current	Staff

17d. Name of Institution/Facility ☐ Primary Practice ☐ Previous Practice
Olive Branch Nursing Home

17e. Institution Mailing Address (Street or PO Box, City, State/Country, Zip Code)
8325 University Parkway Pensacola FL 32514

17f. Title/Position/Staff Category	17g. Specialty practiced or granted privileges in
Medical Director	Family Medicine

17a. Date From	17b. Date To	17c. Type of Affiliation (Practice, Employment, Staff Appointment, etc.)
8 / 1 / 14	Current	Employment

17d. Name of Institution/Facility ☐ Primary Practice ☐ Previous Practice
US Air Force

17e. Institution Mailing Address (Street or PO Box, City, State/Country, Zip Code)

17f. Title/Position/Staff Category	17g. Specialty practiced or granted privileges in
Physician	Aerospace medicine

17a. Date From	17b. Date To	17c. Type of Affiliation (Practice, Employment, Staff Appointment, etc.)
Current	Current	Locums Hospitalist

17d. Name of Institution/Facility ☐ Primary Practice ☐ Previous Practice
Medicus Locums Hospitalist

17e. Institution Mailing Address (Street or PO Box, City, State/Country, Zip Code)
Pending likely Fort Smith, AR or Fayetteville AR

17f. Title/Position/Staff Category	17g. Specialty practiced or granted privileges in
Physician	Hospitalist

17a. Date From	17b. Date To	17c. Type of Affiliation (Practice, Employment, Staff Appointment, etc.)
/ /	/ /	

17d. Name of Institution/Facility ☐ Primary Practice ☐ Previous Practice

17e. Institution Mailing Address (Street or PO Box, City, State/Country, Zip Code)

17f. Title/Position/Staff Category	17g. Specialty practiced or granted privileges in

Denapoles, Christopher Romano, M.D. - Practice - Primary Practice - Entity Placeholder, . USA

Jul 21 2019 9:09AM
Christopher Romano Denapoles, M.D.: 1. West Florida Hospital. 2360 US-29, Cantonment, FL 32533
2. 09/2017 - 01/2020 (Pending Locums Hospitalist Placement)
3. Physician

Jul 15 2019 3:37PM
Gracia Wallace: What is your current primary practice location? This would be where you see the majority of your patients or where your patients are billed from, (i.e., office, clinic, hospital group, contracting company.)
1. Name and Address
2. Dates
3. Position (i.e., Owner, Staff Physician, Independent Contractor, Medical Director)
4. If your primary practice is a hospital then please state the office your patients are billed through. (i.e., hospital group, clinic, contracting company)

WORK HISTORY, continued

17a. Date From / /	17b. Date To / /	17c. Type of Affiliation (Practice, Employment, Staff Appointment, etc.)	
17d. Name of Institution/Facility			☐ Primary Practice ☐ Previous Practice
17e. Institution Mailing Address (Street or PO Box, City, State/Country, Zip Code)			
17f. Title/Position/Staff Category		17g. Specialty practiced or granted privileges in	
17a. Date From / /	17b. Date To / /	17c. Type of Affiliation (Practice, Employment, Staff Appointment, etc.)	
17d. Name of Institution/Facility			☐ Primary Practice ☐ Previous Practice
17e. Institution Mailing Address (Street or PO Box, City, State/Country, Zip Code)			
17f. Title/Position/Staff Category		17g. Specialty practiced or granted privileges in	
17a. Date From / /	17b. Date To / /	17c. Type of Affiliation (Practice, Employment, Staff Appointment, etc.)	
17d. Name of Institution/Facility			☐ Primary Practice ☐ Previous Practice
17e. Institution Mailing Address (Street or PO Box, City, State/Country, Zip Code)			
17f. Title/Position/Staff Category		17g. Specialty practiced or granted privileges in	
17a. Date From / /	17b. Date To / /	17c. Type of Affiliation (Practice, Employment, Staff Appointment, etc.)	
17d. Name of Institution/Facility			☐ Primary Practice ☐ Previous Practice
17e. Institution Mailing Address (Street or PO Box, City, State/Country, Zip Code)			
17f. Title/Position/Staff Category		17g. Specialty practiced or granted privileges in	
17a. Date From / /	17b. Date To / /	17c. Type of Affiliation (Practice, Employment, Staff Appointment, etc.)	
17d. Name of Institution/Facility			☐ Primary Practice ☐ Previous Practice
17e. Institution Mailing Address (Street or PO Box, City, State/Country, Zip Code)			
17f. Title/Position/Staff Category		17g. Specialty practiced or granted privileges in	
17a. Date From / /	17b. Date To / /	17c. Type of Affiliation (Practice, Employment, Staff Appointment, etc.)	
17d. Name of Institution/Facility			☐ Primary Practice ☐ Previous Practice
17e. Institution Mailing Address (Street or PO Box, City, State/Country, Zip Code)			
17f. Title/Position/Staff Category		17g. Specialty practiced or granted privileges in	

FEDERAL DEA & STATE-ISSUED CONTROLLED SUBSTANCE REGISTRATIONS List all current and previous Federal DEA and state-issued controlled substance registrations. If none, enter N/A.

18a. DEA or State Registration #	18b. State	18c. Your Address Associated with this Registration	18d. Expiration Date
FD6985646	FL	341 S. Garcon Point RD Milton, FL	6/30/20
			/ /
			/ /
			/ /
			/ /
			/ /

TIME GAPS Please provide an explanation for ALL time gaps of 30 days or more since the start of medical school. If none, enter N/A.

19a. Did you have a time gap in excess of 30 days between medical school and post-graduate training? ☑ Yes ☐ No

19b. Dates of time gap: 6/2013 - 6/2014

19c. Explanation for time gap: (e.g. traveling, vacation, moving, prepared for residency)

Masters in Healthcare Administration. UMD

19d. Additional time gap. Provide dates and explanation.

19e. Additional time gap. Provide dates and explanation. Use additional sheets if necessary.

MALPRACTICE CLAIMS List all malpractice claims ever filed against you, regardless of disposition. If none, enter "n/a". Use additional sheets if necessary.

20a. Date of Claim	20b. Jurisdiction	20c. Disposition (Dismissed, Settled, Pending, etc.)	20d. Amount of Settlement Paid
/ /		N/A	$
/ /			$
/ /			$
/ /			$
/ /			$
/ /			$
/ /			$
/ /			$
/ /			$
/ /			$

PART IV - ATTESTATION QUESTIONS

21. Do you currently maintain individual or group Professional Liability Insurance (malpractice) coverage? ☒ No ☐ Yes
If no, list reason: Covered by my employer.
Insurance Carrier Name: _____
Policy Number(s): _____
Expiration Date: _____ Coverage Amounts: _____
If Group policy, list group name: _____

SPECIAL INSTRUCTIONS FOR QUESTIONS 22-44

- **Please mark the appropriate box next to each question. Do not leave any questions blank.**
- **For each "Yes" response to questions 22-44, you must provide a separate, signed and dated statement giving full details including date, location, type of action, organization or parties involved, and specific circumstances.** If you are not sure about how to respond to a question, it is best to disclose and provide an explanation.
- **Failure to answer these questions accurately may result in disciplinary action or denial of license application.**
- Confidentiality: The contents of licensing files are generally considered public records under the Freedom of Information Act. If you believe that the additional information you are attaching to explain a "Yes" answer should be considered confidential, state that in the attachment. Be advised, however, that not all requests for confidentiality can be granted.

22. Has your application for examination or licensure ever been rejected, denied or withdrawn? *If yes, explain.* ☒ No ☐ Yes

23. Has any medical licensing board ever placed your license on probation, suspension, or has it revoked a license or certificate it had granted you? *If yes, explain and provide name and address of Board.* ☒ No ☐ Yes

24. Have you ever been ordered to appear before a state medical board for any reason other than licensure? *If yes, explain.* ☒ No ☐ Yes

25. Has a medical board or hospital ever initiated disciplinary procedures against you? *If yes, explain.* ☒ No ☐ Yes

26. Have your privileges at any hospital ever been denied, suspended, diminished, voluntarily or involuntarily relinquished, revoked or not renewed, or is any such action pending? *If yes, explain.* ☒ No ☐ Yes

27. Have you ever voluntarily surrendered your medical license in any state? *If yes, explain.* ☒ No ☐ Yes

28. Since the start of medical school, have you been charged or convicted (including a plea of nolo contendere) of a misdemeanor or felony (including DWI (Driving While Intoxicated) or DUI (Driving Under the Influence)? (NOTE: ***You must answer "Yes" even if records, charges, or convictions have been pardoned, expunged, plead down, released, or sealed.***) *If yes, explain.* ☒ No ☐ Yes

29. Have you ever been denied provider participation in any state or federal Medicaid program? *If yes, explain.* ☒ No ☐ Yes

30. Have you ever been warned, censured by, or requested to withdraw from any hospital in which you have been trained, been a staff member, or held hospital privileges? *If yes, explain.* ☒ No ☐ Yes

31. Have you ever been disciplined or dismissed from any professional activity or training program? Have you ever received a warning, reprimand, or been placed on probation during an internship, residency, or fellowship program? *If yes, explain.* ☒ No ☐ Yes

32. Have you ever voluntarily or involuntarily left a training institution program before completing it? *If yes, explain.* ☒ No ☐ Yes

PART IV - ATTESTATION QUESTIONS, continued

33.	Have you ever been reported to the National Practitioner Data Bank or subject to NPDB adverse action reporting? *If yes, explain.*	☒ No ☐ Yes
34.	Have you ever resigned or surrendered clinical privileges from any medical staff while under investigation for possible incompetence or improper professional conduct, or in return for such an investigation not being conducted? *If yes, explain.*	☒ No ☐ Yes
35.	Have you ever been denied membership, renewal thereof, or been subject to disciplinary action in any medical organization, or is any such action pending? *If yes, explain.*	☒ No ☐ Yes
36.	Have you ever been terminated, sanctioned, penalized or had to repay money to any State Medicaid or Federal Medicare/Medicaid program? *If yes, explain.*	☒ No ☐ Yes
37.	Have you ever been cited by a peer review organization? *If yes, explain.*	☒ No ☐ Yes
38.	Have you ever had to discontinue practice for any reason for a period longer than one (1) month? *If yes, explain.*	☒ No ☐ Yes
39.	Since the age of 21, have you been, or are you currently, being treated for alcoholism or substance abuse in an inpatient or outpatient setting? *If yes, explain.*	☒ No ☐ Yes
	39a. If Yes, was this the result of a medical board action?	☐ No ☐ Yes
40.	Are you currently suffering from any condition for which you are not being appropriately treated that impairs your judgment or that would otherwise adversely affect your ability to practice medicine or to perform professional or medical staff duties in a competent, ethical, and profession manner? *If yes, explain.*	☒ No ☐ Yes
41.	Are you currently being, or have you ever been monitored by a Physicians Health Committee in any state? *If yes, explain, and ask the Physician Health Committee to send documentation of your status.*	☒ No ☐ Yes
42.	Has your license to practice medicine or Drug Enforcement Administration registration in any jurisdiction been denied, reduced, limited, suspended, revoked, placed on probation, not renewed voluntarily, or involuntarily relinquished, or is any such action pending? *If yes, explain.*	☒ No ☐ Yes
43.	Have you ever defaulted on any Health Education Assistance loan? *If yes, explain.*	☒ No ☐ Yes
44.	To your knowledge, are you currently the subject of an investigation by any licensing board as of the date of this application? *If yes, explain.* **If, during the application process, you become aware of any such investigation, you are required to report it to this office.**	☒ No ☐ Yes

PART V - AFFIDAVIT OF APPLICANT

I, the undersigned applicant, after being duly sworn, hereby certify that I have read the complete application and know the full content thereof. I declare, under penalty of perjury, that all of the information contained herein and evidence or other credentials submitted herewith are true, correct, current, and complete to the best of my knowledge. I attest that I am the lawful holder of the degree of Doctor of Medicine or Doctor of Osteopathy, and that said degree was procured in the regular course of instruction and examination, and that it, together with all the credentials submitted, were procured without fraud or misrepresentation or any mistake of which I am aware. I certify that the photograph that appears below is a true likeness of me, taken within the past sixty (60) days. I understand that any falsification or misrepresentation of any item or response in this application, or any documentation supporting this application, even if submitted separately, is sufficient grounds for denying, revoking, or otherwise disciplining a license or permit to practice medicine in the State of Arkansas.

MARK B GRETZINGER
MY COMMISSION EXPIRES
MARCH 18, 2021
GG 049017
Bonded thru
Troy Fain Insurance
NOTARY PUBLIC, STATE OF FLORIDA

Applicant's Signature (in ink)
(must be signed in the presence of a Notary Public)

6/28/19
Date Signed
(must include the month, day and year signed)

SUBSCRIBED AND SWORN TO before me, a Notary Public in and for the State of FLORIDA, this 27 day of JUNE, 20 19.
(Notary date must be the same as the applicant's signature date above)

My commission expires: 3/18/21

Notary Signature
(Notary seal must be below the photograph at left)

DO NOT WRITE BELOW THIS LINE - FOR OFFICE USE ONLY

2019 JUL 11 AM 10:50

PDC PHYSICIAN DATA CENTER

fsmb

PRACTITIONER PROFILE

Prepared for: Arkansas State Medical Board — As of Date:7/11/2019

Practitioner Name: Denapoles, Christopher Romano

ABMS® CERTIFICATION HISTORY

Certifying Board: American Board of Family Medicine
Certificate: Family Medicine
Certification Type: General
Certification Status: Certified
Participating in MOC: Yes

Status	Duration	Effective Date	Expiration Date	Reverification Date	Occurrence	Last Reported
Active	MOC	07/01/2017		02/15/2020	Initial	06/27/2019

AOA® CERTIFICATION HISTORY

No AOA Certifications found.

ENTERED JUL 11 2019

400 FULLER WISER ROAD EULESS, TX 76039 | TEL(817)868 4000 | **FAX** (817)868 4099

ECFMG® EDUCATIONAL COMMISSION FOR FOREIGN MEDICAL GRADUATES

3624 Market Street
Philadelphia PA 19104-2685
215-386-5900 | 215-386-6327
www.ecfmg.org

VERIFICATION OF MEDICAL EDUCATION

INSTRUCTIONS TO THE DEAN

The individual identified on the attached *Medical School Release Request*, *Certification of Identification Form*, or *Certification Statement* has authorized your medical school to provide to the Educational Commission for Foreign Medical Graduates (ECFMG) any and all information pertaining to his/her education at your institution. **Please complete this VERIFICATION OF MEDICAL EDUCATION form and return it to ECFMG with the attached medical diploma and a final medical school transcript in the enclosed, addressed envelope.**

RE: Christopher R. Denapoles
0-824-016-0
Trinity School of Medicine
PO Box 1822
Kingstown
SAINT VINCENT AND THE GRENADINES

Please notify ECFMG if the name of your institution has changed or is different from the name displayed.

SECTION 1: MEDICAL SCHOOL TRANSCRIPT

Attach an official medical school transcript in the original language that displays course grades or marks, not just hours, to this Verification of Medical Education form and return to ECFMG – Affix your official stamp to the transcript – Non-English language transcripts must include a word-for-word English language translation prepared by a recognized translator – An official English language version medical school transcript is also acceptable – Transcripts returned to ECFMG under separate cover must include the individual's ECFMG Identification Number to prevent processing delays.

SECTION 2A: CERTIFICATION

By my signature below, I certify: **(1)** the information provided on this form is an accurate account of the above named individual's official records maintained in this medical school and is true and correct to my knowledge, and, **(2)** that I am authorized to certify this on behalf of this institution as reported to ECFMG on an Authorized Signature List for Medical School Officials or other official notification from this institution.

Signature, Printed Name, Title and Official Seal must match samples provided to ECFMG by the medical school

Signature:

Printed Name: Leslie Keith Hollers

Title: VP of Operations and Student Finance

Date of Signature: 23 May 2013

Phone: 7707810863 **Fax:** 877-445-8746

Email: khollers@trinityschoolofmedicine.org

SECTION 2B: DEGREE CERTIFICATION

This Individual:
Was conferred/issued the degree of **Doctor of Medicine (M.D.)** on **30/04/2013** (dd/mm/yyyy) and the attached medical diploma is authentic and correct.

– Or –

Was not conferred/issued a degree or the attached diploma is not authentic and correct because:

SEAL VERIFIED

ENTERED JUL 29 2019

SECTION 3A: PRE-MEDICAL EDUCATION

Years of education required for admission to your medical school : 3 years

Credential/degree presented by the applicant for admission to your medical school : **Arizona Sate University - BS (Kinesiology/PreMedicine)**

Did this individual transfer credits to your medical school from another institution? YES ( ) NO (X)

If you checked 'YES' please print the name of the institution(s) from where the credits were transferred:

_____

_____

SECTION 3B: MEDICAL EDUCATION

Enrollment and Participation: Our records indicate that **Christopher R. Denapoles** attended our medical school for total of **150** weeks of medical education on the following dates:

From 07/09/2009 (dd/mm/yyyy) **To** 30/04/2013 (dd/mm/yyyy)

_____

SECTION 4: UNUSUAL CIRCUMSTANCES

The following questions apply to unusual circumstances that occurred during any part of the individual's medical education. **Please provide dates and requested information if you check "YES" to questions 1-5.**

1. Does this individual's official record reflect (an) interruption(s) or extension(s) in his/her medical education? YES ( ) NO (X)

If you checked "YES" please select the reason(s) for, indicate the dates of the interruption(s) or extension(s) and check whether the interruption/extension was approved or unapproved.

	From Month/Year	To Month/Year	Approved	Unapproved
Personal/Family	__/____	__/____	( )	( )
Academic remediation	__/____	__/____	( )	( )
Health	__/____	__/____	( )	( )
Financial	__/____	__/____	( )	( )
Participation in joint degree Program (e.g., MD/PhD)	__/____	__/____	( )	( )
Participation in non-research special study (e.g., fellowship, international experience)	__/____	__/____	( )	( )
Participation in non-degree research	__/____	__/____	( )	( )
Other	__/____	__/____	( )	( )

Please Specify: _____

2. Does this individual's official record reflect that he/she was ever placed on academic or disciplinary probation during his/her medical education? **YES ( ) NO (X)**

If you checked "YES" please select the reason(s) for the probation, indicate the date(s) of placement on and removal from probation and attach additional documentation to this report.

_____

	From Month / Year	To Month / Year
Academic Probation_____	__/____	__/____
Probation for unprofessional conduct/behavioral_____	__/____	__/____
Probation for other reason_____	__/____	__/____

Please specify reason: _____

3. Does this individual's official record reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons by the medical school or parent university? **YES ( ) NO (X)**

If you checked "YES" please provide detailed documentation/information about the circumstances and outcome(s):

_____
_____

4. Does this individual's official record reflect that he/she was ever the subject of negative reports or an investigation by the medical school or parent university? **YES ( ) NO (X)**

If you checked "YES" please provide detailed documentation/information about the circumstances and outcome(s):

_____
_____

5. Does this individual's official record reflect that there were any limitations or special requirements imposed on the individual because of questions of academic incompetence, disciplinary problems, or any other reason? **YES ( ) NO (X)**

If you checked "YES" please provide detailed documentation/information about the nature of the limitations or special requirements:

_____
_____

FCVS | FEDERATION CREDENTIALS VERIFICATION SERVICE

Applicant Reported Unusual Circumstances

Federation of STATE MEDICAL BOARDS

Medical School

Medical Professional Name: Denapoles, Christopher R

Trinity School of Medicine

Unusual Circumstances

Did you have any interruption(s) or extension(s) in your medical education?	No
Were you ever placed on probation?	No
Were you ever disciplined or placed under investigation?	No
Were any negative reports for behavioral reasons ever filed by instructors?	No
Were any limitations or special requirements imposed on you because of academic performance, incompetence, disciplinary problems or for any other reason?	No

End of Applicant Reported Unusual Circumstances report for: Denapoles, Christopher R

400 FULLER WISER ROAD | EULESS, TX 76039 | TEL (817) 868 - 5000 | FAX (817) 868 - 5099

TRINITY
SCHOOL OF MEDICINE

TRANSCRIPT

Student Name: Denapoles, Christopher, R.
Student ID: 099-578-006
Degree Program: Doctor of Medicine
Date: Wednesday, May 22, 2013

Degree conferred: Doctor of Medicine (M.D.)
Date conferred: April 30, 2013

Course Number	Course Name	Grade	Credit Hours	Hours Earned	Quality Points
Fall Semester 2009					
CIM 110	Intro to Clinical Med. I	B	3	3	9
ANAT 113	Gross Anatomy I	B	3	3	9
BIOC 111	Biochem and Genetics I	C+	4	4	10
PHYS 112	Physiology I	B	3	3	9
Term Totals				13	37
Term Grade Point Average					2.85
Cumulative Totals				13	37
Cumulative Grade Point Average					2.85
Spring Semester 2010					
CIM 120	Intro to Clinical Med. II	B	3	2	6
ANAT 123	Gross Anatomy II with Embryology	B	3	3	9
ANAT 124	Histology	B+	3	3	7
BIOC 112	Biochem and Genetics II	B	3	3	9
PHYS 122	Physiology II	B+	3	3	10.5
NEUR 125	Neuroscience	C	3	3	6
PHM 122	Introduction to Pharmacology	C	1	1	2
IBS 110	Integrated Basic Science I	P	1	1	4
Term Totals				18	53.5
Term Grade Point Average					2.97
Cumulative Totals				31	90.5
Cumulative Grade Point Average					2.92
Summer Semester 2010					
CIM 211	Intro to Clinical Med. III	P	1	1	4
PATH 230	Pathology I	B+	6	6	21
EPID 301	Epidemiology/Biostatistics	A	1	1	4
BEH 230	Behavioral Sci/Betar. & Phys.	A(h)	2	2	8
MICR 231	Microbiology and Immunology I	B	3	3	9
PHM 234	Pharmacology I	B	3	3	9
IBS 210	Integrated Basic Science II	P	1	1	4
Term Totals				17	55
Term Grade Point Average					3.47
Cumulative Totals				48	149.5
Cumulative Grade Point Average					3.11
Fall Semester 2010					
CIM 350	Intro to Clinical Med. IV	P	1	1	4
PATH 240	Pathology II	B	8	8	24
MICR 241	Microbiology II	B	3	3	9
PHM 244	Pharmacology II	B	3	3	9
IBS 310	Integrated Basic Science III	P	1	1	4
Term Totals				16	50
Term Grade Point Average					3.12
Cumulative Totals				64	199.5
Cumulative Grade Point Average					3.12
Spring Semester 2011					
CIM 350	Advanced Intro to Clinical Med. V	P	1	1	4
MED 510	Basis of Diseases	A	12	12	48
MED 520	Clinical Therapeutics	B	3	3	9
IBS 410	Integrated Basic Science IV	P	2	2	8
Term Totals				18	69
Term Grade Point Average					3.83
Cumulative Totals				82	268.5
Cumulative Grade Point Average					3.27

---------- No further entries in this column ----------

Course Number	Course Name	Grade	Credit Hours	Hours Earned	Quality Points
Fall Semester 2011					
FAMC 508	Basic Clerkship in Family Medicine	A	8	8	32
10/24/11 - 12/16/11, Advocate Illinois Masonic Hosp. IL					
FAMC 502	Elective Clerkship in Family Medicine	A	2	2	8
12/05/11 - 12/17/11, Advocate Illinois Masonic Hosp. IL					
Term Totals				10	40
Term Grade Point Average					4.00
Cumulative Totals				92	308.5
Cumulative Grade Point Average					3.35
Spring Semester 2012					
OBGC 500	Basic Clerkship in OB/GYN	A(h)	6	6	24
12/26/11 - 02/04/12, Swedish Covenant Hosp. IL.					
OBGX 501	Elective Clerkship in OB/GYN	A	1	1	4
02/06/12 - 02/11/12, Swedish Covenant Hosp. IL.					
DERM 502	Elective Clerkship in Dermatology	A	2	2	8
02/12/12 - 02/24/12, Mercy Hosp. & Med. Ctr., IL.					
MEDC 500	Basic Clerkship in Int. Medicine	A	12	12	48
03/05/12 - 05/25/12, Southampton Hosp., NY					
Term Totals				21	84
Term Grade Point Average					4.00
Cumulative Totals				113	392.5
Cumulative Grade Point Average					3.47
Summer Semester 2012					
MEDX 507	Elective Clerkship in Int. Med. (Nutrition)	A(h)	7	7	28
05/28/12 - 07/13/12, Private Practice Darien, CT.					
PSYC 500	Basic Clerkship in Psychiatry	A(h)	6	6	24
07/16/12 - 08/24/12, Univ. of Illinois Chicago Med. Ctr. IL.					
Term Totals				13	52
Term Grade Point Average					4.00
Cumulative Totals				126	444.5
Cumulative Grade Point Average					3.53
Fall Semester 2012					
MEDX 510	Elective Clerkship in Int. Medicine	A	10	10	40
08/27/12 - 11/02/12, Private Practice Darien, CT					
SURC 500	Basic Clerkship in Surgery	A(h)	12	12	48
11/05/12 - 01/25/13, Alexandria Hospital, VA.					
Term Totals				22	88
Term Grade Point Average					4.00
Cumulative Totals				148	532.5
Cumulative Grade Point Average					3.60
Spring Semester 2013					
PEDC 500	Basic Clerkship in Pediatrics	A(h)	6	6	24
01/28/13 - 03/08/13, Virginia Medical Center., VA.					
INTX 506	Basic Clerkship in Intensive Care Med.	A	6	6	24
03/04/13 - 04/12/13, Washington Specialty Hospital, VA.					
Term Totals				11	47
Term Grade Point Average					4.00
Cumulative Totals				160	580.5
Cumulative Grade Point Average					3.63

---------- END OF RECORD ----------

Trinity School of Medicine has electronically submitted this transcript (Denapoles, Christopher, R.) directly to ECFMG Verification Support Services.

SEAL VERIFIED

5/22/2013 6:48 PM

Affixed by medical school on: 23 May 2013

OFFICIAL DOCUMENT

Trinity School of Medicine

ADMISSIONS AND ADMINISTRATION
12600 Deerfield Pkwy, Suite 100
Alpharetta, GA. 30004
Phone: 678-762-3232 Fax: 678-762-3281

CAMPUS AND OFFICE OF THE DEANERY
Ratho Mill
POB 895, Kingstown
St. Vincent, West Indies
Phone: 784-456-9751 Fax: (784)456-9715

ACCREDITATION

Trinity School of Medicine (Trinity) is accredited by the National Accreditation Board of the Ministry of Education of St. Vincent and the Grenadines. Trinity School of Medicine's accreditation is also approved by the Foundation for Advancement of International Medical Education and Research (FAIMER) and lists Trinity in its International Medical Education Directory (IMED).

TERM

Trinity operates on a semester hour calendar with full fall, spring, and summer semesters. Trinity offers a Doctor of Medicine (M.D.) program.

RELEASE OF INFORMATION

Official transcripts are released only with written request and consent of the student and will be released only to the party identified in the request for release.

INTERPRETATION

Questions regarding the interpretation of the Trinity School of Medicine transcript may be directed to the Office of the Registrar at Registrar.info@trinityschoolofmedicine.org.

PREMEDICAL GRADING SCALES

Undergraduate Pre-Medical Program Grades
Grading Scale prior to Summer Semester 2010

Grade	Description	Quality Points
A	Excellent	4.00
B	Good	3.00
C	Satisfactory	2.00
D	Poor	1.00
F	Fail	0
S	Satisfactory	None
U	Unsatisfactory	None
AU	Audit	None
I	Incomplete	0.0
WF	Withdrawal (Official)	None
NG	No Grade Reported	None

Undergraduate Pre-Medical Program Grades
Grading Scale effective Summer Semester 2010

Grade	Description	Quality Points
A (Honors)	96% and better	4.00
A	90% - 95%	4.00
B+	86% - 89%	3.50
B	80% - 85%	3.00
C+	76% - 79%	2.50
C	70% - 75%	2.00
F	Less than 70%	0.00
P	70% - 100%	4.00
I	Incomplete	n/a
W	Withdrawn from course	n/a

MEDICAL PROGRAM GRADING SCALE

Doctor of Medicine (M.D.) Degree Program Grades
Grading Scale prior to Summer Semester 2009

Grade	Description	Quality Points
A	90 - 100	4.00
B	80 - 89	3.00
C	Minimum Passing Score (70 – 79)	2.00
P	Pass on a Pass/Fail Course	0.00
F	Below Minimum Passing Score	0.00
W	Withdraw before Unified Examinations	0.00
WP	Withdraw Passing	0.00
WF	Withdraw Failing	0.00
I	Incomplete	0.00
SP	In Progress- Satisfactory Progress	0.00
UP	In Progress - Unsatisfactory Progress	0.00

Doctor of Medicine (M.D.) Degree Program Grades
Grading Scale effective Summer Semester 2009

Grade	Description	Quality Points
A (Honors)	96% and better	4.00
A	90% - 95%	4.00
B+	86% - 89%	3.50
B	80% - 85%	3.00
C+	76% - 79%	2.50
C	70% - 75%	2.00
F	Less than 70%	0.00
P	70% - 100%	4.00
I	Incomplete	n/a
W	Withdrawn from course	n/a

TRANSCRIPT

The official transcript is prepared by the Office of the Registrar and is a complete depiction of the permanent academic record.

COURSEWORK ON TRANSCRIPT

It is the policy of Trinity School of Medicine to exclusively include all grades approved by the Academic Progress Committee in the student's academic record and official transcript.

TRANSFER CREDIT

Transfer credit is awarded based on Trinity's transfer policies and may be counted toward graduation requirements, but grades earned in transfer are not used in calculating the grade point average. The transfer credits shown represent only those courses accepted for transfer.

TRANSCRIPTS ISSUED TO STUDENTS

Transcripts issued to students will display "ISSUED TO STUDENT" on the transcript

Trinity School of Medicine

In consideration of the satisfactory completion of all requirements prescribed by the faculty and by the authority vested in them by the Trustees of the Trinity School of Medicine hereby confer upon

Christopher Romano DeNapoles

the degree of

Doctor of Medicine

Affixed by medical school on:
23 May 2013

together with all the rights, privileges and responsibilities appertaining thereto.
In testimony whereof, the institutional seal and the signatures of the Chancellor and Dean hereunto affixed.
St. Vincent and the Grenadines, West Indies, in the year Two Thousand and Thirteen.

April 30, 2013

W. Douglas Skelton, M.D.
Dean

Steve R Wilson
Chancellor

SEAL VERIFIED

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

fsmb

Verification of Postgraduate Medical Education

Accreditation Code: 1200811078

Institution Name: Stamford Hospital/Columbia University College of Physicians and Surgeons Program

Affiliated University:

City: Stamford **State:** Connecticut **Country:** United States

Verification For: Christopher Romano Denapoles

Program Participation:

PGY: 1	Accredited By: ACGME	Status: Complete
Specialty: Family Medicine		
From: 07/01/2014	To: 06/30/2015	Program Type: Internship/Residency
PGY: 2	Accredited By: ACGME	Status: Complete
Specialty: Family Medicine		
From: 07/01/2015	To: 06/30/2016	Program Type: Internship/Residency
PGY: 3	Accredited By: ACGME	Status: Complete
Specialty: Family Medicine		
From: 07/01/2016	To: 06/30/2017	Program Type: Internship/Residency
PGY:	Accredited By:	Status:
Specialty:		
From:	To:	Program Type: Internship/Residency
PGY:	Accredited By:	Status:
Specialty:		
From:	To:	Program Type:
PGY:	Accredited By:	Status:
Specialty:		
From:	To:	Program Type:

FID: 217679034

JUL 2 0 2019

PGY:	Accredited By:	Status:
Specialty:		
From:	To:	Program Type:

To report additional training, include training as an attachment at the end of page 2.

Unusual Circumstances

1. Did this individual ever take a leave of absence from his/her training?	Yes	No x	Not Available
2. Was this individual ever placed on probation?	Yes	No x	Not Available
3. Was this individual ever disciplined or placed under investigation?	Yes	No x	Not Available
4. Were any negative reports for behavioral reasons ever filed by instructors?	Yes	No x	Not Available
5. Were any limitations or special requirements placed upon this individual because of academic incompetence, disciplinary problems, or any other reason?	Yes	No x	Not Available

Attestation of Person completing Verification of Postgraduate Training document (Program Director): I hereby attest that the information contained herein accurately reflects the training records of the above-named physician.

ELECTRONIC SEAL VERIFIED	Name: Henry Yoon, MD Title: Program Director Degree: MD Signature: DocuSigned by: [signature] Date of Signature: 1/29/2019

Would you like to upload an additional attachment(e.g. Rotation Schedule)? Yes No x
If reporting additional years in the attachment, include PGY year, specialty, start date, end date, status and program type.

FID: 217679034

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Applicant Reported Unusual Circumstances

fsmb

Graduate Medical Education

Medical Professional Name:	Denapoles, Christopher Romano
Accreditation ID:	1200811078
Institution:	Stamford Hospital/Columbia University College of Physicians and Surgeons Program
Specialty:	Family Medicine

Unusual Circumstances

Training Period: 6/25/2014 - 6/30/2017 **Internship/Residency**

Did you have any interruption(s) or extension(s) in your medical education?	**No**
Were you ever placed on probation?	**No**
Were you ever disciplined or placed under investigation?	**No**
Were any negative reports for behavioral reasons ever filed by instructors?	**No**
Were any limitations or special requirements imposed on you because of academic performance, incompetence, disciplinary problems or for any other reason?	**No**

End of Applicant Reported Unusual Circumstances report for: Denapoles, Christopher Romano

400 FULLER WISER ROAD | EULESS, TX 76039 | TEL (817) 868 - 5000 | FAX (817) 868 - 5099

Stamford Hospital

Columbia University College of Physicians & Surgeons

This certifies that

Christopher Romano DeMapoles, M.D.

has faithfully served on the Resident Staff of this Hospital

as

Chief Resident in Family Medicine

July 1, 2016 - June 30, 2017

Program Director

Joseph Connelly, M.D.
Department Chair

President and CEO

Chair, Medical Staff

PDC PHYSICIAN DATA CENTER

fsmb

PRACTITIONER PROFILE

Prepared for: Arkansas State Medical Board As of Date:7/11/2019

PRACTITIONER INFORMATION

Name:	Denapoles, Christopher Romano
DOB:	1/2/1986
Medical School:	Trinity School of Medicine Kingstown, Saint George, SAINT VINCENT AND THE GRENADINES
Year of Grad:	2013
Degree Type:	MD
NPI:	1578973715

BOARD ACTIONS

To date, there have been no actions reported to the FSMB

LICENSE HISTORY

Jurisdiction	License Number	Issue Date	Expiration Date	Last Updated
ALABAMA	00038134	04/04/2019	12/31/2019	06/25/2019
CONNECTICUT	055624	08/15/2016	01/31/2018	06/25/2019
FLORIDA	ME132255	04/26/2017	01/31/2021	06/17/2019
OHIO	APP-000272079			07/05/2019
OKLAHOMA	34683	04/12/2019	04/01/2020	07/05/2019

400 FULLER WISER ROAD EULESS, TX 76039 | TEL(817)868 4000 | FAX (817)868 4099

License Details - MD/DO/L

Alabama State Board of Medical Examiners

848 Washington Avenue
Montgomery, AL 36104

Personal Information

Licensee name:	Christopher Romano DeNapoles
Location:	Atmore, Alabama

License Information

License type:	MD
License status:	Active
COQ status:	
License number:	MD.38134
License description:	Full Unrestricted MD
Issue date:	04/04/2019
Expiration date:	12/31/2019
Practice Type	Family Medicine
School Name:	Trinity School of Medicine
School Dates:	09/09-04/13
School Location:	Kingstown West Indies
Public file:	No

Alabama Controlled Substances Certificate

Status:

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JUL 11 2019

License number:

Issue date:

Expiration date:

Schedules:

Description:

Restricted Comments:

Dispensing physician:

Collaborative Practice Agreement

Name	Number	Hours	Status
Crystal Genika Nwagwu		10	CP - Fee Received

Registration Agreement Information

No Registration Agreements found.

Printed from http://www.albme.org (http://www.albme.org /) Present Date 07/11/2019

* Please note that the Alabama Board of Medical Examiners and the Alabama Medical Licensure Commission have no authority over Nurse Practitioners or Midwives. For more information on these licenses, please visit the Alabama Board of Nursing, www.abn.alabama.gov

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JUL 11 2019

LICENSE LOOKUP: Search for License, Permit, Certification or Registration

	Name	Credential	Credential Description	State Agency Contact	Status
Detail	CHRISTOPHER DENAPOLES	1.055624	Physician/Surgeon	Department of Public Health	INACTI
Detail	CHRISTOPHER DENAPOLES	CSP.0059549	CONTROLLED SUBSTANCE REGISTRATION FOR PRACTITIONER	Department of Consumer Protection	LAPSE

Search Criteria

All data within License Lookup is maintained by the State of Connecticut, updated instantly, and considered a primary source of verification.

License Type:

Acupuncturist
Advanced Emergency Medical Technician
Advanced Practice Registered Nurse
Ambulatory Surgical Center
Animal Importer

License Number:

License Status:

Business Name/DBA:

First Name:

CHRISTOPHER

Last Name:

DENAPOLES

Address:

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JUL 11 2019

Florida HEALTH Department of Health

CHRISTOPHER DENAPOLES

License Number: ME132255

Data As Of 7/11/2019

Profession	Medical Doctor
License	ME132255
License Status	CLEAR/ACTIVE
License Expiration Date	1/31/2021
License Original Issue Date	04/26/2017
Address of Record	2360 US Highway 29 CANTONMENT, FL 32533 UNITED STATES
Controlled Substance Prescriber (for the Treatment of Chronic Non-malignant Pain)	No
Discipline on File	No
Public Complaint	No

The information on this page is a secure, primary source for license verification provided by the Florida Department of Health, Division of Medical Quality Assurance. This website is maintained by Division staff and is updated immediately upon a change to our licensing and enforcement database.

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JUL 11 2019

Oklahoma Board of Medical Licensure and Supervision

Search Results

Last Update: Thursday, July 11, 2019 1:13 PM CDT

DENAPOLES, CHRISTOPHER ROMANO

Practice Address:	WEST FLORIDA HOSPITAL 2360 S HWY 29 CANTONMENT FL 32533 Address last updated on 3/11/2019	**Status:**	Active
		Status Class:	Fully Licensed
		Restricted to:	
Phone #:	(203) 667-4773	**Registered to Dispense:**	NO
Fax #:		**Medical School:**	Trinity School of Medicine
County:	NOT OKLAHOMA	**Graduated:**	6 / 2013
License:	34683	**CME Year:**	2022
Dated:	4/12/2019		
Expires:	4/1/2020		
License Type:	Medical Doctor		
Specialty:	Family Medicine Urgent Care Medicine Aerospace Medicine		

Disciplinary History: No Disciplinary Action Taken.

All information below is entered by the licensee but not verified by the Oklahoma Medical Board.

Certifications:	AMERICAN BOARD OF FAMILY MEDICINE	**Locations:**	**Hours:**	**Languages:**
New Patients:	Contact licensee	WEST FLORIDA HOSPITAL 2360 S HWY 29 CANTONMENT FL 32533 Phone #: (203) 667-4773 Fax #:		
Medicaid:	Contact licensee			
Medicare:	Contact licensee			
HMO/PPO:	None listed			
Hospital Privileges:	None listed			

ENTERED
JUL 11 2019

GW

HCA

August 22, 2019

Diane Johnson
Arkansas State Medical Board
1401 West Capitol, Suite 340
Little Rock, AR 72201

RE: **Christopher DeNapoles, MD**

This letter acknowledges receipt of your request for verification of the above Practitioner's affiliation with the below entity(ies). The information about the Practitioner is current as of the last Board meeting:

Entity	Specialty	Category	Last Board Meeting Date[3]	Status[1,2]	Original Appt. Date	Appt. End Date
West Florida Hospital	Family Medicine	Ambulatory	12/11/2018	Good Standing	11/14/2017	11/12/2020

NOTES:

[1]If "Good Standing" is referenced in the status field:

- **prior to July 11, 2019**, "Good standing" means that no professional review action as defined in the Health Care Quality Improvement Act (HCQIA) has been taken regarding this practitioner.
- **after July 11, 2019**, "Good standing" means that none of the following events or circumstances has occurred with the Practitioner after that date and during the most recent five (5) years the Practitioner was on the Medical Staff, whichever is the lesser of the two time periods:
  - automatic relinquishment or resignation of appointment or clinical privileges for any reason set forth in the Medical Staff Bylaws and Policies (other than those related to medical record incompletion/delinquency);
  - voluntary agreement to modify clinical privileges or to refrain from exercising some or all clinical privileges for a period of time for reasons related to the Practitioner's qualifications or performance;
  - voluntary agreement to participate in a Performance Improvement Plan;
  - resignation of appointment or clinical privileges while clinical care, professional conduct, or health status was being reviewed;
  - resignation of appointment or clinical privileges while under an investigation in accordance with the Medical Staff Credentials Policy, or in exchange for not conducting an investigation;
  - precautionary suspension of the Practitioner's clinical privileges;
  - formal investigation in accordance with the Medical Staff Credentials Policy;
  - a grant of conditional membership or privileges (either at initial appointment or reappointment), or conditional continued membership;
  - any recommendation that entitled the Practitioner to hearing and appeal rights outlined in the Medical Staff Credentials Policy; and/or
  - a Health Issue that was addressed under the Practitioner Health Policy.

[2]If "Contact MSO" is referenced in the "Status" field, other fields are intentionally left blank. Please contact the Entity MSO for information.

[3]Information is current as of the last date on which the entity Board met to consider credentialing issues.

It is our understanding and expectation that you will maintain this information in a strictly confidential manner, consistent with its protected and privileged status. Thank you.

West Florida Hospital
8383 North Davis Highway

ENTERED
AUG 22 2019

Pensacola, FL 32514-6050
P: (850)494-4705 **Ext:** 4112
F: (850)494-3595

ECFMG®
EDUCATIONAL COMMISSION FOR FOREIGN MEDICAL GRADUATES

3624 Market Street
Philadelphia, PA 19104-2685 USA
215-386-5900 | 215-386-9767 FAX
www.ecfmg.org

Issue Date: 11 Jun 2019

To: ARKANSAS STATE MEDICAL BOARD
KRYSTAL MCCOY
APPLICATION COORDINATOR
1401 WEST CAPITOL
SUITE 340
LITTLE ROCK, AR 72201

State Board Code:
004
Please include this number on all requests.

ECFMG® CERTIFICATION STATUS REPORT

USMLE®/ECFMG Identification Number: 0-824-016-0
Applicant's Name: Christopher R. Denapoles

ECFMG Certified: Yes
Certificate Issue Date: 11 Jun 2013
English Test Valid Through: Valid Indefinitely
Clinical Skills Assessment Valid Through: Valid Indefinitely

Passing Performance on Medical Science Examinations:

Examination	Date	Two Digit Score	Three Digit Score
USMLE Step 1	21 Sep 2011	*	*
USMLE Step 2 CK	02 Oct 2012	*	*

Most Recent Passing Performance on Clinical Skills Examination:

Examination	Date
USMLE Step 2 CS	14 Aug 2012

Name of Medical School and Country: Trinity School of Medicine, Kingstown, SAINT VINCENT AND THE GRENADINES
Degree Year: 2013
Medical Education Credentials Status†: Complete

How to Verify the Authenticity of this Report:

This report was issued to the named recipient on the date shown above. To verify the authenticity of this report, visit https://cvsonline2.ecfmg.org/verify/verify.asp and enter the unique verification code listed below. The information contained in this report is current as of the issue date. Any changes to the physician's status after the issue date will not be reflected, and you are encouraged to request an updated report.

Report Verification Code: 9GO9YQ0R20

The purpose of this Status Report is to indicate whether this individual is certified by ECFMG. It reflects only examinations that were used to fulfill requirements for ECFMG Certification. The most recent passing performance on the clinical skills examination is reflected, regardless of whether this individual was required to take a clinical skills examination for ECFMG Certification. This Status Report is not a complete score history of all examinations for this individual. This Status Report does not include examinations that were taken but not passed. Furthermore, if this individual passed examinations that were not used to fulfill the requirements for ECFMG Certification, these examinations are not included.

* To obtain a complete USMLE examination history for this individual, contact the appropriate registration entity to request a USMLE transcript.

†Since July 1986, ECFMG has verified medical school credentials directly with the issuing medical schools, or through a reasonable alternative that has been approved by the ECFMG Medical Education Credentials Committee.

Important Note:

Requesting organizations must normally secure and retain the physician's signed authorization to obtain certification information. Organizations may not resell the information or make it available to any party beyond the initial request as authorized by the physician. The information may only be used to confirm ECFMG Certification for the purpose for which the physician provided authorization.

ARKANSAS STATE MEDICAL BOARD

LICENSURE DEPARTMENT
1401 W. Capitol Ave., Suite 340, Little Rock, AR 72201
Phone (501) 296-1802 Fax (501) 296-1972 www.armedicalboard.org
Emails with attachments must be sent in PDF format to support@armedicalboard.org

ARKANSAS MEDICAL PRACTICES ACT and RULES AND REGULATIONS AFFIDAVIT

I AFFIRM THAT I HAVE READ THE ARKANSAS MEDICAL PRACTICES ACT, ARKANSAS CODE ANNOTATED SECTION 17-95-101, et. seq., AND THE RULES AND REGULATIONS OF THE ARKANSAS STATE MEDICAL BOARD.

Christopher R. DeNapoles MD
Physician's Full Name (First Middle Last, Suffix, Degree)

Physician's Signature (no rubber stamps)

6/26/19
Signature Date

THIS IS A REQUIREMENT FOR LICENSURE.
YOUR LICENSURE APPLICATION WILL NOT BE PROCESSED WITHOUT THIS COMPLETED FORM.

2019 JUL 11 AM 10:50

ENTERED
JUL 11 2019

ARKANSAS STATE MEDICAL BOARD

& CENTRALIZED CREDENTIALS VERIFICATION SERVICE
1401 W. Capitol Ave., Suite 340, Little Rock, AR 72201
Phone (501) 296-1802 Fax (501) 296-1972 www.armedicalboard.org
Emails with attachments must be sent in PDF format to support@armedicalboard.org

AUTHORIZATION AND RELEASE

To Whom It May Concern:

This document will authorize and direct any physicians with whom I have been associated; employees and medical staff members of any medical facility or hospital where I have been employed, on staff, or associated; any employees of any malpractice insurance carriers; any state medical licensing boards where I have been licensed or have applied for a license; any medical clinics where I have been employed or associated; and any medical schools where I have attended, to give to, copy for, or permit the personal inspection by employees or representatives of the Arkansas State Medical Board of any and all personnel records, disciplinary records, work records, military records, professional performance reviews, and/or evaluations of my performances.

I hereby release and discharge you and any other individuals or organizations referred to in this Authorization, and release you of any confidentiality requirements that might bind you, so that you may carry out the purposes of this document.

A copy of this document* may be provided to entities listed above, and this Authorization shall remain in effect for a period not to exceed two (2) years or until specifically revoked by me in writing.

Typed or Printed Name of Physician: Christopher DeNapoles

Social Security Number _____

Signature of Physician: _____
Dark Blue or Black Ink Only - No Signature Stamps

Signature Date: 6/26/19

**** This document does not authorize the Arkansas State Medical Board to release information collected to third parties except as later authorized by the above physician and Arkansas State Law.***

RECEIVED
JUL 11 2019

2019 JUL 11 AM 10:50

Denapoles, Christopher Romano, M.D. - Misc - Misc Activities - Time Gap, 05/01/2013 - 06/30/2014

Aug 25 2019 8:26PM
Christopher Romano Denapoles, M.D.: From 5/1/2013 to 6/30/14 my plan was to complete my masters in health care administration at UMD. I enrolled and started classes but was not able to complete my studies due to a family matter that required my in person attention for several months at home. During this time period I was able to complete my USMLE STEP 3. Since that time I have completed my family medicine residency, completed my boards and have been practicing as a physician for the past 2 years.

Aug 21 2019 2:43AM
System Administrator: THIS IS AN AUTOMATED MESSAGE:

Your response is still needed. This record will be closed upon receipt of your response.

Aug 13 2019 1:58PM
Gracia Wallace: Please provide an explanation of time gap - You must list the dates exactly as listed above. (If you were moving, on vacation, etc., that is all you will need to state.) These dates are established based on the received verifications and chronology of activities as listed on your application. This record will be closed upon receipt of your response.

Christopher R. DeNapoles, MD

Professional Experience:

United States Air Force Reserve, Captain: Physician, Flight Surgeon — 2014-Present

- Stationed at Eglin AFB, 919th Medical Squadron.
- General responsibilities include physical exams, flight clearance of USAF flying personnel, continued training in Flight and Aeronautic Medicine.
- Area of focus is Occupational Medicine for all Air Force personnel.

West Florida Primary Care: Physician. — 2017-Present

- Immediate care physician treating a wide scope of medical problems and patient populations.
- General responsibilities include managing whatever walks through the door. (avg. 35-45 pt. load daily)
- Competent with a wide variety of procedures, test analysis, first read imaging, emergent medical conditions and managing chronic medical issues.

Olive Branch Nursing and Rehab: Medical Director, Physician. — 2018-Present

- Responsible for care and management of geriatric patients in acute rehab setting.
- General responsibilities include direct patient care, medical oversight of other physicians and providers.
- Experience with formulating and implementation of policy and procedures for infection control, fall risks, cardiac assessment, rehabilitation, dietary assessments, home plans for chronic disease management.

Medical Case Reviewer / Insurance Peer Review Consultant — 2018-Present

- 3rd party review of office-based and hospital procedures, imaging and referrals for multiple insurance companies.
- Ensure compliance with medical necessity and standards of care.
- Peer review to ensure evidence based practice and compliance with treatment standards.

Collaborating Physician — 2018- Present

- Provide in person and remote medical oversight for family nurse practitioners.
- Organize continuing education geared toward family ARNPs.
- Chart reviews to ensure appropriate medical practice and meeting standards of care.

Licensure and Certifications:

EMR Experience:	eClinical Works, Meditech, Epic
Life Support:	ACLS, BLS
Board Exams:	USMLE: Step 1,2,3. ABFM Certified through 2027
Medical Licensing:	Alabama, Connecticut, Florida, Oklahoma

Professional Memberships:

American Academy of Family Physicians — 2013-Present

ENTERED ✓
GW
JUL 16 2019

Research and Publications:

Manchineel Dermatitis in North American Students in the Caribbean
Journal of Travel Medicine, Volume 18, Issue 6, November 2011, pp.422-424

Burden Of Cardiac And Peripheral Vascular Disease And Hypertension Study in The Tropical Island Of St. Vincent.
Advanced Endovascular and Coronary Intervention Global Summit; Orlando, FL.

Residency

6/2014-6/2017

Stamford Hospital / Columbia University, Stamford, CT. Family Medicine with Obstetrics
Chief Resident
In-Hospital coverage includes 3 months ICU, 10 months Inpatient Service, 3 months Night Float, Pediatrics, Obstetrics and ER.

Medical School

9/2009-5/2013

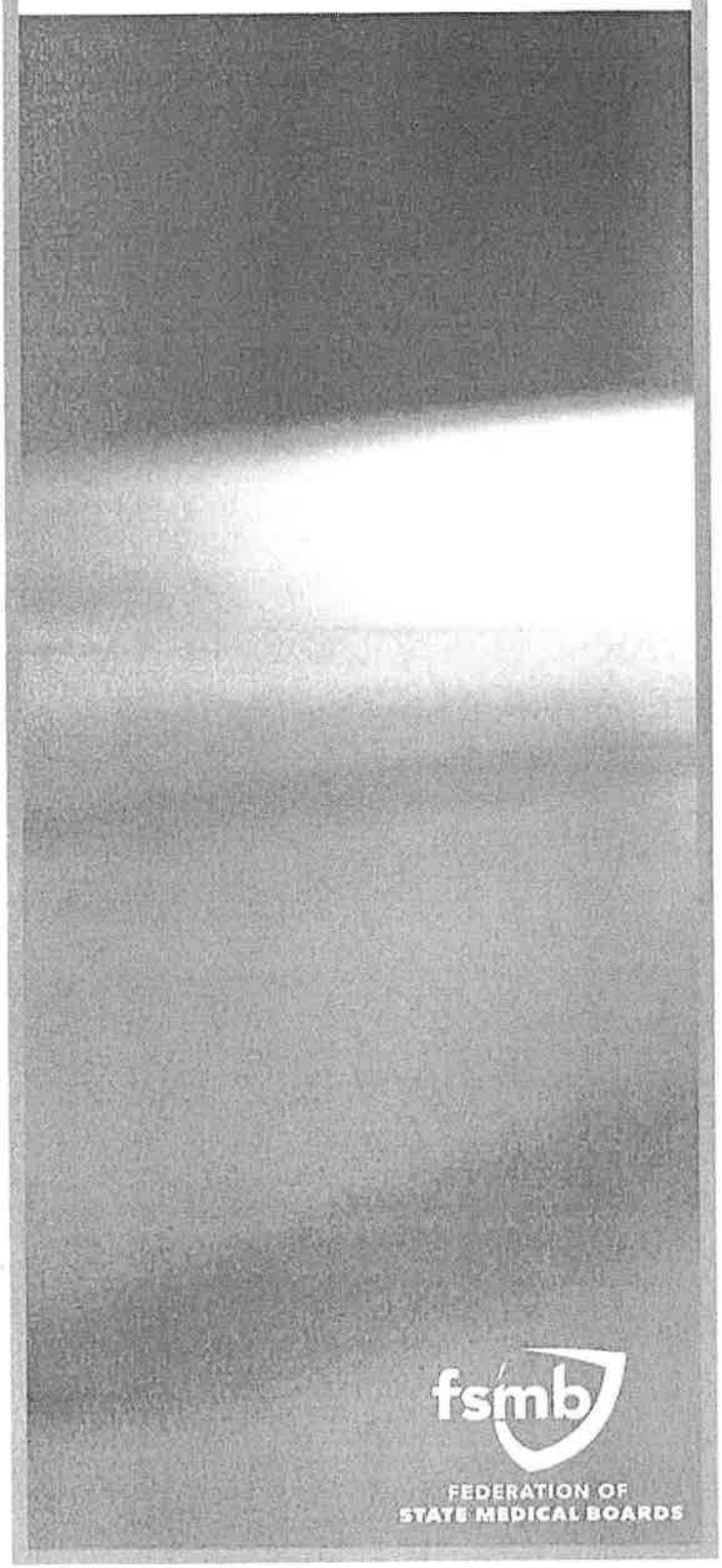
Trinity School of Medicine, St. Vincent and the Grenadines
Doctor of Medicine, Cum Laude
Student Government - President
Society of Surgery and Medicine - Co-founder and Public Relations Officer
Student Government - Treasurer

Undergraduate Studies

9/2004-5/2008

Arizona State University
Bachelors of Science, Kinesiology, Cum Laude
Minor degrees in Business, Nutrition, Psychology
Inter Fraternity Council - President
Phi Kappa Psi Fraternity - President

FCVS | FEDERATION CREDENTIALS VERIFICATION SERVICE



2019 JUN 12 AM 9:

Medical Professional Information Profile

This report provides credentialing information for:

Name:	**Denapoles, Christopher Romano**
FID#:	**217679034**
Recipient:	**AR - Arkansas State Medical Board**
Delivery Date:	**06/11/2019**

ABOUT THIS PROFILE

The Federation Credentials Verification Service (FCVS) was retained by the above referenced medical professional to verify his/her medical credentials for submission to your agency/organization. Unless noted otherwise, all documents contained in this report were received directly from the issuing institution por written request made by FCVS.

NOTICE: All documents bearing an original Official FCVS seal are certified to be an exact reproduction of the original. Where required, original documents are provided according to the agreements with the institution issuing such document. FCVS maintains all original documents (excluding third-party examination transcripts) in the physician's source file.

FCVS | FEDERATION CREDENTIALS VERIFICATION SERVICE

Affidavit and Release

Federation of STATE MEDICAL BOARDS

I, the undersigned, hereby certify under oath that I am the person named in this application, that all statements I have or shall make with respect thereto are true, that I am the original and lawful possessor and person named in the various forms and credentials furnished or to be furnished with respect to my application and that all documents, forms or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

I acknowledge that I have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to me being prosecuted under appropriate federal and state laws.

I authorize and request every person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me to furnish to the Federation Credentials Verification Service any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data and to permit the Federation Credentials Verification Service or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application.

Notary:
Your seal (or stamp) must be partly upon the photo and partly upon the signature of the applicant.

I hereby release, discharge and exonerate the Federation Credentials Verification Service, its agents or representatives and any person furnishing information, of any and all liability of every nature and kind arising out of investigation made by the Federation Credentials Verification Service. I authorize the Federation Credentials Verification Service to release information, material, documents, orders or the like relating to me or this application to any entity at my request.

Christopher DeNapoles
Applicant's Signature (must be signed in the presence of a notary)

DeNapoles
Applicant's Printed Last Name

Christopher, R
Applicant's Printed First Name, Middle Initial, and Suffix (e.g., Jr.)

3/18/2017
Date of Signature (must correspond to date of notarization)

TONI JOSETTE WRIGHT
ELECTRONIC
NOTARY
PUBLIC
REG # 7636128
EXPIRES
6/30/2020
COMMONWEALTH OF VIRGINIA

State of Virginia, County of James City

I certify that on the date set forth below the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document. The statements on this document are subscribed and sworn to before me by the applicant on this 18 day of March, 20 17.

Notary Public Signature: Toni Josette Wright

My Notary Commission Expires: 06/30/2020

Please complete and mail this original document to the Federation of State Medical Boards at:

400 FULLER WISER ROAD | SUITE 300 | EULESS, TX 76039 | TEL(817)868-5000

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Identity

Biographic Information

Medical professional Name(s): **Denapoles, Christopher Romano**

D

Place of Birth: Stamford, CT, UNITED STATES

Contact Information

Home Address: 341 S Garcon Point Rd
Milton, FL 32583
UNITED STATES

Mobile Phone: (203) 667-4773

Email: crdenapoles@gmail.com

Credentials Analysis Information for Identity

There is no Omission/Discrepancy/Miscellaneous information identified.

CERTIFICATION OF IDENTIFICATION

Certification by Notary Public Is Required

Applicant Full Legal Name: DeNapoles (Last) Christopher (First) Romano (Middle)

FCVS ID Number: 217679034

Notary – Please complete the section below:

State of Virginia County of James City

I certify that on the date set forth below, the individual named above, did appear personally before me and presented one of the following forms of identification as proof of his/her identity (Birth Certificate or Passport). I further certify that I did identify this applicant by comparing his/her physical appearance with the photograph on a Government issued photo identification presented by the applicant.

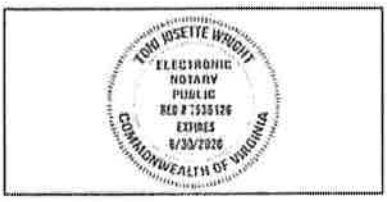
The statements on this document are subscribed and sworn to before me by the applicant on this (Day) 18, of (Month) March, (Year) 2017.

Notary Public Signature: Toni Josette Wright

Commission Expiration Date* (Month) 06 /(Day) 30 /(Year) 2020

*** The notary's commission expiration date must be current and legible. If no expiration date, such as 'lifetime', an explanation must be provided.**

Notary Stamp Here



Please complete and mail this original document and a photocopy of the birth certificate or passport presented to the Notary to:

Federation of State Medical Boards
ATTN: FCVS
400 Fuller Wiser Rd., Suite 300
Euless, TX 76039-3856

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Chronology of Activities

The Chronology of Activities is a comprehensive report of a medical professional's activities as reported to FCVS in the medical professional application.

Start Date	End Date	Activity Type	Location
09/01/2009	06/30/2013	Medical Education	Trinity School of Medicine Kingstown Saint George SAINT VINCENT AND THE GRENADINES
07/01/2013	05/01/2014	PGT/Education	Masters Degree, Healthcare Administration College Park Maryland UNITED STATES
06/25/2014	06/30/2017	Postgraduate Training	Stamford Hospital/Columbia University College of Physicians and Surgeons Program Stamford Connecticut UNITED STATES
08/01/2014		Work	US Air Force Reserve Duke Field Eglin AFB, Florida UNITED STATES
09/01/2017		Work	West Florida Hospital 2360 S Hwy 29 Cantonment, Florida UNITED STATES
10/01/2018		Work	Olive Branch Nursing Facility 8325 University PWY Pensacola, Florida UNITED STATES

End of Chronology of Activities report for: Denapoles, Christopher Romano

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Medical Education

fsmb

Medical Education

Medical School: **Trinity School of Medicine**

Location: Kingstown, 04

SAINT VINCENT AND THE GRENADINES

Credentials Analysis Information for Medical Education

There is no Omission/Discrepancy/Miscellaneous information identified.

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Postgraduate Training

fsmb

Postgraduate Training

Accreditation ID: 1200811078

Institution: **Stamford Hospital/Columbia University College of Physicians and Surgeons Program**

Location: Stamford, CT
UNITED STATES

Credentials Analysis Information for Postgraduate Training

There is no Omission/Discrepancy/Miscellaneous information identified.

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Licensure / Examinations

fsmb

Licensure / Examinations

Exam: USMLE

Credential Analysis Information for Licensure / Examinations

There is no Omission/Discrepancy/Miscellaneous information identified.

PDC PHYSICIAN DATA CENTER

fsmb

PRACTITIONER PROFILE

Prepared for: FCVS As of Date:6/11/2019

PRACTITIONER INFORMATION

Name:	Denapoles, Christopher Romano
Medical School:	Trinity School of Medicine Kingstown, Saint George, SAINT VINCENT AND THE GRENADINES
Year of Grad:	2013
Degree Type:	MD
NPI:	1578973715

BOARD ACTIONS

To date, there have been no actions reported to the FSMB

LICENSE HISTORY

Jurisdiction	License Number	Issue Date	Expiration Date	Last Updated
ALABAMA	00038134	04/04/2019	12/31/2019	05/29/2019
CONNECTICUT	055624	08/15/2016	01/31/2018	05/29/2019
FLORIDA	ME132255	04/26/2017	01/31/2021	05/15/2019
OKLAHOMA	34683	04/12/2019	04/01/2020	06/07/2019

PDC PHYSICIAN DATA CENTER

fsmb

PRACTITIONER PROFILE

Prepared for: FCVS As of Date:6/11/2019

Practitioner Name: Denapoles, Christopher Romano

ABMS® CERTIFICATION HISTORY

Certifying Board: American Board of Family Medicine
Certificate: Family Medicine
Certification Type: General
Certification Status: Certified
Participating in MOC: Yes

Status	Duration	Effective Date	Expiration Date	Reverification Date	Occurrence	Last Reported
Active	MOC	07/01/2017		02/15/2020	Initial	05/30/2019

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AOA® CERTIFICATION HISTORY

No AOA Certifications found.